

## SCIENTIFIC LETTER



# Post-intensive care syndrome: why multidisciplinary care is not enough?

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Dear Editor,

Survival after critical illness has improved markedly over recent decades. For many patients, however, discharge from the intensive care unit (ICU) does not signify recovery but rather the onset of a prolonged and frequently disabling course. This disabling trajectory is characterised by physical, cognitive, psychological and social impairments, collectively referred to as post-intensive care syndrome (PICS) [1]. These sequelae, reported in up to 50–70% of ICU survivors, profoundly affect quality of life, functional autonomy and social reintegration, challenging the traditional focus of critical care on short-term survival alone. In addition, the experience of critical illness often affects relatives, who may develop psychological distress collectively referred to as PICS-Family. The well-being of relatives may in turn influence the patient's recovery trajectory and capacity for reintegration after ICU discharge.

In response, multidisciplinary models of post-ICU care have progressively emerged. In many centres, dedicated follow-up clinics—most often initiated, coordinated and led by members of ICU teams—bring together ICU physicians and allied health professionals to address the multiple dimensions of recovery after critical illness. This approach represents an essential and commendable step forward. By acknowledging PICS as a multidimensional condition and by organising structured post-ICU assessments, these programmes have contributed to improved recognition of long-term morbidity and patient needs.

However, multidisciplinary care alone is probably insufficient. While multidisciplinary care brings together

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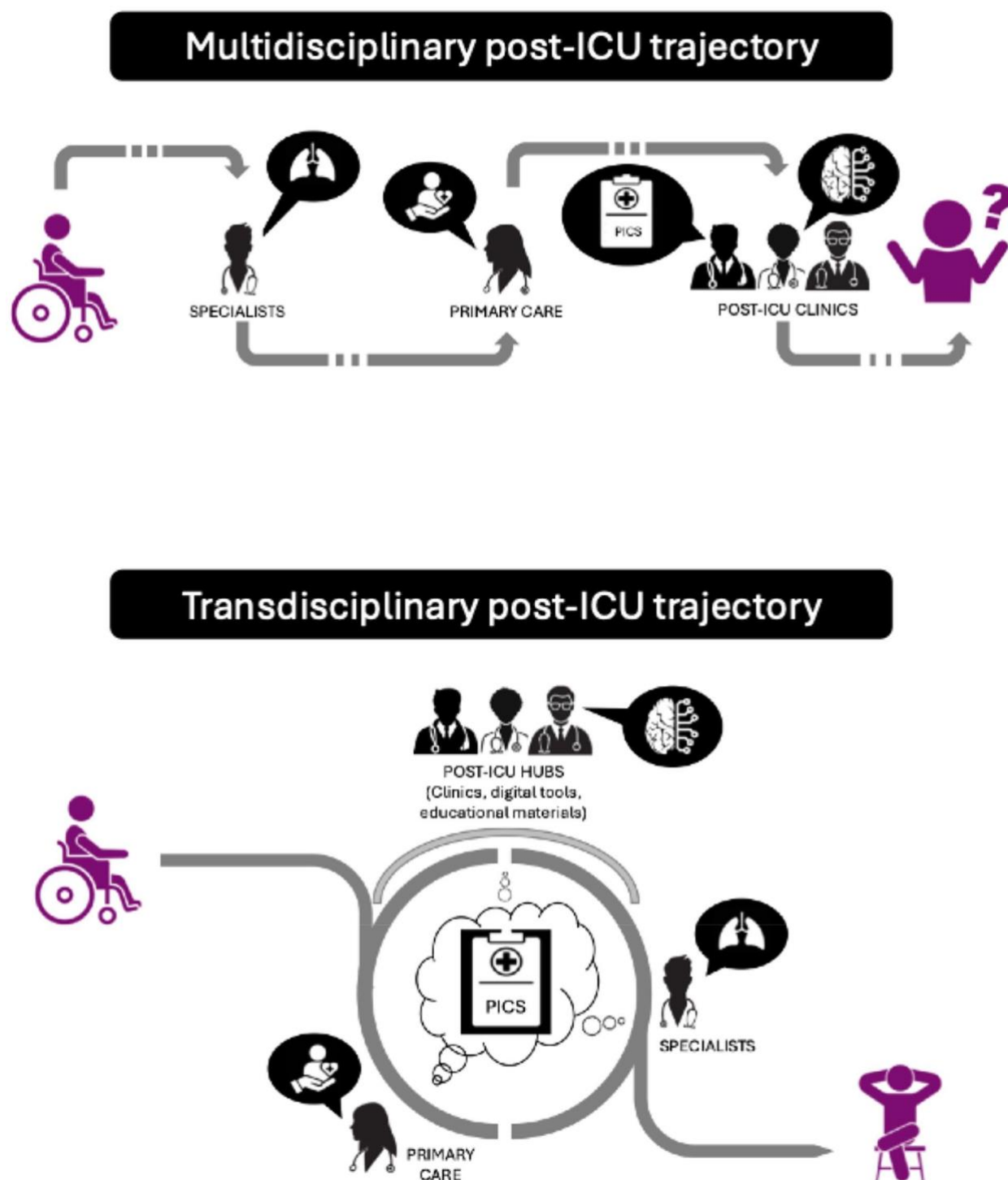
professionals with complementary expertise, it often operates within parallel, discipline-specific silos rather than through truly integrated care. When confined to post-ICU follow-up teams, this model remains largely disconnected from the broader healthcare system in which ICU survivors ultimately evolve. Beyond specialised clinics, most patients are managed primarily by general practitioners and organ-based specialists, who are the main actors in long-term care. Yet, the conceptual framework of PICS rarely extends to these settings.

Outside the ICU, PICS is frequently encountered but often remains unnamed or even undiagnosed (Fig. 1). Primary care physicians and specialists routinely manage symptoms commonly associated with survivorship after critical illness, such as dyspnoea, exercise intolerance, fatigue, cognitive complaints, anxiety, depression or functional decline. These manifestations are typically addressed through organ-specific or problem-based approaches, but without being integrated into a unifying understanding of the patient's global condition as an ICU survivor. As a result, PICS does not meaningfully shape the overall vision of the patient's health status or long-term trajectory. Symptoms are treated in isolation, but the syndrome itself seldom shapes clinical reasoning.

This gap exposes the limitations of multidisciplinary care and underscores the need for a transdisciplinary approach [2]. Collaboration across disciplines has been described as a continuum ranging from multidisciplinary (parallel contributions), to interdisciplinary (interactive collaboration), and ultimately transdisciplinary approaches that integrate perspectives within a shared framework to address complex problems [3]. Transdisciplinary care

refers to a model in which professionals from different disciplines work within a shared framework to jointly interpret patients' problems and develop coordinated care

plans, rather than contributing parallel discipline-specific assessments. It is not about collecting input



**Fig. 1** Differences between a current multidisciplinary and an ideal transdisciplinary post-ICU trajectory. The upper panel represents the current multidisciplinary trajectory, in which different disciplines contribute sequentially or in parallel but often remain loosely connected across care settings, with PICS only inconsistently recognised as a unifying framework. The lower panel illustrates the proposed transdisciplinary trajectory, where PICS serves as a shared conceptual framework allowing continuous integration of perspectives from the ICU, postICU hubs, specialists and primary care. *ICU* intensive care unit, *PICS* post-intensive care syndrome

from different experts; it is about integrating perspectives together so that new, shared approaches emerge. It also acknowledges the existence of different levels of reality—biological, psychological, social and experiential—each governed by distinct logics, none of which can fully account for the patient's condition in isolation. Instead of pursuing mastery across disciplines, transdisciplinary care fosters openness between them, enabling engagement with what cuts across, connects, and ultimately transcends disciplinary boundaries. In doing so, it offers a renewed understanding of health and illness that is particularly well-suited to complex survivorship conditions such as PICS. Although direct evidence demonstrating the superiority of transdisciplinary models remains limited, promising results have been reported in other areas of medicine. For instance, collaborative care models in mental health integrate primary care physicians, care managers and psychiatric specialists within a shared framework and have been associated with improved outcomes compared with usual care (Collaborative Care model, CoCM). However, evidence demonstrating that transdisciplinary approaches improve clinical, functional or quality-of-life outcomes after critical illness remains limited. At present, the transition from multidisciplinary to transdisciplinary collaboration should thus be seen as a conceptual proposal rather than an empirically validated model of care. Nevertheless, by placing PICS at the centre of a shared conceptual framework across disciplines and care settings, transdisciplinarity may offer a useful perspective to address the persistent fragmentation of post-ICU care pathways and to stimulate future research on survivorship after critical illness.

When PICS is not recognised as a shared condition across the continuum of care, the consequences are substantial. Care becomes fragmented across specialties, therapeutic strategies may lack coherence, and opportunities for coordinated rehabilitation and psychosocial support are frequently missed [4]. Rather than competing with specialist management, a transdisciplinary approach offers an additional, integrative perspective on the patient's global condition as an ICU survivor [3], allowing for enriching clinical interpretation, supporting decisionmaking, and prioritising interventions (Fig. 1).

Several structural factors currently hinder this transition. Communication between ICU teams and downstream providers remains limited, responsibility for post-ICU follow-up is often unclear, and time constraints limit coordination. Formal training on survivorship after critical illness is scarce, and even within ICUs, discussions about long-term outcomes and PICS remain inconsistent, limiting patient understanding and continuity of care. Without a shared language and explicit framework, coordination

across settings is unlikely to occur spontaneously. A more fundamental challenge may lie in the conceptual status of PICS itself. Although widely used in the critical care literature, PICS is not currently recognised as a formal diagnostic entity in international classification systems, which may partly explain the difficulties in structuring referral pathways and coordinated follow-up care.

Addressing these challenges requires pragmatic and deliberate actions [5]. First, education is central: awareness of PICS must extend beyond intensivists and be incorporated into training programmes for organbased specialists and primary care physicians. Second, communication tools matter. Explicitly naming PICS in discharge summaries, referral letters and specialist consultations can reconnect persistent symptoms to their underlying cause and facilitate coordinated care. Third, structured follow-up pathways, such as post-ICU clinics, should function as transdisciplinary hubs rather than isolated services, actively interfacing with both specialists and primary care (Fig. 1). Complementary strategies, including digital monitoring and support tools, may also help bridge the often fragmented transition between hospital discharge and community care and facilitate earlier identification of post-ICU recovery problems.

Ultimately, the challenge of PICS is not solely clinical, but cultural. It exposes the limits of siloed medicine when confronted with complex survivorship syndromes. Without a shift from multidisciplinary coexistence to true transdisciplinary collaboration—and without greater awareness among specialists—ICU survivors will continue to navigate fragmented care pathways. PICS should be recognised not as a complication confined to intensive care, but as a shared condition of survivorship, requiring shared responsibility across disciplines.

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