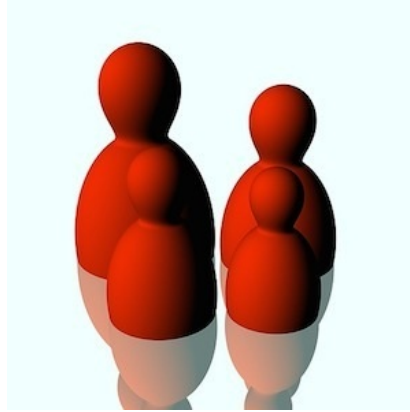




Study: Palliative Care Support Did Not Reduce Caregiver Anxiety



An intervention designed to improve support for families of patients with chronic critical illness did not reduce symptoms of anxiety or depression, according to a study published in *JAMA*.

The investigators recommend that palliative care consultations be provided as recommended by the intensive care team, as their findings do not support palliative-care led discussion of care goals.

"We know that many families benefit from working with palliative care, and clinicians are probably able to determine who they may be in a reliable way. So consultations should be on an as-needed basis rather than consultation for all. This will greatly help direct a limited resource (palliative care clinician time) to where it is most useful, both in the ICU and out", explained [Shannon S. Carson, MD](#), Chief of the Division of Pulmonary Diseases and Critical Care Medicine, Department of Medicine, University of North Carolina School of Medicine, Chapel Hill, North Carolina, USA, in an email to *ICU Management & Practice*.

"It should also be noted that this study did not test the full range of palliative care services including symptom management. I like to think that ICU physicians and nurses are skilled at symptom management, but we always have more to learn", he added.

The study, led by Prof. Carson, Judith E. Nelson, MD, JD, of the Memorial Sloan Kettering Cancer Center, New York, and colleagues, randomly assigned adult patients requiring 7 days of mechanical ventilation and their family surrogate decision makers to at least 2 structured family meetings led by palliative care specialists and provision of an informational brochure (intervention), or provision of an informational brochure and routine family meetings conducted by ICU teams (control). There were 130 patients with 184 family surrogate decision makers in the intervention group and 126 patients with 181 family surrogate decision makers in the control group. The study was conducted at 4 medical ICUs, and the observers measuring the primary outcomes were blinded to group allocation.

The study included palliative care specialists in the intervention as they are trained to provide emotional support, share information, and engage patients and surrogate decision makers in discussions of patient values and goals of care.

Prof. Carson explained that palliative care is still associated by some clinicians and even patients and families as serving only to address needs of the dying patient. But many clinicians are realising that symptom management, patient and family support, and help with care transitions are very helpful to any patient with an acute or prolonged illness, and palliative care clinicians are tremendous partners in that effort, he added.

Results

312 family surrogate decision makers completed follow-up. There was no significant difference between the intervention and the control group at 3 months in:

- anxiety and depression symptoms (measured by the Hospital Anxiety and Depression Scale symptom score);
- discussion of patient preferences;
- median number of hospital days;
- 90-day survival.

The researchers suggest that the lack of difference could be because usual care, with quality communication and emotional support, was considered very satisfactory by the family.

“When informational support provided by the primary team is sufficient, additional focus on prognosis may not help and could further upset a distressed family, even when emotional support is concurrently provided,” the authors write. “Alternatively, the intervention may have been insufficient to overcome the high levels of family stress associated with having a relative with chronic critical illness.”

The research was [presented at the American Thoracic Society 2016 meeting](#), and Prof. Carson said that while many clinicians were initially surprised by the lack of benefit of the intervention, they considered that maybe physicians do a better job of communication and family support than they give themselves credit for. Some raised the possibility that ICU clinicians from hospitals with strong palliative care programmes may be better trained in communication, but increasingly training programmes are building curricula in communication and family support, and most critical care clinicians are well trained in communicating about goals of care simply because they do it so much, he said.

The intervention group had higher post-traumatic stress disorder (PTSD) symptoms, as measured by the Impact of Events Scale-Revised (IES-R). “The PTSD finding was a secondary outcome measure, and the difference is small, so it is possible that it occurred just by chance”, noted Prof. Carson. While this was an unexpected finding, he added that there are examples of interventions for PTSD in other types of patients causing some initial increase in symptoms before ultimately leading to improvements.

See Also: [Divergent Views on Prognosis Between Doctors and Surrogate Decision-Makers](#)

Next Steps

The researchers suggest that earlier or more intensive communication interventions may be needed for families of chronically critically ill patients.

Prof. Carson explained that other than having a history of anxiety or depression, there are not many known risk factors for poor emotional outcomes, especially for families of the chronically critically ill. They will be conducting a secondary analysis to see if they can identify some of these risk factors and they are collaborating on another study to compare the use of a decision aid to support understanding of prognosis and goals of care to family meetings without the decision aid. This study, in collaboration with [Christopher Cox, MD, Associate Professor of Medicine](#) at Duke University School of Medicine and the ProVent Research Network will measure many of the same outcomes. “We can see if increased PTSD symptoms will be a consistent finding with focused communication interventions in this group of family decision-makers”, Carson said.

In an accompanying editorial, Douglas White, MD, MAS, of the University of Pittsburgh School of Medicine explores some of the study’s limitations and the possible reasons for the intervention’s lack of effect. He recommends development of valid predictive models for functional outcomes in chronic critical illness for use in decision making.

Sources: [JAMA](#); interview.

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