SUSPENDING OUR AGENDA: CONSIDERING WHAT WILL SERVE WHEN CONFRONTING ETHICAL CHALLENGES

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Tom Franklin was admitted to the surgical intensive care unit (ICU) 8 weeks ago after resection of necrotic bowel due to superior mesenteric artery occlusion. On postoperative day 3 he suffered a cardiac arrest and was resuscitated. Mr Franklin’s course since then has been complicated by acute respiratory distress syndrome, stroke, renal failure, and multiple episodes of septic shock. He has a sacral decubitus requiring twice-daily dressing changes, during which he grimaces while his blood pressure and oxygen saturation drop. His decision-making capacity has been intermittent. Throughout Mr Franklin’s surgical ICU stay, his care team addressed each acute event and complication with additional treatment interventions. His wife, Mrs Franklin, has power of attorney for health care and has come to view these treatments, including cardiopulmonary resuscitation, as necessary for her husband’s survival. The clinical team is concerned that they are participating in a course that is incrementally adding burden with unclear benefit. Lisa Waller is the attending physician in the surgical ICU this week. She cared for Mr Franklin last month and now wants to have another family meeting to discuss resuscitation preferences and goals of care. She is certain that she can convince the family to shift the focus from aggressive treatment to a palliative approach and to agree to a do not resuscitate (DNR) order. The critical care nurse caring for Mr Franklin states, “I’m not sure what good it will do; we’ve had this conversation many times and it always turns out the same.” Despite Dr Waller’s efforts to redirect the conversation, she is unsuccessful in convincing Mrs Franklin to shift the goals for her husband’s treatment. The team leaves the meeting expressing despair that nothing seems to get through to Mrs Franklin—that she is in denial. As a last resort, they request an ethics consult with the goal “to get the DNR order.”

Scenarios such as this are common in critical care and can provoke anger, frustration, and, in some cases, moral distress. A common refrain begins to emerge as we lament our helplessness during rounds and handoffs and in reports. Patients or their surrogates begin to withdraw, become angry, or...
intensify their resistance to the team’s recommendations. The team’s ongoing insistence about limiting treatments such as resuscitation is commonly interpreted by the family as a lack of commitment or engagement in their loved one’s care. Often trust is broken on both sides of the equation, and this can create the conditions for communication failures, deepening conflict, and lack of understanding. The result is a widening gap between patient goals and clinician recommendations in addition to stalled progress in providing integrity-preserving care.

What Are the Patterns We See in Our ICUs?

The repetition of these scenarios creates patterns of communication, decision-making, collaboration, and conflict resolution within the critical care team as well as individual patterns of responses including emotions, narratives that are created to explain the situation, and activation of fears, among other responses. These systemic patterns, fueled by internal and external financial pressures, regulations, legal concerns, and organizational priorities, create context for both our individual and team responses. Systemic pressures to increase throughput and efficiency make it difficult for us, as critical care clinicians, to fulfill our ethical obligations to provide person-centered care and to be responsible stewards of our own integrity and well-being. We find it difficult to get to know our patients because of these constraints and therefore repeatedly lapse into monotonous or robotic patterns that are not beneficial and may cause harm to our patients, their families, or ourselves. For instance, the medical futility rationale for establishing a DNR order is more likely to be invoked for patients who are older, admitted from a skilled nursing facility, or being cared for in a medical ICU. Surfacing these assumptions requires attention that may be in short supply as a result of external and internal constraints. As critical care clinicians, we believe that ethical conflict and moral suffering are nonnegotiable “parts of the job,” which leads to feelings of powerlessness, victimization, and resignation. This belief is reinforced when repeated attempts to address the issues do not yield what we perceive to be satisfactory results. We routinely overlook the daily examples of integrity-preserving decisions, respectful communication, and compassionate action in both our team members and ourselves. In so doing, we fail to appreciate our contributions and take for granted the effort, wisdom, and skill that manifest daily in clinical practice. Our organizations count on us to go “above and beyond” to ensure that patient care is delivered safely and respectfully without meaningfully acknowledging our routine, and at times extraordinary, contributions. When moral sensitivity and conscience engagement are eroded, it is more likely that clinicians will adopt a we/they reaction that fosters blaming each other, patients or their surrogates, and the health care system for the conditions in which we practice. At the core of our health care organizations are the processes, structures, and designs that can either foster or erode clinician integrity or well-being. When work environments are unhealthy, ethical practice can be impeded, which leads to increasing distress that has been described as “death by a thousand cuts.”

Systems that compound the dissonance between professional and organizational values and the actions taken on behalf of patients add to further erosion in relationships and a we/they mentality. One alternative is for stakeholders to identify and align shared values, which can produce results that shift detrimental patterns. This requires all stakeholders to take responsibility for both the process and the results ultimately produced. This is not to suggest that clinicians are solely responsible for addressing the situations that create moral suffering and distress but rather that processes and tools that restore integrity, meaning, and well-being are simultaneously needed.

Shifting Patterns to Produce Different Outcomes

These recalcitrant clinical encounters accumulate and deplete us because they require expenditure of enormous amounts of energy to fight what is in front of us. Despite our best efforts, we cannot:

- always relieve suffering, restore wholeness and function, or cure our patient’s illness
- make others perceive and understand what they are not ready to accept
- compel patients or their surrogates to make decisions congruent with our values, mind-sets, or recommendations
- easily and fundamentally change the health care environment where we practice
Consider what would happen if we shift our perspective/mind-set instead of striving for a particular outcome: we could pause and consider, “What will actually serve in this situation?” How is this different from the usual modus operandi? What are the patterns that keep us stuck in this repeating cycle?

When we focus our energy on finding a solution to the present problem or symptom, we can overlook the bigger context of the situation, root factors, and possibilities for change. In the case of Mr Franklin, the focus of the clinical team is on getting a particular outcome, a DNR order. By restricting their attention, the team overlooks the root causes of the current stalemate. What is the context of Mr Franklin’s life? How does his wife understand her role as a surrogate decision-maker? What is at stake for the clinicians involved in his care? What factors in the organization have contributed to the pattern of communication and decision-making that is evident in this case? A broader topography is needed, one that reveals intrapersonal and relational patterns, organizational structures and systems, and societal context and forces. We need a process to recognize this landscape, understand its contribution to the present adversity, and inquire how to shift it to create more beneficial outcomes for patients, families, and clinicians.10,11 Rather than continuing to ask why this family member resists our efforts to change her mind, we might begin our mapping process by wondering why this DNR order is the focus of our team’s resources. Why are we stuck?

Applying the “4 Rs” is an approach to release the grip of these complex and recalcitrant issues by focusing on the interplay among patients, families, clinicians, and teams. Figure 1 outlines the 4 R elements. The very real and significant health care system issues are beyond the scope of this column. However, the process described here could also be used by leadership teams, in partnership with frontline staff, to address organizational patterns that contribute to these recalcitrant situations and reveal novel opportunities to shift dysfunctional organizational patterns.

The 4 Rs

Recognize

Naming fundamental ethical values, intentions, and commitments can reveal gaps in understanding, patterns of conflict, confusion, or disagreement. Exploring what is at stake from an ethical perspective, and the consequences to patients, families, colleagues, and ourselves, is an important starting point. In a case such as Mr Franklin’s, we tend to articulate concerns about the just allocation of scarce critical care resources. However, another clinician might consider conscientious refusal as an expression of his duty not to harm, whereas another colleague may express frustration at her inability to provide benefit to the patient. A sense of moral responsibility for another team’s actions or inactions can weigh a team down and undermine communication, decision-making, and collaboration. Pausing to calm reactivity, focus attention, and connect to our professional values, ethical commitments, and responsibilities allows us to recognize patterns and habitual responses within others, the broader system, and ourselves.

A process that cultivates self-awareness, self-regulation, and compassion is vital for creating a foundation that fosters this kind of awareness and insight.12 Deliberately reclaiming our attention from myriad distractions—pagers, alarms, past and future uncompleted items in bottomless in-boxes—and reconnecting to our core intentions as professionals and as human beings focuses our attention on what matters most.9 The process of cultivating mindfulness involves bringing attention to what is happening in the body, mind, and emotions in the moment; repeating this practice creates new neural pathways that are available during periods of stability and, more importantly, when challenges arise. Halifax9 described a process aimed at creating the conditions for compassion to arise that builds on a foundation of mindfulness. The elements, illustrated in the mnemonic GRACE, include 1) gathering our attention, 2) recalling our intention, 3) attuning to self then others, 4) considering what will serve, and 5) enacting ethically and ending the encounter.9 The process has been described in detail elsewhere.9

Figure 1: The 4 Rs, a process to address patterns that contribute to recalcitrant situations and reveal new opportunities and solutions.
With a stable ethical grounding, we can begin to systematically identify and respond to patterns that contribute to conflict, dissonance, or uncertainty. This begins by cultivating the capacities to see things as they are, to be able to carefully and critically understand the morally salient aspects of an issue, and to see new possibilities with fresh eyes. A space of humble inquiry goes beyond the mind to include imagination, conscience, and engages all senses and modes of awareness to understand the truth of the situation.

Instead of focusing on Mrs Franklin’s persistent request for aggressive treatment, there are several opportunities to explore: first, how are those of us involved in Mr Franklin’s care showing up to the patient encounters? Are our nervous systems stuck on hyperalert or are we harried, distracted, or just going through the motions? Are we fully present or distanced in our encounters with patients, families, or colleagues? Additional questions we might consider include the following:

- What essential ethical values do I intend to embody in my moment-to-moment interactions with others?
- How do my opinions and assumptions impact my moral sensitivity, discernment, and action?
- How might my fears, vulnerabilities, and default responses be coloring my assessment of this situation?
- What familiar patterns of speech or behavior am I noticing?
- What aspects of this case are trapping my attention?

Repeating the same phrases—“they don’t get it,” “nothing will change,” “why are we doing this”—signals an unrecognized or unresolved issue to be addressed. Oftentimes, these refrains are predictably accompanied by emotional responses such as becoming angry and frustrated; avoiding patients, families, or colleagues; and numbly going through the motions. These patterns manifest not only in us as individual clinicians but also within and among teams. Examples include making dismissive responses to questions about goals of care and leaving unaddressed conversations for the next team. If Mr Franklin had gone into cardiac arrest, the nurse practitioner on the surgical team may have advocated for a family meeting but have been dismissed and told, “We’re not there yet.” Alternately, he may have received such a response so often regarding past patients that he did not even raise the question on Mr Franklin’s behalf. He may have hoped that the next change in ICU attendings would bring someone whose greater influence could achieve what he felt helpless to do himself. Recognizing patterns of thinking, speaking, and silence related to cases of moral adversity or distress allows us to break out of our autopilot responses. For example, the care team could notice that each discussion with Mr Franklin’s family reflected a consistent pattern (Figure 2). Providers could notice that individual clinicians and teams involved in cases such as this come to feel helplessness as their agendas stall. Clinicians and family members perceive their contributions as neither heard nor valued, and they experience this as disrespect. The divide becomes more firmly entrenched. Understanding what fuels these patterns of communication and decision-making opens up the possibility of changing them. Noticing and naming the patterns provides a foundation to examine them and determine whether they are useful or causing more burden.

**Release**

Once we recognize the patterns that have produced the current conflict, we need to pause to release aspects of our approach that have not served and underscore the basic
values upon which we might align. For instance, what would happen if we were to loosen our grip on the agenda of getting the DNR order? Questions we might ask include the following:

- How does what we are currently doing actually align with our ethical values, intentions, and commitments? Are we inadvertently causing harm to others or ourselves in our current approach?
- What are our ethical responsibilities? What responsibilities are not ours to carry?
- What are we trying to fix or solve?
- What might we be missing?
- What will we need to let go of to consider what else might be possible? Is our attachment to a particular outcome obscuring other integrity-preserving options?

Contemplating these questions begins a process of understanding what underlies the clinical teams’ behaviors and actions and offers insights about what they might need to release. The distress that arises when clinicians perceive that their actions are causing more harm than benefit ignites a repetitive pattern of shame, guilt, anger, and sadness. Such feelings are understandable and offer an opportunity to explore rather than deny them. These feelings reflect unresolved moral residue; repeated exposure to traumatic events; or perhaps an unwavering commitment to a single outcome, such as getting a DNR order, that obscures possibilities for another path to success.

For instance, Mr Franklin’s nurse finds himself internally dialoguing about the next family meeting in light of a past experience: “This meeting will be like the one about that guy in the same bed last year; poor guy, his wife was just like Mrs Franklin, just kept insisting on everything.” If we recognize the pattern of projecting past experiences into the present—with the insight that Mr Franklin is not the prior patient but a unique person with a unique family with particular characteristics and needs—then the connection is released and something new might emerge. Recognizing that something important is constraining our view of this situation is the beginning of being able to choose to release it. Recognizing the connection to the prior experience with a different patient and differentiating it from Mr Franklin’s case does not discount the associated moral residue. In fact, addressing the moral residue requires attention and a commitment to do so. Seeing Mr Franklin’s case with fresh eyes invites a shift that allows us to give the Franklins the full measure of our attention and compassion and creates the conditions for new possibilities to emerge.

Sometimes we, as clinicians, feel that we do not have the ability, confidence, or courage to engage differently and are fearful about what will happen if we allow ourselves to be vulnerable to the patient; the family; or our own suffering, uncertainty, and dissonance. The systemic pressure for throughput or productivity can create a mind-set of scarcity, a fear that there is no time or emotional bandwidth to adequately address these complex issues. This belief instigates a pattern of delaying challenging conversations until there is a “better” time or someone else takes initiative. Sometimes the uncertainty inherent in critical care leads us to doubt our conclusions. On the other hand, relying solely on clinical expertise may prohibit incorporating other perspectives or sources of understanding. For critical care nurses, hesitance to address values and goals often arises from a self-assessed need for additional training or an organizational culture where the direct involvement of nurses is not invited. Acknowledging that these are normal responses, and that our fears are often not reality, is prerequisite to releasing them.

Releasing what no longer serves may take the form of taking a few deep breaths and recalling why we have chosen to serve as critical care nurses and what we hope to bring about in our practice. In the case of Mr Franklin, releasing may mean consciously letting go of the expectation that if we try harder and with more persistence in asking for a DNR order, we will be successful in gaining Mrs Franklin’s agreement. It may also involve letting go of expecting Mrs Franklin to accept the reality of her husband’s impending death when she is not ready to do so. The process of releasing may reveal that we are expending significant amounts of energy to bring about an outcome in a conflict that is intensified by systemic patterns that have not been recognized or addressed. When we are able to name and release what no longer serves, there is space for new awareness and possibilities.

Reconsider

Reconsidering what will serve means being open to discovering a new path forward by letting go of what no longer serves and seeing
the situation with fresh eyes. This iterative process involves inquiring into assumptions, validating facts, and considering all the sources of information. One aspect to contemplate is the implications of how various team members differentiate harm and benefit in cases such as Mr Franklin’s. This appraisal often arises from a literal application of the golden rule. Clinicians treat others as they would want to be treated (“I would never want to live like this”) and so they advocate strenuously for a change in the plan of care, as Mr Franklin’s team is doing. Assessing our own values and preferences is important, and we must avoid substituting our own treatment preferences to eliminate paternalism. A more effective alternative may be to shift to the so-called “platinum rule,” treating people as they would like to be treated, which emphasizes patient autonomy and understanding other’s preferences.

Following the platinum rule could lead to providing requested but medically inappropriate care, with attendant moral and emotional fallout for clinicians.

Mr Franklin’s team may assume that his wife’s request to “do everything” represents Mr Franklin’s preference to receive any intervention, no matter how burdensome, that offers any possibility of extending his life for even the smallest amount of time. Or that he would wish to forgo any intervention, no matter how beneficial, that offers any possibility of shortening his life by any amount of time. The first assumption underlies the belief that one is only bringing harm and the second that one is unable to benefit the person one has a duty to serve. Being explicit about core ethical values and commitments permits clinicians to surface and release their assumptions, biases, and preferences. Into the resulting space new perspectives and opportunities may emerge.

Reconsidering the ways that we might proceed differently invites clinicians to explore and understand the perspectives of others. This involves being open and curious about who the people being cared for are beyond their illnesses, understanding their perspective and what matters to them, and seeing them as whole people. Patients or their surrogates have conscious or unconscious values, intentions, and fears that motivate their responses, as do clinicians. Reconsidering does not imply abandoning clinical expertise or experience but rather applying the very best diagnostic skills while holding lightly to what we think we already know. Engaging with less tangible information, such as emotions, along with cognitive knowledge and somatic signals, can assist clinicians in attuning to the morally relevant aspects of the situation and to step back, take the longer view, and discern what may be true that has not been understood so far. Clinicians may not be able to change the eventual outcome for Mr Franklin, but it may be possible to create the conditions for Mrs Franklin to grieve her loss by remembering the final days of her husband’s life as a reflection of her fidelity to her commitment to her husband and their relationship rather than as a painful conflict with the clinical team. The culmination of the reconsider process is an alternative plan that is grounded in mental stability and nonreactivity, a spacious awareness of the possibilities, and humility. It supports clinicians in letting go of the idea that they are the sole guardians of truth in these complex situations. This requires suspending our agenda and rebuilding trust and rapport with the family and possibly even within the team.

Restart

Thus far, we have gathered our attention, grounded ourselves in our core ethical values, and attuned to conscious and unconscious dynamics within ourselves and our colleagues. Engaging in this kind of rigorous appraisal of ourselves, our teams, and our organizations opens a way out of helplessness into empowered compassion. Once we recognize the ineffective patterns that have kept us mired in stagnation, we are able to release the grip of our agenda so we can begin anew. Moving from reconsidering what will serve propels clinicians into action. What will be done differently? How can we bring our new insights and discernment into reality?

Beginning anew is where the rubber meets the road. In this step the prior steps of recognize, release, and reconsider are synthesized and made visible in action. Mr Franklin’s nurse recognized that he and Dr Waller were replaying familiar scripts. “We’ve had this conversation many times and it always turns out the same.” “We just need to get the DNR order.” Both clinicians were trying to uphold their duties of beneficence and nonharm by placing limitations on the provision of what they perceive to be medically ineffective treatments. This perspective is not wrong; the question is how to engage in a dialogue with Mr Franklin
and his wife that creates space to find a way forward that allows both parties to preserve their integrity and moral/ethical commitments.

How might what we have learned in the first 3 steps of the 4 R process shift the conversation with this family? Instead of being attached to the goal of “getting the DNR order,” what else might be possible as a step forward? What new questions might help both the team and the family move from their positions to a place of greater understanding and engagement?

When clinicians lead a family meeting, we generally create the agenda. We ask families to step into our worldviews and perspectives, often with little preparation or discernment. Can we do it ourselves? As a thought experiment, imagine what might happen if Mrs Franklin convened and facilitated the family meeting instead of the clinical team. Who would she invite? Which clinicians or laypersons? What information about her husband and their life together would she share with the team in order to inform their decision-making? What questions about the clinician’s values and preferences might she have? How would different clinicians answer? As the meeting drew to a close, would she make a recommendation? What might it be? Such a thought experiment gives clinicians an opportunity to synthesize what has been learned in the first 3 Rs. Imagining it this way avoids the trap of falling back on patterns of authority and control that might crush the sprout of new wisdom or possibility. It puts releasing to the test. Can we really let go of our agenda and instead respond to what this other person needs from us? How can we envision an alternative path?

Recall that we left reactions behind at the recognize step when we identified and committed to departing from habitual, automatic patterns that get in the way of listening and understanding. Imagining Mrs Franklin’s family meeting reveals whether we have really done our perspective-taking homework in the reconsider step. If we cannot answer these hypothetical questions, or if the answers come too readily or are contaminated rather than informed by our past experience with similar cases, then we need to return to the previous steps of recognize, release, and reconsider again until we are able to arrive at action that embodies our stated values and who we are as clinicians.

As Mr Franklin’s nurse reaches the end of his shift and prepares his colleague for the family meeting later today, the incoming nurse finds herself grumbling, “Yeah, we’ve seen this movie before” and notices her body tense and her emotions darken with frustration. She takes a breath and reflects on her intention to bring some benefit to Mr Franklin. She mentally plays the memory of the previous non-productive experiences and recognizes it as a cautionary tale rather than a foregone conclusion. Recognizing that she, the team, and Mrs Franklin are united in their intention for healing and are feeling sadness at the current situation, she finds common ground for a fresh start. She identifies new questions she might pose to the team and to Mrs Franklin. One approach is to empathize with her colleagues (“This is a sad situation”) and to inquire what their most important goals are for Mr Franklin. This refocuses the team on their hopes for Mr Franklin in the present and the opportunity that exists to bring those aspirations to fruition. The nurse might demonstrate respect for Mrs Franklin’s sustained support at her husband’s bedside and inquire, “You’ve been his rock. What would he want us to do for you?” This simple inquiry shifts the nurse into a stance of curiosity. What would this person, who has up to now been a silent occupier of an ICU bed, say? It also makes explicit the shared value of care and compassion. Embracing the power of small and large shifts in our patterns to produce alternatives propels us toward action that embodies our values and commitments.

**Conclusion**

Critical care clinicians regularly face challenging ethical issues that leave them feeling helpless and discouraged. One strategy to release the inertia and helplessness associated with these cases is to apply the 4 Rs process to discern if it is possible to shift the process in a way that will produce new opportunities and solutions. Engaging in this way opens us up to the mystery of what we might discover and what we do not yet see. Although many of the ethical challenges that critical care clinicians confront will have a moral remainder, it is possible not only to shift our perspectives but to shift our relationship to the realities that we find ourselves in. Rather than appraise our efforts as failures because they did not resolve the situation in the way we expected, we are able to create space for new insights and solutions to emerge. We come to
accept the limits of our abilities and the reality that we cannot control the behaviors and choices of others, despite our best efforts to act in accordance with our clinical judgment and ethical values.

Organizations must support these individual shifts in perspective and action and provide processes and structures that support ethical practice. Clinicians must collaborate with health care leaders to systematically identify the organizational patterns that create the conditions for threats to clinician integrity and that undermine the quality of patient care. Without such partnership, clinicians will likely find it difficult to sustain their newfound insights and individual patterns. Providing regular opportunities for members of the clinical team to constructively examine their own patterns and the organizational patterns that influence the situation, in a process that focuses on learning rather than placing blame, is a leverage point for change.11 To create space for greater dialogue and solutions, systematic mechanisms should be put in place to address the ethical concerns of all members of the clinical team and to regularly explore ethically challenging cases. Proactive assessment of ethically challenging cases with a nurse champion model is an example of a promising unit-based opportunity to engage in interprofessional dialogue and to design strategies that target the modifiable aspects of these challenging cases.25 Together, critical care clinicians and leaders can suspend their respective requests to forgo treatment.

ACKNOWLEDGMENTS

We are grateful for Roshi Joan Halifax, PhD, for wisdom and insight in the development of the GRACE model of compassion that informs this article. We are also indebted to our colleagues Tony Back, MD; Al Kazniack, PhD; and the members of the Upaya Institute’s Being With Dying professional training program. Special thanks to Michelle Prizzi for her editorial assistance and manuscript preparation.

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