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Conflict in the intensive care unit: Nursing advocacy and surgical agency

Kristen E. Pecanac and **Margaret L. Schwarze**

University of Wisconsin–Madison, USA

Abstract

Background—Nurses and surgeons may experience intra-team conflict during decision making about the use of postoperative life-sustaining treatment in the intensive care unit due to their perceptions of professional roles and responsibilities. Nurses have a sense of advocacy—a responsibility to support the patient's best interest; surgeons have a sense of agency—a responsibility to keep the patient alive.

Objectives—The objectives were to (1) describe the discourse surrounding the responsibilities of nurses and surgeons, as "advocates" and "agents," and (2) apply these findings to determine how differences in role responsibilities could foster conflict during decision making about postoperative life-sustaining treatment in the intensive care unit.

Research design—Articles, books, and professional documents were explored to obtain descriptions of nurses' and surgeons' responsibilities to their patients. Using discourse analysis, responsibilities were grouped into themes and then compared for potential for conflict.

Ethical considerations—No data were collected from human participants and ethical review was not required. The texts were analyzed by a surgeon and a nurse to minimize profession-centric biases.

Findings—Four themes in nursing discourse were identified: responsibility to support patient autonomy regarding treatment decisions, responsibility to protect the patient from the physician, responsibility to act as an intermediary between the physician and the patient, and the responsibility to support the well-being of the patient. Three themes in surgery discourse were identified personal responsibility for the patient's outcome, commitment to patient survival, and the responsibility to prevent harm to the patient from surgery.

Discussion—These responsibilities may contribute to conflict because each profession is working toward different goals and each believes they know what is best for the patient. It is not clear from the existing literature that either profession understands each other's responsibilities.

Conclusion—Interventions that improve understanding of each profession's responsibilities may be helpful to reduce intra-team conflict in the intensive care unit.

Corresponding author: Kristen E Pecanac, School of Nursing, University of Wisconsin–Madison, 701 Highland Ave., Madison, WI 53705, USA. lund2@wisc.edu.

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Keywords

Advocacy; agency; areas of practice; conflict; decision making; end-of-life issues; intensive care; interdisciplinary communication; surgery; topic areas

Introduction

Decision making about the use of life-sustaining treatment for a patient in the intensive care unit (ICU) is a major source of conflict among members of the healthcare team.[1] Conflict most often results from disagreements about the goals of treatment.[2] Such conflict can lead to distress and burnout among staff, potentially resulting in absenteeism, high turnover, and decreased quality of patient care.[3] Intra-team conflict can also contribute to conflict between the healthcare team and family members of ICU patients.[2] For family members, perceived conflict with the healthcare team has been associated with poorer mental health 90 days after the ICU experience.[4] Understanding the underlying motivations for members of the healthcare team to engage in conflict about the goals of using life-sustaining treatment may help prevent intra-team conflict and mitigate its negative consequences.

Nurses and physicians may disagree about the goals associated with the use of life-sustaining treatment due to their perceptions of professional roles and responsibilities.[5] A prominent role in nursing is the professional responsibility to act as the patient's advocate: a responsibility to support the patient's best interest. Subsequently, nurses experience moral distress from intra-team discordance (including disagreements with surgeons) about initiating or maintaining nonbeneficial life-sustaining treatment.[6] Conflict between nurses and surgeons specifically regarding prolonged use of postoperative life-sustaining treatments is well documented, as surgeons are generally reluctant to discontinue the treatments too quickly.[7] In a previous study of preoperative conversations, it was observed that surgeons assert a profound perception of "agency" or personal responsibility for the patient's operative outcome, particularly survival.[8] This responsibility, embedded in surgical culture, may motivate the surgeon's actions when patients require prolonged postoperative life-sustaining treatment.

"Agency" identified in surgery is similar to "advocacy" in nursing: both affirm a strong responsibility for the patient. Nurses and surgeons clearly have different roles in the care of critically ill patients and the nature of their responsibilities to patients deserves further exploration. Could differences in these responsibilities lead to conflict during decision making about postoperative life-sustaining treatment in the ICU?

Methods

We used discourse analysis to examine and compare nurses' sense of advocacy and surgeons' sense of agency in their professional roles. Discourse analysis is the study of language in the everyday sense in which most people use words.[9] The meaning of a word can vary across contexts, and can be connected to different cultural models of specific social groups.[10] "Responsibility for patients" can subsequently vary between nurses and surgeons (as advocates and agents), for these responsibilities are linked to different social groups and

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may have different meanings depending on professional duties and norms. Discourse analysis therefore allows for uncovering different cultural norms based on the words used by the two professions.

There are several approaches to discourse analysis based on the "fit" of the analysis with the question of interest.[10] To answer the question of interest here, we chose a general approach with two objectives: 1) Describe the status quo of the discourse, and 2) Apply scholarly findings in the solution of practical problems.[9] To obtain consistency with this approach, the design of our analysis was to 1) Describe the discourse surrounding the responsibilities of nurses as "advocates" and surgeons as "agents," and 2) Apply these findings to determine how differences in role responsibilities could foster conflict during decision making about postoperative life-sustaining treatment in the ICU.

The data used for discourse analysis are "texts" and can include any written or transcribed communication.[9] In this analysis, we included written communication found in opinion articles, research articles, books, and professional documents. We only included texts that focused on responsibilities to the patient from a clinical or bedside perspective; we excluded discourse related to responsibility to public health or social justice. Texts that mentioned nurses and surgeons' responsibilities but did not describe their meaning, and texts written in a language other than English, were also excluded. The intention was not to be all-inclusive of the possible data sources but rather to garner enough data to describe adequately the professional responsibilities nurses and surgeons have toward their patients.

To identify books that contained discourse on advocacy, we conducted a search of "advocacy" in the health sciences library online catalogue. We identified articles in the CINAHL database, using "patient advoca*" as a key term. We did not define advocacy prior to the search in order to include all descriptions of advocacy in the context of nursing responsibility.

While the responsibility surgeons feel for their patients has been described previously, the term "agency" linked to this responsibility is less common. Therefore, texts were identified more broadly, using "respons*" and "surgeon" as search terms in PubMed. We also searched for names of authors who have described the culture of surgeons. To identify additional sources, we examined the reference lists of both books and research articles.

We also included professional documents: The American Nurses Association's "Code of Ethics", the American Association of Colleges of Nursing's "The Essentials of Baccalaureate Education for Professional Nursing Practice," the Accreditation Council for Graduate Medical Education's "Program Requirements for Graduate Medical Education in General Surgery" and The American College of Surgeon's "Code of Professional Conduct." In total, this analysis contains 18 sources on nursing advocacy and 6 sources on surgical agency.

Notably, texts were not restricted by date or relevance to the ICU setting. To fully describe the discourse of advocacy and agency, we generated a general sense of how these constructs function in nursing and surgery. We read each text to determine how the concepts of advocacy and agency were described. When we found a description, we wrote it down,

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along with a description of the context of the overall text. After reading all sources, we reread the collection of descriptions to identify similarities among them. We grouped descriptions that portrayed a similar essence or objective of responsibility into a theme. Each theme represented a different responsibility that nurses and surgeons have toward their patients. To accomplish the second objective we applied these findings by comparing the identified themes for their potential to influence how nurses and surgeons approach decision making about life-sustaining treatment in the ICU. We considered how these influences could be discordant and subsequently lead to conflict.

Results

Nurse as advocate

We identified four primary themes in the discourse on nursing advocacy: responsibility to support patient autonomy regarding treatment decisions, responsibility to protect the patient from the physician, responsibility to act as an intermediary between the physician and the patient, and responsibility to support the well-being of the patient.

Responsibility to support patient autonomy regarding treatment decisions—In 1975, lawyer George Annas observed patients had limited rights in the hospital due to the nature of the physician-patient relationship; physicians had control of medical information and at times made decisions that were inconsistent with the needs of the individual patient.[11] To improve this relationship, Annas proposed the role of a patient advocate, whose "primary responsibility is to assist the patient in learning about, protecting, and asserting his or her rights within the health care context."[11](p201) Annas noted that nurses were ideally suited for the role of patient advocate because nurses provide moment-to-moment management of patient care, which includes addressing the majority of patient questions and concerns.[12]

Since this designation, empowering patients to voice their needs and concerns and make their own medical decisions has been described in the nursing literature as the "ideal" of patient advocacy.[13, 14] Nurses empower patients by ensuring that the patient's voice is heard during treatment decision-making, and that the treatments the patient receives are the treatments the patient wants to receive. Kohnke further delineated how nurses should assist and empower patients in decision-making: "The advocate's role is clear: to inform and support."[15](p81) Nurses are to provide adequate information for the patient to make his or her own decision and then support the patient's decision. This discourse suggests that by empowering, informing, and supporting, nurses have a responsibility to advocate for the patient's right to make their own treatment decisions.

Responsibility to protect the patient from the physician—Concerns about the physician-patient relationship also led to the notion that nurses should protect the patient from the physician. According to Allmark and Klarzynsk, "…the growth of the idea of advocacy is, at least in part, a response to a perceived need to empower patients, particularly against doctors." [16](p33) Here the importance of empowering patients is in the context of *against* the doctor: nurses are not only to act for the patient, but also may need to push back against the doctor if necessary to protect the patient's needs and desires. Working against the physician for the good of the patient can put nurses in difficult situations. As described by

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Gadow: “The nurse is in the hazardous role of mediating between the patient’s right of self-determination and the well-meaning attempts of those who would override that right.”[17](p55) It is important to note that physicians’ potential abuses and infringement on patient autonomy are described as “well-intended” or “unintentional,” to emphasize that the physician may do so out of duty to promote his or her view of the patient’s best interest. Regardless of the physician’s intention, nurses need to navigate a change in the course of treatment to protect the patient’s right to make the decision.

The discourse implies that the nurse’s assistance is required to protect patients from the physician, and without it, patients could receive care that is not aligned with their values and goals. According to Gaylord and Grace, “If nurses are not considered to be patient advocates, then who will assist the patient in the realization that the care being delivered is not optimal and present means to rectify such problems?”[18](p16) With their knowledge about treatment, nurses can assist the patient in changing the plan of care if it does not appear optimal. The discourse promotes nurses’ vital role empowering patients not just to improve their decision-making but also to protect them from treatment decisions the physician may make for them.

Responsibility to act as an intermediary between the physician and the patient—Aside from protective purposes, the nurse also needs to work with the physician and the patient to ensure understanding between them. O’Connor and Kelly investigated nurses’ perceptions of advocacy and described, “The essence of advocacy for most of the participants interviewed was the role of the nurses acting as intermediaries for patients or, as one participant described it, ‘bridging the gap.’”[19](p462) In this role, the nurse translates information from the physician to the patient or vice versa.[19] It is especially crucial for nurses to inform the physician if the patient does not have an adequate understanding of the plan of care.[20] Jezewski described this “middle man” role of the nurse as a “culture broker.”[14] Patients who enter into the health care system enter into a new cultural system “with its own values, beliefs, customs, behaviors, and language.”[14](p80) Nurses are able to assist patients in this role because they can speak the doctor’s language and translate for the patient in a patient-friendly manner.

There are other members in the health care system that the nurse needs to work with on the patient’s behalf. According to Jones, “A nurse is an advocate in the sense that she acts as an intermediary between the client and his family, his physician(s), other health care personnel, or other helping agencies, with her ultimate goal being the cooperation of all for the client’s benefit.”[21](p40) The intermediary role of the nurse in the discourse shows the importance of the nurse working with all actors involved in the plan of care in order to improve patient understanding and optimize patient care.

Responsibility to support the well-being of the patient—In nursing discourse, the nurse also has the responsibility to work toward the patient’s well-being. According to Winslow, “more than any other health care professionals, nurses tend to be concerned with the well-being of the *whole* patient.”[22](p35) This goes beyond the medical model—which is primarily concerned with eliminating disease processes—to include a concern for psychological, emotional, and spiritual well-being. Nurses aim to help patients live as fully

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as possible and "reach out for a plenitude of being that is always possible, in spite of biologic limitations against which medicine is helpless."[23](p9) Even when medical treatments are exhausted and can no longer provide a cure, nursing care enhances the patient's functional abilities and sense of well-being throughout the illness. Curtin adds that a nurse can be identified as a patient advocate "when her practice helps return a patient to independence or when her practice helps alleviate suffering or when her practice promotes respect for patients as persons."[24](p123) These descriptions reinforce the responsibility of the nurse as one who treats the patient's well-being and essence of their personhood beyond treatment of disease.

The discourse not only emphasizes the patient's well-being but also the nurse's relationship with the patient to determine the patient's own perception of well-being. Gaylord and Grace stated "Advocacy for nursing stems from a philosophy in which nursing practice is the support of an individual to promote his or her own well-being as understood by that individual."[18](p18) Gadow summarized nursing advocacy as "the participation with the patient in determining the *personal meaning* which the experience of illness, suffering, or dying is to have for that individual."[13](p49) Every patient has a different understanding of well-being, based on his or her personal construction of the illness experience and how the illness has an effect on day-to-day life. Nurses speak about the importance of building a therapeutic relationship with patients to find that personal meaning.[25] A review of the literature revealed that "The significance of an emotional connection between nurses and their patients, and the development of a meaningful understanding of, or 'knowing' patients' particular needs and wants, are substantial themes reflected in nurses' views on advocacy."[26](p122) It is only after establishing relationships with patients that nurses can understand how to advocate for their needs and wants. Here, the emphasis is on patient self-determination to choose not only which treatments to receive, but also how to embrace such treatments to live a life that reflects the patient's values.

Nursing advocacy is also apparent in professional and educational leadership shown in the American Association of Colleges of Nursing (AACN) guidelines for nursing education and the American Nurses Association (ANA) Code of Ethics. The AACN document states "Patient advocacy is a hallmark of the professional nursing role and requires that nurses deliver high quality care, evaluate care outcomes, and provide leadership in improving care."[27](p8) The discourse shows that advocacy is a distinct role in nursing that underlies the care that nurses provide. The use of "care" in the description encompasses all kinds of potential care a patient can receive, beyond just medical treatment. The ANA Code of Ethics also focuses on care and maintains, "Nurses are leaders and vigilant advocates for the delivery of dignified and humane care."[28] These notions reflect the role of the nurse advocate as promoting patient well-being and perhaps even protecting the patient from the physician if aggressive, highly burdensome treatments are proposed.

Surgeon as agent

We identified three themes in the surgery discourse: personal responsibility for the patient's outcome, commitment to patient survival, and the responsibility to prevent harm to the patient from surgery.

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Personal responsibility for the patient's outcome—The discourse emphasized that surgeons have a personal responsibility to achieve the desired outcome. From his ethnographic work with surgeons, Bosk observed, "Of all physicians, the surgeon's interventions are most visible and his therapeutic expectations are most specific. These features intimately link the surgeon's action to the patient's condition."[29](p29) Other physicians prescribe therapies intended to affect a patient's body, yet surgeons *are* the intervention, as they actively manipulate the patient's body. According to Katz, "Cutting someone's body and having some control over their subsequent life or death are inherent in the surgical profession, and they entail burdensome responsibilities and risks."[30](p32) The responsibility for the outcome of the operation is especially burdensome when the outcome is death. Surgeons are considered culpable for a patient's death, which is considered as "the surgeon's personal failure (to the patient) and not the patient's failure or a failure of therapy."[31](p846) The surgeon's actions are directly responsible for producing a bad patient outcome: the surgeon cannot fault patient noncompliance or ineffective medications. To further this point, Bosk stated: "By the nature of his craft and his beliefs about it, the surgeon is more accountable than other physicians and he also has much more to account for."[29](p30) Personal responsibility for the operative outcome is intrinsic to the performance of surgery and culturally embedded in the surgical profession. When the surgeon does not achieve the desired operative outcome, the surgeon sees himself/herself as the responsible "agent" for production of such an unfortunate outcome.

Commitment to patient survival—Before surgery, surgeons and patients develop a relationship in which surgeons instill trust in their operative ability. Due to the harmful nature of surgery, it is necessary that the patient trusts the surgeon's capacity to perform the operation and believes the surgeon will enact their survival. In return for the patient's trust, the surgeon commits to the patient's survival. From an ethnographic study, Cassell described this commitment as the surgeon-patient covenant: "The surgeon-patient covenant, then, involves an implicit promise to the patient; I will not abandon you; I will battle death for you; our relationship involves giving and receiving; it is a deeper and stronger commitment than money can buy; such commitment is part of my identity as a surgeon."[7](p73) This promise is implicit and not discussed outright with the patient, yet surgeons strongly internalize the promise. As this relationship is generated before surgery, the strength of the relationship with the patient dictates the strength of the covenant between the surgeon and the patient.[7] Therefore, transplant surgeons have a strong covenant because their relationship is sustained with patients over time whereas trauma surgeons have a weaker covenant because their preoperative relationship is shorter and confounded by external trauma (not inflicted by the surgeon) to the patient.[7] As the discourse suggests, surgeons take this commitment to patient survival seriously and focus their practice on efforts that promote survival.

Responsibility to prevent harm to the patient from surgery—The discourse suggests that surgeons would not operate if they believed the operations would be unsuccessful or result in a bad outcome. By not operating, surgeons are protecting patients from burdensome treatments. According to Cassell, "It is perhaps easier for a surgeon not to operate and accept that the patient has a fatal condition than to operate, find the same thing,

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and then have to 'let go' without having 'fully atoned' for the increase in pain and suffering wrought by the knife and the scissors, the clamps and the retractors."[7](p77) When surgeons do not operate, they understand that subsequent patient death results from disease. However, if the surgeon did perform the surgery and the patient incurred pain and suffering before dying, the surgeon would then be responsible for not only the death, but also the pain and suffering that resulted from the surgery. Therefore, surgeons only agree to operate if they believe there would be a good outcome, as demonstrated in a qualitative study exploring surgeons' views on limiting treatment after high-risk operations: "A common theme in these discussions was the expectation of success by the surgeon as a necessary premise for performing an operation." [31](p846) The harms associated with surgery would be acceptable to the patient if a good outcome could be expected. Without believing that they can obtain a good or good enough outcome, surgeons aim to protect patients from undue burdens by not offering surgery.

There is discourse in the American College of Surgeons' Code of Professional Conduct that resembles the sentiment of surgical agency. It begins with the phrase, "We treasure the trust that our patients have placed in us, because trust is integral to the practice of surgery."[32] This statement reinforces the importance of the surgeon-patient relationship, and "trust" implicitly reinforces the responsibility of the surgeon to commit to patient survival and prevent harm to the patient. In addition, the Code declares surgeons accept the responsibility to "Serve as effective advocates of our patients' needs."[32] The surgeon being "effective" also suggests obtaining a successful patient outcome.

It is important to note that the Accreditation Council for Graduate Medical Education's (ACGME) program requirements for general surgery does not include discourse requiring that surgery residents learn the role of the agent.[33] There are no program requirements for content related to the three themes described above. This is notably different from nursing education requirements, which highlighted teaching the role of the nurse as an advocate.

Comparison and potential for conflict in the ICU

Goals of treatment

There are important differences between nursing advocacy and surgical agency as revealed by the discourse. While nurses' discourse embraces patient autonomy and well-being, surgery discourse focuses on personal responsibility for patient survival. These goals may conflict during decisions about postoperative life-sustaining treatment. Nurses may feel that death is preferable when treatments only contribute to patient suffering without enhancing well-being. Surgeons promote continued life-sustaining treatment because they feel emotionally culpable for poor outcomes and duty-bound to ensure survival. Considering that advocacy was born out of a perceived need to protect patients from physicians, nurses feel compelled to engage in conflict with surgeons in order to protect the patient from burdensome life-sustaining treatments. Entering into decisions about the use of life-sustaining treatment with different goals, coupled with nurses' perceived responsibility to push back against surgeons when necessary, nurses and surgeons likely experience conflict with each other.

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Relationship with patient

There is also potential for conflict that stems from the relationship each profession has built with the patient. While nurses and surgeons may feel they "know" the patient based on their relationship, they know the patient in very different ways and circumstances. The relationship between the ICU nurse and patient often begins postoperatively and focuses on a sense of knowing the patient's personal meaning of well-being. Nurses can informally engage in on-going conversations about the patient's concerns (regarding illness, family, future, etc.) to understand the patient's goals of recovery. The relationship between the surgeon and patient often begins preoperatively while discussing whether the potential benefit to the patient's life is worth enduring the operation. The patient demonstrates trust in allowing the surgeon to operate to meet the patient's goals of care. Conflict can occur postoperatively in the ICU if the nurse senses that the patient's goals have changed since the operation, yet the surgeon is still committed to honoring the patient's trust to proceed with the initial plan of care.

Conflict can also occur if the patient is unable to communicate postoperatively due to severity of illness. Nurses are then unable to engage in conversation with the patient and often cannot establish the relationship that appears to be so integral to the advocacy role. The discourse suggests that nurses are to respect the patient as a person and advocate for the alleviation of suffering to promote well-being, typically by withdrawing life-sustaining treatment. This duty to ease suffering is critically important to the advocacy role when unconscious patients are suffering with continued use of life-sustaining treatment and yet cannot share whether they would want such treatment. The surgeon may disagree with this plan because he or she is the only one who knew the patient, and therefore knows what the patient values and the patient's previously stated goals (often, surviving). These opposing versions of what might be best for the patient regarding life-sustaining treatment can lead to significant conflict.

Discussion

The discourse surrounding both advocacy and agency endorses strong responsibilities to the patient. Nurses are to promote patient autonomy and develop a relationship with the patient to support his or her understanding of well-being: protecting the patient from the surgeon to fulfill these goals, if necessary. Surgeons are responsible for the patient's outcome, which impels them to remain faithful to the patient's trust to achieve his or her goals and commit to patient survival. These responsibilities may contribute to conflict during decision making about postoperative life-sustaining treatment in the ICU because each profession is working toward different goals and each believes they know what is best for the patient.

It is not clear that either profession understands or has knowledge of the role responsibilities of the other. Oberle and Hughes found that both physicians and nurses experienced a burden regarding life-sustaining treatment decisions: physicians have to make a decision about the treatment and nurses have to live with the decision by providing the treatment.[5] However, there is little recognition of each other's burden.[5] Given that surgeons may feel an operation occurs between themselves and the patient, it is also possible that surgeons may not understand that nurses have a deeply ingrained responsibility to the patient in an advocacy

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role. Surgeons may therefore see no need for nurses to be involved in any decision-making process regarding the patient's outcome.

Similarly, nurses may not understand that surgeons have an intense duty to the patient that stems from their agency role. Nightingale noted, "It is often thought that medicine is the curative process. It is no such thing; medicine is the surgery of functions, as surgery proper is that of limbs and organs. Neither can do anything but remove obstructions; neither can cure; nature alone cures… And what nursing has to do in either case, is to put the patient in the best condition for nature to act upon him."[34](p133) This statement provides insight into how nurses understand the nature of their patients' health and it is notable that it removes the surgeon as the agent for a patient's outcome. If nurses do not recognize that surgeons feel a profound commitment to the patient's survival, they may infer different, selfish reasons for the surgeon's actions, such as concern for mortality numbers. When nurses hold such assumptions, while simultaneously feeling an intense sense of responsibility for advocating for the patient, they could easily undermine the surgeon's perspective. Hewitt has argued that the advocacy role in nursing is problematic because it vilifies the medical profession while assuming nurses are the only ethically oriented group in contact with patients.[35] Nurses need to be cautious in assuming that they work toward the benefit of the patient and surgeons do not.

Interventions that improve understanding of each profession's roles and responsibilities might reduce conflict and achieve effective collaboration. According to Pecukonis, Doyle, and Bliss, each health discipline has its own professional culture, and "training health care providers in isolation creates *profession-centric* practitioners with limited interprofessional cultural competence."[36](p422) Intuitively, interprofessional education would help to alleviate profession-centric biases; however, we need to consider how these biases are actually learned. The advocacy role is emphasized throughout nursing education, yet agency is not a role that is taught but rather adopted by surgeons through the practice culture. In a survey comparing nurses, resident physicians, and attending physicians' opinions of the quality of dying and death of patients in the ICU, residents and nurses similarly gave less favorable ratings to the quality of death whereas the attending physicians gave high ratings.[37] These findings show that while students, physicians' beliefs are more congruent with nurses yet may change over time after years of practice and when adopting a more senior role away from the bedside. Therefore, interprofessional education at the student-level would not fully alleviate profession-centric thinking that develops in the culture of practice.

Literature focused on collaboration among different cultures suggests that an important step in creating a culture of inclusion involves identifying common moral ground and uncovering group-based assumptions that drive behavior.[38] A solution for both professions to understand what drives each other's behaviors is to discuss each patient scenario where there is potential for conflict. Acknowledging the issue of intra-team conflict, Singer and colleagues put "achieving interprofessional team consensus" as the first step in the process of decision making for the appropriate use of life-sustaining treatment.[39] An intra-team meeting, without the patient's family, can provide an avenue for all team members to discuss motivations for their proposed plan open and honestly, including conversations each has had with the patient. This process can help improve understanding of what is driving the

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behaviors and attitudes of nurses and surgeons during difficult patient encounters involving postoperative life-sustaining treatment.

There are limitations to this study. Only the discourse of nurses and surgeons were explored; however, there are many other actors involved in the decision making process such as intensivists, social workers, family members, etc. who may impede or promote the potential for conflict. In addition, there were few sources describing surgical agency, which may provide for an incomplete assessment of the construct.

Conclusion

Improved understanding is necessary to enrich collaboration between nurses and surgeons in the ICU. Working together is essential for quality care of the patient and family during decision making about postoperative life-sustaining treatment. Acknowledging important differences of each other's roles and their associated responsibilities could decrease ICU conflict and improve quality of care.

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