

EDITORIAL

ICU: The New Hospice

Because 20% of Americans die in ICUs, critical care has become the new hospice. Consequently, intensivists find themselves, often without enthusiasm, in the role of palliative care physicians.

Reluctance to engage in ICU palliative care may occur because critical care is about saving lives, rather than facilitating peaceful deaths. Also, dealing with death can be emotionally averse. This is compounded by a paucity of end-of-life training within critical care medicine.

There is widespread agreement that better end-of-life communication is a key ingredient in decision making and implementing palliative care in the ICU. In fact, physician-patient/family communication can be seen as an essential step, without which it is nearly impossible to institute ICU palliative care.

Better communication may result in improved ICU patient outcomes in three areas:

► **Quality of death and dying.** Observers—either family members or nurses—can rate the dying experience on a scale, such as the Quality of Death and Dying Scale. A study that used nurse ratings on this scale showed that quality of death and dying can be improved by a multifaceted intervention that includes clinician education, local champions, academic detailing, feedback to clinicians, and system support (Am. J. Respir. Crit. Care Med. 2008;178:269-75). Thus, a tailored intervention that leads to better communication may improve the dying experience.

► **Emotional impact on next of kin.** Family members of patients in the ICU are psychologically distressed by the experience. In one study, at 90 days after an ICU discharge, posttraumatic stress symptoms were seen in 29% of family members of patients who survived an ICU admission, and in 50% in situations where the patient died. When next of kin participated in end-of-life decision-making, 82% scored above threshold for posttraumatic stress and also had higher rates of anxiety and depression (Am. J. Respir. Crit. Care Med. 2005; 171:987-94). The emotional trauma of an ICU admission on next of kin thus

presents a compelling reason to improve the quality of an ICU death.

In a recent randomized trial, a simple intervention (a schema for conducting a family meeting and a brochure about what to expect from dying) reduced rates of posttraumatic stress symptoms, depression, and anxiety in grieving family members (N. Engl. J. Med. 2007;356:469-78). Improving post-ICU death outcomes, which has the potential to significantly benefit the family, is a new outcomes paradigm for critical care medicine.



BY TOMER T. LEVIN, M.B.B.S.

► **Institutional outcomes.** The idea that so-called “soft” psychosocial interventions can reduce ICU length of stay is

quite remarkable. In the 2008 study cited above of a multifaceted ICU intervention, ICU length of stay fell from a median of 7.2 days to 5.8 days. In a recent study, only 31% of patients with advanced cancer reported end-of-life discussions with their oncologists. Health-care costs in the last week of life for patients who had discussed end-of-life care were 36% lower than for those who had not discussed end-of-life care. Survival was identical in both groups (Arch. Intern. Med. 2009;169:480-8). Thus, better end-of-life communication saves health dollars because people make better treatment choices.

Communication skills are seen as core competencies by the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, and the National Board of Medical Examiners. Simulation training in communication skills has been adopted by centers such as the University of Pittsburgh, Children’s Hospital Boston, Temple University, Northwestern University, and Children’s National Medical Center.

Cancer communication is, by nature, emotionally saturated, especially in regards to discussing dying. Most of us, given the choice, will avoid it. Recognizing this, Memorial Sloan-Kettering Cancer Center has developed the Communication Skills Research and Training Laboratory (Comskil Lab), the only dedicated communication training facility at a comprehensive cancer center. The ICU modules focus on family communication rather than the traditional doctor-patient model, because most ICU patients are incapacitated. Actors portray family members. Before and after the training sessions, skill levels are assessed using a 12-minute standardized assessment that is videotaped and scored.

Simulations address points in the dying trajectory, including the transition from curative to palliative goals, discussions about “do not resuscitate” orders, and withdrawal of life-extending treatments. A didactic program provides an evidence-based framework, and demonstration videos model proper communication techniques. The steepest part of

the learning curve comes from role-play, because training at this point is individualized to meet the physician’s deficits. Video-assisted feedback allows for recognition of inefficient techniques, reflection, and practice of better strategies.

A typical skill that a physician might work on is empathic communication. Overwhelming emotions such as distress or sadness make it more difficult for a family member to process the medical data required for informed decision making. Critical care medicine trainees learn to address these emotions first, prior to moving forward in the conversation.

There are many ways to ameliorate emotions, such as normalization (“It is normal to be upset

...”) and paraphrasing and repeating back (“So, what you are saying is that ...”), but critical care physicians seem to find silence or listening difficult. Silence represents understanding and sharing in the pain of suffering. Video feedback can demonstrate the value of timely silence. Physicians who tend to lecture patients or families are often not aware of this until they view themselves on video feedback. Doctors who talk less and listen more are perceived as being more empathic.

Communication training often addresses double-talk—physicians saying one thing when they mean another. For example, discomfort talking directly about dying often drives physicians to use metaphors. “Would you like everything done?” is actually an attempt to say, “If you were close to death, we physicians would like to avoid futile resuscitation.”

The problem is that patients and families understand “everything” to mean a comprehensive approach. The opposite of “everything” is understood to be a halfhearted approach. Communication training can unpack the metaphor “everything,” clarifying the real underlying issue, that CPR in dying cancer patients has almost zero efficacy.

“Heroic measures” is another metaphor for futile CPR that is understood in divergent ways. Would you prefer physicians to use “heroics” or the opposite, “cowardly” measures? I would select heroic measures—it reminds me of the movie “Saving Private Ryan.” But the real issue is physician discomfort discussing futile CPR and dying. Communication training helps physicians add better lines to their end-of-life communication scripts, to more accurately reflect their good intent.

I was shocked recently when training a group of Eastern European palliative care physicians. One broke down in tears during role-play—he had never told a patient that he or she was dying. “Truth telling” is an old story in the West, so imagine my dismay when, a week later,

I heard of a ventilated, brain-dead patient being kept alive for weeks at a top U.S. hospital. Earlier communication would have helped the patient and family find their respective peace.

The physicians involved in this case were competent and caring, yet they found it difficult to initiate a conversation about withdrawal of life-extending treatment. A desire not to disappoint the family, fears of litigation, a communication skill deficit, or cultural divergence may have impeded communication. Nevertheless, earlier initiation of this painful negotiation would have helped the patient and family find peace.

The need for ICU communication training

is ubiquitous, even in the most prestigious medical institutions, because discussing death is intrinsically difficult, even among kind-hearted, experienced critical care physicians.

Although it seems obvious that communication training would be beneficial in the ICU setting, the challenge remains to demonstrate that improved skills lead to better clinical outcomes. Currently, critical care medicine communication training is at an early, but exciting, stage of development. ■

DR. LEVIN is an assistant professor in the Department of Psychiatry and Behavioral Sciences, Memorial Sloan-Kettering Cancer Center, and the Weill Cornell Medical College, New York, where he conducts communication skill training and research that focuses on the ICU.

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