An Exploration of Collaboration in End-of-Life Decision Making Among Intensive Care Physicians and Nurses

by

Lorelei Driver

BSN, University of Victoria, 2000

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Supervisory Committee

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Dr Rosalie Starzomski, (School of Nursing)
Professor, Supervisor

Dr Bernie Pauly (School of Nursing)
Assistant Professor, Committee Member

Abstract

"A dying man needs to die, as a sleepy man needs to sleep, and there comes a time when it is wrong, as well as useless, to resist."---Stewart Alsop

The life-saving focus of intensive care, coupled with patients who are too ill to participate in their own end-of-life decisions, creates challenges to ensure healthcare professionals respect and follow patients' health care wishes. Combining an understanding of patient choices with clinical expertise and compassion is the quintessential goal. Good collaborative communication with families, and within the healthcare team, is the single most important factor for achieving quality end-of-life care for patients and reducing negative outcomes (Boyle & Kochinda, 2004; Curtis, et al., 2001; Levy, 2001; Puntillo & McAdam, 2006).

Maximizing nurse physician collaboration holds promise to improve not only patient and family member care, but also has been shown to improve intensive care unit (ICU) nurses and physicians' workplace satisfaction. Overcoming the barriers for effective communication and collaboration remains the challenge. My purpose, in this paper, is to critically examine and present an in-depth analysis of the multiple factors that both impede, and facilitate, collaborative end-of-life decision-making among intensive care nurses and physicians. Following this analysis, I propose several recommendations to facilitate collaboration among nurses and physicians.

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An Exploration of Collaboration in End-of-Life Decision Making Among Intensive Care Physicians and Nurses

Tensions arising from our enthusiasm for advanced medical technology, prognostic uncertainty, and our death-denying culture often put ICU nurses and physicians in ethically and morally difficult positions as they strive to care for patients. Technological advances in intensive care have created high expectations from both health care professionals and families. The transition from curative to end-of-life care is often fraught with ambiguity and anguish. Prolonging the living-dying process with aggressive therapies creates issues of moral distress for nurses, physicians and other members of the healthcare team (Robichaux & Clark, 2006). Skilled collaborative communication increases patient survival, improves staff ability to meet family needs, and enhances professional relationships (Stein-Parbury & Liashenko, 2007; Van Ess Coeling & Cukr, 2000). Multiple factors, such as historical determinants, medical and technological advances, nurse physician roles and moral distress influence and affect the collaborative process.

In healthcare, collaboration is understood to mean the way in which nurses and physicians interact with each other in relation to clinical decision-making (Curtis & Shannon, 2006; Hamric & Blackhall, 2007; Kramer & Schmalenberg, 2003; Miller, 2001; Puntillo & McAdam, 2006; Stein-Parbury & Liaschenko, 2007). Researchers suggest nurse-physician collaborative communication can be improved when both disciplines have shared understanding and respect for the other's roles and responsibilities (Boyle & Kochinda, 2004; Falise, 2007; Puntillo & McAdam, 2006). Considering that the roles of nurses and physicians are embedded within

historical frameworks, a brief history of the often disparate values, beliefs, and attitudes toward end-of-life care that continue to create barriers for the two professions will be included in this paper. Examining the complex issues can facilitate a deeper understanding of collaborative communication, and can illuminate avenues to create change. Therefore, in this paper, I will begin with an overview of the nature and benefits of collaboration. A review of the history and culture of ICU will be followed by a discussion of the impact of moral distress and burnout on collaboration, team building, and patient care. Collaborative strategies and recommendations will be presented in the final section of the paper. Although this discussion may be relevant to other ICU's, the inquiry and practice recommendations will be restricted to the ICU in which I practice.

Problem Statement

Breslin, MacRae, Bell, Singer, & the University of Toronto Joint Centre for Bioethics clinical ethics group (2005) are the authors of a Canadian medical ethics study that ranked disagreements among patients, families and healthcare professionals over treatment decisions as the top ethical challenge facing the public in healthcare. The panel of clinical bioethicists that participated in the study described healthcare conflicts in the intensive care area as the most common reason for ethical consultations. Further, they described end-of-life situations in critical care as the most challenging, as they literally amounted to life or death. The investigators revealed that healthcare conflicts received very little attention in the media and there was very little awareness among members of the public about this issue. This finding is quite remarkable as healthcare conflicts occur across Canada on a daily basis.

Advanced technology and prognostic uncertainty combine to create difficult treatment decisions. The complexity of end-of-life decisions in ICU can challenge collaborative nurse physician professional relationships. Studies conducted in intensive care units indicate nurses

believe collaboration is inadequate, and are dissatisfied with the quality of dialogue with physicians, yet physicians often state that communication and collaboration with nurses is good (Bucknell & Thomas, 1997; Coombes & Ersser, 2004; Eliasson, Howard, Torrington, Dillard, & Phillips, 1997; Manias & Street, 2001; Miller, 2001). I[1] have chosen to examine the different viewpoints of physicians and nurses through a critical perspective on the positions of power held by these professionals within the healthcare hierarchy.

Historical power discrepancies continue to present challenges to collaborative teamwork. The critical care environment can make collaborative decision-making difficult as emergent situations often preclude group process. Additionally, moral distress, burnout and compassion fatigue are common hazards for healthcare professionals in critical care, and are believed to be potential barriers to collaboration (Delgado, Hamric, & Blackhall, 2005; Elpern & Silver, 2006; Gutierrez, 2005; Storch & Kenny, 2007). Identifying these stressors has become even more important to collaborative communication as a causal cycle has been shown to exist (Meltzer & Huckabay, 2004). Poor collaboration can lead to emotional exhaustion and individuals suffering from emotional exhaustion can become disengaged from relationships.

Recommendations alone are generally not a sufficient impetus to affect change in nurses' and physicians' degree of collaboration. The literature review for this paper reveals an abundance of articles where authors describe the positive benefits of collaboration for patients, families, and healthcare professionals; however, examples of actual implementation are scarce (Hamric & Blackhall, 2007; Kramer & Schmalenberg, 2003; Miller, 2001; Puntillo & McAdam, 2006). Hence, there appears to be strong evidence to support collaboration, yet examination and research of implementation of collaborative practice in the workplace are lacking in the literature.

[1] The author of this paper has practiced as a registered nurse for 21 years, with eight of those years in intensive care.

Literature Review

This exploration of end-of-life decision making in ICU is viewed through the lens of collaboration. The goal of this examination is to improve our understanding of the important aspects of end-of-life decisions through identification and analysis of key concepts. An extensive review of the literature facilitated the emergence of recurring themes. These themes or concepts were expanded upon to develop a framework from which to illustrate end-of-life decision making.

An examination of the literature facilitated a summarization of past research and enabled overall conclusions to be drawn from the volume of information. This process can contribute to the body of knowledge through identification of central issues, identifying gaps in current research, and clarifying the need for future research (San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005; Polit & Beck, 2008). For this project, the literature search strategy involved using the keywords end-of-life decision-making, critical care, nurse-physician communication and collaboration, moral distress, and burnout. The search terms were developed through an initial broad literature search and then a compilation of keywords that 'showcased' the main characteristics of the review. For a paper to be selected, end-of-life decision-making in critical care, moral distress, burnout, or communication and collaboration among nurses and physicians had to be its main topic. Citations of select articles were examined as a springboard to additional material; this method is referred to as the ancestry approach (or footnote chasing). The literature search was restricted to articles no older than 10 years, unless an article contained information of particular value that was not evident in more recent literature. The keywords were searched within several databases for the period 1997-2007 and included Medline, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), and the Biomedical

Reference Collection. Library staff at the University of Victoria (UVIC)) and UVIC infoline offered valuable assistance in the search for relevant articles. In addition to the literature review, several individuals with expertise in ICU end-of-life decision-making and collaboration contributed knowledge and insight. The purpose of conversations with these individuals was to create a broader understanding and perspective on communication and collaboration among physicians and nurses, and methods to foster improved end-of-life care for patients and families. The conversations were essentially 'food for thought'; they provided a means to informally discuss ideas and concepts, and gain more clarity about what is being reported in the literature. The individuals[2] who shared their expertise came from different practice areas, and they included a Clinical Nurse Specialist who completed a Masters in Nursing (MSN) thesis on palliative care in ICU, medical experts from ICU, a palliative care specialist, and a nursing ethics expert whose areas of interest included end-of-life care and nurse-physician collaboration.

Benefits of Collaboration

Nature and Benefits of Collaboration

Collaboration is more than an exchange of information. It is the active intent to share knowledge and assume joint responsibility for patient care. Ideas and perspectives are exchanged in a mutually respectful and trusting environment. In fact, those who argue for collaboration, consider it so important, that not to collaborate is an ethical issue, because patients receive less than the best care (Gardner, 2005; Taylor, 1996). Collaboration is not restricted to face-to-face encounters, it may occur through any means of communication. Further, collaboration does not always mean agreement is reached, however, all perspectives are always considered. As one physician said, "the key to collegial relationships is recognizing that each has something unique

[2] The individuals who kindly spoke with me to share their expert knowledge confirmed the reliability and validity of the many points presented in this paper.

and essential to offer the patient and that the patient's survival and health require both" (Schmalenberg et al. 2005, p. 457). Collaboration is both a process and an outcome. The collaborative process involves a synthesis of different perspectives to better understand complex problems. A collaborative outcome is the result of integrative solutions that exceed individual vision to create productive, imaginative resolutions.

Medicine and nursing share common goals of bringing information and skill to the care of sick people.

> To give of their best, physicians and nurses need to sustain their unique professional strengths (their knowledge, skills and ethical commitments) and they need to work in close collaboration with each other. Only in doing so can they ensure that people receive the care they need in the best possible manner (Storch & Kenny, 2007, p. 478).

The unique cultural and knowledge perspectives of each discipline have presented both a hindrance and a help to establishing collaborative relationships. When nurses and physicians achieve working relationships that synthesize the interdependent and complementary expertise of each group, they are well situated to deliver excellent health care while also maintaining sensitivity to patients' values and interests.

Nurses and physicians have an ethical obligation to work collaboratively. This is reinforced by professional organizations. For example, in the Canadian Nurses Association 2008 Code of Ethics there is a statement that says, "Nurses collaborate with other health-care providers and other interested parties to maximize health benefits to persons receiving care and those with health-care needs, recognizing and respecting the knowledge, skills and perspectives of all" (p. 10). The Canadian Medical Association (CMA) declares that members must recognize limitations and seek additional opinions, and to be willing to learn from other health professionals. Further,

the following statement is included in the CMA Code of Ethics (2004). “Collaborate with physicians and other health professionals in the care of patients and the functioning and improvement of health services. Treat your colleagues with dignity and as persons worthy of respect” (p. 4).

Close interdisciplinary collaboration in the ICU is ethically desirable and improves clinical outcomes (Boyle & Kochinda, 2004; Beckstrand, Callister, & Kirchhoff, 2006; Gardner, 2005). In the 1980’s, several researchers determined that ICU nurse physician collaboration improved patient care because the decisions were based on more complete information (Baggs, Ryan, & Phelps, 1992; Knaus, Zimmerman, & Wagner, 1981; Mitchell, Armstrong, & Simpson, 1989; Shortell, Rousseau, & Gillies, 1989). The investigators of these studies concluded that ICU nurse physician collaboration improved patient mortality and decreased patients’ length of stay and ICU readmissions. The more collaboration nurses reported, the lower the risk was of a negative patient outcome.

Further, collaboration enhances nurse physician relationships, increases learning and improves work satisfaction. Collaboration has also been shown to decrease ICU nurses and physicians stress, including moral distress, and burnout (Boyle & Kochinda, 2004). As moral distress has been described as a serious issue in ICU affecting retention, any measures that can alleviate staff distress should be a priority (Elpern, Covert, & Kleinpell, 2005; Poncet, et al., 2006).

Barriers to Collaboration

Despite several decades of awareness of the positive impact of interdisciplinary collaboration, barriers continue to linger that prevent optimal implementation. A wealth of

information exists that discusses the importance of collaboration; however, literature on implementing collaborative practice is scarce (Boyle & Kochinda, 2004; Gardner, 2005).

The high-pressure milieu of ICU may present an obstacle to collaborative teamwork. Advanced technology, critically ill patients and conflict can create stress levels that lead to inadequate coping strategies, and impede collaboration (Yeager, 2005). Relationship conflicts between physicians and nurses have been associated with contributing to burnout (Embriaco, Papazian, Kentish-Barnes, Pochard, & Azoulay, 2007). Moral distress and vicarious trauma are also issues common to ICU that may hinder collaboration. These stressors have been shown to negatively affect nurse physician communication as affected individuals may become emotionally exhausted, angry and withdrawn (Elpern & Silver, 2006; Embriaco et al.; Sundin-Huard & Fahy, 1999; Van Soeren & Miles, 2003).

In addition, the nature of ICU spawns a climate of discontinuity and interruptions, further challenging communication and collaboration. Emergency situations can contribute to poor communication among team members. In one study of errors in the ICU, researchers found that communication between physician and nurses accounted for only 2% of all the activities, yet, was responsible for 37% of all the errors (Schull, Ferris, Tu, Hux, & Redelmeier, 2001). It is important for all staff to be aware of the potential for error when communication is not clear and collaboration breaks down (Henneman, 2007). Although environmental factors create challenges to collaborative communication, numerous other elements strongly influence relationships in healthcare. Therefore, a discussion of these factors may help to explain the often-divided relationship.

Structural Influences Affecting Collaboration

Many of the influences that routinely affect nurse-physician relationships may be generations old. Overcoming the myriad contextual forces that continue to endure and allow traditional practice norms to persist can be challenging to overcome, thus, a more comprehensive examination of these factors may help to explain the persistence of oppressive practices. A study of the differences in nursing and medical practices, ideologies, power hierarchies and sociohistorical events that have dominated nurse-physician relationships may facilitate change to occur.

Medical paradigm.

The fundamental knowledge base of medicine and nursing has always differed. Medical knowledge is based on scientific, empirical knowledge that values rational, objective, and measurable data, whereas nurses tend to value knowledge derived from a more holistic patient perspective (Coombes & Ersser, 2004; Storch & Kenny, 2007). A hierarchy of knowledge continues to exist in which medical knowledge remains dominant over areas of knowledge held by nurses (Campbell-Heider & Pollock, 1987; Coombes & Ersser; Stein-Parbury & Liashenko, 2007). The elevation of the science of medicine above the humanity of the patient is a serious problem in intensive care. There is often an assumption by ICU healthcare professionals that if a treatment is available it must be used. As technology increases, so must our questioning of what ultimately is in the best interests of patients (Dare, 1998).

Nonetheless, change is happening. In recent years, aspects of quality of life have entered as a significant issue in the decision-making process. Although this is an important element in end-of-life decision-making, different beliefs about individual patients' future quality of life can

lead to disagreements about healthcare decisions, and may lead to conflicts between physicians and nurses (Frick, et al., 2003).

The quality of each of our lives can only truly be measured by our own value system (Breier-Mackie, 2001). As critically ill patients are usually unable to relay their healthcare wishes, families and healthcare professionals must assume this burden of responsibility. Nurses witness the diversity and limitations of medical knowledge, including the variability among physicians to withdrawing life support (Cook, et al., 1995). Hence, despite the adherence of physicians to objective data, determining patient outcomes is ultimately a subjective decision (Hall, & Rocker, 2000; Pettila, Ala-Kokko, Varpula, Laurila, & Hovilehto, 2002; Poulton, Ridley, Mackenzie-Ross, & Rizvi, 2005).

Nurses are often more pessimistic than physicians when disparity exists towards patient survival and quality of life (Puntillo & McAdam, 2006). Although nurses often appear to be more realistic about patient outcomes, and are more willing to withdraw treatment, they are occasionally wrong and very sick patients will go on to recover and have a satisfactory quality of life. Frick et al. (2003) conducted a study on predicting outcomes of intensive care unit patients. They concluded that neither doctors nor nurses could reliably predict which patients would be satisfied with his or her quality of life after ICU admission. Their study also revealed that the sicker the patients were, and the longer they stayed in the ICU, the greater the disagreements among nurses and physicians.

Perceptions of health and its meaning differ between individuals and within an individual over time.[3] These findings affirm that physicians and nurses must not presume patients' future quality of life as a basis for withdrawing or withholding treatment. The divergent attitudes of nurses and physicians toward treatment options of critically ill patients are alarming, as optimal

[3] The author has certification in advanced care planning from Fraser Health Authority

patient care needs a cohesive team approach. Hence, discerning the reasons for these conflicting judgements needs to be identified and eliminated (Frick et al., 2003). Ideally, ICU clinicians would be able to predict when survival becomes impossible or the chance of enjoying an acceptable quality of life becomes inconceivable. However, prognostic uncertainty and the ambiguous definition of futility preclude making definitive predictions.

Futility.

Medical futility is often introduced as a means to justify limiting or withdrawing life support. However, futility is a concept that is inherently fraught with bias and value judgements. The concept of futility presents many ethical issues for physicians and nurses in intensive care units. Medical care that physicians or nurses deem to be of no benefit may be used to justify not informing patients and their families of potential treatment options (Bailey, 2003). In other situations, medical futility is presented to families as a rationale for why a potentially life-saving medical treatment is considered not in the patient's best interest. On the face of it, futility appears to imply a particular treatment will provide no benefit whatsoever to the patient. However, futility may be presented as an empirical fact, when in reality it may mask a value judgement. Physicians and nurses must take care not to cloak a values-based deliberation as an objective clinical decision. The patient's goals of care and subjectively held values must be established before a treatment can be determined to be incapable of providing any benefit (Olson, 2000). Healthcare clinicians sometimes assume a similarity in values with patients and families where such is not the case.

One study that compared physician and nurse preferences for their own care revealed that both disciplines were unlikely to wish aggressive treatment if they became terminally ill, demented, or persistently vegetative (Gillick, Hesse, & Mazzapica, 1993). ICU nurses and

physicians comprise a unique population as a result of their exposure to medical interventions and what treatments will entail. Values influence behaviours and attitudes, and nurses and physicians need to be aware that patient values may differ vastly from their own (Eliasson, et al., 1997).

Unfortunately, it is seldom clear just what the patient would want. Concerns have been expressed by nurses and physicians that families do not always appreciate the implications of continued treatment and sometimes act in their own best interests rather than those of the patient (Oberle & Hughes, 2001). Communication continually emerges as a distinct theme that weaves through the various contextual features of each situation (Oberle & Hughes). Nurses and physicians are often aware before family members of the patient's probable death (Norton, Tilden, Tolle, Nelson, Eggman, 2003). This puts families at a disadvantage as they mentally and emotionally attempt to 'catch-up' to the direction of care healthcare professionals are proposing. Maintaining open and honest communication with family members will facilitate delivering the care the patient would want, and avoid a breakdown of trust.

Technology.

Technological advances in western medicine have enabled many people to survive their illness and live a productive, enjoyable life. However, for others, advancements in technology and treatment of acute and chronic diseases spare some patients impending death, only to have them experience a subsequent prolonged death (Beckstrand et al., 2006). The challenge for healthcare professionals working in critical care is the constant shadow of uncertainty that presides over decision-making. The uncertainty lies not only with concerns over patients' goals of care and prognostication, but also with limits to suffering, and the question of whether survival justifies any suffering. The availability of resources and sophisticated interventions has lead

caregivers and families to have high expectations for cure (Ferrell, 2006). The almost limitless potential of technology to prolong life makes it critical that healthcare professionals fully attend to the fundamental issues of humanity.

Although the possibility of under treatment exists, over treatment is the more prevalent situation (Robichaux & Clark, 2006; Simmonds, 1996). The advancement of medical technology has created opportunities and temptations to provide aggressive care to dying patients (Shotton, 2000). Nurses and physicians describe their frustration and moral distress that arises from prolonging a patient's inevitable death. The life saving focus of ICU creates an environment whereby extending life and pursuing aggressive treatment is the goal, hence, deciding when that goal is no longer wanted or achievable is the challenge.

Complex situations surrounding end-of-life decision-making are expected to escalate as medical technology increases our ability to sustain life. My review of the literature reveals good communication and collaboration among healthcare professionals can markedly improve the outcome for patients' and families' satisfaction with care. Further, in the CNA (2000) position statement on end-of-life issues, it is recognized that technological advances have raised a number of troubling ethical dilemmas and these dilemmas may be confounded by interdisciplinary team conflicts.

Education and Hierarchy

Hierarchical traditions can continue to perpetuate old forms of behaviour. Nurses and physicians may not appreciate how their routine, interpersonal exchanges may still be influenced by the organizational, educational, or communication legacies that have been internalized through multiple generations of caregivers (Stein-Parbury & Liaschenko, 2007). Traditionally,

socialization within individual disciplines has resulted in very limited knowledge of the expertise, responsibilities, skills and practice of other disciplines (San Martin-Rodriguez, et al., 2005).

The basic components of collaboration require mutual trust and respect (Lindeke & Sieckert, 2005; Stein-Parbury & Liashenko, 2007; Yeager, 2005). Trust and respect in practice develop from a belief in another's competency. Problems arise as a result of friction surrounding competency. There is a generally held belief that higher education and power are associated with greater competency. Therefore, the contrast that exists between nurses and physicians' education, economic rewards, and power, favours physicians and penalize nurses. Hence, a physician's competency is assumed, whereas a nurse's competency must be demonstrated (Hughes & Turner, 1996; Schmalenberg, et al., 2005). For collaboration to occur, both disciplines need to be responsible for ongoing competency.

The different educational cultures of nursing and medicine may present challenges to collaboration. During their entire education and socialization, health professionals are immersed in the philosophies, values and theoretical perspectives inherent to their respective disciplines (Storch & Kenny, 2007). Medical students' socialization into the traditional scientific medical role contrasts with nurses' holistic and relational values.

Stein-Parbury & Liashenko (2007) discuss nurses' and physicians' use of different types of knowledge as contributing to a failure of collaboration. They theorized that when nurses' assessments and concerns were not based on biomedical knowledge, physicians dismissed their contributions. Patient behaviours that defy explanation through diagnostic examination often result in a breakdown of collaboration as nurses seek alternate forms of knowledge to explain the behaviour. When one form of knowledge is valued and enhanced, while others are excluded from the realm of discourse, the stage is set for conflict. The significant disparity among both nurses

and physicians regarding actual or preferred levels of nursing authority continue to create confusion and conflict for both disciplines (Corser, 2000). Research indicates that both disciplines significantly differ in their opinion regarding ideal levels of nursings' professional jurisdiction. Challenging the process of decision-making allows hierarchies to be exposed and openly discussed (Coombes, 2003). In addition, individual differences can result in creative solutions when handled well. For example, careful communication can bypass the behaviour in order to examine the underlying issue. True understanding of the issue may reveal group similarities or strategies that can be utilized.

Although the different methods nurses and physicians have for arriving at prognostic assessments can contribute to conflicts among the professions, nurses and physicians usually agree in most cases about patient outcomes (Eliasson, et al., 1997; Frick, Uehlinger, & Zuercher Zenklusen, 2003). However, the patient situations with the most ambiguity tend to create the greatest degree of conflict. The sicker the patient becomes, and the longer they stay in the ICU, the more nurses and physicians judgements diverge (Frick et al.). Nurses and physicians, who are truly committed to improving collaboration, would do well to 'red flag' patient situations that have the greatest potential to create conflict. It is alarming that for many patients dying in the ICU, there is some kind of disagreement with respect to treatment strategy.

Nurses witness the fluctuating clinical course of patients and the subsequent turmoil families' experience. The ensuing emotional stresses nurses encounter can create the formation of passionate opinions. Even brief disagreements among healthcare providers can generate divisiveness, and impact nurses' opinions about the care plan (Eliasson, et al., 1997; Richter & Eisemann, 2000). When nurses and physicians disagree about end-of-life decisions, the educational and liaison role that nurses often assume for their patients is disrupted. This role,

previously described by Jezewski (1994) as ‘cultural brokering’ stresses the powerful influence nurses may have on the patient and family accepting the physician’s recommendations. Nurses usually act as a broker of information between physicians and family members. Hence, for end-of-life decision-making to go smoothly, it is important that all members of the healthcare team agree about the patient’s plan of care.

Nursing issues.

Nurses are the caregivers most intimately involved in end-of-life care, yet, are often the least involved in the decision-making process. As the bedside caregivers, nurses are better able to understand individual patient situations by virtue of the fact that they are involved in them (Beckstrand, et al., 2006; Ellis, 1993; Hov, Hedelin, & Athlin, 2006). Deeply rooted structures of hierarchy and organizational frameworks continue to present barriers to collaboration. The considerable moral responsibility conferred on nurses by their unique proximity to patients and their families, and their interaction with physicians, are strong arguments in support of including nurses’ knowledge in end-of-life decision-making (Ferrand, et al., 2003).

The sense of connectedness and trust nurses develop through relationship with patients and patients’ families enables nurses to foster collaboration between families and other healthcare providers. Nurses can take a leading role in bringing patients, families and physicians together to negotiate end-of-life decisions. However, current practices often limit nurses’ involvement in patient care decision-making despite nurses being very involved in patient care. Excluding nurses from participating in these important decisions contributes to nurses’ moral distress, and omits valuable patient information from discussions (Corley, 1998; Manias & Street, 2001; McCauley & Irwin, 2006). When nurses’ knowledge is not included, a greater burden of responsibility for patient decision-making is situated on physicians. Hence, good collaborative communication can

improve quality of patient care, improve staff ability to meet family needs, enhance professional relationships, and relieve physician stress (Boyle & Kochinda, 2004; Puntillo & McAdam, 2006).

Omitting nursing knowledge from end-of-life decision-making is a barrier to providing good end-of-life care. The close involvement and comprehensive responsibility nurses have with patients often allows for recognition of the imminence of death earlier than physicians and other healthcare professionals (Anspach, 1987; Hamric & Blackhall, 2007; Robichaux & Clark, 2006; Shotton, 2000). When care is delivered that is no longer helpful to the patient, there is a risk of harm both to the patient and to those providing care. An increased understanding of the perceptions of critical care nurses of changes that would facilitate appropriate end-of-life care is important to ultimately improve the care of dying patients. Nurses' proximity to patients and their families allow nurses to develop expert knowledge in this area. Further, the important role of physicians in making decisions for dying patients carries a burden of responsibility that may be alleviated by the involvement of additional perspectives (White et al., 2007).

Power.

Nurses are socialized to appreciate more than their worldview (Coombes, 2003). At the same time, physicians tend to have a poor grasp of nurses' worldviews. Physicians, as the dominant group in healthcare, do not always perceive power disparities. Subsequently, it is nurses who must conform to the dominant culture in order to create opportunities to contribute their knowledge and information. Nurses, however, as the less powerful group, need to avoid passive opposition or resistance when they disagree with decisions. When conflict is managed through avoidance or accommodation, disagreements are not resolved and collaboration is eroded (Ferrand, et al., 2003; Gardner, 2005; Yeager, 2005). Failure to present ones' ideas and perspectives from a position of strength and confidence is counterproductive for teambuilding.

Conflicts between competing ethical values can be painful, but good communication skills will improve staff satisfaction.

Patient focused decision-making.

The complexity of medical advances[4] has created uncertainties and dilemmas over end-of-life care (Storch, 2004). As healthcare professionals and families recognize the limitations of the scientific paradigm as the deciding factor in end-of-life care, it becomes more apparent that the context of each situation must be explored in order to address the humanistic perspective.

Patients generally trust physicians to make the right decisions for them if they become incapacitated (Heyland, Tranmer, O'Callaghan, & Gafni, 2003). However, physicians vary widely in their choices regarding life support, thus decisions made solely by the treating clinician could lead to unwarranted variation in life-support decisions for some patients (White et al., 2007). Decision-making in ICU is undeniably complicated. Involving multiple perspectives and disciplines in the decision-making process offers the opportunity to articulate decisions among the group, and it allows others to raise questions and offer suggestions.

Although nurses and physicians recognize the patient perspective is the most important component of decision-making, quality of life and prognostic uncertainty are the two obstacles that generate the most divergent judgements around end-of-life decision-making (Anspach, 1987; Dare, 1998; Goold, Williams, & Arnold, 2000; Robichaux & Clark, 2006).

The Canadian Nurses Association 2008 Code of Ethics states, "Nurses respect the informed decision-making of capable persons, including choice of lifestyles or treatment not conducive to good health." (p. 12). The Canadian Medical Association's 2004 Code of Ethics

[4] Advance directives are not discussed in this paper. The use of sophisticated interventions and equipment make it difficult for patients and families to understand the scope of interventions that may be used in ICU. Critical care nurses play a crucial role in interpreting the patients' experience of illness and treatment to assist the families in decision-making. The family conference is the usual means of informing family members of treatment options.

simply states, “To treat all patients with respect” (p. 2). Hence, it the ethical responsibility of nurses and physicians to value and abide by patient’s personal health-care choices.

Ethical decision-making requires sensitivity, understanding, compassion, and caring. Each patient’s health decisions must be made on an individual basis, from the personal, social, and contextual aspects of the individual. As ethical human beings engaged in a healing enterprise, nurses and physicians must focus their care on the person, not simply the body.

In the technological realm of ICU, a temptation exists to disregard some patient’s stories in an effort by healthcare professionals to treat each patient fairly and avoid making value judgements about deservedness (Cassell, 2004). The danger of ignoring patients’ stories lies in the risk that healthcare professionals may reframe the body to a medical object. When healthcare clinicians focus on the disease, the patient is no longer central, and consequently neither are decisions that arise from the moral nature of the person. It is naïve to pretend that healthcare professionals can ignore a patient’s story, and as healthcare professionals are moral agents engaged in a healing enterprise, every effort must be made to care for all patients to the best of their ability. A patient’s behaviour may be judged as morally culpable. However, it is crucial that professional moral standards are maintained at all times. Patients are imbedded in their life stories; thus it is the unique situation of each person that helps healthcare professionals understand patients’ values and appreciate their healthcare wishes.

A decision to limit treatment may be viewed as the quintessential ethical decision (Baggs & Schmitt, 2000). Decisions involve combining clinical information with the beliefs and values of the patient. Clearly, it is crucial that decision-makers examine all information related to the situation. Exercising a contextual ethical perspective allows the decision makers to ensure judgements are based on the specific context and nuances, in conjunction with the personal

meaning of the circumstance to the patient (Rodney, Pauly & Burgess, 2004). Contextual ethics is a means of examining the relevant details that pertain to a particular situation. This includes gathering pertinent subjective as well as objective data. In other words, "contexualism transcends the reductionist tendency of principle-based ethics by focusing on particular people and particular relationships in particular contexts" (Rodney, et al. 2002, p. 92). Professionals practicing within the dominant medical paradigm have historically based patients' healthcare decisions on empirical data alone. However, empirical data is only one element, it is important to also seek insight into the patient's personal meaning and the significant features of each situation in order to provide good ethical care (Gilligan & Raffin, 1996; Oberle & Hughes, 2001). Conflicts surrounding treatment decisions are serious issues, and nurses and physicians need to continually seek to understand the essence of the patient's wishes.

Nurse-physician decision-making perspectives.

The scientific paradigm continues to wield significant power in intensive care units, and although many healthcare professionals recognize the need for a more holistic perspective, medical technology is proving to be a formidable barrier (Storch, 2004). Part of the problem is a result of the value bestowed upon biomedical technology to deliver the answers.

Scoring systems have even been developed for intensive care clinicians to predict probability of patient survival; however, their value is proving to be limited in the individual patient (Frick, et al., 2003). Despite the extensive amount of patient information nurses possess, it is ICU physicians who generally direct end-of-life decision-making, and nurses are expected to adhere to these decisions whether they agree with them or not (Bucknell & Thomas, 1997; Walter et al., 1998).

Nurses' lack of involvement in decision-making has long been a source of interprofessional tensions (Baggs & Schmitt, 2004; Coombes & Ersser, 2003; Gutierrez, 2005; Puntillo & McAdam, 2006; Stein-Parbury & Liashenko, 2007; Storch, 2004). Conflict regarding healthcare decisions are particularly difficult for nurses to endure, as they are often required to provide care based on decisions they were excluded from participating in, yet may result in the delivery of care they believe is tantamount to physical abuse. When nurses perceive overly aggressive treatment is increasing the suffering of a patient, they often experience moral distress (Gutierrez, 2005). Lack of collaboration among nurses and physicians regarding patient care decisions results in feelings of powerlessness for nurses. Outward emotions of anger and frustration are symptomatic of the deeper emotion of moral distress (Ferrell, 2006). When nurses are not able to contribute to decisions surrounding patient goals of care, the unspoken message is that their knowledge and experience is not valued (Bucknell & Thomas, 1996). This may lead to feelings of frustration, lower self-esteem, and dissatisfaction, all of which can lead to burnout.

Contrary to nurses' perceptions, physicians believe nurses are involved in end-of-life decision-making (Ferrand, et al., 2003). Poor communication among nurses and physicians can lead to these misunderstandings. Considering several researchers indicate that physicians tend to believe they are collaborating well, even when their nursing colleagues disagree, little change will occur until explicit discussions between the two professional groups take place (Gardner, 2005; Hamric & Blackhall, 2007; Miller, 2001; Thomas, Sexton, & Helmreich, 2003).

Authors indicate nurses' lack of inclusion in end-of-life decision-making is common in many ICU's (Beckststrand, et al., 2006; Robichaux & Clark, 2006). Investigators that dispute these findings tend to be involved in studies where data was collected primarily from physicians. In other words, when nurses are asked about their involvement in collaborative decision-making,

they report that they are not included (Benbenishty et al., 2006; Ferrand, et al., 2003; Puntillo & McAdam, 2006). Conversely, many physicians believe nurses are involved in decisions surrounding end-of-life. Additionally, physicians often state they have good communication and collaborative teamwork with nurses (Coombes, 2003; Stein-Parbury & Liashenko, 2007; Taylor, 1996). I believe the discrepancy among the two disciplines results from some lingering hierarchy that continues to exist in hospitals. Medical dominance that privileges physicians may prevent physicians from recognizing the inequality. In addition, power discrepancies may constrain nurses from fully expressing their dissatisfaction with poor collaborative decision-making.

Nurses and physicians often have different perspectives of care. When nurses observe patient suffering, it is important to them to ensure physicians are aware and understand the degree of suffering the patient is enduring (Hov et al., 2006). Therein lies one of the greatest areas of conflict for nurses and physicians. The different roles of physicians and nurses subscribe to different degrees of physical closeness to patients (Benbenishty et al., 2006; Hov et al). Physicians' often-limited contact with patients may make it much easier to pursue aggressive treatment, as their decisions tend to be made from a distance. Nurses however experience moral distress as they encounter the consequences of physicians' decisions. "It may be morally less burdensome to give the orders than to carry them out or to live closely with their consequences" (Peter & Liashenko, 2004, p. 221). Conversely, the threshold for calling a situation futile may be lower for healthcare personnel who do not have the responsibility for the final decision of withdrawing or withholding life support (Frick et al., 2003).

Critical care nurses proximity to the patient bedside is a position of privilege, yet, it can also be a position of distress. The physical closeness promotes optimal nurse-patient relationships, and is a significant part of the satisfaction of nursing work. However, when

physicians do not value nurses' contributions and the burdens of care are not shared, nurses may experience moral distress and burnout.

Intensive Care Units and Clinician Stress

Burnout

Burnout syndrome was identified in the early 1970's and occurs primarily in care professions (Embriaco et al. 2007; Maslach & Schaufeli, & Leiter, 2001). Burnout is described as a "process in which the professional's attitudes and behaviour change in negative ways in response to job strain arising out of work environment triggers such as frustration, powerlessness, and an inability to achieve work goals" (Sabo, 2006, p.138). Burnout is essentially a result of a disconnect between one's professional role expectations and an inability to fulfill the role due to organizational factors. Burnout tends to occur over time; it is a gradual wearing down of the individual. ICU physicians, who have experienced burnout, describe physical exhaustion from the long hours required in critical care, and the stressful, demanding work environment (Reader, Cuthbertson, & Decruyenaere, 2008).

Intensive care units are associated with a high degree of stress, a factor known to increase the risk of burnout (Daines, 2000; Donchin & Seagull, 2002; Embriaco, et al., 2007; Poncet, et al., 2007; Verdon, Merlani, Perneger, & Ricou, 2008). When one considers the levels of patient care, workload, stress, and task complexity associated with intensive care, it is easy to understand why ICU nurses and physicians are found to experience symptoms of burnout (Reader, et al., 2007). Nurses and physicians afflicted with burnout may lose all concern, all emotional feeling for the people they work with, and come to treat them in a detached or dehumanized way. Communication with individuals who are experiencing compassion fatigue or burnout will be challenging and thus nurse physician collaboration will be difficult (Lindeke & Sieckert, 2005).

Conflict and poor communication among physicians and nurses has been identified as a risk factor for developing burnout. Nurses and physicians who experience burnout describe feelings of emotional exhaustion and loss of personal accomplishment (Embriaco et al., 2007). The different perspectives of nurses and physicians on work relationships, and patient care decisions surrounding life-sustaining treatments, are significant factors that contribute to conflict and potentially burnout within both disciplines.

Nurses and physicians are affected by burnout and this is a particularly important issue for critical care. Along with having serious consequences for individual well-being, burnout affects job performance, including quality of patient care and nurse physician collaboration (Delgado, et al., 2005; Reader, et al., 2008). Both the CNA (2008) and CMA (2004) Code of Ethics refer to a professional responsibility to maintain an acceptable level of health, and practice appropriate coping strategies to manage stress factors in professional and personal lives. Burnout results in symptoms of physical and emotional fatigue, depression, and inability to concentrate. Such factors are detrimental to performance in areas where high levels of attention and motivation are required for long periods of time (Reader et al., 2007). The fiscal costs associated with burnout can be staggering due to sick time and high staff turnover. Since burnout results from ineffectively managed stress, finding ways to help ICU staff manage stress or making changes to eliminate stressors from the environment would seem to be an effective strategy.

Of interest to researchers is the possibility that individual personality factors can affect coping with the stresses of ICU (Daines, 2006). The concept of personality hardiness has been explored as a protective role against stress and burnout. Individuals who are able to respond to stressors by utilizing various coping skills seem to tolerate stressful events with fewer personal repercussions than others experience (Daines). Although the literature on personal hardiness is

inconclusive, other measures such as education in conflict management, assertiveness training, stress management, and problem-solving workshops have been identified as being effective.

Collaborative teamwork helps to alleviate stress, as healthcare professionals recognize other team members are committed to patient care decision-making and assessments (Gutierrez, 2005; Poncet et al., 2006; Sundin-Huard & Fahy, 1999). When multiple team members are involved in the care of critically ill patients, the diverse perspectives generate a comprehensive patient assessment. The burden of responsibility is much easier to bear when it is shared.

Examining Moral Distress

Moral distress is the physical or emotional suffering that is experienced when constraints prevent one from following the course of action that one believes is right (Gutierrez, 2005; Jameton, 1984; Pendry, 2007). It is an attack on personal integrity when individuals are unable to act in a manner that is in accordance with their personal and professional values. Moral distress is recognized as a serious, but often ignored problem for certain professions. Part of the issue lies in the poor recognition of the symptoms of moral distress. Feelings labelled as stress, burnout, emotional exhaustion, and job dissatisfaction may actually be symptomatic of moral distress (Pendry).

Nurses do not have the cornerstone on moral distress; physicians also suffer over end-of-life decisions. Physicians discuss being very aware that they must sign the order to withdraw life support, and thus experience the burden associated with the possibility they may prematurely end the life of a patient who could have been saved (Hamric & Blackhall, 2007). Recognizing that stopping or withholding aggressive treatment is not a decision to end a person’s life, rather it is stepping aside, a recognition that the patient is dying of his/her disease and allowing that to happen, may help physicians accept their decisions.

Both physicians and nurses suffer during times when they believe they are administering futile care. At these times, administering treatment without reasonable prospect of success amounts to the infliction of harm on dying people (Curtis & Burt, 2003). Both physicians and nurses describe experiencing the greatest moral distress when pressured to continue aggressive treatment in situations where they believed this would only result in continued patient suffering. Collaborative communication is most at risk of breaking down during these stressful patient situations, which is precisely when it is most needed (Lindeke & Sieckert, 2005). Given the importance of end-of-life decisions, and the passionate opinions that may be involved, it is vital to nurse' and physicians' well-being to examine the factors that contribute to their workplace stress. Understanding the perspectives and burdens appreciated by the other can alleviate nurses and physicians sense of moral distress. Hence, exploring nurse-physician stress is integral to improving collaborative interdisciplinary relationships.

Moral distress is a hazard known to afflict the nursing and medical professions, and high emotional risk areas such as ICU have been a concern for scholars almost as long as critical care units have been established. Although moral distress is recognized to occur in both nurses and physicians, the literature on nurses' moral distress is much more prevalent (Elpern & Silver, 2006; Schmalenberg, et al., 2005). The findings of Delgado et al., (2005) suggest that physicians may experience moral distress to a lesser degree than nurses. However, both nurses and physicians have been found to experience the greatest moral distress from the same type of situations. Pressure to continue aggressive treatment in situations where they believed treatment was not warranted is ubiquitous in healthcare literature (Elpern, et al., 2005; Hamric & Blackhall, 2007; Oberle & Hughes, 2001). When faced with similar 'futile' situations, nurses may feel more

intensely distressed than physicians because they have less impact on end-of-life decisions (Hamric & Blackhall; Poncet et al., 2006).

Sexton, Thomas, & Helmreich (2000) have shown that ICU physicians tend to deny personal vulnerability to factors such as stress. Compared with other stressful professions, intensive care physicians are less likely to acknowledge the effect of personal problems upon performance at work, and are more likely to report that they can perform effectively during critical situations of patient care when they are fatigued (Sexton et al). Hence, physicians may be reluctant to admit to feelings of distress, thereby minimizing the research findings.

Prolonging treatment has been identified for more than 30 years as the most frequently occurring ethical dilemma for nurses and physicians (Rodney, 1988). Nurses, however, report situations of overly aggressive care as occurring more frequently than physicians claim (Hamric & Blackhall, 2007). This reported difference among nurses and physicians may be the reason nurses perceive greater moral distress than physicians. Most physicians have practices and obligations outside of the unit that allows them time away from the ICU. This contrasts with nurses who cannot leave the unit as easily, and, therefore, are exposed to a greater number of distressing situations.

One of the biggest challenges for ICU nurses is the patient suffering they often bear witness to, and the resultant moral distress. The proximity to patient suffering is often the catalyst that stimulates nurses to broach the subject of limiting or withdrawing treatment before other healthcare professionals or family members. Nurses may experience greater moral distress than physicians when giving care they perceive is unwarranted due to the longer amount of time spent at the patient's bedside (Peter & Liashenko, 2004). It is not that nurses are morally superior; rather, it is the nature of nursing work that requires sustained close proximity, and consequently

results in nurses experiencing the moral responsibility more acutely. Further, nurses may have increased frustration with decisions that are made where their information had little impact. The physical nearness inherent in the nurse-patient relationship contributes to the greater moral distress that nurses' experience, however, it may also contribute to nurses' moral ambiguity (Gutierrez, 2005; Peter & Liashenko).

Moral ambiguity is believed to result from patient proximity in association with nurse physician conflict or poor collaborative teamwork. Nurses are witness to patient suffering, yet their position within the hierarchies of healthcare prevents them from participating in patient's healthcare decisions (Peter & Liashenko, 2004). Nurses' experience with the suffering of moral distress has implications for patient care (Elpern & Silver, 2006; Peter & Liashenko).

Nurses describe distancing themselves from patients and families while they attempt to cope with their distress. "Suffering has been identified as being very personal and private for the person experiencing it, but suffering also has been demonstrated to be interpersonal, with resulting communal or societal effects" (Jezuit, 2000, p. 146). Nurses also need to be aware that the perception of their own misery may be projected to others. Nurses' own suffering and feelings of hopelessness might be perceived to be the patients (Hov, et al., 2006).

Moral distress has also been linked to decreased collaboration among nurses and physicians (Delgado, et al., 2005; Elpern & Silver, 2006). Other variables that correlate with high reports of moral distress are important factors to note in nurses' reports of moral distress. Nurses who describe experiencing high levels of moral distress also report a more negative ethical environment in their ICU, lower satisfaction with quality of care, and less collaboration with physicians. Further, moral distress is one of the most frequently cited reasons for leaving ICU (Elpern, et al., 2005; Gutierrez, 2005; Hamric & Blackhall, 2007). Given the nationwide

continuing shortage of Registered Nurses (RNs), these findings need to be addressed in ICU settings.

Interventions to relieve moral distress need not be costly and should begin with education. Providing education in the form of informal discussions, pamphlets, and newsletters that describe symptoms of moral distress may provide an avenue for nurses and physicians to recognize and discuss their experience. Simply recognizing moral distress, naming it, and openly discussing it, can provide considerable relief for nurses and physicians (Pendry, 2007; Van Soeren & Miles, 2003). Recognizing that others share their experience can assure those in distress that their feelings are shared and reasonable (Elpern & Silver, 2006). For example, staff in patient care areas that have been identified as high risk for situations of moral distress, such as critical care, can organize onsite educational programs and provide moral distress education during orientation for new staff members.

Many nurses discuss taking their suffering home with them, indicating that professional suffering may impact nurses' personal lives. Communication is the most important factor to resolve personal suffering. Sharing the suffering with a compassionate individual allows the sufferer to work through and interpret the suffering (Sabo, 2006). Nurses believe that other nurses are able to provide the most empathetic understanding of distressing situations that occur in the workplace. Hence, nurses use one another for support and validation. The difficulty with this practice lies in the potential harm to the nurse colleagues through vicarious trauma.

Vicarious Trauma and Compassion Fatigue

Vicarious trauma (VT) refers to harmful changes that occur in professionals' lives as a result of exposure to traumatic events or information (Baird & Kracen, 2006). Numerous investigators have sought to identify correlations between vicarious trauma and the related

constructs of burnout and compassion fatigue. Unfortunately, clear relationships have not yet been identified, making it difficult to use research findings to inform practice (Baird & Kracen). Professionals, such as ICU nurses and physicians, who are exposed to trauma from empathetically engaging with patients and families, may experience VT. People all have the need to believe the world is a relatively safe place. Vicarious trauma is associated with disruptions to this view, and it is pervasive, cumulative, and permanent (Baird & Kracen). The emotional cost of caring can be considerable (Embriaco et al., 2007; Sabo, 2005).

The stressful environment of ICU, coupled with the frequent ethical dilemmas that arise, can have negative effects on physicians and nurses. The act of caring, compassion, and empathy may be a double-edged sword; on the one hand, empathy facilitates caring work, yet, it also leaves healthcare professionals vulnerable as they bear the suffering of others (Sabo, 2006). Compassion fatigue, that some people associate with burnout, is a term coined to define those nurses and physicians who are no longer able to provide emotional support to patients and families due to the constant need to give and support others (Sabo). When nurses and physicians protect themselves from the constant exposure to the emotional pain of others, they may become so well defended that they are unable to provide supportive care to those in need. Health care professionals suffering from compassion fatigue describe feeling ‘emptied’ with nothing left to give (Wright, 2004). Although the body of research is growing, compassion fatigue remains a fairly new observation. It is believed that those nurses and physicians who suffer from burnout are at greater risk for developing compassion fatigue (Sabo).

Collaborative Strategies

Successful collaboration requires intentional team building (Aston, Shi, Bullot, Galway, & Crisp, 2005; Falise, 2007; Gardner, 2005; Kramer & Schmalenberg, 2003; Lindeke &

Sieckert, 2005). Team building takes time, and is accomplished through developing behaviours such as trust, conflict management, containment of negative behaviours and respectful negotiation. Historical inequality of power and authority may create challenges to interdisciplinary collaboration. Nurses must remain confident in their expertise and not attempt to overcome an unequal playing field by striving for dominance. An attitude of confrontation nullifies collaboration and closes down the possibility of building relationships (Day, 2006; Hughes & Turner, 1996). The team can also facilitate neutralizing power inequalities by dropping titles and addressing one another by given names (Lindeke & Sieckert; McCauley & Irwin, 2006). When mutual goals of patient well-being are the common objective, shared knowledge and expertise become the focus rather than power discrepancies.

Education in teamwork and end-of-life care should be a priority for medical and nursing professions. Interdisciplinary educational sessions that focus on understanding multiple perspectives and communication skills can facilitate overcoming differences. Acquiring the knowledge, skills and attitudes that help to achieve compassionate end-of-life care in ICU is of the greatest importance (Puntillo & McAdam, 2006; Stevens et al., 2002). However, patients are cared for by multiple practitioners in various disciplines, hence, truly excellent end-of-life care requires learning the skills to be an effective team member.

Positive teamwork requires team members to avoid counterproductive behaviours such as the blame-game (Henneman, 1995). Nurses must stop acting like an oppressed group; rather they need to project strength and confidence in their contributions to patient care. When nurses seek to understand each other, they can move away from accusation and blame to respect and trust.

Patient advocacy is commonly understood by nurses to be a core component of their professional identity. Unfortunately, for some nurses the role of patient advocate has become

adversarial, and created an ‘us against them’ way of thinking. Language of some professional nursing organizations may be partly to blame for this interpretation (Day, 2006; Henneman, 1995). Practice that encourages discovering and revealing the shortcomings of colleagues undermines trust and collaboration within the team (Day). Patient and family needs should remain central to nurses’ agency. Yet, given the equally important role of collaboration for patient outcomes, nurses must broaden their understanding of advocacy to include aspects that will promote optimal team functioning while keeping patients and families at the centre. A nurse advocate with this broader understanding goes beyond just protection and engages with other healthcare team members in open and honest communication that results in mutual concerns for each others practice.

Appreciating that no single caregiver can support the complexity of care, collaborative practice allows each partner to use his/her own skills, expertise, and clinical judgement to plan and deliver healthcare to patients. Awareness of their scope of practice and professional limitations allows each professional to contribute their unique perspective.

It is unrealistic to think that situations of conflict will not occur. When seen as a healthy component of group cohesiveness, conflict can generate innovative, productive ideas and prevent stagnation and apathy. The skill during times of conflict is to maintain openness, and respectful dialogue (Schmalenberg, et al., 2005).

Despite the inherent challenges of collaborative practice, today’s healthcare complexities in end-of-life care require healthcare professionals to work together to achieve optimal patient care, as well as personal growth for collaborators (Baggs & Ryan, 1990; Lindeke & Sieckert, 2005). The fact that collaboration improves patient outcomes should be the impetus for all

disciplines to seek open and respectful communication that values all contributions equally (Rodney, Brown & Liashenko, 2004; Stein-Parbury & Liashenko, 2007).

In a healthcare climate that demands efficiency, cost-effectiveness, and quality improvement, nurse-physician collaboration holds promise for improving patient care and creating satisfying work environments. In the fast-paced, ever-changing environment of ICU, there is not always the time to develop long-term relationships among healthcare professionals. Interactions may be brief and under stressful conditions. Therefore, the goal is to optimize each interaction, in order to make use of the best knowledge and abilities of all healthcare team members and produce optimal patient outcomes.

Good collaboration skills are essential in today's complex healthcare system. Each team member has knowledge that other team members need in order to practice successfully. Neither profession can stand alone; sharing information is crucial to maximize patient care, and ensure patient safety (Lindeke, & Sieckert, 2005; Yeager, 2005). A highly functioning team acts like biologic systems. Lungs, heart, kidneys, and circulatory system are interdependent. Multidisciplinary care is the same; all members exist for one ultimate purpose; transitioning patients and families either to a new state of wellness or a peaceful death.

A healthy work environment is considered to be so important that failure to address it would affect the well-being of all aspects of critical care practice (McCauley & Irwin, 2006). Skilled communication, true collaboration and effective decision-making are standards that the American Association of Critical Care Nurses (AACN) maintains will contribute to a healthy work environment (2005). The AACN believes nurses must be as proficient in communication skills as they are in clinical skills. They believe nurses must strive to foster true collaboration, and also that nurses must be partners directing and evaluating clinical care (McCauley & Irwin).

The Canadian Association of Critical Care Nurses (CACCN) believes that critical care nurses play an integral part in how the decision making process regarding withholding or withdrawing of life support occur for the critically ill (2001).

> When nurses have vision and a clear sense of direction, and are confident and articulate about the value of all aspects of nursing they can facilitate teamwork and collaboration. Working together, we are at the forefront of incorporating advanced technology into healthcare without losing the human element. We are determined that science and technology remain the servant of compassionate and ethical caring that includes meeting spiritual and emotional needs (Ashworth, 2000, p. 128).

Despite the persistence of several obstacles, movement does appear to be going in a spiral direction, rather than just in circles. Many intensive care nurses and physicians now have the kind of relationship that is needed to care for critically ill patients (Ashworth, 2000; Aston, et al., 2005; Kramer & Schmalenberg, 2003; Mawdsley & Northway, 2007). These relationships are based on mutual respect and recognition of each other's expertise. The level of education of nurses has risen, and with that comes the ability to articulate the nursing perspective more clearly with physicians and other members of the health are team. Critically ill patients require physicians and nurses to work together as a cohesive team.

Although achieving collaborative relationships among nurses and physicians has proven to be challenging, studies are emerging demonstrating that collaboration and end-of-life care can be improved in ICU (Aston, et al., 2005; Boyle & Kochinda, 2004; Falise, 2007; Gardner, 2005; Schmalenberg et al., 2005). Nurses and physicians who are committed to improving their collaborative communication, strong leadership, and development of communication skills are some of the components to facilitating collaboration.

True collaborative practice requires a shift in focus that prioritizes teamwork over individuals. Hence, collaboration is not working side-by-side; rather it is joining forces in recognition that the sum will be greater than the individual parts. In addition to individual characteristics of emotional maturity, understanding the perspectives of others, and avoiding compassion fatigue, team building is an essential component of collaboration (Lindeke & Sieckert, 2005). In other words, it is not enough to simply state that the group will engage in collaboration. Team building requires a commitment from each member to seek a common goal of patient well-being. A shared patient focus helps team members to remain steadfast in their resolve to build and maintain a supportive environment. Additionally, each of us brings individual biases, values, and assumptions to the table, therefore, members need to discuss their particular vision of collaboration as this may differ significantly from person to person. Different communication styles may also create diversity, as women are generally more concerned with relationship building, and men are more task oriented (Gardner, 2005). While it is recognized that stereotype generalizations are often erroneous, it is counterproductive to ignore differences. Understanding differences in communication can increase self-awareness about the assumptions and interpretations that people may make in their interactions with others.

In this project, I focus on collaboration among nurses and physicians, however, it is anticipated that collaborative relationships will extend to other healthcare disciplines in ICU. Team members or stakeholders are identified as any party directly influenced by the actions others take to solve a complex problem (Gardner, 2005). Specialized knowledge and competencies that are required to work in ICU's and the highly interactive relationships are thought to favour collaboration. Therefore, in many ICU's, nurse physician collaboration is stronger than in non-critical care areas.

Nonetheless, change will not occur without leadership and role modelling by physicians and nurses in clinical practice. Expectations of respect and collaboration will help to bring about positive behaviours. Strong leadership is required from nursing and medical directors to uphold mutual respect and support teamwork. It is important to remember that team building and collaboration takes time and patience. Establishing trust and learning skills of respectful negotiation and conflict management does not happen overnight.

Learning to negotiate respectfully may present challenges to some physicians and nurses as a result of the hierarchical baggage they may continue to carry. Some nurses may dominate the team as a result of overcompensating for previous perceived inequalities. Conversely, some physicians may be unwilling to give up personal power for the sake of team empowerment. Strong leaders that remain committed to enhanced patient care, and improved relationships among healthcare professionals, are required when individual members create friction (Boyle & Kochinda, 2004; Yeager, 2005).

Team members can improve their negotiating skills and conflict management through attending workshops, instructional videos, or in-house conferences. Every team will encounter disagreement and conflict. Being prepared for these eventualities will help to decrease the anxiety team members may experience. Cohesiveness and joint problem solving are the desired results, however, team members will not always agree, and at those times a venue for disagreement must be available. It is important that nurses and physicians do not suppress their solutions in an attempt to suppress conflict (Gardner, 2005). The generation of different ideas promotes multiple solutions and fosters creativity and diversity. Integrative solutions go beyond the capability of individual vision, rather they are the result of a synthesis of perspectives to create a productive resolution that could not be accomplished by any single person or organization.

Teams must also be aware of how to proceed when they are unable to resolve conflict. At these times, team members must be careful to restrict their analysis to the facts, and refrain from discussing personal opinions. Teams are strengthened and become more cohesive when they are able to successfully manage challenging situations (Gardner, 2005). Assertiveness skills are beneficial for members to learn ways to calmly explain their perspective without becoming defensive or counter-productive. Team members must be flexible and open-minded if they are to remain receptive to the ideas of others. Ethics consultations offer promising approaches to improve decision-making and communication by helping to identify, analyse, and resolve ethical problems. Schneiderman et al. (2003) concluded ethical consultations were useful in resolving conflicts that were related to nonbeneficial treatments or unwanted treatments at the end of life. The CACCN (2001) believes a process to deal with conflict resolution should be in place to assist nurses, physicians and family members with end-of-life decisions.

An emergency situation is often a challenging time to communicate effectively. Since emergencies are common occurrences in intensive care units, nurses and physicians are well advised to strengthen their communication skills in these situations. When information is exchanged in emergency situations, it is important to keep interactions efficient and prioritize to provide current information. Additionally, it is important to get the facts from informed sources, avoid blowing issues out of proportion, respond promptly and calmly, and divulge only necessary information.

The necessity of immediate action in ICU may result in cases where, upon reflection, different decisions might be made. Establishing a process to follow up on issues later, and debriefing about processes and outcomes, will enhance collaborative efforts and relationships. Creating clarity and explaining rationales will further improve team function.

Certain individual characteristics can influence the degree of collaboration between healthcare professionals. Emotional intelligence has been described as a maturation process that involves the ability to control one's own emotions, and also to be able to understand the perspectives of others (Lindeke & Sieckert, 2005). Developing emotional maturity and perceiving the viewpoints of others, instils confidence and enhances one's behaviour within groups. Emotional maturity is fundamental to effective collaboration. Mature team members continually seek to expand their knowledge and keep their skills current. They maintain a positive attitude, and assume responsibility for their actions.

ICU nurse and physician leaders create the environment for collaborative communication among healthcare professionals. In addition to improved collaboration among nurses and physicians, healthcare clinicians need to ensure families, as patients' substitute decision-makers are fully included in the process. Understanding and improving communication about end-of-life care among clinicians and families in the ICU is an important focus for improving the quality of care in the ICU. Nurses can play a crucial role in fostering clear communications among team members and patients and families.

Practical Application of Recommendations

1. Meet with ICU nursing manager and ICU medical director.

   Seek management support for implementing collaborative strategies.

   Discuss implementation strategies and institutional resources and costs.

   Propose introducing collaborative initiatives during daily interdisciplinary rounds.

   Work with mangers to obtain necessary resources to support the staff in collaborative development.

2. Prepare for project.

   The respectful workplace development project with the Fraser Health Authority (FHA) supports workplace initiatives such as collaborative communication and conflict resolution.

   Build support for project.

   Discuss project with colleagues.

3. Attend the ICU patient care coordinators (PCC) meeting.

   Discuss creating a more collaborative workplace.

   Discuss leadership role modeling.

   Distribute research articles about the benefits of collaborative practice.

4. Identify nurses and physicians who are interested in assuming the role of collaborative champions.

   Facilitate problem solving and collaboration.

   Coach and help staff members develop collaborative skills.

   Help resolve dysfunctional behaviour.

5. Meet with ICU nursing educator.

   Introduce plans for collaborative initiatives.

   Discuss sharing collaborative goals with new staff members during orientation.

6. Organize an ICU nurse and physician staff meeting.

   Introduce the plan to improve collaboration teamwork.

   Provide the team with a vision of the project.

   Recognize that collaboration is a journey that takes time.

   Share strategies that promote collaboration.

Provide information on collaborative relationships.

Discuss having regular meetings that focus on nurse and physician practice issues.

7. Arrange in-service speakers on collaborative teamwork and communication skills.
8. Plan for follow-up staff meeting in 6 months to assess recommendations.

ICU nursing and physician leaders are integral to creating a collaborative environment among healthcare providers. Prior studies have established that leaders play a key role in improving collaborative relationships among unit staff (Boyle & Kochinda, 2004). The leadership focus should be on creating a milieu of open and honest communication. Strong leadership can provide role models and mentorship for other staff members.

Link to Nursing Practice/Education/Research

This project has important links to nursing practice as challenges to end-of-life decision-making in ICU are likely to progress in intensity and frequency as the number and complexity of life support interventions and heightened expectations will inevitably increase (Luce & White, 2007). Nurses and physicians have an ethical obligation to develop and support collaborative working relationships as collaboration leads to improved patient quality of care, and enhanced professional relationships. The critical nature of ICU places nurses and physicians at risk for experiencing moral distress and burnout. A collaborative relationship decreases nurses' and physicians' personal distress and fosters the development of common patient goals. A collaborative approach to health care is essential when patient's needs and problems are multiple and complex. A thorough scholarly understanding of the differences in nursing and medical practices and ideologies is necessary before change will occur in the nurse-physician work relationship.

Future areas of work should continue to focus on establishing collaborative relationships among ICU nurses and physicians. Nurses need to overcome their own socialization into the traditional healthcare system to facilitate collaborative working relationships. To limit any subordination of the nursing profession, nurses need to clearly understand and educate other health professionals about the scope of practice of nurses. Nurses can contribute their knowledge and expertise in multiple arenas, such as patient care rounds, patient consultations, and professional development workshops. Nurse leaders can role model skilled communication, true collaboration, effective decision-making, and authentic leadership.

Nursing and medical education must include knowledge and information on the professional responsibilities and roles of each profession to enhance understanding of the other's perspectives. Interprofessional teamwork is an essential characteristic of healthcare reform. According to Health Canada (2007), collaborative patient-centred practice promotes "the active participation of several healthcare disciplines and professions"(para 4). Interprofessional education at undergraduate, graduate, and practice levels is essential if we are to prepare health-care professionals to change the culture of healthcare from one of professional silos to a model that facilitates collaboration and teamwork. Health Canada is committed to meeting the learning needs of healthcare professionals through the Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP). The IECPCP program, and other Health Canada programs are avenues that can be explored for available resources and associations.

The Canadian ICU collaborative is a group that offers opportunities for those who administer care to influence change. The collaborative was formed with the goal to improve patient care by providing support and infrastructure to ICU nurses interested in championing improvement and change initiatives in their workplace. The Canadian ICU Collaborative focuses

on multidisciplinary teamwork, networking and sharing among teams, systems analysis, and the integration of frontline critical care nurses as integral members of successful practice change. The ICU collaborative supports professional development through exposing members and other interested parties to quality improvement process education, reviews of current best practice and working with a motivated unit-based and national team. A quarterly publication describes projects that other groups in the collaborative have introduced or implemented in their workplace. Recently, the ICU collaborative identified end-of-life care as a topic for which they are accepting proposals.

In addition, examining the organizational structures of hospitals, including management and administrative factors that perpetuate old forms of communication, need to be reviewed. The healthcare organization can be lobbied to provide support for and access to educational programs to ensure that nurse leaders develop and enhance knowledge and abilities in: skilled communication, effective decision-making, and true collaboration.

Other avenues that offer the opportunity to disseminate information include submitting letters and articles to the CACCN, CMA, and the CNA. Professional conferences also provide opportunities to educate and inform other healthcare professionals. National attention can be attained through correspondence to different media outlets.

Conclusion

The complex ethical and moral issues intensive care nurses and physicians are increasingly being faced with results in end-of-life decision-making being one of the greatest challenges in critical care. Unprecedented advances in medical technology have resulted in patient lives that are often sustained far beyond the point of meaningful quality of life. The structural and organizational milieu of hospitals places physicians in a disengaged position, and

nurses in a very engaged position. This results in different focuses of information and knowledge. Nurses play a central role in the care of dying people, and, as such, are well equipped to advocate for the needs and wishes of patients and families. An increased understanding by nurses and physicians of the demands and stresses associated with their respective roles and responsibilities may foster improved working relationships between both professions (Coombes & Ersser, 2004). Research on improving physician and nurse collaboration is urgently needed (Storch & Kenny, 2007). In this paper, I provide a step in that direction through exploring the barriers and facilitators to collaboration. Collaborative decision-making through integration of all patient knowledge is required for optimal patient care, making nurse physician collaboration the heart and soul of excellent patient care.

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