FOCUS EDITORIAL

Focus on palliative care in the ICU

Crystal E. Brown^{1,2}, Dominique D. Benoit³ and J. Randall Curtis^{1,2*}

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Recent studies about the provision of high-quality communication and integration of palliative care into the ICU have increased our understanding of how best to care not only for patients but also for their family. We review some of these contributions.

Advancement of medical technologies has resulted in patients living longer, but an increasing number of patients are dying highly medicalized deaths. Hillman and Cardona-Morrell summarize ten societal barriers that prevent high-quality ICU care at the end of life, including unreal expectations, discomfort discussing aging and dying, increasing medical specialization, uncertainty around prognosis, lack of emphasis during medical education on palliative care, and limited training for clinicians on how to provide hope along with a realistic and compassionate picture [1]. Clear and compassionate communication about prognosis is essential to facilitate understanding and decision-making, as well as to help prepare family for a patient's death.

Though numerous guidelines recommend incorporation of palliative care for critically ill patients, implementation of these recommendations is inconsistent. A prospective, before-and-after study examined integration of a palliative care clinician into daily ICU rounds [2]. This study demonstrated that, with the intervention, there was increased likelihood of ICU family meetings and shorter time to the first meeting. Hospital length of stay was shorter with the intervention and, among patients who died in the ICU, ICU length of stay was shorter, yet ICU and hospital mortality were similar. This study presents an important model for integrating palliative care into the ICU.

A randomized trial of condolence letters from ICU physicians and nurses to family members 15 days after

a death in the ICU had a surprising result, showing the letter was associated with increased symptoms of depression and post-traumatic stress disorder (PTSD) at 6 months [3]. This study suggests that routine condolence letters are not helpful—at least at 6 months—and highlights the importance of evaluating interventions we think will improve patient- and family-centered outcomes. Another randomized trial suggested that routine palliative care-led family meetings, conducted largely without ICU physicians, were associated with increased family symptoms of PTSD at 3 months and again highlighted the importance of evaluating interventions we assume will improve communication and support for family [4]. These studies also suggest that we may need to examine longer-term impact of interventions that, by providing support, focus family members on issues of dying and death, to determine whether a temporary increase in psychological symptoms may be associated with better long-term adjustment.

Numerous studies have shown that family of critically ill patients experience high levels of symptoms of depression, anxiety, and PTSD for months after an ICU stay [5]. These symptoms have collectively been labelled “post-intensive care syndrome-family” (PICS-F). These symptoms are more common if patients die in the ICU, compared to other places in the hospital or at home [5]. Kentish-Barnes and Prigerson [5] review prolonged grief disorder (PGD), an attachment disorder characterized by persistent yearning for the deceased, social isolation, and an inability to form new relationships, and provide an overview for how PGD differs from PICS-F. They also highlight evidence that ICU clinicians can mitigate the likelihood of PICS-F and PGD through high-quality communication.

There is increasing attention on the way that we frame treatment options to family members. Choice architecture is a term discussed by Anesi and Halpern in an editorial that articulates the importance of presentation and framing [6]. The authors describe how choice

*Correspondence: jrc@u.washington.edu

² Division of Pulmonary, Critical Care, and Sleep Medicine, Harborview Medical Center, University of Washington, Box 359762, Seattle, WA 98104, USA

Full author information is available at the end of the article

architecture is inevitable in our discussions with family, and understanding this can provide a powerful tool to improve healthcare decisions.

Communication with patients and family can also be influenced by external factors, such as ICU strain. A retrospective cohort study of 9891 patients examined the relationship between ICU strain, the timing of implementation of do not resuscitate (DNR) orders, and the timing of patient deaths [7]. The authors measured ICU strain through standardized census, proportion of new admissions, and patient acuity, showing that higher ICU strain was associated with shorter time to DNR and to death for patients with limitations on life-sustaining therapy. These findings highlight that there are important influences other than the patient or family on end-of-life care in the ICU. This study found no association between ICU strain and time to death for patients without limitations on life-sustaining therapy, suggesting that there was not worse quality of care during times of strain, but rather an increased awareness of limited resources.

Bosslet and colleagues summarize a recent multisociety statement on potentially inappropriate care, emphasizing the importance of early, proactive strategies to improve communication in order to prevent conflict about potentially inappropriate care [8, 9]. The authors also highlight the importance of negotiation and enlisting the assistance of consultants with expertise in communication and conflict resolution, as well as a process-based approach to resolving conflicts that develop.

Conflicts between physicians and nurses around end-of-life care are common and Hartog and Benbenishty summarize what is known about this conflict [10]. Nurses consistently rate interprofessional communication lower than physicians and are more likely to report suboptimal conflict resolution. These authors identify personal, procedural, organizational, and contextual barriers that contribute to interprofessional conflict and they provide recommendations for preventing conflict and promoting collaboration. A cross-sectional survey of 226 ICU physicians and 225 ICU nurses in France identified important differences in preferences and opinions around the terminal withdrawal of mechanical ventilation [11]. Although there were differences between physicians and nurses, strongly held preferences between terminal extubation and terminal weaning were most associated with how they perceived dying, particularly around patient distress, conflict, and the medicalization of death.

Given these strong and divergent opinions of ICU clinicians, guidelines for withholding and withdrawing life-sustaining treatments may help guide care and mitigate conflict between physicians and nurses. A Canadian working group developed an interdisciplinary set of guidelines for withdrawal of life-sustaining measures

[12]. They recommend that an interprofessional care plan be available and communication among interdisciplinary team members be open and clear. They also recommend a comfortable environment for the patient and family, grief and bereavement support, frequent assessment of patient symptoms using standardized assessment scales, and adequate medications to treat and prevent symptoms, as well as removal of all therapies not providing comfort and individualized plans for removal of life-sustaining treatments.

Predicting time to death following withdrawal of life-sustaining therapies is difficult. More accurate prediction may help better prepare family for their loved one's death. A recent systematic review and retrospective study demonstrated that patient characteristics predicting time to death include controlled ventilation, oxygenation, vasopressors, GCS scores, and absence of brain stem reflexes [13, 14]. However, this review also found that currently available prediction tools are moderately sensitive at best [13].

These recent publications help improve our understanding of ICU palliative care. However, further research is needed to develop, implement, and evaluate interventions to improve palliative care in the ICU.

Author details

¹ Cambia Palliative Care Center of Excellence, University of Washington, Seattle, WA, USA. ² Division of Pulmonary, Critical Care, and Sleep Medicine, Harborview Medical Center, University of Washington, Box 359762, Seattle, WA 98104, USA. ³ Department of Intensive Care Medicine, Ghent University Hospital, Ghent, Belgium.

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