We write to advocate for the introduction of palliative care principles and services into Taiwanese intensive care practice.

Palliative care practice in Taiwan has been pioneered by oncologists and nursing specialists with the support of religious foundations, such as the Buddhist Lotus Hospice Foundation, the Catholic Sanipax Social-Medical Service and Education Foundation, and the Hospice Foundation of Taiwan. The latter foundation has convened a hospice committee since the 1980s. As cancer is the leading cause of death in Taiwan, the pioneers in palliative care principally engaged in applying these concepts to the care of patients who were in the terminal stage of their cancer. In 1993, the first education center was established by the Hospice Foundation of Taiwan to organize a standard curriculum and training program in palliative care nationwide for clinicians, social workers, and chaplains. By 2007, this had led to the establishment of 556 palliative care beds in 35 hospitals, each with a consultation care team, 52 hospice home care teams, and 16 teaching hospitals accredited for palliative care training. This development of palliative care in Taiwan has considerably advanced the quality of end-of-life cancer care for both patients and their families.

Those who die of diseases other than cancer, however, have not benefited from these advances in palliative care. Many of these patients spend their last days in an intensive care unit (ICU). Despite this, there has been little interchange between the disciplines of palliative and intensive care in Taiwan. Up to now, there have only been three half-day education programs for experienced clinicians in emergency, critical care and palliative medicine in 2006, and one conference poster presented at the 7th Asia Pacific Hospice Conference in 2007 with the title, "The promotion of hospice palliative medicine in the emergency and critical care unit in Taiwan". No articles from Taiwan on this topic have been published in the last 5 years.

But why should palliative care have any involvement in intensive care practice? Although this has been advocated previously, especially in North America, such involvement would be quite new in the Taiwanese critical care environment. The ultimate goal of management in the ICU is the cure of critically ill patients,
and the initial emphasis for the patient, the relatives and the staff is on survival. However, despite the dedication of staff and the most sophisticated therapies, many of these patients will die. Many of these deaths are more or less predictable on admission; some patients have chronic conditions in which the intensive care admission may signal the terminal phase of their illness, while others are admitted with major prognostic uncertainties. Thus, when people are admitted to the ICU, death is a possibility and often a reality. Our duty as clinicians is to care for all our patients and their relatives whether cure is available or not. Clinicians are committed to never abandon their patients, to care for them, to relieve their suffering, to stay with them to death, and to care for the family and relatives through the person’s illness, death and beyond. Caring for patients means that cure and palliative care are not mutually exclusive; when cure is not possible, treatment should not be any less vigorous but should be directed to relief of suffering and maximizing quality of life. If death is inevitable, the person should be cared for physically, psychologically and spiritually. Such principles are articulated well within the practice of palliative care. However, cultural elements fundamentally shape attitudes to and the conduct of end-of-life care. ICU clinicians in Taiwan, therefore, need to develop a culturally appropriate model for the end-of-life care of critically ill patients.

In view of the little communication and connection between palliative and intensive care in Taiwan presently, we suggest the following to develop this connection:

1. Education and training of ICU staff in palliative care should apply to all medical and nursing staff with regular training sessions, including role playing sessions on communication skills with families.
2. Initially, all patients admitted to the ICU with a high probability of death should have a palliative care consultation.
3. The palliative care team should include key designated ICU staff in the consultation. These key staff would develop expertise in palliative care over time and eventually take over this role and only use the palliative care team in a supervisory role.
4. These designated ICU staff should also, if possible, participate in palliative care outside the ICU.
5. Critical/palliative care staff would be expected to conduct ongoing evaluation and research to understand the life experience of patients and their families and their cultural preferences for end-of-life care, and eventually to formulate guidelines for Taiwan.

We suggest that such a program would, over time, integrate palliative care principles into intensive care practice and would serve the unique needs of patients in Taiwan.

References

1. Hwang SF, Chang CF, Lai YL, Huang CH. Hospice palliative care in Taiwan: adding to the complete global mapping. The 7th Asia Pacific Hospice Conference, Philippines, September 27–29, 2007; 123.
2. Chen YR, Chang CF, Chen SD, Huang SJ, Lai YL, Huang CH. The promotion of hospice palliative medicine in the emergency and critical care unit in Taiwan. The 7th Asia Pacific Hospice Conference, Philippines, September 27–29, 2007; 119.