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CORRESPONDENCE

Ave CAESAR: at the end of life in the intensive care unit

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Dear Editor,

We read with great interest the article "CAESAR: a new tool to assess relatives' experience of dying and death in the ICU" [1] in which the authors describe a new tool to assess the experience of relatives of non-surviving ICU patients. We congratulate the authors and absolutely agree that in end-of-life (EOL) situations not only does patient (comfort) care seem pivotal but also that the care of relatives might be of comparable importance. To us, the CAESAR questionnaire seems an appropriate and well-designed approach to evaluate the specific situation of relatives in this context.

In the final 15-item CAESAR questionnaire, we identify two groups of questions similar to the 50-item and 33-item questionnaire initially used to produce the CEASAR questionnaire. The first group of questions focuses on the relatives' perception of respective patient care. The second group focuses on issues related to communication and interaction with relatives. In this light, however, it should be noted that not only "relatives" but also "related parties" should most likely be assessed. One open key question may be to understand which respective aspect dominantly influences the relatives' risk for symptoms of depression and anxiety. With the answer to this question, focused interventions could be developed to further improve the experience of relatives of non-surviving ICU patients. Moreover, is there still a need to improve the patients' care and/or is there a need to improve the "communication" and interaction with relatives? If there is indeed a need to improve "communication", we have to clearly specify it. Thus, the CAESAR questionnaire may not be detailed enough and may fail to answer this relevant question.

To define how to conduct "communication" in EOL situations seems a key challenge that should be addressed in an effort to establish effective interventions. This may allow one to significantly reduce the burden of relatives in this specific setting. Therefore, we are convinced that further clarification of how communication with relatives should be performed must be investigated in subsequent studies. For a substantial period of time, the focus of ICU physicians was primarily directed toward patient EOL care, and relatives were often left somewhat out of scope. However, we now begin to clearly realize that respective communication seems of comparable importance in this complex setting.

The next important step may be to evaluate the situation from a healthcare provider point of view (i.e., mainly physicians' and nurses'). Stress and overwhelming situations such as death of young patients on the ICU could particularly affect involved EOL care teams. Thus, we are looking forward to the results of the analysis of the physicians' questionnaire and nurses' questionnaire to identify respective burdens in an effort to better understand underlying mechanisms as well as to potentially support healthcare providers with specific interventions. In regard to our daily work on the ICU and in the light of the complexity of interacting parties (including the ICU EOL-care-providing team), the ultimate goal would then be to develop strategies and interventions to best cope with respective situations.

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