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# Goals of Care in the ICU
# Palliative Care at the End of Life

More than half of the 2 million deaths in the United States each year take place in hospitals, nearly half of those (an estimated 500,000) in intensive care units (ICUs).[1] Data suggest that an even higher percentage of the 600,000 veterans who die annually die in ICUs.[2] Quality of ICU-based care at the end of life and attendant ethical issues thus loom large as concerns for patients, families, and health care professionals in VA.

## Palliative Care in the ICU

In addition to familiar questions of patient autonomy, decision-making capacity, and surrogate decision making, one of the most significant ethical challenges in ICU care for patients at the end of life is assuring that they receive appropriate, timely palliative care. The World Health Organization defines palliative care as a holistic approach that "improves the quality of life of patients and families facing ... life-threatening illness through the prevention and treatment of pain and other problems, physical, psychosocial and spiritual."[3]

Providing good palliative care requires more than technical skill; it depends on knowing the patient's preferences and goals for treatment. Too often, however, end-of-life care in the ICU is compromised by inadequate discussion with patients and families about their preferences and goals for medical therapy and palliative care. It can also be compromised by failure to assure that all clinicians providing care for the patient understand how those preferences and goals should shape the plan of care.

In the ICU, the urgency of therapy and attendant pressure to make decisions rapidly intensifies the need to clarify the patient's goals early on and discuss his or her preferences for treatment proactively. Opening that conversation early in the patient's ICU stay not only respects the autonomy of both patient and family; it can also help to minimize possible conflict as the patient's situation changes and new decisions must be made about care.[4]

### Defining Goals of Care in the ICU

*What are the patient's underlying conditions, recent history, functional status, and quality of life?*

*What conditions require ICU care and what are possible and most likely outcomes with ICU treatment?*

*What are the patient's and family's hopes and expectations for ICU care?*

*What symptoms are the patient and family most concerned about?*

*Who will assist in decision making?*

*Has the patient and/or family expressed preferences or goals for care?*

*What are the burdens associated with therapy and the anticipated benefit?*

*What are the specific, time-delimited, short-term therapeutic goals that can clarify the clinical trajectory?*

*What is the plan for palliative care?*

*When and how will the plan of care be reviewed?*

Adapted from Mularski and Osborne 2004a.[5]

## Defining Goals of Care in the ICU

Not many patients and families have ready opinions about goals for ICU therapy at the outset, beyond hoping for an outcome that offers as much life and as high a quality of life as possible. And in the ICU, clinicians who have not had the opportunity to interact with the patient over time must often engage in emergent discussions of preferences for care.

Before admitting a patient to the ICU clinicians should clarify the patient's medical condition, identify those illnesses or conditions that treatment in the ICU might improve and determine what the foreseeable outcomes of ICU treatment would be for the patient, and

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explore what is known about the patient's preferences. Using a checklist can help clinicians identify and document preferences for care, identify symptoms in need of palliation, establish a plan of care, and coordinate re-evaluation and ongoing discussion to clarify goals and respond appropriately as the patient's clinical condition changes.[4,5]

When acute illness requires intensive therapy, most people accept a compromise between comfort and the chance to regain health. As disease progresses, organ systems fail, and prognosis for recovery dims, patients and families will begin to contemplate preferences for end-of-life care more intensively. The challenge for clinicians is to explore these possibilities through ongoing dialogues in advance of physiological failure. A skilled clinician should provide aggressive therapy as appropriate—with due attention to meliorating symptoms and side effects—in hopes of aiding a recovery while at the same time anticipating the possibility of disease progression and needs for end-of-life palliative care.

## Meeting Goals of Care in the ICU

By helping patients and families clarify immediate and longer term goals, clinicians can help them understand more clearly that ICU care ranges from aggressive interventions to comfort care. It can also help them to better appreciate that different kinds or levels of care may be appropriate over the patient's ICU course.

Setting objective, short-term goals with clear clinical markers helps the patient, family, and treating clinicians understand the patient's trajectory and changing needs. Establishing a consistent process for regularly re-assessing and clarifying goals in light of clinical changes helps to assure appropriate care and effective communication between patient, family, and caregivers, as well as among clinicians.[5,6]

Quality palliative and end-of-life care in the ICU is an ethical imperative. Initiating early discussion about patient preferences and palliative needs and structured daily reassessment is an approach that promotes excellent palliative care simultaneously with curative and life-sustaining therapies in the ICU.

### Meeting Goals of Care in the ICU

*Are specific criteria toward medical goals being met?*

*Are there clinical changes that will affect the ability to meet desired goals?*

*Are the patient's physical symptoms being adequately palliated?*

*Are the patient's and family's psychosocial and cultural needs being addressed?*

*Do the patient and family understand the diagnosis, prognosis, and possible outcomes?*

*Has new information or perspectives emerged to help clarify the patient's goals and preferences?*

*What are the implications for the plan of care—what will be done today and what will be integral for the next day's assessment?*

Adapted from Mularski and Osborne 2004b.[6]

## References & Resources


1. Angus DC, Barnato AE, Linde-Zwirbe WT, et al. Use of intensive care that the end of life in the United States: an epidemiological study. *Critical Care Medicine* 2004;32:638–43.

2. Veterans Health Administration, Office of Academic Affliliations, Geriatrics and Extended Care, Strategic Healthcare Group. Creating and expanding hospice and palliative care programs in VA.

3. World Health Organization, *WHO Definition of Palliative Care*.

4. Mularski RA, Bascom P, Osborne ML. Educational agendas for interdisciplinary end-of-life curricula. *Critical Care Medicine* 2001;29(2Suppl.):N16–23.

5. Mularski RA, Osborne ML. Fast Fact and Concept #122: Palliative Care and ICU Care: Pre-admission assessment. End-of-Life Physician Resource Center (EPERC). Posted September 29, 2004.

6. Mularski RA, Osborne ML. Fast Fact and Concept #123: Palliative Care and ICU Care: Daily ICU care plan checklist. End-of-Life Physician Resource Center (EPERC). Posted October 7, 2004.


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