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Opinion Article

Palliative Care Services in the Intensive Care Unit

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DESCRIPTION

On the surface, palliative medicine and intensive care seem to have little in common. The Intensive Care Unit (ICU uses the latest innovations and skills to lift critically ill patients from the brink of death. In contrast, palliative care tends to minimize painful interventions in individuals that are the expected and accepted consequences of death. However, an increasing proportion of patients admitted to the ICU die after discontinuation of aggressive treatment, and for these patients attention to symptom control, psychological support to the family, and staff support is paramount. It will be an intervention. These aspects of care can be provided through close integration with existing palliative care services or by incorporating palliative care skills into critical care education. This paper outlines current practices for end-of-life care in the ICU and proposes an integrated model between the ICU and the palliative care and critical care outreach teams. Some patients admitted to the intensive care unit may be exposed to an incurable condition that is usually fatal. Knowledge of palliative care is highly recommended for healthcare providers who care for these patients. Patients often do not benefit from the introduction of further treatment and should be evaluated daily. Discussions between medical team members related to prognosis and treatment goals should be carefully evaluated in collaboration with patients and their families. Adoption of protocols related to end-of-life patients in the ICU is fundamental. Cross-disciplinary teams are important in determining whether extended care withdrawal or withholding is necessary. In addition, patients and relatives should be informed that palliative care includes best care for their situation, respect for their wishes, and consideration of social and psychological backgrounds.

The purpose of intensive care medicine is to reduce the mortality rate of patients with severe and serious illness and to maintain important functions to prevent morbidity. Despite the development of new technologies and improved care, intensive care unit (ICU) mortality rates are still high, depending on the geographic region, but range from 20%-35%. Mortality was higher in high- and middle-income countries than in ICUs in low- and middle-income countries and low- and middle-income or high-income countries. In recent years, hospitalizations in the intensive care unit for the last months of life have increased by up to 30%. If a serious illness, organ dysfunction, fails to respond to treatment and fails to meet treatment goals, or is no longer proportional to the expected life-sustaining prognosis, ICU physicians need to ensure acceptable death. There are. If life-sustaining therapy fails to meet the patient's goals, or if it turns out to be more burdensome than paradoxically beneficial, discontinuation and withholding of therapy is common among emergency physicians. Dying patients generally lack the ability to make decisions. Often this is a medical team decision, but if enhanced instructions are available, need to guide the decision-making process. This process is complex and can be emotionally exhausting. Medical training as part of the training of medical graduates and graduates can provide orientation and support. In addition, there are concerns about polypharmacy complications, lack of realistic overview, lack of attention to quality of life, and communication with loved ones. However, it is often difficult for doctors to start proper conversations with the patient's relatives. Thus, ICU clinicians require knowledge and competence on the many aspects of withholding/withdrawing interventions and, in general, on end of life supports, including adoption of some treatment limiting the suffering, good communication with relatives, and how to afford some ethical issues. The use of sedatives, analgesics, and other non-pharmacological methods, and to support decision-making processes, including autonomy, identification, and surrogacy, is proactive. It is most important even during the period of treatment. In addition, being in the ICU is also an unpleasant experience. Many of the common symptoms of palliative medicine, such as pain, thirst, anxiety, sleep disorders, and shortness of breath, are common in critically ill patients. These symptoms persist after leaving the ICU and can cause post-ICU syndrome with cognitive, psychiatric, and physical consequences. Perhaps emergency physicians need to anticipate this approach to alleviate these problems. The patient's family may experience psychological and physical stress such as depression, anxiety, anxiety, malaise, loss of appetite, and early

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post-traumatic stress symptoms, and the persistence of post-ICU symptoms it can cause "post-ICU syndrome" in the bereaved family. Finally, ICU clinicians are at risk of psychological and psychological distress when faced with these situations.

Palliative care professionals have traditionally been involved in the issue of end-of-life care. Palliative care is patient- and family-centric care that predicts, prevents, and treats distress, regardless of age, diagnosis, or prognosis, and provides comprehensive care to patients with end-stage disease. The former is considered "speaking medicine" and the latter is considered "technical medicine". However, treatments have something in common, as both areas can overlap in a virtuous circle to provide the best benefit to ICU patients. As the fusion of approach and culture begins to look natural and the opportunities for collaboration are consistent, this overview explores some points about the obvious contradiction between ICU and palliative care.

Palliative care assesses and treats a patient's symptoms, provides psychosocial support to the patient and family identifies the patient's personal goals and integrates them into health care. Over the last two decades, intervention studies have sought ways to better provide palliative care and critical care, including involving palliative care professionals and assisting critical care centers in providing primary palliative care. While these studies suggest the benefits of palliative care, the most effective and efficient ways to achieve these benefits are not yet clear. A statement from the Critical Care Society calls for ICU clinicians to provide primary palliative care and, if necessary, specialized palliative care. Existing educational tools and resources enable ICU providers to improve their knowledge and skills in palliative care. Future research is needed to better determine the best way to provide palliative care to critically ill patients and their families, both inside and outside the ICU.