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WHAT'S NEW IN INTENSIVE CARE

Palliative care in intensive care

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Over the last 2 decades, palliative care in the intensive care unit (ICU) has been recognized as an approach which can mitigate physical, psycho-social and spiritual burden for patients and their families. Palliative care has been defined by the World Health Organization as "an approach that improves the quality of life of patients and their families facing the problems associated with *life-threatening* illness, through prevention and relief of suffering by means of early identification, impeccable assessment, and treatment of pain and other problems: physical, psychological, social and spiritual" [1]. Therefore, there is increasing acceptance that intensive and palliative care are complementary within a patient-centered approach. Approximately, 14–20% of intensive care patients could benefit from palliative care consultations, partly due to the frailty of an increasingly aging patient population with extensive co-morbidities and consequently increased risk [2]. In this article, we present what is new on palliative care for the multi-professional intensive care team, and discuss open questions and potential next steps in the field.

Recognition that palliative care is more than end-of-life care

Since its origination from hospice care, the term palliative care has frequently been used interchangeably with end-of-life care. However, the specialty has developed and expanded to involve symptom control, improvement of patient and family-centered communication, ethics consultations, education, advance care planning and goals-of-care discussions with effects on patients, relatives and ICU staff and reducing the risk of post-intensive care syndrome. There is emerging evidence that timely integration of palliative care prevents overtreatment [3]. Quality of life for critically ill patients improves [4], and the length of ICU stay is shortened, without impact on mortality [5]. Families report increased satisfaction and less stress, partly because communication and participation in patient care improves by shared-decision-making [4]. Improvement in ethical climate through timely integration of palliative care treatment concepts can reduce moral distress within the team [6]. During the coronavirus disease 2019 (COVID-19) pandemic, intensive care patients had less symptoms after the team's involvement [7]. Whenever doubt about the appropriateness of ICU admission is in question, early involvement of palliative care, as soon as a time-limited trial is started, may facilitate the transition from curative treatment to symptom-control care [8].

Last, in light of increasing awareness of health care's environmental footprint [9], timely implementation of palliative care may also have an environmental impact. Offering value-concordant care frequently means discharge from ICU to a less energy-intensive area (Table 1).

More than one 'right way' to integrate palliative care

Palliative care may be incorporated into intensive care at two levels—generalist (provided by health professionals who care for palliative patients in their field, but for whom palliative care is not the main focus of their clinical work) and specialist (provided by professionals specifically trained in palliative care) [10]. Drawing an analogy with experts in other medical specialties, palliative care specialists offer additional knowledge and skills; however, competences for the care of the seriously ill and dying should be available to all intensive care teams. There are three common strategies of integrating palliative care into intensive care—the integrative, the consultative and the mixed model. While the latter two can only be implemented by multi-professional experts, the former requires trained intensivist and intensive care nurses,

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Table 1 Potential benefits of palliative care in intensive care

Potential benefits of palliative care in intensive care	
Patient	• Improved symptom control • Improved quality of life • Improved multi-professional care • Improved patient-centered decision-making and advanced care planning • Improved patient-centered communication • Increased use of ethical consultation • Prevention of post-intensive care syndrome • Shortened length of stay in intensive care unit without shortening length of life • Less invasive intensive care
Relatives	• Improved satisfaction with treatment and communication • Improved relative-centered communication • Reduction of post-intensive care syndrome family
Team	• Reduction of moral distress • Education
Society	• Greener and more sustainable

who address palliative care needs within their daily routine. Research has not demonstrated a 'right way' to offer palliative care in the ICU [4] but has highlighted the variability in resources, culture and expertise which should inform the model [10]. The involvement of specialist palliative care teams has conceptual benefits: a recently published consensus paper, supported by several German professional societies, underscores the immense importance of timely integration of palliative care into intensive care [11]. However, advanced integration of palliative care as a specialty has been achieved in only a few countries. Thus, a sustainable model is needed to address palliative care needs of ICU patients on a global level. This is further reflected by the urge of medical students, intensivists and nurses to receive more training in palliative care and lack of data on ICU/palliative care integration in regions outside Europe and the United States [4].

To enable palliative care in light of limited resources, a central challenge is to identify ICU patients who would benefit from specialist palliative care treatment [12]. The use of triggers has been proposed, although their acceptance widely differs among countries and professions [13]. Joint multi-professional and interdisciplinary rounds by members of the intensive care team and the palliative care service are another instrument to help identify patients who can benefit from palliative care. Ultimately, increased recognition that palliative care is much more than end-of-life care allows to focus on the function of integration (incorporate in ICU curricula) rather than form (specific models of care like triggers or co-rounding) [10].

Last, there is increasing awareness about the barriers that prevent the integration of palliative care in ICU, including unrealistic expectations on the part of patients, families, and clinicians about patient prognosis or effectiveness of ICU treatment; insufficient training of physicians in relevant communication skills; and competing demands for clinicians' time [14]. Furthermore, a negative perception that follows the 'palliative care' term has been highlighted in patients with cancer and their clinicians to such an extent that a rebranding of the service has been proposed [15]. Avoiding the negative connotations of 'palliative' and using the term 'supportive care' to better describe the holistic approach it provides may reframe stakeholders' thinking. It may also facilitate incorporation of its principles to standard ICU care, rather than that a service is chosen *instead* of ICU treatment.

Clearer targets for future research

First, clinicians should aim for a clear definition of what palliative care is in the ICU setting; clarify which of the critical care interventions are also palliative care ones and set outcomes that matter. Second, extending research focus globally is warranted, leading to development of accepted models that facilitate palliative care integration in low-resource constellations. In addition, a line of research should focus on implementation science of palliative care models. Last, integration of palliative care values (symptom control, communication, and ethical training) in ICU training and de-stigmatization of the meaning of palliative care need to be achieved.

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