

## **Les facteurs de stress du personnel infirmier qui fournit des soins palliatifs de fin de vie dans les services de soins intensifs**

**Céline Gélinas, Lise Fillion,  
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Cette étude avait pour objectif de décrire les facteurs de stress du personnel infirmier qui fournit des soins palliatifs de fin de vie (SPFV) dans des services de soins intensifs (SSI). L'étude a été réalisée selon un plan d'analyse descriptive et qualitative, et 42 infirmières au total provenant de cinq SSI de la province de Québec, au Canada, y ont participé, réparties dans 10 groupes de discussion. Les facteurs de stress ont été regroupés dans trois catégories : organisationnels, professionnels et affectifs. Les principaux facteurs de stress organisationnels mentionnés ont été le manque d'une approche en matière de soins palliatifs, les difficultés interprofessionnelles, l'absence de continuité dans les plans de maintien des fonctions vitales et de traitement, et les demandes contradictoires. Les facteurs de stress professionnels étaient le manque de compétences en SPFV ainsi que la difficulté de communiquer avec les familles et de collaborer avec les autres membres de l'équipe médicale. Les facteurs de stress affectifs décrits comprenaient les conflits de valeurs, le manque de soutien affectif, et la souffrance des patients et de leur famille. Les auteures concluent que la prestation des SPFV est stressante pour le personnel infirmier des SSI et qu'il faudrait élaborer des programmes de formation et de soutien permettant d'assurer la qualité des SPFV dans un environnement de soins intensifs.

Mots clés : facteurs de stress, infirmières, fin de vie, soins palliatifs, services de soins intensifs

# **Stressors Experienced by Nurses Providing End-of-Life Palliative Care in the Intensive Care Unit**

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The purpose of this study was to describe stressors experienced by nurses in providing end-of-life palliative care (EoL/PC) in intensive care units (ICUs). A descriptive qualitative design was used. A total of 42 nurses from 5 ICUs in the province of Quebec, Canada, participated in 10 focus groups. Stressors were found to be clustered in 3 categories: organizational, professional, and emotional. The major organizational stressors were lack of a palliative care approach, inter-professional difficulty, lack of continuity in life-support and treatment plans, and conflicting demands. Professional stressors included lack of EoL/PC competencies and difficulty communicating with families and collaborating with the medical team. Emotional stressors were described as value conflicts, lack of emotional support, and dealing with patient and family suffering. The authors conclude that providing EoL/PC is stressful for ICU nurses and that education and support programs should be developed to ensure quality EoL/PC in the critical care environment.

Keywords: stressors, nurses, end of life, palliative care, intensive care unit, adults

## **Introduction**

Palliative care is intended to improve the quality of life for both patients experiencing a life-threatening illness or at end of life and their families (World Health Organization, 2002). In Canada, access to specialized palliative care is limited and deaths occur in a wide variety of health-care settings (Canadian Hospice Palliative Care Association, 2008), many in hospital settings. Of the 235,217 deaths in Canada in 2007, 156,685 (66.6%) occurred in hospital, and in the province of Quebec the proportion of deaths taking place in hospital reached 86% (Statistics Canada, 2007, p. 21, table 2.2). Many of these deaths occur in specialized care units, including intensive care units (ICUs). In a Canadian report (Heyland, Lavery, Tranmer, Shortt, & Taylor, 2000), a mean of 18.6% of hospital deaths occurred in specialized care units, mainly ICUs and coronary care units, with a larger proportion of these deaths occurring in teaching hospitals (27%) than in non-teaching hospitals (15%). Given the

high incidence of deaths in the ICU, end-of-life palliative care (EoL/PC) in this critical care setting is a major concern. Providing EoL/PC in the ICU may be stressful for nurses as it differs from curative care, which is the primary goal of intensive care medicine. This present study is specific to the ICU context and is a follow-up to the work of Fillion, Saint-Laurent, and Rousseau (2003), which describes the stressors related to palliative care nursing in Quebec.

## Background

Workplace stress generally occurs when the demands (also called “stressors”) of the work environment exceed the employee’s coping resources (Cox, Griffiths, & Rial-Gonzalez, 2000; Fillion et al., 2007). It contributes to negative outcomes at both the organizational and the individual level. At the organizational level, work-related stress tends to be associated with high rates of absenteeism (Brun, Biron, Martel, & Ivers, 2003; Moreau et al., 2004; Verhaeghe, Mak, Van-Maele, Kornitzer, & De-Backer, 2004) and can affect employees’ performance and productivity (Beehr, Jex, Stacy, & Murray, 2000). At the individual level, stress experienced at work is understood to be related to a high incidence of health problems (Niedhammer, Tek, Starke, & Siegrist, 2004), burnout (Jourdain & Chênevert, 2010), and job dissatisfaction (Fillion et al., 2007).

It is well documented that nurses perceive several demands or stressors in providing EoL care, and this applies to a wide variety of contexts of care (Holland & Neimeyer, 2005; Hopkinson, Hallett, & Luker, 2005). In a study by Fillion et al. (2003), which was aimed at describing stressors related to palliative care nursing in Quebec, 60 nurses working in various settings (i.e., palliative care units in hospitals, CLSCs [government-run clinics], private palliative care hospices) participated in nine focus groups. ICUs were not included in the study. The authors describe an interesting framework of three categories of stressor experienced by nurses: organizational, professional, and emotional. *Organizational stressors* are demands related to work organization and to the particular environment in which nurses practise. Several difficult working conditions confronted by nurses on a daily basis can generate stress. The main organizational stressors identified by Fillion et al. (2003) are lack of recognition of palliative care as a specialty, lack of structural organization, work overload, ambiguity of roles, lack of human and material resources, lack of involvement in decision-making, and lack of support. *Professional stressors* correspond to demands and expectations related to the nurse’s professional role. Lack of collaboration on the medical team (e.g., lack of a treatment plan), difficulty relieving pain and managing symptoms, lack of education and training, lack of time to devote to patients and families, and difficulty main-

taining distance within therapeutic relationships were the major professional stressors identified by nurses. *Emotional stressors* are associated with emotional demands and existential issues linked to death and the dying process. Exposure to the suffering of patients and families and exposure to multiple deaths are examples of emotional stressors that can contribute to distress in nurses (Fillion et al., 2003). Value conflicts and conflictual demands associated with providing acute and palliative care simultaneously are also described in this category and are related to emotional stress (Fillion et al., 2003). Emotional stress associated with moral stressors is also referred to as moral distress or ethical suffering (Langlois, Dupuis, Truchon, Marcoux, & Fillion, 2009).

In their literature review, Espinosa et al. (2008) analyze 22 studies (13 quantitative and 9 qualitative) describing the stressors or obstacles experienced by nurses while providing EoL care in the ICU. While most of these studies did not deal with integration of stressors in depth, they enabled the identification of major sources of stress to which ICU nurses are exposed. This first attempt to integrate diverse findings identifies three major organizational stressors: lack of involvement in the planning of care, staffing issues and work overload, and environment. Not surprisingly, nurses stated that they were frequently excluded from discussions regarding a patient's care plan and that they played a limited role in decision-making on withdrawal of life support (Calvin, Kite-Powell, & Hickey, 2007; Halcomb, Daly, Jackson, & Davidson, 2004; Keenan, Mawdsley, Plotin, & Sibbald, 2003; Kirchhoff et al., 2000; Rocker et al., 2005). Work overload was perceived as an obstacle to the provision of quality EoL care and scheduling did not permit continuity of care for patients (Beckstrand & Kirchhoff, 2005). Space limitations in the ICU precluded family access to dying patients, family meetings, and a place to rest (Kirchhoff et al., 2000; Nelson et al., 2006; Rocker et al., 2005).

Professional stressors experienced by ICU nurses included disagreement among physicians and other members of the health-care team, inadequacy of pain relief, unrealistic expectations by families, and lack of experience and education (Espinosa, Young, & Walsh, 2008). For nurses, disagreement among physicians regarding the patient's prognosis was one of the major obstacles (Beckstrand & Kirchhoff, 2005; Calvin et al., 2007; Kirchhoff et al., 2000; Nelson et al., 2006). Such disagreement can lead to the use of extraordinary measures and the prolongation of unnecessary treatment (Calvin et al., 2007; Halcomb et al., 2004; Keenan et al., 2003; Kirchhoff et al., 2000; Puntillo et al., 2001; Robichaux & Clark, 2006; Rocker et al., 2005). Nurses often felt that the patient's pain was not adequately relieved (Puntillo et al., 2001). High expectations from families can also be disruptive and lead to changes in the patient's treatment plan in order to accommodate their needs (Badger, 2005). The time required

for nurses to intervene with family members can interfere with patient care (Beckstrand & Kirchhoff, 2005; Calvin et al., 2007; Halcomb et al., 2004; Nelson et al., 2006). Also, family members and friends continually calling the nurse rather than a designated person for an update is highly disruptive (Beckstrand & Kirchhoff, 2005; Crump, Schaffer, & Schulte, 2010). In addition, nurses have expressed a need for more education in EoL care (Desbiens & Fillion, 2011; Fillion, Fortier, & Goupil, 2005; Nelson et al., 2006; Rucker et al., 2005).

Difficulty coping has been reported as the main emotional stressor for ICU nurses (Espinosa et al., 2008). Accompanying the patient and the family in the dying process can cause suffering and moral distress in nurses (Elpern, Covert, & Kleinpell, 2005; Jezuit, 2000). In one study (Puntillo et al., 2001), only 13% of 906 ICU nurses reported that they had access to support. The presence of high moral distress and the absence of support can contribute to burnout in nurses (Holland & Neimeyer, 2005; Meltzer & Huckabay, 2004).

In a recent descriptive phenomenological study (Espinosa, Young, Symes, Haile, & Walsh, 2010), 18 ICU nurses at a US teaching hospital participated in individual interviews and focus groups. The findings supported stressors identified in the integrative review (Espinosa et al., 2008) but also identified other sources of stress. In the category of professional stressors, nurses described concerns related to the medication dosages necessary to keep the patient comfortable, which can potentially cause respiratory depression. Two additional emotional stressors were described: a feeling of abandonment and powerlessness, and difficulty caring for younger patients. Nurses spend most of their time with the patient, yet have to cease treatment and withdraw tubes as per the physician's orders. Therefore, they often feel abandoned and responsible for patients as they die. Also, they experience feelings of powerlessness and failure when the patient does not get well. The situation is particularly difficult for nurses providing EoL care to younger patients, as it makes them realize that mortality can touch their own lives (Espinosa et al., 2010). That study was limited to a single setting in the United States and its findings cannot be transferred to the Canadian context. Transferability would require the inclusion of different settings, as in the approach by Fillion et al. (2003).

### **Purpose**

This study was aimed at better understanding the stressors experienced by nurses providing EoL/PC in Canadian ICUs. The objective was to describe the stressors related to the provision of EoL/PC in the ICU from the perspective of nurses in different settings in the province of Quebec.

## **Methods**

### ***Design***

A descriptive qualitative design was used for the study.

### ***Sample***

The sample comprised different groups of nurses working in various ICU settings. Settings were selected to be representative of the variety of hospitals in Quebec in terms of location (urban or rural), organization (presence or absence of intensivists and of a palliative care team), and status (teaching or non-teaching). A total of five French-speaking and English-speaking ICUs in three regions of the province were selected. In each setting, an intentional sample of bedside ICU nurses from all work shifts (day, evening, and night) was recruited.

### ***Procedure***

With the support of the nurse managers, the study was orally presented to ICU nurses by the research coordinator, and nurses who were interested in participating gave their names. Two focus groups were scheduled in each setting, for a total of 10 focus groups. The sessions were co-facilitated by a researcher and the research coordinator, were 40 to 60 minutes in duration, and were audiorecorded. The focus groups were held in non-threatening environments (i.e., rest areas or conference rooms) and the facilitators were respectful of the diversity of opinions (Krueger, 2006). Saturation of data was achieved, as no new information emerged at the completion of the focus groups. The study received ethical approval at each site.

<b>Themes</b>	<b>Questions</b>
Description of sources of stress (stressors)	Based on your role as an ICU nurse, tell us about the sources of the stress (barriers or obstacles) you experience when providing EoL/PC to your patients?
Factors associated with the production of these stressors	In your opinion, what factors contribute to the stress you experience when providing EoL/PC in the ICU?  What makes you feel uncomfortable or dissatisfied when providing EoL/PC to a patient?

**Table 1 ICU Settings and Participants**

Site	Urban or Rural	Teaching or Non-teaching Hospital	Open or Closed ICU	Palliative Care Resources	Gender		Mean Age	Age (SD)	Education			Years' Experience	
					Male	Female			Diploma	BSc	MSc	ICU	Total
A	Urban	Teaching	Semi-closed	Yes	1	6	37.4	12.1	4	3	0	10.7	14.9
B	Urban	Teaching	Closed	No	0	6	43.0 <sup>a</sup>	12.3	5	0	1	14.1	21.0
C	Rural	Non-teaching	Open	No	0	9	36.2	5.9	4	5	0	10.6	13.0
D	Urban	Teaching	Closed	Yes	0	12	44.9 <sup>a</sup>	8.5	4	8	0	14.0	20.0 <sup>a</sup>
E	Urban	Teaching	Closed	Yes	1	7	35.0	6.5	5	2	1	6.6	8.06

<sup>a</sup>Missing data

### ***Instruments***

The discussion guide developed by Fillion et al. (2003) was adapted to the ICU context and included two themes: identification and description of stressors experienced in providing EoL/PC in the ICU, and process or causative factors associated with the production of these stressors in the ICU context. Specific questions are provided in Figure 1.

### ***Data Analysis***

The audiorecordings for all focus groups were integrally transcribed and reviewed. The three categories of stressor (organizational, professional, and emotional) as described by Fillion et al. (2003) were used as a foundation for developing a categorization scheme. Using the NVivo7<sup>®</sup> program, we created descriptive codes by attributing a code to each unit of analysis (words, phrases, or paragraphs) highlighting an issue. Content analysis followed the approach of Miles and Huberman (1991). The merging of similar descriptive codes created thematic categories representing a set of conceptual components (stressors). To ensure rigour, we addressed transferability, credibility, and plausibility (Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998). The diversity of the sites served to enhance transferability, while double codification by two members of the research team served to enhance credibility. Respondent validation was performed with ICU nurses in two of the settings. Finally, to enhance plausibility, stressor classification and their related verbatim dialogue were discussed by the team in order to reach consensus.

## **Results**

### ***Settings and Sample***

Except for one rural, non-teaching site, all sites were both urban and teaching. Three settings had full-time intensivists in charge of the ICU (what is called a “closed ICU”), one site had intensivists only during the week (semi-closed ICU), and one site had non-intensivists in charge of ICU patients (open ICU). Three sites had palliative care teams covering the ICU, one site had one physician specialized in palliative care, and one site had no palliative care resources at all. A detailed description of each setting is provided in Table 1.

The sample comprised 42 bedside ICU nurses (Table 1). Most participants were female and their mean age was 35.4 years. Two participants held a master’s degree in nursing; the others held either a nursing diploma ( $n = 22$ ; 52%) or a bachelor’s degree in nursing ( $n = 18$ ; 43%). The mean number of years working as a nurse was 15.0, including 11.3 years working in the ICU.



**Table 2 Organizational, Professional, and Emotional Stressors**

<b>Organizational</b>	<b>Professional</b>	<b>Emotional</b>
Lack of a palliative care approach – <i>environmental resources</i> – <i>human resources</i>	Lack of EoL/PC competencies	Value conflicts
Interprofessional difficulty	Difficulty communicating with families; complaints	Lack of emotional support
Lack of continuity in life-support and treatment/care plans Conflicting demands	Difficulty collaborating with medical team on EoL/PC issues – <i>lack of involvement of nurses in life-support and treatment planning</i> – <i>lack of medical leadership in EoL/PC decision-making</i> – <i>lack of EoL/PC protocols</i>	Dealing with patient and family suffering

## **Stressors**

A list of stressors was identified for each of the three categories: organizational, professional, and emotional. All stressors described were addressed in half or more of the focus groups. A list of the identified stressors is provided in Table 2.

**Organizational stressors.** According to this three-category approach, organizational stressors correspond to the demands related to work organization and to the particular environment in which nurses practise (Fillion et al., 2003). Four major organizational stressors were identified: lack of a palliative care approach, interprofessional difficulties, lack of continuity in life support and treatment plans (level of care), and conflictual demands.

*Lack of a palliative care approach.* The main issue highlighted by nurses was the omission of EoL/PC in the structural organization and culture of the ICU. Indeed, the ICU was considered mainly as an aggressive curative care environment in which EoL/PC did not appear to fit:

*In the ICU we save people. We're not at end of life in the ICU. There isn't this mentality. That's not . . . the population . . . In the ICU there are chances that they will survive, absolutely.* (free translation<sup>1</sup>)

This lack of a palliative care approach appeared to be reflected in two main organizational aspects: environment and material resources and human resources.

Environment and material resources. The major stressor highlighted by nurses in all focus groups was the ICU environment. The technology surrounding the patient's bed (e.g., monitors) and the noise from monitor alarms made the ICU a stressful environment in which to die:

*An ICU room is not the ideal place to die. There's a monitor, a team . . . a respirator, pumps . . . We try to remove some [of the equipment] to make it as nice as possible, but the fact remains that it's not a nice unit . . . with a view of the river or a garden.* (FT)

Some ICUs had a limited number of closed rooms and intimacy was difficult to achieve. Also, rooms in the ICU could be so small that it was challenging to make space for the family to be at the bedside. Spaces reserved for families were limited or non-existent. The shortage of ICU beds created additional pressure:

*I had a family who were waiting for a brother coming from elsewhere to pull the plug. We were waiting, but I still had the operating room: "hurry, hurry, hurry" . . . And it turned out that the sister, the patient's daughter,*

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<sup>1</sup> Hereafter, the abbreviation FT will be used to indicate "free translation."

*heard this. And then she said to us, “Well, I mean, if we have to pull the plug we won’t wait for him” . . . I still get the shivers . . . So I said, “We’re talking about your father here, you are the priority” . . . but I thought it was . . . I can’t even find the word for it . . . well, it was inhuman. (FT)*

Human resources. In addition to the shortage of specialized ICU nurses, especially on weekends or on the evening or night shift, limited availability of health professionals such as mental health or spiritual care providers was described as a barrier to EoL/PC in the ICU:

*We get stuck if such a situation happens in the evening. Stuff happens at night, you got to deal with it by yourself. They have a social worker for these situations, but then basically everything stops at 4 o’clock . . . from 4 o’clock [on] from Monday to Friday [and] on the weekend you’re totally, totally without support — you have nobody.*

*Interprofessional difficulties.* According to all the nurses, interprofessional collaboration and efficient ways to exchange information were key elements in achieving coherent care and treatment plans and ensuring continuity of communication between health-care team members and families:

*The doctors disagree with each other, too, which is why decisions get changed, but, you know, it needs to be communicated with the nurse why we’re changing this . . . why we’re changing the decision this week because this doctor feels there’s this hope or this other test that can be done, at least so we know how to communicate that to the family and we’re all on the same . . . level.*

Nurses reported that, too often, information about changes in care plans, life support and treatment plans was neither noted in the medical file nor communicated to the nurse in charge. Such situations put the nurses in an uncomfortable position:

*Sometimes they don’t even have time to put us up to date with the changes in their own plan, so then sometimes we don’t even know what they change . . . sometimes we have to ask the patient, the family members . . . sometimes the family members know more than I do.*

Interestingly, some nurses stated that they did not often consult with the palliative care team of the hospital and could not clearly explain why. For them, it was still new to have this team in the ICU, while it was more common in the case of oncology patients.

*Lack of continuity in life support and treatment plans.* Many nurses described problems reaching consensus on decision-making surrounding

the curative/palliative care transition and on medical decisions concerning level of care. While some physicians decided to maintain an intensive level of care, others prescribed comfort care for the same patient. Therefore, the plan of care/treatment changed with the rotation of physicians and created difficult conditions for the nurses, the patient, and the family:

*Then 1 week later . . . [the] doctor changes and then they change the plan, which then gets the family even more confused because one doctor has one idea and then the other doctor has another idea.*

*For me, stress is caused by the absence of consensus. We have patients who one day are at level 2 and the next day at level 1 . . . we know they're alive but there can be no medical consensus. It can be a stressor, because one day they can be level 2 and the next day level 1, so we start over. There's no medical consensus on how to define a patient as being at end of life. The level of care required is often very ambiguous from one doctor to another . . . it's the perfect stressful element. (FT)*

*Conflictual demands* related to providing curative and palliative care simultaneously with different patients were described as a source of stress by most nurses. Nurses could be assigned to a patient with a chance of survival as well as a dying patient. The participants believed that, in such situations, they had to give priority to the patient who might survive and to dedicate most of their time to providing technological care with effectiveness and speed. Too often, there was no time left for palliative care:

*Sometimes I see them . . . looking [sigh] and they're alone. . . You wish you could spend that time with them . . . like, sit with them . . . sometimes family is not there and you should be there . . . so a person doesn't die by himself/herself, and, well . . . they're not, and the person dies alone. . . . For me that's a big thing, for someone to die alone . . . you can't be there, like, to sit 2 minutes and hold a person's hand if they're scared or — "I'm sorry, my alarms are beeping across" [in the other room].*

**Professional stressors** included demands and expectations related to the nurse's professional role (Fillion et al., 2003). Three main professional stressors were described: lack of competency in EoL/PC and in the palliative care approach, difficulty communicating with families and dealing with complaints, and difficulty collaborating with the medical team around EoL/PC issues.

*Lack of competency in EoL/PC and in the palliative care approach.* All nurses mentioned their lack of competency in providing EoL/PC care, including the assessment and management of symptoms, and lack of

competency in the palliative care approach, including the social, emotional, spiritual, and practical domains.

*To have better tools . . . when I look [around] I get the impression that there are symptoms associated with death that maybe we're not familiar with. . . . The pain . . . the stress associated with it — do we have the tools for this? Whether the patient is conscious or not — sometimes they're completely conscious until the end. Are we doing what we should? . . . sometimes I'm not sure, and that can be stressful. (FT)*

*When a lot of people ask about funeral arrangements and things like that, we get lost as to what to say . . . so maybe to have that reference, someone to sit with the family and talk about those things and help them make arrangements. It's a very stressful thing to do when someone dies.*

Nurses deplored having to learn EoL/PC on the job and having to support the residents and fellows as well as new, young ICU nurses.

*Difficulty communicating with families and dealing with complaints.* All the nurses discussed experiencing difficulty communicating with families. Because nurses are more present at the bedside of the patient than physicians, families regularly query them about different aspects of the patient's condition and about the care and treatment plans. Nurses said that they felt uncomfortable not being able to communicate information to the family:

*I think it's frustrating when you can't be authentic with the family. You know that this patient is going to die and the family will ask you how they're doing, [if] they're doing better, and . . . you can't be honest with them. So there's a sense that you can't be authentic, you can't be real with the family. . . . everybody else is in denial and won't bridge that . . . reality with the family, so you have to continue to perpetuate it.*

In addition, families may have difficulty understanding the information provided by the physician and will turn to the nurses for explanation. This situation added to the stress of having to be the bridge between the family and the physician. As a consequence of these communication difficulties, nurses sometimes received complaints from one or another of the parties. In half of the focus groups, nurses said that they found it stressful to receive critical comments from the family or the physician:

*We've received complaints that we've poorly managed end of life . . . The entire unit is affected . . . you have the impression that you've done a lot and the family thanks you at the time, but afterwards you receive a complaint. That makes it difficult. . . . It puts your own work into question. (FT)*

*Difficulty collaborating with the medical team around EoL/PC issues.* The nurses described three stressors related to their collaboration on the medical team: lack of involvement of nurses in life-support and treatment plans, lack of medical leadership in EoL/PC decision-making, and lack of EoL/PC protocols.

*Lack of involvement of nurses in life-support and treatment plans.* While nurses are the medical professionals most present at the bedside and have a privileged relationship with the patient and family, many nurses explained that they were not involved in the planning of care as part of the medical team:

*It ended up that both times the doctor didn't include me in the meeting with the family to find out what had been going on, what had been said, how they felt about it. So all of a sudden the family arrived with the doctor, at the bedside, and he told me, "Okay, unplug everything." . . . the family members were there and they were looking at me. (FT)*

*Lack of medical leadership in EoL/PC decision-making.* Similarly, some nurses pointed to the neglected role of the physician in guiding families in the decision whether to withdraw life support. They deplored the absence of open discussion around EoL/PC issues that were not under nurses' control and that had to be initiated by the patient or the physician:

*There are families who are unable to make the decision . . . to end a life, so the doctors should take on that role more. They are the ones with the medical experience, not the families. The families don't feel comfortable making the decision because they don't possess the knowledge. (FT)*

*Lack of EoL/PC protocols.* The lack of EoL/PC protocols can lead to discomfort for the patient and difficulty controlling symptoms. Most nurses mentioned how hard it was to obtain prescriptions to adequately relieve symptoms, including pain. Having access to a predetermined care protocol would accelerate and facilitate the process for both the nurse and the patient:

*Protocols. . . directions . . . [so that] it's not left to the individual nurse or even the resident or staff person to have to anguish over decisions that have been made, because it's about the things that you should be doing for a patient who's dying. . . . They don't have to make the call, they don't have to feel guilty that, oh, you know, I should have done this or I should have done that. No, this is what we'll be doing.*

**Emotional stressors** are emotional demands and existential issues linked to EoL care and the palliative care approach (Fillion et al., 2003; Vachon, Fillion, & Achille, 2009). Three emotional stressors were

addressed: value conflicts, lack of emotional support, and dealing with patient and family suffering.

*Value conflicts.* All the nurses described being uncomfortable with unnecessary life-support and treatment measures. Nurses expressed discomfort not only with treatment plans but also having to go against their own values:

*There's another conflict that nurses are not too comfortable [with], like, you think that the patient should be on comfort measures but the doctors are still going on and on with all these treatments . . . so there's a conflict with the doctors and nurses taking care of the patient.*

They found it very frustrating that once all treatments were completed and there was no hope for life, little space was made for EoL/PC:

*It infuriates me when I persist for 2 to 3 weeks with a patient with highly technological care using incredible techniques . . . and [then] we just give up and say, "Well, now we're done," and we give no importance to that aspect of end of life. I'd like to be able to give as much attention to the time they [patient and family] will be spending together. I'd like to be able to do that. I'd say, look, mission accomplished, I succeeded. (FT)*

Similarly, dealing with conflicting demands associated with providing curative and palliative care simultaneously, described earlier as an organizational stressor, became a source of ethical suffering. Many nurses expressed dissatisfaction with their work because they were unable to provide optimal care. They felt that they were rushed and could not do their best for the dying patient and the family:

*It's disappointing for us, . . . we're not able to give our maximum because, you know, if we have two patients and one of them requires more care, we'll go to them . . . while the other will die . . . we don't get any satisfaction. (FT)*

*Lack of emotional support.* Most nurses also felt that they were not given emotional support when they needed to express their feelings, and it was difficult as well for them to find this support outside of work:

*We go through a lot during the week, not just death but huge traumas — young people — and you go home and talk to people who don't want to hear [about] it: "Could you change [the] subject?" . . . "It's depressing." "Do you have to talk about this over dinner?" . . . we see a side of life . . . that most people don't see.*

This *lack of emotional support* could make nurses less available to patients' families and place them at risk for coping problems and intense

suffering: “Sometimes I cry once I get home, from being so exhausted.” (FT)

*Dealing with patient and family suffering.* It appeared that supporting patients’ families had not been taken into account in the planning of care. Most of the nurses were often left to handle the family’s needs and the patient’s care by themselves: “We want to take care of the patient but there’s also the family who demand a lot [of attention].” (FT)

Many nurses said they found it difficult to be exposed to suffering by the patient and the family. Being the ones to disconnect the patient from the machines was stressful and represented a weighty medical task. Also, nurses had the feeling that the families associated their actions with the death of the patient:

*That burden, of the family standing around, looking at you and saying, “Hey, he’s pulling the plug,” and . . . you arrive with your syringe to relieve the pain. Well, if the patient dies 10 minutes later . . . what’s noticed, that you relieved their pain or that you made them die? Well, unfortunately, what they remember is that you made them die. . . . all those last moments, they’ve permeated [their brains].* (FT)

## **Discussion**

Stressors experienced by nurses working in the ICU were similar to those described by nurses working in palliative care in hospitals and in the community (Fillion et al., 2003) and to those described in the review by Espinosa et al. (2008). Many stressors were identified in the three categories established by Fillion et al. (2003): organizational, professional, and emotional. Consistent with the findings of Fillion et al. (2003), while stressors identified in each category seemed to be interrelated, the nurses reported mostly organizational stressors. The most demanding issue appeared to be *not* having to deal with death, dying, and suffering, but, rather, having to fight to ensure decent conditions for the patient.

From an organizational perspective, the main stressor — which contributed in turn to other sources of stress — appeared to be the absence of a palliative care approach or the failure to consider EoL/PC as part of the ICU culture, and the related difficulty with decision-making and the planning of care. This finding is consistent with the results of an ethnographic study on ICU culture by Baggs et al. (2007). EoL/PC in this critical care context should be seen as a natural step and should be better integrated into the care plan for the patient and family. The interprofessional difficulty reported was mainly the result of disagreement between physicians on the directives for treatment (Beckstrand & Kirchhoff, 2005; Espinosa et al., 2010) and breakdown in communications between physicians and nurses. In both cases, the absence of open discussion around



EoL/PC issues between physicians and patients/families seemed to be a source of stress for the nurses. This is also reflected in several comments about difficulty communicating with families and physicians included in the category of professional stressors. Clinical guidelines for the palliative care approach clearly advise that end-of-life issues be addressed directly (Clayton, Hancock, Butow, Tattersall, & Currow, 2007; Truog et al., 2008). When a discussion is opened, a broad range of palliative care services may be offered, including symptom management, advance care planning, psychological and spiritual support, transition of care, and referral to a palliative care unit or a palliative care team (Clayton et al., 2007; Truog et al., 2008). Documentation on how and which of these services can be emphasized in the ICU setting is clearly needed.

Conflictual demands associated with the mixed approach of providing both curative and palliative care, while not new, do warrant more attention (Beckstrand & Kirchhoff, 2005; Fillion et al., 2003; Fillion, Desbiens, Truchon, Dallaire, & Roch, 2011). This mixed approach becomes an issue when professional activities are not well defined. Taking care of a dying patient and his/her family is demanding and time-consuming work. This does not seem to be taken into account in the assignment of ICU nurses. Also, as the ICU is considered mainly a curative care environment, nurses give priority to patients who have a chance of survival and feel that they are abandoning the dying patient — thereby adding to emotional stressors and causing ethical suffering. Time constraints and other stressful factors characteristic of the mixed approach have also been described for home care practice (Burt, Shipman, Addington-Hall, & White, 2008) and oncology settings (Campos de Carvalho, Muller, Bachion de Carvalho, & de Souza Melo, 2005). The ability to provide EoL care in different settings, including the ICU, has advantages, such as facilitating access to EoL care for patients and families. But it also has stressful effects that need to be addressed at an organizational level. Adapting, implementing, and evaluating a palliative care approach and services tailored to the critical care setting constitute an interesting area for future work.

Professional stressors are related mainly to inadequate education and supervision in EoL/PC, as is largely acknowledged by ICU nurses (Espinosa et al., 2010; Nelson et al., 2006; Rocker et al., 2005). As the ICU is seen primarily as an aggressive curative care environment, nurses are not well trained to provide EoL/PC, although they may develop competencies with exposure to death over time. As dying is a reality in the ICU, there is a clear need for nurses and other members of the medical team to be trained in EoL/PC. The availability of EoL/PC education and training programs would increase their knowledge and their competencies in planning and delivering EoL/PC (Efstathiou & Clifford, 2011). Such an educational strategy would also address other

stressors described by ICU nurses, including difficulty in assessing and managing pain and other symptoms and in communicating effectively with families as a health-care team (Beckstrand, Callister, & Kirchhoff, 2006; Espinosa et al., 2010). Communication problems were another stress factor described by the nurses — for example, complaints by a family or a physician could add to their suffering and moral distress. Such situations ought to be taken seriously and managed, with the support of the nurse manager and the nursing administration.

Emotional stressors can be seen as a consequence of the other two categories of stressor. Indeed, it is not surprising that the ICU nurses were exposed to value conflicts related to aggressive curative treatments being offered until the end, when they were considered unnecessary (Espinosa et al., 2008, 2010). Promoting earlier cessation of treatments or not initiating aggressive treatments when they are expected to be futile would minimize this moral conflict (Beckstrand et al., 2006), which could lead to ethical dilemmas and ethical suffering (Langlois et al., 2009). Also, their role as the health-care professional who stops treatment and withdraws tubes makes ICU nurses feel abandoned and powerless while carrying a weighty medical burden (Espinosa et al., 2010). An intervention has recently been developed to facilitate interdisciplinary decision-making and thus improve the decision-making process and prevent ethical suffering (Bolly, 2011). Similarly, to ease discomfort surrounding decisions on levels of care, the provision of advanced life-support necessitates explicit decision-making about how life-support measures should be used (Cook et al., 2006).

### ***Implications for Nursing***

Our findings suggest that stressors related to the provision of EoL/PC in the ICU are numerous, are similar to those found in other contexts of care, and exist internationally. Recommendations to improve EoL/PC in the ICU have recently been published by the American College of Critical Care Medicine (Truog et al., 2008). These include development of the competencies of ICU clinicians in providing this type of care, improved communication with families, and bereavement programs for families or for health professionals/clinicians. Given our findings and these recommendations, it is urgent that education and support programs be developed in collaboration with nurses and other members of the health-care team to improve the quality of EoL/PC in the ICU.

### **Conclusion**

Providing EoL/PC is stressful for ICU nurses in Quebec. The numerous stressors to which ICU nurses are exposed can contribute to their own

suffering and distress. Research is needed to develop, implement, and evaluate programs in order to better support ICU nurses in providing EoL/PC. We need documentation on the impact of such programs on nurses' well-being and job satisfaction as well as on organizational outcomes and clinical outcomes for patients and families.

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