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EDITORIAL

The importance of an interprofessional palliative approach for the critical patient☆

Importancia del abordaje paliativo interprofesional en el paciente crítico

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Due to today's increasing ageing population approximately 75% of people will die from chronic progressive disorders,[1] with this patient profile being ever more frequent in the intensive care units (ICU). However, due to social changes, death is considered a taboo subject and there is idealization and inordinate trust in technology, particularly in the ICU, where approximately 90% of patients survive. Notwithstanding, it is extremely important to cover the need for quality palliative care not just for those patients who die, mostly due to the limitation of life sustaining treatments (LSTL), but also for those who are discharged from the ICU, but have a limited prognostic and/or quality of life.[2–4]

The complexity of the critically ill patient entails prognostic uncertainties which hinder decision-making, such as LSTL, and this may prolong the agony of both patient and family for much longer than the actual course of their disease. It may even result in possible situations of therapeutic obstinacy which trigger the risk of violating the actual process of death for the patient.[5–7]

Today's challenge lies in the application of both a curative treatment and a palliative approach in situations where it is indicated, since in the majority of situations when patients are admitted to the ICU it is uncertain whether the treatment is having any effect or they will fail to respond and it will begin to be futile. Early use of palliative care promotes appropriate and compassionate care to a greater number of patients, especially those who are critically ill, allows for better management of symptoms, suffering, pain, a better management of anxiety and the treatment failure of professionals. It promotes the participation of both the patient and

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the family in decision making and facilitates comprehensive follow-up in the family grief and bereavement.[8]

As suggested by Enric Benito, the determining action will be to identify and diagnose the beginning of the death process, so that future interventions focus on it, regardless of the situation or previous diagnoses leading to this situation.

There are several projects which already deal with this. In 2002 the American Society of Critical Care Medicine, and the *Robert Wood Johnson* foundation, drawing from the principles of palliative medicine, launched a project called *Promoting Excellence in End of Life Care* which defined the basic components for quality end-of-life care in the ICU.[9,10] They pointed out the key points: acquire communication skills between the team/family/patient; carry out adequate assessment and control of symptoms; base the focus on patient care, exploring their values; include care from the family; regularly have interdisciplinary meetings.

A series of indicators and operational measures were developed from these components to guarantee the quality of care and make them accessible to any ICU. Said indicators were:[11] taking decisions focused on the patient and the family; improving communication between the team, patient and family; ensuring continuity of care; offering practical and emotional support to the patient and the family; carrying our appropriate management of symptoms and comfort care; offering spiritual support to the patient and the family and receiving emotional and organizational support for the clinical symptoms.

Another project which arose to integrate palliative care in the ICU was the *Integrating Palliative and Critical Care*[12] (IPALICU), which prioritized 5 areas of improvement: training of professionals in palliative medicine; collaboration with specialists in palliative care; identification of obstacles for providing end-of-life care in the ICU and proposing solutions; review of quality criteria in caring for patients who die in the ICU and their families; and the designing of protocols, support documents, and forms for families.

As a result of this activity and with the aim of improving end-of-life care of patients who have been admitted to ICUs in Spain, a collaboration agreement was created between the Spanish Society of Intensive Nursing and Coronary Units (SEEIUC), the Spanish Society of Critical Care Medicine and Coronary Units (SEMICYUC), the Spanish Society of Palliative Care (SECPAL) and the HU-CI project. The aim of this agreement is to attain excellence in the care of critically ill patients and offer support to the professionals involved in this process.[13]

The main themes aim at evaluating the need for a quality palliative approach (well-being, symptom control), psychological support to both the patient and the family (particularly when grief and bereavement ensue) and inter-professional work (including interconsultation with psychologists and palliative care professionals).

To sum up, the aim was to offer comprehensive attention to the ICU patients right from admission, regardless of their prognosis, with early identification of palliative measures (daily assessment of palliative patient needs), to address multidimensional needs better, practise a model of interprofessional care, together with identification of values and patient preferences[14] (prior instructions document and shared planning of care model) and active participation of the family, with the difficulty of taking decisions being reduced, and agreeing a joint plan of action which is coordinated and comprehensive, adapted to each stage of the disease and patient circumstances.

However, one of the points where there is a great variability in clinical practice is team decision making, integrated by nurses and intensive care professionals along with other specialties if necessary, where the figure of the nurse is not taken into account.[2,15,16] In this sense active real participation is key throughout the whole process, and particularly regarding LSTL decisions, where the nurse is in a privileged position to identify the values and needs of both the patient and the family because she spends more time with them, and may better know their desires, and identify earlier when treatment begins to be invalid. A better approach to physical aspects may also be possible (well-being, control of symptoms) as well as psychological ones (early addressing of grief and spirituality). It will therefore be essential for the nurse to become involved as a necessary professional to jointly adapt to treatment aims at each stage of the disease and to the particular circumstances of each patient, participating in daily evaluation of active detection of palliative needs and offering holistic care to both the patient and their family members.[16–21]

Conflict of interest

The authors have no conflict of interest to declare.

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