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CORRESPONDENCE

One ring to rule them all: education in ICU palliative care

Discussion on "Ten key points about ICU palliative care"

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Initial correspondence from Drs Zante and Schefold

Dear Editor,
We read with great interest the article "Ten key points about ICU palliative care" in which the authors highlight ten crucial keys to palliative care in the intensive care unit [1]. The authors present an excellent condensed description and respective recommendations for palliative care on the ICU, which may serve as a guide for daily considerations of end-of-life (EOL) and palliative situations.

In the second proposed key point, a mixed model in which primary palliative care is combined with specialist palliative care contributions is recommended. Although we certainly agree that this may be an option, we believe that this aspect needs reflection in the light of several differences between in-ICU care vs. palliative care situations outside of an ICU. In a palliative care setting outside of the ICU, patients and relatives are more likely to have long been confronted, have reflected, and coped with respective EOL situations. When admitted to an ICU, however, both patients and relatives are most often suddenly confronted with critical, life-threatening, and potential EOL situations and, given the abruptness in change of respective life situations, establishing of a link between ICU staff and patients/relatives becomes a key importance. Interestingly, a recent comparison of palliative care specialist-led vs. ICU physician-led family meetings did not influence the incidence of family anxiety and depression [2], which are considered key factors for development of ICU post-traumatic stress disorder (PTSD). We thus believe that when a "mixed model" is applied, an excellent prospective integration of palliative care consultants must then be aimed for. Keeping in mind many respective similarities, there are also very specific challenges to the ICU staff regarding palliative care, which must be focused on adequately.

It appears that, first of all, adequate preparedness and EOL training should be provided to all professional ICU staff providing EOL care. Currently, most ICUs do not provide structured EOL training programs for physicians or fellows. This seems optimizable in the light of the fact that even short teaching sessions may improve self-confidence in EOL communication providers [3]. In addition, presence of a trained EOL provider may increase satisfaction of relatives in family meetings [4], and inadequate communication with relatives may result in PTSD and augmented grief [5]. However, whether training beneficially impacts on post-ICU PTSD in next-of-kin remains unclear.

In conclusion, we are convinced that the current—mostly "ad hoc"—concept of EOL/palliative care and ICU-specific EOL education deserves revision. Preparedness and empowerment of professional ICU caregivers seem essential in an effort to set up professional EOL care which may, e.g., be guided on the basis of the "ten keys of ICU palliative care".

Reply from Drs Nelson, Edwards, and Voigt

We appreciate the comments of Zante and Schefold on our recent article highlighting "ten key points about ICU palliative care". (1) The main thrust of the letter is that all professional ICU staff need knowledge and skills for effective communication with families of the critically ill, but that education in this area is not consistently provided. We completely agree, and strongly encourage

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wide use of available educational resources, such as those included in Table 1 in our article, as well as development of new resources to ensure full preparation of ICU clinicians for the communication and other palliative care challenges they face every day. When available, palliative care specialists may be helpful in educating, coaching, and supporting the ICU interprofessional team to optimize primary palliative care. Direct involvement of such specialists may not be needed on a mandatory or routine basis for discussions of goals of care with all families of patients with chronic critical illness requiring prolonged mechanical ventilation, at least where the quality of communication and emotional support by the primary ICU clinicians is highly rated by families. (2) There is ample evidence, however, of the substantial value added by palliative care specialists in critical care as well as other settings. Like critical care and palliative care, primary and specialist palliative care are not mutually exclusive—they are synergistic.

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Compliance with ethical standards

Conflicts of interest
The authors declare that they have no competing interests.

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