Psychiatric and Palliative Care in the Intensive Care Unit

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KEYWORDS

- Palliative care • Palliative psychiatry • End-of-life care • Comfort care
- Intensive care • ICU communication • Family meeting

KEY POINTS

- Palliative care is a core component of critical care and addresses the multiple domains of suffering that patients and families experience.
- Current models of palliative care in the intensive care unit (ICU) combine consultative and integrative approaches to ensure standard palliative care quality measures and continuity of care if the patient moves out of the ICU.
- Communication behaviors that are family centered can improve both patient and family outcomes.
- Patients with preexisting severe mental illness present as a unique and vulnerable population in the ICU and require a palliative psychiatric approach to ensure ethical decision making.

INTRODUCTION

Why consider palliative care in the setting of critical care? Palliative care is an essential component of the clinical practice of critical care. Although trends in place of death have shifted over time, with more patients dying outside of the hospital, 1 in 5 deaths still occur in the intensive care unit (ICU) or just after an ICU stay.[1] The World Health Organization defines palliative care as "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."[2] The Center to Advance Palliative Care commissioned a national polling firm to conduct a public opinion survey regarding palliative care in 2011. Based

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on preferences for communication and language, they described palliative care as "specialized medical care for people living with serious illness" with a focus on "providing relief from the symptoms and stress" and a goal "to improve quality of life for both the patient and the family."[3] Palliative care is often confused with hospice, but the two are distinct. Palliative care can be delivered at any point in the course of a serious illness, whereas hospice requires a prognosis of 6 months or less.[3] In the setting of the ICU, palliative care can be applied to any patient with serious illness, particularly with the high stakes and significant emotional distress that often accompany decision making regarding treatment goals in the ICU.

This article describes the psychiatric aspects of providing palliative care for patients and their families. In the ICU, palliative care has historically centered on care for the dying and support for their families. With the increase of chronic critical illness, palliative care for ICU patients is beginning to extend beyond the experience in the ICU with persisting physical and psychiatric symptoms after hospital discharge.

PALLIATIVE CARE EVALUATION OF INTENSIVE CARE UNIT PATIENTS AND FAMILIES

Although palliative care in the ICU is not exclusive to end-of-life care, the development of the domains of high-quality palliative care have stemmed from work focused on what constitutes high-quality end-of-life care. The Robert Wood Johnson Foundation Critical Care End-of-Life Peer Workgroup, a group originally convened in 1998 for the foundation's Promoting Excellence in End-of-Life Care project, synthesized the literature and expert opinion to develop domains for high-quality end-of-life care. They identified the following 7 domains: (1) patient-centered and family-centered decision making; (2) communication within the team and with patients and families; (3) continuity of care; (4) emotional and practical support for patients and families; (5) symptom management and comfort care; (6) spiritual support for patients and families; (7) emotional and organizational support for ICU clinicians.[4]

Although management of common psychiatric complications and syndromes in the ICU are addressed elsewhere in this issue, it is important to acknowledge the tension that sometimes arises in treating symptoms of critically ill patients who are at the end of life while the goals of care remain uncertain. Families can struggle with the conceptual model of comfort care with the misunderstanding that comfort is not attended when the patient is in a curative mode of care. In other instances, while a patient is sedated to maintain comfort while on a ventilator, families may request that sedation be discontinued so that they can speak with the patient about their wishes; or, they may attribute a patient's neurologic impairment to medications rather than an underlying fatal or deteriorating condition (**Box 1**).

Box 1
Common psychiatric symptoms in the intensive care unit for patients at the end of life

Delirium

Agitation

Anxiety

Pain (both neuropathic and nonneuropathic)

Data from Akgun KM, Capo JM, Siegel MD. Critical care at the end of life. Semin Respir Crit Care Med 2015;36:921–33.

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