

INVITED COMMENTARY

Integrating Palliative Care into the Neurointensive Care Unit



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Patients with severe acute brain injury (SABI), including traumatic brain injuries, typically present acutely neurologically devastated, with uncertain prognosis, and are unable to participate in crucial treatment decisions. To incorporate palliative care for patients with SABI, health care providers must consider the unique care needs for both the patient and their family members and potential barriers to meeting those needs. In this issue of *Neurocritical Care*, Dolmans et al. [1] make a strong argument regarding the need for neuropalliative care in the intensive care unit (ICU) setting. For example, altered communication abilities and decreased levels of consciousness due to the brain injury, sedation, or both, impact the assessment of a patient's distress or discomfort. The authors also describe barriers to incorporating neuropalliative care in the ICU, including prognostic uncertainty, lack of advance directives, and misconceptions regarding palliative care. To address these barriers, the authors endorse a structured palliative care program and education to effectively communicate with patients and family members, as supported by the literature [1].

Palliative care is medical care that aims to reduce physical, psychological, social, and spiritual suffering and improve quality of life for patients with serious illness and their families [2–6]. Two common misconceptions about palliative care need to be highlighted: First, palliative care is still typically associated with end-of-life care. However, palliative care principles can and should be incorporated at any stage of a life-threatening illness, even overlapping

with curative and rehabilitative treatment [2–6]. Second, the use of the term “palliative care” is often equated with the subspecialists themselves, who are highly skilled and knowledgeable around comprehensive symptom assessment and management and serious illness communication and tend to work in an effective and collaborative multidisciplinary team. However, palliative care is also more than a medical subspecialty; palliative care should be considered as an approach to patient care by any clinician, as a set of skills for clinicians to learn, and as a public health goal to ensure high-quality care and communication for all people affected by serious illness. Therefore, improving palliative care in the neuro-ICU needs to be manifold and include timely skilled assessments and effective communication by the primary medical team (“primary palliative care”) as well as reflexive use of other services, such as spiritual care, psychology, social work, and palliative care specialists [7]. Because the use of palliative care can mean all those things, the presence or absence of it is hard to measure. When Dolmans et al. [1] suggest, for example, that “palliative care is used less frequently in neurology and neurosurgery patients,” they are overlooking the possibility that these patients may be receiving excellent primary palliative care.

Neuropalliative care is an emerging subspecialty that focuses on providing palliative care principles to patients with neurological disorders, including chronic and progressive neurological diseases as well as severe acute ones [8, 9]. Palliative care needs are highly prevalent in the neuro-ICU, where the abruptness of severe impairment, the high risk of early death, and substantial prognostic uncertainty present patients and families with unique needs. In a recent study using a palliative care needs checklist (SuPPOrTT checklist, Table 1) in the neuro-ICU, clinicians identified at least one palliative care need for 53% of patients and their families, and

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Table 1 The SuPPOrTT checklist can be used on a routine basis to explore palliative care needs for patients and families [10]

Questions to ask clinicians and family members	Needs to consider, skills to build
Support: Does the patient or family need social or spiritual support or help with coping?	Coping, grief, loss (of identity, of social role, of abilities); Finances, care transitions, leave from work; Prognostic uncertainty; Existential distress
Pain: Does the patient have pain or other distressing symptoms?	Careful assessment of pain, anxiety, depression (ask family members)
Prognosis and treatment options: Does the family have concerns about prognosis or treatment options?	Dealing with uncertainty; Best case, worst case, most likely case; Delivering anticipatory guidance
Goals of care, treatment targets: Do we need to (re)address goals of care or target treatment toward them?	Eliciting patient values and preferences around medical care; Formulating recommendations; Discussion of withholding and withdrawal of life-sustaining interventions, including artificial nutrition and hydration; Working with interdisciplinary team to document care wishes and discussions (POLST, HC-DPOA, advance directives, etc.)

HC-DPOA, healthcare durable power of attorney, POLST, physician orders for life sustaining treatment

family members did so for 88% [10]. The most commonly identified needs by clinicians were to (re)address goals of care and to communicate prognosis; family members most commonly identified concerns around prognosis and pain or other distressing symptoms in their loved one [10].

Integrating palliative care in the neuro-ICU means taking a team-based approach to identify and address unmet needs of patients and their families, to allow for shared decision-making, and to better address conflict [11, 12]. The first step to neuropalliative care integration is to upskill clinicians in primary palliative care [7, 13, 14]. Second, timely assessment of individual physical, psychosocial, spiritual, and informational needs using a needs assessment tool such as the SuPPOrTT checklist (Table 1) may help to better assess, plan, and provide primary or specialist palliative care [12]. As Dolmans et al. [1] emphasize, this needs to include family members, who also have substantial needs as they face prognostic uncertainty, surrogate decision-making responsibilities, and existential distress. Third, neuropalliative care research remains a pressing need [9]. We need to increase the evidence base that supports palliative care general principles as well as those specific to neurological disease (e.g., prognosis communication, symptom management, care coordination) and develop targeted care pathways that truly support the needs of patients and their families.

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