

LETTER



Will your patient benefit from palliative care? A multicenter exploratory survey about the acceptance of trigger factors for palliative care consultations among ICU physicians

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Dear Editor,

We read with great interest the publication by Mathews and Nelson about the predicted value of palliative care in the intensive care unit (ICU) of 2050 [1]. The authors emphasize the importance of developing standardized trigger factors for a palliative care consultation in intensive care patients. Several trigger factors have already been published ([2–4] and references in Electronic Supplement 1), all of which are recommended by experts or expert panels for use with ICU patients. However, from our experience, trigger factors for palliative care consultations are not systematically used in ICU daily routine. Therefore, we wonder whether those triggers are widely accepted among practicing ICU physicians. To date, only one study has tested acceptance of trigger factors among a large group of ICU clinicians. The study group consisted of physicians, nurses and other care professionals [5]. Of note, critical care consultations are usually initiated by physicians. Thus, it is crucial to establish trigger factors which are accepted by ICU physicians.

Our aim is to support the development of guidelines for the standardized initiation of specialized palliative care. For this purpose, we conducted a study investigating the

acceptance and use of palliative care consultations among young German ICU physicians. We used a self-developed questionnaire (for further details, see Electronic Supplemental Material 2 and 3). Inclusion criteria for physicians were ICU experience for more than 1 month and access to palliative care consultations. We defined a trigger factor as accepted with a 95% confidential interval above 50%.

We distributed 1219 questionnaires to German ICU physicians from September 2016 to February 2017. Of these, 784 (64.3%) were returned, among which 283 fulfilled the inclusion criteria. The selection of the study population is shown in a flow chart in Electronic Supplemental Material 4. Most physicians treated patients with palliative needs often (73.0%), but only a minority felt confident in doing so (39.0%). Only six of 24 trigger factors were broadly accepted: patient request (94.2% acceptance), family request for a palliative care consultation (92.0%), no curative options available (71.8%), high and non-manageable symptom burden (68.5%), carcinoma or unresectable malignancy (66.5%) and curative options rejected by the patient (63.4%). The acceptance rates for all trigger factors are shown in Fig. 1. The majority of trigger factors were not accepted by ICU physicians, even though most of them were previously described in the literature as valid for ICUs [2–4]. We wonder how such a discrepancy between literature knowledge and clinical practice can be resolved.

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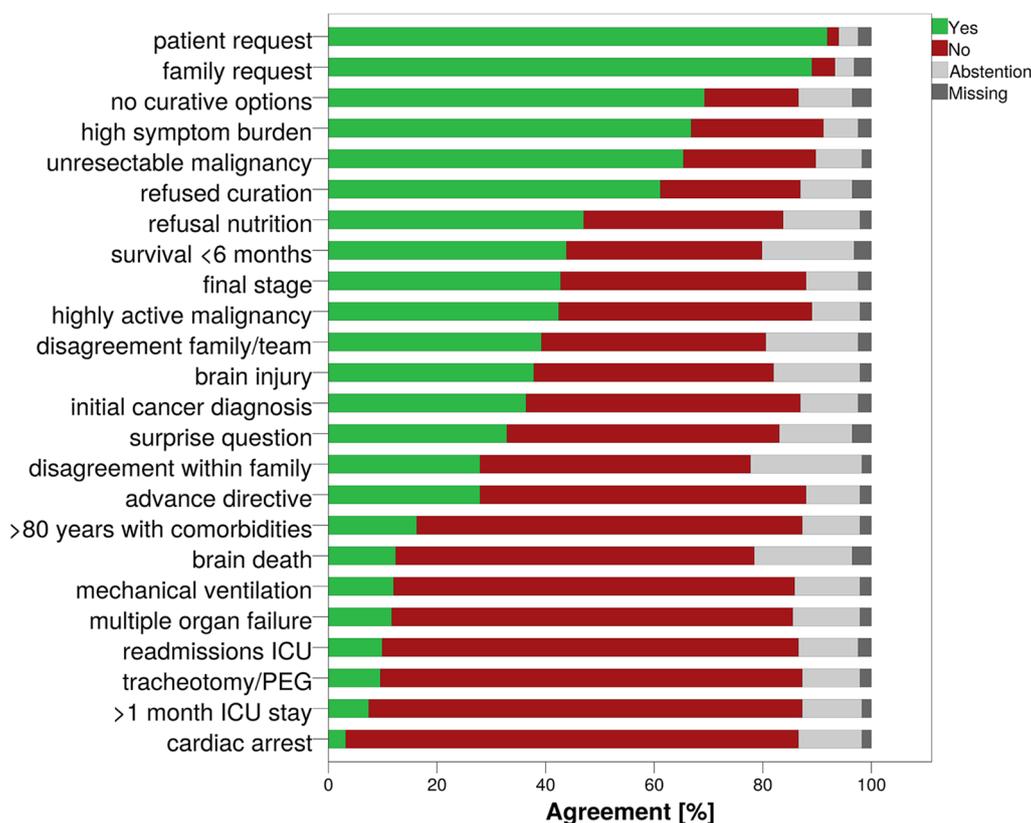


Fig. 1 Answers to all offered trigger factors. Triggers are shown in order of their acceptance ($n = 283$). Trigger factors in this figure are shown abbreviated. The full definitions are as follows: patient request for a palliative care consultation, family request for a palliative care consultation, no curative options available, high and non-manageable symptom burden, carcinomatosis or unresectable malignancy, curative options rejected by the patient, hastened death by self-denial of food and drink (refusal nutrition), median survival prognosis < 6 months, patient is dying (final stage), highly active malignancy, disagreement between family and medical team about the therapeutic aim > 7 days, severe brain injury/vegetative state, initial diagnosis of an incurable cancer, patient's death within the ICU stay would be no surprise (surprise question), disagreement within family about the therapeutic aim > 7 days, advance directive authorizing withdrawal of care, age > 80 years with two or more comorbidities, brain death, intracerebral hemorrhage requiring mechanical ventilation, multiple organ failure > 3 organ systems, > 3 ICU admissions during same hospital stay, tracheotomy/PEG after traumatic brain injury, ICU stay > 1 month, and cardiac arrest. *ICU* intensive care unit, *PEG* percutaneous endoscopic gastrostomy

In conclusion, the six widely accepted triggers can be used in clinical routine to identify ICU patients with palliative needs. Although acceptance of triggers may vary by country or region, our findings suggest potential value in regular screening of patients with the help of the six accepted trigger factors in this study to reveal unmet palliative needs.

Electronic supplementary material

The online version of this article (<https://doi.org/10.1007/s00134-018-5461-9>) contains supplementary material, which is available to authorized users.

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Compliance with ethical standards

Conflicts of interest

The authors declare that they have no conflict of interest.

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