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A qualitative look at end-of-life care in the ICU

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Qualitative research, long under the purview of anthropology and the social sciences, investigates the relationships between individuals and their experience of their environment. Unlike quantitative research, the aim of which is to accurately and precisely measure phenomena and generate numerical data ('how much' and 'when'), qualitative research uniquely explores the depth of a phenomenon or behavior ('how' and 'why'): aspects that cannot be accurately and precisely measured. Often considered the softer science, qualitative research complements quantitative research and can be used on the one hand to generate ideas or form hypotheses for subsequent quantitative research and on the other to dig deeper into developing a more complete understanding of a particular problem or phenomenon.^{1–3}

For example, quantitative research can identify for us the patients with the greatest statistical chance for success from a treatment, but it cannot create understanding from a crumpled POLST form pulled from a forgotten drawer in the dead of night, or help us explore the best decisions about end-of-life care based on the words "unless it is survivable" or "only if reversible" scrawled in the margin. It is often these scenarios, intensified by prognostic uncertainty and muddled by potentially competing roles and interests (patients, families, physicians, nurses)^{4,5} that give rise to tensions between caregivers in the ICU. The complexities of these relationships, and emotions that arise from them, are explored in the accompanying study in this issue of Critical Care Medicine.⁶

Using in-depth interviews of staff members in two intensive care units (ICUs) in an academic medical center, Dr. Laurent and colleagues explore the emotional experiences of nurses and physicians around decisions about end-of-life care, and how their experiences influence those decisions. As the participants were asked to reflect on past difficult decisions in the ICU, the nurses reported feeling abandoned and not involved in the decision-making process. Emphasizing their close relationship with the patient, nurses felt torn between caring and advocating for the incapacitated patient and carrying out physician's orders that seemed to them to increase or prolong the patient's suffering. The physicians on the other hand identified primarily with the patient's family and considered this partnership as the

cornerstone of their decision-making process. Feeling ultimately accountable for the decisions made and therefore the patient's outcome, the physicians felt conflicted about their responsibilities towards the family, the patient, and the medical team.

At first glance, it is easy to endorse the authors' conclusions as they resonate with some of our own experiences and identify important sources of moral distress. Further appraisal of the research design and execution is necessary as we consider how to apply these findings to our own critical care experiences. As with quantitative research, qualitative research is only valid (or 'trustworthy', the preferred term in qualitative research) if the methods used are rigorous and transparent, the analysis appropriate, and the interpretation coherent.^{1,2,7} In this article, the authors' use of interpretative phenomenological analysis⁸ allows for in-depth exploration of each participant's feelings, but obtains that depth of expression at the expense of capturing a wider breadth of experience and accepting the constraints of a small, non-representative sample (in this case, 10 physicians and 10 nurses). The choice of this small sample size is deliberate, as it is not meant to accurately measure the size or frequency of a problem, but to better understand the problem in depth. In addition, the authors chose not to include quantitative data ('mixed methods research'), such as information on race or ethnicity of the participants, their level of training, or data about the patients or the type or urgency of treatment decisions. Unfortunately, the reader is given little information on how the participants were sampled, making it difficult for us to judge the appropriateness of the sampling criteria or to compare this sample to our own ICU.

As clinicians who are mostly trained to use deductive, empirical research, we look to the literature for a single, generalizable truth. The aim of qualitative research, however, especially that of interpretative phenomenological analysis as used in this article, is not to generalize but rather to uncover and explore phenomena such as lived experiences, thoughts, and opinions. Overall, we feel that this study is sufficiently trustworthy to enhance our understanding of how nurses and physicians experience difficult end of life decisions in the ICU and how these experiences may influence their behavior and impact their interprofessional relationships.

How then can we use these experiences of others to improve end-of-life practices in our own ICU or to develop more effective tools to improve communication between ICU team members? These findings should promote dialogue about the social dynamics in our ICUs and their influence on decisions about end-of-life care. The relationship focus of nurses with patients and physicians with families needs to be explored further. Integration of nurses and other team members into the decision-making processes should start early, occur regularly (for example during daily rounds) and always be encouraged. Finally, novel tools to improve communication and decision-making in the ICU, such as a specially trained ICU navigator,^{9,10} are promising and require additional research.

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