

PALLIATIVE CARE

Sedation-analgesia

- The goal of palliative sedation is to relieve suffering near the end of life
- The use of sedatives and analgesics to treat refractory end-of-life symptoms and suffering is referred to as *palliative sedation*

Concerns persist about *palliative sedation* unintentionally causing or hastening death

- Treating suffering at the end of life is morally justified even if death is hastened if the intention of the action is to relieve the suffering and not to cause death
 - Observational studies have found that the use of palliative sedation is not associated with shorter survival and, in some cases, may lengthen survival due to adequate control of life-threatening conditions
 - The principle of double effect
 - Debate remains as to whether the principle of double effect is appropriate, however, consensus remains that aggressive management of patients' symptoms and suffering near the end of life is ethically, legally, and professionally justified

Based on the above, for patients receiving end-of-life care in an ICU:

- The use of IV boluses or infusions of opioids to treat pain and dyspnea and benzodiazepines to treat agitated delirium and anxiety are common and recommended by professional societies.
- The use of propofol infusion used as a last resort for end-of-life symptoms associated with extreme distress that are refractory to other agents is also supported by professional recommendations, ethical principles, and legal precedent.
 - Although propofol infusions may raise concerns for causing respiratory depression and hastening death for patients not receiving mechanical ventilatory support, its use to treat end-of-life symptoms associated with extreme distress that are refractory to other agents is supported by professional recommendations, ethical principles, and legal precedent
 - Example of using propofol infusion:
 - Patient with refractory status epilepticus near the end of life on propofol IV infusion
 - Aggressive management of the patient's symptoms and suffering is warranted, and thus continuation of propofol IV infusion should continue after extubation

Organ procurement donation after circulatory death (DCD)

When pts receiving IMV with severe neurological damage short of "brain death" can donate organs

- Consult the organ procurement organization
- If the choice by family is to participate in the donation after circulatory death make arrangements with the transplant teams
- ICU provider goes to the OR to determine death

- Administer medications to keep the pt comfortable until death within the required time window for DCD
- Time threshold for cardiac death is usually 60 min after withdrawal of life support to meet the criteria for donation per DCD protocols
 - Most pts (76%) will die within 60 min and the median time to death is 20 min
- If a pt does not die within 60 min, the pt should return to the ICU, and end-of-life care should be continued
- After the withdrawal of life support and cessation of circulation, a waiting period of 2 to 5 min is required, the pt is then determined to be deceased, and the organs are retrieved
- A critical factor in the DCD program is that there is an absence of harm to the donor and valid consent to donation to allow organ donation
- Withdrawing means of life support allows the patient to die but does not cause death
 - Administering additional doses of sedation and analgesia in the absence of symptoms would cause the patient harm and hasten death

Lack of capacity and competency

Physicians can assess capacity or lack of capacity, but competency is a legal term

- Capacity is defined as a functional assessment and a clinical determination made by a clinician
- Competency is a global assessment and legal determination that extends beyond medical decision-making, includes financial and legal decisions, and is made by a judge in court
 - A person deemed incompetent by the courts can no longer refuse or accept treatment
 - Neither one physician nor two physicians can establish competency because this is a legal status determination

Lifesaving procedure in situations of medical emergency

- A physician has the right and responsibility to perform a lifesaving procedure if a patient lacks capacity without a substitute decision-maker in place.
- The physician can perform only lifesaving procedures (not all procedures) without consent from either the patient or surrogate if the patient lacks capacity for decision-making.

Examples of procedures considered lifesaving:

- Intubation for respiratory failure
- Central line placement for vasopressors
- Blood transfusions for patients bleeding and hemodynamically unstable

Less clear scenario:

- EGD - conscious sedation with stable Hb and hemodynamic stability