Education About Palliative Care in the Intensive Care Unit: Rediscovering Opportunity

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Underlying palliative care is a philosophy that aligns patients' health care with what they deem most important. For patients in the final stages of life, this often includes the desire to avoid burdensome and high-intensity care. In the intensive care unit (ICU), where we see the highest acuity of illness, often there are many competing priorities. The principles of palliative care are vital in refocusing our attention on what matters most to the patient and his or her family. Because of the value of these principles, there is increasing interest in finding ways to improve education in palliative care and to integrate palliative care education into the ICU. To achieve this goal, 3 models for incorporating palliative care in the ICU have been proposed: the integrative model (education in primary palliative care skills for ICU clinicians); the consultative model (access to palliative care specialists); and the mixed model that uses both of these approaches simultaneously.[1,2] It is increasingly clear that a mixed model, in which the education and deployment of palliative care specialists is combined with the education of all clinicians in basic principles of palliative care, is the optimal approach to address the diverse range of palliative care needs in the ICU.[2]

Effective integration of palliative care into the ICU setting has important implications for graduate medical education. The ICU is 1 of the settings in our health care system where residents and fellows have the most contact with critically ill or dying patients. Despite this intimate exposure, there is little formal training about how best to care for these patients and their families. Effective communication, a key role of the ICU clinician, is 1 of the 6 core competencies from the Accreditation Council for Graduate Medical Education. More specialties are incorporating Milestones into the Next Accreditation System that include palliative care principles, such as delivering difficult news, conducting family conferences, and using shared decision making tailored to a patient's values.[3]

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In this issue of the *Journal of Graduate Medical Education*, Saft and colleagues[4] set out to determine if 3 factors related to palliative care—(1) the perceived quality of critical care fellowship training in palliative care, (2) the number of point-of-care support tools for palliative care, and (3) the availability of an inpatient palliative care consultation service—were associated with ICU utilization in the final 6 months of life. The authors ground this study in "provider behavioral theory," which suggests that the best way to effect positive change in patient care is to rely less on the variable nature of individual clinicians and instead improve support for the entire patient-provider-system unit.[5] They hypothesized that these 3 initiatives, each supporting a different aspect of care delivery, would decrease ICU utilization. Their observational study encompassed 71 training programs in 89 hospitals, using surveys from program directors (with an approximately 50% response rate) and data from the Dartmouth Atlas.[6] It found that for every additional bedside tool an institution had implemented in the ICU, there was an associated 0.31-day decrease in ICU length of stay at the end of life. Additionally, for every 1-point increase in self-rated quality of palliative care education, there was a 0.57-day decrease in length of stay. The study did not find any association between the presence of a palliative care consultation service and ICU utilization at the end of life.

One of the most notable findings by Saft and colleagues[4] was the high proportion (more than 80%) of hospitals that had a palliative care consultation service. Because there were so few hospitals without a palliative care consultation service, this study was not powered to examine the effect of having access to specialty palliative care. Furthermore, the authors had no information about the degree to which the palliative care specialists were integrated into the ICU. In our experience, there is enormous variability in how palliative care specialists are incorporated into the ICU. This ranges from hospitals where the palliative care service first began in a critical care setting to hospitals where the intensivists and the palliative care specialists collaborate very little or not at all. It would be interesting to examine whether the degree of incorporation of palliative care specialists into the ICU is a predictor of quality of palliative care in the ICU.

Another curious finding of this study was the very low rate of implementation of bedside tools to improve palliative care. The tools listed included a family information pamphlet, point-of-care communication card, withdrawal-of-life-support protocol, bereavement brochure, and comfort measures order set. Surprisingly, 45% of hospitals had none or only 1 of these tools. These 2 findings—high proportion of palliative care consultation services and low proportion of bedside tools for implementing palliative care—highlight how far we have come in palliative care and yet how far we have to go with instituting basic resources such as comfort care protocols and bereavement information.

The association between the lower duration of ICU stay for patients who died in the ICU with a higher self-rating of the palliative care education by critical care fellowship program directors is also intriguing. We previously found that self-evaluation of overall communication about end-of-life care by internal medicine residents and fellows had no association with evaluations by patients and their families.[7] However, when we asked residents and fellows to focus on a specific aspect of this communication—religion and spirituality—we found this was associated with patient and family ratings (D.W. Ford, MD, unpublished data, 2013). It is possible that program directors are accurate raters of the quality of palliative care education. Furthermore, it is possible that those with high-quality palliative care education deliver better palliative care in the ICU, which results in improved communication with patients and families, more rapid identification of patients' goals of care, and thus a reduction in the prolongation of dying that is too often seen in the ICU. This would suggest that better training in palliative care skills, as well as increased use of bedside tools, could improve the quality of palliative care in the ICU and decrease use of unnecessary ICU care at the end of life. We would be happy to believe this were true. In a single-center study of a quality improvement project to improve palliative care in the ICU in our own institution, we found some evidence to support this hypothesis.[8] However, in a subsequent multicenter, cluster-randomized trial of the same intervention, we were not able to show improvements in quality of palliative care delivered to patients and their families, which suggests that extending these results to other institutions would be difficult.[9]

There is another possible explanation for the findings by Saft and colleagues[4] that should be considered. It is possible that the association between the 2 predictors (quality assessments by program directors and bedside tools) and the outcome (ICU length of stay for patients who die) is not causal, but is the result of what some call an "ecological fallacy."[10] In fact, it is quite plausible that both program director assessment of the quality of palliative care education and the number of bedside tools for palliative care are actually predictors of another determining factor, such as the culture of palliative and end-of-life care in the institution. There is compelling evidence that the intensity of care at the end of life in a hospital is largely driven by the culture within a particular hospital toward palliative and end-of-life care.[11] A hospital culture that embraces palliative care is likely to improve the ability of critical care training programs to provide palliative care education and facilitate development and implementation of bedside palliative care tools. In fact, 1 of the key roles of palliative care specialists in a well-functioning mixed model is to provide role modeling and education for the provision of primary palliative care by critical care clinicians.

Regardless of the mechanism of the associations identified in this study, the implications are similar. Whether program director ratings of quality of palliative care education and number of bedside tools are directly causal in their relationship with intensity of care at the end-of-life or whether they are influenced by the culture of palliative care in the institution, this study highlights important opportunities that will likely improve the quality of palliative care delivered in ICUs. Our health care system is facing an aging population with a higher burden of comorbid illness. Simultaneously, we are seeing a potential "perfect storm" of marked advances in life-sustaining interventions, increased utilization of critical care, and rising prevalence of chronic critical illness.[12,13] The ICU will undoubtedly remain a place where palliative care needs are high. The best solution will be some combination of primary and specialty palliative care delivered in (as well as before) the ICU. The minimal use of bedside tools for palliative care seen in this study represents low-hanging fruit that hospitals can address quickly. The likely benefit of quality palliative care education for critical care fellows adds to a growing body of literature supporting these activities. For the next generation of ICU clinicians, palliative care skills will be entrustable professional activities. This study should encourage training programs to direct additional resources toward palliative care education. Improvements in ICU palliative care are likely to be an important strategy to improve the overall culture and quality of palliative and end-of-life care in our institutions.

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