No Conflicts to Declare
Overview

• Social context – evolving attitudes towards end of life care
• Three important trajectories
• Three scenarios/presentations
• Three important sets of skills
• What about “MAD”
What does she have tattooed on her chest?
What does she have tattooed on her chest?
Living Will Document

• PART 2. My Living Will
• These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself.
• A. These are my wishes if I have a terminal condition
  • Life-sustaining treatments
    • _____ I do not want life-sustaining treatment (including CPR) started. If life-sustaining treatments are started, I want them stopped.
    • _____ I want the life-sustaining treatments that my doctors think are best for me.
    • _____ Other wishes
  • Artificial nutrition and hydration
    • _____ I do not want artificial nutrition and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.
    • _____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.
    • _____ Other wishes
  • Comfort care
    • _____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.
    • _____ Other wishes
• B. These are my wishes if I am ever in a persistent vegetative state
  • Life-sustaining treatments
    • _____ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.
    • _____ I want the life-sustaining treatments that my doctors think are best for me.
    • _____ Other wishes
  • Artificial nutrition and hydration
    • _____ I do not want artificial nutrition and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.
    • _____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.
    • _____ Other wishes
  • Comfort care
    • _____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.
    • _____ Other wishes
Do Forms Help Us??

TRIAD VI: how well do emergency physicians understand Physicians Orders for Life Sustaining Treatment (POLST) forms?

Mirarchi F, Doshi A, Zerhul SW, Coney TE

Author information

Abstract

BACKGROUND: Physician Orders for Life-Sustaining Treatment (POLST) documents are active medical orders to be followed with intention to bridge treatment across health care systems. We hypothesized that these forms can be confusing and jeopardize patient safety.

OBJECTIVES: The aim of this study was to determine whether POLST documents are confusing in the emergency department setting and how confusion impacts the provision or withholding of lifesaving interventions.

METHODS: Members of the Pennsylvania chapter of the American College of Emergency Physicians were surveyed between September and October 2013. Respondents were to determine code status and treatment decisions in scenarios of critically ill patients with POLST documents who emergently arrest. Combinations of resuscitations (do not resuscitate [DNR], cardiopulmonary resuscitation) and levels of treatment (full, limited, comfort measures) were represented. Responses were summarized as percentages and analyzed by subgroup using the Fisher exact test. \( P = 0.05 \) was considered significant. We defined confusion in response as absence of consensus (supermajority of 95%).

RESULTS: Our response rate was 26% (223/855). For scenarios specifying DNR and either full or limited treatment, most chose DNR (59%-84%) and 26% to 75% chose resuscitation. When the POLST specified DNR with comfort measures, 90% selected DNR and withheld resuscitation. When cardiopulmonary resuscitation/full treatment was presented, 95% selected "full code" and resuscitation. Physician age and experience significantly affected response rates; prior POLST education had no impact. In most scenarios depicted, responses reflected confusion over its interpretation.

CONCLUSIONS: Significant confusion exists among members of the Pennsylvania chapter of the American College of Emergency Physicians regarding the use of POLST in critically ill patients. This confusion poses risk to patient safety. Additional training and/or safeguards are needed to allow patient choice as well as protect their safety.

PMD: 25692522 DOI: 10.1097/PTS.0000000000001065

[PubMed - indexed for MEDLINE]

MeSH Terms

LinkOut - more resources
Interpreting End-of-Life Documents

How Should Mr Jones Be Managed?

In this scenario, this individual presenting with this condition and document should be provided with aggressive care, including defibrillation. There are many patients with a good quality of life who have prepared living wills as part of an estate plan in which they consent to all aggressive treatment until their condition is felt to be terminal or they are in a state of persistent unconsciousness. This patient was previously well and is now in a critically ill state for which effective treatment exists. Failure to act would result in his death.

It is important to clarify that clinicians should not follow a living will simply because the document exists. A previously developed living will should not prevent further consultation in a patient with
“Advance directives were developed to ensure that the decisions people make when fully able are followed when they can no longer speak for themselves. However, these checkbox-style documents have proven inflexible, inconsistent with subsequent events and decisions, and for various reasons both ineffective and unpopular”

National Academy of Sciences “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life”
If this doesn’t work, then what?

• PART 2. My Living Will
• These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself.
• A. These are my wishes if I have a terminal condition
• Life-sustaining treatments
  • _____ I do not want life-sustaining treatment (including CPR) started. If life-sustaining treatments are started, I want them stopped.
  • _____ I want the life-sustaining treatments that my doctors think are best for me.
  • _____ Other wishes _____________________________________________________________
• Artificial nutrition and hydration
  • _____ I do not want artificial nutrition and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.
  • _____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.
  • _____ Other wishes _____________________________________________________________
• Comfort care
  • _____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.
  • _____ Other wishes _____________________________________________________________
• B. These are my wishes if I am ever in a persistent vegetative state
• Life-sustaining treatments
  • _____ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.
  • _____ I want the life-sustaining treatments that my doctors think are best for me.
  • _____ Other wishes _____________________________________________________________
• Artificial nutrition and hydration
  • _____ I do not want artificial nutrition and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.
  • _____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.
  • _____ Other wishes _____________________________________________________________
• Comfort care
  • _____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.
  • _____ Other wishes _____________________________________________________________
The patient was an 88-year-old female with advanced dementia, she had aspiration pneumonia, was in respiratory failure, in septic shock and was a “full code.”

I can still recall our 4 a.m. conversation:

“Hi, Dr. M this is Monica Murphy in the ER. I have an 88-year-old female with advanced dementia who has pneumonia and is septic. I intubated her; she’s got a central line with antibiotics and pressors hanging, so we need to admit her to the intensive care unit.”

There was a long pause … entirely too long.

I said, “Hello, are you still there?”

He answered with a question, “Are you new?”

I felt a bit bumfuzzled by this response, “Yes.”

After a briefer pause, he asked, “Are you American?”

“Yes sir.”

Then, he let me have it, “What’s wrong with you Americans? Why do you not know when to let your people die?”
From “It’s OK To Die”
M. Williams-Murphy, emerg doc
Who Am I to Decide Whether This Person Is to Die Today? Physicians’ Life-or-Death Decisions for Elderly Critically Ill Patients at the Emergency Department–ICU Interface: A Qualitative Study

Thomas Fassier, MD, MPH*; Elizabeth Valour, MSc; Cyrille Colin, MD, PhD; François Danet, MD, PhD

*Corresponding Author. E-mail: thomas_fassier@uhs.edu.kh.

**Study objective:** We explored physicians’ perceptions of and attitudes toward triage and end-of-life decisions for elderly critically ill patients at the emergency department (ED)–ICU interface.

**Methods:** This was a qualitative study with thematic analysis of data collected through semistructured interviews (15 emergency physicians and 9 ICU physicians) and nonparticipant observations (324 hours, 8 units, in 2 hospitals in France).

**Results:** Six themes emerged: (1) Physicians revealed a representation of elderly patients that comprised both negative and positive stereotypes, and expressed the concept of physiologic age. (2) These age-related factors influenced physicians’ decisionmaking in resuscitate/not resuscitate situations. (3) Three main communication patterns framed the decisions: interdisciplinary decisions, decisions by 2 physicians on their own, and unilateral decisions by 1 physician; however, some physicians avoided decisions, facing uncertainty and conflicts. (4) Conflicts and communication gaps occurred at the ED-ICU interface and upstream of the ED-ICU interface. (5) End-of-life decisions were perceived as more complex in the ED, in the absence of family or of information about elderly patients’ end-of-life preferences, and when there was conflict with relatives, time pressure, and a lack of training in end-of-life decisionmaking. (6) During decisionmaking, patients’ safety and quality of care were potentially compromised by delayed or denied intensive care and lack of palliative care.
MORE CARE, LESS PATHWAY
A REVIEW OF THE LIVERPOOL CARE PATHWAY
'Death Panels' Will Be Sarah Palin's Greatest Legacy

BEN COSMAN
Allowing Natural Death...

...is a plan for life’s end which seeks to provide comfort and dignity above all else
...acknowledges that death is the inevitable result of the aging process
...supports a kinder and gentler way to die
...relies less on medicine, technology and hospitalizations and more on the relief of pain and discomfort
...is helpful language to use in shared decision making for elders as they speak about their desired death
...is not the same as Do Not Resuscitate (DNR) orders
...must be negotiated with families and providers who agree to honor the wishes of the elder person for a good death
...chooses to maintain the loved one’s quality of life even when it means that death will come sooner
...is not euthanasia
...does not rule out the use of substances that bring comfort

More than anything else, Allowing Natural Death requires courage and love that can take us to the places that scare us most - so that we are able to enjoy each precious day that we are given in this life.

Latest Post

No thank you, Ira

In a long ago post here, I thanked Ira Byock for all his work to improve end of life care, but after his recent appearance on a Sixty Minutes episode highlighting the end of life planning of Brittany Maynard, I have to say no thanks for this new focus of his work. Byock continues this work in a recent article in the New York Times.

I have witnessed Dr. Byock at the bedside of terminal patients exhibiting utmost caring and impeccable clinical skills. He clearly brings love into his practice, but there is much about him that I can’t figure out. Why is he compelled to speak out against personal choice at the end of life? Why is it not enough to continue the good work of educating doctors and improving conditions for those who are dying? Why pretend that the drugs prescribed by physicians do NOT bring death nearer while alleviating suffering? Why diminish the details of the use of terminal sedation?

After 20 years on the front lines of health care, there is no possibility that the compassionate care Byock advocates will happen for any, but the privileged few who can afford to be cared for in their homes. Those who
Limits to Medicine

IVAN ILLICH

LIMITS TO MEDICINE

Medical Nemesis: The Expropriation of Health
Being Mortal

Atul Gawande

Being Mortal

Medicine and What Matters in the End
Challenges Specific to the ED

- Last fiscal 4,451 deaths in ON ED’s out of 5.4M visits = .08% or ~ 1 death/week/ED
Tim Hortons-turned-ER a sign system works: Hansen
Trajectories of Dying

[Diagram showing a graph with axes labeled Time and Function. The graph shows a sudden drop from high function to death within a certain time period.]
Other Trajectories

Number of deaths in each trajectory, out of the average 20 deaths each year per UK general practice list of 2000 patients

- Cancer (n=5)
- Organ failure (n=6)
- Physical and cognitive frailty (n=7)
- Other (n=2)
Presenting Scenarios

• Patient appears to fall on one of these 3 trajectories AND;
  1. You have clear direction on the goals of care
  2. You have no direction and clinical decisions that need to be made before you can clarify directions
  3. You have time and opportunity to discuss “goals of care”
Scenario 1 – “AND”

• Need right attitude and a few skills
• An honour to support a patient/family through their final journey
• Simple things are huge;
  • Acknowledge
  • Set the scene
  • Manage the symptoms
  • Cover the bases
Comfort Care / End of Life

PLEASE NOTE: This routine order is ONLY to be used when patient is in the last hours/days of life. Please see reverse for additional information regarding end of life symptom management.

1. Resuscitation Status: □ DNR (document resuscitation status in chart)

2. Consultation: □ Palliative Medicine □ Chaplain □ Social Work □ Pharmacy □ Comfort Tray for Family □ Other

3. Pain

A. If patient currently on opioid:
   i) Discontinue all previous PO opioids.
   ii) Convert current regimen to IV or SC (see reverse for details). Parenteral dose should be one-half (1/2) of oral dose. Some patients may require additional pain at end of life. Consider a small decrease in dose or hold opioids for a time if signs of opioid toxicity such as myoclonus (twitching), sedation and confusion.
   iii) New opioid regimen:
      a) Morphine ___mg IV/SC q4h
      b) HYDROMorphone ___mg IV/SC q4h
      iv) New breakthrough opioid regimen (breakthrough dose is usually 1/2 of the q4h dose):
         a) Morphine ___mg IV/SC q30min PRN for pain
         b) HYDROMorphone ___mg IV/SC q30min PRN for pain

B. If patient is opioid naive consider starting:
   Choose one:
   a) Morphine ___mg IV/SC q30min PRN for pain
   b) HYDROMorphone ___mg IV/SC q30min PRN for pain

4. Delirium (Agitation/Confusion)
   □ Haloperidol 0.5-1.0 mg PO/SC q4h PRN for agitation hallucinations or delirium
   Methotrimeprazine (Niwarem) 12.5 mg - 25 mg SC q4h PRN for severe agitation or distress, if haloperidol not effective

5. Dyspnea
   Morphine ___mg IV/SC q30min PRN for dyspnea or increase current opioid by 25% unless signs of toxicity
   Lorazepam 1-2 mg IV/SC q4h PRN for dyspnea relieved by opioids
   Titrate supplemental oxygen via NP to relieve dyspnea to a maximum of 6L/min.
   Educate family about observed respiratory changes at the end of life - see reverse for information

6. Antipyretic/Analgiesia: Ibuprofen 600 mg PO/PR q4h PRN pain or fever (max 4 g in 24 h)

7. Respiratory secretions
   Hyoscine butorphanol (Buscopan) 0.4 mg SC q4h PRN for excessive secretions
   No deep suctioning unless absolutely necessary
   Position patient in semi-prone position

8. Sedation (choose one)
   a) Lorazepam (Ativan) 1-2 mg PO/SC q1h PRN for restlessness, anxiety, insomnia
   b) Midazolam (Versed) 5 mg SQ q30min PRN for severe agitation or distress or acute bleeding
   Other:

9. Parenteral fluids:
   Consider whether non-enteral hydration is necessary for patient comfort. In some cases, it is best to discontinue parenteral fluids and other cases it may be best to continue fluid at a lower rate. (See reverse for details). If fluids are given, assess frequently for CHF and peripheral edema.
   - Saline lock
   - Discontinue intravenous fluids
   - Normal saline IV ________ ml/hr
   - SC hydration (Hypodermoclysis): Normal saline SC ________ ml/hr
   Other:

10. Elimination
   Access for urinary retention
      - Insert urinary catheter PRN
      - Moistening Cleanser for per care PRN

11. Mouth and Eye Care
   - Baking soda and saline mouthwash apply topically q8h PRN. Mix 1/2 tsp sodium bicarbonate with 1/2 tsp salt in 500 mL water. Solution should be discarded after 24 hours and a new solution prepared daily.
   - Oral base gel (Vaseline) topically to lips q4h PRN
   - Natural tears 1-2 drops to both eyes q4h PRN

12. Oral Intake
   - Diet as tolerated
   - May take medications with sips of water
   - Dysphagia diet
   - NPO
   - Soft foods prn for comfort (families may accept risk of aspiration)

13. Insert an SC butterfly for the administration of SC medications. Each SC medication requires a separate SC butterfly.

14. Discontinue Orders
   Review current medications. Discontinue those that are burdensome to the patient and non-essential medications. Many patients at the very end of life do not require standing medications e.g. for diabetes, etc. Discuss this with patient and family.
   Continue medications that add to patient comfort e.g. fumaramide
   □ Discontinue all medications except:

<table>
<thead>
<tr>
<th>DRUG</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>FREQUENCY</th>
<th>INDICATION</th>
</tr>
</thead>
</table>

   - Discontinue routine vitals and oxygen saturation measurement
   - Discontinue routine blood work, diagnostic procedures, and interventions
   - Discontinue parenteral feeding or g-tube feeding if patient and family consent
   - Patient has Internal Cardiac Defibrillator (ICD device) - contact Electrophysiology service to discontinue
   - If symptoms not well-controlled, patient may need sedation at the end-of-life. Please consult palliative care service if end of life symptoms not well-controlled.

16. Care after death
   □ Notify Palliative Care Medicine consult team if involved in care during regular working hours
   The care and treatment changes reflected in this order sheet have been discussed with:
   - Patient
   - Family member (specify relationship and name)
   - Other (specify)

   Date: ____________  Time: ____________  Print Name: ____________  Signatures: ____________  ________ M.D.  ________ R.N.

Copy Distribution: White Original → Patient Chart  Yellow Copy → Pharmacy
Scenario 2 – Crisis and Uncertainty

- Acute crisis; ABC’s
- Err on the side of intervention if unsure
- Buy time if needed/possible;
  - Oxygen/BiPap even bag before intubation
  - IV fluids
  - Pain control
  - Treat the treatable first
- IF the patient is in arrest/pre-arrest consider extent of resuscitation efforts based on status and response to initial efforts
Scenario 3 - ? Most Important Skill

• Must be expert at conducting a skilled, brief, and focused discussion on “goals of care”
• Often done poorly leading to stress, conflict, guilt
• Don’t ask; “what would you like us to do?” or “if your heart stops do you want us to....”
• Don’t argue, avoid a power struggle
Goals of Care Decision

• Establish rapport (listen!) and confirm understandings;
  • Introduce yourself, whatever info you have reviewed
  • Establish pt/family understanding of underlying medical situation and recent functioning and quality of life
Goals of Care Decision

• Ask about goals of care;
  • Why did you come to the ED today?
  • What are you hoping we can do for you?
  • What are you most afraid of?
  • If you were to die tomorrow what do we need to do before that?
• Explain current scenario as you see it, and what YOU ADVISE
• Gauge response
• If consensus achieved THEN explain hospital requires an order to ensure wishes are honoured
Assisted dying: Elation and alarm at top court's ruling (with video)

IAN MACLEOD, OTTAWA CITIZEN
More from Ian MacLeod, Ottawa Citizen

JORDAN PRESS, OTTAWA CITIZEN
More from Jordan Press, Ottawa Citizen

Published on: February 7, 2015 | Last Updated: February 7, 2015 9:22 AM EST

In historic ruling, Supreme Court strikes down ban on doctor-assisted death
Canada's parliament passes assisted suicide bill

Canada's parliament has passed a contentious bill to allow medically-assisted death for terminally ill people.

The law was put forward after the Supreme Court struck down a ban on doctors helping the incurably sick to die.

The move makes Canada one of the few countries where doctors can legally help sick people die.

But critics say the new legislation is too restrictive.

They argue it will prevent people with degenerative conditions, such as multiple sclerosis, from seeking assisted suicide.

Government officials say the new law is a first step and can be expanded in the future.
“MAD” and the ED

• Scenarios;
  • A request for MAD, options?;
    • Psych assessment
    • Referral to a hospital service (? Admit if unstable/ill/suffering)
    • Community referral
  • Unsuccessful MAD in the community;
    • Resuscitate
    • Palliate
    • Complete or facilitate MAD
My Tattoo Message?

USE YOUR BEST JUDGEMENT!
To Cure sometimes,
To Treat often,
To Comfort always!