

Editorial

AGGRESSIVE CARE AND PALLIATIVE CARE

By Cindy L. Munro, RN, PhD, ANP, and Richard H. Savel, MD



The intensive care unit (ICU) is a place where aggressive care is paramount. Critically ill patients have serious, life-threatening illnesses that demand cutting-edge treatments and the concentrated engagement of an interdisciplinary care team. Health care providers in the ICU deal with high acuity and rapid decision-making. Nursing care is intense, and medical care is assertive. Treatment focuses on normalizing abnormalities and on prolonging life in the face of serious injury or illness.

As the patient's prognosis worsens, the emphasis may shift to providing end-of-life care. The interdisciplinary ICU team reconsiders aggressive care that has no reasonable chance of influencing the patient's outcome, and the team supports family decision-making regarding withdrawal of futile treatments.

Palliative care focuses on management of symptoms and prevention and relief of suffering for any patient who has a serious, life-threatening illness; palliative care aims to improve quality of life for the patient and the patient's family.¹ Palliative care is holistic, dealing with physical, psychosocial, and spiritual problems associated with any life-threatening illness. The National Institute for Nursing Research is the National Institutes of Health's lead institution for palliative care research and "recognizes palliative care as a critical component of high-quality,

evidence-based health care that improves the quality of life for those suffering from the symptoms of serious illness."²

Palliative care has long been associated with end-of-life and hospice care. Much of the foundational research about palliative care has been conducted in association with cancer care. Although the World Health Organization's website emphasizes that palliative care is applicable early in the course of an illness and in conjunction with therapies intended to prolong life, palliative care content is housed in the cancer section of the website.¹

Differentiating palliative care from end-of-life care is important, however, because failing to distinguish between the 2 may lead clinicians to overlook ongoing palliative care needs during critical illness. Palliative care can be provided concurrently with aggressive care; it need not be initiated only at the end of life. Palliative care can contribute to symptom management at every stage of serious illness, and it is not restricted to those who have a poor or terminal prognosis.³ It can and should be provided "for all ICU patients, from the time of admission, regardless of prognosis."⁴ It may be of particular importance for ICU patients who are receiving aggressive treatments that induce or exacerbate problematic symptoms; palliative care may mitigate these effects.

Every patient may experience a unique constellation of distressing symptoms, depending on the nature of their illness and treatments. Common symptoms

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include pain, dyspnea, fatigue, nausea, loss of appetite, and problems with sleep.² In ICU patients, pain, thirst, and dyspnea were reported to be the 3 most common and troubling symptoms.⁴ Early assessment and intervention are important to reduce suffering from these symptoms. The Improving Palliative Care in the ICU (IPAL-ICU) Project was an interdisciplinary task force sponsored by the National Institutes of Health and the Center to Advance Palliative Care.⁴ A report by the IPAL-ICU Advisory Board reviewed evidence for effective symptom management in the ICU, and other evidence-based guidelines also have been published.⁵

Pain is prevalent in the ICU. It may be related to injury, illness, treatments, or procedures. Patients report remembering pain related to routine ICU care, including turning, endotracheal tube suctioning, and medical procedures. Treatment of pain in the critically ill is complicated by underlying condition, comorbid conditions, and stress responses. Opioids remain the most widely used medications for relief of pain in the ICU.^{4,5} Nonpharmacologic treatments such as relaxation, music therapy, or massage may be important adjuncts to pharmacologic treatment of pain in the ICU, but additional research is needed before widespread adoption of those treatments.

Nonpharmacologic treatments for dyspnea include positioning, spacing of care activities to reduce oxygen consumption, and use of a fan. Opioids may also be administered for relief of dyspnea in the ICU. Interestingly, although oxygen is often administered to dyspneic patients, recent meta-analyses have yielded conflicting evidence regarding the effectiveness of oxygen administration for reducing dyspnea.^{6,7}

In a recent nursing research study,⁸ researchers found that an intervention bundle of oral swab wipes, sterile ice-cold water sprays, and a lip moisturizer

reduced thirst intensity and thirst distress in ICU patients. A companion study⁹ showed that high doses of opioids were a predictor of thirst. The beneficial effects of opioids on pain and dyspnea, accompanied by a negative effect on thirst, cautions us that management of symptoms must be approached comprehensively.

In addition to symptom management, palliative care incorporates communication to improve understanding among patients, their families, and clinicians. An American Association of Critical-Care Nurses (AACN) Patient Care Page on improving communication in palliative care states that,

By applying palliative care communication skills, the health care team learns about the patient's individual priorities and values, and the patient and the patient's family gain a better understanding of the disease prognosis and the treatment options.¹⁰

Understanding of goals of treatment and options is important in care coordination, especially during care transitions or when the patient's condition changes.²

Three models of palliative care have emerged: an integrated model, where the ICU team provides palliative care as a part of the ICU clinical care; an interdisciplinary specialty, where a palliative care consultant or team is responsible for directing palliative care; and a blended model.³ There are many examples of successful programs, and many resources are available to institute "palliative care bundles." The model and processes that work best for an individual unit will depend on institutional culture, resources, and palliative care skills. Ideally, every member of the interdisciplinary team should be involved in palliative care and have palliative care competencies. Nurses can lead in provision of palliative care, given nursing's emphasis on symptom management and "the historical importance of palliative care competencies in nursing education, the proven record of nurse-led interventions, and the limited physician-to-patient ratio."¹¹ The IMPACT-ICU (Integrating Multidisciplinary Palliative Care into the ICU) Project is a successful system-wide model for involvement of bedside nurses in palliative care in the ICU.¹²

We have a beginning foundation of knowledge about palliative care for critically ill patients. We

About the Authors

Cindy L. Munro is coeditor in chief of the *American Journal of Critical Care*. She is dean and professor, School of Nursing and Health Studies, University of Miami, Coral Gables, Florida. **Richard H. Savel** is coeditor in chief of the *American Journal of Critical Care*. He is director, Adult Critical Care Services, Maimonides Medical Center and adjunct professor of clinical medicine and neurology, SUNY Downstate College of Medicine, both in New York City.

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should apply what is known about symptom management and family engagement and should seek to expand the evidence base in this important area. Palliative care is crucial to the well-being of patients and their families, throughout the patient's trajectory of illness.

The statements and opinions contained in this editorial are solely those of the coeditors in chief.

FINANCIAL DISCLOSURES

None reported.

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Update

Following the recommendation of the mayor of New York City's commission on the subject, the statue of Dr J. Marion Sims referred to in the January 2018 editorial, "History Is a Tangled Mess: Medical Progress, But at What Cost?" (*Am J Crit Care*, 2018;27[1]:6-8), is being moved from Manhattan to Greenwood Cemetery in Brooklyn, where Sims is buried.