



SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Ospedaliero - Universitaria di Ferrara

Società Medico Chirurgica di Ferrara

Grandi insufficienze d'organo "end stage": cure intensive e/o cure palliative

Il parere del medico d'urgenza

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Ore 23.38

Codice rosso in shock room. A.B. 69 aa. Maschio

Ex grande fumatore, BPCO, Silicosi, Terapia inalatoria con Salmeterolo + Fluticasone e Tiotoprio. Metilprednisolone 16 mg x os. Teofillina. NIMV domiciliare per 16 ore al giorno. O2 1 l/min per il resto. Semiallettato da > 1 anno. Cachettico.

Febbre dal pomeriggio.

Progressivo deterioramento della coscienza

Kelly 3

SaO2 92 in O2 6 l/min

EGA: pH 7,22 pO2 64 mmHg pCO2 115 mmHg, Lac 5 mmol/l

TC 38° C

FC 122 bpm

PA: 80/50 mmHg, dopo riempimento volemico

Rx Torace: voluminoso addensamento flogistico campo medio e superiore a sinistra.

Ore 00.04

Convocati i familiari per comunicare le condizioni e l'intenzione di non procedere a trattamenti invasivi.

Risposta: "Dottore ma cosa sta dicendo, 1 mese fa al controllo andava tutto bene!"

Ore 17,45

Codice rosso al dispatch. C.F. 81 aa. Maschio

L'auto medica arriva con il paziente in arresto cardiaco in PEA.

I familiari insistono per non procedere a RCP.

Non sono state espresse dal paziente direttiva anticipate sul fine vita (DNAR)

Rapidamente si appura l'esistenza di una cardiopatia ischemica nota, classe NYHA IV in paziente più volte rivascolarizzato, semiallettato, cachettico.

Ultima coro 1 mese prima con esclusione di possibilità di rivascolarizzazione.

Ore 17,48

Il medico decide di sospendere la RCP

Ethical Dilemmas in Emergency Medicine

a report by

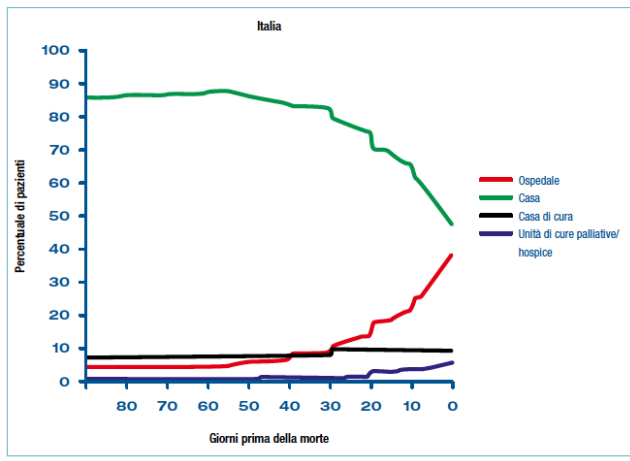
Jeremy S Franklin, MD¹ and Kenneth V Iserson, MD, MBA, FACEP, FAAEM²

Current ethical thought denies any fundamental moral difference between withholding and withdrawing medical treatment.¹ However, withholding medical treatment is a weightier matter, and requires a higher degree of evidence and support than withdrawing previously instituted medical treatments,² but withholding and withdrawing treatment still occur daily. Usually, this happens in a controlled inpatient or an ICU setting, and only after the medical evidence and input from the family or appointed medical decision-makers has been considered. However, in emergency medicine this controlled setting does not exist. Intervening quickly (usually with only limited information available) is central to our specialty. When treating our most critical patients, the norm is to have no knowledge about their past medical history, no family input, and an unclear picture of what has brought them into the ED.

Come si muore in Italia

Storia e risultati dello studio Senti-MELC

FIGURA 13.
Spostamenti del luogo di cura negli ultimi tre mesi.



In 2 su 3 la morte non è stata improvvisa o del tutto inattesa

Negli ultimi 3 mesi le transizioni sono:
~50% da casa ad ospedale
~10% dall'ospedale a casa
~10% da casa all'hospice

FIGURA 14.
Le ragioni degli spostamenti in Italia.

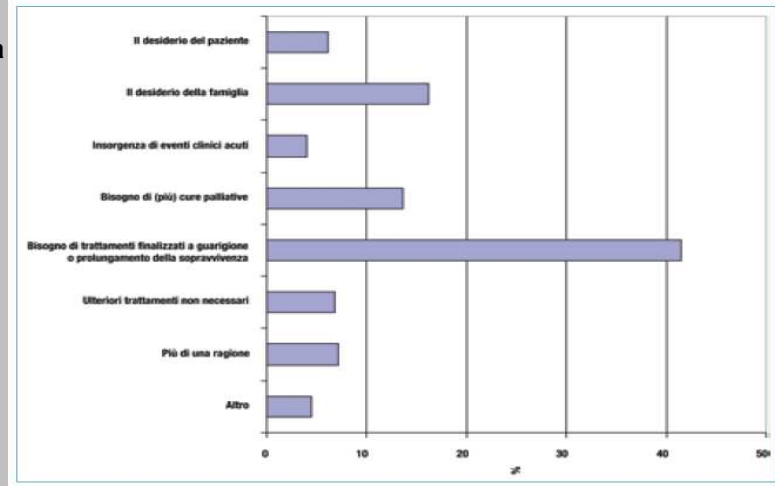


FIGURA 17.
Comunicazione della gravità di malattia.

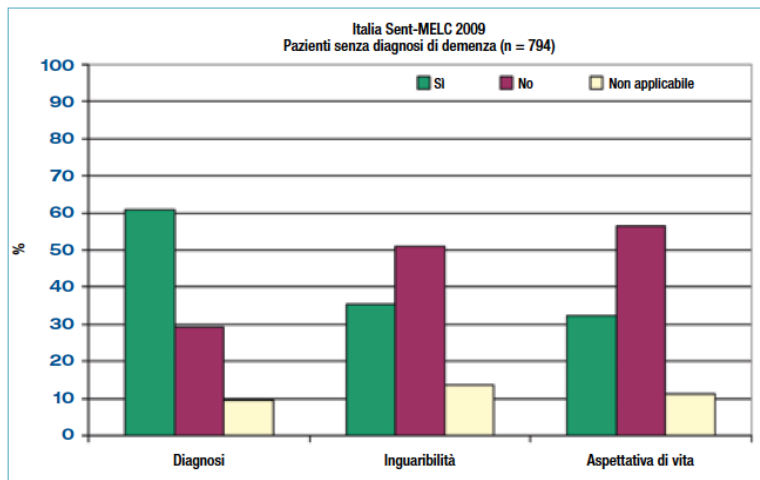
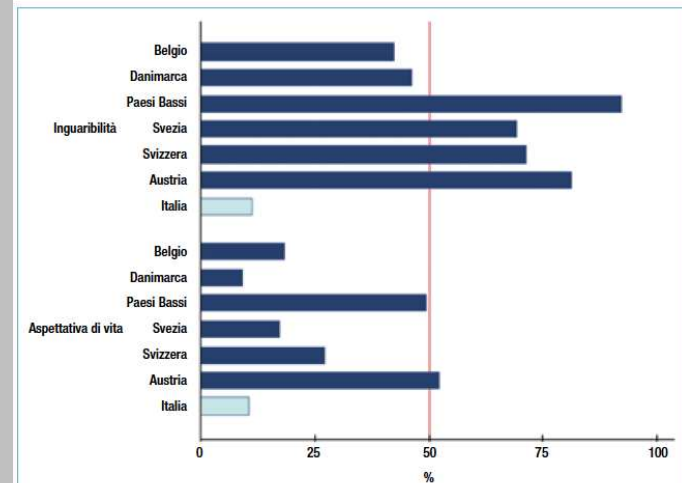


FIGURA 18.
Informazione nel fine vita: Eureld 2003 (da Cartwright et al, 2007, mod.)⁵.



In USA

In 2005, over 200,000 patients died in an emergency department (ED) in the US.

Nawar EW, Niska RW, Xu J. National Hospital Ambulatory Medical Care survey: 2005 emergency department summary. *Adv Data* 2007;29:1e32.

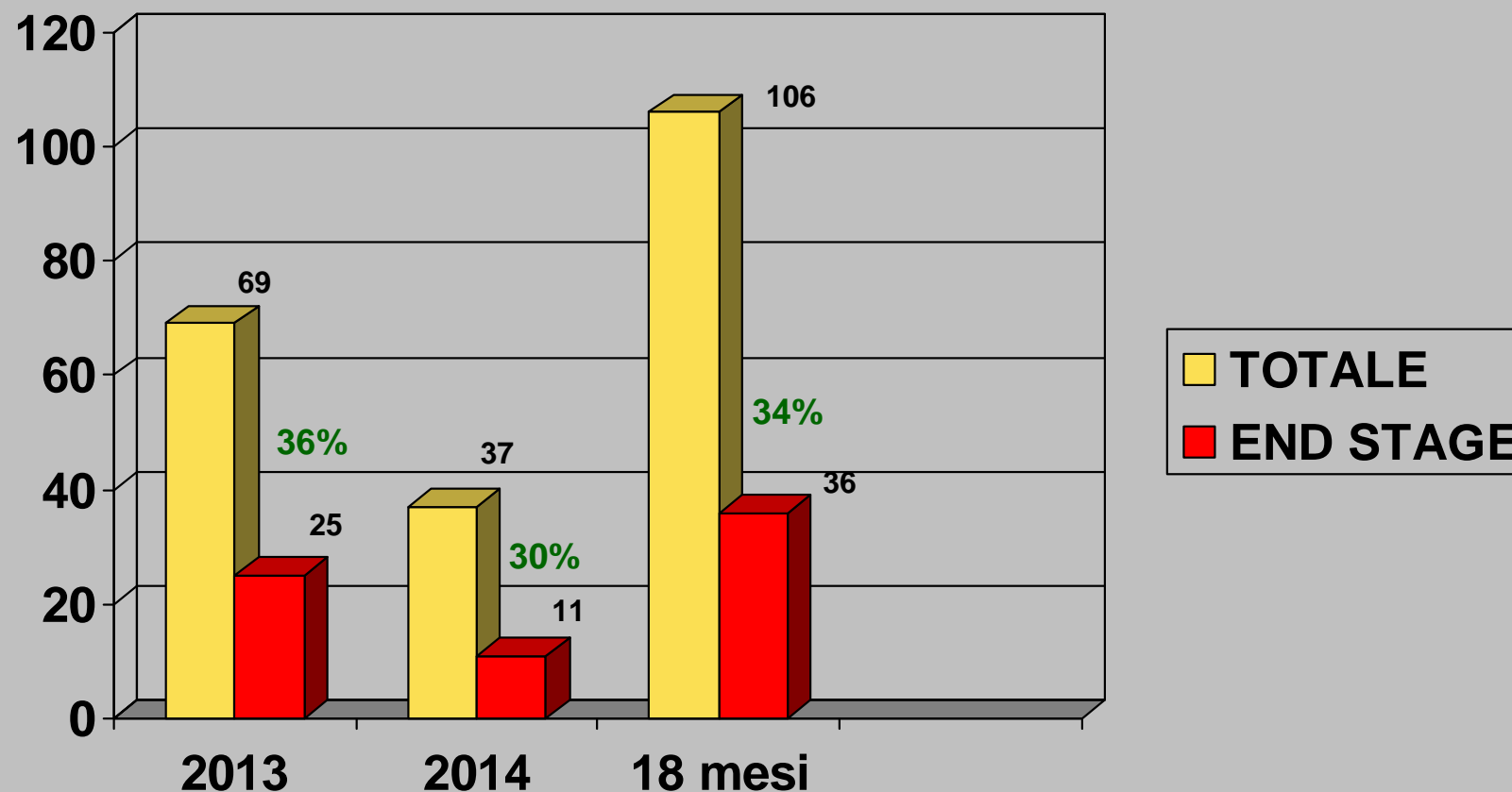
ENA. End-of-life care in the emergency department. [Position Statement]. 2005. Available from http://www.ena.org/SiteCollectionDocuments/Position%20Statements/End_of_Life_Care_in_the_Emergency_Department_ENA_PS.pdf. Accessed July 8, 2010.

Although the majority of Americans polled in a 1996 survey indicated that they would prefer to die in their homes, over 80% of US patients still die in hospitals or other institutions.

Emanuel LL, Quest T (eds), *The Education in Palliative and End-of life Care for Emergency Medicine (EPEC™-EM) Curriculum*©, The EPEC Project, 2008.

EPEC: Education in Palliative and End-of-life Care

Deceduti o Giunti Cadavere a Cona (1/1/2013 – 31/06/20149)



PALLIATIVE AND END-OF-LIFE CARE IN THE EMERGENCY SETTING

Description

The scope of emergency nursing involves the care of individuals throughout the lifespan, thus it is common for emergency nurses to care for patients with advanced, serious illness or injuries or who are nearing the end of their lives.¹ Since much of the care in the emergency setting is focused on lifesaving measures and urgent or immediate care, it can be challenging to change direction in the midst of a complex and often chaotic environment to provide palliative and end-of-life (EOL) care. Challenges to providing this specialty care have been described as time constraints, lack of patient information, and societal expectations of emergency care.²⁻⁵

Multiple definitions of palliative and EOL care exist in the literature. The National Consensus Project for Quality Palliative Care defined palliative care as “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.”⁶ Of note, palliative care is not solely reserved for patients at the end-of-life. Palliative care is given from the moment of diagnosis, concurrently with curative or disease-modifying therapy, as well as when illness is in its most advanced stages. Other sources further explain it as care that includes optimizing the quality of life; giving attention to emotional, cultural, social, and spiritual needs of the patient; involving family; preserving patient autonomy and rights; providing pain management; and supporting patient and family medical decision-making.²⁻⁵ Additional alternative care practices that allow the patient and family members to better manage the end-of-life experience include Allowing Natural Death (A.N.D.) and Physician Orders for Life-Sustaining Treatment (POLST).^{7,8} Integral to the core of these approaches is thoughtful, perceptive, open, and respectful communication.

A family has been defined in many ways. For the purposes of this position statement, the term “family” includes heterosexual or same-sex partners, with or without children, married or not, single-parent households, extended family members, and cohabitating couples, among others.⁹

ENA Position

It is the position of the Emergency Nurses Association that:

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Clinical & Practice Management

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Ethical Issues at the End of Life

Reaffirmed and approved by the ACEP Board of Directors April 2014

Revised and approved by the ACEP Board of Directors titled, "Ethical Issues at the End of Life" June 2008

Originally approved by the ACEP Board of Directors titled, "Ethical Issues in Emergency Department Care at the End of Life" September 2003

The American College of Emergency Physicians believes that:

- Emergency physicians play an important role in providing care at the end of life (EOL).
- Helping patients and their families achieve greater control over the dying process will improve EOL care.
- Advance care planning can help patients formulate and express individual

Related Links

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- » [Emergency Ultrasound Certification by External Entities](#)
- » [Participation in Activities While Distracted by Mobile Device Use](#)
- » [Freestanding Emergency Departments](#)
- » [911 Caller Good Samaritan Laws](#)



SIAARTI

PRO VITA CONTRA DOLOREM SEMPER

Documento condiviso

...., si ritiene che, sulla base del principio di precauzione e di intervento in stato di necessità, il medico debba intervenire anche in maniera invasiva per guadagnare tutto il tempo necessario per prendere successive decisioni disponendo di ulteriori dati clinici e biografici. La eventuale successiva decisione di sospendere i supporti invasivi può avvenire per l'emergere di una chiara volontà del malato o di una evidente futilità dei trattamenti

In caso di sofferenza psico-fisica provocata da sintomi refrattari nella fase terminale (ultimi giorni-ultime ore) è clinicamente appropriata e eticamente doverosa una sedazione terminale/palliativa che riduca la vigilanza, anche sino alla sua abolizione per il controllo della sofferenza giudicata intollerabile dal malato stesso.

DNAR e Trattamento futile

- In Italia il DNAR non esiste
- Trattamento futile è un trattamento che, in studi controllati, ha dimostrato una probabilità inferiore all'1% di sopravvivenza significativa ([Council on Ethical and Judicial Affairs, JAMA, 1999](#))
 - Il criterio quantitativo è vago e inutile in condizioni di emergenza soprattutto in pazienti compromessi
 - Anche qualitativamente il giudizio medico sul termine “significativa sopravvivenza” può non coincidere con quello del paziente o dei suoi familiari

Comunemente si considera futile un trattamento per effetto del quale non sono state riportate, in circostanze simili, sopravvivenze significative in studi controllati

EPEC[®] - Emergency Medicine

Education in Palliative and End-of-life Care for Emergency Medicine

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EPEC for Emergency Medicine

Education in Palliative and End-of-life Care for Emergency Medicine (EPEC - Emergency Medicine) is an adaptation of the original EPEC Curriculum that was designed to teach the essential clinical competencies in palliative care to professionals who work in the emergency department (ED). This curriculum was written and edited by emergency physicians and nurse educators with the goal of addressing issues that are specific to the practice of emergency medicine. Linda Emanuel, MD, PhD, is principle investigator and Tammie Quest, MD, is the co-investigator and project director. This project is supported by the National Institutes of Health.

Educational topics include quick steps for performing a rapid palliative care assessment in the ED; formulation of trajectories and prognoses; the care of hospice patients, patients who have cancer, and patients who experience chronic pain; and family-witnessed resuscitation. Emergency clinicians are taught how, when, and why to contact hospice or a primary care provider; how to communicate bad news to patients and families; and how to assess patients for psychological, spiritual, and social needs. Techniques for teaching palliative care to other emergency practitioners are also taught.

EPEC - Emergency Medicine is a high impact, conference-based education dissemination project that utilizes the train-the-trainer model developed in the original EPEC. Conference participants learn palliative and end-of-life care skills and principles and are also trained in teaching techniques that will allow them to train colleagues and students at their home institutions.

One goal of EPEC - Emergency Medicine is to work with the directors of emergency medicine residency programs to ensure that physicians-in-training are exposed to the core principles of palliative and end-of-life



Participants at the 2009 'Become an EPEC - EM trainer' Conference in Chicago.

The EPEC - Emergency Medicine faculty comprises a diverse set of emergency department professionals. The workshop sessions are taught by physicians, nurses, lawyers, and chaplains who have experience in emergency medicine and palliative care.

The inaugural 'Become an EPEC - Emergency Medicine Trainer' Conference was held in Chicago, IL. EPEC - Emergency Medicine trained the first set of trainers at this conference on August 3 & 4, 2007 and over 40 physicians, nurses, and social workers attended the two-day event. This was the first education in palliative and end-of-life care conference specifically geared to emergency department providers and it drew participants from across the United States and Canada.

'Become an EPEC - Emergency Medicine Trainer' Conferences have been held in Chicago, IL (September 5-6, 2008; July 10-11, 2009; April 30-May 1, 2010) and in New Orleans, LA (February 27-28, 2008). Check our

THE IPAL PROJECT

IMPROVING PALLIATIVE CARE

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Policy and Position Statements

American Academy of Pediatrics Committee on Pediatric Emergency Medicine; American college of Emergency Physicians Pediatric Committee; Emergency Nurses Association Pediatric Committee. Joint Policy Statement--Guidelines for Care of Children in the Emergency Department. Pediatrics. 2009; 124 (4):1233-1243.

American College of Emergency Physicians (ACEP) Position Statement on Ethical Issues at the End of Life. Available at <http://www.acep.org/Content.aspx?id=29440>. Accessed August 23, 2011.

Emergency Nurses Association (ENA) Position Statement on End-Of-Life Care in the emergency Department. Available at <http://www.ena.org/SiteCollectionDocuments/Position%20Statements/EndofLifeCareintheEmergencyDepartment.pdf>. Accessed August 23, 2011.

Hawryluck LA, Harvey WR, Lemieux-Charles L, Singer PA. Consensus guidelines on analgesia and sedation in dying intensive care unit patients. BMC Med Ethics. 2002;3:E3.

Herr K, Coyne PJ, Manworren R, McCaffety, Merkel S, Pelosi-Kelly J, Wild L. Pain assessment in the nonverbal patient: Position statement with clinical practice recommendations. Pain Management Nursing 2006;7:44-52.

Hospice and Palliative Nurses Association (HPNA) Position Statement on Withholding and/or Withdrawing Life Sustaining Therapies. Available at: [http://www.hpna.org/DisplayPage.aspx?Title=Position Statements](http://www.hpna.org/DisplayPage.aspx?Title=Position%20Statements). Accessed: June 1, 2010.

National Hospice and Palliative Care Organization (NHPCO) Position Statement and Call to Action on Access to Palliative Care in Critical Care Settings. Available at: http://www.nhpc.org/files/public/NHPCO_PC-in-ICU_statement_Sept08.pdf. Accessed June 1, 2010.

Wright JL, Johns C, Joseph JG. When Children Die: Improving Palliative and End-of-Life Care for Children and Their Families (2003) Board on Health Sciences Policy (HSP) Institute of Medicine (IOM). Appendix F: END-OF-LIFE CARE IN EMERGENCY MEDICAL SERVICES FOR CHILDREN.

Il compito del medico di urgenza

- Comunicare con i familiari
 - Preparare il colloquio
 - Aver chiara la successione degli eventi, essere sicuri dell'identità del paziente e del tipo di relazione del paziente con coloro con cui si sta comunicando, scegliere un ambiente idoneo.
 - Conoscere cosa sa il paziente (i familiari)?
 - Capire quanto il paziente (i familiari) vogliono sapere?
 - Condividere le informazioni
 - Saper approcciare i familiari anche se non si è al corrente di tutte le informazioni relative al paziente.
 - Saper gestire le emozioni
 - Saper affrontare la varietà delle reazioni (differenze personali, culturali, etniche), coinvolgere altre figure del PS che possano fornire conforto.
 - Saper comunicare un decesso

Il compito del medico di urgenza

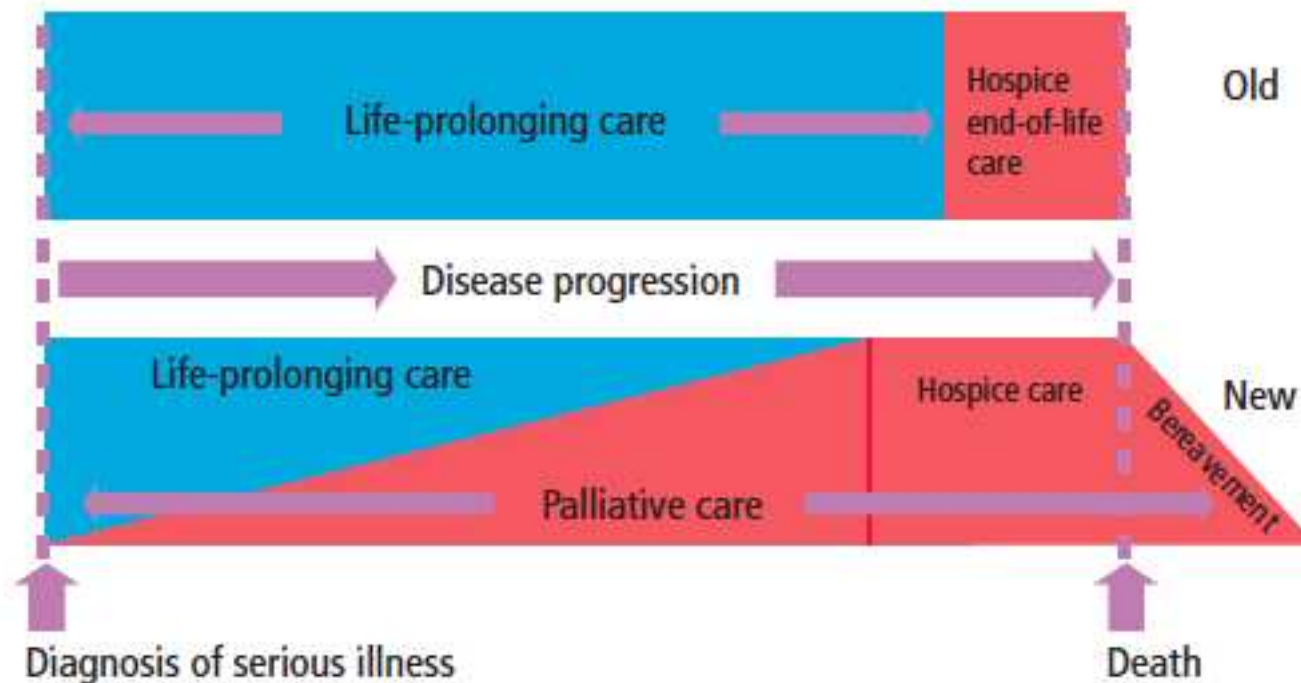
- Comunicare con il paziente, in caso non sia impellente un trattamento supportivo
 - Conoscere ed onorare eventuali direttive anticipate
 - Valutare la capacità decisionale del paziente e capire se qualche familiare o amico è riconosciuto come principale riferimento
 - Cercare di condividere gli obiettivi di un trattamento (in pazienti sufficientemente stabili) considerando necessità immediate, percezione del proprio stadio di malattia, sintomi che richiedano immediato trattamento, disponibilità a intraprendere un trattamento per un problema intercorrente e disponibilità ad un eventuale trattamento invasivo
- Eventualmente stimolare il paziente a considerare di esplicitare delle direttive anticipate per il futuro

Palliative and End-of-life Care in the Emergency Department

a report by

Michael A Gisoni, MD,¹ Tammie E Quest, MD² and Linda L Emanuel, MD, PhD³

Figure 1: Palliative Medicine Paradigms



Reference: Emanuel LL, Quest T (eds). *The Education in Palliative and End-of-life Care for Emergency Medicine (EPEC™-EM) Curriculum*. © The EPEC Project, 2008.

Cure palliative simultanee in PS

- Controllo del dolore
- Controllo degli squilibri idrici ed elettrolitici
- Gestione di nausea/vomito/costipazione
- Drenaggio di versamenti od ostruzioni
- Trattamento di infezioni intercorrenti
- Gestione dell'incontinenza
- O2/NIV
- Ansiolitici o antidepressivi se necessari

Review Article

A Literature Review on Care at the End-of-Life in the Emergency Department

Roberto Forero,¹ Geoff McDonnell,² Blanca Gallego,² Sally McCarthy,^{3,4} Mohammed Mohsin,^{5,6} Chris Shanley,⁷ Frank Formby,^{8,9} and Ken Hillman^{1,10}



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Royal College of EM - UK



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CLINICAL EFFECTIVENESS COMMITTEE

End of life care for adults in the Emergency Department

Best Practice Guidance (February 2012)

**Emergency Department
Palliative Care
Information Paper**



ADVANCING EMERGENCY CARE 

*Developed by Members of the
Emergency Medicine Practice Committee*

June 2012

ACEP - USA





A dying man needs to die, as a sleepy man
needs to sleep, and there comes a time when
it is wrong, as well as useless, to resist.

Stewart Johonnot Oliver Alsop (May 17, 1914 – May 26, 1974)
Stay of Execution: A Sort of Memoir (1973)