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Symposium
Introduction

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The Whole Is More Than the Sum of Its Parts: Critical Care and Palliative Care

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The binary paradigm of critical care first and palliative care second is shifting toward a more modern model. Today, it is widely accepted that intensive care unit (ICU)–based palliative care is both an essential component of high-quality critical care and a core competency for all ICU clinicians, including nurses, advanced practice registered nurses (APRNs), and physicians. The major critical care societies, including the American Association of Critical-Care Nurses, the Society of Critical Care Medicine, the American Thoracic Society, and the American College of Chest Physicians, have issued clinical practice guidelines or position statements. Palliative care has evolved from predominantly end-of-life (EOL) care to the awareness that most, if not all, ICU patients have palliative care needs and should receive primary or specialty palliative care. Although the research in ICU-based palliative care is limited by the dearth of randomized controlled trials, multiple studies over 3 decades do indicate that interprofessional palliative care, provided by both the ICU team and the palliative care team, is safe and effective and can improve patient outcomes.

Still, there is work to do and more consistent integration needed. Critical care nurses and APRNs can and should take a leading role in integrating palliative care by offering tested palliative care interventions, obtaining and providing education, and conducting continuous process improvement. This is a natural fit, as nurses spend the most time of all clinicians at the bedside with the patient and family. The COVID-19 pandemic showed that to a nation in crisis. It was nurses who provided the human touch at the end of life, who answered the call to the bedside despite the risks of an unknown virus, and who used remote communication strategies to connect critically ill patients with their loved ones. The lasting impact of COVID-19 on ICU-based palliative care and the ICU workforce is still being studied, but what critical care nurses showed is that palliative care is critical care. Indeed, the whole—critical care nurses, APRNs, and physicians providing critical care right along with primary or specialist palliative care—is more than the sum of its parts.

The 5 articles in this symposium provide important updates, evidence, and information that the critical care nurse and APRN can use to lead the integration of ICU-based palliative care and to drive the shift from a binary paradigm—one in which patients, families, and teams must wait and choose—to a fully modern and integrated model. It is imperative that nurses and all members of the ICU team be informed about palliative care and avoid myths and misinformation. In the first article, I provide an overview of the current state of palliative care in the ICU and the historical efforts to bridge what may appear to be divergent goals of

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palliative care and critical care. I also examine how the barriers to ICU-based palliative care have shifted, review primary and specialist palliative care, and present evidence-based resources that nurses and all members of the interdisciplinary team can use to achieve optimal outcomes in the care of the critically ill.

Professional organizations recommend the early integration of palliative care in specialty ICU populations such as heart failure and stroke. Just as palliative care has matured and evolved, our knowledge of stroke has evolved from "nothing can be done" to a state of full emergency to "save brain." The article by Hundt and Stevens provides an essential update, and historical perspective, on current evidence-based stroke care and the need for full and early provision of palliative care. The authors summarize the 2014 and 2016 clinical guidelines by the American Stroke Association and American Heart Association[1] and address neuropathic pain, other stroke-related symptoms, and the unique challenges of prognostication and withdrawal bias. The critical care nurse and APRN should be well versed in how stroke evolves and affects prognostication of patient outcomes, as so well explained by Hundt and Stevens. Finally, the authors place the nurse at the center of bedside support and goal-centered communication with patients and families, which is a call to action.

Pediatric palliative care shares foundational elements with adult palliative care but in the third article, Crain and Miller address the subtle and not so subtle differences. Although uncertainty in disease trajectory is a challenge in all ICU-based palliative care, the authors address the more complex uncertainty in the pediatric ICU setting. They also provide detail about the 2010 Concurrent Care for Children Act that allowed for concurrent delivery of curative care and hospice care. Through 3 case studies, Crain and Miller offer the reader an analysis of common ethical dilemmas in the pediatric ICU and introduce the concept of burden displacement. Finally, they discuss the challenges of decision-making to address goals of care in dependent children while fully supporting the voice, needs, and rights of parents.

Communication is the most important intervention in ICU-based palliative care, in the opinion of many experts. Skilled communication is essential if the patient's goals, values, and preferences are to align with the ICU treatment plan. Yet, the National Academy of Medicine has reported that all physicians and nurses need better training in communication especially when dealing with serious illness. Wolf and Alimenti respond to this need in their elegant article on intersectionality and communication in serious illness. Through a detailed and complex case, they analyze the intersection of race, ethnicity, language, and culture on the care of a critically ill man. They provide insight and knowledge on how the critical care nurse and APRN can use more inclusive serious illness communication in the ICU. Every patient in the ICU brings a unique blend of culture, ethnicity, and experiences in life to the ICU episode, and this article helps to build awareness and skill in providing inclusive care when it matters the most.

The final article in this symposium takes a more specific look at 2 innovative strategies that were tested in a surgical ICU and medical ICU. This is important work given that there is no standard of care for providing individualized EOL care or identifying which ICU patients may benefit most from ICU-based palliative care. Harrison and colleagues report on the use of a nurse-driven serious illness support tool to screen for patients in a surgical ICU who could benefit from goals-of-care conversations. They also provide the outcomes of the use of the 3 Wishes Project for providing individualized EOL care to medical ICU patients. Of note, this project provides some insight into the effect of palliative care interventions not just on patients but on teams. Eighty-three percent of medical ICU team members who responded to a postproject survey indicated that the 3 Wishes Project had a meaningful impact on the team. This is an important reminder that ICU team members can also benefit from ICU-based palliative care.

Critical care nurses and APRNs are leaders in shifting the old binary paradigm of critical care first and palliative care second. This symposium provides current knowledge and important historical perspectives to continue to integrate ICU-based palliative care. Palliative care at its heart is person centered, and nurses have always been at the bedside, with the patient, where it matters the most.

REFERENCE

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