

# Perceptions of Appropriateness of Care Among European and Israeli Intensive Care Unit Nurses and Physicians

Ruth D. Piers, MD

Elie Azoulay, MD, PhD

Bara Ricou, MD

Freda DeKeyser Ganz, RN, PhD

Johan Decruyenaere, MD, PhD

Adeline Max, MD

Andrej Michalsen, MD, MPH

Paulo Azevedo Maia, MD

Radoslaw Owczuk, MD, PhD

Francesca Rubulotta, MD, FRCA

Pieter Depuydt, MD, PhD

Anne-Pascale Meert, MD

Anna K. Reyners, MD, PhD

Andrew Aquilina, MD

Maarten Bekaert, MSc

Nele J. Van Den Noortgate, MD, PhD

Wim J. Schrauwen, MSc

Dominique D. Benoit, MD, PhD

for the APPROPRICUS Study Group  
of the Ethics Section of the ESICM

CLINICIANS PERCEIVE THE CARE they provide as inappropriate when they feel that it clashes with their personal beliefs and/or professional knowledge.<sup>1</sup> Intensive care unit (ICU) workers who provide care perceived as inappropriate experience acute moral distress and are at risk for burnout.<sup>2</sup> This situation may jeopardize the quality of care and increase staff turnover.<sup>2-4</sup>

The principal causes of moral distress reported in ICU nurses are delivery of futile care, unsuccessful patient

**For editorial comment see p 2725.**

**Context** Clinicians in intensive care units (ICUs) who perceive the care they provide as inappropriate experience moral distress and are at risk for burnout. This situation may jeopardize patient quality of care and increase staff turnover.

**Objective** To determine the prevalence of perceived inappropriateness of care among ICU clinicians and to identify patient-related situations, personal characteristics, and work-related characteristics associated with perceived inappropriateness of care.

**Design, Setting, and Participants** Cross-sectional evaluation on May 11, 2010, of 82 adult ICUs in 9 European countries and Israel. Participants were 1953 ICU nurses and physicians providing bedside care.

**Main Outcome Measure** Perceived inappropriateness of care, defined as a specific patient-care situation in which the clinician acts in a manner contrary to his or her personal and professional beliefs, as assessed using a questionnaire designed for the study.

**Results** Of 1651 respondents (median response rate, 93% overall; interquartile range, 82%-100% [medians 93% among nurses and 100% among physicians]), perceived inappropriateness of care in at least 1 patient was reported by 439 clinicians overall (27%; 95% CI, 24%-29%), 300 of 1218 were nurses (25%), 132 of 407 were physicians (32%), and 26 had missing answers describing job title. Of these 439 individuals, 397 reported 445 situations associated with perceived inappropriateness of care. The most common reports were perceived disproportionate care (290 situations [65%; 95% CI, 58%-73%], of which "too much care" was reported in 89% of situations, followed by "other patients would benefit more" (168 situations [38%; 95% CI, 32%-43%]). Independently associated with perceived inappropriateness of care rates both among nurses and physicians were symptom control decisions directed by physicians only (odds ratio [OR], 1.73; 95% CI, 1.17-2.56;  $P = .006$ ); involvement of nurses in end-of-life decision making (OR, 0.76; 95% CI, 0.60-0.96;  $P = .02$ ); good collaboration between nurses and physicians (OR, 0.72; 95% CI, 0.56-0.92;  $P = .009$ ); and freedom to decide how to perform work-related tasks (OR, 0.72; 95% CI, 0.59-0.89;  $P = .002$ ); while a high perceived workload was significantly associated among nurses only (OR, 1.49; 95% CI, 1.07-2.06;  $P = .02$ ). Perceived inappropriateness of care was independently associated with higher intent to leave a job (OR, 1.65; 95% CI, 1.04-2.63;  $P = .03$ ). In the subset of 69 ICUs for which patient data could be linked, clinicians reported received inappropriateness of care in 207 patients, representing 23% (95% CI, 20%-27%) of 883 ICU beds.

**Conclusion** Among a group of European and Israeli ICU clinicians, perceptions of inappropriate care were frequently reported and were inversely associated with factors indicating good teamwork.

JAMA. 2011;306(24):2694-2703

www.jama.com

advocacy, and communication of unrealistic prospects to the patients and families.<sup>4-8</sup> ICU physicians may be troubled by a perceived lack of power to make the clinical decision that most benefits a specific patient.<sup>5</sup> A survey among 504 Eu-

**Author Affiliations and a List of the APPROPRICUS Study Group** appear at the end of this article.

**Corresponding Author:** Ruth D. Piers, MD, Ghent University Hospital, Gent, De Pintelaan 185, Gent, 9000, Belgium (ruth.piers@ugent.be).

**Caring for the Critically Ill Patient Section Editor:** Derek C. Angus, MD, MPH, Contributing Editor, JAMA (angusdc@upmc.edu).

European ICU physicians showed that 73% of units frequently admitted patients with no realistic hope of survival, although only 33% of the physicians felt that such patients should be admitted.<sup>9</sup> More recently, 87% of 114 Canadian ICU physician directors reported that futile care was provided in their ICU over the last year.<sup>10</sup> However, earlier studies of perceived inappropriateness of care in the ICU did not provide data linked to individual cases. Consequently, the extent of perceived inappropriateness of care in the ICU is unknown and the magnitude of situations causing moral distress may be underestimated.

The primary objective of this study was to determine the prevalence of perceived inappropriateness of care among clinicians in European and Israeli ICUs, to describe the patient-related situations associated with perceived inappropriateness of care, and to explore the level of agreement among clinicians concerning perceived inappropriateness of care. The secondary objective was to evaluate the hypothesis that perceived inappropriateness of care is associated not only with situational factors, but also with personal characteristics and work-related factors as well as with intentional job leave. The theoretical framework is given in FIGURE 1.<sup>1-7,11-21</sup>

**METHODS**

**Study Design and Procedure**

We conducted a single-day cross-sectional study among clinicians in European and Israeli adult ICUs including nurses, head nurses, and junior and senior ICU physicians. Ten members of the European Society of Intensive Care Medicine (ESICM) ethics section agreed to serve as national coordinators with 1 representative in each country (Belgium, France, Germany, Israel, Italy, Malta, Poland, Portugal, Switzerland, and The Netherlands). Each national coordinator recruited adult ICUs for the study and obtained approval from the relevant ethics committee for each ICU. In each ICU, a local investigator contacted and enrolled the ICU clinicians scheduled to work in the ICU on the study day and

organized an information session during the week before the study.

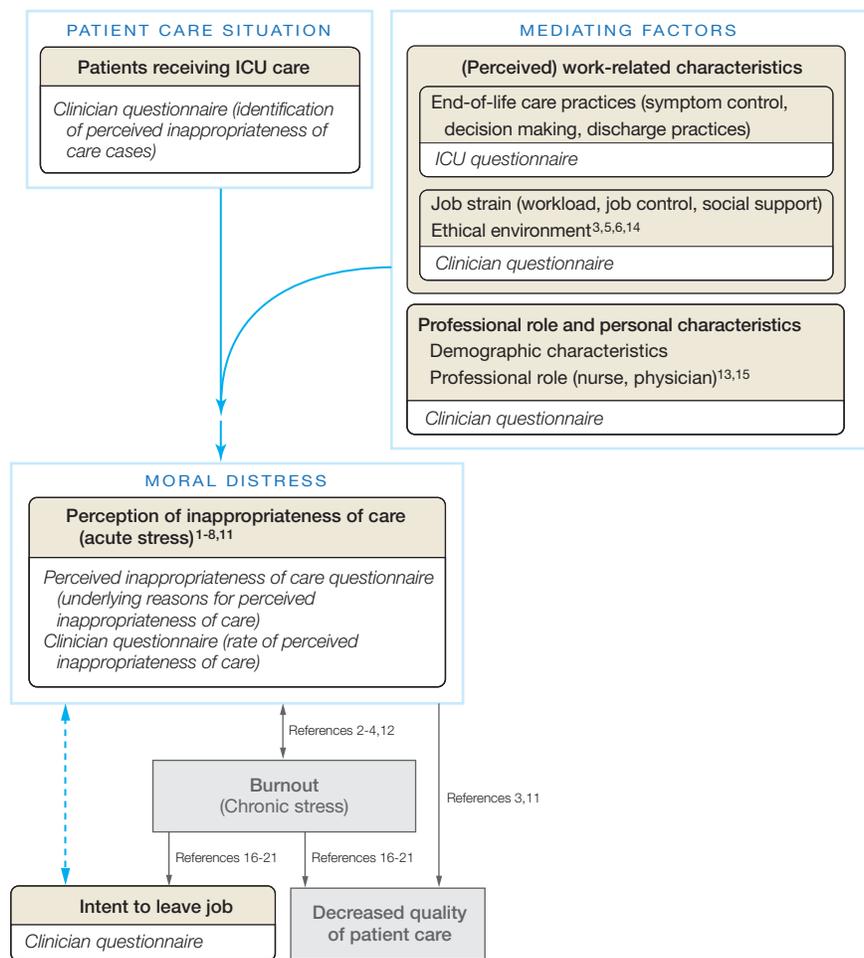
The study took place from 8 AM, on Tuesday May 11, 2010, to 8 AM, on Wednesday May 12, 2010, in all participating countries except Israel, where the study took place on May 25, 2010, for organizational reasons. The local investigators were asked to establish a coded list of the patients admitted to the ICU on the survey day. This list was destroyed after data collection to pre-

clude identification of the patients. The local investigators were asked to re-send the questionnaires within 1 week, making recall bias unlikely.

**Instruments**

Three questionnaires were used for data collection: the ICU questionnaire, the clinician questionnaire, and the perceived inappropriateness of care questionnaire (eAppendices 1, 2, 3, available at <http://www.jama.com>).

**Figure 1.** Theoretical Framework for the Perception of Inappropriateness of Care and Study Instruments



ICU indicates intensive care unit. A patient care situation that is perceived as inappropriate according to the clinician's personal and work-related background may cause moral distress. When moral distress is repetitive, cannot be avoided, or is not acknowledged by the clinical team or superiors who might potentially affect the distress-causing situation, moral distress may accumulate and subsequently lead to job leave, burnout, decreased quality of patient care, or a combination of these outcomes. The relationship between perception of inappropriateness of care and intent to leave job was investigated in this research (dashed arrow); and the directionality of any association cannot be determined by the study design. Components of the theoretical framework shown in gray were not measured in this study.

**The ICU Questionnaire.** In each study ICU, the local investigator completed the ICU questionnaire about ICU characteristics (type of hospital and ICU; mortality rate; number of ICU clinicians; and availability of an ethics consultant, psychologist, or both) and end-of-life practices (symptom control, decision making, and discharge of dying patients to the wards).

**The Clinician Questionnaire.** Each nurse and physician working in the ICU on the day of the survey completed a questionnaire about personal characteristics (including age, sex, religion, professional role, and work experience), perceived work characteristics (job strain

and ethical environment), and intent to leave. The respondents indicated the number of patients in their care on the survey day and the number of patients perceived as receiving inappropriate care.

The clinician questionnaire included the Job Strain Scale, a validated 12-item scale exploring job demand, control, and social support.<sup>20,21</sup> According to the job strain model developed by Karasek and Theorell,<sup>20</sup> job strain occurs when job demands (workload) are high and job control (sum of skill use and decision-making authority) is low. A third factor in this job strain model is social support (from the supervisor and coworkers), which protects against job strain.

The total score is obtained by adding the control and social support subscores then subtracting the demand score. Higher scores indicate less job strain.

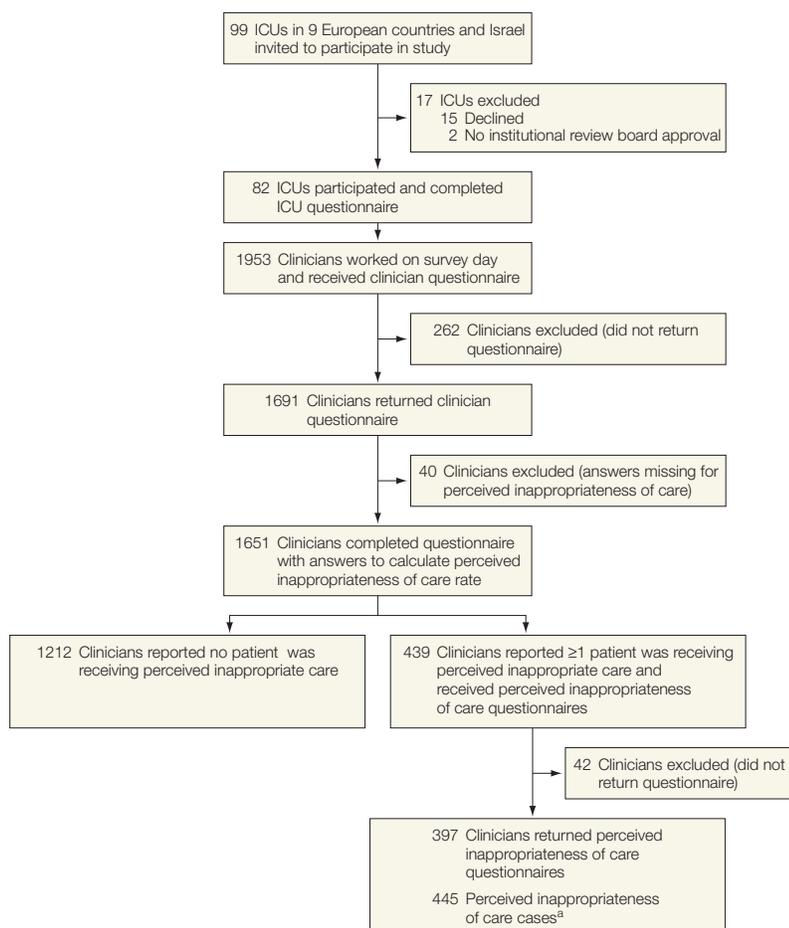
The ethical environment was defined as “the organizational conditions and practices that affect the way ethically difficult patient care problems are discussed and decided.”<sup>22</sup> We assessed 7 aspects of the ethical work environment previously identified in scientific studies: tolerance of different opinions and values; possibility of ethical debate<sup>5,6,22-24</sup>; empathic understanding provided by colleagues; collaboration among colleagues<sup>3,8,23,24</sup>; nurse-physician collaboration<sup>5,6</sup>; presence of nurses during communication of end-of-life information; and active involvement of nurses in decision making.<sup>25-27</sup> These 7 items showed good internal reliability (Cronbach  $\alpha$ , 0.79;  $P < .001$ ).

The clinicians were asked to report whether they had thoughts of leaving their current job or profession. Past effective job leave due to disagreement about patient care was recorded.<sup>5-7</sup>

**The Perceived Inappropriateness of Care Questionnaire.** Clinicians who reported perceived inappropriateness of care were requested to complete the perceived inappropriateness of care questionnaire for each patient who was perceived as receiving inappropriate care. The questionnaire evaluated the reasons leading the clinician to consider that care was inappropriate. The patient code allowed us to link the questionnaire responses to data about the relevant patient and therefore to assess the level of agreement among clinicians regarding perceived inappropriateness of care for a given patient.

In this study, we defined perceived inappropriateness of care as a patient-care situation perceived by the respondent to fit 1 or more of the following statements or scenarios: (1) disproportion between the amount of care given and the expected prognosis (too much or too little care); (2) persistent nonadherence of the patient; (3) other patients would benefit more from ICU care; (4) inaccurate information was given to the patient or family; (5) the patient's wishes concerning treatment preferences were known but not respected; (6) one of the parties involved did not par-

**Figure 2.** Flow of Questionnaire Responses for All Participating Centers



ICU indicates intensive care unit.

<sup>a</sup>The number of clinicians who returned perceived inappropriateness of care questionnaires and the number of perceived inappropriateness of care cases differ because clinicians were asked to complete a questionnaire for each patient for whom they believed inappropriate care was given.

ticipate in decision making related to the patient; and (7) the patient was not getting good-quality care.

To build the study questionnaires, we asked a panel of experts in intensive care, palliative care, and communication to use a Delphi method to develop a consensus about the 7 scenarios and the content of the 3 questionnaires. The original English-language questionnaire was translated into the first language of each participating country then back-translated to English (Brislin method).

The prevalence of perceived inappropriateness of care was defined as the number of clinicians reporting perceived inappropriateness of care for at least 1 of their patients divided by the total number of surveyed clinicians in the same ICU. The perceived inappropriateness of care rate for each clinician was defined as the ratio of the number of patients with perceived inappropriateness of care reported by the clinician over the total number receiving care from the same clinician.

This study has been approved by the appropriate institutional review board in all participating ICUs and countries. Except for Belgium, where written informed consent was obtained from the participating clinicians, completing the questionnaire was taken as evidence of consent to study participation.

**Statistical Analysis**

Values were described as median or percentage. The  $\chi^2$  test was used to assess differences between nurses and physicians and to assess differences in patient characteristics between patient groups.

Two hierarchical multivariate models were built to identify ICU and clinician characteristics (fixed effects) associated with (1) the perceived inappropriateness of care rate and (2) intentional job leave. We modeled the correlation between clinicians working in the same ICU by including a random ICU effect, nested within a given country, to take into account a possible correlation between ICUs in the same country. The full model included all the variables of the ICU and clinician questionnaires. A stepwise backward selection procedure with a signifi-

cance level of 5% was used to build the final model. All statistical analyses were performed using SAS statistical software version 9.2 and SPSS version 17.

**RESULTS**

**Participating ICUs and Clinicians**

Of the 99 ICUs invited to join the study, 82 participated and 17 declined (2 because of no institutional review board approval) (FIGURE 2). In total, 1953 clinicians worked on the survey day and were eligible to receive the questionnaire (median clinicians/ICU, 19.5;

IQR, 15-29). The median response rate within participating ICUs was 93% overall (IQR, 82%-100%), 93% among nurses (IQR, 82%-100%), and 100% among physicians (IQR, 80%-100%). The characteristics of the ICUs and clinicians are described in TABLE 1, TABLE 2, TABLE 3, and TABLE 4.

**Prevalence of Clinicians Reporting Perceived Inappropriateness of Care**

Of the 1651 clinicians who provided responses for calculating the perceived inappropriateness of care rate (number of

**Table 1.** ICU Characteristics (N=82)

Characteristics	Value <sup>a</sup>
Type of hospital	
University and university affiliated	45/81 (55.6)
Public	31/81 (38.3)
Private	5/81 (6.2)
Hospital beds	
<250	9/82 (11.0)
250-500	26/82 (31.7)
500-750	19/82 (23.2)
>750	29/82 (34.1)
Individual(s) initiating ICU admissions	
Critical care physician	82/82 (100)
Specialist in the wards	33/82 (40.2)
Patients and relatives	5/82 (6.1)
ICU treatment provision by patient category	
Medical	78/82 (95.1)
Surgical	78/82 (95.1)
Trauma	61/82 (74.4)
Cardiac	53/82 (64.6)
Transplant	19/82 (23.2)
Burn	12/82 (14.6)
Other	11/82 (13.4)
Type of ICU	
Closed	61/81 (74.4)
Open	7/81 (8.5)
Mixed	13/81 (15.9)
Availability of an ethics consultant in the hospital	46/81 (56.8)
Nurses working 8-hour shifts	52/78 (66.7)
24-Hour presence of a senior intensivist	60/81 (74.1)
Availability of a psychologist/psychosocial worker	40/81 (59.4)
No. of ICU beds	11 (8-14.5)
No. of ICU admissions per year	650 (356-1085)
ICU mortality in 2009, %	12 (7-20)
ICU length of stay, d	5.2 (3.7-7.0)
No. of ICU nurses	30.5 (23.5-46.0)
Patient-to-nurse ratio	2.0 (2.0-2.7)
No. of ICU physicians	5.5 (3-9)
Junior	2 (1-4)
Senior	4 (2-6)
Patient-to-intensivist ratio	3.3 (2.6-6.0)

Abbreviation: ICU, intensive care unit.

<sup>a</sup>All data are shown as No./total No. (%) or median (interquartile range). Percentages may not sum to 100% due to rounding. Denominators may differ because of missing data (respondent did not fill in).

**Table 2.** ICU Characteristics for End-of-Life Care (N=82)

Characteristics of End-of-Life Care Practices	No./Total No. (%) <sup>a</sup>
Symptom control decisions	
Physicians only	32/81 (39.5)
Nurses and physicians	49/81 (60.5)
Timing for regular nurse/physician meetings about end-of-life care decisions	
Always or routinely	49/82 (59.7)
Frequently	11/82 (13.4)
Rarely or never	22/82 (26.8)
Nurses present during communication of end-of-life care information to family members	
Always or routinely	40/82 (48.7)
Frequently	16/82 (19.5)
Rarely or never	26/82 (31.7)
Use of terminal sedation	64/81 (79.0)
Use of terminal extubation	38/82 (46.3)
Discharge practices (patient type to destination)	
Intubated patients to the wards	17/82 (20.7)
Dying patients to the wards	54/82 (65.9)
Dying patients to their homes	25/77 (32.5)

Abbreviation: ICU, intensive care unit.

<sup>a</sup>Percentages may not sum to 100% due to rounding. Denominators may differ because of missing data (respondent did not fill in).

**Table 3.** Clinician Characteristics

Characteristics	No./Total No. (%) of Clinicians (n = 1691) <sup>a</sup>
Age, median (IQR), y	34 (28-42)
Female sex	1108/1686 (65.7)
Resides with partner	1207/1665 (72.5)
Has children	833/1669 (49.9)
Country	
Belgium	379/1691 (22.4)
France	302/1691 (17.9)
Germany	202/1691 (11.9)
Israel	33/1691 (2.0)
Italy	78/1691 (4.6)
Malta	37/1691 (2.2)
Poland	112/1691 (6.6)
Portugal	169/1691 (10.0)
Switzerland	231/1691 (13.7)
The Netherlands	148/1691 (8.8)
Religion or religious status	
Roman Catholic	808/1676 (48.2)
Protestant	133/1676 (7.9)
Muslim	47/1676 (2.8)
Jewish	36/1676 (2.1)
Buddhist	11/1676 (0.7)
Not religious	504/1676 (30.1)
Other	38/1676 (2.3)
"I do not wish to answer this question"	99/1676 (5.9)
Importance of religion (1 very important to 4 not important), median (IQR)	3 (2-4)

Abbreviation: IQR, interquartile range.

<sup>a</sup>Data are shown as No./total No. (%) unless otherwise indicated. Percentages may not sum to 100% due to rounding. Denominators may differ because of missing data (respondent did not fill in).

patients with perceived inappropriateness of care over the total number receiving care from the same clinician), 439 reported perceived inappropriateness of care in at least 1 patient (27%; 95% CI, 24%-29%; Figure 2) (range across countries, 8%-49%). Of the 1218 nurses who completed the perceived inappropriateness of care questionnaire, each provided care to a median of 2 patients (IQR, 1-3); among them, 300 reported perceived inappropriateness of care (25%; 95% CI, 22%-27%). The 407 ICU physicians provided care to a median of 6 patients (IQR, 4-9) and among them, 132 (32%; 95% CI, 27%-38%) reported perceived inappropriateness of care in at least 1 of their patients. Seven of 26 clinicians failed to indicate their job title (nurse or physician) in the questionnaire.

**Reasons for Perceived Inappropriateness of Care**

In all, 397 clinicians completed 445 perceived inappropriateness of care questionnaires (Figure 2). The most common reported reason for perceived inappropriateness of care was perceived disproportionate care (65%) (FIGURE 3); in 89% of these cases, the amount of care was perceived as excessive and in 11% as insufficient. Disproportionate care was the leading reason for perceived inappropriateness of care among nurses (182/286, 64%) and physicians (99/144, 69%) (15 answers missing on professional role, P=.33). The second most common reason for perceived inappropriateness of care was a feeling that other patients would benefit more from ICU care than the present patient (38%) (Figure 3). This feeling of distributive injustice was significantly more common among physicians (64/144, 44%) than among nurses (98/286, 34%) (P=.05). Observing a lack of participation in decision making, persistent nonadherence of the patient, a lack of accurate information giving, perceptions of poor-quality patient care, and disregarding a patient's wishes were less frequently given as reasons to report inappropriateness of care in this study (Figure 3).

Of the 379 reports of perceived inappropriateness of care for which this information was available, 237 (63%; 95% CI, 55%-70%) stated that similar situations were common in the ICU. The recurrence of situations was more often reported by nurses when compared with physicians (73% vs 43%;  $P < .001$ ). In 214 of 377 reports (68 missing this response; 57% [95% CI, 49%-64%]), the clinician was not confident that the situation associated with perceived inappropriateness of care would be resolved in the near future (nurses 39% vs physicians 48%;  $P = .08$ ). More nurses, when compared with physicians, were quite, very, or strongly distressed by the perception of inappropriate care (68% [165/241] in nurses compared with 55% [71/128] in physicians;  $P = .01$ ).

**Agreement Between Different Clinicians Caring for the Same Patient**

Patient codes were correctly recorded in 69 ICUs (FIGURE 4). Perceived inappropriateness of care was reported for 207 patients, corresponding with 23% of 883 ICU beds (95% CI, 20%-27%). For 136 of these patients (66%; 95% CI, 55%-77%), a single clinician, who in most cases was a nurse vs a physician, reported perceived inappropriateness of care (71% vs 29%; Figure 4). For 71 of the 207 patients (34%; 95% CI, 26%-42%), more than 1 clinician reported perceived inappropriateness of care; and in 66% of these patients (45/68 [ $\geq 1$  professional role unknown in 3 cases]), at least 1 nurse and 1 physician reported the same view (Figure 4). These 71 patients represent 8% (95% CI, 6%-10%) of the 883 ICU beds.

Except for a longer length of stay, no other patient characteristics were associated with agreement on appropriateness of care (eTable 1).

**Factors Related to Perceived Inappropriateness of Care**

The perceived inappropriateness of care rate is the ratio of the number of patients perceived as receiving inappropriate care, as reported by the clinician, over the total number of patients receiving care from the clinician. The results of uni-

variate analysis are presented in the on-line supplement (eTable 2).

Multivariate analysis revealed that the following factors were independently associated with lower perceived inap-

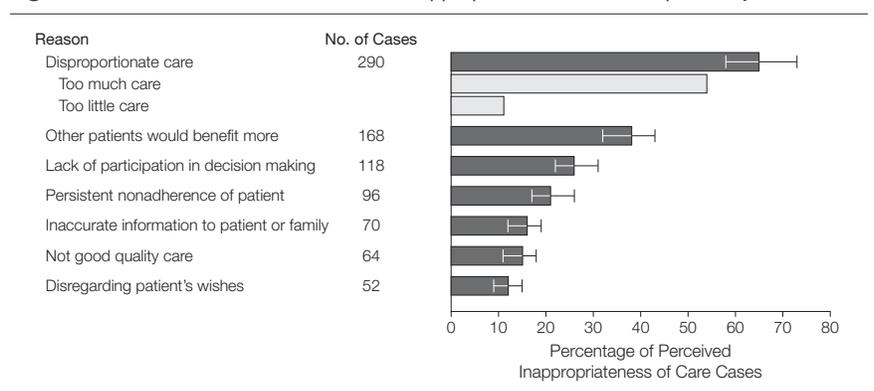
propriateness of care rates (fixed effects): (1) decisions about symptom control shared by nurses and physicians as opposed to being made by the physicians only; (2) involvement of

**Table 4.** Clinician Characteristics in the Work Setting

Characteristics (n = 1691)	No./Total No. (%) <sup>a</sup>
Professional role in the ICU	
Nurse	
Nurse	1115/1685 (66.2)
Head nurse	48/1685 (2.8)
Nursing assistant	91/1685 (5.4)
Nursing school student	10/1685 (0.6)
Physician	
Junior physician	180/1685 (10.7)
Senior physician	198/1685 (11.7)
Head of ICU	32/1685 (1.9)
"I do not wish to answer this question"	11/1685 (0.7)
Years working in ICU, median (IQR)	6 (2-14)
Hours worked per week, median (IQR)	40 (35-42)
Working night shifts	1393/1644 (84.7)
If night shifts, number per month, median (IQR)	5 (3-6)
Participation in an ICU working group	552/1654 (33.4)
Job Strain Scale, median (IQR)	
Total score (-3 most job strain to 9 least job strain)	5 (3-7)
Demand score (0 lowest to 3 highest)	2 (1-3)
Job control score (0 lowest to 5 highest)	4 (3-4)
Social support score (0 lowest to 4 highest)	4 (2-4)
Ethical environment	
Tolerance of different opinions and values	1330/1661 (80.0)
Ethical debate possible	1226/1657 (74.0)
Empathic understanding of colleagues	1481/1664 (89.0)
Good collaboration among colleagues	1600/1676 (95.5)
Good nurse-physician collaboration	1254/1654 (75.8)
Presence of nurse during EOL communication	1073/1657 (64.8)
Involvement of nurses in EOL decision making	857/1648 (52.0)

Abbreviations: EOL, end-of-life; IQR, interquartile range.  
<sup>a</sup>Data are shown as No./total No. (%) unless otherwise indicated. Percentages may not add up to 100% due to rounding. Denominators may differ because of missing data (respondent did not fill in).

**Figure 3.** Reasons and Rates of Perceived Inappropriateness of Care Reported by Clinicians



Error bars indicate 95% CIs.

nurses in end-of-life decisions; (3) good collaboration between nurses and physicians; (4) work autonomy; and (5) perceived lower workload, only among nurses (TABLE 5).

The perceived inappropriateness of care rates were correlated with one another within ICUs and countries (random effect), showing some degree of homogeneity in perceived inappropriateness of care rates in ICUs within a given country.

### Intent to Leave

Nine percent of clinicians (95% CI, 7%-11%) left a previous job because of disagreements related to patient care (147/1593; 58 answers missing). More nurses compared with physicians (10% vs 6%)

reported past effective job leave ( $P = .02$ ). Almost one-third of the respondents (31%; 95% CI, 28%-33%) had thoughts about leaving their current job (500/1630; unreported professional role for 21; 27% physicians vs 32% nurses;  $P = .08$ ).

Perceived inappropriateness of care was independently associated with higher intentional leave from a job (Table 5). Being a nurse or a physician had no independent effect on job departure (Table 5).

### COMMENT

To our knowledge, this is the first large-scale observational study describing perceptions of inappropriate care linked to patient-care situations both in ICU

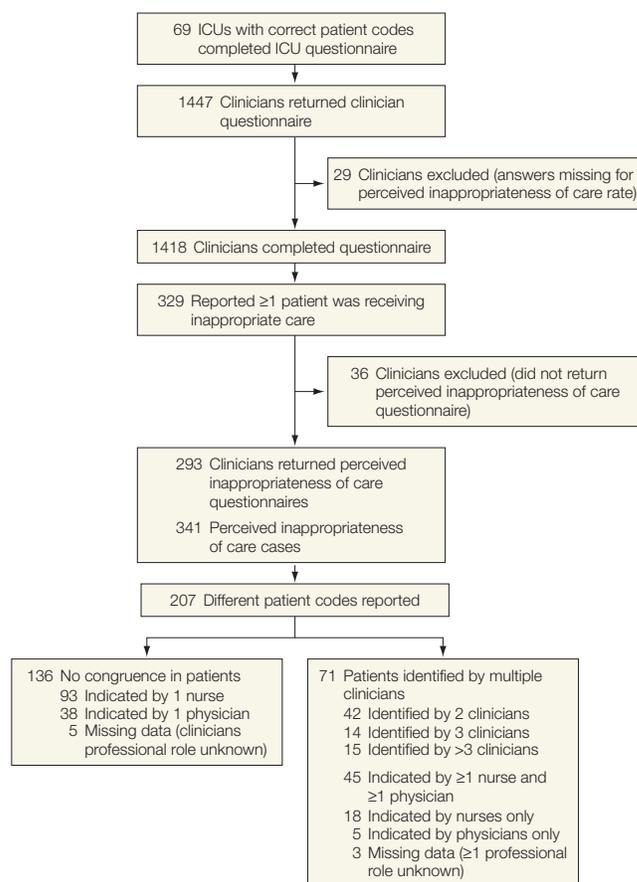
nurses and ICU physicians involved in direct patient care. We found that about 1 in 4 ICU nurses and 1 in 3 ICU physicians believed that they delivered inappropriate care to at least 1 of their patients on the day of the survey. Most of the respondents indicated that similar situations were common in their ICU, and more than half were not confident that these situations would be resolved in the near future.

Repeated perceived inappropriateness of care may strongly influence perceptions of a new patient care situation and as such, affect the quality of patient care.<sup>3,4,12</sup> Moreover, in our study perceived inappropriateness of care was independently associated with intentional job leave among nurses and physicians.

The most commonly reported reason for perceived inappropriateness of care was excessive intensity of care. In the ETHICUS study (end-of-life practices in European intensive care units), 89% of ICU physicians reported feeling comfortable with the end-of-life decisions they had made.<sup>28</sup> In our study, end-of-life decisions were mostly reported as being made too late or too infrequently. In addition to disproportionate care inducing perceived inappropriateness of care, a perceived failure to observe distributive justice was common, most notably among physicians.<sup>25,29,30</sup>

For two-thirds of patients receiving care from more than 1 respondent, only 1 respondent reported perceived inappropriateness of care. No severity of illness-related characteristics of the ICUs such as average ICU stay length or ICU mortality were significantly related to perceived inappropriateness of care. In addition, the prevalence of perceived inappropriateness of care varied widely across countries and across ICUs and clinicians within a given country. These data underline the subjective nature of perceived inappropriateness of care.<sup>5,13,15,31</sup> The high variability in judgement about appropriateness of care reflects that an individual clinician's judgement is a personal issue related to the clinician's own world view and is therefore colored by his or her

**Figure 4.** Flow of Questionnaire Responses With Patient Codes



ICU indicates intensive care unit.

<sup>a</sup>The number of clinicians who returned perceived inappropriateness of care questionnaires and the number of perceived inappropriateness of care cases differ because clinicians were asked to complete a questionnaire for each patient in whom they believed inappropriate care was given.

own emotions, attitudes, backgrounds, and beliefs.<sup>32-37</sup>

As such, perceived inappropriateness of care will always be part of health care; however, in those workplaces with higher prevalence of perceived inappropriateness of care, there are organizational factors that are intensifying or not helping clinicians to cope with perceived inappropriateness of care.<sup>3,22,23,32,37</sup> In our study, the variability in perceived inappropriateness of care was largely associated with differences in the ethical environment across ICUs. For example, perceived inappropriateness of care was less common in ICUs in which physicians and nurses had a certain degree of job autonomy, an acceptable workload, and a high level of interdisciplinary collaboration and decision making. Interventions aimed

at improving these factors may decrease the likelihood of perceived inappropriateness of care via both an effect on subjective determinants of perceived inappropriateness of care and improved objective matching of the level of care to the expected outcome.

Another interesting finding from our study is the strong link between perceived excessive workload and perceived inappropriateness of care among the nurses only. Conceivably, nurses may be more likely to suffer from a perceived imbalance between the efforts they expend in caring for the patients and the perceived likelihood that their efforts will be rewarded by better patient outcomes.<sup>38</sup> Furthermore, nurses spend considerable time at the bedside and are consequently more acutely aware of the suffering of their patients

than are the physicians.<sup>5,15,39,40</sup> Another possible factor is that the medical decisions lie chiefly in the hands of the physicians, with the nurses being asked to accept and to execute those decisions.<sup>15,39,40</sup> Perceived powerlessness is a key determinant of moral distress in nurses and is related to a lack of collaboration in patient-care decision making.<sup>5,23,33</sup> Integrating the perspectives of nurses and the physicians may lead not only to greater mutual understanding with fewer conflicts,<sup>41</sup> but also to better end-of-life decision making and care for the patients and their families.<sup>13,39,42-46</sup> Teaching individual ICU clinicians to create a symbolic distance from their work experiences and outcomes by becoming aware of their own personal values and beliefs might be another effective intervention.<sup>32,38,47,48</sup> Re-

**Table 5.** Hierarchical Multivariate Regression Analyses

Full Multivariate Models					
Perceived Inappropriateness of Care Rate <sup>a</sup>			Intention to Leave Job <sup>b</sup>		
Factors	OR (95% CI)	P Value	Factors	OR (95% CI)	P Value
Symptom control decisions (physicians only vs nurses and physicians together)	1.73 (1.17-2.56)	.006	Perceived inappropriateness of care rate	1.65 (1.04-2.63)	.03
Involvement of nurses in EOL decisions (agree vs not agree)	0.76 (0.60-0.96)	.02	Patient-to-nurse ratio	1.41 (1.07-1.85)	.02
Nurse-physician collaboration (good vs poor)	0.72 (0.56-0.92)	.009	Availability of psychologist/psychosocial worker (agree vs not agree)	0.71 (0.51-0.98)	.04
Freedom to decide how to facilitate own work (agree vs not agree)	0.72 (0.59-0.89)	.002	Ethical debate possible (agree vs not agree)	0.67 (0.50-0.89)	.007
Interaction between role and perceived workload (nurse with high workload vs nurse without high workload)	1.49 (1.07-2.06)	.02	Involvement of nurses in EOL decisions (agree vs not agree)	0.74 (0.56-0.98)	.04
Physician with high workload vs physician without high workload	0.81 (0.56-1.19)	.29	High workload (agree vs not agree)	1.38 (1.04-1.58)	.03
			Inadequate time to complete work (agree vs not agree)	1.57 (1.38-2.10)	.002
			No repetitive work (agree vs not agree)	0.76 (0.58-0.99)	.04
			Job requires creativity (agree vs not agree)	0.69 (0.52-0.92)	.01
			Freedom to decide how to do your work (agree vs not agree)	0.75 (0.57-0.97)	.03
			Working with helpful people (agree vs not agree)	0.57 (0.34-0.96)	.03
			Working with people who take a personal interest (agree vs not agree)	0.60 (0.45-0.81)	.001
<b>Covariance parameter</b>	<b>Estimate (95% CI)</b>		<b>Covariance parameter</b>	<b>Estimate (95% CI)</b>	
ICU, nested within country	0.49 (0.32-0.84)		ICU, nested within country	0.17 (0.013-0.35)	

Abbreviations: EOL, end of life; ICU, intensive care unit; OR, odds ratio.

<sup>a</sup>Variables from the ICU questionnaire: hospital (type, number of beds, availability of ethics consultant); type of patients (medical, surgical, trauma, cardiac, transplant, burn patient); number of ICU beds; number of ICU admissions per year; ICU mortality; mean length of stay; type (open, mixed, or closed); number of nurses; nurses working 8- or 12-hour shifts; number of ICU physicians; availability of junior intensivist 24 hours per day; availability of senior intensivist 24 hours per day; availability of psychosocial worker; regarding ICU end-of-life care, decisions about symptom control; regular meetings between nurses and physicians for end-of-life decisions, performance of terminal sedation; performance of terminal extubation; possibility of discharging intubated patients to the wards; possibility of discharging dying patients to the wards; and the possibility of discharging dying patients home. Variables from the clinician questionnaire: demographic characteristics (age, sex, partner, children, religion, and importance of religion); work experience in the ICU; average working hours; working nightshifts or not; performing ICU research or participating in an ICU working group; professional role (nurse, physician); job strain (12-item questionnaire involving demand, control, and support); and 7 items regarding the ethical environment.

<sup>b</sup>Variables included in the full multivariate model for intentional job leave include the same variables used in footnote a plus the perceived inappropriateness of care rate.

alizing that there are different ways of thinking about moral issues can help the clinicians understand their own process of decision making and tolerate differences both in other clinicians' moral reasoning and decision making and in patients'/families' moral reasoning.<sup>11,35,37</sup> As such, disagreeing on the appropriateness of care and openly discussing these different views may be the starting point of good quality decision making truly adapted to the needs and preferences of the patient (or the family in case of incompetence).<sup>34,37,47-49</sup>

The challenge for ICU managers is thus to create ICUs in which self-reflection, mutual trust, open communication, and shared decision making are encouraged in order to improve the well-being of the individual clinicians and, thereby, the quality of patient care.

### Limitations and Further Studies

First, the study was not facilitated in a randomly selected sample of countries and ICUs. We chose to work with motivated national coordinators and local investigators to obtain high response rates and therefore to draw sound conclusions about the participating ICUs.

Second, patient coding was not performed in 13 of the 82 ICUs and our evaluation of agreement among clinicians regarding perceived inappropriateness of care for individual patients was consequently incomplete.

Third, a longitudinal study design would be needed to infer causal relationships between perceived inappropriateness of care and burnout or intent to leave. A longitudinal study might also allow an evaluation of the moral residue left by each instance of perceived inappropriateness of care in a given clinician.<sup>3,4,12</sup>

In conclusion, perceived inappropriateness of care is common among nurses and physicians in ICUs and is significantly associated with an intent to leave the current clinical position, suggesting a major impact on clinician well-being. The main reported reason for perceived inappropriateness of care is a mismatch between the level of

care and the expected patient outcome, usually in the direction of perceived excess intensity of care. Perceived inappropriateness of care is a subjective factor that does not necessarily indicate a failure to adhere to recommendations for patient care but that may serve as a marker for inadequate communication, decision sharing, and job autonomy within the ICU.

**Author Affiliations:** Departments of Intensive Care Medicine (Drs Piers, Decruyenaere, Depuydt, and Benoit), Geriatrics (Drs Piers and Van Den Noortgate), and Medical Oncology (Mr Schrauwen), Ghent University Hospital, Gent, Belgium; Medical ICU, Hôpital Saint-Louis and University Paris-7, Paris, France (Drs Azoulay and Max); Department of Intensive Care, University Hospitals and University of Geneva, Geneva, Switzerland (Dr Ricou); Hadassah-Hebrew University, School of Nursing, Jerusalem, Israel (Dr DeKeyser Ganz); Department of Anaesthesiology and Critical Care Medicine, Tuttingen Hospital, Tuttingen, Germany (Dr Michalsen); Serviço Cuidados Intensivos 1, Hospital Santo António, Centro Hospitalar do Porto, Porto, Portugal (Dr Azevedo Maia); Department of Anaesthesiology and Intensive Therapy, Medical University of Gdansk, Gdansk, Poland (Dr Owczuk); Imperial College NHS Trust, Centre for Perioperative Medicine and Critical Care Research, Charing Cross Hospital, London, UK (Dr Rubulotta); Service des Soins Intensifs Médico-Chirurgicaux et Oncologie Thoracique, Institut Jules Bordet, Brussels, Belgium (Dr Meert); Department of Medical Oncology, University Medical Center Groningen, Groningen, the Netherlands (Dr Reyners); Department of Anaesthesia, Mater Dei Hospital, Msida, Malta (Dr Aquilina); and Department of Applied Mathematics and Computer Science, Ghent University, Gent, Belgium (Mr Bekaert).

**Author Contributions:** Dr Piers had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

**Study concept and design:** Piers, Azoulay, Ricou, DeKeyser Ganz, Decruyenaere, Van Den Noortgate, Schrauwen, Benoit.

**Acquisition of data:** Piers, Azoulay, Ricou, DeKeyser Ganz, Max, Michalsen, Maia, Owczuk, Rubulotta, Depuydt, Meert, Reyners, Aquilina, Bekaert, Benoit. **Analysis and interpretation of data:** Piers, Azoulay, Ricou, DeKeyser Ganz, Rubulotta, Van Den Noortgate, Benoit.

**Drafting of the manuscript:** Piers, Azoulay, DeKeyser Ganz, Schrauwen, Benoit.

**Critical revision of the manuscript for important intellectual content:** Piers, Azoulay, Ricou, Decruyenaere, Max, Michalsen, Maia, Owczuk, Rubulotta, Depuydt, Meert, Reyners, Aquilina, Bekaert, Van Den Noortgate, Benoit.

**Statistical analysis:** Piers, Bekaert, Benoit.

**Obtained funding:** Piers, Azoulay, Benoit.

**Administrative, technical, or material support:** Piers, Ricou, DeKeyser Ganz, Decruyenaere, Benoit.

**Study supervision:** Ricou, Decruyenaere, Meert, Reyners, Van Den Noortgate, Schrauwen, Benoit.

**Conflict of Interest Disclosures:** All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Drs Piers, Decruyenaere, Van Den Noortgate, and Benoit report receipt of a grant from the European Society of Intensive Care Medicine/European Critical Care Research Network (ESICM/ECCRN). Dr Azoulay reports board membership, consultancy, grants received or pending, and speakers bureau participation with Gilead,

Pfizer, and Merck, Sharp, and Dohme. Dr Decruyenaere reports receipt of meeting expenses from the European Society of Clinical Microbiology and Infectious Diseases; and other research grants from Astra-Zeneca, Bayer, Pfizer, Merck, Sharp, and Dohme, and General Electric. Dr Owczuk reports receipt of consultancy fees from Abbott Laboratories, Poland. Dr Depuydt reports receipt of a grant or a pending grant from Pfizer. The remaining authors report no disclosures.

**The APPROPICUS Study Group of the Ethics Section of the ESICM: Steering Committee:** Piers, Azoulay, Ricou, DeKeyser Ganz, Decruyenaere, Benoit. Participating hospitals and ICUs: Belgium: Ghent University Hospital, Gent (P. Depuydt, R. Piers, D. Benoit, J. Decruyenaere, N. Mauws), AZ Maria Middelaere, Gent (C. De Cock), O.L.Vrouwziekenhuis, Aalst (N. De Neve, K. De Decker), ASZ, Aalst (B. Nonneman), AZ Sint-Blasius, Dendermonde (W. Swinnen), AZ Sint-Jan Brugge - Oostende, Brugge (M. Bourgeois), ZNA Stuviaenberg, Antwerpen (I. De laet, A. Jans), Institut Jules Bordet, Bruxelles (A.-P. Meert), CHU Saint-Pierre, Bruxelles (E. Stevens, P. Dechamps), CHWAPI Site Notre Dame, Tournai (F. Vallot), CHU Brugmann, Bruxelles (J. Devriendt), Cliniques universitaires Saint-Luc, Bruxelles (P.-F. Laterre), CHRN, Namur (F. Lemaître), Hôpital Erasme, Bruxelles (M. Norrenberg). FRANCE: Hôpital Saint Louis, Réanimation médicale, Paris (A. Max, A. Lafabrie, V. Lemiale, E. Azoulay, B. Schlemmer), Hôpital Cochin, Réanimation médicale, Paris (J.-P. Mira, B. Zuber), Hôpital René Arbelletier, Soins Continus, Coulommiers (B. Bonneton, L. Baillot, F. Compagnon), Hôpital Lariboisière, Réanimation médicale, Paris (B. Mégarbane, F. Baud), Hôpital Raymond Poincaré, Garches (M. Antona, T. Sharshar, D. Annane), Hôpital Gabriel Montpied, Clermont-Ferrand (A. Lautrette, B. Souweine), Hôpital André Mignot, Le Chesnay (S. Legriell, J.-P. Bedos), Hôpital Saint Joseph, Réanimation polyvalente, Paris (M. Garrouste-Orgeas, C. Briel, F. Philippart, B. Misset), Hôpital Saint Louis, Réanimation chirurgicale, Paris (F. Fioux, L. Jacob), Hôpital André Grégoire, Montreuil (V. Das, J.-L. Pallot), Hôpital Hôtel Dieu, Paris (A. Rabbat), Hôpital Avicenne, Bobigny (F. Vincent, Y. Cohen), Hôpital Victor Dupouy, Argenteuil (M. Thirion, H. Mentec). Germany: Neurologische Klinik Medical Park Loipl, Bischofswiesen/Loipl (A. Michalsen), St. Elisabeth-Krankenhaus Bad Kissingen, Bad Kissingen (L. Weller), HELIOS Klinikum Berlin-Buch, Berlin (S. Kubitzka, D. Schweiger), Kreisklinikum Calw-Nagold, Calw (R. Clement), Georg-August-Universität Göttingen, Göttingen (O. Mörer), Klinikum Konstanz, Konstanz (V. Kurzweg), Krankenhaus Leonberg, Leonberg (M. Plattner), Klinikum Rechts der Isar, München (J. Schneider), Klinik Tettang, Tettang (G. Schoser). Israel: Tel Hashomer Medical Center, Ramat Gan (O. Raanan), Kaplan Medical Center, Rehovot (M. Ben Nun). Italy: Ospedale Maggiore, Bologna (E. Cerchiarri), Annunziata, Chieti (F. Petrini), Ospedale San Raffaele, Milan (L. Cabrini), Azienda Ospedaliero-Universitaria Policlinico, Catania (G. Rubulotta), Azienda Ospedaliero-Universitaria Vittorio Emanuele, Catania (A. Conti), Azienda Ospedaliero-Universitaria S. Luigi Gonzaga, Orbassano (G. Rabeschi, B. Andretto). Malta: Mater Dei Hospital, Msida (A. Aquilina). Poland: Medical University of Gdansk, Gdansk (M. A. Wujewicz), Medical University of Silesia, Zabrze (H. Misiolek), District Hospital, Elbląg (W. Wenski), District Hospital, Olsztyn (D. Onichimowski), University Hospital, Lodz (W. Machala), Florian Ceynowa Hospital, Wejherowo (M. Czajkowska), Regional Teaching Hospital, Bielsko-Biala (D. Maciejewski), 7th University Hospital, Katowice (D. Szurlej). Portugal: Hospital Santo António, Porto (P. Maia), Centro Hospitalar de Coimbra, Coimbra (P. Coutinho, J. Lúzio), Hospital Pêro da Covilhã, Covilhã (M. Branco), Hospital Dr Nélito Mendonça, Madeira (E. Maul), Centro Hospitalar Trás-os-Montes e

Alto Douro, Vila Real (F. Esteves), Instituto Português Oncologia, Porto (F. Faria), Centro Hospitalar de Vila Nova de Gaia (P. Castelões), Hospital Pulido Valente, Lisboa (Alvaro A. Pereira), Hospital São João, Porto (S. Barbosa, C. Dias). Switzerland: Hôpitaux universitaires de Genève, Genève (B. Ricou), Hôpital neuchâtelois, La Chaux-de-Fonds (H. Zender), Hôpital de Neuchâtel, Neuchâtel (R. Zürcher), Hôpital Fribourgeois site Fribourg, Fribourg (G. Sridharan), Hôpital de Sion, Sion (R. Friolet), Ospedale Civico, Lugano (A. Karachristianidou, R. Malacrida), Ospedale La Carita, Locarno (G. Penati, M. Llamas), Ospedale San Giovanni, Bellinzona (A. Perren), Ospedale Beata Vergine, Mendrisio (A. Pagnamenta). The Netherlands: UMCG, Groningen (A.K. Reyners, A. Heesink), Medisch Centrum Leeuwarden, Leeuwarden (R. Gerritsen), Flevoziekenhuis, Almere (M. Sleeswijk), Wilhelmina Ziekenhuis Assen, Assen (J. Luitisan, R. Janssen).

**Funding/Support:** Support was provided by the European Society of Intensive Care Medicine/European Critical Care Research Network Award (iMDsoft Patient Safety Research Award, Vienna 2009).

**Role of the Sponsors:** The sponsor had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; and the preparation, review, or approval of the manuscript.

**Online-Only Materials:** eTable 1, eTable 2 and eAppendix 1, eAppendix 2, and eAppendix 3 are available at <http://www.jama.com>.

## REFERENCES

- Schwenzer KJ, Wang L. Assessing moral distress in respiratory care practitioners. *Crit Care Med*. 2006;34(12):2967-2973.
- Meltzer LS, Huckabay LM. Critical care nurses' perceptions of futile care and its effect on burnout. *Am J Crit Care*. 2004;13(3):202-208.
- Corley MC. Nurse moral distress: a proposed theory and research agenda. *Nurs Ethics*. 2002;9(6):636-650.
- Mobley MJ, Rady MY, Verheide JL, Patel B, Larson JS. The relationship between moral distress and perception of futile care in the critical care unit. *Intensive Crit Care Nurs*. 2007;23(5):256-263.
- Hamric AB, Blackhall LJ. Nurse-physician perspectives on the care of dying patients in intensive care units: collaboration, moral distress, and ethical climate. *Crit Care Med*. 2007;35(2):422-429.
- Corley MC, Minick P, Elswick RK, Jacobs M. Nurse moral distress and ethical work environment. *Nurs Ethics*. 2005;12(4):381-390.
- Corley MC, Elswick RK, Gorman M, Clor T. Development and evaluation of a moral distress scale. *J Adv Nurs*. 2001;33(2):250-256.
- Gutierrez KM. Critical care nurses' perceptions of and responses to moral distress. *Dimens Crit Care Nurs*. 2005;24(5):229-241.
- Vincent JL. Forgoing life support in western European intensive care units: the results of an ethical questionnaire. *Crit Care Med*. 1999;27(8):1626-1633.
- Palda VA, Bowman KW, McLean RF, Chapman MG. "Futile" care: do we provide it? why? a semistructured, Canada-wide survey of intensive care unit doctors and nurses. *J Crit Care*. 2005;20(3):207-213.
- Raines ML. Ethical decision making in nurses: relationships among moral reasoning, coping style, and ethics stress. *JONAS Healthc Law Ethics Regul*. 2000;2(1):29-41.
- Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. *J Clin Ethics*. 2009;20(4):330-342.
- Ferrand E, Lemaire FO, Regnier B, et al; French RESENTI Group. Discrepancies between perceptions by physicians and nursing staff of intensive care unit end-of-life decisions. *Am J Respir Crit Care Med*. 2003;167(10):1310-1315.
- Piers RD, Van den Eynde M, Steeman E, Vlerick P, Benoit DD, Van Den Noortgate NJ. End-of-life care of the geriatric patient and nurses' moral distress [published online ahead of print February 10, 2011]. *J Am Med Dir Assoc*.
- Oberle K, Hughes D. Doctors' and nurses' perceptions of ethical problems in end-of-life decisions. *J Adv Nurs*. 2001;33(6):707-715.
- Maslach C, Jackson SE, Leiter M. *Maslach Burnout Inventory Manual*. 3rd ed. Palo Alto, CA: Consulting Psychologist Press; 1996.
- Visser MR, Smets EM, Oort FJ, De Haes HC. Stress, satisfaction and burnout among Dutch medical specialists. *CMAJ*. 2003;168(3):271-275.
- Poncet MC, Toullic P, Papazian L, et al. Burnout syndrome in critical care nursing staff. *Am J Respir Crit Care Med*. 2007;175(7):698-704.
- Embriaco N, Azoulay E, Barrau K, et al. High level of burnout in intensivists: prevalence and associated factors. *Am J Respir Crit Care Med*. 2007;175(7):686-692.
- Karasek R, Theorell T. *Healthy Work: Stress, Productivity and the Reconstruction of Working Life*. New York, NY: Basic Books; 1990.
- Karasek R. Control in the workplace and its health-related aspects. In: Sauter SL, Hurrell JJ, Cooper CL, eds. *Job Control and Worker Health*. New York, NY: Wiley; 1989:129-159.
- Schluter J, Winch S, Holzhauser K, Henderson A. Nurses' moral sensitivity and hospital ethical climate: a literature review. *Nurs Ethics*. 2008;15(3):304-321.
- Kälvemark S, Höglund AT, Hansson MG, Westerholm P, Arnetz B. Living with conflicts-ethical dilemmas and moral distress in the health care system. *Soc Sci Med*. 2004;58(6):1075-1084.
- Penticuff JH, Walden M. Influence of practice environment and nurse characteristics on perinatal nurses' responses to ethical dilemmas. *Nurs Res*. 2000;49(2):64-72.
- Curtis JR, Vincent JL. Ethics and end-of-life care for adults in the intensive care unit. *Lancet*. 2010;376(9749):1347-1353.
- Thompson BT, Cox PN, Antonelli M, et al; American Thoracic Society; European Respiratory Society; European Society of Intensive Care Medicine; Society of Critical Care Medicine; Société de Réanimation de Langue Française. Challenges in end-of-life care in the ICU: statement of the 5th International Consensus Conference in Critical Care: Brussels, Belgium, April 2003: executive summary. *Crit Care Med*. 2004;32(8):1781-1784.
- Fassier T, Lautrette A, Ciroldi M, Azoulay E. Care at the end of life in critically ill patients: the European perspective. *Curr Opin Crit Care*. 2005;11(6):616-623.
- Sprung CL, Woodcock T, Sjøkvist P, et al. Reasons, considerations, difficulties and documentation of end-of-life decisions in European intensive care units: the ETHICUS Study. *Intensive Care Med*. 2008;34(2):271-277.
- Sprung CL, Geber D, Eidelman LA, et al. Evaluation of triage decisions for intensive care admission. *Crit Care Med*. 1999;27(6):1073-1079.
- Daly K, Beale R, Chang RW. Reduction in mortality after inappropriate early discharge from intensive care unit: logistic regression triage model. *BMJ*. 2001;322(7297):1274-1276.
- McNarry AF, Goldhill DR. Intensive care admission decisions for a patient with limited survival prospects: a questionnaire and database analysis. *Intensive Care Med*. 2004;30(2):325-330.
- Rushton CH. Defining and addressing moral distress: tools for critical care nursing leaders. *AACN Adv Crit Care*. 2006;17(2):161-168.
- Altun I. Burnout and nurses' personal and professional values. *Nurs Ethics*. 2002;9(3):269-278.
- Weiner JS, Cole SA. Three principles to improve clinician communication for advance care planning: overcoming emotional, cognitive, and skill barriers. *J Palliat Med*. 2004;7(6):817-829.
- Nussbaum MC. *Upheavals of Thought: The Intelligence of Emotions*. Cambridge, UK: Cambridge University Press; 2001.
- De Dreu CKW, Gelfand MJ. Conflicts in the workplace: sources, functions, and dynamics across multiple levels of analysis. De Dreu CKW, Gelfand MJ. In: *The Psychology of Conflict and Conflict Management in Organizations*. New York, NY: Lawrence Erlbaum; 2007:3-54.
- Goleman D. *Emotional Intelligence: Why It Can Matter More Than IQ?* New York, NY: Bantam Books; 1995.
- Vanheule S, Lievrouw A, Verhaeghe P. Burnout and intersubjectivity: a psychoanalytical study from a Lacanian perspective. *Hum Relat*. 2003;56(3):321-338 doi:10.1177/0018726703056003614.
- Puntillo KA, McAdam JL. Communication between physicians and nurses as a target for improving end-of-life care in the intensive care unit: challenges and opportunities for moving forward. *Crit Care Med*. 2006;34(11)(suppl):S332-S340.
- Ho KM, English S, Bell J. The involvement of intensive care nurses in end-of-life decisions: a nationwide survey. *Intensive Care Med*. 2005;31(5):668-673.
- Azoulay E, Timsit JF, Sprung CL, et al; Conflicus Study Investigators and for the Ethics Section of the European Society of Intensive Care Medicine. Prevalence and factors of intensive care unit conflicts: the conflicus study. *Am J Respir Crit Care Med*. 2009;180(9):853-860.
- Lilly CM, De Meo DL, Sonna LA, et al. An intensive communication intervention for the critically ill. *Am J Med*. 2000;109(6):469-475.
- Lilly CM, Sonna LA, Haley KJ, Massaro AF. Intensive communication: four-year follow-up from a clinical practice study. *Crit Care Med*. 2003;31(5)(suppl):S394-S399.
- Curtis JR, Patrick DL, Shannon SE, Treece PD, Engelberg RA, Rubenfeld GD. The family conference as a focus to improve communication about end-of-life care in the intensive care unit: opportunities for improvement. *Crit Care Med*. 2001;29(2)(suppl):N26-N33.
- Azoulay E, Pochard F, Kentish-Barnes N, et al; FAMIREA Study Group. Risk of post-traumatic stress symptoms in family members of intensive care unit patients. *Am J Respir Crit Care Med*. 2005;171(9):987-994.
- Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA*. 2008;300(14):1665-1673.
- Krasner MS, Epstein RM, Beckman H, et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA*. 2009;302(12):1284-1293.
- Meier DE, Back AL, Morrison RS. The inner life of physicians and care of the seriously ill. *JAMA*. 2001;286(23):3007-3014.
- Seale C. The role of doctors' religious faith and ethnicity in making ethically controversial decisions during end-of-life care. *J Med Ethics*. 2010;36(11):677-682.