The term “supportive care” is preferable to “palliative care” for consults in the cardiothoracic intensive care unit

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An increasing number of cardiothoracic (CT) surgical patients require prolonged critical care. Several factors are responsible. Patients currently tend to be older and to have more associated conditions. Complex and reoperative procedures are more common and include open chest protocols for coagulopathies and edema. There is widespread use of mechanical support devices that provide prolonged circulatory and respiratory support. This technology includes ventricular assist devices and extracorporeal membrane oxygenation.¹

As part of the response to the challenges of caring for severely ill patients who are close to death or on maximal mechanical support, medical centers have created support teams. These “supportive” care teams address the complex psychologic, ethical, and financial issues that patients and families are experiencing. The teams may include psychologists, social workers, and religious leaders, as well as physicians trained in providing communication support during end-of-life care. The teams have unfortunately been termed “palliative care” teams by some centers.² This term conflicts with the basic goal of CT surgery, which is to restore the patient to a meaningful life outside the hospital. The patient has been offered the surgery with the potential for recovery from the clinical condition that led to the patient’s hospital admission. The term “palliative” sends a negative message. However, the surgeon’s perspective may be too optimistic and unrealistic. Members of the “supportive care” team can provide a balanced perspective to a patient’s family and health care providers, and provide support if “end-of-life care” is instituted. This latter role is the same as that of “palliative care” teams in hospitals when patients with cancer and stroke have a dismal prognosis with no chance for recovery.

McKenna and Clark³ addressed this discordance in terminology in relation to cardiopulmonary transplant recipients. They emphasized that the term “palliative care” creates the misperception among patients, their families, and transplant clinicians that the consult is for “end-of-life care.” This contrasts with the role of cardiopulmonary transplantation as a life-prolonging therapy.

Patient receiving extracorporeal membrane oxygenation and renal replacement therapy after cardiac surgery.

Central Message

A consult for “supportive care” is preferable to one for “palliative care,” because it provides the patient, the family, and the providers with a balanced focus on the potential for recovery.

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It is appropriate for health care providers in the CT intensive care unit (ICU) to request consultation with a team that can provide support to the patient and the patient’s family during this very stressful time. Such “supportive care” teams can supplement care by CT ICU staff and provide additional counseling regarding psychologic issues, social services, religious issues, and financial matters. Recent emphasis on participation of patients together with their families during critical care rounds fits well with the role of a supportive care team in the CT ICU.

With the increasing expertise of critical care professionals to manage complex conditions, including multisystem failure, survival to a meaningful life outside the hospital is now possible, when previously it was not thought to be. The time for recovery may extend to weeks and even months; however, achievement of the ultimate goal of the CT surgery to return the patient to a meaningful life is now possible. Remarkable recoveries have been well documented, such as recovery from refractory postsurgical cardiogenic shock to a New York Heart Association Class I and II functional status.⁴

The overall goal of the CT surgery and the postoperative care then is recovery, and not palliation. However, despite optimal care, the patient’s clinical situation may be unresponsive to intensive measures with a downward course and no chance for recovery. Supportive care teams in this case need to provide counseling to families and care providers, and guidance for “end-of-life” care. The term “supportive

care” is the appropriate term for both situations and reflects the supportive needs of patients and their families. A benefit of the term “supportive care team” is that it may lead CT surgeons to request such a consult when they might otherwise not do so, concerned that the term “palliative care” sends a negative message to patients and their families.

Conflict of Interest Statement

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