



EDITORIAL

Multidisciplinary palliative care at the end of life of critically ill patient[☆]



Cuidados paliativos multidisciplinares al final de la vida del paciente crítico

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This year the Spanish Society of Intensive and Critical Care Medicine and Coronary Units (*Sociedad Española de Medicina Intensiva, Crítica y Unidades Coronarias*, SEMICYUC) has signed a cooperation agreement with the Spanish Society of Palliative Care Medicine (*Sociedad Española de Medicina Paliativa*, SECPAL), the Spanish Society of Intensive Care Nursing (*Sociedad Española de Enfermería Intensiva*, SEEIUC) and the HUCI Project, with the specific aim of improving end of life care in patients admitted to the Intensive Care Unit (ICU). This agreement speaks against the topical and false view that intensive care and palliative care represent antagonistic disciplines. Critical patients are characterized by life-threatening clinical situations and con-

tinuous and unpredictable evolutive changes. The treatment objectives are therefore also dynamic and are conditioned to the patient evolutive course and response to therapy. Current intensive care practice must contemplate not only supportive treatment for the seriously ill but also the adoption of measures in the event of a negative evolutive course, poor response to therapy and a high risk of death during admission to the ICU or in the course of hospital stay.

Multidisciplinary or integral management of the critical patient therefore needs to include palliative care,¹ which must form part of treatment in the ICU, with a view to guaranteeing maximum quality care in such patients, where healing intent gives way to optimum end of life care. Early identification of the palliative needs of these patients is crucial in this regard.

Humanization of healthcare projects have been developed in recent years, promoting open ICU policies, introducing more flexible visiting policies, and favoring the presence and participation of the families in the care of the critically ill patient.² The Societies that participate in this cooperation agreement have set the ambitious goal

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of encouraging measures to improve end of life care in patients admitted to the ICU. This requires the adoption of interventional strategies comprising the assessment of clinical, psychological, social and contextual aspects with the purpose of reorienting the care of those patients that present an unfavorable clinical course, seeking to afford relief from suffering, improve the symptoms and ensure greater wellbeing. A further objective is to address the needs of the families of these patients and of the healthcare professionals, who may suffer from exhaustion or other syndromes such as moral stress, compassion fatigue, or inappropriate care function.

Due respect for the autonomy of critical patients, including them in the clinical decision process from the time of admission, proves particularly relevant in those situations where the patients lose their capacity to decide. This is where anticipated planning of healthcare or the contemplation of living wills (or advance directives) is important and should form part of daily practice in the ICU. Such practice is not always implemented, however, and patient will may be infringed as a result.^{1,3,4} The control of symptoms such as pain, dyspnea, fear or anxiety must be a priority concern in end of life care, facilitating patient accompaniment by loved ones and ensuring an environment as comfortable as possible for both the patients and their families.^{5,6} Close and true communication, adapted to the clinical situation, should play a key role with the same importance as other care processes during patient admission to the ICU.⁷⁻⁹

Limitation of life support measures are common in Spanish ICUs¹⁰ and must be decided on a team basis¹¹ with participation of the different healthcare professionals involved. The contribution of points of view serves to reinforce such decisions. In this regard, the opinions of the professionals directly in charge of caring for the patient are particularly relevant. These decisions must be based on prudent clinical criteria supported by clinical facts such as the patient course, response to treatment and prognosis. Furthermore, however, the values of the patients and their families, and of the healthcare organization, also need to be taken into account. The principal aim is to avoid therapeutic obstinacy, futile treatments or therapies regarded as inappropriate, as well as to foresee the different outcomes and deal with them adequately both within and outside the ICU. Coordination with the palliative care teams is crucial in this sense.⁶

Healthcare professionals in the ICU need to acquire knowledge and skills in order to comply with the essential role played by palliative care in certain critical patients.⁵

The development of training programs for the professionals that care for critically ill patients in the end of life scenario, and the updating and divulgation of management recommendations in these situations, justify the mentioned cooperation agreement, which should serve to ensure the optimum care of such patients – offering integral management for both the critically ill and their families, and support for the professionals involved in the process.

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