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WHAT'S NEW IN INTENSIVE CARE

Ten key points about ICU palliative care

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Introduction

Palliative care is a core component of comprehensive care for patients facing critical illness, regardless of age, diagnosis, or prognosis. Key domains of intensive care unit (ICU) palliative care include relief of distressing symptoms, effective communication about care goals, patient-focused decision-making, caregiver support, and continuity across care settings. In this article, we highlight ten evidence-based principles of palliative care that help support optimal critical care practice.

1. Palliative care is relevant for all critically ill patients

Although early efforts in ICU palliative care focused on improving the quality of dying and death, the scope of this care extends more broadly to encompass needs of patients pursuing full critical care/life-supporting therapies and expected to survive. Palliative care addresses issues across the spectrum of critical illness within and beyond the ICU, including symptom distress (physical, psychological, spiritual), exchange of information for shared decision-making, and burdens for caregivers.

2. Palliative care is the responsibility of all clinicians in the ICU

"Primary/generalist" palliative care is the responsibility of all ICU clinicians, who require basic knowledge and skills for symptom management, clear and sensitive communication, and shared decision-making based on patients' values, goals, and preferences [1]. Although palliative care specialists are increasing in number in some countries and can provide essential input in the ICU where available, the workforce of such specialists will remain inadequate to meet increasing needs. A mixed model, in which primary palliative care is combined with specialist palliative care contributions, is recommended.

3. ICU clinicians can and are obliged to ensure patient comfort at the end of life

As most ICU deaths follow a decision to limit life support, critical care clinicians require competence in the applied and ethical aspects of withholding/withdrawing intensive care interventions [2, 3]. These include the use of sedatives, analgesics, and nonpharmacologicals to ease distressing symptoms, as well as thoughtful communication to support important elements of decision-making (e.g., autonomy, capacity determination, and surrogacy). ICU clinicians also must anticipate and address the needs of surviving relatives and marshal resources to mitigate the impact of their loss. Structured approaches are available to guide practice [4].

4. A decision to allow a natural death does not by itself mean that comfort is the patient's exclusive goal or that intensive care interventions should be withheld/withdrawn

Patients' goals of care can be multidimensional, encompassing a desire to allow natural death (e.g., DNR/DNAR) along with a preference to pursue life-prolonging interventions. Without explicit discussion, a DNR directive should not be interpreted as extending to interventions other than cardiopulmonary resuscitation. Clear, sensitive, and nuanced discussion of the patient's true values, goals, and preferences is essential.

5. Critical illness and intensive care have profound impact on families as well as patients

The impact of critical illness is deeply felt by patients' families, who experience psychological and physical distress as well as practical and financial burdens [5]. This can manifest acutely as depression, fear, anxiety, fatigue, anorexia, and early posttraumatic stress symptoms. Persistence of symptoms after the ICU can result in

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Table 1 ICU palliative care educational resources and clinical tools found online

	Online courses/ education	Webinars	In-person workshops	Clinical tools/ guidelines
American Association of Colleges of Nursing - The End-of-Life Nursing Education Consortium (http://www.aacn.nche.edu/elnec)				
American Association of Critical-Care Nurses (http://www.aacn.org/wd/practice/content/palliative-and-end-of-life-care.pcms?menu=practice)				
Center to Advance Palliative Care (https://www.capc.org)				
Coalition for Compassionate Care of California (http://coalitionccc.org)				
Education in Palliative and End-of-life Care (http://www.epec.net)				
European Association for Palliative Care (http://www.eapcnet.eu/Themes/Education.aspx)				
The IPAL-ICU Project (https://www.capc.org/ipal/ipal-icu/)				
National Consensus Project for Quality Palliative Care (http://www.nationalconsensusproject.org/NCP_Clinical_Practice_Guidelines_3rd_Edition.pdf)				
PCNOW (http://www.mypcnow.org)				
VitalTalk (http://vitaltalk.org/courses)				

worsening health-related quality-of-life and "post-intensive care unit syndrome-family" in families of patients who survive and bereaved families [6]. Risk and protective factors for family morbidity and burden have been investigated; some are potentially modifiable [6].

6. Palliative care can support ICU clinicians who experience moral or psychological distress in the course of caring for patients

ICU clinicians are at risk for moral distress (e.g., from conscientious objections) and psychological distress (e.g., grief and burnout). Primary and specialist palliative care offer a paradigm to help understand, anticipate, and address these effects. Strategies include strong interprofessional collaboration, support for resilience, attention to and normalization of grief and other emotions, mindfulness and meditation training, and forums to share experiences and reflections.

7. Educational resources and clinical tools are available to support delivery of high-quality palliative care in the ICU

Examples of online resources and tools for knowledge and skills supporting primary ICU palliative care are found in Table 1. Other resources include online courses (e.g., VitalTalk http://vitaltalk.org/courses) and published protocols to improve communication [7], studies demonstrating the effect of communication interventions [8, 9], and published guidelines [3]. Palliative care specialists also can contribute importantly in educating the ICU team to assess and respond to palliative needs at the primary level.

8. The ICU nurse plays a crucial role in palliative care including communication between the health care team and the patient/family

High-quality ICU palliative care depends on crucial contributions made by ICU nurses, who are typically patients' closest and most constant providers. Among other key roles, these nurses can help open lines of interprofessional communication with families, while also providing clarity, reassurance, consistency, and continuity in ICU family meetings [8, 10, 11]. Nurses' participation in such meetings is an indicator of ICU care quality [12].

9. The quality of ICU palliative care can be measured

Domains of high-quality ICU palliative care have been defined by ICU patients, families, clinicians, and expert consensus, and have been operationalized as process measures for monitoring, feedback, and improvement [12, 13]. Opportunities to improve performance on such measures exist in many ICUs [14]. The relationship between process measures and outcomes of importance to ICU patients and families requires further investigation.

10. High-quality ICU palliative care can improve ICU metrics and patient-oriented outcomes

ICU-based palliative care interventions have been shown to improve utilization (e.g., length of stay), the quality and content of clinician communication, and family psychological well-being, satisfaction, and decision-making [9, 15–17]. Ongoing research is expanding the range of such interventions and comparing efficiency, effectiveness, and scalability. It will also be important to investigate which outcomes are most valid and responsive, which patients/families are most likely to benefit, and which interventions might be accompanied by unintended adverse effects [18].

Palliative care complements and augments intensive care in addressing the needs of critically ill patients and their families. Palliative care is based on need, not prognosis, and is optimally provided together with all appropriate life-prolonging or restorative care. Palliative care delivered by ICU clinicians and specialists contributes positively to outcomes of importance to ICU patients, families, and clinicians. Going forward, increasing evidence of the challenges facing survivors of critical illness and their families opens new opportunities for palliative care to support optimal critical care practice.

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Compliance with ethical standards

Conflicts of interest
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