

From the Desk of the Editor

Palliative care in ICU: Scope and Limitations that ICU physicians need to knowMehnaz Ferdous¹, Mohammad Omar Faruq²DOI: <https://doi.org/10.3329/bccj.v11i2.69184>

The Intensive Care Unit (ICU) presents a unique challenge in measuring palliative care quality. Unlike many other settings in which palliative care is delivered, ICU care is uniquely multidisciplinary and collaborative, dominated by seriously ill patients, and challenged by care that is complex and often longitudinal. Regular and standardized integration of palliative care represents an important evolution in modern delivery of serious illness care in the intensive care unit (ICU)¹.

The multidisciplinary team working in ICU should always re-evaluate the clinical course of the patients, which includes redefining the treatment goals and considering palliative care when there are no benefits to treatment. The primary ICU purpose should not only be to promote aggressive treatment: it should also help patients and families make wise end-of-life decisions². Palliative care in ICU supports patients and families and can provide more comfortable environment, better healing, and increased awareness of the end of life^{2,3}. When life-sustaining therapies are unable to meet the patient's goals, or paradoxically may result to be more burdensome than beneficial, withdrawal and withholding of therapies is a commonplace among ICU physicians⁴.

In ICU environment, palliative care should follow the ethical principles of autonomy, beneficence, non-maleficence, justice and fidelity⁵. The definition of dying with dignity recognizes unconditional intrinsic human values, such as physical comfort, quality of life, autonomy, meaning, preparation, and interpersonal connection. Preserving dignity, avoiding harm, and preventing and resolving conflicts are the responsibilities of the health care provider who is in charge of the patient during the end-of-life^{2,5}.

To integrate primary palliative care and professional palliative care into ICU care management, there are different modes: integrative, consultative, and a combined approach⁵. This Consultative model utilizes a professional palliative care team that focuses on ICU patients with the highest risk of death. Palliative care professionals have regular access to the ICU to screen and identify patients who may benefit, and more often rely on the judgment of the ICU physicians to initiate the professional palliative intervention. The factors that initiate consultation include acute disease status, and patient factors such as age and different stages of disease. Initiating specialty consultation based on predetermined criteria is the most feasible way to achieve the integration of enhanced treatment and palliative care⁶. The combined model places "extra" demands on ICU staff, and the consultative model requires adequate palliative care expertise and resources. The most

effective way to integrate intensive care and palliative care is to combine the two models. Basic palliative care is provided by ICU staff, and professional palliative care is sought when needed. To meet the need for palliative care, it is important to improve the ability of ICU medical staff to provide basic palliative care and to expand the professional palliative care team. The mixed model ensures the quality of standard palliative care and continuity of care even the patients leave the ICU⁶.

Early efforts of palliative care in ICU focus on improving the quality of dying and death. However, its scope extends more broadly to meet the needs of patients affording life-supporting therapies and expected to survive. The general palliative care issues should be responsibility of all ICU clinicians, who need a basic knowledge and skills for symptoms management, appropriate techniques of communication, capability in sharing decision-making based on patients' values, goals and preferences (named also "integrative model") The integration of palliative care experts in ICUs is of benefit to patients, families, and critical care clinicians.

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 quality and availability of 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 often religious clergy man⁶.

Communication is vital for palliative care in intensive care. The intensivist must discuss preferences of care and decision making with surrogates who may or may not have specific knowledge of the patient's wishes if he is terminally ill. There should be a shared understanding with family about patient care planning, particularly in end of life decisions. Medical treatment should only be withdrawn on clinical grounds. Every withdrawal decision should be made upon its own merits and must not be made on basis of cost or medical convenience. Identifying surrogate decision makers clarifying patient's goal of care including wishes for cardio-pulmonary resuscitation (CPR), and withdrawing/withholding of care^{3,7}.

In a while, palliative care and intensive care share the same values and goals. All ICU patients receiving effective (usually invasive) treatments should receive palliative care either concurrently or separately, depending on the needs and preferences of the patient and family. Invasive treatments are necessary to save the lives of ICU patients, and sometimes

they might be helpful for symptom relief. Decision-making, alignment of treatment with the patient's goals, emotional support for families, and the basics of symptom management are core elements of palliative care and should be routine aspects of critical care. Studies have shown that integration of palliative care in the ICU improves quality of life, shortens hospital and ICU length of stay, lowers the care-giver burden, and reduces the use of emergency resources.

Palliative care is to prevent and relieve suffering through early identification, perfect assessment and treatment of pain and other physical, psychological, social and spiritual issues. ICU patients are prone to present symptoms such as pain, dyspnea, thirst, anorexia, constipation, fatigue, fear, depression, anxiety and delirium that affect the quality of life. These symptoms persist even after the patients being transferred out of the ICU. The symptom palliation domain includes: presence of palliative care team, patient-family relationship, multidisciplinary team approach, policy of approaching patients, symptom screening and management, and presence of ethical reviewboard families disagree with the treatment the team recommends.

Spirituality is a vital part of human wholeness and plays an important role in the healing process. An important topic related to communication is the understanding of the patients' and families' spiritual beliefs. Actively dying patients need special attention to their psychosocial and spiritual needs. Although we cannot offer the hope of a cure, we can offer the hope of a dignified death Therefore, current critical care should be balanced between palliation and critical curative conditions².

In a modern view, the principal domains of palliative care, including relief of distressing symptoms, effective communication about care goals, patient-focused decision-making, caregiver support, and continuity across care settings, should be performed in ICU⁴.

The barriers of the implementation of palliative care in the intensive care unit include critical care clinicians are not aware of the palliative care needs of ICU patients due to competing demand, inadequate palliative care screening for ICU patients, difficulty in communicating adequately with patient's family at the right time, clinician concerns regarding palliative care hastening death, inadequate palliative care training for ICU medical staff, palliative care staff unavailability, patient/ family misconception of palliative care, time and cost to train critical care clinicians for the palliative care^{3,7}.

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. Second, we need to identify and implement efficient and effective ways to identify those patients and family members who would benefit most from specialty palliative care. 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).

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