

The Dilemma of Goodness: Acknowledging Beneficence Tension in the Search for Consensus

W. David Clark, MD

Patient care in family medicine and palliative medicine involves important communication with stakeholders. Beneficence is assumed to be crucial to achieving consensus in these encounters. However, stakeholders may have different perspectives of beneficence. The term *beneficence tension* is introduced to conceptualize these differing perspectives. Acknowledging beneficence tension is suggested as a way to enhance effective communication with patients and families. (J Am Board Fam Med 2010;23:674–676.)

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The clinical encounter is a special interaction in which the clinician is privileged to step into the world of the patient and family at levels of privacy and transparency that few others experience. These encounters have the potential for both professional fulfillment and frustration. At the heart of these encounters the clinician desires to do good for the patient. How do we see the motives and desires of the other stakeholders? Do they also desire the best for the patient? The purpose of this article is to encourage the reader to consider these questions. How they are answered may influence the search for consensus when potentially life-altering decisions are required.

Ideally, physicians get most of their internal motivation from altruism (ie, beneficence). But we also are known for large egos—egoism being the opposite of altruism—which often get exposed when we hear messages of dissatisfaction about our care. Physicians develop aversion to negative messages early in life. After all, our intense desire to please and achieve is part of our natural selection into medicine. Some of us have responded to messages of dissatisfaction and lack of appreciation by withdrawal and avoidance; others have tried harder to find consensus and harmony.

Palliative medicine seems to be drawing out a subset of consensus seekers and peacemakers from the ranks of family medicine. Palliative medicine physicians endeavor to avoid chaotic finishes. Sometimes, despite our helpful intent, we also hear messages of dissatisfaction that can be emotionally painful. Fortunately the situation does not typically escalate to the point of being fired by the patient or family, but the feelings experienced are similar to those expressed in an article discussing such an event:

Palliative care is fundamentally relationship-centered work. When the relationship is severed, we may feel that we have failed in one of our most important tasks. We are immensely vulnerable to feeling as if we have failed precisely because of our high expectations of ourselves as outstanding communicators.¹

Early in my medical career I became biased against the peripherally involved family member—every area of the country has a medical euphemism for this person—who would come to our rural Iowa hospital several days into the hospitalization of their loved one and create discord around my medical management. The tension I felt in the room was invariably unpleasant, and this unpleasantness was usually validated by the negative responses of my nurse and physician colleagues. Who did they think they were? Where was their concern *before* the patient got

From Mercy Medical Center–North Iowa, Mason City.

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Corresponding author: W. David Clark, MD, Mercy Medical Center North Iowa, 1000 Fourth Street SW, Mason City, IA 50401 (E-mail: clarkw@mercyhealth.com).

ill? What unmet psychological need was being nurtured at our expense? Looking back, these were narrowly focused but understandable defensive responses.

I have no formal training in ethics. However, time, maturity, and clinical experience have been instructive. I have observed that, in my attempts to do the right thing and evaluate circumstances and encounters with suboptimal levels of satisfaction, it is important to recognize the presence of what I call *beneficence tension*. Beneficence tension refers to the group conflict resulting from the internal desire of each member involved in clinical encounters to seek, according to their own perspective, the most beneficial outcome for the patient. Rather than the tension between competing ethical principles, it is the tension of good intentions. In evaluating patient and family relationships I have found it helpful to assume that, regardless of the external behaviors, the stakeholders almost always have patient beneficence as a goal. At the outset clinicians are challenged with sorting through what may seem to be conflicting motives and stressors; guilt, financial loss (or gain), cultural differences, internal family conflicts, and loss of perceived control are but a few. Subsequent events may force alternative conclusions, but this initial assumption of beneficence as a desired outcome helps buffer the inclination to prematurely pass judgment on the behavior of others. Acknowledging this assumption verbally can be especially helpful.

The program director at the family medicine residency where I have served as a faculty member once made an observation that was quite insightful. He noted that much of the work performed in the hospital by palliative medicine physicians focused on conversations that previously were orchestrated by altruistic and capable primary care physicians. I agree with him. What we older physicians knew intuitively and practiced without fanfare years ago has been studied and compartmentalized. The quality of death and dying domains are now multidimensional, with 7 broad categories: physical experience, psychological experience, social experience, spiritual or existential experience, the nature of health care, life closure and death preparation, and the circumstances of death.² I have observed that the most productive end-of-life conversations are those in which the patient and family experience deeper insight in these domains. Consensus on important decisions is more likely to be achieved

if I as a palliative medicine physician acknowledge (to myself if not to others) the presence of beneficence tension. This acknowledgment helps dismantle the self-protective barriers that patients and family members erect when they perceive a lack of validation for their points of view.

We know that opportunities for achieving clearer consensus exist in the intensive care unit (ICU) setting. One study reviewed the content of audiotaped physician-led ICU family conferences that involved end-of-life decision making or giving bad news. Researchers found that 29% of ICU family conferences had what they considered missed opportunities to provide relevant information or support to the family. Three main categories were identified as missed opportunities. The first was opportunities to listen and respond to family; the second, opportunities to acknowledge and address emotions; and the third, opportunities to pursue key principles of medical ethics and palliative care. This third category included exploration of patient preferences, explanation of surrogate decision making, and affirmation of non-abandonment.³ Is it unreasonable to suspect that some of these missed opportunities were influenced by the biases and doubts of the participants as they processed each other's motives?

It is not only with patients and families that beneficence tension can be appreciated. Nurses and physicians have the potential to communicate better when both affirm their desire for the best patient outcome, even though the opinions about achieving those outcomes may differ. Physicians may have a greater responsibility than nurses to acknowledge beneficence tension. Surveys from 90 physicians and 230 nurses working in 8 nonsurgical ICUs revealed that 73% of the physicians rated the quality of communication and collaboration with nurses as high or very high, whereas the high or very high ratings from nurses totaled only 33%. The surveys further revealed that, relative to physicians, nurses reported that it was difficult to speak up, disagreements were not appropriately resolved, more input into decision making was needed, and nurse input was not well received.⁴

My professional life these days has been lived largely in the context of the patient and family meeting. Before and after the meeting I try to both hear and value the perspectives of nurses and other caregivers. I spend time talking with patients about the things that are most important

to them and their families. I wish these meetings all went perfectly but sometimes the outcomes fall short of my expectations. Patients and families are not always happy with the new realities that I often bring to the conversations. However, I try to see each stakeholder as wanting, at the most basic level of understanding, patient beneficence. It seems to help in achieving consensus. It also makes my work as a palliative medicine physician a lot more satisfying.

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