ICU
MANAGEMENT & PRACTICE

5 Strategies to Improve End-of-Life Care in the ICU

Although patients do die in the intensive care unit (ICU), it may not the best place for end-of-life care, argue Prof. Derek Angus, from the Department of Critical Are Medicine, University of Pittsburgh School of Medicine, and Associate Editor, JAMA with Prof. Robert Truog, Center for Bioethics, Harvard Medical School, in a viewpoint article in the January 19 issue of *JAMA*. The difficulty is in knowing if seriously ill patients are close to death or on their way to recovery. “A trial of ICU care will often be a rational and appropriate clinical choice consistent with patient wishes”, even though in retrospect it occurred at the end of life, they write.

Technological determinism, they argue drives admissions to the ICU and once admitted, use of technological interventions, regardless of a patient’s prognosis.

How to Improve End-of-Life Care in the ICU Setting

Angus and Truog suggest five strategies for improvement in end-of-life care in the ICU.

1. Reduce Inappropriate ICU Admissions

- Promote **advance care planning**.This needs to reflect care possibilities in the ICU and society’s expectations about end-of-life care.
- ICU physicians should be **responsible gatekeepers**. Angus and Truog write: “Requiring expert and careful consideration by an ICU attending physician can help avoid inappropriate ICU admission, as well as reduce the error of refusing a trial of ICU care for a patient who might benefit.”
- **Reduce bed numbers**. The authors acknowledge that this is a blunt instrument, but argue that clinicians and hospitals are unlikely to regulate more responsible and careful admissions unless beds are scarce.

See Also: Canadian Researchers at the End of Life Network (CARENET): Interview with Professor Daren Heyland

2. Reevaluate Goals of Care During the ICU Stay
Physicians need to be clear that ICU care is to help patients improve to discharge, not just to sustain life. Regular reviews and discussions with patients and families on whether therapy is appropriate is required. The authors acknowledge the difficulty as continued ICU care can be seen simply as the "path of least resistance". People tend to avoid those difficult conversations.

3. Improve Shared Decision Making
End-of-life conversations should be a core competency for ICU Physicians. Although educational programmes have been developed for non-palliative care physicians, they need to be widely disseminated.

4. Improve Consensus Building in the Clinical Team
Although clinical practice silos exist, Angus and Truog emphasis that “the onus rests with the healthcare system to implement strategies that emphasise communication, respect and consensus building while mitigating distrust and moral distress.”

5. Make ICUs More Humane
We need to challenge the notion that ICU care includes pain, incapacity and mental anguish, write Angus and Truog. They suggest areas for improvement:

- reduce unnecessary testing
- reduce invasive monitoring
- reduce noise and light pollution
- have open visitor hours
- use the least restrictive barriers for infection control.

They conclude: “ICU care can evolve to be a rational and reasonable option as part of optimal end-of-life care.”

Source: JAMA
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