

**Implementing a palliative approach in the Intensive Care Unit: an oxymoron or a realistic possibility?**

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*“Many of us will spend the last few days of life in an intensive care unit. For many, it will be a painful and futile experience, causing unnecessary suffering for both the patient and loved ones”*(Hillman, 2010) (p.7).

The ageing of the population, increasing incidence of non-communicable diseases (NCDs), and technological advances has resulted in a growing number of older people being admitted to an intensive care unit (ICU) (McDermid and Bagshaw, 2011, Duke et al., 2014). Many older ICU patients have other co-morbid illness, (Bagshaw et al., 2009) and require advanced technological and life-preservative techniques such as: mechanical ventilation (Duke et al., 2014), renal replacement therapy (Frost et al., 2010) and/or high doses of vasoactive agents (Alves et al., 2010). The Australian and New Zealand Intensive Care Society Adult Patient Database reported during 2000 to 2005 that older patients now account for 13% of all ICU admissions, and this rate increased by 5.6% annually during the study period for the same age group (Bagshaw et al., 2009). Similarly, data from one large acute hospital in New South Wales, Australia reported that between 1997 and 2007, one fifth of all inpatients aged over 80 years had a planned ICU admission (Frost et al., 2010). However, a recent data linkage study from New South Wales, Australia reported that inpatients aged over 80 years who died were less likely to have had an ICU admission as part of their final admission than inpatients aged between 60-79 years (a OR 0.14, 95% CI 0.12-0.17 and a OR 0.46, 95% CI 0.42-0.49 respectively) (Goldsbury et al., 2015). While this study was unable to confirm the actual number of older inpatients who died in ICU it does confirm that a small proportion of older people who die in a hospital may have an ICU visit/admission? in the weeks or days preceding their death (Goldsbury et al., 2015).

Many deaths in the ICU are not preventable, particularly in older people with multiple irreversible comorbidities (Bloomer et al., 2010). The mortality rate for planned ICU admissions for patients aged over 80 years is (25%) compared to the unplanned ICU admissions mortality rate which is almost double (47%) (Frost et al., 2010). Older inpatients who die during an ICU admission are more likely to: live in a chronic care facility; have co-morbid illness; be admitted for a non-surgical reason, have greater illness severity; require mechanical ventilation, and have a longer ICU stay (Bagshaw et al., 2009).

Due to a number of patient, provider and health system factors, it is often challenging to ensure that dying ICU patients receive appropriate symptom management and end-of-life care (Milic et al., 2015). Critically ill patients in ICU and their families are often not well informed about prognosis and goal of care (Milic et al., 2015). These gaps in end-of-life care may be related to: ICU physicians' and nurses' end-of-life care beliefs; local care processes and practices (Westphal and McKee, 2009); as well as insufficient evidence; guidelines or benchmark data to inform a palliative approach. Managing the tensions between recognising when survival is possible and when medical futility has been reached is challenging. Clinicians' perception of the value and relevance of a palliative approach for critically ill older patients largely determines the level and quality of end-of-life care provided in ICU (Milic et al., 2015). While much has been written about the elements of a "good death", this concept is rarely applied to older patients dying in ICU (Bailey et al., 2014). In this opinion piece we contend that there is room for improvement in our management of older dying patients in ICU and that a palliative care approach to care is indicated.

### **Palliative care approach is improving quality of end-of-life**

Optimizing clinical outcomes in a critical illness is the driving force for an ICU admission (Bagshaw et al., 2009). However, when it transpires that the outcomes that were envisaged are no longer attainable a timely transition to a palliative approach to care is required (Graham and Clark, 2008). This requires the ICU team to recognize when pursuing every reasonable

treatment to prolong life is no longer appropriate and that initiating a palliative approach is indicated (Luce, 2010). A palliative approach to care is grounded in comfort and dignity and can be readily provided by the older dying patients' ICU team. This approach allows the ICU team to palliate the patients' symptoms, seek concordance between treatment and dying patient's wishes by providing holistic care, decision making, communicating effectively and facilitating end-of-life care transitions (Cook and Rocker, 2014, Nelson et al., 2010). ICU nurses have an important role in prognosis and goals of care at end-of life discussions with patients and their families and communicating with physicians about the needs of patients and family member (Milic et al., 2015). Following a determination that the older patient in the ICU is likely not going to survive, a discussion involving the patients, if they are able to participate, and their family is required to establish the new goals of care and to facilitate the transition to the patients' preferred place of care (Hunt et al., 2014). Whilst these conversations are inevitably challenging they are essential for shifting the focus from cure to palliation and providing the older people dying in ICU with the highest quality end-of-life care (Fonseca et al., 2012).

### **Palliative care management strategies**

Currently in ICU, a palliative approach to care is usually only initiated once all treatment options have been exhausted. In the context of older ICU patients reaching this 'treatment ceiling' contributes to a perception of overtreatment of dying older patients (Miller et al., 2015). While physicians take responsibility for managing treatment and negotiating "Not-For-Resuscitation" orders where indicated, nurses are responsible for upholding these orders and providing quality end-of-life care. Inter-professional ethical conflict between members of the ICU team can arise during the decision-making process to withdraw life-sustaining treatment (Truog et al., 2008); or if members of the team perceive that ICU patients and/or their families are being pressured to endure aggressive therapy that they are unlikely to benefit from (Hamric and Blackhall, 2007). A combination of inconsistent and inadequate communication and meetings between clinicians and patients or family members and/or unrealistic goals and expectations of patients, family

members and clinicians adds to the complexity of initiating a palliative approach to care for many older ICU patients (Papadimos et al., 2011). Moral distress is a well-known hazard for ICU nurses, especially when they are providing care that they perceive to be futile (Hamric and Blackhall, 2007). These ICU ethical dilemmas can be avoided through frequent open communication and shared decision-making among physicians, nurses and the older patient's family.

Providing a palliative approach in ICU acknowledges the importance of: i) effective communication with conscious patients and families about the goal of care preparing them for the withdrawal of the life-sustained treatment and their transition to a palliative approach, according to their beliefs and wishes and supporting and involving families and proxies in clinical decision making (Aslakson et al., 2014); ii) the opportunity for removal or avoidance of burdensome or painful therapies (Hunt et al., 2014); iii) individual tailoring of appropriate pharmacological and non-pharmacological interventions to eliminate or minimise patient's symptom burden (pain, respiratory distress, dyspnoea, anxiety etc.), including preventing delirium and suffering (Truog et al., 2008); iv) judicious bedside assessment of the need for opioids and benzodiazepines and appropriate titration (Truog et al., 2008); v) psychosocial support and strategies to minimise moral distress, burnout and post-traumatic stress disorder for both families and ICU clinicians (Truog et al., 2008); and vi) bereavement support for families.

### **Concept of “good death”**

While much has been written about a “good death”, little focus has been placed on describing what this looks like for older patients dying in ICU. It is conceivable that the four most important elements of end-of-life hospital care identified by inpatients and families in a recent systematic review are also relevant to the ICU setting (Virdun et al., 2015). The patients' and their families' wishes are: effective communication; expert care; respectful and compassionate care; and trust and confidence in clinicians (Virdun et al., 2015). Within the context of ICU, a good death is achievable when ICUs adopt the principles of a palliative approach and the ICUs team

communicates with patients and families and involves them in patient-focussed end-of-life care decision-making (Fonseca et al., 2012, Cook and Rocker, 2014). Every endeavour should be made to honour the older ICU patient and family members' wishes, to meet the patient's comfort, dignity and personhood needs, to support the patient and their family appropriately and make sure that the necessary environmental changes are made to afford the patient and family privacy and dignity within the ICU setting (Nelson et al., 2010).

### **Summary**

Providing a "palliative approach" in ICU is "not an oxymoron" and is within our reach today. Implementing a palliative approach will better ensure the needs of older patients and their families are met. Investing in developing the palliative care capabilities of ICUs and implementing appropriate policies that support the delivery of best-evidence based palliative care, will help ICU clinicians move seamlessly from implementing intensive therapies focussing on cure to palliation and relief of symptoms and care of families.

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