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Asking Ourselves and Others the Right Questions: A Vehicle for Understanding, Resolving, and Preventing Conflicts Between Clinicians and Patients and Families

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Deep divisions among clinicians and families about goals for patient care represent one of the most troubling situations that occur in the critical care setting. Patients, families, and clinicians struggle to balance their competing values and obligations in a way that fosters their integrity. Ideally, in such situations, relationships are cultivated and preserved throughout the process, and flexibility, understanding, and respect are demonstrated. In the end, both families and health care professionals are able to go on after the situation has ended, with the confidence and reassurance that the right thing was done in the face of uncertainty, intense emotions, and possibly death.

Such best case scenarios involve (1) ongoing, respectful discussions about the patient's/surrogate's goals for treatment; (2) clarity about how decisions will be made and by whom; (3) exploration of the meaning of quality of life, death, and disability; (4) exploration of differences and examination of assumptions; and (5) a process that allows all parties to maintain their integrity regardless of the outcome. Key features of these cases involve clear and trustworthy communication,¹ time to discover the ethically permissible and clinically appropriate actions,² and the ability to be fully present with the situation and its participants.³

Unfortunately, this ideal reality is often elusive in the critical care setting. In contrast, a more common and disturbing process often ensues: The patient/family requests the continuation of therapies that the team deems as either disproportionately burdensome or futile. Then, the family or patient's surrogate disagrees with these recommendations and demands that all treatments be continued, despite mounting evidence that the loved one's condition may not improve or that death is impending. In response to these demands, clinicians sometimes adopt a stance of trying to convince the patient/family that the treatments being provided are not actually beneficial and may be harmful, or that continuing or adding therapy violates clinical, ethical, or legal guidelines. Often each interaction of this process becomes focused on getting the patient or family to see things from the clinician's perspective and to agree to a

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limitation of treatment—typically cardiac resuscitation and then other life-sustaining therapies—or a discontinuation of these therapies and “allowing death to occur.”

Families, particularly those who have a long history of distrust of the health care system and perhaps of life in general, respond to these clinician efforts with resistance and negativity. The more these families and patients push to get the outcome they desire, the less they are able to listen to experience-based clinical suggestions and wisdom, and the more resistant they become. The consequence of this frustrating cycle is that relationships deteriorate, trust is broken, and the therapeutic alliance is shattered. Worse, the suffering of patients and families becomes unnecessarily exacerbated and the effectiveness and integrity of clinicians can be undermined. Potential consequences, moreover, extend far beyond the clinical unit; they can have credibility and financial impacts on the hospital and even the entire health system. There may also be costs in terms of the reputation of individual practitioners. Furthermore, a team's ability to manage similar future challenging situations may be less successful.

In general, all participants—clinicians, patients, and families—share similar goals about the patient's quality of life experiences in a critical care situation, regardless of the eventual outcome. However, clinicians cannot expect patients and families, most of whom are suffering and frightened, to have the “emotional capital” to navigate these potentially choppy waters in the most reasoned and collaborative ways. The professional's role is to facilitate this difficult, often conflict-laden process, a journey that will probably be imperfect, even under the best of circumstances.

Most clinicians have an idealized sense of how such situations should unfold, a general understanding of *what* needs to happen. However, although most are expert captains, *how* to facilitate this particular journey is often a daunting challenge. For these reasons, we need more skillful and practical ways to answer questions such as the following: “How can we approach such challenging situations so the outcome is more closely aligned with the ideal rather than the troubling scenario?” “What assumptions are being made on both sides?” and “How can we find common ground to support understanding, integrity, collaboration, and the most effective and compassionate care for patients and their families?”

Identifying a New Perspective for Partnership

This column presents a practical mindset model based on Question Thinking⁴ that can help sort out this challenging complexity and provide a way of thinking and interacting that can make a positive difference in many of these situations. First, we present a case that highlights some of the typical challenges clinicians face in critical care situations. Then, we explore the mindset model along with a graphic that illustrates it, the Choice Map.⁵ We also describe some typical questions that are asked under best-case and worst-case scenarios, along with strategies and suggestions for reinforcing “best-case” situations. It is hoped that these strategies may contribute to an enhanced paradigm for partnership between clinicians, patients, and families.

Case

Justine Samson is a 46-year-old woman with a 7-year history of hepatitis C that has now progressed to liver failure. Ten weeks ago, she was urgently admitted to the medical intensive care unit because of sepsis. She developed respiratory insufficiency and was intubated and placed on mechanical ventilation that required high air pressures and oxygen. Currently, she has a tracheotomy and is ventilator dependent. She has continued to be physiologically unstable requiring 2 to 3 vasopressors, has developed renal failure requiring hemodialysis, and has had another episode of life-threatening sepsis. She has also developed a stage 4 sacral decubitus ulcer that requires frequent dressing changes. She is neurologically intact and has required increasing doses of opioids to manage her pain. She is not a candidate for liver transplant because of her poor functional status, sacral decubitus, and continuous need for vasoactive medications.

Justine has struggled with alcoholism for 20 years, receiving outpatient treatment 3 times with subsequent relapses. Prior to this admission, she had been sober for 2 months. During the times when she has been drinking, she has had difficulty holding down a job and caring for her family. She has also had difficulty following the medical regimen, resulting in frequent emergency department visits and subsequent hospitalizations. She has not had a consistent primary care physician because she moves often and relies on the liver specialists for her care.

Justine lives in a small apartment several blocks from the hospital. She has been intermittently employed as a clerical worker in the last 2 years. Justine has been married to Daniel for the last 5 years. She has 2 children aged 14 and 15 who live part of the time with their maternal grandmother. Their father lives in another city and is not involved in their care. She does not have an advance directive but has designated her husband as her surrogate decision maker.

The medical team and family are in conflict about further treatment. Members of the health care team believe that further treatments should be limited and that she not be resuscitated, should she experience cardiac arrest. The family, on the other hand, wants “everything” done. In the critical care setting, cases such as these are complex and challenging, from both medical and emotional perspectives. Many critical care clinicians, frustrated at the frequent repetition of these experiences, become caught in a vortex of unproductive patterns of thinking and responding that can interfere with their ability to facilitate a satisfactory process that can lead to the quality of life experience that everyone genuinely desires.

Einstein once said, “Insanity is doing the same thing over and over and expecting different results.” Applying perspectives and skills based on the Learner-Judger mindset model in the critical care setting offers one route for thinking differently that can lead to more effective behavior and more desirable outcomes.⁶ The goal is to interrupt this cycle of frustration and negativity and reroute the process to be more compassionate, collaborative, and effective.

Learner and Judger Mindsets and Questions

People tend to respond to challenging situations primarily from 1 of 2 stances: one of openness, receptivity, and curiosity or one of contraction, criticism, and negativity. The Learner/Judger mindset model provides a way of understanding these 2 basic ways of operating, along with questions that contribute to the thinking that undergirds each.⁶ Basically, the model distinguishes a way to “think about thinking” that also enhances productive and practical ways to alter behavior and outcomes. This model has been used by mediators, health care professionals, clergy, counselors, and coaches as a vehicle for understanding and

resolving conflict, as well as diminishing and even preventing it.

Both Learner and Judger mindsets are normal, human, and inevitable; everyone uses both and also shifts more or less frequently from one to the other. At any moment, a person might be in the Learner mindset (thoughtful, responsive, accepting, questioning assumptions, empathetically aware of others). Or, at any moment, a person might be in the Judger mindset (judgmental, reactive, seeking to be right, defending or not questioning assumptions, looking only from one’s own perspective). Learning to distinguish between the 2 mindsets leads to some practical and effective innervations for interrupting unproductive cycles of relating. This helps people become more nonjudgmental observers of themselves and others. These perspectives can also help clinicians be more easily empathetic with distraught and demanding families who, in less-frightening circumstances, may well be reasoned and collaborative.

The Judger mindset is fundamentally about survival and protection; it is generally “hard-wired,” perhaps corresponding to the “amygdala hijack” described in the emotional intelligence literature.^{7,8} The predominant emotion that activates the Judger mindset is fear, which of course is also the predominant emotion for patients and families in critical care situations. Judger can be focused internally; for example, a family member may say to himself or herself, “What’s wrong with me? I should have gotten him/her to the hospital sooner.” Family members may also direct their Judger mindset externally and say to themselves, “Why isn’t anyone trustworthy? Why won’t they listen to us?” Typically, the externally focused Judger is manifested when patients and families are continually angry and demanding to health care professionals. Appreciating the impact of the Judger mindset in frustrating, unproductive cycles in critical care settings brings to the fore strategies for ameliorating these difficult situations.

In contrast, the predominant mood that activates the Learner mindset is curiosity and awareness of self and others. The ideal and normative clinical mindset is that of the Learner; when operating from this mindset, clinicians have access to their best critical, creative, and solution-focused thinking. The Learner mindset helps clinicians be most resourceful, empathetic, and able to facilitate

through the complex, difficult, and fear-dominated emotions and behaviors associated with critical care situations. The Learner mindset is also similar to the “Appreciative mindset” described in the literature of Appreciative Inquiry interventions, which have been used with success in health care settings.⁹ Remembering to appreciate that often it is fear and anxiety that are speaking, regardless of how it may appear, also helps clinicians resist reacting to challenging patients and families.

The Choice Map

The Choice Map is a visual summary of the Learner/Judger mindset model.⁵ In the context of “words create worlds,” it illustrates how a person’s thinking, listening, and speaking—moment by moment by moment—can impact how he or she behaves and relates. The Choice Map also shows the world of experience, possibility, and outcomes where each mindset can eventually lead. Conflicts between clinicians, patients, and families in the critical care setting

may lead to the Judger Pit, an outcome that no one wants and that may feel intractable and hopeless. These are the exact circumstances when the clinician’s most expert Learner facilitation skills are called for.

While the Learner and Judger Paths on the Choice Map promote awareness, the skills and questions associated with the Switching Lane also make it a practical, user-friendly guide for positively influencing thinking, behavior, and outcomes. The clinician can ask Switching questions such as the following: “How else can I think about the patient’s or family’s behavior? “What do they really want?” and “How can I listen from a neutral, ‘present,’ and compassionate place?” (Figure 1).

Applying the Learner/Judger Mindset Model in Critical Care Situations

Developing a firm foundation of the Learner mindset and Learner skills helps clinicians facilitate “Learner alliances” with patients and

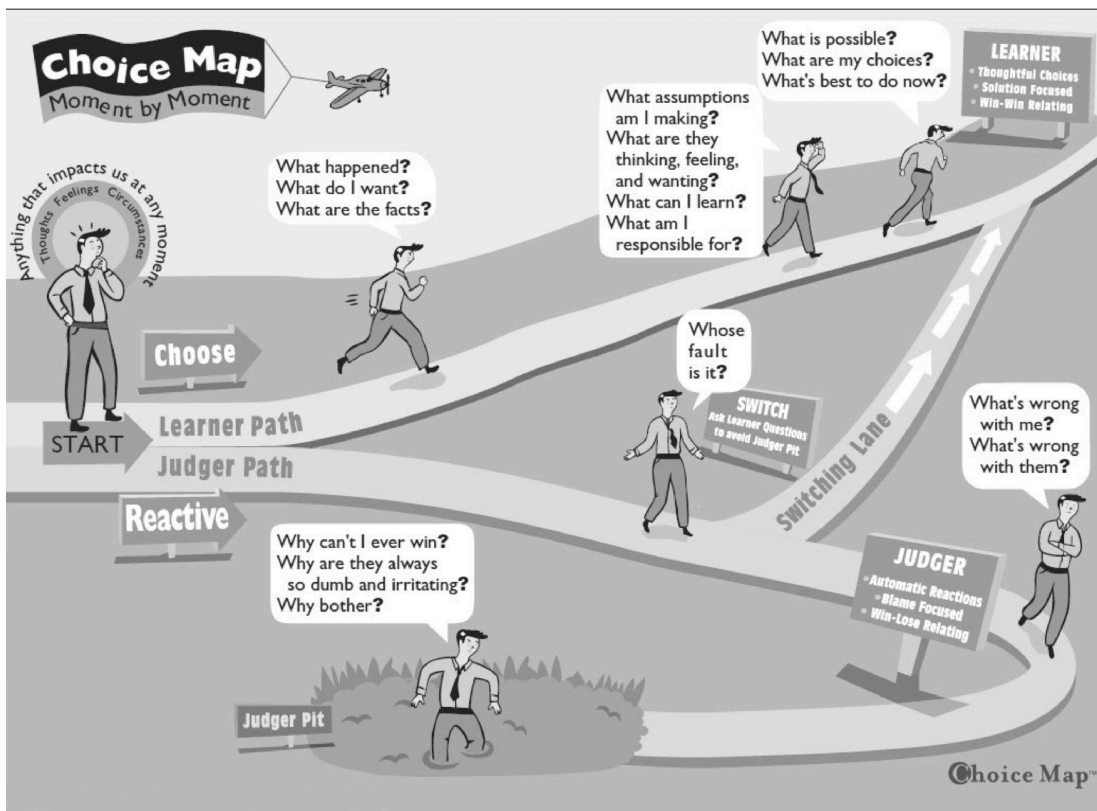


Figure 1: The Choice Map. Adapted from Goldberg.⁶ Used with permission from John Wiley & Sons, Inc. Copyright 1998. Copyright 2009 Marilee Adams. A free color copy can be downloaded from www.InquiryInstitute.com.

their families. The same skills help clinicians resolve or even prevent “Judger stand-offs” that characterize the conflicted clinical situations described earlier. An important intervention to interrupt this cycle is for clinicians to learn to be less reactive to the Judger mindset on the part of patients and families. They can do this by asking more Learner questions and using Switching questions to reestablish the Learner mindset when any Judger thinking, reactions, or behaviors occur.

The more that clinicians can develop a “resilient Learner,” the more calm and self-possessed they will become at facilitating through challenging and potentially conflicted critical care situations. For example, they can reframe questions such as the following: “Why is this patient or family member so irritating?” and “Why won’t they listen to me?” Instead, they can ask themselves, “Is this patient or family member overcome by Judger fear at the moment, regardless of how they’re expressing themselves?”

In the case of Justine, for example, the family members are probably asking themselves Judger questions such as the following: “Who’s fault is it that she’s doing so poorly?” “Why don’t they care about her or us?” and “Why don’t they understand that every minute is precious?” The clinician can instead stay on course for Learner by asking himself or herself questions such as the following: “What’s really going on with this family/husband?” “If I thought about him in the most generous way, how might I be more empathetic to his distress?” and “What might he be struggling with that he doesn’t have the resources to deal with?”

Although the Learner mindset is ideally the clinical and professional mindset, this does not mean that it is always easy to maintain, especially under pressure of time, urgency, and fear associated with the critical care setting. Nevertheless, the Learner mindset can be cultivated and reinforced so that it becomes more reliable and available. It is important to remember, however, that Learner Living is a lifelong learning journey, as well as a destination.

Strategies for Shifting From Conflict to Collaboration Monitor Mindsets

Bring awareness to your own mindset first. Notice any thoughts, words, and behaviors that may be indicative of a Judger “hijack.” Be

on the look out for signs of a Judger stance among patients, families, and other clinicians. Begin to cultivate awareness of red flags that might reflect a Judger stance, such as getting defensive or “overexplaining.”

Shift From Judger to Learner

When you recognize that you or someone else has slipped into the Judger mindset, use the Choice Map and Switching questions to guide you back to a Learner perspective (see Figure 1). Also resist being “Judger about Judger” whenever Judger shows up.

Pause

Take a “time out” to reflect, explore, and understand. This pause is a Learner strategy that helps create space in conversations and processes that can allow the best decisions to emerge without being forced or demanded.²

Create a New Dialogue

Use forums such as patient care conferences, ethics rounds, or ethics consultation to illuminate the prevalent mindset and to engage in asking new and the most productive questions.^{10,11} Ethics consultants, for example, can help create the moral space to examine and illuminate value conflicts, mediate differing viewpoints, and assist in constructing ethically grounded action.

Be Proactive

Begin to identify patient, family, or clinician characteristics that may be more likely to result in “Judger reactivity.” What are the unexamined biases or assumptions that clinicians hold about certain patients or groups of patients that need to be examined? What characteristics typically result in clinicians lamenting “Here we go again!” or “Same old situation—it never changes!” When these phrases arise, use them as a trigger for examining processes, communication, and decision making.

Ask for Help

Involve mental health care professionals, spiritual advisors, and ethics consultants early in the patient’s course of illness. Do not wait until relationships have deteriorated or conflict becomes intractable to ask for help. The earlier the situation is addressed, the greater the chance that it can be shifted into a satisfying and effective process for all concerned.

Be Humble

Shifting one's mindset involves the humility of realizing that one does not have all the answers in a particular situation. Instead of being the expert whose job it is to *tell* others the right answer, listen with humility to the perspectives of patients and their families. Also, emphasize that you are there to discover together what would serve best.

Forgive Yourself and Others

Any change in behavior takes time. Some of these patterns of thinking and behaving are deeply rooted in the psyche. Although one may aspire to let go of Judger reactions, it will take time, practice, and support to do so. Being aware of when you are most vulnerable to slip into Judger thinking is an important first step in addressing it. When lapses occur (and they will), be compassionate and generous toward yourself and others. Remember that the Judger mindset is normal and inevitable. Awareness and forgiveness are liberating and healing.

Summary

The critical care setting is inevitably fraught with fear, tension, and anxiety; therefore, the potential for conflict between clinicians, patients, and families is always present.

This means that communication and decision making in the critical care setting will always be challenging. Despite this, there are practical opportunities to recognize and intervene in situations in which the tenor of the dialogue and relationship has deteriorated.

This column has presented an additional perspective to bring to working with distressed families in life and death situations.

Understanding the impact of the Judger mindset on patients and families, as well as for clinicians, can increase understanding and empathy for everyone and help interrupt cycles of reactivity. Learning to ask Switching questions and “reset” to the Learner mindset can transform difficult situations in effective and compassionate ways. This information about the Learner mindset and asking Learner questions can help shift the energy, focus, and dialogue to a place of possibilities and partnership to support the integrity of the critical care situation and everyone involved in it.

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