

No Agenda

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NOT HAVING AN AGENDA is usually considered a bad thing. Who wants to elect a politician who has no agenda? When a vascular surgeon rushes to the OR to repair the leaking abdominal aortic aneurysm of a patient, she better have an agenda. But can having an agenda sometimes cloud our eyes to what is happening in front of us, limit our scope of view to see only what matches our agenda, and cause us to miss important information?

I was consulted on a 40-year-old Hispanic woman with multiorgan system failure in our medical ICU. The patient was dying, septic, and in new renal failure, and according to the team, the family “just didn’t get it” and wanted to continue aggressive care. I read the chart, talked with the nurses, reviewed the scans myself, and looked at all the notes. I walked into the room. Religious music was playing softly on a CD player; the bulletin board next to the patient’s bed was crowded with religious get-well cards. The *Book of Mormon* was open on her bedside table, with passages of love and support underlined. The patient was very ill, sedated, and on a ventilator, and couldn’t talk with me. No family members were present. I checked the intake form and the patient was listed as “Mormon.” I wondered: Could the family be making medical decisions from a faith perspective, and was that possibly contributing to the conflict?

After examining her I walked out and spotted the resident who had called in the consult and discussed my recommendations. “Did you know she’s Mormon?” I asked. He looked surprised. “See, that’s why you all are so good at what you do. You find these things out that no one else knows and are so helpful!” he said, with great admiration. But of course it really wasn’t that hard—the medical team was so focused on the medical pieces of the puzzle (which were extremely important), that they didn’t see all the “person” pieces.

I learned about the concept of “no agenda” from my chaplain colleagues when I was a fellow. They explained it as being open to whatever opened in front of you, going where the patient led. When I teach trainees I talk about this concept a lot, and I try to explain it as follows.

I think there are two components. To be a good palliative care clinician we need to be as knowledgeable as our referring colleagues. We need to be top-notch clinicians, able to navigate through and digest the medical information about our

patients. “We need to be as cardiologist as the cardiologists,” I like to say.

Not that we’re going to have all their knowledge and experience, but I need to know what I know and what I don’t know, and have the confidence to ask if I don’t know. I need to look at the scans myself, talk with people involved in the care of the patient, and gather my own information, not relying on anything secondhand, because doing this can cause mistakes.

But when I enter a patient’s room I like to drop it all and go in without an agenda. I like to use myself as an “instrument” of care: What do I see? What do I feel? What do I hear? What do I sense? What are the interactions of the people in the room? What are my reactions to what I’m seeing? Is my chest in a tight ball because of the anxiety? Do I feel like a ton of lead dropped on me after I leave the room because of the patient’s depression? All of this information is data. And I need to “calibrate” myself to receive the information.¹ I need to have a clear understanding of what is “my stuff” and what is “the patient’s stuff,” and see things clearly. For instance, if I had a 40-year-old sister who died of cancer, and I transpose that experience every time I see a 40-year-old woman with cancer, and not see the uniqueness of this person’s experience, that “lens” may blur what I’m seeing and how I interpret it, and cause me to make mistakes.

The medical details are interesting, but the most interesting thing to me is: How are this unique patient and family dealing with this experience? And then, How can our team help them? This “subjective” data can be combined with the more “objective” data in deciding what to do next.

This approach allows me to be present, flow with the interaction, respond to what comes in front of me, and I hope provide better care. I think of it as entering the room with a “blank canvas” that gets painted during the interaction. The colors and shapes are the “data”—which encompass not just the objective data, which are important, but all the nuances of this particular person and this particular family and my interaction with them. And I’m part of that interaction—not just an inert scientific mind, but a human being too.

Calibrating yourself is a lifelong process. I don’t know that we’re ever “calibrated,” since we’re constantly learning and new experiences are occurring for us, just like our patients and families. But talking with our team or trusted colleagues, engaging in activities that help us focus and be more aware,

taking time to reflect on our experiences and learn from them: all of these things can help keep us more aware and observant and be a lot more creative in the interaction.

References

1. Novack DH, Suchman AL, Clark W, et al.: Calibrating the physician: Personal awareness and effective patient care. JAMA 1997;278(6):502-509.

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