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CE

Ethical Decision-making Using Trauma-Informed Principles: A Case Example

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Irma Cannon (composite case and fictional name) is a 45-year-old patient (she/hers) who was admitted to the telemetry unit of an academic medical center 2 weeks ago after an unwitnessed syncopal episode. This is her third admission for complications of infective endocarditis within the past 7 months. Three days ago, she was transferred to the medical intensive care unit (MICU) in septic shock for which she received intravenous (IV) vasopressors and broad-spectrum antimicrobial medications. Blood cultures obtained at the time of her transfer to the MICU revealed new evidence of a systemic fungal infection for which IV micafungin was added to her care plan. Irma experienced symptoms reminiscent of opioid withdrawal upon administration of the first dose of micafungin and adamantly refused all subsequent doses of the medication. After repeated and urgent attempts to counsel Irma to accept micafungin for lifesaving reasons, the MICU care team consulted the hospital ethics committee to evaluate the option of administering micafungin to Irma against her express wishes. She has a lifetime history of substance use disorder (SUD) including IV injection of opioids, which she continues to use despite successful enrollment in a local methadone clinic.

Moreover, some of the nurses on the unit—who were cross-trained to work in both the telemetry unit and the MICU—have noted that it can be challenging to care for Irma. They document that she is alternatively withdrawn, uncommunicative, and disrespectful. She sometimes calls them names, swears at them, or demands they leave the room. Irma also complained that they do not provide her with adequate pain management.

Members of the ethics consultation team were available to meet with team members and the patient, who was agreeable to meeting. The consultation team included 3 clinical ethicists (2 physicians and a former critical care nurse). This

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hospital's consultation service recognizes the importance of using a trauma informed (TI) approach, where indicated, and members approach situations accordingly. From a TI stance, there is an assumption that many persons have suffered traumatic events in their lives, and this affects their behavior in stressful situations, perhaps especially when facing the further trauma of being hospitalized with all of the accompanying pain and procedures and loss of control over daily activities. Prior to meeting with the persons involved, the team gathered relevant data from the patient's medical record, including the nurses' notes. As noted, Irma had been successfully enrolled in a state-sponsored methadone program after her first admission and continued to receive 20 mg of methadone daily for management of her opioid use disorder and chronic pain.

On closer review of the nursing notes pertaining to Irma's daily care, the ethics consultants learned that she had only objected to the administration of the second dose of micafungin, accepting all other antibiotics and routine medications. Irma often requests additional pain medications, although the location and nature of the pain is either not specified or generalized by the patient as "all over."

In the MICU, the ethics consult team members were speaking with Irma's current primary nurse, the oncoming nurse, and the MICU nurse manager to gather more information, when one of the physicians from the infectious diseases (ID) service joined the conversation. He noted that, while he was not yet familiar with Irma, having just assumed weekend coverage, he was willing to brainstorm with the team and the patient to find a possible way forward.

Importance of Trauma-Informed Approaches for Ethically Sound Practice

We will analyze this case and offer strategies to increase clinician awareness of how prior, as well as present, traumatic events can result in alienating behavior that, paradoxically, leads to further traumatization or retraumatization. Definitions of *trauma* vary, but it is generally understood to include an experience that overwhelms a person or child's ability to function or cope with daily life and that may have enduring emotional, social, and/or physical effects. The experience of trauma, especially if caused by a trusted person, can also result in withdrawal, mistrust, fear, aggression, and hypervigilance.[1] The effects of trauma may be cumulative and on a continuum from subconscious to subtle to devastating.[2]

Originally a public health initiative aimed at improving mental health services for survivors of war, TI approaches are relevant in, and important for, the care for individuals in all health care settings. The health care environment and the reasons for seeking care can exacerbate or revive prior traumatic experiences that have engendered distrust of both the environment and clinicians. Research from the National Council for Behavioral Health shows that around 70% of people have experienced 1 or more major traumatic events in their lives.[3] Importantly, the results of childhood trauma pervade adult lives. Childhood traumas are measured using the number of identifiable adverse childhood events to which the individual has been exposed. Additionally, those who have experienced serious trauma are disproportionately at risk for ill health and disadvantaged groups are also disproportionately represented among the traumatized and those suffering chronic illnesses.[2]

A TI approach to ethical practice is aligned with nursing goals of promoting, protecting, and restoring health and relieving suffering and with the perspective of humanizing the health care environment.[4,5] Among other benefits, a TI approach emphasizes that an inability to bounce back from traumatic events is not a character flaw or a moral weakness for which a person can be blamed. It should not be a label, which can be dehumanizing. A TI approach also acknowledges that clinicians and other caregivers are among those who may have experienced trauma, and this can affect their actions toward patients who may be perceived as challenging, or in cases that are reflective of their own past traumas in some way.

Guiding Principles for Trauma-Informed Approaches to Care and Problem Resolution

Having a TI approach to patients and colleagues involves understanding the nature and effects of trauma on persons and their behavior. It means going beyond the surface presentation and one's personal reactions to try to understand, at least in some small measure, how the person's many seemingly

Table: Trauma-Informed Assumptions and Principles to Guide Ethical Decision-Making in Health Care Practice[a]

Assumptions[b]	Principles	Priority Focus
Realize the extensive and pervasive reach of trauma *Recognize* indications of trauma in persons *Respond* by including knowledge about trauma into institutional and societal policies, procedures, and practices *Resist* retraumatization	1. Be aware of the patient's identity: Carefully seek history Avoid retraumatization Be aware of one's own identity Avoid stereotyping and bias	Patient and clinician
	2. Engender trust and be transparent.	Patient
	3. Empower the patient's voice and their choices.	Patient
	4. Provide physical and emotional safety.	Patient
	5. Carefully listen, acknowledge, and be aware of the possibility that health care team members may also have experienced trauma.	Team members and associated stakeholders
	6. Include the perspective of all relevant stakeholders. Focus on mutual goals of patient care and provide peer support.	Team members and associated stakeholders

[a] Modified from Substance Abuse and Mental Health Services Administration.[2]
[b] Assumptions apply to both patients and health care staff.

"difficult behaviors" stem from the social fabric and their prior history. A TI approach stops us from dismissing the person as purely a "difficult personality" and perhaps revictimizing them in the process. It does not necessarily mean that, absent specialized psychiatric and mental health training, we have to explore their trauma in-depth. Indeed, to do so might be retraumatizing, but we should appreciate the possibility and the impact that it may have on the person before us.

Four assumptions and 6 principles related to a TI approach are proposed by the US Government's Substance Abuse and Mental Health Services Administration (SAMHSA).[2] The assumptions, which they call the 4 Rs, are: realizing that trauma is pervasive; recognizing signs of trauma; responding to trauma through trauma-informed care; and resisting retraumatization by remaining aware of this possibility. Along with the 4 assumptions, there are 6 principles that provide more direction. For the current case, and paraphrased from the SAMHSA guidelines, 4 of these are more pertinent to the patient and 2 of them more pertinent to the clinicians and health care team. The principles have been reordered for the specific purpose of ethics consultation and ethical analysis processes as they relate to exploring difficult practice problems (see the Table).

Note that with a TI approach, the perspectives of all relevant team members are sought and hierarchies identified and controlled on behalf of upholding mutual goals of patient care and team member support.[2] Especially important is acknowledgment that all persons, including clinicians, are susceptible to experiencing the aftermath of trauma, and this may affect how they interact with others, including patients and/or colleagues. An important aspect of a TI approach is that clinicians reflect on their traumas and how these might affect their interactions with patients.

Case Analysis

In Irma's case, we illustrate the added value of a TI approach to ethical decision-making. Instead of starting from a point of asking what is wrong in this situation, we want to know, with regard to the person at the center of the issue, "what happened to them, (and) what experiences inform their behavior and reactions."[1(p47)] A TI approach—together with accepted facets of ethical decision-making such as fact gathering, eliciting the perspectives of those involved, accounting for contextual influences and power imbalances, and conceptualizing possible appropriate actions—permits illumination of predisposing human factors that might otherwise be missed. For example, a patient who has been subject to control by another, as in intimate partner violence, may feel powerless and seem withdrawn and uncommunicative. This behavior can alienate those

who perceive their intentions as helpful rather than controlling.[2]

Redefining the Stated Ethical Issue

The presenting ethics question posed by an attending physician in the MICU was "can a patient's decision be overridden if they are rejecting treatments that the team believes to be lifesaving?" The ethics question, initially, seemed to be one of patient capacity to make a particular decision. Having decision-making capacity means the person can take in information, digest it, and appreciate the likely consequences of choosing or declining a therapy.[6] It is, generally, not considered ethically permissible to override a decision made by a person who has capacity. However, a clinician does have obligations to ensure the person in question receives adequate and sound information tailored to their needs for them to make a good decision.

When a patient's interests seem to conflict with what the medical team proposes or what the medical team feels will allow them to do their job well, care must be taken to explore the issue in some depth. In the face of life-threatening consequences, the stakes of allowing a patient's ill-considered choice can be high. Ill-considered patient choices derive from inadequate information, psychological and other pressures (including lingering effects of trauma), or the patient not feeling as if they have a choice.[7] Thus, an ethics team using standard ethical analysis would have also redefined the stated "ethics question." However, the added component of an intentional TI approach permits the uncovering of occult dimensions, thus facilitating a broader range of possible concerns for someone we suspect has suffered serious trauma in the past, as in Irma's case.

Patients, like Irma, who spend protracted time in the hospital, receiving painful procedures and having to adapt to hospital routines, coupled with the ongoing effects of prior traumas, may become frustrated and resistant to aspects of their care, resulting in decision-making that can bring them harm. Nursing and medical team members can become frustrated and concerned when a patient seems to be acting against their own interests, such as by refusing medications or not wanting to be turned, or to get out of bed. Indeed, Irma had been labeled as "difficult" by members of the team. But applying such labels to people tends to lead to their dehumanization, worsens any lack of self-esteem, and increases the likelihood they are treated with less respect than that accorded to others.[4] Instead what is needed is an approach that highlights that the person is a historical being with a story that may involve trauma and its aftermath. The following illustrates how using a TI approach to problem-solving provides a different lens on the team's initial perception of the problem.

A Trauma-Informed Consultation Process

The TI principles in the Table, which are reordered from SAMSHA's original concept to fit the goals of analysis in a nonmental health setting, served as considerations for the ethics consultation process described next. The principles tend to overlap and be interrelated in terms of eliciting a more complete picture of what is at stake. Thus, the order in which the principles apply is, to a certain extent, dependent on the situation. For example, in the case of an ethics consultation, consultants need to reflect on their own biases and prejudices related to patient history and presenting problems so as to neutralize them insofar as possible. Thus, as much information as possible is gathered before talking with the patient. These actions are foundational to further inquiry. They permit looking beyond implicit or explicit assumptions that may have been applied or suggested by clinical team members.

Principle 1: Awareness of the Patient's Identity and One's Own

Although not always an easy task, health care team members, including ethics consultants, need to be aware of their own identity, identify any negative feelings toward the person in question, and explore what may be triggering these feelings. Additionally, understanding who the patient is, how they see themselves, and at least some aspects of their history can permit empathetic connections to be made, thus lessening the likelihood of dehumanization. Through this approach, the possibility of stereotyping and bias is explored and managed. Further history is gathered from the patient in a way that is sensitive to and resists retraumatization but also validates their experiences.[5,8] Strategies for exploring potential bias and prejudices are important

for both clinicians and ethics consultants to initiate. In Irma's case the consultants met ahead of time to plan how best to talk with Irma given her long history of substance use and the strong likelihood that she had experienced trauma.[3]

Principle 2: Engender Trust and Transparency

Trust is difficult to build in the context of an ethics consult due to the limited time frame. Transparency of, and clarity about, purpose is critical. Discussing with the patient why the consultants have been called and reassuring them that the goals of an ethics consultation are to help them and their needs and preferences be understood by the team is an important step. Treating Irma with respect and compassion, ignoring labels, and seeking to understand the patient as a person was both foundational to providing her good care and, in this case, was critical to her sense of safety (Principle 4). When the consultation team and ID specialist entered Irma's room, the lead ethics consultant introduced the team and the ID physician. She described the ethics service as one that aims to help resolve concerns that have been raised by the patient, family members, or members of the health care team. In this case, she acknowledged what the consultants had been told about her refusal of the IV antifungal medication dose and why the medical team was concerned, but that they were there to understand her experience and to help her advocate for herself. At first Irma did not make eye contact and was quiet. Another member of the team reiterated that the concern was for her and meeting her needs, and that they worried that she might feel overwhelmed being surrounded by 4 people. Another team member stressed the mutual goals of helping her get her needs met. In engendering the small and tenuous degree of trust possible during the initial encounter with Irma, the ethics team was able to encourage Irma to articulate at least some of the important aspects of her hospitalization that were of concern.

Principle 3: Empowering the Patient's Voice and Choice

For patients such as Irma, who may feel they are not heard or listened to, a concerted attempt has to be made to ensure her perspective is heard and accounted for. The ethics consultants' goals are both to elicit her understanding of what is being proposed and to help her convey her point of view to the clinical team. As noted, in a pre-encounter consultant meeting, it was decided one of the team members would take the lead unless Irma's body language indicated that she was more comfortable directing her answers to another member. After introductions, a statement of the consultation team's goals, and that the team wanted to know her thoughts, Irma talked about several things that were bothering her. First, Irma remarked, "Everyone keeps telling me that I'm going to die if I don't do what they ask but I haven't died yet." Then, Irma noted that the new IV antifungal medicine gave her the same feeling as past episodes of withdrawal and it was "terrifying, I don't ever want that again…death can't be worse than that." Also, she told the team that when she asked for pain medicines, she was given doses that did not relieve her pain and she was only receiving half the dose of methadone as prescribed at home. The numerous "sticks" for blood cultures were "wearing her down." Another worry that emerged was her fear of losing her current subsidized housing if she remained hospitalized much longer. Thus, some insights into her current behavior were revealed, facilitating possible routes of action that would be amenable to Irma.

Principle 4: Providing Physical and Emotional Safety

Providing physical and emotional safety can be difficult for several reasons, including that the patient may have good reasons to be generally distrustful of others. One problem is that clinicians, in carrying out what for them are routine acts, can forget that these may not be so routine for patients and may be taken as further affirmation that a clinician is not to be trusted. For example, the ID physician questioned what sort of IV access was available and Abe, her primary nurse, was asked for information. Abe entered the room, reached over Irma and pulled her gown part way down to show the team the subclavian line. He did not ask Irma first. Although such actions may become routine in health care settings, a TI approach reminds us to be aware that it is disrespectful, and possibly retraumatizing, not to ask permission (except perhaps in emergency situations). Offering an able patient, such as Irma, the option of moving the gown

herself restores a measure of control. But even if Irma were incapacitated, an explanation of what one is about to do is good nursing practice. Most if not all clinicians have been insensitive at times without intending to be—we are often overworked and must move fast. Small acts such as this can be done by even the kindest of people inadvertently, but they do send a message. It is important to be mindful that for those with a background of trauma and perhaps abuse, such acts can be perceived as dehumanizing, uncaring, invasive, and even violent. Persons who have been victims of trauma of any kind (physical, emotional, verbal) can carry lasting scars that may affect their ability to trust others, feel physically and emotionally safe, make healthy choices, or deal with issues of control.

Principles 5 and 6: Team-Centered Principles

Careful listening, acknowledgement of, and accounting for health care team members' trauma are also aspects of ethics consultants' responsibilities, as is providing peer support. First, it is paramount that ethics consultants be aware of, and control for, their own biases. Ideally, ethics consultants explore these on a regular basis to approach problem-solving from a neutral stance. Additionally, the job of ethics consultants includes understanding how all stakeholders in an ethical conflict perceive the situation. This allows consultants to have a more complete picture of a conflicting ethical issue. In this case the ethics consultants interviewed the nurse separately. They were interested in understanding how he and other staff perceived Irma's situation, as he had been her nurse for several days both while she was in the telemetry unit and now in the MICU. During the discussion, he admitted that he felt irritated that Irma could not seem to do what was best for her. One of the consultants, acknowledging his frustration, asked whether there was something particular about Irma's situation that bothered him. He revealed that he had a brother who died of a drug overdose. He remains angry about it, blaming his brother, whom he had been close to, for not "being able to get it together and for leaving me." He was frustrated at not being able to help Irma but was also battling feelings of anger and guilt from his brother's death years earlier. In eliciting this information, the ethics consultants could provide some peer support for Abe and help him think through ways to deal with the residuals from his trauma, including how to access appropriate resources.

Ethics Recommendations for Irma's Care

As a result of the consultation, several avenues of action were recommended by the ethics consultants. The consultation team recognized that Irma's history of trauma led to her being distrustful of clinicians and staff and recommended eliminating unhelpful comments like, "You're going to die if you don't have this medication" (Principle 2). Additionally, the action of moving Irma's gown without first asking or without asking her to move the gown and show her central venous catheter was disrespectful, a clear breach of personal space and risked further damaging her sense of safety (Principle 4). Such seemingly micro missteps are ubiquitous, and mindfulness is needed to avoid them. They discussed with the nurse strategies to make a connection with Irma and why discussing even minor interventions with her might help build trust. After considering Irma's perspective and preferences (Principle 3) along with ID clinician input, the consultants recommended that blood cultures be drawn from a dedicated lumen of the central venous catheter, saving frequent sticks. Additionally, the ID physician and Irma agreed to try an oral antifungal drug, monitoring for side effects and efficacy. It was recommended that the MICU residents review her pain medications and consult with the pain management team, who have experience with treating pain in patients with SUD. Finally, the unit social worker was updated about Irma's housing concerns.

Case Follow-up: Trauma-Informed Education for Unit Staff

The ethics consultants offered to help the unit nurses and staff learn more about TI approaches in concert with the nurse manager and the nurse educator. Accounting for possible trauma underlying a patient's behavior and our prior traumas that can influence our attitudes toward a patient offer a chance for us, as nurses, to make connections with the patient that might not otherwise be possible, thus allowing us to provide them with good care (Principle 1). Nurses need a safe place both to debrief about such situations and to explore their own biases and prejudices. In a seminal article, Margaret Urban Walker

discusses the need for "moral open spaces."[9] By this she means time should be organized for members of the health care team to debrief about difficult cases in a nonjudgmental manner. Although ethics consultants can serve this role, nurses on the unit who have specialized ethics education can lead the way in taking a TI approach to patient care.

Abe's situation is a reminder that we are all influenced by prior events; his concerns were the result of a prior trauma he experienced, which needed to be addressed in a supportive way (Principles 5 and 6). The ethics team suggested that nurses keep a phrase or comment in their pocket, to respond to harsh and disrespectful words they sometimes receive from patients and even colleagues. Instead of reacting, perhaps using a phrase such as "did you mean to say that?" or "do you want to tell me what is bothering you?" can temporarily release the tension, reset the stage, and remind patients that they are interacting with another person who may have feelings too. A nurse who has received harsh or demeaning comments from a cognitively aware patient should also be empowered to say, "That is not appropriate or respectful, and it is not tolerated here." The institution absolutely needs to support this by having mechanisms in place to protect staff from violence.

Conclusion

All people are vulnerable to trauma. The long-term effects of trauma are ubiquitous and affect health care clinicians and patients alike. However, the power differential that exists between patient and clinician means that the responsibility to anticipate and manage the effects of past traumas on patient demeanor and behavior tilts toward the health care team. Biases and prejudices are accumulated throughout our lives and are a facet of human nature thought to serve an evolutionary purpose.[10] Clinicians' labeling of a person is one way that bias plays out. Labeling someone as difficult dehumanizes them and leads to loss of respect for them. We have a professional responsibility to understand and thus control these biases, as much as possible, on behalf of providing good patient care.

Being aware and remaining mindful of the assumptions and principles of TI approaches to ethical problems and nursing care enhances nurses' ability to treat all persons with respect and intention. Trauma-informed approaches to the care of persons include building trust where one can, seeing the person underneath the label, being transparent, and trying to understand nuances of why patients are acting the way they are. When ethical conflicts arise, a TI approach can uncover hidden aspects of a situation and provide avenues for resolution. In addition, a TI approach can help diminish the moral distress we feel when a patient does not seem to be acting in their own interests. It helps us understand how they perceive these interests and why they are acting a certain way. In Irma's case, the team was worried about not being able to "save" her from the danger of refusing important interventions, but she had other priorities—including being heard and having her pain managed. The goals of clinicians and consultants alike are to facilitate good patient care. Good patient care necessarily has to account for individual differences and needs. Trauma-informed approaches add a dimension to this goal by highlighting how trauma can leave its mark on individual patients and on clinicians and their interactions with patients.

REFERENCES

1. Lanphier E, Anani UE. Trauma informed ethics consultation. *Am J Bioeth.* 2022;22(5):45-57. doi:10.1080/15265161.2021.1887963
2. Substance Abuse and Mental Health Services Administration (SAMHSA). Concept of trauma and guidance for a trauma-informed approach. 2014. Accessed January 10, 2024. https://store.samhsa.gov/sites/default/files/sma14-4884.pdf
3. National Council for Behavioral Health. How to manage trauma. 2022. Accessed May 2, 2024. https://www.thenationalcouncil.org/resources/fostering-resilience-and-recovery
4. American Nurses Association. *Code of Ethics for Nurses With Interpretive Statements.* American Nurses Association; 2015. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only
5. Willis DG, Grace PJ, Roy C. A central unifying focus for the discipline: facilitating humanization, meaning, choice, quality of life, and healing in living and dying. *ANS Adv Nurs Sci.* 2008;31(1):E28-E40. doi:10.1097/01.ANS.0000311534.04059.d9 2.
6. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research Making health care decisions (33.PB83236703). US Government Printing Office; 1982.
7. Blacksher E. On being poor and feeling poor: low socioeconomic status and the moral self. *Theor Med Bioeth.* 2002;23(6):455-470. doi:10.1023/a:1021381616824
8. Tran NT, Baggio S, Dawson A, et al. Words matter: a call for humanizing and respectful language to describe people who experience incarceration. *BMC Int Health Hum Rights.* 2018;18(1):41. doi:10.1186/s12914-018-0180-4
9. Walker MU. Keeping moral space open. New images of ethics consulting. *Hastings Cent Rep.* 1993;23(2):33-40.
10. Grace PJ. Nurses spreading misinformation. *Am J Nurs.* 2021;121(12):49-53. doi:10.1097/01.NAJ.0000803200.65113.fd

CE Evaluation Instructions

This article has been designated for CE contact hour(s). The evaluation tests your knowledge of the following objectives:

1. Discuss how clinician biases and/or prejudices can interfere with good care of a person who has experienced current or past trauma.
2. Articulate 2 ways in which a trauma-informed approach can elicit or allow the development of patient trust.
3. Describe 3 guiding principles for ethical decision-making using a trauma-informed approach.

Contact hour: **1.0**
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