

# Symposium

## Introduction

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### Caring for the Critically Ill Patient With Cancer

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The publication of this oncology series serves as a welcome herald of 3 important developments in the evolution of care for patients with cancer as well as other critical and life-threatening conditions. The rapid growth in both our understanding of the biology of cancer and the development of new treatment modalities, as noted in the article by Beatty, Winkelman, Bokar, and Mazanec, have been part of the transformation of cancer from an inevitably fatal disease to a chronic illness, with episodes of quiescence and exacerbation that can be successfully treated. We have learned how to minimize the toxic effects of some interventions, while discovering other novel and efficacious approaches. Some of these aggressive therapies, such as stem cell transplants described by Kasberg and authors, still entail risks and exposure of patients to serious adverse effects. Fortunately, advances in critical care therapeutics have kept pace with advances in cancer care and have yielded an equally impressive ability to support patients through critical episodes. Significantly improved mortality and morbidity data from studies of critical illness in cancer patients serve as the marker of this first key development.

A second advance in our understanding of how best to care for critically ill persons with cancer is a relatively new appreciation of the need to evaluate and continually reevaluate goals of care in treatment planning. Critical care and our approach to decisions about aggressiveness of care have evolved from a norm of “all or nothing,” when admission to a critical care unit was thought to be inappropriate if any limitation, particularly a “do not resuscitate” order, was in place. Under this norm, admission of patients with advanced malignancies was thought to be pointless. Because we were not able to “cure” the cancer, admission to an intensive care unit and application of advanced technologies served no purpose and was a misuse of scarce resources.

Change in this norm comes from several specific sources. First, critical care technologies have evolved, and we now have a much greater ability to treat organ failure and respond effectively to the physiologic emergencies seen in oncology, as noted in the article by Demshar, Vanek, and Mazanec. In addition, one of the more exciting developments accompanying the growth in technological capacity is the more routine incorporation of excellent symptom management in the plan of care. All patients, of course, have the right to have effective management of pain and other symptoms. Oncologic patients in critical care often present particularly difficult challenges, given their likely previous exposure to opiates, acute-on-chronic scenario, and often multifactorial nature of their pain. Raising the overall level of competence in pain management, as well as providing access to

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DOI: 10.1097/NCI.0b013e31822f57b5

sophisticated palliative care throughout the illness, not just at life's end, is an important improvement in standards of care. The decision to devote an article to the management of cancer-related pain in the critically ill, as written by Dolan, Paice, and Wile, appropriately reflects recognition that it is the bedside critical care nurse who often is the person who identifies the need to more effectively address symptoms and advocates for consultation with experts.

With this evolution in our understanding that critical care interventions can be appropriately used even in the context of a likely terminal event, we have also witnessed a much-needed improvement in our ability to provide care and support to patients and their families at end of life. A decade ago the notion of either collaborating with our hospice colleagues or applying concepts and principles from the hospice philosophy would have seemed entirely out of place in both critical care and acute oncology care. Fortunately, as reviewed in the article by Brennan and coauthors, comprehensive and sensitive patient- and family-centered care during the last phase of life, regardless of the environment of care, is now as much a part of acute care as is the traditional focus on physiologic stability.

Importantly, as health care professionals, our moral norms have evolved along with our scientific knowledge. Among the accepted standards today are the expectation that patients and their families have an opportunity to make informed decisions about the benefits and burdens of aggressive interventions; that frequent, ongoing communication and dialogue about goals of care and treatment decisions are essential, particularly in life-limiting illnesses; and that neither patients nor their care providers have complete authority over treatment decisions.

The unfettered legal and moral right of patients to refuse any and all interventions is

unquestioned. The justification for this authority of autonomy is closely tied to the recognition that judgments of benefit and burden are intimately connected to each individual's values and preferences. Regardless of the predicted length of life or the degree of impairment, only the patient him/herself can assess whether the burden of continued aggressive treatment is "worth" the potential for recovery. Patients and families are challenged to come to grips with this issue, to understand the complex biomedical facts, and to make informed decisions under conditions of extreme emotional and physical stress. It is here that nurses often make their most notable contribution. As noted in the article by Wiencek, Ferrell, and Jackson, there is an overlay of meaning to the diagnosis of cancer as well as to the need for transfer to the intensive care unit. Nurses, more than any other clinicians, have both the opportunity and ability to play a key role in supporting patients and their family members in gaining the needed knowledge, reflecting on their unique personal perspective and priorities, and reaching decisions that are right for patients.

The third advance, and perhaps the most promising for the future, is a formal recognition that the highest-quality care can be achieved only if we commit ourselves to meaningful collaboration and interdisciplinary work. Toward that goal, this symposium series makes a significant contribution. Although there has been discussion in the literature of the importance of interdisciplinary collaboration, this is the first comprehensive publication that has been designed and produced, in every article, by teams of critical care nurses, oncology and palliative care nurses, social workers, physicians, and spiritual care providers. It thus can serve as an exemplar of what we hope can be brought to the care of our patients—skilled, knowledgeable professionals working together toward a common goal—the highest quality of service.