

INTRODUCTION

Moonscape: The Surgical Intensive Care Unit

The first impact is like finding oneself on the moon, or a planet, light years away from the dissatisfactions and delights of everyday life. Everything is strange, different. The landscape is unrecognizable. The rules are dissimilar. It even smells different.

I felt this way when I first visited an operating room (OR) in 1983. But the strangeness wore off. I learned how to dress (in fresh scrubs, with sterile cap, mask, and booties over my sneakers), where to position myself (next to the anesthesiologist on a few stacked stools during an operation), how to move (to keep sterility and not touch and thus contaminate a surgeon who has scrubbed). Although I never became fluent, I learned enough of the language to understand the exchanges between surgeons, residents, and nurses. The strangeness was domesticated, became familiar. I was able to joke with nurses and residents: when the anthropologist can grasp jokes and make a few herself, she is beginning to learn the rules—spoken and unspoken—that motivate, guide, and constrain a foreign culture.

When I entered the intensive care unit (ICU), not only the landscape and the language were unfamiliar, although indeed they were. The place seemed “deeply weird,” as I said to residents who asked what I thought of the place (a few smiled as though they recognized the sentiment). It was the patients who were profoundly disturbing; most, ap-

parently unconscious as the action swirled around them, poised between life, death, and something else, what one might call a “living” or “social” death. The stories of what brought each person to the unit were disquieting, each embodying a drama, a tragedy, an ethical dilemma moving a social being to this liminal place, this liminal state, betwixt and between,¹ neither here nor there, neither dead nor completely alive. How does a listener twist her brain around the situation of a man, admitted because of an automobile accident (called in ICU argot MVA, motor vehicle accident, later changed to MVC, motor vehicle crash),² who is HIV positive with serious renal disease, previously treated by the VA (Veteran’s Administration), who now refuses all future responsibility for him? How about a young man found with crack cocaine in his blood and multiple gunshot wounds, who had buckshot in his body from a previous incident? Or a schizophrenic burn patient who had poured gasoline on herself and set it on fire and who, some years earlier, had been found not guilty by reason of insanity of an attempt to cut the throat of her three-year-old? Or a woman, on the way to her mother’s house to attend a birthday party for her son, whose car was hit by a truck, killing her boyfriend and two of her three children? Or an 85-year-old MVA (or crash) victim, who the doctors say is “doing well,” which means he can be released to a nursing home? Is that doing well? Who decides what is a “good result”?

Such issues did not seem to concern the doctors. They cared for the patients with equal attentiveness, be they gunshot victims (termed VOV, victims of violence), addicts, alcoholics, or cherished mothers, wives, or grandmothers. Perhaps this concentration on patients’ bodies, ignoring their social context, was easier because most patients were so highly sedated that their responses were minimal: someone might flinch when a painful stimulus was applied, or “sundown” (become confused and upset at night), but a patient’s social self was rarely in evidence, except when that person was ready to be discharged from the unit. Although family photos, children’s drawings, and get-well cards might be displayed in the room, the patients were rarely in a condition to observe them.

The nurses, too, looked matter of fact as they carried out their tasks. They appeared to love their work. “It’s habit-forming,” said a nurse-manager while a former nurse-manager added, “once you’ve worked here it’s hard to go to other places.” “We’re the best!” the ICU nurses often said in a half-joking tone, but they meant it. They

were proud of themselves, their competence, the unit, the ICU team. I overheard a conversation between two nurses: “I’ll do it,” said one. “I’ll help you,” said the second, who was finishing her 12-hour stint. “You don’t have to. Go home,” said the first. “No, I’ll help you!” insisted the second woman.

The residents, too, however confused or alienated they may have felt, seemed to know what they were doing. But, for the first month-and-a-half of research, I kept getting lost. I couldn’t find the bathroom, the way out, the elevator. I was psychically as well as physically lost. All that sadness, all that sorrow. (An intensive care doctor in New Zealand labeled his ICU “the house of endless grief.”) I found myself sleeping ten hours a night.

I have seen photographs of ICUs. They show the intimidating technology, the inert patients, on occasion, the nurses, technicians, doctors. But I’ve seen none that capture the *feel* of the unit, its extra-terrestrial quality, the sensation of being detached from the everyday world in a different time-and-space warp. Naturally, illness itself alters the world of the sufferer in extreme and unpredictable fashion. Anthropologist, Susan DiGiacomo, discussing her diagnosis of and treatment for cancer, speaks of “the kingdom of the sick,” noting that “the seriously ill take up residence in another country for the duration.”³ This unreality, this distance, this liminality or betwixt and betweenness is intensified in the ICU, where patients are in transition, neither vividly alive nor incontrovertibly dead, with the end state in doubt.

From the Earth to the Moon

How did I get here?

It began with surgeons, whom I have studied for more than twenty years.⁴ “You’re my savage tribe” I tell them. The surgeon I am now working with, who tends to push things as far as they will go, informs his surgical colleagues that they are my “primitive tribe.” I am fond of surgeons—as are most anthropologists of the peoples we study—even when one misbehaves and throws a “doctor fit” (the phrase comes from the mentor of a woman surgeon I studied).

In the late 1990s, a trauma surgeon who was co-head of a surgical ICU in an academic medical center contacted me. Having read my book on women surgeons, he asked if I had a student who might be interested in studying end-of-life issues in an ICU. I told him I had no students: I do not teach; I conduct research and write books. But

I wanted to learn more, thinking that I, myself, might be interested in such research.

The surgeon and I met, liked one another, and felt we might work well together. The two of us assembled a grant proposal. I wrote the ethnographic sections and offered suggestions for editing the remainder. Among the projected results, we proposed that I write a book based on my research. After some time, our project was funded by the National Institute of Nursing Research, of the National Institutes of Health.⁵

I had two conditions for agreeing to conduct the research. First, that no one but myself had access to my fieldnotes. To maintain confidentiality, I would type them at home and send copies to a friend abroad, so that in the remote chance that I was subpoenaed, I could destroy the notes on my computer and refuse to submit any information. I had spent several years working on the ethics of social science research and knew that breaching confidentiality is one of the gravest risks to the people anthropologists study.⁶ Such confidentiality is urgent in a medical situation threatened by potential lawsuits and government demands for data.⁷ My second condition was that I would call it as I saw it: no one else would sign, read, or approve my work ahead of time, unless I showed it to a doctor or nurse for factual corroboration. Although I might produce joint articles with other members of the research team, *my* work, including the promised book, would be mine alone. The surgeon agreed and made a good thing of it, telling everyone in the ICU that he had no idea of what I was going to say and saw no indications of what I observed and was told.

My theory is that when conducting fieldwork, or ethnographic research, the people you are studying observe you carefully and take their time deciding whether or not you are trustworthy. Some will always keep their guard up and never trust you. Others will test you. And most, after a while, will decide you are trustworthy—if indeed you *are* trustworthy. (I am convinced that most people know when someone is deceiving them, even if they do not know that they know.)

What this meant was that I had my own research project within a project. This was a comfortable position: I could do what I wanted, in whatever fashion I felt was most productive, write articles as they occurred to me, and submit them to journals for publication. Unlike my study of general surgeons, where the surgeons were nervous about being observed and did as much as possible to frustrate my research, or my research on women surgeons, where I had to locate each

woman and negotiate with her individually in order to observe her at work, the fact that the ICU research was initiated by the co-head of the surgical intensive care unit (SICU) gave me immediate entrée to the site and to the people I wanted to study. The surgeon not only initiated entrance, he shepherded the project through the hospital's Institutional Review Board. More than a year later, he located another unit in Texas for me to study, when the head of the ICU in a southwestern hospital I had planned to visit stopped answering communications (a painful but eventually obvious way of saying he had changed his mind about the permission he had given to study his unit). Finally, the surgeon arranged for me to spend ten weeks studying an ICU in New Zealand to compare their ideas and practices with American practices.

When I first met him, I did not realize how fortunate I was to work with an exceptionally intelligent man who epitomizes the American surgical "can-do" outlook. He could, did, and does do everything necessary to get a job done well. We still have some disagreements about research methods; he is an academic physician, with a Ph.D. in molecular biology, committed to "hard" scientific research. But we have come to a friendly standoff: he does things his way, despite my on occasion vociferous disapproval when it comes to our joint project; I do things my way, despite his on occasion quiet displeasure.

While conducting research, I observed and reflected on situations involving patients whom the ICU personnel—nurses, residents, or intensivists—felt had extremely poor odds of surviving their stay in the unit. The first surgical ICU I studied is "semi-closed": responsibility for patients is shared between surgeons and intensive care doctors (known as intensivists or critical care physicians).

Studying the SICU, I was struck by the extraordinary competence, morale, and commitment of the nurses. When I conducted research among general surgeons, the nurses were surely *there*, but I did not pay much attention to them. Some years later, when observing women surgeons, it became obvious that OR nurses might make a woman's life more difficult by imposing a relaxed set of behavioral standards for male, and another, harsher one, for female surgeons. But I must have implicitly accepted the traditional surgical view of nurses, confirmed by their subordinate role in the OR, as the doctors' "hand-maidens." (In retrospect, this blindness was probably more my fault than that of the surgeons I studied.) In the SICU, the nurses' role was too crucial to overlook. Not only did they deliver the day-to-day

hands-on care that frequently meant the difference between the survival or demise of a gravely ill patient, they cared *about* patients as well as *for* them. It was the nurses who waved at patients through the glass walls as the ICU team “rounded.” It was the nurses who hugged patients, held their hands, embraced grieving family members. It was the nurses I asked when I wanted to learn a patient’s family constellation or “story.” My awareness of the compassion and caring of nurses was extended by observing a member of our research team in action, a former nurse-manager of the unit. While conducting research in the unit, or moving through the hospital, this woman would swing into action whenever her considerable skills were needed: she responded during codes, comforted family members, instructed nurses, and encouraged new nursing recruits. It was obvious that she, and the other nurses in the ICU, loved nursing, cherished their roles, and cared deeply about the welfare of patients and their families. Reading the work of Patricia Benner⁸ and spending time with an exceptional clinical nurse coordinator in New Zealand strengthened my conviction that nurses play a crucial role in caring for, comforting, and healing patients and their families. The American intensivists focused primarily on *curing* disordered bodies; the nurses too were interested in cure, but many took a wider focus as well, on *healing* the sick person.⁹

Moral Economies

What I mean by moral economy is a web of affect-saturated values that stand and function in well-defined relationship to one another.¹⁰

—Daston, 1993

When the premisses of science are held in common by the scientific community each must subscribe to them by an act of devotion. These premisses form not merely a guide to intuition, but also a guide to conscience; they are not merely indicative, but also normative. . . . A spiritual reality which stands over them and compels their allegiance.¹¹

—Polanyi, 1946

While conducting research, I tried to understand the alien world of the ICU. The first surgical ICU I studied is semi-closed: responsi-

bility for patients is shared between surgeons and critical care specialists. Early on, I observed disagreement and, on occasion, conflict between surgeons and intensivists about whether or not to abandon aggressive treatment for a gravely ill patient. In such situations, surgeons invariably expressed more optimism than the intensivists.

It became apparent that the surgeons and intensivists conceptualized their relation to patients very differently. In end-of-life situations, this divergence led to miscommunication and conflict between surgeons and intensivists as well as inconsistent messages to patients' families.

The existence of these differences was confirmed when I observed an "open" ICU in Texas, where surgeons have final responsibility for their patients. My ideas became even more sharply focused when studying a closed ICU in Auckland, New Zealand, where intensivists had complete responsibility for patients, deciding whom they admitted to the unit and what should be done once that patient was accepted. Reading Margaret Lock and Lorraine Daston on moral economies¹² augmented and clarified these impressions. I decided that these differences could be fruitfully conceptualized as *moral economies*.

The differing values observed among surgeons and intensivists were expressed in action, not philosophical theorizing. The notion that the two groups subscribe to contrasting ethics is mine, as is the characterization of them as moral economies.

In her definition of moral economies, Daston continues: "This is a psychology at the level of whole cultures, or at least subcultures, one that takes root within and is shaped by quite particular historical circumstances."¹⁰

Lynn Payer examines cultural differences in medicine, contrasting theories of illness, medical practices, and ways of relating to patients in France, West Germany, England, and the United States. In her discussion of "culture bias in medical science," she describes American doctors' "imperative to intervene," noting that British physicians question the need for technological interventions and pay more attention than their American colleagues to the comfort and well-being of patients.¹³ Attitudes toward death differ as well. Payer quotes a British physician on why hospices for the dying grew up first in Britain, not America: "To accept the idea of hospice, one must accept the fact that people die" and "in the UK we strive less officiously to keep alive."¹⁴ My observations in the United States and New Zealand (which follows a British medical model) support Payer's contrasts between

American and British medicine. Surgeons provide the quintessential example of the aggressive American “can-do” approach; when a treatment fails, the solution is to be more aggressive. Payer attributes such differences to “national character,” a concept popular among anthropologists in the 1940s and 1950s but somewhat discredited since then. In a new edition of her book, Payer regrets using this term, saying that “national culture” is sufficient.

The concept of moral economies is more specific and, at the same time, more encompassing than national culture. It supports an interpretation that includes the other major participants (family, critical care nurses) in the medical drama. *Economy* emphasizes that physicians are actors within a social system that continually requires them to decide among alternatives—each bearing risks and hopes, benefits and costs. *Moral* economy detaches from the monetary marketplace and recognizes that the benefits and costs have to do most strikingly with life and death, and the terms on which life might be conducted—from utterly comatose to active participation—the qualities of life, relationships to self and other. Daston compacts these vital considerations by the phrasing, “webs of affect-saturated values.” I have extended Daston’s notion of moral economies in science to cover the values that affect clinical decisions, especially those at the end of life.¹⁵

To discuss these differing values, I could employ various classical social scientific terms.¹⁶ None, however, seem to quite fit the intellectual, emotional, and spiritual system of values that I characterize as a moral economy. In the end, I am more interested in identifying and understanding these differences than in complex theoretical and classificatory systems.

At this stage, a case may illuminate the distinctive, and on occasion conflicting, moral economies of surgeons and intensivists, as well as the doctors’ passionate commitment to these values.¹⁷

Mr. Burke was a 78-year-old retired geology professor who was operated on May 7 for bowel fistulas (openings), which caused a distressingly damp and ill-smelling genital region. Until developing colon cancer five years earlier, the patient had led yearly summer field trips, composed of graduate students and junior professors, to national parks. His colon cancer was operated on, he underwent chemotherapy and radiation, and was symptom-free for two years. Since the death of his wife, ten years before, Mr. Burke had lived alone. He valued his independence and was proud that he had been able to drive himself

to and from his chemotherapy sessions. After two years, however, he developed metastatic cancer in his liver and had another operation to excise it.

The following year, he developed fistulas in his radiated bowel and between his colon remnant through to his anal region, probably due to the earlier radiation treatments. This caused increasing pain, discomfort, and embarrassment, and he became homebound. What he missed most was his ability to get out of the house, drive himself to doctors' appointments, and show up at the local science museum where he led Saturday morning tours. He underwent another colon resection, after which his surgeon, Dr. Gordon, told his family he had "got everything," indicating that he had removed all the cancer. But the patient then developed abscesses, which required additional surgery. Dr. Gordon had promised: "Of course, you'll be back to leading those tours," but after the two surgeries, Mr. Burke ended up with worse fistulas, now into his bladder. The wound broke down and he was now leaking urine as well.

The patient had severe sepsis (infection), which was drained in the OR, and despite the surgeon's comment that he had "got everything," the ICU staff suspected that metastatic cancer remained.

The patient's two younger sisters and his nephew were devoted to him and visited him regularly in the SICU, where he was sent after the fistulas were repaired. They told the SICU doctors that they felt Mr. Burke would "not want any of this" because a prolonged recovery would likely place him in a nursing home in a dependent living situation. They said he had been in severe pain for the last two years of his life and was miserable. What had given him joy in the past was leading his science museum tours and being able to at least drive himself to and from his own chemotherapy treatments. At a family conference, attended by his sisters, nephew, and a nurse, the intensive care physician, Dr. Mannheim, asked: "What would he have wanted?" His nephew was articulate about his uncle's wishes. He stated that everyone in the family had living wills, except for his uncle, who refused to discuss it. "They'll know what to do," Mr. Burke had told his family, although family members never determined who "they" were. The family had already contacted a funeral home to make arrangements. The intensivist told them that the final decision had to be made by Dr. Gordon, the operating surgeon.

Dr. Gordon was convinced that another procedure, to drain the

fluid around his lungs, would improve help him, and, despite the doubts of the ICU staff, this was performed. The patient's condition did not improve.

At ICU rounds the day after the family conference, Dr. Mannheim decided to remove the patient from the ventilator, put him on "bi-pap"¹⁸ and give him drugs to keep him comfortable. "His comfort is the most important thing, now" he told the residents, saying that perhaps the patient could be transferred to a private room on the floor, free of the noise and distractions of the ICU.

The intensivist saw a man whose dying was being painfully prolonged. When asked "what would he want?" family members were clear that Mr. Burke would never chose prolonged illness and dependency. When queried about the case, Mannheim e-mailed me:

I took another look at this patient, did some calculations, did a "gut check." Numbers say, in-hospital mortality, 75% to 95%, if he gets to a nursing home, 90% one year mortality, or still in nursing home, only 10% will go home and be independent. Put the numbers together, and best case scenario is a 2% to 3% chance of making it home independent.

Mannheim was convinced that the rational, the compassionate, the medically correct action at this stage was to move the patient from "cure" to "comfort care." He noted that Mr. Burke had been seen by a pulmonary specialist whose opinion was: "never independent again, and will need indefinite period on ventilator."

Soon after the ventilator tube was removed, the surgeon made rounds in the ICU, saw the tube out, and exploded, accusing the intensivist of "trying to kill" Mr. Burke.

The ventilator tube was reinserted. The surgeon called a family conference, where (according to the intensivist) he did all the talking. This was attended by several cousins, in addition to the sisters and nephew. According to the intensivist's report, the surgeon said: "You don't want him to die, do you? All we have to do is just let him get better and he'll be okay." The family assented.

(Let me note that the intensivist and the surgeon posed two *different* questions to family members. Asking "what would he want" is quite different from inquiring "You don't want him to die, do you?")

Attempting to interview Dr. Gordon to get his take on the case, I contacted a colleague of his who warned me to stay out of it, explaining that the situation was just too hot for me to intrude. Surgeons had experienced similar problems with intensivists in the past, he said, and

I gathered that the surgeon was contemplating a formal accusation of euthanasia, a serious charge that would have momentous repercussions. “This is something you don’t want to walk into,” he warned, “you’d be forced to take sides.”

Through another surgical colleague, I did manage to talk with Dr. Gordon, an intelligent, caring physician with a sterling reputation. We talked near the OR, where a patient of his was being prepped for an operation. Dr. Gordon was guarded. After explaining what I did to keep confidentiality, I said I understood that there had been a lot of misunderstanding and disagreement about Mr. Burke and I wanted to know how he saw what happened. He relaxed and started talking.

It was extraordinary! The intensivist and the surgeon could have been describing two completely different cases. Dr. Gordon told how Mr. Burke had been in the hospital almost seven weeks, and how he had operated and corrected his fistulas. But his abdomen kept filling with fluid (there is a duct in back that kept filling the abdomen with fluid). His abdomen was distended. They “tapped” him,¹⁹ but then when he ate, the fluid turned white. So they started feeding him intravenously. These sorts of difficulties typically stop after conservative therapy. But the fluid got infected, he was septic, and ended up in the ICU. On Tuesday, Dr. Gordon had drained him in the OR and told the family he had done everything he could. The family figured out from this that he had said that there was nothing else that could be done for him, that he did not know what else to do. But on Wednesday, the drainage stopped. The infection was gone. The only trouble the patient had was in breathing. He had huge pleural effusions.²⁰ They had drained the patient’s lungs before, which had been successful, and he knew draining his lungs again would work. But the intensivist refused. Dr. Gordon wanted him tapped and, in fact, when he finally was, his oxygen requirements went from 100 to 40. He knew that this was “just a dip in the road,” and that Mr. Burke would recover. He was “a completely viable person.” Everything was going well. His oxygen requirements were lower after he had made them tap Mr. Burke on Thursday.

Friday was Memorial Day. On Saturday, he came by the ICU and found him extubated (the ventilator tube had been removed). After sedation, said the surgeon, you need 24 hours to come back. Mannheim, the intensivist, knew this, as he had been doing this for twenty years. And he removed the ventilator tube after only six hours off the medications used to sedate him for the procedure. The intensivist

talked to the family on Thursday; he swears he did not paint a dark picture; he swears the family wanted the patient off the “vent.” A nurse who had been present at the family conference talked to Dr. Gordon and attempted to back Mannheim up. It seemed clear that the surgeon doubted the nurse’s account. (When I questioned the nurse, she reported that the patient’s nephew had inquired, “Why keep going if we know he is going to die?” The family had given the nurse the name of a funeral home in case he passed away when a family member was not present.)

Mannheim had taken the patient off the vent without consulting the surgeon. He did not call Dr. Gordon or his resident; he said nothing. Gordon never knew. The intensivist said that the family wanted him off. The surgeon contacted the family and said, “What are you doing!” and they responded that, well, Mannheim had painted such a dreary picture.

They put the patient back on the ventilator and “everything’s working,” said the surgeon, listing all the physiological systems that were working. “This happens to our patients on a regular basis,” reported the surgeon. “Everyone thinks Mannheim is out to do physician-assisted euthanasia.” The patient could not be fully awake six hours after the medications given to him to sedate him for the procedure. He was unable to take a deep breath with the drugs still working.

I asked the surgeon what he thought the patient’s prognosis was. He said that Mr. Burke had a 50 percent chance of living three years out of the hospital. The patient wanted his fistulas fixed; he had talked with the patient and asked: “Are you sure you want to go through this?” and he had responded, “yes.”

The intensivist sees his patients for two or three weeks, said the surgeon. He does not see them walk into his office the way they do with him, Alex Gordon, saying “thank you!” “We treat the sickest of the sick,” declared Dr. Gordon, “and they get better. Mannheim doesn’t see his patients afterwards, he doesn’t have that experience.”

When Dr. Gordon talked about Mr. Burke, he told how his nephew calls him by a nickname; I think it was “Tip.” When he mentioned the nephew, he said he lives four hours away. Dr. Gordon mentioned more *personal* details about Mr. Burke than did the intensivist: he saw him awake and interacting with his family; when Dr. Mannheim met the patient, he was gravely ill, perhaps dying. I wondered whether Mr. Burke was more of a *person* to the surgeon and a *case* to the intensivist. It is, of course, more difficult for an intensivist

to perceive patients as persons (although as I noted in my fieldnotes, the ICU nurses do it, as do the intensivists I studied in New Zealand).

“This really bothered me,” said the surgeon. “I lost sleep for four days.” Some of the intensive care doctors call us and discuss what they want to do. Sometimes they are right, he said, and he finally agrees. This time, he did not get that phone call. He never got a chance to discuss the options. It was just by luck, after performing an operation that Saturday, that he happened to stop by the ICU and saw Mr. Burke extubated²¹ and put him back on the ventilator. He would have been gone in an hour.

He said he hoped if I wrote about it, it might help other cases.

What happened to Mr. Burke after he left the ICU? He remained on the surgery ward for another month and a half. His wound did not heal, requiring extensive care with a “wound vac” system, a device applied to the wound surface to suction and clean the wound. On September 1, the patient died.

Does this mean that Dr. Mannheim, the intensivist, was correct and Dr. Gordon, wrong? Not really.

We are dealing with utterly incompatible views of medical reality. To each doctor, the other’s viewpoint and behavior appears not only misguided but *immoral*.

I presented this case to illustrate why such “webs of affect-saturated values” are best described as moral economies. It exhibits the “act of devotion” (it is no accident that Polanyi employs a religious allusion) with which a community subscribes to such values.¹¹

The following chapters outline distinctive moral economies: the nurses’ ethic of caring, the covenantal ethic of surgeons, the intensivists’ ethic of scarce resources. Although I employ the term *ethic* and discuss differing *values*, the concept of moral economy is more encompassing, referring to a system of values. These values are shared; they are “held in common” by a community, a profession, a nation. Moreover, as Daston and Polanyi note, they are subscribed to by a nonrational act of devotion: they possess an emotional and, indeed, spiritual valence.^{10,11}

In the American surgeons’ moral economy, death is the supreme enemy to be battled at any cost. The intensivists, on the other hand, think in terms of distributing a limited resource among members of a community. Moreover, not death but *suffering* is the supreme enemy; consequently, rather than attempting to sustain life to the bitter end, intensivists consider survivors’ potential quality of life.

Patients' families have their own webs of affect-saturated values that influence their trust in, or distrust of, the doctors as well as the choices they make (or refuse to make). Ethnic differences exist; these will be touched on as we examine life, death, and crucial decisions in the three intensive care units.

Hospitals, too, can have specific systems of values, shared by patients and physicians. These moral economies may have ethnic or religious bases. Conflict may erupt when two hospitals with differing value-systems merge. Such difficulties, often attributed to individuals, may have a deeper, more systemic source.

National differences in moral economies are also observable. These provide the context in which doctors,' patients,' and families' decisions are achieved. Thus, intensivists have more freedom to make difficult end-of-life decisions in New Zealand than they do in the United States; these differences are supported by divergent methods of financing medical care, by a high value placed on consensus, by legal verdicts that support, as opposed to constrain, doctors' choices, by a relatively nonlitigious society as opposed to distrustful family members convinced that a lawsuit may be in their best interests, and by a unified health care system financed by a socialist government as opposed to a patchwork, market-driven system of health care. Physicians do not impose these linked systems of values on resisting patients, they are shared by doctors, patients, and family members.

Although the notion of moral economies is central to my argument, the first four chapters of this book concentrate more on the *actors* than on their value systems. The behavior of the nurses, residents, fellows, and attending physicians in the two American surgical ICUs I studied, has profound moral repercussions affecting life, death, suffering, and family attachment. Yet few of these medical workers would characterize themselves as moral agents. Some accept the moral responsibilities thrust on them by medical happenstance, while colleagues ignore the moral implications of their work by defining their task as caring for patients' *bodies*, leaving consideration of the *persons* inhabiting these bodies to others.

Chapter 5 addresses the diverging values of surgeons and intensivists, while Chapter 6 shows how these values play out, and on occasion conflict with the values of family members, at the end of life.

Chapters 7 and 8 investigate an entirely different culture with different systems of values. The New Zealand intensivists I studied seemed less bound than their American counterparts by the "impera-

tive to intervene” with its technological corollary. They accepted responsibility as moral agents, attempting to make decisions that were culturally and interpersonally sensitive.

Chapter 9 examines a dissimilar linked system of values held by the midwestern hospital administrators. I am reluctant to characterize these as a moral economy; the values are surely interconnected, but the accent is more on *economy* than *moral*. The spiritual reality mentioned by Polanyi is absent; their values and decisions are pragmatic, not moral. The administrators are concerned with survival in a difficult and antagonistic milieu, where medical centers compete for paying patients while attempting to cope with an expanding and constantly changing host of regulatory directives. These regulations cut reimbursement while increasing the bureaucratic requirements constraining doctors and administrators, requirements that have little connection to delivering informed, compassionate medical care or teaching young doctors how to care for and about patients.

The final chapter of this book reflects on dying in an American ICU where varied value systems—of nurses, medical specialists, and families—often conflict, and financial exigencies, dictated by outside bureaucratic fiat, can hamper the way patients and families are dealt with.

The book illustrates how differing systems of professional, regional, and national values affect life and death in the ICU. Thus, at the end of life, the New Zealand intensivists consider suffering and quality of life rather than battling death to the bitter end; physicians are reimbursed in a manner that allows them time to talk with families, establish trust, and discuss personal and therapeutic issues; and medical care is largely financed by the government, so that unlike the United States, one group or disease (e.g., the aged or kidney disease) is not favored over another (e.g., children or diabetes). In contrast, we Americans get medical care that is consonant with our mercantile value system: we get the care we pay for and are denied the care *and the caring* we do not pay for.



A Caring Ethic: Nurses and the Dilemma of Powerlessness

The trained nurse has become one of the great blessings of humanity, taking a place beside the physician and the priest, and not inferior to either in her mission.

—William Osler, circa 1900

I remember the days on the floor when we gave back rubs, filled water pitchers and intermittently had time to sit down (not stand and wonder what else I am supposed to be doing) and talk with a patient. Unfortunately those days are long gone.

—Personal communication from a surgical ICU nurse, 2002

When I first started studying the Midwest SICU, I was struck by the differences between the ways the nurses and doctors related to patients.

The nurses cared *about* patients as well as *for* them. It was a nurse who waved at a conscious patient through the glass walls as he walked past the room. It was a nurse who held a patient's hand when a painful procedure was carried out. (Only once, in almost 18 months of research in this SICU was a resident observed holding a patient's hand, and that resident was an exceptional woman.) It was a nurse who sat silently during an end-of-life family conference, clasping and stroking the hand of the patient's wife. (This behavior is not recorded in the audiotape our project made

of this conference, but in focus groups, when bereaved family members were asked who was in charge of the patient, 96 percent responded: “the nurse.”)

The more time I spent in the unit, the more impressed I was by the nurses’ morale and compassion. They were the infantry who conducted the hand-to-hand battle with disease while the officers concentrated on strategy. They cared deeply about their work and the patients, and appeared to know more about patient care than the first- and second-year residents who rotated through the unit for four-week stints.

A former nurse-manager said that historically the SICU was viewed as the hardest ICU to work in because it cared for the most challenging, critically ill. Most patients had not only undergone major surgery, but also suffered from multisystem problems. The patients were extremely sick, frequently infected (having more modes of entry for pathogens), heavy, and often unable to move because of large abdominal wounds (which meant the nurse had to shift them in the course of daily care). If you trained in the SICU, this woman said, you could work anywhere else in the hospital.

When the nurses declared “We’re the best!” several comparisons were implied. They were convinced that their hospital was “the best,” with a stellar reputation in the region and the country. (On daily rounds, the intensivists emphasized that the hospital received patients that other hospitals lacked the knowledge and facilities to care for, so that patients who would have died elsewhere survived in this unit. “I told you we resurrect the dead!” affirmed a nurse, discussing a patient who had survived a condition that I had been told was 98 percent fatal. The nurses knew that they had more training and technological expertise than the nurses on the floor. They were also claiming superiority to the ICU nurses in the medical and cardiac care units. (In Texas, a surgical research nurse affirmed that the nurses in the surgical ICU were different: They were more outspoken and confident than those in the medical unit.)

“We’ve got the teamwork!” proclaimed a nurse when I expressed admiration for their proficiency and esprit de corps. The little room adjoining the nurses’ lockers, where nurses ate their lunches, displayed notices where people could sign up for various activities: golfing, a hockey game, a gathering at someone’s house to play Bunko, a potluck meal, a shower for someone who just had a baby, or a bachelorette party for a newly engaged woman. Christmas brought forth “Secret

Santa,” where a player drew a name for whom he or she bought a gift, which was exhibited, beautifully-wrapped, in the little room. At Halloween, the nurses joined in “haunting,” where an anonymous gift of candy obliged the recipient to send candy to three others.

As the nurses sat around the table in the little room, they occasionally traded “war stories” affirming their competence, quick-wittedness, and composure under pressure. “Tell them about the time you paralyzed Grandpa,” one nurse urged another. Nicole related the story: One day when everything was breaking loose at the same time, they were doing a perc trach (a percutaneous tracheotomy)¹ on one patient, and an old man, she could not remember his name—“Grandpa, we’ll call him Grandpa. He was a cute little old grandfather”—had an emergency. She left the trach and ran into his room where Patty, his inexperienced nurse, was terrified. She sent Patty for medication and paralyzed the patient.² Miguel, the fellow, finally arrived, and the nurse told him what the problem was and what she had done. “You can sign for it,” Nicole had announced, “Or I can not chart it.”³ This was greeted with roars of laughter, and Sandy, another nurse, told about the day the power failed. The hospital was switching from one generator to another, but something went wrong and the emergency generator failed, and there was no power at all in the unit for 20 minutes. “It was black, black, black,” said Sandy, “no lights at all, no ventilators working.” She was running from one end of the unit to the other, trying to take care of all the patients. There was one gunshot patient quietly bagging himself,⁴ while she went down the line with Fentanyl⁵ giving shots to patients, trying to calm them while this was all going on. Then the guy who was bagging himself “seized” [had a seizure] and they had to revive him. They did not lose anyone, but it was terrible. Sandy still finds it terrifying to think about. Her colleagues nodded sympathetically.

Experienced nurses showed green residents how best to administer medications and perform procedures and tried to allay what they perceived as a callous attitude of some young doctors toward patients and families. (Whenever I wanted to learn about a resident, I asked the nurses; they knew who was technically competent and knowledgeable and who was inept and unteachable, who was caring, and who, unfeeling. I doubt if the residents realized how closely they were observed and how exactly they were judged.) The nurses took credit for the conscientiousness and compassion of one young intensivist who had

completed his residency and critical care fellowship at this hospital. “We trained him!” they said fondly. (He understood the tender-hearted nurses, as well; when he needed a new home for the family cocker spaniel, whom his toddler kept mauling, he brought in a color photograph of the dog and announced that it would have to be destroyed unless someone adopted it. Naturally, a nurse took the dog in.) The nurses also recounted how they had helped smooth the rough edges from the unit co-director, who had been unacceptably harsh and brusque when he first arrived.

The nurses always seemed to know patients’ prognoses. They hated caring for people whose surgeons insisted on “flogging” them—using technology to keep the body going when death was immanent. Some surgeons would paint rosy pictures to family members. The nurses were caught in the middle; they were unable to tell the truth, as they saw it, to the family, who might inquire about the condition of a moribund patient who, according to the surgeon, was improving. On occasion, an experienced nurse might quietly help a family member reach a surgeon who had been resolutely “unavailable” for days; the nurse would page the surgeon and then hand the phone to the wife or son. They knew which surgeons were reckless, had poor results, and refused to acknowledge dying. The nurses called one such man, Dr. Dreyer, “let-’em-expire-Dreyer.”

It was difficult, if not impossible, for a nurse to oppose a physician. She might hint at her opinion or quietly offer a suggestion, but the doctor—be he or she resident, attending, or even medical student—was free to ignore these hints or suggestions. Despite their wishes and claims for professional status, nurses have been trained to obey. Comparing the training of nurses and doctors, one commentator says: “While medical training can be seen as a ‘toughening up’ process preparing students for the rigors of a doctor’s life, nurse training is an object lesson in submission. In nurse training, *others* get tough. The nurse is taught to follow rules, to be deferential to doctors, and the importance of routine is emphasized.”⁶

It would be a brave—perhaps foolhardy—nurse who would openly contradict a doctor, especially a senior attending physician. What this meant was that nurses were forced to utilize traditionally “feminine” modes of disagreement: gentle suggestions, sotto voce comments, and gossip. (Perhaps as a result, the nurses’ “grapevine” was incredibly efficient, extending throughout the medical center.)

Patients' Stories and the Moral Order

One morning, an attending physician, leading rounds in the unit, declared: "I don't like to think about the story, it interferes with medical care." (The patient, who tested positive for alcohol and cocaine, had reported being shot by an unknown assailant after making several wrong turns in his car.)⁷ The doctor turned to me: "Someone said the story was the most interesting part. Was that you?" It was not, but it could have been, and I told him I found the stories fascinating.

I waited until rounds were finished to inquire whether this doctor's distaste for stories applied only to patients to whom one might apply an unfavorable moral calculus. He responded, "No. Although some details are part of the medical picture, I prefer not to think about the rest." Later, I asked a critical care fellow whether she, too, preferred to ignore the patient's story. She said that she no longer thinks about the story; she tries not to since she found she was joking about certain patients outside their rooms. She said she found that sort of behavior unprofessional, so now she tries to concentrate on getting the patient better.

The nurses, on the other hand, invariably knew the patients' stories. Often they volunteered the information without being asked:

She's 70; he was her high school sweetheart; they were married for a month when the stove exploded; he burned his hands trying to rescue her, but she was burned over 40% of her body.

Her boyfriend shot her. They were having an argument: she came after him with a knife, and he got his gun loaded with exploding bullets, the kind they call a "cop killer." They found alcohol in her blood.

The day after a young man, shot and paralyzed in a tragic hunting accident, was sent to the unit, an exceptionally compassionate attending informed me that the patient had been accidentally shot by a family member. "He just found out today?" asked a nurse in surprise. The nurses learned this the day the patient arrived.

Knowing the patients' stories, which they pieced together from family members, the medical chart, and patients when they were able to communicate, was only one of the ways in which the nurses affirmed the personhood of patients.

The nurses, male and female, performed a culturally female-identified expressive role in the unit. They could describe the size, sex distribution, and ages of the patients' children, the relationship be-