MUNI MED

Palliative Care and EOLD

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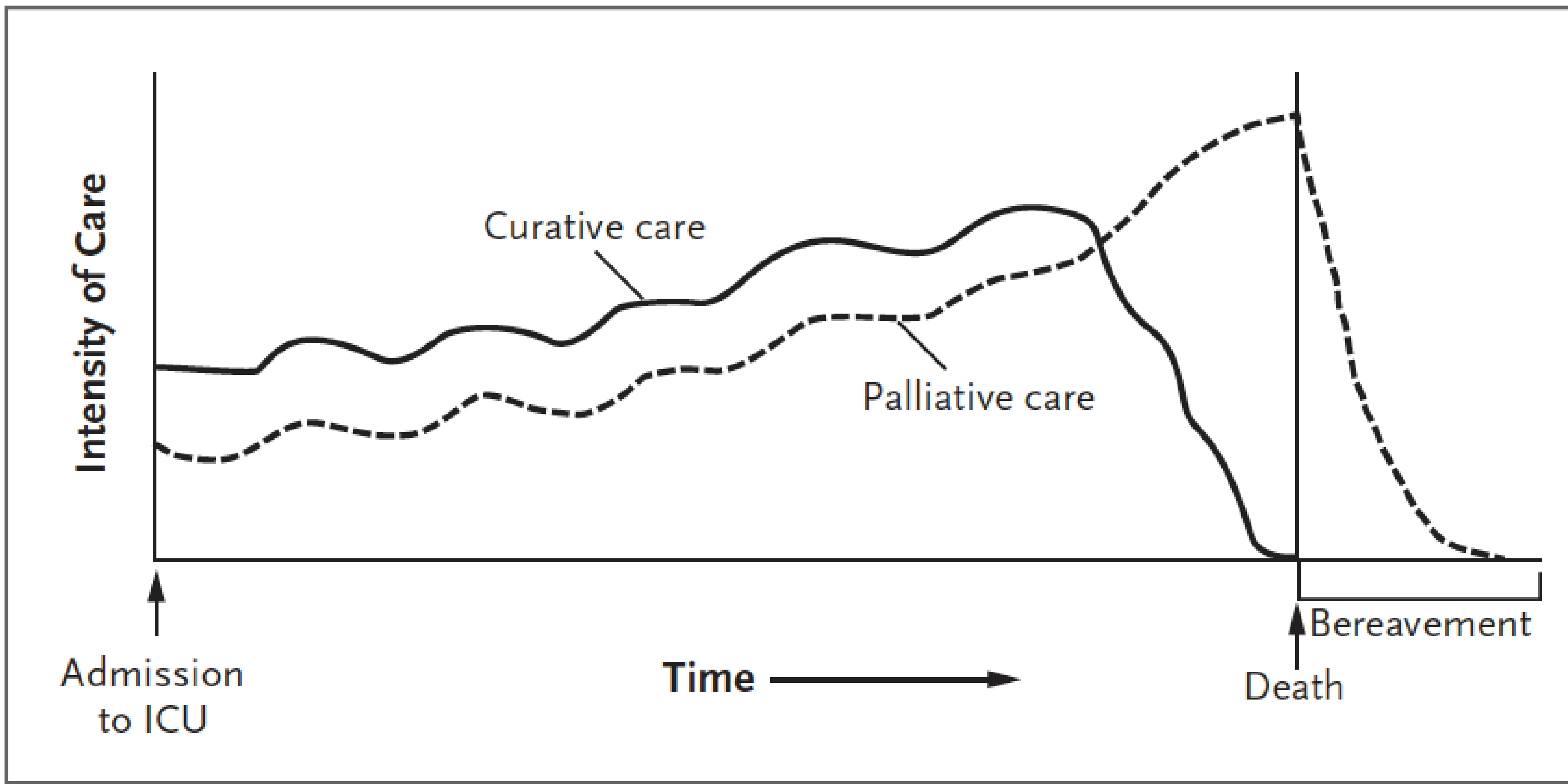
Learning Outcomes

The student will understand:

- Basic principles and goals of palliative care in the ICU
- Basic terminology in palliative care
- Basic ethical principles applied in the ICU
- Basic principles end-of-life decisions (EOLD)
- Withdrawing and withholding of organ support
- Basic principles of EOL care

Intensive and palliative care in the ICU

- **Goals of Intensive Care** – saving patients' life with accepted QoL
- *This goal is sometimes unrealistic– transition of care intensive/palliative*
- **Goals of Palliative Care in the ICU –** relief of suffering, improving of comfort and dying with dignity


Intensity of Care
Curative care
Palliative care
Bereavement
Admission
to ICU
Time
Death

Basic terminology in palliative care

- **Terminal disease–** illness or injury, in which applying medical care could not lead to restoring health

- **End-of-life -** short period before natural death occurs

Basic terminology in palliative care

- **Transition of Care**

- **Transition from cure to comfort**

- Change in goals in provided care
- Typically organ support is withheld or withdrew
- Goal is improve QoL and alleviating distress and suffering

Basic terminology in palliative care

LST – Life-Sustaining Treatment

Organ support that is indispensable for prolonging patient life without primary goal to cure the cause (primary disease)

Basic terminology in palliative care

- **Inappropriate organ support –** situation in which provided organ support is no longer in accordance with patient‘s values and probability of survival and QoL is very low
- **Limitation of Treatment - in the situation of inappropriate organ support:**
  - **Withhold of organ support**
  - **Withdraw of organ support**

Basic terminology in palliative care

- **DNR** *(Do Not Resuscitate) – we do not start CPR*
- **Palliative sedation** –using sedative drugs for controlling the symptoms (pain, dyspnoea) that are not controlled by using standard treatment

Basic terminology in palliative care

- **Active Dying** – time preceding the death with progressively declining of vital functions
- **Dying with dignity-** dying with respect to the basic determinant of dignity
- **Dysthanasia** – artificial prolonging of life using inappropriate organ support

Four ethical principles

- **Autonomy** – each person should be allowed to exercise his or her capacity for self-determination
- **Beneficence**– the obligation of physician to act for the benefit of the patient
- **Nonmaleficence** – the obligation of a physician not to harm the patient
- **Justice (distributive justice)**- the fair, equitable, and appropriate distribution of health-care resources

EOLD – when?

- Progressive organ dysfunction
- The treatment goals cannot be reached
- Approachable goals are not in concordance with patients values and wishes
- Probability of good QoL and survival is low

EOLD

- The age should not be factor for EOLD
- The most predictive factor of mortality is Frailty syndrome *(Clinical Frailty Scale)*
- Tem and multiple disciplinary approach
- There should be sufficient time for communication with the patient and his/her relatives

Surrogate decision making in EOLD

Advanced Directives

- Patient could express advanced consent or dissent with some procedures or organ support measures in future situation he/she will not be able to decide with full competency (coma). The specific form is specified by law of each country and should be written.

Czech Republic

- *Zákon o zdravotních službách (372/2011 Sb.,§ 36)*.

Surrogate decision making in EOLD

Health-Care Proxy or Surrogate Decision-Maker

Patient could choose proxy or surrogate for the case in which he will not be able to make competent decision. It is typically for the decision regarding healthcare provision.

Czech Republic

– *Zákon o zdravotních službách (372/2011 Sb.,§ 33 odst. 1+§ 34 odst. 7)*

Withhold and withdraw organ support - examples

- Artificial ventilation (AV)
- Intubation
- *CPR*
- *Vasopressors/inotropes*
- *RRT*
- *Abx*
- *Surgery*
- *Nutrition/fluids*
- *Diagnostics*

Withhold and withdraw organ support – How to prepare

- Precise preparedness
- Offer relatives to be present *(fully respect wishes of the relatives)*
- Slow weaning from AV *(prevent potential distress)*
- Respect comfort and dignity of the patient
- Record in documentation

Prepare staff members

- Review the planned procedures in detail with all relevant staff members.
- Ensure that the referring physician is aware of the plans, if not already engaged.
- Ensure that spiritual care services are offered, if not already engaged.
- Remind staff members that all their actions should ensure the dignity of the patient.
- Remind staff members that the patient and family are the unit of care.
- Prepare a staffing schedule to maximize the continuity of care during the dying process, if possible.
- Ensure that the bedside nurse has not been assigned to care for another acutely ill patient, if possible.
- Ensure that the bedside nurse is experienced in palliative care; if not, change the assignment or arrange for supervision to be provided by a nurse experienced in palliative care.
- Ensure that physicians are readily available and do not abandon the patient or family.
- Introduce the relevant housestaff members to the patient and family.
- Introduce the respiratory therapist to the patient and family, when applicable.
- Ensure that staff members minimize unnecessary noise immediately outside the room.

Prepare the patient's room

- Consider the comfort of the patient and family (e.g., lighting, temperature, personal items).
- Liberalize visiting restrictions (e.g., timing, duration, number of visitors).
- Remove unnecessary equipment.
- Bring additional chairs into the room, if necessary.
- Secure a quiet room for the family away from the bedside.

Prepare the patient

- Position the patient as comfortably as possible.
- Honor requests for cultural, spiritual, and religious rituals.
- Dim the lighting on screens required for monitoring (e.g., electrocardiography).
- Discontinue unnecessary monitoring (e.g., oximetry), unnecessary devices (e.g., feeding tubes), unnecessary tests (e.g., blood work), and unnecessary treatments (e.g., enteral nutrition).
- Discontinue medications that do not provide comfort and provide those that do.
- Ensure that the patient is as calm and distress-free as possible before proceeding to withdraw life support.

EOL CARE

- **Providing holistic care:**
- Physical Distress– control of symptoms
- Psychosocial Distress – communication with patients and relatives
- Emotional Distress– psychological support
- Spiritual Distress – chaplain and spiritual support

EOL CARE

Management of symptoms

- Dyspnoea
- Pain
- Weakness
- Anxiety and fear
- Fatigue
- Immobility

EOL CARE

- Psychosocial Distress – psychological support
- Spiritual Distress – Respect to the faith

Legislation in CZECH REPUBLIC

- **Doporučení České lékařské komory č.1/2010**

- **Rozhodnutí osoby určené pacientem neboli zástupce pro medicínská rozhodnutí** *Zákon o zdravotních službách (372/2011 Sb.,§ 33 odst. 1+§ 34 odst. 7)*

- **Předem vyslovené přání** podle zákona o zdravotních službách *Zákon o zdravotních službách (372/2011 Sb, § 36)*

Take home message

- Goal of intensive care is saving life and restoring of but not prolonging dying
- Palliative care is consequently provided to the patients in the ICU
- Dying with dignity is one of the important goals of the care in the ICU
- EOLD must be preformed within the legislation frame of each country

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Sources

- MALÁSKA, Jan, Jan STAŠEK, Milan KRATOCHVÍL a Václav ZVONÍČEK. *Intenzivní medicína v praxi*. Praha: Maxdorf, [2020]. Jessenius. ISBN 978-80-7345-675-7.
- Deborah Cook, M.D., and Graeme Rocker, D.M. Dying with Dignity in the Intensive Care Unit N Engl J Med 2014;370:2506-14. DOI: 10.1056/NEJMra1208795

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