Editorial

How Much Care Is Too Much Care?

By Richard H. Savel, MD, and Cindy L. Munro, RN, PhD, ANP

One of the most stressful situations physicians and nurses face is when we must provide care we feel is inappropriate for the patient. A number of negative repercussions tend to result. Two common ones are moral distress and burnout, both of which are important as well as closely associated with one another.

Much has been written about moral distress and burnout in general in the intenive care unit (ICU).[1-12] However, little academic research or analysis have focused on how the feeling that we are providing inappropriate care actually contributes to these 2 barriers that make it difficult to attract and keep the highest quality practitioners in our field.

The APPROPRICUS Trial

One exception to this lack of data is what we've seen from the exciting and important APPROPRICUS trial.[13] Surprising results from this large, 1-day, cross-sectional trial across multiple ICUs in Europe and Israel are germane to all critical care practitioners, particularly nurses. In fact, the results provide an excellent springboard for considering whether we critical care providers ought to bring our moral values to the bedside when we care for patients.

The APPROPRICUS trial was performed on May 11, 2010, as a cross-sectional evaluation of 82 adult ICUs in Israel and 9 European countries. A total of 1953 ICU nurses and physicians were asked if they felt they were providing inappropriate care. Of the 1651 participants, 27% (25% of the nurses and 32% of the physicians) responded that, yes, they were. Sixty-five percent of those who answered yes felt that the care was "disproportionate"; in 89% of cases, the amount of care was perceived to be excessive. Following disproportionate care, 38% of respondents felt the care was inappropriate because they felt other patients would benefit more from ICU care. In addition, perceived inappropriateness of care was independently associated with a higher likelihood of leaving a job.

The investigators also examined level of agreement among clinicians that a patient was receiving inappropriate care. The results were startling: in 66% of cases, a single clinician reported a perception of inappropriate care, but in only a minority of cases (34%) did at least 2 clinicians agree that there was a legitimate concern that inappropriate care was provided. Although generally we all seem to feel that we know inappropriate care when we see it, data from this study do not support the belief.

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On a more positive note, the authors were able to use a multivariate analysis to find 5 independent factors associated with a lowered rate of perceived inappropriate care: (1) when decisions about symptom control were shared between nurses and physicians, (2) involvement of nurses in end-of-life decisions, (3) good collaboration between physicians and nurses, (4) work autonomy, and (5) perceived lower workload among nurses.

Good News and Bad News

There is good news and bad news when it comes to perceptions about inappropriate care in the ICU. Bad news first: the perception appears to be quite prevalent. Roughly 30% of caregivers in this study felt they were providing inappropriate care and felt that there is much discordance regarding when care is inappropriate. We find such results disconcerting. Anytime *any* member of the multidisciplinary team feels that inappropriate care is being delivered, there ought to be critical dialogue with the other caregivers. As Scott D. Halpern observes in his discussion of the APPROPRICUS trial,[14] this perceived discordance may highlight the subjective nature of inappropriate care or may indicate a lack of construct validity of the measure.

Now the good news. Even if it is unclear exactly what is being measured in terms of "inappropriate" care, there are ways to decrease the likelihood that such care (and the moral distress and potential burnout that are associated with it) will take place. Allowing ICU physicians and nurses higher degrees of job autonomy and creating a multidisciplinary collaborative environment, for example, are associated with a decreased perception of inappropriate care. Results from this and similar studies suggest that the creation of a collaborative nurse-physician relationship in end-of-life decisions is what's ultimately best for patients, families, and clinicians alike.

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Because critical care practitioners are individuals with different backgrounds, attitudes, personalities, and beliefs, it is not surprising that we bring our own value systems to the bedside when we care for patients. We all want what is best for patients. But in the complex setting of the ICU, what is "best" can be unclear, controversial, and essentially a judgment call on the part of the practitioners involved.

If any member of the team feels that he or she is providing inappropriate care, something is amiss somewhere in the patient-family-clinician care paradigm. Of course, as long as critical care exists, such conflict is inevitable. But ignoring the problem will not solve it, and may even lead to poor patient care. Conflict resolution is one of the most important skills we can develop as critical care practitioners. Working toward win-win solutions is one of the most effectives means for ensuring that everyone's voice is heard.

Accounting for Personal Values

Some leaders in the field of critical care ethics believe we must leave our personal value systems behind when we care for patients.[15] Others suggest that we must "teach individual ICU clinicians to create a symbolic distance from their work experience and outcomes by becoming aware of [our] own personal values and beliefs."[13] But is that realistic? Perhaps a better way to handle such circumstances is to acknowledge that we are who we are: human beings with our own emotions and moral compass. These things cannot easily be turned on or off. We should be passionate about caring for our patients and, if we feel care is being provided inappropriately, we should have an organized, structured mechanism for resolving the conflict through thoughtful dialogue and the exchange of ideas.

Such conversations ought to begin with a meeting of the multidisciplinary team to lay out the issues at hand. Who feels the care is inappropriate, and what are the recommendations of the person who feels that way? This approach may lead to an ethics consultation to help mediate the issue. Ideally, all relevant physicians and surgeons would be part of the dialogue, but anyone on the team could signal that discussion is needed. In fact, nurse and physician leaders must coordinate together closely to ensure that everyone gets a seat at the table.

In most cases there should be an initial meeting separate from the family, assuming the patient

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is unable to participate. Soon afterward, a meeting with representatives from nursing, intensivists, other relevant physicians, and, if necessary, ethics or palliative care experts should be held with the family to talk about 3 important things: where we've been, where we are, and where we're going. One way to initiate the dialogue is to explain: "We are meeting now because members of the team feel that some of the current therapeutic goals may be unrealistic or inappropriate, and we need to reevaluate the goals of care with the team and the family."

Conclusion

The fact is that we all bring our background and moral values to the bedside every time we come to work. This includes a certain framework for what we feel is right or wrong in caring for our patients. It is difficult, if not impossible, for us to set aside our judgments, particularly if we feel that continuing invasive care will not lead to a good outcome for our often vulnerable patients. We have seen these situations before and we will see them again. We want to care for patients; we like what we do and are proud to do it. We don't want to burn out, we don't want to become callous, and we don't want to quit.

There is reason for hope that resolving these complex and often upsetting clinical situations is within our control. By improving system-wide issues—such as creating a more collaborative work environment, lowering nursing workloads, and continuing to involve nurses in end-of-life decisions—we have many opportunities to optimize outcomes and reach consensus despite perceptions of inappropriate care, thereby decreasing the likelihood of moral distress and burnout in our highly charged but critically important field of work.

The statements and opinions contained in this editorial are solely those of the coeditors.

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None reported.

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