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## Palliative and Intensive Care

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One of the important challenges for intensive care in Australia and, for that matter, in many other countries, is how we deal with the increasing number of patients being managed in intensive care for the last hours or days of life. Initially, intensive care units (ICUs) were developed in order to temporarily sustain life while a disease takes its natural course, as in Guillain Barré Syndrome, or while active intervention takes effect, such as antibiotic treatment or care after surgery. There was usually a large, potentially preventable acute component to the disease being managed in the ICU. However, hospitalized patients gradually became older, with co-morbidities and a high level of underlying chronic conditions. These patients often have a relatively minor acute component to their disease; most of the disease is chronic and irreversible. We are working with a relatively minor part of the patient's entire disease load, treating, for example, a minor infection in a chronic obstructive airways disease (COAD) patient or pulmonary edema in patients with chronic heart failure (CHF). At best, the patient is discharged from hospital, often severely incapacitated, with a prognosis similar to many forms of malignancy.

What are the reasons for placing these patients on a conveyor belt, taking them through the health system, resulting eventually in their admission to the ICU? Firstly, society is less comfortable with dying at home. Primary care physicians are less involved with total patient care, especially the often time-consuming process of providing care to patients dying at home and, at the same time, supporting relatives. It is easier to call an ambulance when a person becomes seriously ill, whether the illness is the result of an acute, reversible condition or part of a normal dying process. Ambulance personnel are not trained nor empowered to make decisions about whether the patient should be allowed to die at home or be admitted to hospital. Even physicians managing patients outside the hospital setting are discouraged from making endof- life decisions (Rocker 2006). On arrival at the hospital's Emergency Department (ED), the patient is usually rapidly assessed, resuscitated and sent to an appropriate part of the hospital. It is not common for ED staff to make decisions about withdrawing or withholding life support. If the patient deteriorates on the general wards of a hospital, assistance is often sought from the ICU, even if the patient is obviously and inevitably dying. This is understandable, as patient response to resuscitation is difficult to predict, and there may be a relatively large, acute, reversible component of the disease with which to work.

With increasing specialization, our colleagues often do not understand what the ICU can and, more importantly,

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what it cannot offer. They simply know that seriously ill patients require the attention of experts in acute medicine and that some patients who they thought would have died are, in fact, discharged from the ICU. It is not that our colleagues do not understand that the patient is seriously ill, but they are not familiar with the advances in and limitations of intensive care medicine.

There are other forces driving patients onto an inevitable conveyer belt to the ICU. Society has higher expectations of ICU services. Newspapers report daily on the latest medical miracles, and television shows rarely highlight failure and death in acute hospitals. Litigation has also been an important factor; death is often seen as a medical mistake, an opportunity for suing individuals and organizations. There is a common impression that people should no longer die in an acute hospital, surrounded by so much impressive technology.

With all of these forces operating, intensivists often do not feel empowered to refuse admission to the ICU. There is always uncertainty in medicine. Patients and their relatives want to be assured that everything is done for the patient; not that everything appropriate is done. This situation can often become perverse when relatives are asked what they would like done – it would take a brave and seemingly heartless relative to say at this emotional time they want less than everything. The 'everything' could, of course, involve admission to the ICU, mechanical ventilation, dialysis, inotropes and heart-lung transplantation, and death may, nonetheless, be inevitable.

How do we challenge this situation? Intensivists are probably best placed to confront this issue. Politicians and health administrators are unlikely to legislate on limitations to therapy – death in spite of the potential to sustain life for a short time can be an emotional area. Our colleagues do not understand what we can and cannot offer, and society has unreal expectations. Intensivists should be leading the debate around this issue. We should be honest with society about our limitations, as well as our successes.

Intensivists should learn more about how to introduce relatives and (when possible) the patients themselves to the inevitability of death, emphasizing continuing care and treatment appropriate for the condition – not just active interventions for treatment's sake. Relatives often find it difficult to deal with the burden of deciding whether to withdraw or withhold treatment and usually revert to the fallback position of continuing active management. The diagnosis that a patient is dying is made within the same limits of certainty and uncertainty as any other diagnosis. Withdrawing and withholding treatment can be open to discussion with relatives and friends, but the diagnosis of dying should not be a matter of choice, as with any other clinical diagnosis.

Intensive care clinicians are increasingly involved with the seriously ill outside of ICUs with systems such as the medical emergency team (MET) (Hourihan et al. 1995; Lee et al. 1995). These systems are often developed and run by staff in the ICU and are designed to recognize and resuscitate patients in the early stage of their disease, before serious complications and death occur. Many patients seen by these early intervention teams are seriously ill but do not have an obvious, reversible component to their disease and inevitably will die in the short term. Some patients with a 'do not resuscitate' (DNR) order are seen as part of a MET-type system before they suffer cardiac arrest, and the team must decide what active measures should be taken.

This type of system enables the intensivist, who is best acquainted with the potential benefits and limitations of ICU care, to be involved early in the dying process and offer an opinion on whether further treatment is appropriate. In other words, the intensivist is increasingly playing a palliative care role with the seriously ill, hospitalized patient. This can be a rewarding part of the expanding role of intensive care physicians and one where our specialty can lead research initiatives and public discussions and debates.

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