



Improving Care at the End of Life

Emergency physicians must be expert in managing the dying process. Unfortunately, decisions regarding when to resuscitate, what therapeutic interventions are appropriate, and when to withhold care are often difficult. The difficulties are compounded when the patient is experiencing distressing symptoms that are difficult to relieve. This seminar will discuss state-of-the-art medical strategies to optimize end-of-life care, provide information regarding the latest efforts to improve communication and documentation of DNR requests, and offer strategies to assist in decision making about interventions at the end of life.

- Identify optimal medical management of the patient near the end of life.
- List therapeutic interventions that can be helpful to patients with stressing symptoms.
- List statewide strategies to improve the communication of DNR orders.
- Explain the process of decision making when faced with questions about the appropriateness of advanced life support maneuvers.

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FACULTY

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Improving Care at the End of Life

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Course Objectives

- Identify optimal medical management of the patient near the end of life.
- List therapeutic interventions that can be helpful to patients with distressing symptoms.

- List statewide strategies to improve communication of DNR orders.
- Explain the process of decision-making when faced with questions about the appropriateness of advanced life support maneuvers.

- There is a rising incidence of cancer, and increasing palliative care needs.
- Many forms of cancer will cause pain and symptom control problems that respond well to informed management.

Do we need to re-think emergency care for patients near the end of life?

- "They should not come to the ED."
- "Their doctor should come in and take care of it." These patients are too much work and we don't know what is going on."
- Should we be available for these patients?
 - If so, then we need to think about how to do it right.

Re-thinking emergency care

- The greeting
- Family context
- Comfort
- Symptom control
- Coordination of care
- Objectives of care

Medical Challenges

- Pain
- Nausea
- Shortness of breath
- Constipation
- Bowel obstruction
- Hypercalcemia
- Agitation, restlessness
- Depression, anxiety

Pain Management

- Protocol for patients near the end of life
- Morphine
- Fentanyl patch
- NSAIDS
- Ketamine

Pain management protocol

Step 1

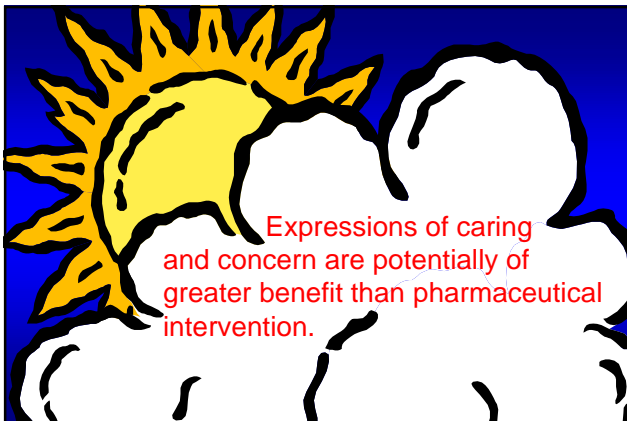
Dampen the noxious stimulus.

Always attempt to decrease the noxious stimulus at the periphery and thus decrease nociception. This is done by dealing with pain at its source where free nerve endings may be stimulated in the skin, connective tissue and viscera by pressure, heat, inflammation, tissue injury, etc.

The tumor may be dealt with by XRT or chemotherapy; if infection is present antibiotics are used; or sometimes tylenol or NSAIDS. Other measures are dexamethasone, local blocks, immobilization, massage, etc.

Step 2

Always raise the pain threshold by reducing anguish. Anguish and suffering affect the way the pain is perceived. We all know that the pain is worse when they are depressed, anxious, angry, frightened, etc.



Step 3

Give morphine.

Some people, especially the elderly and frail only require very small doses, say 2.5 mgm.

Give what they need. Anticipate side effects.

Step 4

Recognize neuropathic pain and treat accordingly.

This problem arises from irritation or destruction of a peripheral nerve or plexus.

It results in severe burning or shooting pain and may only be partially helped by morphine.

It is important to recognize this type of pain and introduce a neuropathic agent rather than escalating the dose of morphine. Commonly used neuropathic agents are anticonvulsants, tricyclic antidepressants, corticosteroids and local anesthetics.

Don't forget the bowel.

It is surprising how often preventable constipation is caused by this omission. It is very easy to be so focused on the pain that such measures are forgotten.

Fentanyl Patches

Fentanyl patches are a very good opioid analgesic that are particularly useful for those intolerant to morphine. However, it should be considered a second line drug after morphine and is not nearly as flexible.

It is used particularly for those with severe morphine related constipation or nausea, those who excessive morphine induced sedation, those with poor compliance or inability to swallow and those who have inadequate pain relief with morphine. It is easy to use and well accepted by the patient.

Each patch is worn for 72 hours and has about the same effect as using twice daily oral sustained release (SR) morphine. However, from a quality of life point of view, there are some advantages in using fentanyl patches for some patients.

The main side effects complained of by patients on morphine are nausea, vomiting, constipation and drowsiness, all of which can significantly impact on quality of life even though pain relief may be adequate. For total pain management both physical and psychological factors need to be taken into account. According to a study comparing transdermal fentanyl versus sustained release oral morphine the following has been found.

Pain Control

No significant difference was found between fentanyl and SR morphine in regards to pain control. However, those on fentanyl did require slightly more breakthrough doses of morphine.

MS Contin: 30 mg po q 8-12 hrs.

MS Elixir (Roxanol): 10-30 mg po q4hr
(20mg/5 ml)

Fentanyl appeared to be **less sedating** than morphine both in the daytime and night.
Nausea was less in the fentanyl group.

Treatment Preferences

Significantly more patients indicated that the fentanyl patches had caused less interruption to their daily activities and the activities of family and careers, and had been more convenient to take than morphine tablets.

Transferring from Morphine to Fentanyl

Withdrawal from morphine symptoms were common and symptoms such as abdominal pain, agitation or anxiety, sweating and flu like symptoms were reported during the first few days of fentanyl treatment consistent with morphine withdrawal.

A Second Line Drug

It should be emphasized that a fentanyl patch is not suitable for unstable pain or rapid titration. In those situations morphine must be used until adequate pain control is achieved. If there are then indications to use fentanyl, the change is made according to the conversion formula listed.

24-hour morphine (mgm/day)	Fentanyl Dose (mcg/hr)
<135	25
135-224	50
225-314	75
315-404	100
405-494	125
495-584	150
585-674	175
675-764	200
765-854	225
855-944	250
945-1034	275
1035-1124	300

There are four sizes of patch and more than one patch can be used if a higher dose is needed. The four sizes of patch have a delivery rate of 25, 50, 75, and 200 mcg per hour. Fentanyl is excreted in the urine and the dose may need to be reduced if there is increasing dehydration and renal failure.

Fentanyl

- IV 2-3 mcg/kg, but it is short acting
- Transdermal (duragesic): one 2.5mg patch q3days
 - patches 2.5, 5, 7.5, 10mg
- Transmucosal lollipops (fentanyl oralet):
 - 5-15 mcg/hr (200, 300, 400 mcg)

Nausea

Try anti-emetics (metoclopramide, droperidol, promethazine, ativan, ondansetron) or switch to subcutaneous morphine

High bowel obstruction

Don't be afraid to use morphine to treat the pain.

NSAIDS in Palliative Care

The non-steroidal anti-inflammatory drugs (NSAIDS) constitute one of the largest single group of drugs prescribed. They act primarily as inhibitors of prostaglandin synthase

Activities include inhibition of neurophil migration, mild immunosuppression, and interference with cell membrane function. As well as being useful in a wide range of inflammatory arthropathies, they may also be beneficial in other types of pain such as renal colic, bone pain due to cancer and in hypercalcemia.

Recent studies have also shown NSAIDS may inhibit tumor growth and the ability of tumors to metastasize in animal models, and a recent paper has demonstrated that suldinac will reduce the rate of growth of colonic polyps in humans.

Mean (SD) Plasma Half-Lives of Different NSAIDS

Drug half-life (hr)

Short half-life

- Aspirin 0.25
- Diclofenac 1.1
- Ibuprofen 2.1
- Indomethacin 4.6
- Ketoprofen 1.8

**Mean (SD) Plasma Half-Lives of
Different NSAIDS**

Drug half-life (hr)

Long half-life

- Naproxen 14
- Phenylbutazone 68
- Piroxicam 57
- Suldinac (sulfide) 14

NSAIDS are produced in a number of different forms including oral (standard, enteric-coated and slow release), suppositories, parenteral preparations and recently available transcutaneous preparations. Transcutaneous preparations may be useful for localized areas of pain such as metastases.

Significant concentrations are found within a synovial joint over which the transcutaneous NSAID has been applied.

Relative Risk of Peptic Ulceration from NSAIDS

Drugs Ratio 95% Confidence Interval

- Ibuprofen 2.0 1- 4-2.8
- Diclofenac 4.2 2.6 - 5.8
- Naproxen 9.1 5.5 - 15.1
- Indomethacin 11.3 6.3 - 20.3
- Piroxicam 13.7 9.1 - 25.3
- Ketoprofen 23.7 7.5 - 74.2

In patients who have a previous history of gastric ulceration or who develop a GI side effect while taking an NSAID, the following steps should be carried out:

1. Ask, does the patient need the NSAID?
2. If yes, then change the NSAID or lower the dose or add an H2 blocker (for gastric ulceration).

NSAIDS

- **Salicylates**: aspirin, salsalate, diflunisal (dolobid)
- **Propionic acids**: ibuprofen, naproxen, ketoprofen (orudis), oxaprozin (daypro), fenoprofen (nalfon), flurbiprofen (ansaid)
- **Acetic acids**: diclofenac (voltaren), etodolac (Iodine), indomethacin, ketorolac, nabumetone (relafen), sulindac (clinoril),
- **Fenamates**: meclofenamate, mefenamic acid
- **Oxicams**: piroxicam (feldene)

3. If duodenal ulceration is found, then misoprostil (cytotec 200mcg po qid) may be used. This has the common dose related adverse event of diarrhea (which may be useful in patients on opioids).

4. Reflux esophagitis may be alleviated by a change of NSAID, co-prescribing metoclopramide or using cisapride (propulsid 10 mg po qid) or a proton pump inhibitor such as omeprazole (prilosec 20 mg po qd).

VIOXX: Rofecoxib Tablets and Oral Suspension

- Non-steroidal anti-inflammatory drug that inhibits prostaglandin synthesis via inhibition of cyclooxygenase-2 (COX-2)

Indications and Usage

- For relief of the signs and symptoms of osteoarthritis.
- For the treatment of primary dysmenorrhea
- Promoted to have less side effects, less ulceration.

VIOXX Oral Suspension 12.5mg/5mL or 25 mg/5 mL may be substituted for VIOXX tablets 12.5 or 25 mg, respectively, in any of the above indications.

An Old Drug With a New Role

Ketamine has been around for about 30 years and used by anesthetists as a dissociative general anesthetic. It activates the limbic system and depresses the cerebral cortex, producing profound analgesia, slight respiratory depression, cardiovascular stimulation and amnesia.

The protective reflexes are maintained. Ketamine is an N-methyl-D-aspartate (NMDA) receptor antagonist. It has particularly been looked at in the so called "wind up" phenomena where there is a progressive increase in dorsal horn neuronal response to rapidly repeated, identical noxious stimuli.

In clinical terms it may mean that simple touch input is converted into a painful sensation called allodynia. It can also mean that a painful response to any given painful stimuli is magnified (hyperalgesia) and prolonged. The "wind up" appears to be mediated by the NMDA receptors and can be reduced by ketamine. It is very resistant to opioids and neuropathic agents.

Clinical Implications

There is evidence that NMDA receptors are involved in the induction and maintenance of the pain response in any pain syndrome with allodynia, hyperalgesia and prolongation of the pain response as well as inflammatory pain, neuropathic pain, phantom limb pain and peripheral vascular pain.

However, it is not yet clear cut as to the exact role of ketamine in the management of these pain syndromes, and it is certainly inappropriate to get over-optimistic as to the benefit of this drug at this stage. Its exact role in the palliative care setting is yet to be determined.

Side Effects

Although in palliative care ketamine is used in subanesthetic doses, there are still the well known side effects seen after anesthesia using this drug. They are confusion, delirium, vivid dreams, hallucinations and feelings of detachment from the body. Some clinicians routinely use haloperidol or a benzodiazepine to alleviate these distressing symptoms.

Ketamine and Opioids

There is evidence that ketamine reverses morphine tolerance and clinically this results in the reappearance of morphine sensitivity. In practical terms this means that it is necessary to reduce the morphine dose at the same time as introducing ketamine to avoid the problems associated with morphine toxicity. It may need to be reduced by 30-50%.

Dosage

The doses recommended are 10-30mg, given subcutaneously (sc), then starting an infusion dose of 300mg/24hrs via a syringe driver, then 350mg/24 hr etc to maximum of 700mg/24 hr. Alternatively, rather than using a syringe driver intermittent doses can be given by the sc route. This may also have a role for painful wound dressings.

Hypercalcemia in Malignancy

Hypercalcemia is the most common life threatening metabolic disorder associated with cancer. Ten percent of cancer patients develop hypercalcemia. It occurs most frequently with myeloma (up to 50% of patients) and with breast, lung and renal cancers. Up to 20% of cases occur without bone metastasis.

A patient with hypercalcemia in malignancy (HCM) may present with mild symptoms such as fatigue, mental dullness, weakness, anorexia or constipation. More severe symptoms may be nausea, vomiting, confusion, drowsiness or even coma. Pain may be precipitated or exacerbated by hypercalcemia. Dehydration or cardiovascular collapse may occur in severe cases.

Diagnosis is by biochemical investigation. Allowances should be made for hypoalbuminemia commonly seen in these patients. (For every 1g/L, the plasma albumin concentration falls below the mean normal albumin for a given laboratory, add 0.02 to the total calcium concentration as measured in mmol/L.)

Normal Calcium Metabolism

The body stores 1 Kg of calcium mostly in bone, and the kidney monitors this. Two hundred mg is absorbed from the diet each day, and a similar amount is excreted by the kidney, maintaining homeostasis.

The kidney is very important in the day to day calcium balance - it filters 10,000 mg of calcium a day, reabsorbing most (9,800 mg) of this, but it can excrete up to 1,000 mg, if required, to maintain homeostasis.

Three hormones are important in calcium metabolism: parathyroid hormone (PTH), vitamin D and calcitonin. PTH acts on the kidney and bone as well as activating vitamin D, which acts on the gut, kidney and bone, to increase calcium.

Raised serum calcium normally switches off PTH and switches on calcitonin, stopping calcium release from bone, and reducing renal calcium resorption, increasing urinary calcium loss.

Hypercalcemia is not principally due to bone destruction by metastases, but rather it is a paraneoplastic phenomenon and unrelated to the presence of bone secondaries. In most cases hypercalcemia is due to release of humoral factors by the tumor which activate osteoclasts and interfere with renal excretion.

Symptoms and Management

The symptoms of hypercalcemia are well known but variable, and relate more to rate of change than actual calcium level. Various treatments are available, including tumor ablation (if possible), rehydration (but not forced saline diuresis), inhibition of bone resorption by mithramycin, steroids, and biphosphonates.

Other agents include calcitonin, gallium nitrate and octreotide. Note that none of these drugs have any effect on the renal component of hypercalcemia except calcitonin, and it is short lived. All the rest interfere with bone resorption by osteoclasts.

Quality of Life

Physiotherapy in palliative care is oriented to achieve the optimum quality of life as perceived by the patient. It aims to facilitate the patient's ability to function with safety and independence in the face of diminishing resources. Traditional physiotherapy treatments need to be modified to accommodate the changing needs of the patient.

Lymphoedema occurs when the lymphatic system is damaged or blocked. Protein continues to enter the tissues from the blood capillaries in the normal way and a build up occurs in the tissues the lymphatics should be draining.

The accumulation of protein in the tissues causes excess fluid to enter them and the tissues to swell. The swelling decreases the oxygenation of the tissues, interferes with the normal functioning and makes them heal at a slower rate than normal.

Complex Physical Therapy (CPT)

CPT involves four aspects:

- skin care,
- special massage,
- compression bandaging and later intreatment fitted garments,
- special exercises to complement the massage.

Massage

The massage is based on the concept of emptying the central regions first to give the lymph from the periphery somewhere to go. Correct massage causes the collateral lymphatics in the superficial lymphatic networks to become larger and carry more lymph over to normally draining areas or lymphotomes.

Part of the idea of the massage is to gently force lymph across lymphatic watershed (lines dividing lymphotomes that drain in different directions). This dilates the collateral vessels and allows an alternative drainage path to the deeper collectors of a normal region. The other aspect of the massage moves tissue fluid into the initial and collecting lymphatics and through its lymph nodes.

Often the optimum drainage pathways in the palliative care patient are blocked by hard fibrous regions, ulcers, pressure sores, radiation burns, metastases, scar tissue etc. So again a practical understanding of the lymphatic system is important to modify treatment and choose an effective pathway for clearance.

Patient Education

Patients should be instructed:

- not to ignore a slight increase in size or ache in/or adjacent to the area;
- always keep the affected limb spotlessly clean; avoid trauma (knocks, cuts, sunburn, insect bites, and be careful cutting nails)

- notify doctor immediately if any redness or infection occurs as this should be treated at once with antibiotics. Tinea should also be treated with anti-fungal powders.
- not to carry heavy loads on the lymphoedematous arm; do not have blood pressure taken, injections or IV therapy on the lymphoedematous limb.

- When travelling by air a compression sleeve/stocking must be used; loose clothing/underwear should be worn so the few remaining lymphatics do not get blocked.
- do not over-exercise - ie do not make the limb ache with tiredness, or overheat; keep the skin supple and moist. Hamilton skin care products are good to use.

This is a particular risk with the build up of morphine seen as renal function diminishes during a terminal illness. Morphine dose and administration intervals need to be adjusted in these situations.

Morphine for Ischemic Pain

Morphine is of some but limited use for severe ischemic pain. Peripheral vasodilators are also of some use. An old drug well known to anesthetists is ketamine. Ketamine activates the limbic system and depresses the cerebral cortex producing profound analgesia, slight respiratory depression, cardiovascular stimulation and amnesia.

When simple touch leads to intense and prolonged pain resistant to other analgesics, ketamine may be considered.

Antidepressants in Palliative Care

Before discussing the use of antidepressants, it is appropriate to comment on the difficulty of diagnosing depression in the medically ill. Sad feelings are an acknowledged part of physical illness, especially when the illness is irreversible. However, dysphoria in itself is not sufficient for the diagnosis of depression.

The vegetative symptoms of depression, e.g. are lethargy and anorexia, often occur as part of illness and if these are not particularly disproportionate, the clinician is forced to rely upon the psychic symptoms of depression; particularly anhedonia (or loss of interest). If the affect is unreactive and anhedonia is pervasive for more than two weeks, the diagnosis of major depression is likely.

The frequency of this diagnosis amongst the medically ill is estimated at around 8-20%, depending on methodology. The diagnosis is missed in 30-50% of these patients. If there is significant doubt, a trial of treatment should be instituted.

Given that a diagnosis of major depression is made, the choice of pharmacological management is broad, bearing in mind that psychological and social strategies are also important.

Amongst the antidepressants available, all are of equal efficacy at adequate dose, being 60-70% efficacious in major depression over a four week period. All have a delayed onset of clinical effect and are less efficacious in "minor" or "neurotic/reactive depression". However, all agents are not equal in their accessory function and the choice will be dictated by the other functions that the medications are to serve and the side effect profile of each agent.

Specific Serotonergic Re-uptake Inhibitors

Currently the agents available are fluoxetine, paroxetine and sertraline. Fluoxetine has a very long half-life and is usually given at a dose of 20 mg/day but can be given second daily in the circumstances of significant liver dysfunction or a small, wasted patient.

Fluoxetine is as effective as the tricyclics in major depression, although it is not helpful as a sedative hypnotic and its role as a co-analgesic is not yet clear despite its serotonergic properties. Although mostly well tolerated in the medically ill, adverse effects do occur. Frequently, a subjective agitation will make this unsuitable in anxious patients.

In these patients it should therefore be coupled with a benzodiazepine or another agent should be used. Some nausea and anorexia is obviously a worry in a population concurrently at risk for this. Insomnia is also a common complaint although palliative patients may well be using other sedative medication already.

Headache may be complained of and this drug also has some extrapyramidal side effects which, given the dopaminergic sensitivity of those with HIV encephalopathy, make it unsuitable for many patients with advanced AIDS. Fluoxetine is safe in overdose and initial claims of particular worsening of suicidal behavior seem not to have been substantiated.

Complete Bowel Obstruction in the Terminally Ill Patient

Vomiting and colicky abdominal pain in a terminally ill patient with metastatic cancer causing bowel obstruction presents a major challenge.

When all surgical options have been explored and considered futile, it is time to commence appropriate medical management to minimize the suffering for such a patient.

The traditional approach of IV fluids and nasogastric suction while awaiting surgery is quite inappropriate for the continuing medical management of irreversible complete bowel obstruction in a patient with terminal cancer. IV fluids increase the hydration and potential for more gastric bowel secretion with resultant vomiting. Dehydration is a better tolerated option, so long as diligent mouth care is attended to.

Can The Obstruction Be Relieved Medically?

Sometimes obstruction, particularly if only partial, can be relieved by bowel rest, avoidance of over-hydration, and NG suction only if there is persistent vomiting.

Some physicians use steroids in an attempt to reduce peri-tumor edema and open the stenosis.

The dose used is controversial, some use dexamethasone 4mgm qid initially . Because the patient is unlikely to absorb this medication orally, it is recommended that it be given subcutaneously through a butterfly needle.

Reducing Nausea and Vomiting

- Restricting oral fluids to small frequent quantities of nutritious fluids (low residue) while continuing diligent mouth care. Ice can be helpful to keep the mouth moist.
- Minimizing IV therapy as mentioned above.

• If the obstruction is high, metoclopramide as a gastric emptying agent may make the situation worse and is contraindicated. If the obstruction is lower in the bowel and only partial, cisapride (propulsid 10mg qid) may have a role to play.

Haloperidol

This is a powerful antiemetic and can easily be given by the SC route. Dose used is 5-15mgm/day - parkinsonian side effects may occur in high doses.

Reducing Abdominal Pain

Abdominal pain can be either colicky or continuous and is to some degree opioid responsive. In addition to the use of SC morphine in carefully titrated doses, it is often necessary to add an antispasmodic for colicky pain.

Results of Medical Management of Terminal Malignant Bowel Obstruction

Control of continuous abdominal pain is very good with 89 percent of patients becoming pain free. Colic is harder to treat and 31 percent of patients continue to have mild colic. The management of nausea and vomiting is more difficult and the majority of patients continue to vomit about once a day, but experience little nausea.^{1*}

¹Barnes MJ, Oliver DJ, Carter RL. Medical management of intestinal obstruction in patients with abdominal malignant disease: a clinical and pathological study. *Lancet*. 1985; 11:990-3.

Terminal Restlessness:
Pain
Drugs
Metabolic disturbance
Infection
Constipation
Cerebral dysfunction
Post ictal
Anxiety
Withdrawal

Uncontrolled Pain and Other Symptoms

Uncontrolled pain can be a major contributor to restlessness and it is important to explore all avenues of dealing with pain, particularly the more difficult to manage neuropathic pain and pain due to anguish. Other symptoms such as dyspnea, retained secretions and urinary retention also need to be addressed.

Drugs

Many drugs cause cognitive decline, agitation, hallucinations and abnormal behavior. Polypharmacy is common in palliative care and great care is needed to rationalize drug treatment particularly in the elderly and frail patients.

Metabolism of drugs also needs to be taken into consideration with liver and renal failure so often seen in the deteriorating patient. Morphine doses can often be reduced, particularly if there is renal failure and/or dehydration. Drug interaction and side effects so often develop in a dehydrated patient with multisystem failure.

Stopping drugs is vitally important in terminal care but care is also needed to continue with judicious use of analgesics, and other drugs essential for pain and symptom control.

Metabolic

Uremia, hypercalcemia, hyponatremia, hypoxia from anemia or respiratory disease may be treatable but obviously should only be treated with comfort goals in mind. Invasive and detailed investigations and active treatment with unrealistic goals should be avoided.

Infections

Treating UTIs and respiratory infection may be helpful in reducing terminal restlessness in certain instances.

Constipation

This difficult problem in palliative care is worth treating diligently and may improve the mental state of some patients, but expectations should relate realistically to intake of food.

Cerebral Causes

Primary or secondary tumor can cause severe mental confusion and drowsiness which usually responds well to dexamethasone 4 management qid which can be given either by the oral or subcutaneous route (mgm for mgm). Sometimes other sedatives are needed as described below.

Post Ictal

Anticonvulsants may improve the mental state for some patients with recurring fits.

Anxiety

Terminal restlessness can be caused by unresolved family conflict, denial, fear, spiritual dilemmas etc. and counseling and support can be helpful in this situation.

Withdrawal

Withdrawal of alcohol, narcotics or even nicotine in heavy users can cause restlessness in terminal patients. Simple measures such as nicotine patches can help.

Treatment

Sedation

The Benzodiazepines

This group of drugs is very helpful for terminal restlessness, sedation, fitting, myoclonic jerking, etc. They are also useful for minor procedures (e.g. fecal disimpaction), and for catastrophic events such as severe hemorrhage (because of their amnesic effects).

Neuroleptics

For the more severely disturbed and confused patient, neuroleptics are often needed, sometimes in conjunction with benzos. Also if there is an adverse reaction to benzos, neuroleptics may be needed.

Bereavement support is an essential component in the care of the dying; it must be available to the patient and family during the illness period. Care for the patient must extend beyond the time of immediate death of the patient. The type of support required should be based on the needs of survivors, including the degree to which they are at risk of complicated grief reactions.

Palliative care is based on the following firm ethical and philosophical beliefs:

- People who are dying are of individual worth and value.
- Patient autonomy and control are to be respected.

- The relationship between care-giving professionals and patients should be one of integrity and truth, blended with sensitivity and compassion.
- Patients who are dying must be permitted to live their remaining lives in a manner consistent with their belief systems, personalities and values. Whenever possible, health care providers and society must strive to be flexible.

- The unique sociocultural values of patient, family and staff are recognized and respected.
- The intent of palliative care is neither to hasten nor inappropriately prolong the dying process.

Every physician and surgeon in practice should have a degree of knowledge about the care of dying patients. This includes:

- An understanding of the philosophy and ethics intrinsic to the care of the dying.
- Some knowledge of symptom control, including the use of opioid analgesics.

- Communication skills, particularly in giving difficult news, and telling truth in a gentle and accurate manner.
- An awareness of the needs of dying patients and their families, and of the local resources available to meet those needs in palliative and bereavement care.

- Knowledge about grief reactions and strategies for providing supportive counseling, the manifestations of acute grief (behaviors, emotions) and grief expressed through chronic sadness and loss.

Emergency Physician

- Knowledge of crisis theory and acute grief -- its manifestations and management
- Breaking difficult news in a sensitive way.
- Basic symptom control, particularly use of opioid analgesics, and conversion from oral to subcutaneous or intravenous dosing.

- Knowledge of community resources, particularly what is available if sending patient home.
- *Out of Hospital DNR*
- Working with colleagues (e.g., social workers, chaplains, nurses) to provide total care.

Out of Hospital DNR

- Do you know the rules in your state?
- Case

End of Life Decision-Making

- Case
