Pitfalls and Opportunities Integrating Palliative Care in ICU

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Sumita B. Khatri, MD MS
Pulmonary & Critical Care

Relief of symptom distress is a key component of critical care in all ICUs regardless of condition or prognosis

Mrs. Simpson
Mrs. Simpson
Hypoxic respiratory failure
Intubated on 70% FiO2
Slow chronic process, sudden worse
Hoping to have lung transplant
Multiple interventions yet not getting better over 7 days

Mrs. Simpson
Significant anxiety and work of breathing on ventilator
Patient and family disturbed, frustrated that not a candidate
'Too late'
Soon patient is tired
Some glimpses of joy

Mrs. Simpson's Family
Anger and disbelief; severe grief—unfair
Concentrated on what makes her happy
Pet therapy
Transition to comfort care, time with family
Effective aspects of Ms. Simpson’s care?

• Involved all specialists
• Treated the patient—anxiety and pain
• Supported family throughout
• Storytelling to know patient so interactions with her meaningful and allowed substituted judgment
• Transition from intent to cure to intent to relieve suffering—family came
• Comfortably died in hospital—terminal wean

Family support

• Communication
• Empathy
• Non-abandonment absolving of guilt
• Addressed their fears of suffering
• Concordance with our suggestions—withdrawal was appropriate based on her goals

Palliative medicine concepts fit in the ICU

Opportunity to see palliative medicine and critical care as mutually enhancing forms of care rather than mutually exclusive care

-Nelson MD, JD
Critical Care Societies supportive of integration

- 20% deaths in US occur after admission to the ICU
- 50% of people dying in hospital have been in ICU within last 3 days
- ‘Choosing wisely’
- Palliative care should begin at ICU admission and then be adjusted, analogous to curative care

American Thoracic Society, Society of Critical Care Medicine, American College of Chest Physicians, American College of Critical Care Medicine

Mixed Model

- Palliative Medicine Specialists consulting in ICU
- Managing
  - Physical/psychological symptoms
  - Family support
  - Establish common care goals
  - Progression of serious illness
  - Care during dying

Pain… Dyspnea… Thirst…

- 70% of patients recall pain after being critically ill
- 34% experience dyspnea
- 71% unsatisfied thirst
- Patient reported scales
  - Proxy assessment from family often in agreement
Managing Pain

- Most painful procedure is turning
- ET Tube suction, Chest Tube removal, ABG and IVs.
- Treatment
  - Opioid dosing depends on age and end-organ function
  - Bowel regimen

Managing Dyspnea

- Respiratory distress observation scale:
  - Scoring RR, accessory muscle use, nasal flare, grunting
- Optimizing condition
- Noninvasive ventilation only if provides symptom relief
  - Often better than oxygen

Managing Dyspnea

- Positioning
  - Upright with arms elevated
  - Lung up / down based on ventilation or perfusion issues
- Oxygen but no robust data-
  - Fan provides relief
- Opioids:
  - low and slow IV titration q 15 min
Managing Thirst

- Topical:
  - Olive oil
  - Betaine
  - Xylitol
  - Artificial saliva
- Frozen gauze pads, ice
- Sprays of cold sterile water
- Mouth and lip moisturizer

Improving Palliative Care in the ICU (IPAL-ICU) report 2014

ICU Doc need to be facile in Palliative care so therapeutic relationship is not undermined

- Increasing proportion of deaths in hospital > home
- Ability to diagnose dying even outside the ICU
- Need to have responsible and credible diagnosis of dying
  - NOT rationing care
  - NOT euthanasia

Opportunities to triage outside ICU

Patient and family attitudes and perceptions of end of life care

Hilton et al. Critical Care 2013
Challenges

- Symptom distress for patient
- Post-intensive care syndrome in patients and families
- Misperception of palliative care and critical care as mutually exclusive
- Conflation of palliative care with EOL or hospice care

Challenges in communication

- Fragmented
- Insufficient time
- Missed opportunities for empathy
- Multiple transitions across variety of institutions even post ICU
- Insufficient training of clinicians in communication
- Competing demands on ICU without reward for pall care excellence
Challenges

• Surrogate decision making
  - Intrapersonal stress
  - Deal by focusing on details
  - Mixed message-need the info but do not want to hear it
• Unrealistic expectations for ICU treatment on patient, family, and clinical team

Physical / Institutional challenges

• Perceived barriers to EOL differed by level of training, discipline, and institution
• Lack of appropriate meeting space
• Failure to apply effective approaches for system or culture change to improve palliative care
• Inter-institutional variability

Best practices for family satisfaction*

• Expressions of empathy
• Discussing spiritual needs and patient EOL wishes during family conferences
• Extubation before death
• Increased shared decision making:
  - when MD believes withdrawal appropriate
  - higher family education level
• Include family on work rounds
• Written communication-what to expect
  - Example: duration of survival after withdrawal

*not much changes satisfaction
Why has patient and family satisfaction not increased?

• Despite multiple interventions
  - Champions
  - Triggered palliative medicine consult
• Not measured properly-instruments too coarse
• Not individualized
• Optimal communication not defined

Future opportunities

• Get ICU docs out of ICU and in the field
• Interdisciplinary staff with specific interventions
• Champions that are individuals who are respected and have authority
• Enduring change for changing work systems
• QI projects/perspective
Key concepts

- Enhanced partnership between critical and palliative care
- Intensivists must be facile and understand palliative medicine concepts
- Communication training
- Individual-level interventions

References

- Schenker et al. Health care system distrust in the ICU. Journal of Critical Care (2012) 27: 3-10
- Freidenberg et al. Barriers to EOL Care in the ICU. Jnl of Palliative Medicine (2012) 15: 404-411

Cleveland Clinic

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