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Quality of dying in the intensive care unit: it's a matter of time

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Dear Editor,

We read with interest the retrospective study by Long et al. [1] in which the authors found that families of patients who were admitted to the intensive care unit (ICU) from the hospital wards provided lower ratings for quality of dying and satisfaction with care delivery than families of patients who were admitted from the emergency department (ED). Because early family conferences and discussions about prognosis were less likely to have occurred in the former cohort of patients, the authors inferred that the source of ICU admission contributed to differences in the provision of palliative care. Specifically, they postulated that families of patients admitted from the hospital wards had been conditioned by the chronicity of their loved ones' illnesses and antecedent lengths of admission to develop specific expectations that were incongruous with the unforeseen and sometimes irrevocable consequences of clinical deterioration.

The longevity and complexity of patients' health problems can certainly influence the ability of their

families to cognitively and emotionally process changes in clinical status [2]. That ward admissions were more likely than ED admissions to have hepatic and respiratory diseases and malignancies and were less likely to have cerebrovascular disease supports the notion that families of the former group might have had more time to mentally prepare for ICU transfer, but in so doing, formulate expectations about the subsequent course. It would be instructive to know whether a higher proportion of patients in the ED cohort presented with acute neurological events, as this might explain their disproportionate burden of cerebrovascular disease. Moreover, compared to families whose loved ones had protracted illnesses and/or hospitalizations, families of patients admitted to the ICU with stroke or cerebral hemorrhage as the sentinel manifestations of subclinical processes (e.g., atrial fibrillation, atherosclerosis, or excessive anticoagulation) could have recalled their experiences more favorably because prognostic information [3, 4] was apparent from the outset. Despite their obvious differences, recovery of premonitory function and rapid death without the perception of suffering could positively bias family memories of the ICU.

In total, Long et al. [1] present further evidence of inertia toward prognostic discussions in the ICU. Even when circumstances permit [5], clinicians often neglect this element of counseling. Why families of ward admissions receive less communication than families of ED admissions remains unclear, but as the authors suggest, this likely reflects latency in the involvement of palliative care specialists. We offer that challenges to effective care transitions also

contribute to this problem and warrant investigation.

Conflicts of interest Authors declare no conflict of interest.

References

1. Long AC, Kross EK, Engelberg RA, Downey L, Nielsen EL, Back AL, Curtis JR (2014) Quality of dying in the ICU: is it worse for patients admitted from the hospital ward compared to those admitted from the emergency department? *Intensive Care Med*. doi: [10.1007/s00134-014-3425-2](https://doi.org/10.1007/s00134-014-3425-2)
2. Hickman RL Jr, Douglas SL (2010) Impact of chronic critical illness on the psychological outcomes of family members. *AACN Adv Crit Care* 21:80–91
3. Fanshawe M, Venkatesh B, Boots RJ (2002) Outcome of stroke patients admitted to intensive care: experience from an Australian teaching hospital. *Anaesth Intensive Care* 30:628–632
4. Steiner T, Mendoza G, De Georgia M, Schellinger P, Holle R, Hacke W (1997) Prognosis of stroke patients requiring mechanical ventilation in a neurological critical care unit. *Stroke* 28:711–715
5. White DB, Engelberg RA, Wenrich MD, Lo B, Curtis JR (2007) Prognostication during physician-family discussions about limiting life support in intensive care units. *Crit Care Med* 35:442–448

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