Published in final edited form as:

Arch Intern Med. 2012 June 11; 172(11): 889–890. doi:10.1001/archinternmed.2012.1671.

ICU Clinicians' Perceptions of Appropriateness of Care and the Importance of Nurse-Physician Collaboration

Erin K. Kross, MD and J. Randall Curtis, MD, MPH

Division of Pulmonary and Critical Care, Department of Medicine, Harborview Medical Center, University of Washington, Seattle

Perceptions of appropriateness of care among intensive care unit (ICU) nurses and physicians are potentially important for several reasons. First, clinicians with perceptions of inappropriate care may experience moral distress and be at risk of burnout, which in turn may result in decreased job satisfaction and retention.^{1–3} Second, moral distress and burnout among clinicians may be associated with reduced quality of care for patients and families.⁴ Finally, perceived inappropriate care—if truly inappropriate—may be a burden on the resources of our health care system. In this interesting article, the primary goals of Piers and colleagues⁵ were to explore the prevalence of perceived inappropriateness of care among clinicians in 82 European and Israeli ICUs and describe the patient-related situations associated with perceived inappropriateness of care and the level of agreement among clinicians concerning perceived inappropriateness of care. Their secondary goal was to evaluate their hypothesis that perceived inappropriateness of care is associated not only with situational factors but also with clinicians' personal characteristics, work-related factors, and their self-reported intent to leave their job.

In this large survey-based study of ICU nurses and physicians, the authors achieved an excellent response rate (93%) and found that 439 of 1651 respondents (27%) perceived inappropriateness of care for at least 1 of their patients on the day of study. The most commonly reported reason for perceived inappropriateness of care was perceived disproportionate care (65%). In most of these cases (89%), the amount of care was perceived as excessive. This was the most common reason for perceived inappropriateness of care among nurses and physicians. Other reasons included feeling as if other patients would benefit more, lack of participation in decision making, persistent nonadherence of the patient, and inaccurate information to patient or family. While nurses and physicians both reported disproportionate care as the most common reason for perceived inappropriateness of care, physicians were more likely to report that other patients would benefit more from the ICU level of care. The agreement among clinicians is difficult to quantitate given the study design, but the authors' data suggest there was agreement among clinicians on less than a third of the patients deemed to be receiving inappropriate care. The relatively high prevalence of inappropriate care suggests this is an important problem in critical care, although the relatively low agreement among clinicians as to whether an individual patient's

Correspondence: Dr Curtis, Division of Pulmonary and Critical Care, Department of Medicine, Harborview Medical Center, University of Washington, PO Box 359762, Seattle, WA 98104 (jrc@u.washington.edu).

Financial Disclosure: None reported.

care was inappropriate suggests there is little agreement among clinicians about what constitutes inappropriate care.

The researchers use multivariate analysis to explore factors that were independently associated with a lower proportion of perceived inappropriateness of care and found that when decisions about symptom control are shared by nurses and physicians (as opposed to physicians only), when nurses are involved in end-of-life decisions, and when there is collaboration between nurses and physicians, there were fewer perceptions of inappropriateness of care. They also found a strong link between perceived excessive workload and perceived inappropriateness of care among the nurses in their study. This cross-sectional study cannot definitively determine the causal pathway for these associations. Nonetheless, prior research also suggests that perceived powerlessness is associated with moral distress among nurses and that moral distress is associated with a lack of collaboration in decision making.^{6–8} These associations between perceived inappropriateness of care and the interdisciplinary environment highlight the importance of nurse-physician collaboration in the care of ICU patients. Previous studies support the importance of collaboration in satisfaction with clinical decision making for both physicians and nurses, although this collaborative relationship appears relatively more important for nurses.⁹ Intensive care unit nurse reports of collaboration have been positively associated with patient outcomes,¹⁰ and poor nurse-physician communication has been associated with medical errors.¹¹ This study by Piers and colleagues⁵ adds to the notable literature in this area, calling attention to the importance of interdisciplinary collaboration and its relationship to job satisfaction and retention. Interventions to improve interdisciplinary teamwork have the potential to reduce perceptions of inappropriateness of care, reduce burnout and moral distress among the entire clinical team, and ultimately improve the quality of care for patients and their families.

The article by Piers and colleagues⁵ provides interesting insight into the prevalence and taxonomy of perceived inappropriateness of care in the ICU—from the ICU clinicians' perspective—as well as the associations with ICU clinician distress and intent to leave their jobs. It also highlights the relative lack of agreement among clinicians about what constitutes inappropriate care and the importance of interdisciplinary communication as a potential mechanism to reduce perceptions of inappropriate care and decrease clinician distress. Although this study cannot assess the relationship of perceived inappropriateness of care to the quality of care or the impact on our health care resources, it suggests this is an important area for future research and quality improvement. Future work should also consider the outcomes associated with care that is perceived to be inappropriate, including quality of life, short- and long-term survival, burdens of care and caregiving, and costs of care.

REFERENCES

1. Corley MC. Nurse moral distress: a proposed theory and research agenda. *Nurs Ethics*. 2002; 9(6): 636–650. [PubMed: 12450000]
2. 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. [PubMed: 15149054]

3. Mobley MJ, Rady MY, Verheijde 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. [PubMed: 17681468]
4. Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med*. 2002; 136(5):358–367. [PubMed: 11874308]
5. Piers RD, Azoulay E, Ricou B, et al. APPROPRIATUS Study Group of the Ethics Section of the ESICM. Perceptions of appropriateness of care among European and Israeli intensive care unit nurses and physicians. *JAMA*. 2011; 306(24):2694–2703. [PubMed: 22203538]
6. Altun I. Burnout and nurses' personal and professional values. *Nurs Ethics*. 2002; 9(3):269–278. [PubMed: 12035432]
7. 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. [PubMed: 17205001]
8. 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. [PubMed: 18388166]
9. Baggs JG, Schmitt MH, Mushlin AI, Eldredge DH, Oakes D, Hutson AD. Nurse-physician collaboration and satisfaction with the decision-making process in three critical care units. *Am J Crit Care*. 1997; 6(5):393–399. [PubMed: 9283677]
10. Baggs JG, Schmitt MH, Mushlin AI, et al. Association between nurse-physician collaboration and patient outcomes in three intensive care units. *Crit Care Med*. 1999; 27(9):1991–1998. [PubMed: 10507630]
11. Manojlovich M, DeCicco B. Healthy work environments, nurse-physician communication, and patients' outcomes. *Am J Crit Care*. 2007; 16(6):536–543. [PubMed: 17962497]

JAMA

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

Piers RD, Azoulay E, Ricou B, et al; APPROPRICUS Study Group of the Ethics Section of the ESICM

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