End of Life Care

To Care is to Dare

Salah Zeineldine, MD FACP
American University of Beirut
The End Points

- Differentiate between “Good Death” and “Bad Death”
- Recognize the modifiable dimensions in End Of Life Care
- Differentiate Palliative from Curative Care
- Appreciate the role of Physicians/Nurses in End Of Life Care
Case

- A 60 year old woman with metastatic recurrent breast cancer, admitted with pneumonia and respiratory failure
- Received multiple courses of chemotherapy, now with bone, chest wall and brain mets.
  Brought to ER because of difficulty breathing.
  She is Gasping in ER
Case

- Family requesting that all measures be done and not to tell the patient about her diagnosis and prognosis
- Patient was intubated and transferred to ICU
- Agitated in pain, confused (had to be restrained)
- Received intermittent sedation, nutrition, antibiotics
- After 10 days of hospitalization, she died with MSOF
How are we dying??

“… too many patients die unnecessarily bad deaths—deaths with inadequate palliative support, inadequate compassion, and inadequate human presence and witness…”

Jennings et al, Hastings Center Report 2003
Can we talk about DEATH?
Is there a **Good Death?**
Good Death…

- Adequate pain and symptom management
- Avoiding a prolonged dying process
- Clear communication about decisions by patient, family and physician
- Adequate preparation for death, for both patient and loved ones
...Good Death

- Feeling a sense of control
- Finding a spiritual or emotional sense of completion
- Affirming the patient as a unique and worthy person
- Strengthening relationships with loved ones
- Not being alone
What can we do?
How can we change?
Fixed characteristics of the patient

- Diagnosis, Prognosis
- Race, Ethnicity and Culture
- Religion
- Socioeconomic Class
Modifiable dimensions

Patient

- Spiritual, cultural, existential beliefs
- Physical symptoms
- Caregiving needs
- Economic demands
- Hopes, expectations
- Social relationships, support
- Psychological, cognitive symptoms

Spiritual, cultural, existential beliefs
Physical symptoms
Caregiving needs
Economic demands
Hopes, expectations
Social relationships, support
Psychological, cognitive symptoms
Ethical Issues

- Futility
- Resuscitation
- Withdrawal of supportive care
Ethics and Care of the Critically Ill

- **Nonmaleficence** - Hippocratic principle, “first do no harm”
- **Beneficence** - a duty to do good (not just avoid harm)
- **Autonomy** - the recognition of the right of self-determination, establishing one’s own goals of care
- **Justice** – the equitable distribution of often limited healthcare resources
Medical Futility
Futile

Futile: ‘useless, ineffectual, vain, frivolous’
(Oxford English Dictionary)

Medical futility implies ‘treatment that will not achieve the somatic goal intended’. The assertion that treatment will not work.
Medical Futility

- Hippocratic writings: Three major goals for medicine
  - Cure
  - Relief of suffering
  - Refusal to treat those who are over mastered by their diseases
Futility throughout History

- Medical Science and practice progression
  - One generation futile treatment becomes next generation’s bold experiment, which go on to become efficacious therapy
  - Examples: Diabetes, infection, Cardiac diseases, Asthma, renal failure…
  - 1960’s first reports of CPR defeating death
Definition: Medical Futility

- **Quantitative**: Treatment found useless in the past 100 cases.

- **Qualitative**: If a treatment merely preserves permanent unconsciousness or cannot end dependence on intensive medical care. (Brody & Halevy, 1996)
Medical Futility

- Treatment that prolongs the dying process without achieving cure nor alleviating suffering
Medical Futility

- Should the patient and/or family have the final word in deciding about the administration of treatment??

- Are we (physicians) protected in case we withhold a medically futile treatment??
Medical Futility: Communication with Patient’s Family
Personal factors

- Distrust
- Guilt
- Grief
- Intra-family issues
- Secondary gain
- Physician / Nurse (How comfortable they feel)
Communication with Family: Futility

- Choose a primary communicator
- Give information in
  - small pieces
  - multiple formats
- Use understandable language
- Frequent repetition may be required
Communication with family: Futility

- Assess understanding frequently
- Do not hedge to “provide hope”
- Encourage asking questions
- Provide support
- Involve other health care professionals
Medical Futility

- Accepted legally
  - US
  - Europe
  - Lebanon
    - Do not initiate a futile treatment: YES
    - Withdraw a futile treatment: NO
Cardio-Pulmonary Resuscitation & DNR
DNR orders

- Patients for whom CPR may not provide benefit
- Patients for whom surviving CPR would result in permanent damage, unconsciousness, and poor quality of life
- Patients who have poor quality of life before CPR is ever needed, and wish to forgo CPR should breathing or heartbeat cease
DNR

- We (Physician) *should make the decision* in communication with the patient and/or family
- DNR should not preclude any other care (Palliative nor Curative)
- *Family might have a great deal of guilt feelings*

Taking Ownership
Medical Practice: Curative vs. Palliative

- Focus on curing illnesses and healing injuries
  - Curative treatment in terminal illnesses do not relieve physical suffering
  - May not address emotional, spiritual, and psychological suffering
- Symptom relief is often a secondary focus
Non-Palliative Care: Ethical Violation

- Failure to address suffering in end of life violates two main ethical principles:
  - **Beneficence**: failing to relieve pain and other symptoms, not helping or benefiting the patient
  - **Non-maleficence**: Failing to relieve pain and other symptoms can harm the patient and his loved ones
Most Common Symptoms in Dying Patients

- Pain: 36% to 75% of terminally ill
- Difficulty breathing: 75% experience air hunger and dyspnea
- Depression: 25% of patients in palliative units

LaDuke, S AJN. 101 (11):26-31
Pain Management

- Morphine is the most commonly used narcotic, good in relieving pain and shortness of breath
- Fear of respiratory failure, overdosing and hastening death
- Fear of criminal punishment
- Unfounded: Research has not found narcotics to shorten life or depress respiration in dying patients, even when higher doses of narcotics are given

*Sykes N, Thorns A. Oncology, 2003 4(5): 312-318*
*Pellegrino JAMA 1998; 279 (19): 1521-1523*
*Fleming DA, Missouri Medicine, 2002;99 (10):560-565*
The “Principle of double effect”

- Medical act e.g.: Giving sedatives and analgesics
  - Morally good effect: Relief of pain
  - Morally bad effect: Hastening death
The “Principle of double effect”

- Such acts are permitted provided that only the morally good effect are intended. The morally bad effect may be foreseen, but it may not be intended.

- Risking death is reasonable in palliating a terminally ill patient only if there are no less risky ways of relieving suffering.
Sedation and Analgesia Principles

- No ceiling of opioids – the necessary dose is the dose that relieves the distress (variable between patients)
- Do not walk away from the patient! Repeated observation is critical to safe titration
- Define practical physiologic parameters to assist titration (e.g. RR<30 HR<100, eliminating grimacing)
Antibiotic Treatment

- Dying patients are susceptible to infection
- 32% to 88% of terminally ill patients receive antibiotics
- Antibiotics might alleviate symptoms
- Antipyretic more effective

Other Supportive Measures

- Hemodynamic Support: Vasopressors
- Dialysis
- Mechanical Ventilation
- Transfusion of Blood Derivatives...
Training our Residents, Interns & Nurses??
Proposed Training of End of life Care : Death Rounds !!!
Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer


CONCLUSIONS
Among patients with metastatic non–small-cell lung cancer, early palliative care led to significant improvements in both quality of life and mood. As compared with patients receiving standard care, patients receiving early palliative care had less aggressive care at the end of life but longer survival. (Funded by an American Society of Clinical Oncology Career Development Award and philanthropic gifts; ClinicalTrials.gov number, NCT01038271.)
Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers’ Outcomes Group

**Conclusion:** Hospital palliative care consultation teams are associated with significant hospital cost savings.

*Arch Intern Med. 2008;168(16):1783-1790*
Conclusions

- Address the issue of End of Life Care
- Communication/Ownership
- Palliative Care
- Futility
- DNR
- Training
Palliative Efforts in Lebanon

Palliative Care Taskforce is coordinating with the Lebanese Cancer Society

Palliative Care Consult (Hospital)

Hospice (Home)
Thank You