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LASTING LEGACY IN INTENSIVE CARE MEDICINE

Integrating palliative care into the ICU: a lasting and developing legacy

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From the inception of the intensive care unit (ICU), end-of-life care has always been delivered in this setting due to the high severity of illness of the patients. Approximately 50 years ago, there was a developing interest in improving the quality of end-of-life care in the ICU giving rise to such landmark studies as SUPPORT and documenting the poor quality of end-of-life care in ICUs and hospitals [1]. The concept of palliative care in the ICU did not emerge until late 1990's or early 2000's, perhaps because the earlier years of intensive care were more focused on physiological support and because patients' family members were often excluded from the ICU. Palliative care includes end-of-life care, but is broader than only end-of-life care incorporating "an approach that improves the quality of life of patients and their families who are facing… life-threatening illness {to} prevent and relieve suffering through the early identification, correct assessment and treatment of… problems, whether physical, psychosocial or spiritual." [2]. By this definition, palliative care is relevant for many patients with critical illness and their family members. Further, there has been an important distinction drawn between the primary palliative care that is provided by any clinician caring for a patient with life-threatening illness and the specialty palliative care provided by those with specialty training in palliative care [3].

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Over the last 25 years, there has been an increasing acceptance of the importance of palliative care in the ICU setting. Although this was a matter of debate in the early 2000s, by 2022 it is widely accepted that ICU clinicians need training and expertise in primary palliative care skills including symptom assessment and management, communication about prognosis and potential treatment options, incorporation of patients' values and goals into shared decision-making, and transitions in goals of care, and provision of high-quality end-of-life care [4]. These skills are now included in all good curricula for critical care clinicians [5]. With this transition, the field of critical care has been transformed to attract more trainees who come to critical care specifically because they are interested in providing high-quality palliative care to patients and their families alongside efforts to provide organ support and restore health.

Integrating palliative care into the ICU

There are three conceptual approaches for providing palliative care in the intensive care unit [6, 7] (Fig. 1). The first approach is to focus on primary palliative care provided by ICU clinicians. This is the predominant approach in many parts of Europe. The second approach is to have palliative care specialists provide the majority of palliative care in the ICU, an approach not commonly used but seen in some institutions in the United States of America (USA). The third approach, and the most common model in the USA and the United Kingdom (UK), is a mixed approach where ICU clinicians provide primary palliative care and only enlist palliative care specialists to consult for the subset of patients and families with more complex palliative care needs, then share care between the ICU and palliative care teams. In addition, palliative care clinicians are often involved in training, support, and advice for ICU clinicians. There have been studies that evaluated ways to implement these approaches

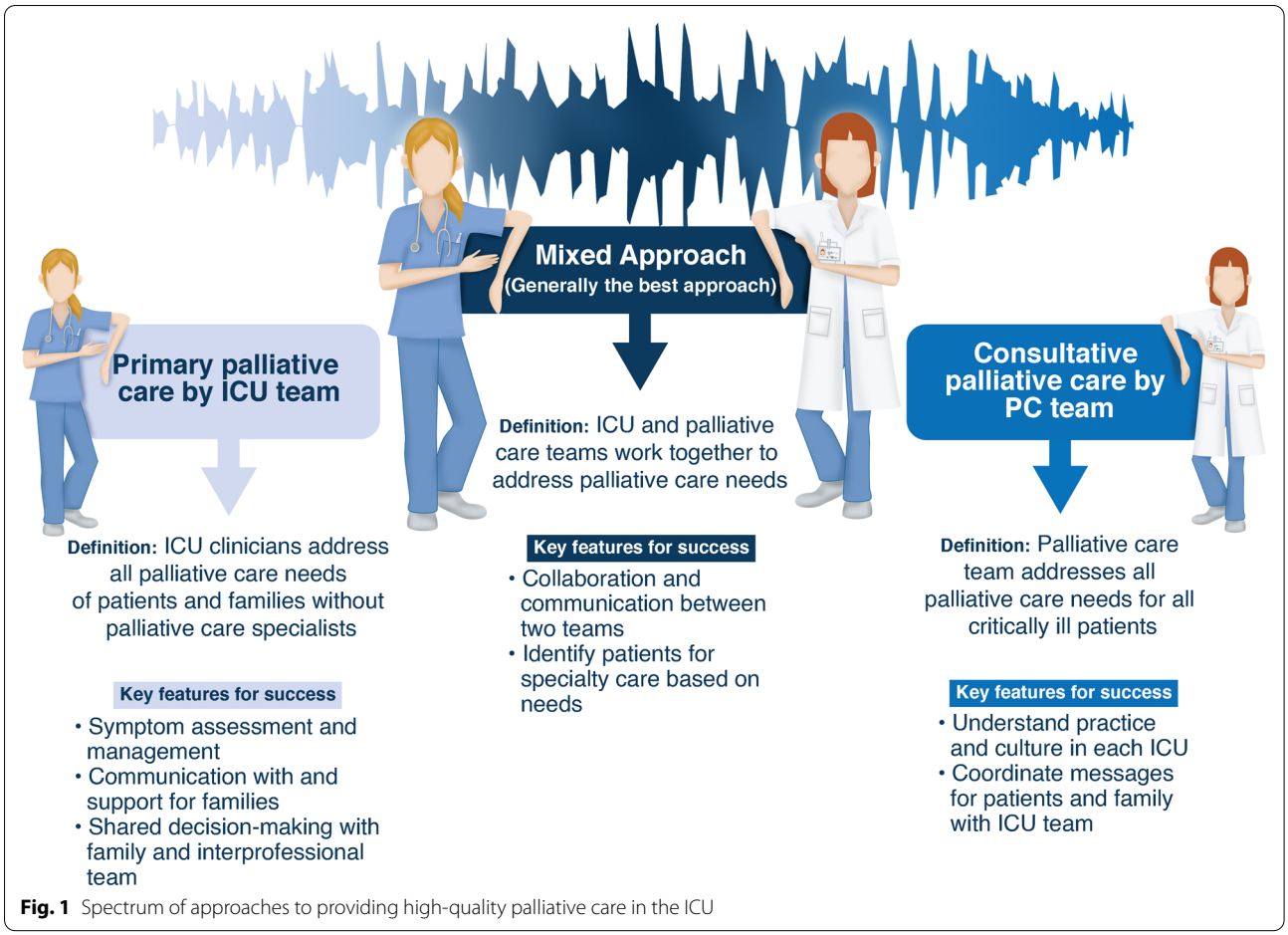

Fig. 1 Spectrum of approaches to providing high-quality palliative care in the ICU

showing benefit of palliative care interventions, especially for interventions designed to improve primary palliative care [8–10].

It is not possible to use existing evidence to identify the best approach and it seems likely that the "best" approach will vary by ICU, based on the quality and availability of the primary and specialty palliative care at a given institution, as well as the expertise and interest of individual clinicians and the needs of individual patients and family members. The best approach will also depend on additional resources in a given ICU including the availability of clinicians such as social workers, psychologists, and chaplains.

Successful use of the mixed model also depends on the successful interprofessional collaboration between the ICU and palliative care teams in the process of supporting individual patients and their families. There is some evidence that incorporating palliative care specialists to run one or two family meetings without full integration with the ICU team provides no benefit and may even result in increased post-traumatic stress for family members [11]. There are few things more stressful to family members than feeling like the different clinicians caring for their critically ill loved one are not all on the same page.

There are several key features of successful integration of primary and specialty palliative care. First, it is essential that the ICU team respects the unique skills that the palliative care team brings to the care of critically ill patients. This may be difficult for ICU clinicians who believe they are skilled at communicating with families and controlling symptoms, but it can help to realize that the specialty palliative care skillset includes much broader skills such as helping with anticipatory bereavement, assessing spiritual needs, and supporting families through complex family dynamics and the stress and conflict that comes with uncertainty [12]. Second, it is also essential that the palliative care team understands ICU practice and the culture of the specific ICU. A palliative care team without this understanding will not be effective in the ICU [13]. Third, successful integration requires a way to identify the patients and families who would benefit most from palliative care consultations. Many approaches have been used to identify "triggers"

for palliative care consultation, but most of these triggers are based on high risk for mortality [14] and risk of mortality may not correlate with unmet palliative care needs [15]. It is also important to consider tools to help ICU clinicians in delivery of primary palliative care, for example the Psychosocial Assessment and Communication Evaluation (PACE), which seeks to improve communication and palliative care in the ICU [16]. Finally, successful integration of ICU and palliative care teams is essential: if effective teamwork is not achieved, there is a risk that the whole will be less than the sum of its parts due to duplicated effort and miscommunications or conflicts between the ICU and PC teams.

Three recommendations for the future

First, we need consensus and widespread dissemination of the skills and training that ICU and palliative care clinicians need to provide high-quality care in the ICU. ICU clinicians, including physicians, nurses, and others, need training and experience in primary palliative care skills relevant in the ICU. Such skills include symptom assessment and management, parallel planning for diverse outcomes, communication with and support for critically ill patients and their families, and shared decision-making with patients and families that is inclusive of the interprofessional team [17]. These skills need to be part of the basic skillset of ICU clinicians. In addition, palliative care clinicians need training and experience in intensive care medicine and need to understand the culture of the ICU [13]. This includes the ICU culture of interprofessional collaboration as well as of ethical decision-making [18]. Only through this understanding can palliative care clinicians be in a position to effectively integrate their care with the ICU team with the goal of improving patient and family outcomes.

Second, we need to identify and implement efficient and effective ways identify those patients and family members who would benefit most from specialty palliative care. The specialty palliative care workforce will never be such that all patients and families in the ICU with palliative care needs can be seen by specialists. Triggers for specialty palliative care involvement that focus exclusively on risk of mortality will not be enough to maximize the benefit of specialty palliative care, but effective alternatives have yet to be developed. For example, screening patients or families for palliative care needs and enlisting palliative care specialists only in those patients with high levels of need is a promising strategy, but major questions remain regarding how to efficiently operationalize the screening process. This is an important area for the future.

Finally, the delivery and integration of primary and specialty palliative care should focus on the function (principles of integration) rather than the form (specific models of care like triggers or co-rounding). Given the diversity of cultures of different ICUs, we can be certain that the best form for how patients' and families' palliative care needs are met and how primary and specialty palliative care are integrated will vary from ICU to ICU, but the functions of providing high-quality palliative care to critically ill patients and their families are universal. To achieve our highest potential for meeting the needs of critically ill patients and their families, we must reliably implement these functions for all patients.

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