

TERMINAL CARE

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TERMINAL CARE

- Death incidence 11.8/1000/year
- 30 deaths/GP IN UK
- 65% die in Hospitals, 10% in hospices or public places, 25% at home
- 50% of those 25% will be anticipated deaths

ORGANISING DEATH!

- Open discussion
- Discuss place of death early
- Explore fears, concerns, beliefs
- Respect
- Family issues and involvement
- Multi-disciplinary approach
- Pre-bereavement support

GRIEVING PROCESS

- Numbness
- Denial
- Yearning
- Depression
- Guilt & Aggression
- Reintegration

PHYSICAL CARE

- Anticipate symptoms and treat
- Consider Total pain
- ‘Rescue medicines’

? IMMINENT DEATH:

- Rapid deterioration
- Weakness → Bed bound
- Difficulty with oral intake
- Central muscle loss
- Altered consciousness
- Increasing drowsiness

COMMON SYMPTOMS

- Pain
- Nausea & Vomiting
- Breathlessness
- ‘Death rattle’
- Restlessness
- Urinary problems

GENERAL MANAGEMENT

- Decrease medications
- Review route
- Consider Syringe Driver
- PRN Medications
- Review repeatedly

SYMPTOMS

- May need a Syringe Driver
- Diamorphine for Pain (convert the opioid dose or continue with patch, 5-10 mg for opioid naïve patients)
- Levomeprazine for agitation, nausea and hallucinations (12.5 – 50 mg)
- Midazolam for terminal agitation (5-60 mg)
- Hyoscine Hydrobromide for chest rattle and vomiting (800-100 mcg)

SYRINGE DRIVER

- Persistent nausea and vomiting
- Dysphagia
- Inability to take oral medications even before final stages
- Managing symptoms during terminal phase.

CARE OF THE DYING - 1

- Personal Hygiene
- Mouth care
- Pressure areas care

CARE OF THE DYING - 2

CONSIDER (DISCUSS):

- Bedside attendance
- Religious / cultural rituals
- Family /Friends
 - ...Fears ...Feelings ...Need for support
 - ...? Young children ...Elderly parents
- Patient's wishes
- Respect after death

SOME USEFUL PATHWAYS

- Liverpool Care Pathway
- Gold Standards Framework
- Refer to Local Hospice/Hospital/PCT Guidelines

GOOD DEATH

- What makes a good death?
 - peace, location, company, pain-free, with dignity
- Lack of data on how people die
 - especially patients' perspectives
 - different conditions, cultures, ages
- Are people afraid of dying rather than death?

END-OF-LIFE ISSUES

- Consent
- Confidentiality / Team
- Autonomy
- Truth Telling
- Life Prolonging Treatments (Hydration, withholding treatment, Resuscitation)
- Advanced Directives
- Provision of Alternative Therapy
- Research
- Assisted suicide / Euthanasia

MORAL THEORIES

- Deontology
Ethical or not decided by the action
 - Absolutism
 - Prima Facie
- Consequentialism
Ethical or not decided by the effects
- Virtue Ethics
- Ethics of care

ETHICS

- Prima Facie principles:
 - * Beneficence – Help your patients
 - * Non-Maleficence - Do not harm your patients
 - * Autonomy – Respect
 - * Justice – Treat fairly

ETHICS IN PALLIATIVE CARE

- Ethics applied against a background of:
 - * Respect for life
 - * Acceptance of the ultimate inevitability of death

AUTONOMY

- Doctors have an obligation to discuss treatment with patients
- Not having a consent for any form of treatment can be charged as ‘battery’.

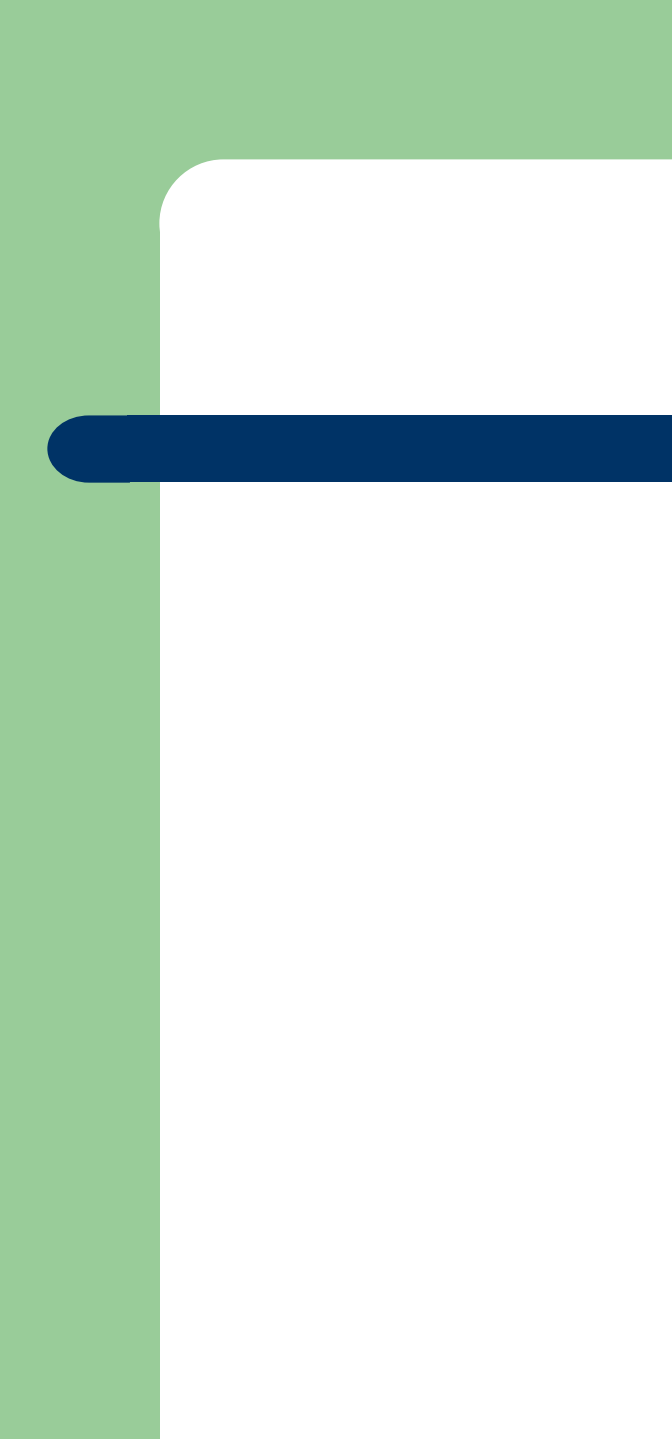
CONSENT

- The patient must be ***competent*** to give consent
- The consent must be based on provision of adequate ***information*** which must be shown to be ***retained***
- The consent must be ***voluntarily*** given

UK-1990

LIFE PROLONGING TREATMENT

- Parenteral hydration or medications
- Medications for concomitant diseases
- Cardiopulmonary Resuscitation



LIFE PROLONGING TREATMENTS

- Decide appropriate treatment with the patients, keeping in mind:
 - * the patient's biological prospects
 - * the therapeutic aim and benefits of each treatment
 - * the adverse effect of treatment
 - * the need not to prescribe a lingering death

(BMA 1998)

LIFE PROLONGING TREATMENT

- Obstacles:
 - Expectations
 - Difficulty with communications
 - Medical hierarchy
 - Fear of “failure”

DOCTRINE OF DOUBLE EFFECT

- If measures taken to relieve physical or mental suffering cause the death of a patient, it is morally and legally acceptable provided the doctor's intention is to relieve the distress and not to kill the patient.

(The trial of Dr John Bodkin Adams)

ADVANCED STATEMENT

- *‘Living Will’*
- Valid if patient is deemed incompetent
- Statement that how they wish to be or not to be treated
- Should be taken into account while making a decision (BMA-1995)
- Not legally binding (*unless case-specific*)
- *Mental Capacity Act from 2007*

EUTHANASIA

- *‘Good Death’*
- A deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering
- Active act (as opposed to Physician Assisted Suicide)
- Lord Joffe’s Bill in House of Lords

EUTHANASIA

- *Is NOT:*
- Allowing nature to take its course
- Stopping biologically futile treatment
- Using Morphine and other drugs to relieve pain
- Using sedatives to relieve intractable mental suffering in dying patients

EUTHANASIA

- Legalised in Netherlands and Belgium
- Select Committee on Medical Ethics – UK (1997):

‘(There is) not sufficient reason to weaken society’s prohibition of intentional killing which is the cornerstone of law and of social relationships. Individual cases cannot reasonably establish the foundation of a policy which have such serious and widespread repercussions. The issue of euthanasia is one in which the interests of individual can not be separated from those of society as a whole.’