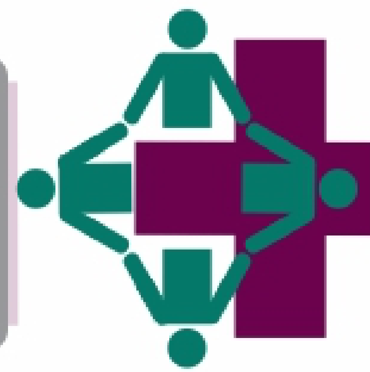
II FÓRUM DE CUIDADOS PALIATIVOS
DO CONSELHO FEDERAL DE MEDICINA

Data: 30 de novembro de 2016
Horário: das 08h às 18h
Local: Tivoli Hotel | São Paulo - SP



Cuidados Paliativos em UTI

Daniel Neves Forte

Caso clínico UTI

- **Maria, 79 anos, viúva**
- Trazida hoje ao Pronto-socorro pelo filho, sr. Antonio
- **QD: falta de ar há 1 dia após engasgar**

Caso clínico UTI

- **Maria, 79 anos, viúva**
- Trazida hoje ao Pronto-socorro pelo filho, sr. Antonio
- **QD: falta de ar há 1 dia após engasgar**

- **Antecedentes:**
  - Demência avançada (Alzheimer) – dependente para todas ABVD há pelo menos 1 ano
  - Pancitopenia a/e

Caso clínico UTI

- **Maria, 79 anos**
- **QD: falta de ar há 1 dia após engasgar**
  - Demência avançada (Alzheimer)
  - Pancitopenia a/e

Caso clínico UTI

- **Maria, 79 anos**

- **Exame físico de entrada:**
- Glasgow 6, FC 110, PA 8x5, TEC ~5s, FR 36, T37,8ºC, Sat 79% em AA => 89% com máscara reservatório, uso de musculatura acessória intercostal e fúrcula, roncos grosseiros bilaterais.
- Abdomen escavado
- Emagrecida, sem edemas, pele íntegra

Caso clínico UTI

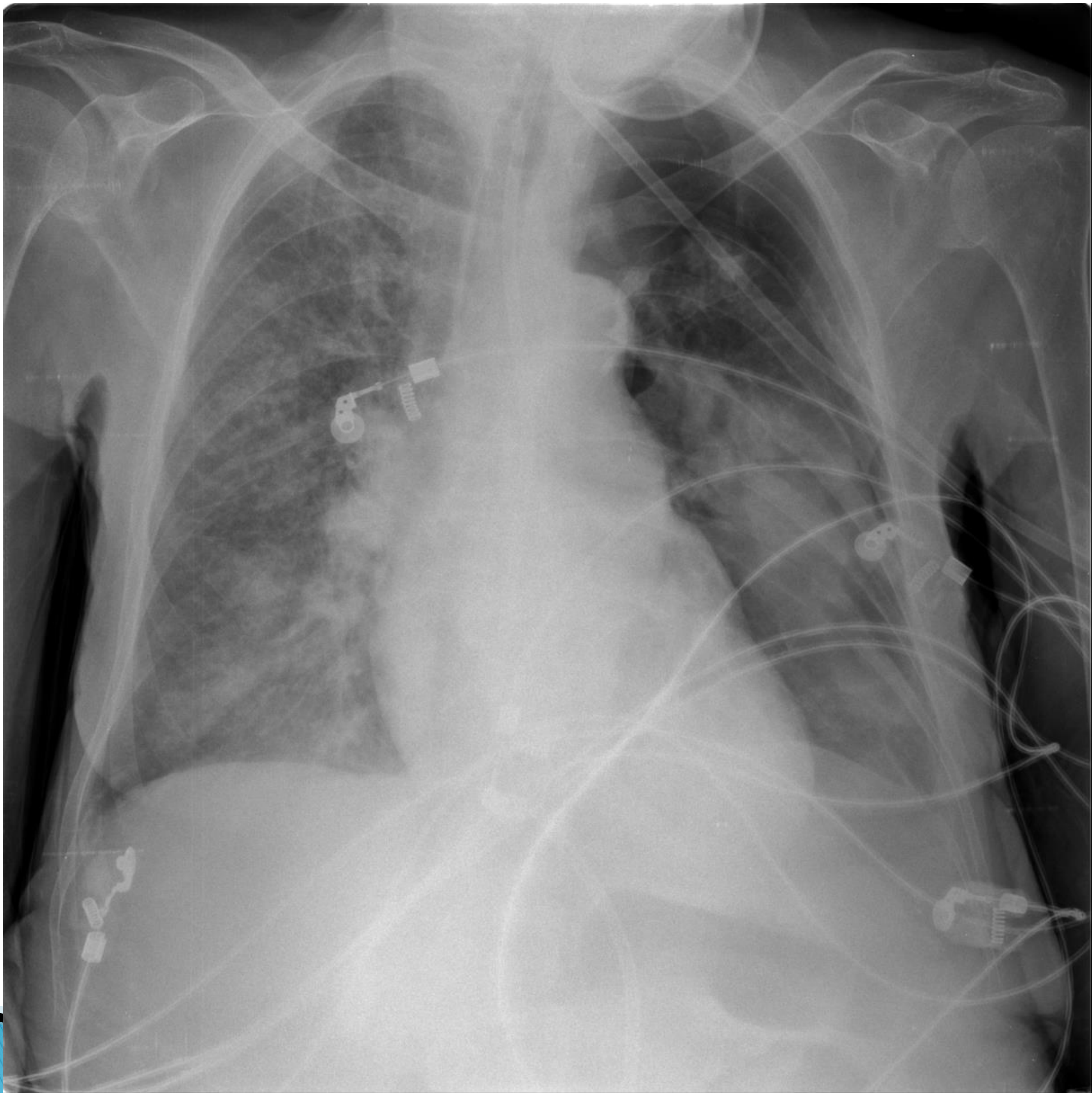
- **Maria, 79 anos**
- **QD: falta de ar há 1 dia após engasgar**
- Demência avançada (Alzheimer)
- Pancitopenia a/e

- **Diagnósticos:**
- **Broncoaspiração + insuf. Respiratória aguda**

Caso clínico UTI

- **Maria, 79 anos**
- **QD: falta de ar há 1 dia após engasgar**
- Demência avançada (Alzheimer)
- Pancitopenia a/e

- **Diagnósticos:**
- **Broncoaspiração + insuf. Respiratória aguda**
- **Cd:**
- **1. sala de emergência + MOV**
- **2. SF 500ml EV aberto agora**
- **3. Ceftriaxone 2g EV agora**
- 4. Morfina 1mg EV agora
- 5. VNI
- 6. RX + lab



Exames de entrada

- Hemoglobina 6,9 g/dL
- Leucócitos 3.5 mil/mm³
  Neutrófilos 93,5%
  Eosinófilos 0,1%
- PLAQUETAS 80 mil/mm³
- PROTEÍNA C REATIVA (PCR) 69,7 mg/L
- SÓDIO 144 mEq/L
- CREATININA 1,6 mg/dL
- URÉIA 93 mg/dL
- ALBUMINA 2,7 g/dL
- Gasometria arterial: BE **–6,4 mmol/L**
  SO2 **93,4 %**
- LACTATO **12 mg/dL**

CFM
CONSELHO FEDERAL DE MEDICINA

RESOLUÇÃO CFM Nº 2.156/2016

(Publicada no D.O.U. de 17 de novembro de 2016, Seção I, p. 138-139)

Estabelece os critérios de admissão e alta em unidade de terapia intensiva.

RESOLUÇÃO CFM Nº 2.156/2016

(Publicada no D.O.U. de 17 de novembro de 2016, Seção I, p. 138-139)

Art. 6º A priorização de admissão na unidade de tratamento intensivo (UTI) deve respeitar os seguintes critérios:

§ 1º – Prioridade 1: Pacientes que necessitam de intervenções de suporte à vida, com alta probabilidade de recuperação e sem nenhuma limitação de suporte terapêutico.

§ 2º – Prioridade 2: Pacientes que necessitam de monitorização intensiva, pelo alto risco de precisarem de intervenção imediata, e sem nenhuma limitação de suporte terapêutico.

§ 3º – Prioridade 3: Pacientes que necessitam de intervenções de suporte à vida, com baixa probabilidade de recuperação ou com limitação de intervenção terapêutica.

§ 4º – Prioridade 4: Pacientes que necessitam de monitorização intensiva, pelo alto risco de precisarem de intervenção imediata, mas com limitação de intervenção terapêutica.

§ 5º – Prioridade 5: Pacientes com doença em fase de terminalidade, ou moribundos, sem possibilidade de recuperação. Em geral, esses pacientes não são apropriados para admissão na UTI (exceto se forem potenciais doadores de órgãos). No entanto, seu ingresso pode ser justificado em caráter excepcional, considerando as peculiaridades do caso e condicionado ao critério do médico intensivista.

RESOLUÇÃO CFM Nº 2.156/2016

(Publicada no D.O.U. de 17 de novembro de 2016, Seção I, p. 138-139)

Art. 6º A priorização de admissão na unidade de tratamento intensivo (UTI) deve respeitar os seguintes critérios:

§ 1° – Prioridade 1: Pacientes que necessitam de intervenções de suporte à vida, com alta probabilidade de recuperação e sem nenhuma limitação de suporte terapêutico.

§ 2º – Prioridade 2: Pacientes que necessitam de monitorização intensiva, pelo alto risco de precisarem de intervenção imediata, e sem nenhuma limitação de suporte terapêutico.

§ 3º – Prioridade 3: Pacientes que necessitam de intervenções de suporte à vida, com baixa probabilidade de recuperação ou com limitação de intervenção terapêutica.

§ 4° – Prioridade 4: Pacientes que necessitam de monitorização intensiva, pelo alto risco de precisarem de intervenção imediata, mas com limitação de intervenção terapêutica.

§ 5º – Prioridade 5: Pacientes com doença em fase de terminalidade, ou moribundos, sem possibilidade de recuperação. Em geral, esses pacientes não são apropriados para admissão na UTI (exceto se forem potenciais doadores de órgãos). No entanto, seu ingresso pode ser justificado em caráter excepcional, considerando as peculiaridades do caso e condicionado ao critério do médico intensivista.

- Médico do PS “desculpa, mas não estou conseguindo segurar esta paciente aqui” → pede vaga na UTI

- Médico do PS "desculpa, mas não estou conseguindo segurar esta paciente aqui" ➔ pede vaga na UTI

- Filho: sr. Antonio
  "eu quero que façam tudo!!"
  "aonde eu preciso assinar para intubarem minha mãe?"
  " já pediram a transfusão?"
  " vocês vão colocar logo a nutrição parenteral?"

E agora??

1989
Organização Mundial da Saúde

Cuidado Paliativo:

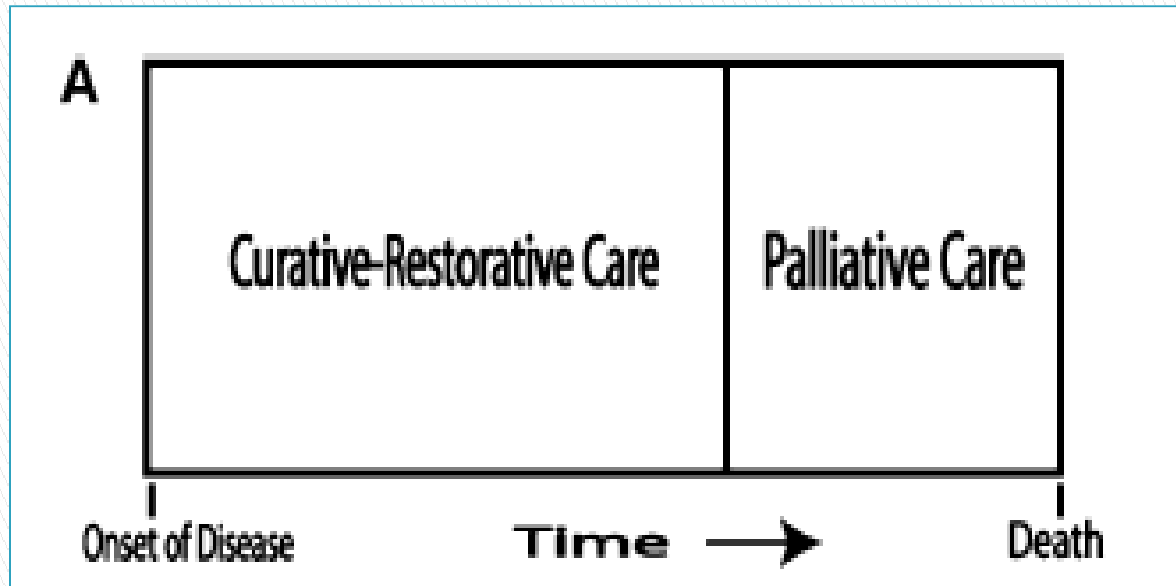
O cuidado total ativo de **pacientes cuja doença não é responsiva ao tratamento curativo**. O controle da dor, outros sintomas, e da psicológica, social e problemas espirituais é primordial.

Clarke, Lancet 2007

1989
Organização Mundial da Saúde

Cuidado Paliativo:

O cuidado total ativo de **pacientes cuja doença não é responsiva ao tratamento curativo**. O controle da dor, outros sintomas, e da psicológica, social e problemas espirituais é primordial.

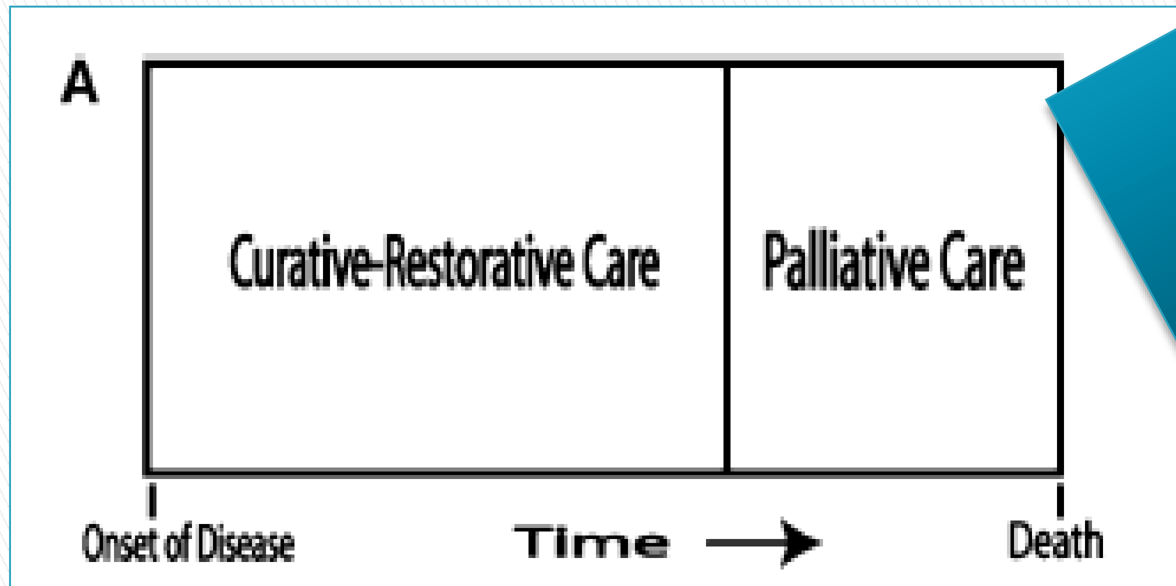


Lanken, 2008

1989
Organização Mundial da Saúde

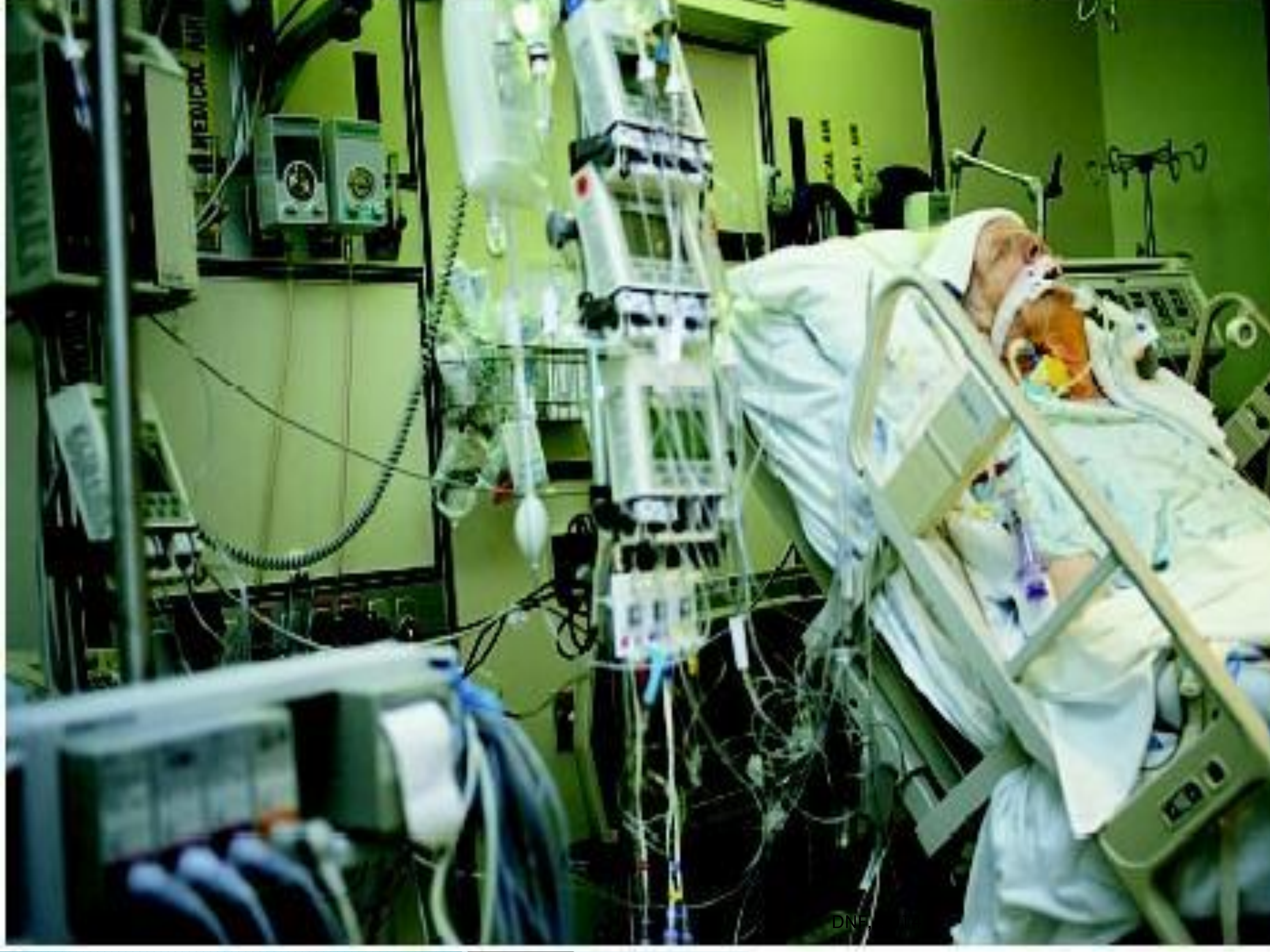
Cuidado Paliativo:

O cuidado total ativo de **pacientes cuja doença não é responsiva ao tratamento curativo**. O controle da dor, outros sintomas, e da psicoló ... social e problemas espirituais é primordia...



?

Lanken, 2008


DNF,

2002 Organização Mundial da Saúde Definição Cuidados Paliativos

www.who.int

2002 Organização Mundial da Saúde Definição Cuidados Paliativos

"Abordagem que busca
qualidade de vida...

www.who.int

2002 Organização Mundial da Saúde Definição Cuidados Paliativos

"…prevenção e alívio do sofrimento…

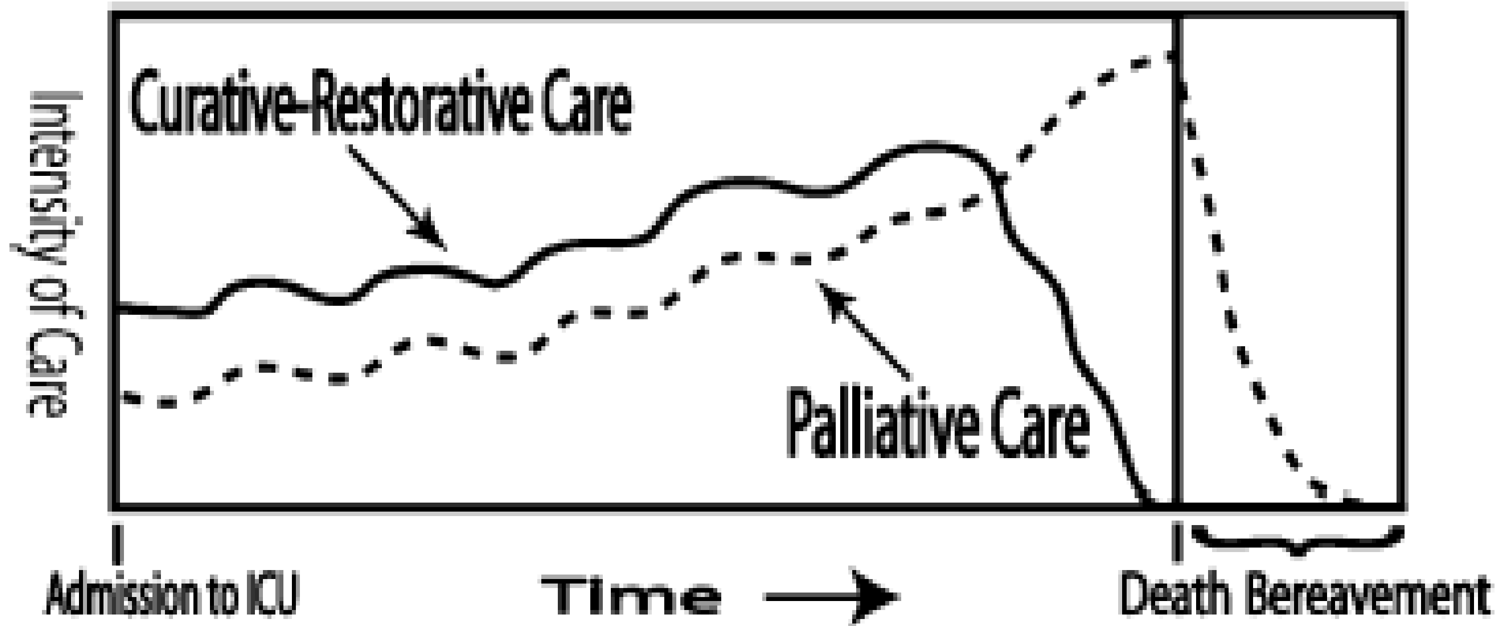
www.who.int

Definição Cuidados Paliativos Organização Mundial da Saúde

"…doenças que ameacem a vida…"

www.who.int

Cuidado paliativo



Consenso cuidados paliativos

Organização Mundial de Saúde 2002
American Thoracic Society 2008
CREMESP 2008
Academia Nacional de Cuidados Paliativos 2009
Forum AMIB 2011
American Society of Clinical Oncology 2012
American Heart Association, 2012

PubMed

"palliative care"

NCBI has completed the https test for today that ran from 8:00 AM - 12:00 PM EDT (13:00-17:00 UTC). If you experienced problems with NCBI web sites during that time, please read more about our https testing.

Format: Summary Sort by: Most Recent

Search results

Items: 1 to 20 of 56125

1. Policy on end of life and **palliative care** in the emergency department (P455).
   [No authors listed]
   Emerg Med Australas. 2016 Oct;28(5):617-621. doi: 10.1111/1742-6723.12674. No abstract available.
   PMID: 27651210

2. Eliciting the child's voice in adverse event reporting in oncology trials: Cognitive interview findings from the Pediatric Patient-Reported Outcomes version of the Common Terminology Criteria for Adverse Events initiative.
   Reeve BB, McFatrich M, Pinheiro LC, Weaver MS, Sung L, Withycombe JS, Baker JN, Mack JW, Waldron MK, Gibson D, Tomlinson D, Freyer DR, Mowbray C, Jacobs S, Palma D, Martens CE, Gold SH, Jackson KD, Hinds PS.

PubMed "palliative care"

NCBI has completed the https test for today that ran from 8:00 AM - 12:00 PM EDT (13:00-17:00 UTC). If you experienced problems with NCBI web sites during that time, please read more about our https testing.

Format: Summary Sort by: Most Recent

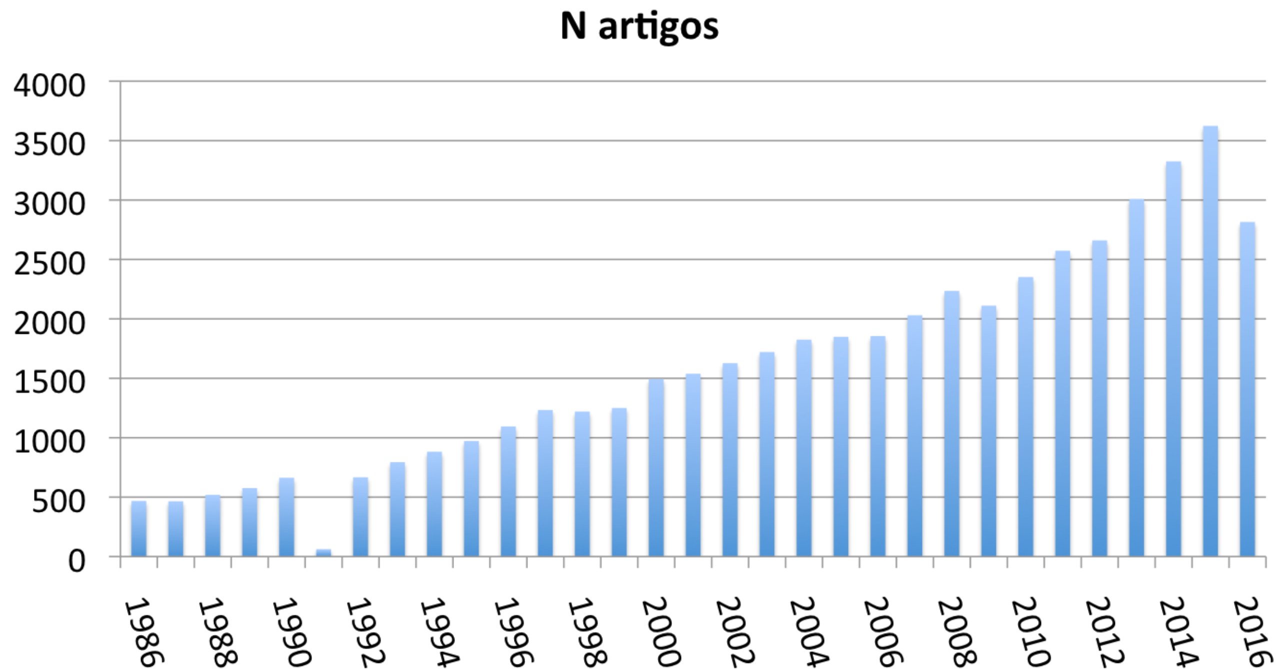
Search results

Items: 1 to 2 of 56125

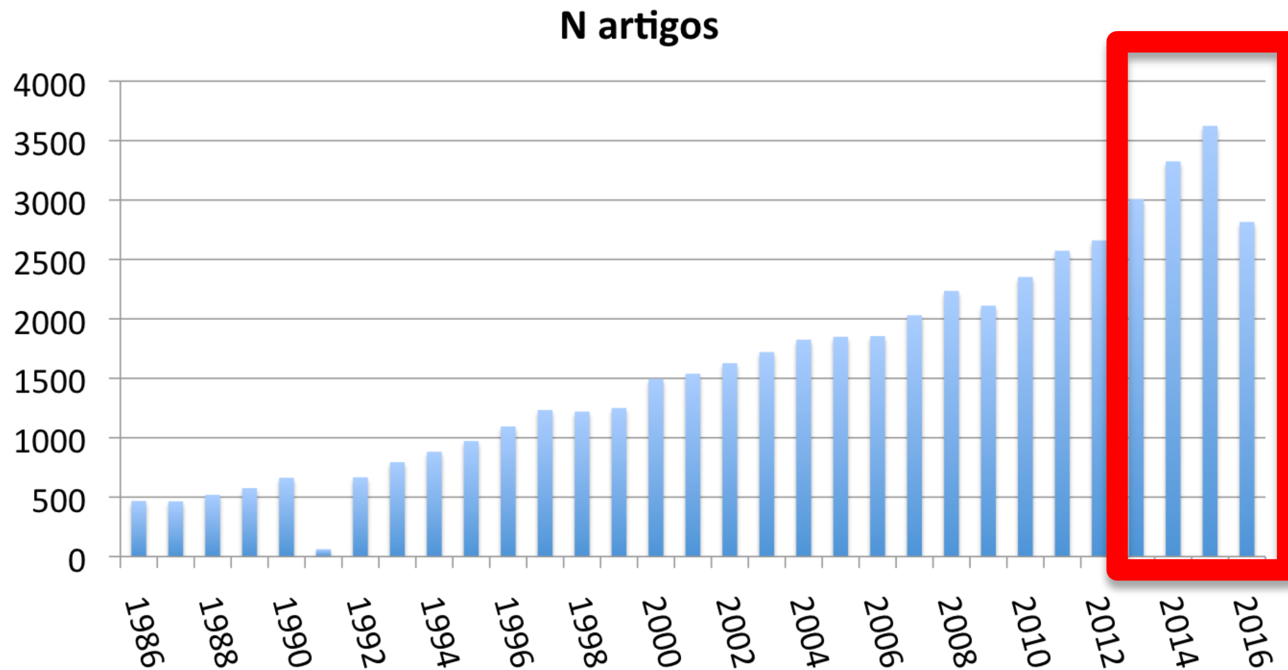
1. Policy on end of life and **palliative care** in the emergency department (P455).
[No authors listed]
Emerg Med Australas. 2016 Oct;28(5):617-621. doi: 10.1111/1742-6723.12674. No abstract available.
PMID: 27651210

2. Eliciting the child's voice in adverse event reporting in oncology trials: Cognitive interview findings from the Pediatric Patient-Reported Outcomes version of the Common Terminology Criteria for Adverse Events initiative.
Reeve BB, McFatrich M, Pinheiro LC, Weaver MS, Sung L, Withycombe JS, Baker JN, Mack JW, Waldron MK, Gibson D, Tomlinson D, Freyer DR, Mowbray C, Jacobs S, Palma D, Martens CE, Gold SH, Jackson KD, Hinds PS.

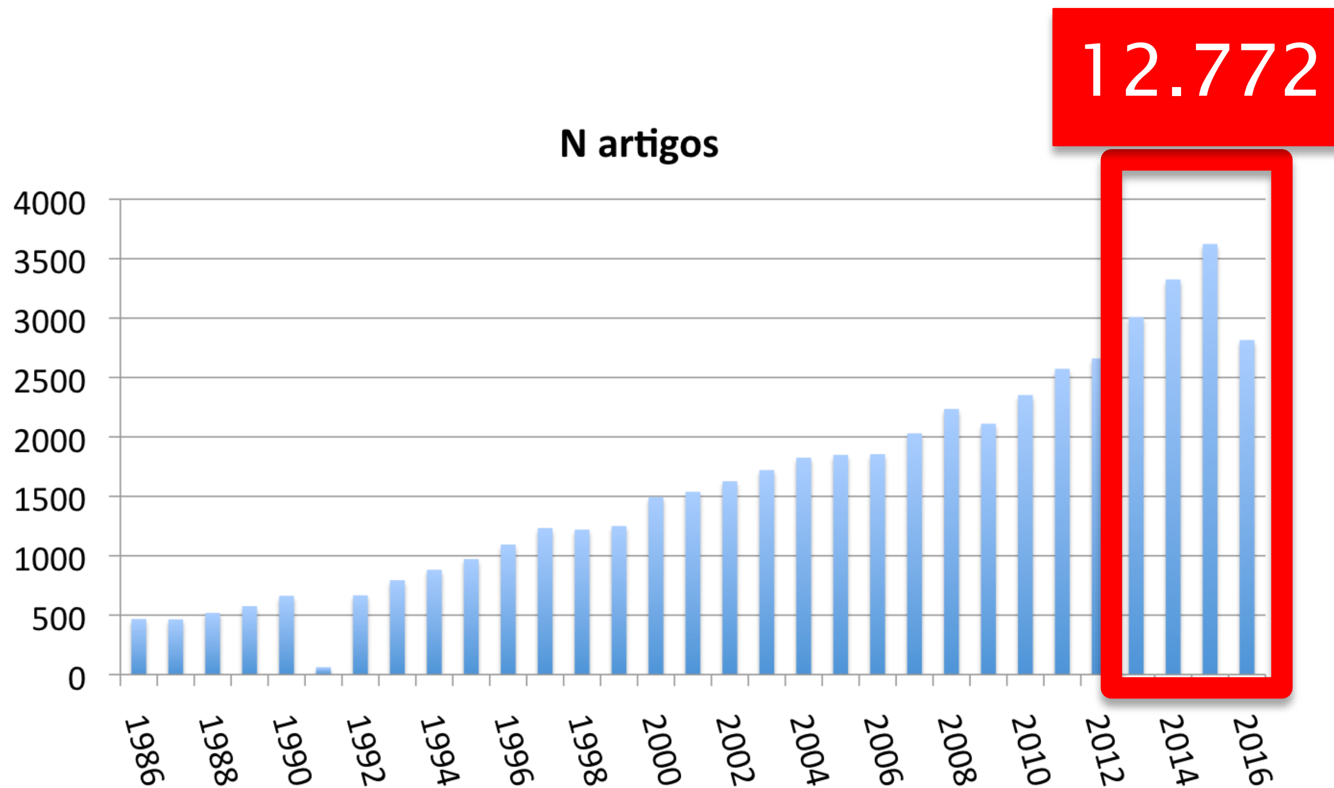
Pub med: artigos publicados sobre Cuidados paliativos/ano



Pub med: artigos publicados sobre Cuidados paliativos/ano



Pub med: artigos publicados sobre Cuidados paliativos/ano



REVIEW ARTICLE

CRITICAL CARE MEDICINE

Simon R. Finfer, M.D., and Jean-Louis Vincent, M.D., Ph.D., *Editors*

Dying with Dignity in the Intensive Care Unit

Deborah Cook, M.D., and Graeme Rocker, D.M.

N Engl J Med 2014;

REVIEW ARTICLE

CRITICAL CARE MEDICINE

Simon R. Finfer, M.D., and Jean-Louis Vincent, M.D., Ph.D., *Editors*

Dying with Dignity in the Intensive Care Unit

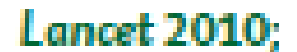
Deborah Cook, M.D., and Graeme Rocker, D.M.

N Engl J Med 2014;

Critical Care 2

Ethics and end-of-life care for adults in the intensive care unit

J Randall Curtis, Jean-Louis Vincent



REVIEW ARTICLE

CRITICAL CARE MEDICINE

Simon R. Finfer, M.D., and Jean-Louis Vincent, M.D., Ph.D., *Editors*

Dying with Dignity in the Intensive Care Unit

Deborah Cook, M.D., and Graeme Rocker, D.M.

N Engl J Med 2014;

Critical Care 2

Ethics and end-of-life care for adults in the intensive care unit

J Randall Curtis, Jean-Louis Vincent

Lancet 2010;

REVIEW

Clinical review: The role of the intensivist and the rapid response team in nosocomial end-of-life care

Andrew K Hilton[1], Daryl Jones[1,2] and Rinaldo Bellomo*[1,2]

Critical Care 2013,

An Official American Thoracic Society Clinical Policy Statement: Palliative Care for Patients with Respiratory Diseases and Critical Illnesses

Paul N. Lanken, Peter B. Terry, Horace M. DeLisser, Bonnie F. Fahy, John Hansen-Flaschen, John E. Heffner, Mitchell Levy, Richard A. Mularski, Molly L. Osborne, Thomas J. Prendergast, Graeme Rocker, William J. Sibbald†, Benjamin Wilfond, and James R. Yankaskas, on behalf of the ATS End-of-Life Care Task Force

THIS OFFICIAL STATEMENT OF THE AMERICAN THORACIC SOCIETY (ATS) WAS ADOPTED BY THE ATS BOARD OF DIRECTORS, MARCH 2007

TABLE 2. CORE COMPETENCIES IN PALLIATIVE CARE FOR PULMONARY AND CRITICAL CARE CLINICIANS RECOMMENDED BY THE *AD HOC* ATS END-OF-LIFE CARE TASK FORCE

Communication and Relationship Competencies

- Ability to communicate with empathy and compassion
- Ability to guide the family during the patient's final hours
- Ability to help the family during their period of grief and bereavement
- Ability to identify the patient's values, life goals, and preferences regarding dying
- Ability to identify psychosocial and spiritual needs of patients and families and resources to meet those needs
- Advance care planning with patient and family
- Coordination of care and ability to work effectively in an interdisciplinary team
- Cross-cultural sensitivity and cultural competence
- Information sharing, including ability to break bad news skillfully

Clinical and Decision-making Competencies

- Ability to apply sound ethical and legal decision making to situations arising from symptom management and withholding and withdrawing life-sustaining therapy
- Ability to resolve conflicts over futility, requests for physician-assisted suicide, or active euthanasia
- Establishing an overall medical plan including palliative care elements
- Ability to prognosticate survival and expected quality of life
- Managing withholding and withdrawing life-sustaining therapy and the patient's impending death
- Pain and nonpain symptom management, including dyspnea
- Using the shared decision-making model with families and other surrogates for patients lacking full decision-making capacity (32)

Lanken, 2008

II Forum of the "End of Life Study Group of the Southern Cone of America": palliative care definitions, recommendations and integrated actions for intensive care and pediatric intensive care units

Rev Bras Ter Intensiva. 2011;

Rachel Duarte Moritz[1], Alberto Deicas[2], Mônica Capalbo[3], Daniel Neves Forte[1], Lara Patrícia Kretzer[1], Patrícia Lago[1], Raquel Pusch[1], Jairo Othero[1], Jefferson Piva[1], Newton Brandão da Silva[1], Nara Azeredo[1], Raphaella Ropelato[1]

II Forum of the "End of Life Study Group of the Southern Cone of America": palliative care definitions, recommendations and integrated actions for intensive care and pediatric intensive care units

Rev Bras Ter Intensiva. 2011;

Rachel Duarte Moritz[1], Alberto

Intensive care unit palliative care flowchart	
For all phases, Prioritize • Individual decision-making • Symptoms control (pain, discomfort, dyspnea, dry mouth, noisy breathing, etc.)	**In all phases: Provide psychological and spiritual support** • Respect the existing beliefs/disbeliefs • Allow farewell ceremonies (appropriate to the environment) • Provide psychological support for: • Patient/family/team
Phase II **Death anticipated within days, weeks or months** Associated with the pathophysiological condition, chronic technological and/or therapeutic dependence • Stimulate empathic communication measures • Stimulate solidarity attitudes • Ease family members' presence • Evaluate the best site for providing palliative care • Allow ICU discharge • Establish priorities between palliative and/or curative cares • Prioritize the patient's comfort • Avoid futile interventions • Appropriate sedation-analgesia, ventilation support and nutrition measures • Appropriate monitoring and multi-professional care	**Phase III** **Death anticipated within hours or days** • Intensify empathic communication measures • Intensify solidarity measures • Permanently ease family members' presence • Prioritize the patient's comfort • Remove futile therapies (nutrition, vasoactive drugs, dialysis methods, etc.) • Appropriate measures (sedation-analgesia, ventilation support, etc.) • Appropriate monitoring and multi-professional care

Benefícios da abordagem de CP na UTI

Outcome	Selected Relevant Studies
↓ Intensive care unit/hospital length of stay	Campbell et al;[11] Campbell et al;[32] Norton et al;[13] Curtis et al[48]
↓ Use of nonbeneficial treatments	Campbell et al;[11] O'Mahony et al;[14] Pierucci et a[33]
↓ Duration of mechanical ventilation	Payen et al[38]
↑ Family satisfaction/comprehension	Azoulay et al[34]
↓ Family anxiety/depression, posttraumatic stress disorder	Lautrette et al[35]
↓ Conflict over goals of care	Lilly et al[27]
↓ Time from poor prognosis to comfort-focused goals	Campbell et al[11]
↑ Symptom assessment/patient comfort	Erdek and Pronovost;[36] Chanques et al[37]

↓, decreased; ↑, increased.

Nelson JE, Crit Care Med 2010

EAPC update www.ejpc.eu.com

Competências Centrais em Cuidados Paliativos: Um Guia Orientador da EAPC sobre Educação em cuidados paliativos – parte 1

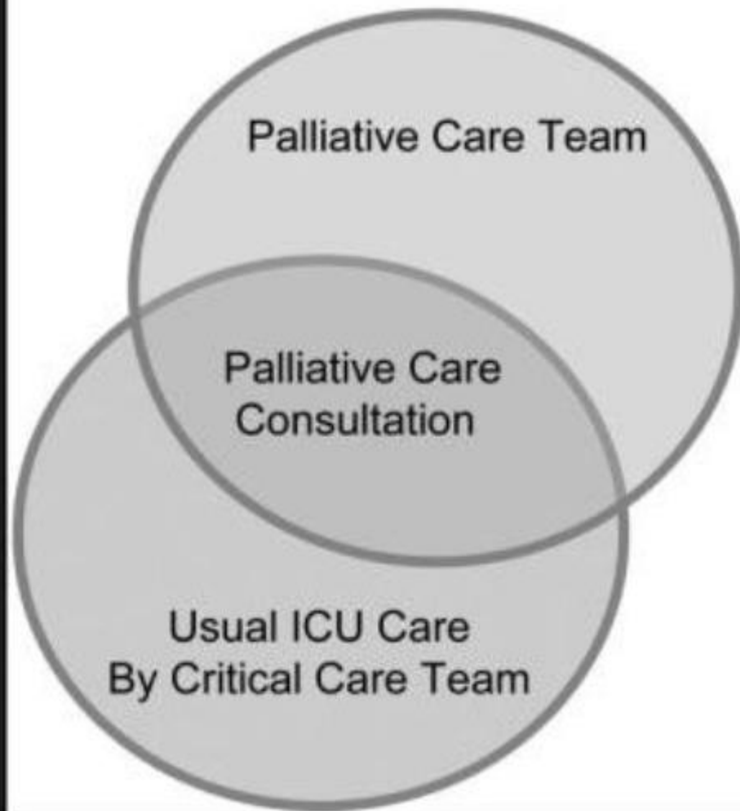
- Abordagem de cuidados paliativos
- Cuidados paliativos gerais
- Cuidados paliativos especializados

Cuidado Paliativo e UTI:
2 modelos principais

Nelson JE, Crit Care Med 2010

Models for Structuring An ICU-Palliative Care Initiative

Consultative Model



Integrative Model

Nelson JE, Crit Care Med 2010

Crit Care Med. 2010 September ; 38(9): 1765–1772. doi:10.1097/CCM.0b013e3181e8ad23.

Models for structuring a clinical initiative to enhance palliative care in the intensive care unit: A report from the IPAL-ICU Project (Improving Palliative Care in the ICU)*

Bundle CP – “care and communication bundle” IPAL-ICU

- Dia 1

a) identificar o familiar responsável
b) Avaliar se há diretiva antecipada/testamento vital
c) Avaliar status sobre RCP
d) Entregar folheto informativo
e) Avaliar e tratar dor

Nelson et al. Crit Care Med 2010

Bundle CP – “care and communication bundle” IPAL-ICU

Dia 1

a) identificar o familiar responsável
b) Avaliar se há diretiva antecipada/testamento vital
c) Avaliar status sobre RCP
d) Entregar folheto informativo
e) Avaliar e tratar dor

Até dia 3:

- oferecer suporte religioso/ assistente social

Nelson et al. Crit Care Med 2010

Bundle CP – "care and communication bundle" IPAL-ICU

Dia 1

a) identificar o familiar responsável
b) Avaliar se há diretiva antecipada/testamento vital
c) Avaliar status sobre RCP
d) Entregar folheto informativo
e) Avaliar e tratar dor

Até dia 3:

- oferecer suporte religioso/ assistente social

Até dia 5:

- conferência familiar

Nelson et al. Crit Care Med 2010

TABLE 2. CORE COMPETENCIES IN PALLIATIVE CARE FOR PULMONARY AND CRITICAL CARE CLINICIANS RECOMMENDED BY THE *AD HOC* ATS END-OF-LIFE CARE TASK FORCE

Communication and Relationship Competencies

- Ability to communicate with empathy and compassion
- Ability to guide the family during the patient's final hours
- Ability to help the family during their period of grief and bereavement
- Ability to identify the patient's values, life goals, and preferences regarding dying
- Ability to identify psychosocial and spiritual needs of patients and families and resources to meet those needs
- Advance care planning with patient and family
- Coordination of care and ability to work effectively in an interdisciplinary team
- Cross-cultural sensitivity and cultural competence
- Information sharing, including ability to break bad news skillfully

Clinical and Decision-making Competencies

- Ability to apply sound ethical and legal decision making to situations arising from symptom management and withholding and withdrawing life-sustaining therapy
- Ability to resolve conflicts over futility, requests for physician-assisted suicide, or active euthanasia
- Establishing an overall medical plan including palliative care elements
- Ability to prognosticate survival and expected quality of life
- Managing withholding and withdrawing life-sustaining therapy and the patient's impending death
- Pain and nonpain symptom management, including dyspnea
- Using the shared decision-making model with families and other surrogates for patients lacking full decision-making capacity (32)

DNF, 2014

Lanken, 2008

TABLE 2. CORE COMPETENCIES IN PALLIATIVE CARE FOR PULMONARY AND CRITICAL CARE CLINICIANS RECOMMENDED BY THE *AD HOC* ATS END-OF-LIFE CARE TASK FORCE

Communication and Relationship Competencies

- Ability to communicate with empathy and compassion
- Ability to guide the family during the patient's final hours
- Ability to help the family during their period of grief and bereavement
- Ability to identify the patient's values, life goals, and preferences regarding dying
- Ability to identify psychosocial and spiritual needs of patients and families and resources to meet those needs
- Advance care planning with patient and family
- Coordination of care and ability to work effectively in an interdisciplinary team
- Cross-cultural sensitivity and cultural competence
- Information sharing, including ability to break bad news skillfully

Clinical and Decision-making Competencies

- Ability to apply sound ethical and legal decision making to situations arising from symptom management and withholding and withdrawing life-sustaining therapy
- Ability to resolve conflicts over futility, requests for physician-assisted suicide, or active euthanasia
- Establishing an overall medical plan including palliative care elements
- Ability to prognosticate survival and expected quality of life
- Managing withholding and withdrawing life-sustaining therapy and the patient's impending death
- Pain and nonpain symptom management, including dyspnea
- Using the shared decision-making model with families and other surrogates for patients lacking full decision-making capacity (32)

DNF, 2014

Lanken, 2008

Am J Respir Crit Care Med Vol 180. pp 853–860, 2009

Prevalence and Factors of Intensive Care Unit Conflicts
The Conflicus Study

Élie Azoulay[1], Jean-François Timsit[2], Charles L. Sprung[3], Marcio Soares[4], Kateřina Rusinová[5], Ariane Lafabrie[1], Ricardo Abizanda[6], Mia Svantesson[7], Francesca Rubulotta[8], Bara Ricou[9], Dominique Benoit[10], Daren Heyland[11], Gavin Joynt[12], Adrien Français[2], Paulo Azeivedo-Maia[13], Radoslaw Owczuk[14], Julie Benbenishty[3], Michael de Vita[15], Andreas Valentin[16], Akos Ksomos[17], Simon Cohen[18], Lidija Kompan[19], Kwok Ho[20], Fekri Abroug[21], Anne Kaarlola[22], Herwig Gerlach[23], Theodoros Kyprianou[24], Andrej Michalsen[25], Sylvie Chevret[26], and Benoît Schlemmer[1], for the Conflicus Study Investigators and for the Ethics Section of the European Society of Intensive Care Medicine*

- 1 dia, 323 UTIs, 24 países, 7498 profissionais

Am J Respir Crit Care Med Vol 180. pp 853–860, 2009

Prevalence and Factors of Intensive Care Unit Conflicts

The Conflicus Study

Élie Azoulay[1], Jean-François Timsit[2], Charles L. Sprung[3], Marcio Soares[4], Kateřina Rusinová[5], Ariane Lafabrie[1], Ricardo Abizanda[6], Mia Svantesson[7], Francesca Rubulotta[8], Bara Ricou[9], Dominique Benoit[10], Daren Heyland[11], Gavin Joynt[12], Adrien Français[2], Paulo Azeivedo-Maia[13], Radoslaw Owczuk[14], Julie Benbenishty[3], Michael de Vita[15], Andreas Valentin[16], Akos Ksomos[17], Simon Cohen[18], Lidija Kompan[19], Kwok Ho[20], Fekri Abroug[21], Anne Kaarlola[22], Herwig Gerlach[23], Theodoros Kyprianou[24], Andrej Michalsen[25], Sylvie Chevret[26], and Benoît Schlemmer[1], for the Conflicus Study Investigators and for the Ethics Section of the European Society of Intensive Care Medicine*

- 1 dia, 323 UTIs, 24 países, 7498 profissionais
- Conflitos graves percebidos por 53%
- Mais frequente: médico–enfermeiro

Am J Respir Crit Care Med Vol 180. pp 853–860, 2009

Prevalence and Factors of Intensive Care Unit Conflicts
The Conflicus Study

Élie Azoulay[1], Jean-François Timsit[2], Charles L. Sprung[3], Marcio Soares[4], Kateřina Rusinová[5], Ariane Lafabrie[1], Ricardo Abizanda[6], Mia Svantesson[7], Francesca Rubulotta[8], Bara Ricou[9], Dominique Benoit[10], Daren Heyland[11], Gavin Joynt[12], Adrien Français[2], Paulo Azeivedo-Maia[13], Radoslaw Owczuk[14], Julie Benbenishty[3], Michael de Vita[15], Andreas Valentin[16], Akos Ksomos[17], Simon Cohen[18], Lidija Kompan[19], Kwok Ho[20], Fekri Abroug[21], Anne Kaarlola[22], Herwig Gerlach[23], Theodoros Kyprianou[24], Andrej Michalsen[25], Sylvie Chevret[26], and Benoît Schlemmer[1], for the Conflicus Study Investigators and for the Ethics Section of the European Society of Intensive Care Medicine*

- 1 dia, 323 UTIs, 24 países, 7498 profissionais
- Conflitos graves percebidos por 53%
- Mais frequente: médico-enfermeiro

- Fatores associados (A.M.): carga de trabalho>40h, UTI>15 leitos, sintomas não adequadamente controlados, paciente em fim de vida, UTI sem visita multi

CHEST

Inappropriate Care in European ICUs

Confronting Views From Nurses and Junior and Senior Physicians

Ruth D. Piers, MD, PhD; Elie Azoulay, MD, PhD; Bara Ricou, MD; Freda DeKeyser Ganz, RN, PhD; Adeline Max, MD; Andrej Michalsen, MD, MPH; Paulo Azevedo Maia, MD; Radoslaw Owczuk, MD, PhD; Francesca Rubulotta, MD, PhD; Anne-Pascale Meert, MD; Anna K. Reyners, MD, PhD; Johan Decruyenaere, MD, PhD; and Dominique D. Benoit, MD, PhD; for the Appropricus Study Group of the Ethics Section of the European Society of Intensive Care Medicine

CHEST 2014; 146(2):267-275

CHEST

Inappropriate Care in European ICUs

Confronting Views From Nurses and Junior and Senior Physicians

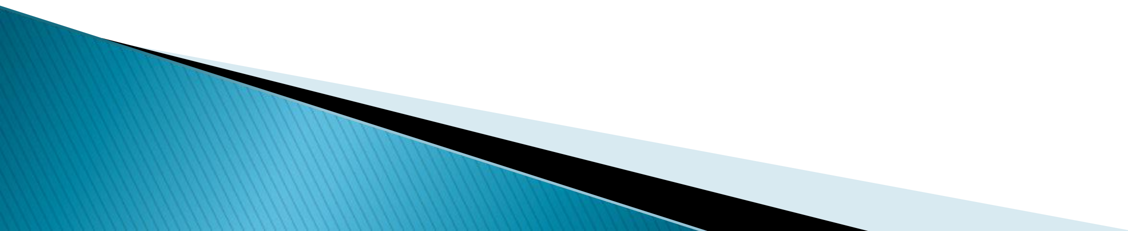
Ruth D. Piers, MD, PhD; Elie Azoulay, MD, PhD; Bara Ricou, MD; Freda DeKeyser Ganz, RN, PhD; Adeline Max, MD; Andrej Michalsen, MD, MPH; Paulo Azevedo Maia, MD; Radoslaw Owczuk, MD, PhD; Francesca Rubulotta, MD, PhD; Anne-Pascale Meert, MD; Anna K. Reyners, MD, PhD; Johan Decruyenaere, MD, PhD; and Dominique D. Benoit, MD, PhD; for the Appropricus Study Group of the Ethics Section of the European Society of Intensive Care Medicine

TABLE 2] Differences on Types of Scenarios of Perceived Inappropriate Care by Type of ICU Care Provider

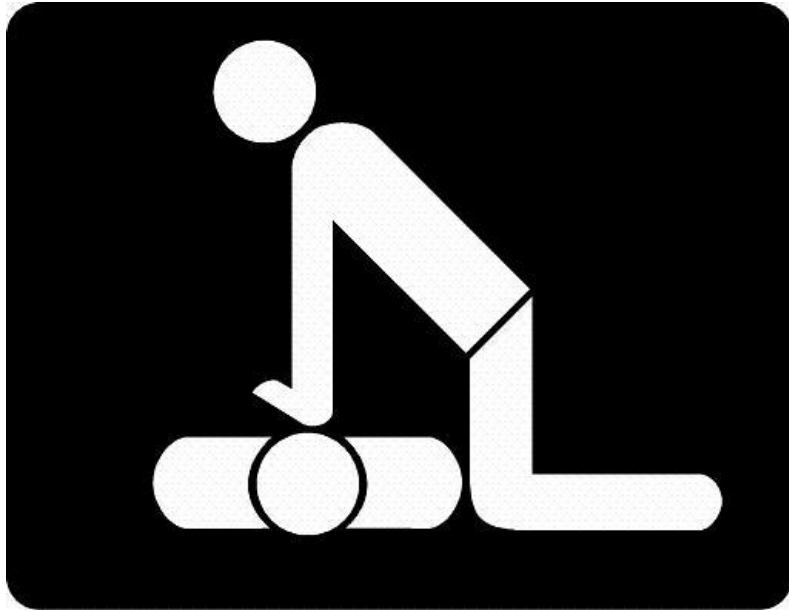
Scenario	Nurses (289 PIC cases)	Junior Physicians (54 PIC Cases)	Senior Physicians (90 PIC Cases)	*P* Value
Lack of proportion between level of care and prognosis (disproportionate care)	184 (64)	36 (67)	63 (70)	. 532
	85% excessive	93% excessive	94% excessive	. 205

CHEST 2014; 146(2):267-275

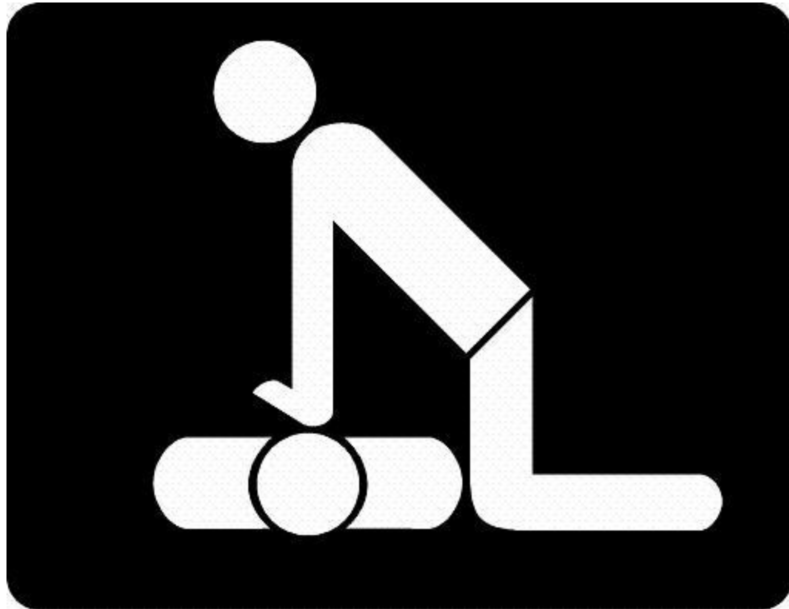
A família quer que faça tudo



A família quer que faça tudo



A família quer que faça tudo



The NEW ENGLAND JOURNAL of MEDICINE

N Engl J Med 2012;

ORIGINAL ARTICLE

Trends in Survival after In-Hospital Cardiac Arrest

Saket Girotra, M.D., Brahmajee K. Nallamothu, M.D., M.P.H.,
John A. Spertus, M.D., M.P.H., Yan Li, Ph.D., Harlan M. Krumholz, M.D.,
and Paul S. Chan, M.D., for the American Heart Association
Get with the Guidelines–Resuscitation Investigators

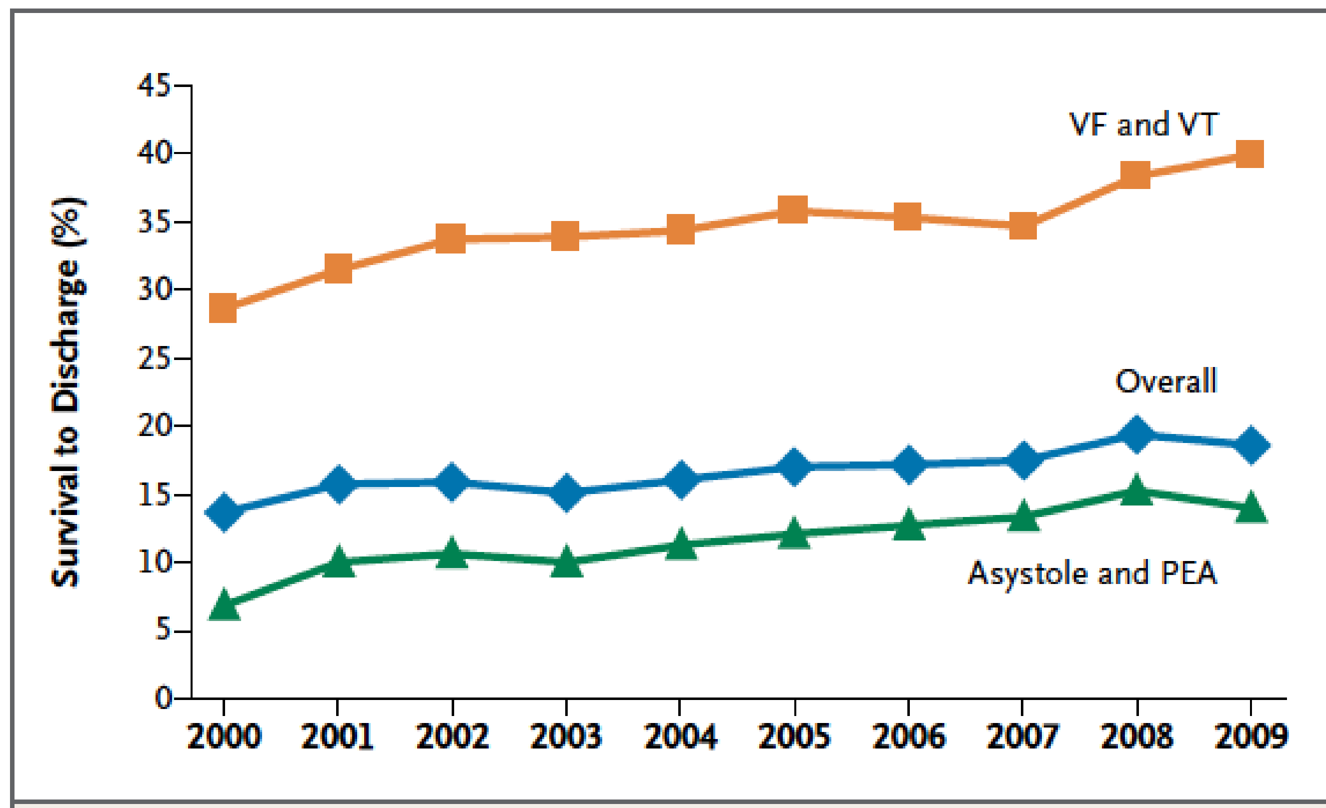
The NEW ENGLAND JOURNAL of MEDICINE

N Engl J Med 2012;

ORIGINAL ARTICLE

Trends in Survival after In-Hospital Cardiac Arrest

Saket Girotra, M.D., Brahmajee K. Nallamothu, M.D., M.P.H., John A. Spertus, M.D., M.P.H., Yan Li, Ph.D., Harlan M. Krumholz, M.D., and Paul S. Chan, M.D., for the American Heart Association Get with the Guidelines–Resuscitation Investigators



SPECIAL ARTICLE

CARDIOPULMONARY RESUSCITATION ON TELEVISION

Miracles and Misinformation

SUSAN J. DIEM, M.D., M.P.H., JOHN D. LANTOS, M.D., AND JAMES A. TULSKY, M.D.

Table 3. Survival after CPR in Three Television Series.

Series	No. of Episodes	No. of Occurrences of CPR	Short-Term Survival after CPR	Survival to Discharge after CPR	Short-Term Survival, Death in Hospital	Short-Term Survival without Follow-up
			number of patients (percent)			
Chicago Hope	22	11	7 (64)	4 (36)	3 (27)	0
ER	25	31	21 (68)	NA*	3 (10)	18 (58)
Rescue 911	50	18	18 (100)	18 (100)	0	0
Total	97	60	46 (77)	22 (37)	6 (10)	18 (30)

*Not applicable. *ER* deals only with events in the emergency department.

- 92% acreditavam em sobrevida > 50%
- 50% desconhecia chance de lesão pós anóxica

Agard, J Intern Med 2000

- Mudanca com informacao

O’Brien, JAMA 1995

CHEST Topics in Practice Management

Practical Guidance for Evidence-Based ICU Family Conferences*

J. Randall Curtis, MD, MPH, FCCP; and Douglas B. White, MD, MA

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

A Communication Strategy and Brochure for Relatives of Patients Dying in the ICU

Alexandre Lautrette, M.D., Michael Darmon, M.D., Bruno Megarbane, M.D., Ph.D.,

Communication Strategies and Cultural Issues in the Delivery of Bad News

JOSHUA S. BARCLAY, M.D.,[1,2] LESLIE J. BLACKHALL, M.D., M.T.S.,[3]
and JAMES A. TULSKY, M.D.[1,2,4]

JOURNAL OF PALLIATIVE MEDICINE
Volume 10, Number 4, 2007

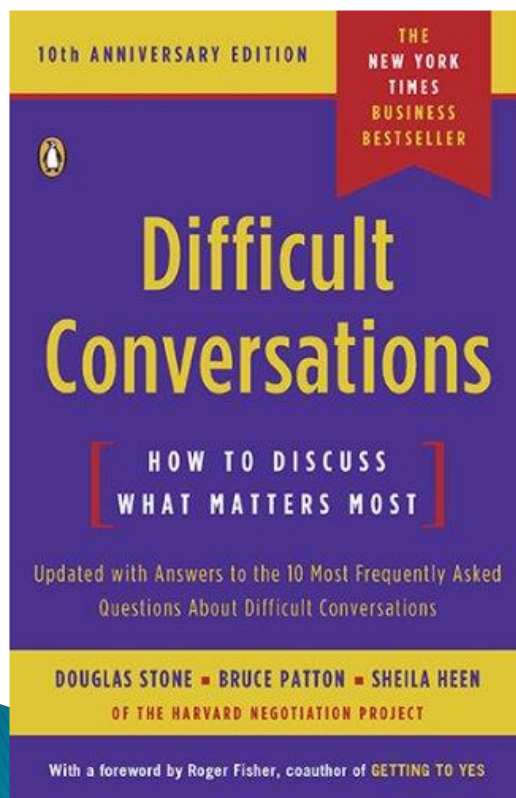
Dealing With Conflict in Caring for the Seriously Ill

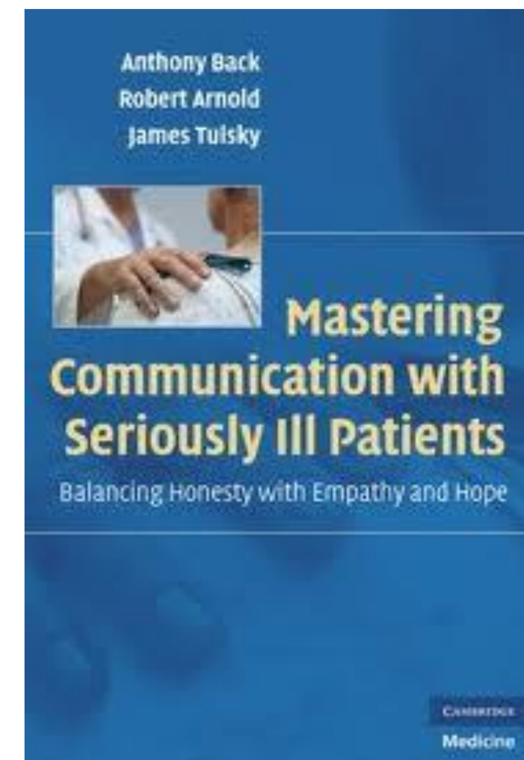
"It Was Just Out of the Question"

Anthony L. Back, MD

Robert M. Arnold, MD

JAMA. 2005;293:1374-1381





Conflict Management Strategies in the ICU Differ Between Palliative Care Specialists and Intensivists

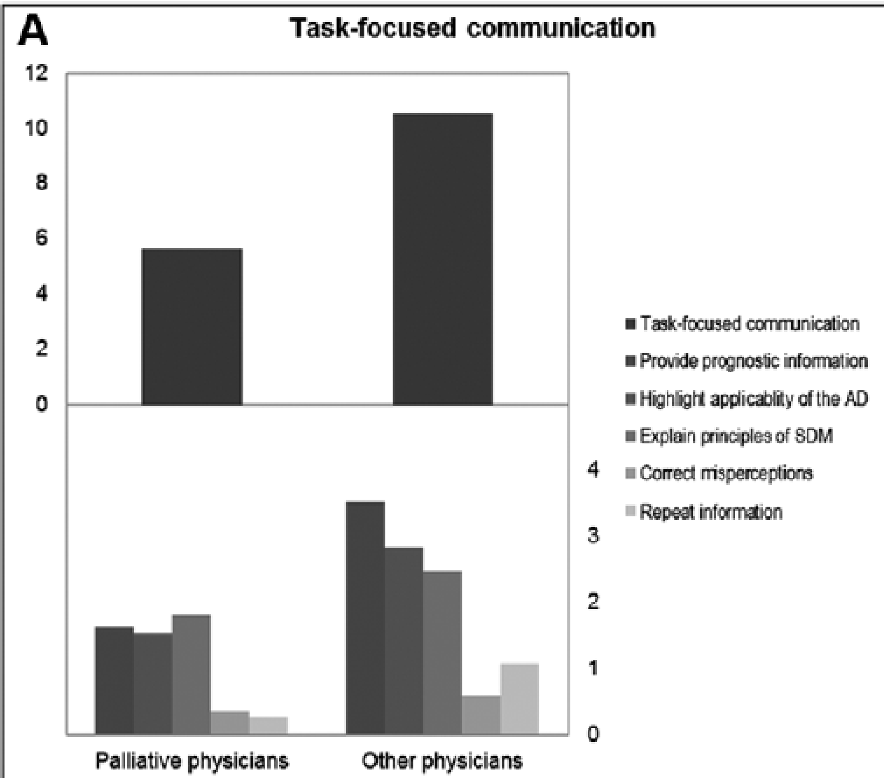
Jared Chiarchiaro, MD[1,2]; Douglas B. White, MD, MAS[2–4]; Natalie C. Ernecoff, MPH[2]; Praewpannarai Buddadhumaruk, MS, RN[2]; Rachel A. Schuster, MD, MS[1]; Robert M. Arnold, MD[5]

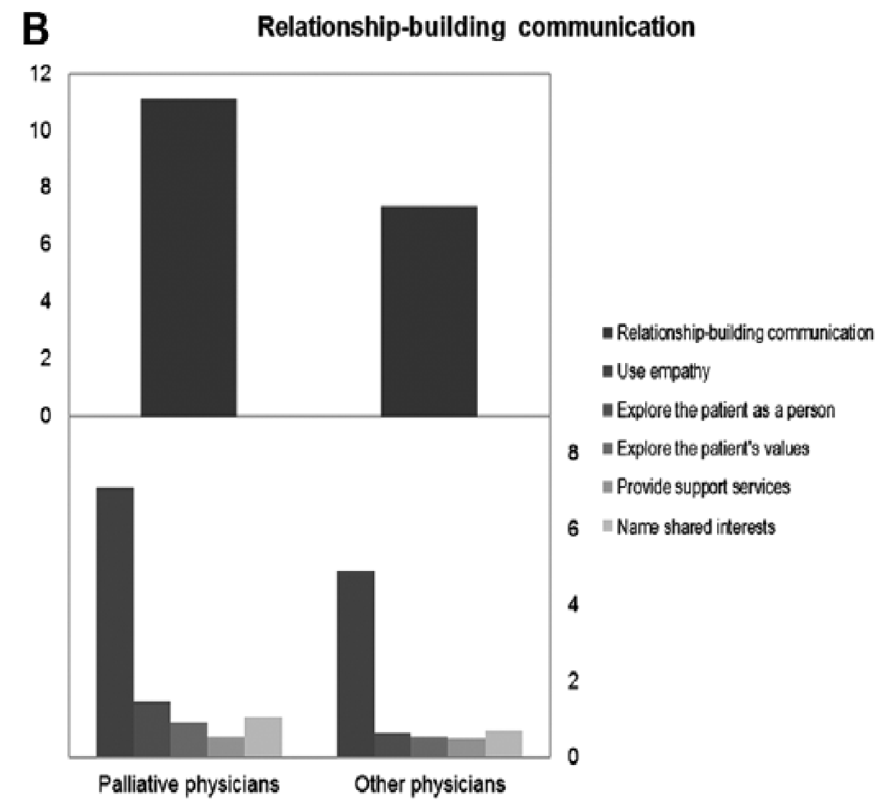
(*Crit Care Med* 2016

Conflict Management Strategies in the ICU Differ Between Palliative Care Specialists and Intensivists

Jared Chiarchiaro, MD[1,2]; Douglas B. White, MD, MAS[2–4]; Natalie C. Ernecoff, MPH[2]; Praewpannarai Buddadhumaruk, MS, RN[2]; Rachel A. Schuster, MD, MS[1]; Robert M. Arnold, MD[5]

Crit Care Med 2016





Armadilhas em conflitos

Table 2. Pitfalls in Handling Conflict: Behaviors to Avoid When Dealing With Conflict

Pitfall	Consequences
Avoiding or denying conflict	Issue may percolate, become worse; in long term, avoidance or denial creates perception of lack of leadership
Assuming that you know the whole story	Misses opportunity to improve mutual understanding
Repeatedly trying to convince the other party	Misses opportunity to understand true concerns and annoys the other person, who may stop listening
Assuming you know the other party's intentions	Labeling other party's character rather than focusing on behavior leads you to view him/her as inflexible
Holding the other party responsible for fixing the issue	Resolution more difficult unless both parties take responsibility for finding reasonable outcome
Proceeding as if the issue can be settled rationally or based on evidence	Ignores emotions that have been triggered by conflict
Declaring other party as ethically questionable	Condescending and potentially insulting to other party
Using anger or sarcasm as coercive threat	Creates resentment and undermines trust in relationship
Ignoring one's own strong emotions	Emotions tend to leak out and become obvious to other party and may complicate negotiation
Proceeding in the heat of the moment	Strong emotions tend to narrow perspective and reinforce existing conflict

Arnold, JAMA 2005

Table 2. Pitfalls in Handling Conflict: Behaviors to Avoid When Dealing With Conflict

Pitfall	Consequences
Avoiding or denying conflict	Issue may percolate, become worse; in long term, avoidance or denial creates perception of lack of leadership
Assuming that you know the whole story	Misses opportunity to improve mutual understanding
Repeatedly trying to convince the other party	Misses opportunity to understand true concerns and annoys the other person, who may stop listening
Assuming you know the other party's intentions	Labeling other party's character rather than focusing on behavior leads you to view him/her as inflexible
Holding the other party responsible for fixing the issue	Resolution more difficult unless both parties take responsibility for finding reasonable outcome
Proceeding as if the issue can be settled rationally or based on evidence	Ignores emotions that have been triggered by conflict
Declaring other party as ethically questionable	Condescending and potentially insulting to other party
Using anger or sarcasm as coercive threat	Creates resentment and undermines trust in relationship
Ignoring one's own strong emotions	Emotions tend to leak out and become obvious to other party and may complicate negotiation
Proceeding in the heat of the moment	Strong emotions tend to narrow perspective and reinforce existing conflict

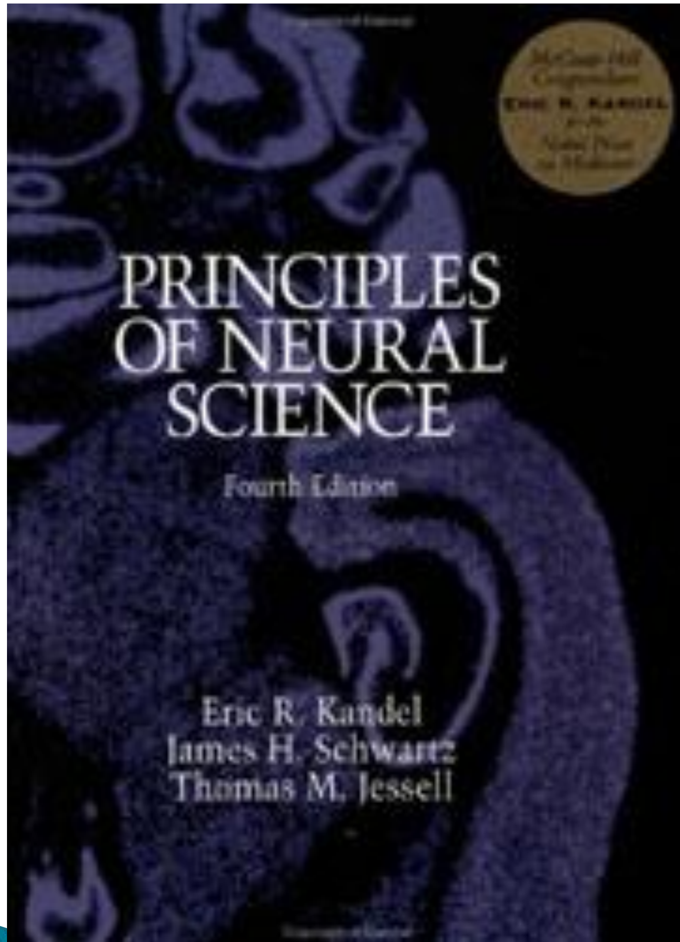
Arnold, JAMA 2005

Table 2. Pitfalls in Handling Conflict: Behaviors to Avoid When Dealing With Conflict

Pitfall	Consequences
Avoiding or denying conflict	Issue may percolate, become worse; in long term, avoidance or denial creates perception of lack of leadership
Assuming that you know the whole story	Misses opportunity to improve mutual understanding
Repeatedly trying to convince the other party	Misses opportunity to understand true concerns and annoys the other person, who may stop listening
Assuming you know the other party's intentions	Labeling other party's character rather than focusing on behavior leads you to view him/her as inflexible
Holding the other party responsible for fixing the issue	Resolution more difficult unless both parties take responsibility for finding reasonable outcome
Proceeding as if the issue can be settled rationally or based on evidence	Ignores emotions that have been triggered by conflict
Declaring other party as ethically questionable	Condescending and potentially insulting to other party
Using anger or sarcasm as coercive threat	Creates resentment and undermines trust in relationship
Ignoring one's own strong emotions	Emotions tend to leak out and become obvious to other party and may complicate negotiation
Proceeding in the heat of the moment	Strong emotions tend to narrow perspective and reinforce existing conflict

Arnold, JAMA 2005

Razão e emoção



Lidando com emoções

Ser empático e validar emoções

Back, Arnold, Tulsky
In "Mastering communication with seriously ill patients"

Table 2. Pitfalls in Handling Conflict: Behaviors to Avoid When Dealing With Conflict

Pitfall	Consequences
Avoiding or denying conflict	Issue may percolate, become worse; in long term, avoidance or denial creates perception of lack of leadership
Assuming that you know the whole story	Misses opportunity to improve mutual understanding
Repeatedly trying to convince the other party	Misses opportunity to understand true concerns and annoys the other person, who may stop listening
Assuming you know the other party's intentions	Labeling other party's character rather than focusing on behavior leads you to view him/her as inflexible
Holding the other party responsible for fixing the issue	Resolution more difficult unless both parties take responsibility for finding reasonable outcome
Proceeding as if the issue can be settled rationally or based on evidence	Ignores emotions that have been triggered by conflict
Declaring other party as ethically questionable	Condescending and potentially insulting to other party
Using anger or sarcasm as coercive threat	Creates resentment and undermines trust in relationship
Ignoring one's own strong emotions	Emotions tend to leak out and become obvious to other party and may complicate negotiation
Proceeding in the heat of the moment	Strong emotions tend to narrow perspective and reinforce existing conflict

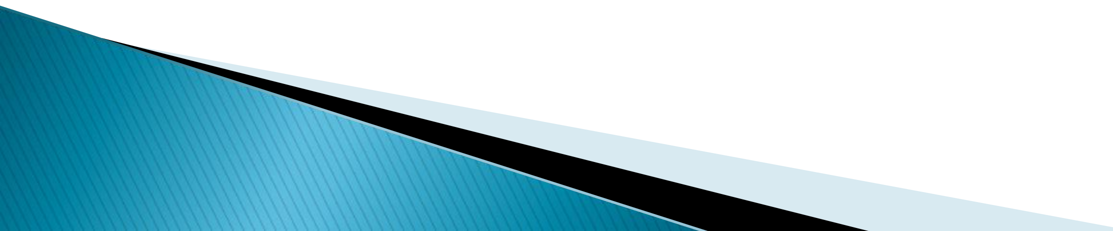
Arnold, JAMA 2005

Ann Intern Med. 2009;151:345-349.

Annals of Internal Medicine | Perspective

Discussing Treatment Preferences With Patients Who Want "Everything"

Timothy E. Quill, MD; Robert Arnold, MD; and Anthony L. Back, MD



Ann Intern Med. 2009;151:345-349.

Table 2. **Potential Underlying Meanings of "Everything"**

Domain	Concept	What "Everything" Might Mean
Affective	Abandonment	"Don't give up on me."
	Fear	"Keep trying for me."
	Anxiety	"I don't want to leave my family."
	Depression	"I'm scared of dying."
		"I would feel like I'm giving up."
Cognitive	Incomplete understanding	"I do not really understand how sick I am."
	Wanting reassurance that best medical care has been given	"Do everything you think as a doctor is worthwhile."
	Wanting reassurance that all possible life-prolonging treatment is given	"Don't leave any stone unturned."
		"I really want every possible treatment that has a chance of helping me live longer."
		"I will go through anything, regardless of how hard it is."
Spiritual	Vitalism	"I value every moment of life, regardless of the pain and suffering (which has important meaning for me)."
	Faith in God's will	"I will leave my fate in God's hands; I am hoping for a miracle; only He can decide when it is time to stop."
Family	Differing perceptions	"I cannot bear the thought of leaving my children (wife/husband)."
	Family conflict	"My husband will never let me go."
	Children or dependents	"My family is only after my money."
		"I don't want to bother my children with all this."

AMERICAN THORACIC SOCIETY DOCUMENTS

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units

Gabriel T. Bosslet, Thaddeus M. Pope, Gordon D. Rubenfeld, Bernard Lo, Robert D. Truog, Cynda H. Rushton, J. Randall Curtis, Dee W. Ford, Molly Osborne, Cheryl Misak, David H. Au, Elie Azoulay, Baruch Brody, Brenda G. Fahy, Jesse B. Hall, Jozef Kesecioglu, Alexander A. Kon, Kathleen O. Lindell, and Douglas B. White; on behalf of The American Thoracic Society *ad hoc* Committee on Futile and Potentially Inappropriate Treatment

Defining Futile and Potentially Inappropriate Interventions: A Policy Statement From the Society of Critical Care Medicine Ethics Committee

Alexander A. Kon, MD, FCCM[1]; Eric K. Shepard, MD, FCCM[2]; Nneka O. Sederstrom, PhD, MPH, FCCM[3]; Sandra M. Swoboda, RN, MS, FCCM[4]; Mary Faith Marshall, PhD, FCCM[5]; Barbara Birriel, MSN, ACNP-BC, FCCM[6]; Fred Rincon, MD, MSc, MBE, FCCM[7]

AMERICAN THORACIC SOCIETY DOCUMENTS

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units

Gabriel T. Bosslet, Thaddeus M. Pope, Gordon D. Rubenfeld, Bernard Lo, Robert D. Truog, Cynda H. Rushton, J. Randall Curtis, Dee W. Ford, Molly Osborne, Cheryl Misak, David H. Au, Elie Azoulay, Baruch Brody, Brenda G. Fahy, Jesse B. Hall, Jozef Kesecioglu, Alexander A. Kon, Kathleen O. Lindell, and Douglas B. White; on behalf of The American Thoracic Society *ad hoc* Committee on Futile and Potentially Inappropriate Treatment

fútil

vs

potencialmente inapropriado

vs

inapropriado

The ICU Trial: A new admission policy for cancer patients requiring mechanical ventilation*

Lucien Lecuyer, MD; Sylvie Chevret, MD, PhD; Guillaume Thiery, MD; Michael Darmon, MD; Benoît Schlemmer, MD; Élie Azoulay, MD, PhD

Crit Care Med 2007

The ICU Trial: A new admission policy for cancer patients requiring mechanical ventilation*

Lucien Lecuyer, MD; Sylvie Chevret, MD, PhD; Guillaume Thiery, MD; Michael Darmon, MD; Benoît Schlemmer, MD; Élie Azoulay, MD, PhD

Crit Care Med 2007

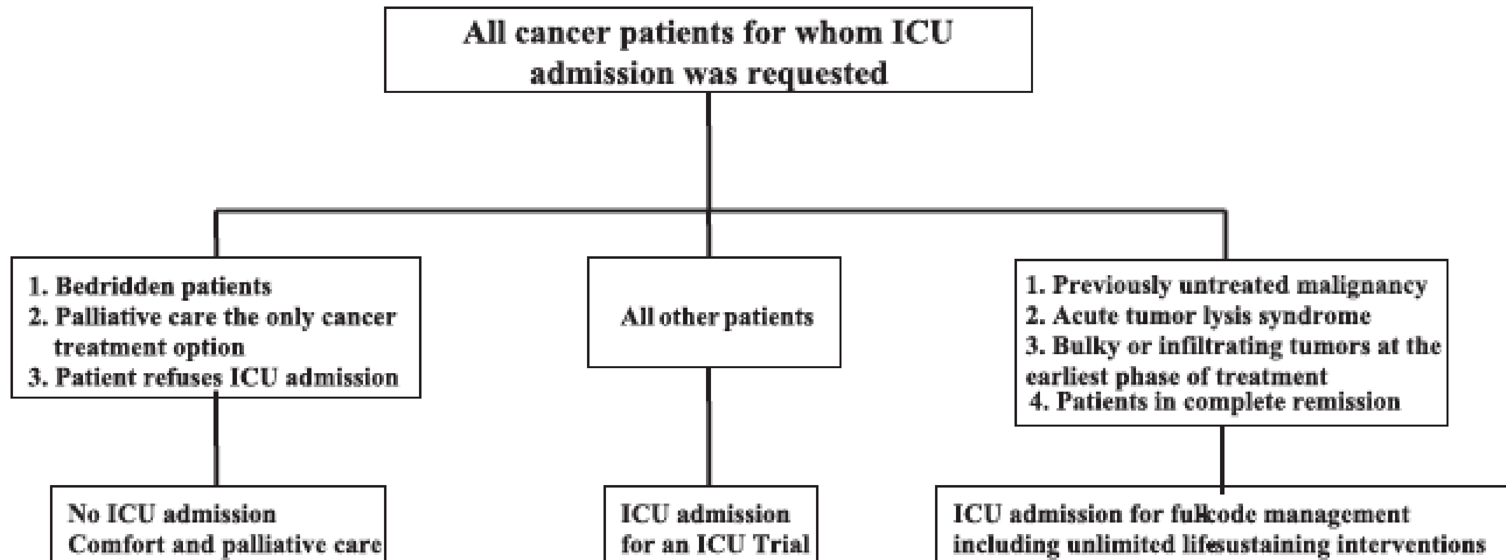
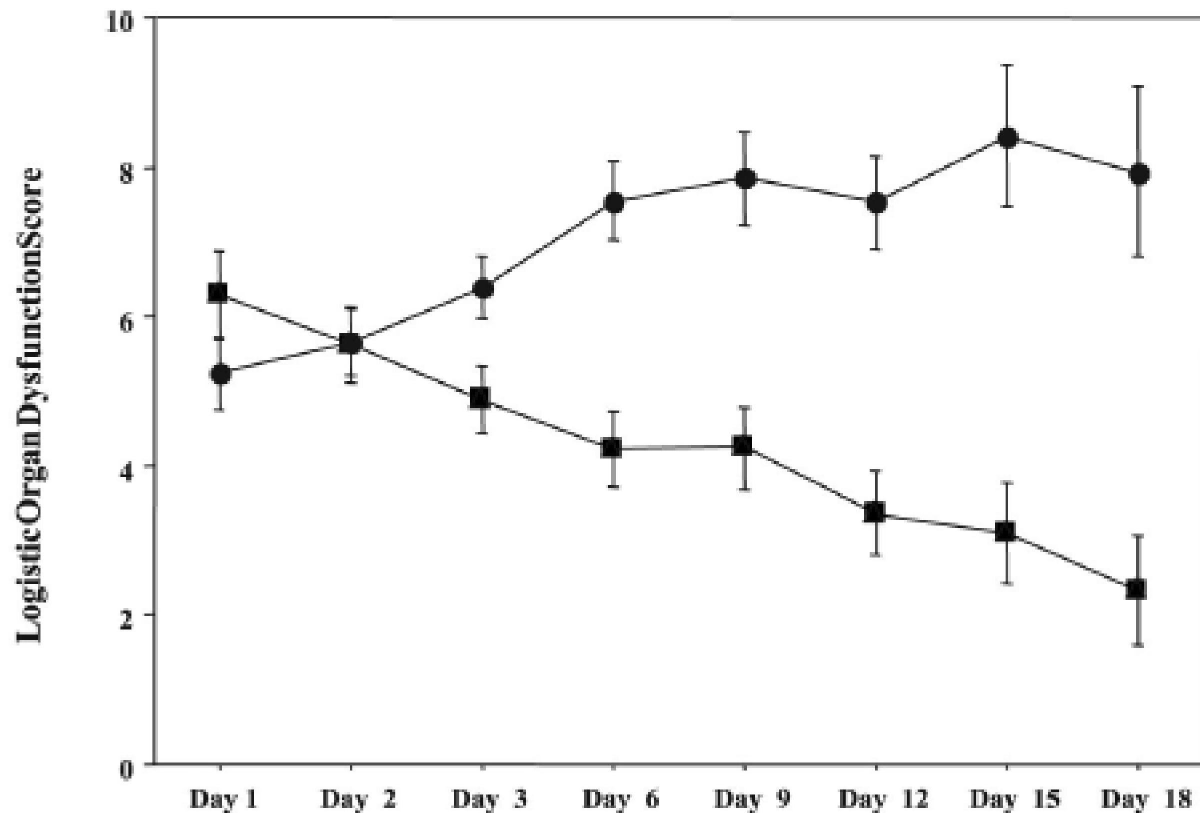


Figure 1. Intensive care unit (*ICU*) admission policy initiated in 2001 at the Saint-Louis Hospital.

The ICU Trial: A new admission policy for cancer patients requiring mechanical ventilation*

Lucien Lecuyer, MD; Sylvie Chevret, MD, PhD; Guillaume Thiery, MD; Michael Darmon, MD; Benoît Schlemmer, MD; Élie Azoulay, MD, PhD

Crit Care Med 2007



Estratégias para comunicacao em conflitos

obs:

Stone, Patton, Heen 2010

Estratégias para comunicacao em conflitos

obs:

NEM TODO CONFLITO TEM SOLUÇAO CONSENSUAL

Stone, Patton, Heen 2010

The JAMA Network

From: **Effect of Ethics Consultations on Nonbeneficial Life-Sustaining Treatments in the Intensive Care Setting: A Randomized Controlled Trial**

JAMA. 2003;290(9):1166-1172. doi:10.1001/jama.290.9.1166

Date of download: 10/12/2015

Copyright © 2015 American Medical Association. All rights reserved.

From: **Effect of Ethics Consultations on Nonbeneficial Life-Sustaining Treatments in the Intensive Care Setting: A Randomized Controlled Trial**

JAMA. 2003;290(9):1166-1172. doi:10.1001/jama.290.9.1166

Table 2. Comparison of Treatments and Days Between Ethics Consultation and Control Patients From Day of Study Entry to Day of Death in the Hospital

	Days, Mean (SD)			
	Intervention (n = 173)	Control (n = 156)	Difference	*P* Value
Hospital	8.66 (9.39)	11.62 (16.36)	−2.95	.01
Intensive care unit	6.42 (6.89)	7.86 (10.48)	−1.44	.03
Receiving ventilation	6.52 (8.52)	8.22 (11.16)	−1.70	.03
Receiving nutrition/hydration	7.36 (9.46)	8.38 (12.14)	−1.03	.14

Date of download: 10/12/2015

Copyright © 2015 American Medical Association. All rights reserved.

From: **Effect of Ethics Consultations on Nonbeneficial Life-Sustaining Treatments in the Intensive Care Setting: A Randomized Controlled Trial**

JAMA. 2003;290(9):1166-1172. doi:10.1001/jama.290.9.1166

Table 2. Comparison of Treatments and Days Between Ethics Consultation and Control Patients From Day of Study Entry to Day of Death in the Hospital

	Days, Mean (SD)			
	Intervention (n = 173)	Control (n = 156)	Difference	*P* Value
Hospital	8.66 (9.39)	11.62 (16.36)	−2.95	.01
Intensive care unit	6.42 (6.89)	7.86 (10.48)	−1.44	.03
Receiving ventilation	6.52 (8.52)	8.22 (11.16)	−1.70	.03
Receiving nutrition/hydration	7.36 (9.46)	8.38 (12.14)	−1.03	.14

Sem diferença em mortalidade

87% dos profissionais e familiares consideraram a intervenção útil

Date of download: 10/12/2015

Copyright © 2015 American Medical Association. All rights reserved.

AMERICAN THORACIC SOCIETY DOCUMENTS

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units

Gabriel T. Bosslet, Thaddeus M. Pope, Gordon D. Rubenfeld, Bernard Lo, Robert D. Truog, Cynda H. Rushton, J. Randall Curtis, Dee W. Ford, Molly Osborne, Cheryl Misak, David H. Au, Elie Azoulay, Baruch Brody, Brenda G. Fahy, Jesse B. Hall, Jozef Kesecioglu, Alexander A. Kon, Kathleen O. Lindell, and Douglas B. White; on behalf of The American Thoracic Society *ad hoc* Committee on Futile and Potentially Inappropriate Treatment

Table 2. Recommended Practices for Improving Communication and Support for Surrogates in the Intensive Care Unit

Systems-level interventions
- Conduct regular, structured interprofessional family meetings (63–68)
- Integrate palliative care and/or ethics teams into ICU care for difficult cases (11, 14, 68–71)
- Provide printed educational materials to family (66, 67, 72, 73)
- Maintain dedicated meeting space for ICU family meetings

Caso clínico UTI

- **Maria, 79 anos**
- **QD: falta de ar há 1 dia após engasgar**
- Demência avançada (Alzheimer)
- Pancitopenia a/e

- **Diagnósticos:**
- **Broncoaspiração + insuf. Respiratória aguda**

Caso clínico UTI

- **Maria, 79 anos**
- **QD: falta de ar há 1 dia após engasgar**
- Demência avançada (Alzheimer)
- Pancitopenia a/e

- **Diagnósticos:**
- **Broncoaspiração + insuf. Respiratória aguda**
- **IOT+VM, CVC-DVA, SNE, ATB**
- **Conferência familiar- trial de UTI**

Caso clínico UTI

- **Maria, 79 anos**
- **QD: falta de ar há 1 dia após engasgar**
- Demência avançada (Alzheimer)
- Pancitopenia a/e

- **Diagnósticos:**
- **Broncoaspiração + insuf. Respiratória aguda**
- **IOT+VM, CVC-DVA, SNE, ATB**
- **Conferência familiar- trial de UTI**
- 3º DUTI: objetivo de cuidado estabelecido

Caso clínico UTI

- **Maria, 79 anos**
- **QD: falta de ar há 1 dia após engasgar**
- Demência avançada (Alzheimer)
- Pancitopenia a/e

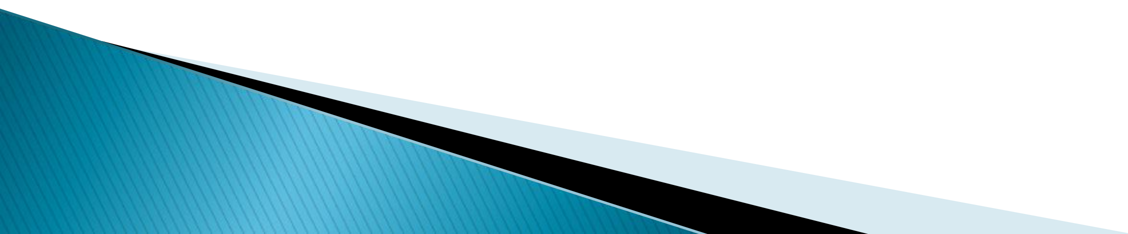
- **Diagnósticos:**
- **Broncoaspiração + insuf. Respiratória aguda**
- **IOT+VM, CVC-DVA, SNE, ATB**
- **Conferência familiar- trial de UTI**
- 3º DUTI: objetivo de cuidado estabelecido
- 5º DUTI: extubação paliativa

Caso clínico UTI

- **Maria, 79 anos**
- **QD: falta de ar há 1 dia após engasgar**
- Demência avançada (Alzheimer)
- Pancitopenia a/e

- **Diagnósticos:**
- **Broncoaspiração + insuf. Respiratória aguda**
- **IOT+VM, CVC-DVA, SNE, ATB**
- **Conferência familiar- trial de UTI**
- 3º DUTI: objetivo de cuidado estabelecido
- 5º DUTI: extubação paliativa
- 7º DUTI: óbito

Conclusão



Decisões médicas

Objetivo:

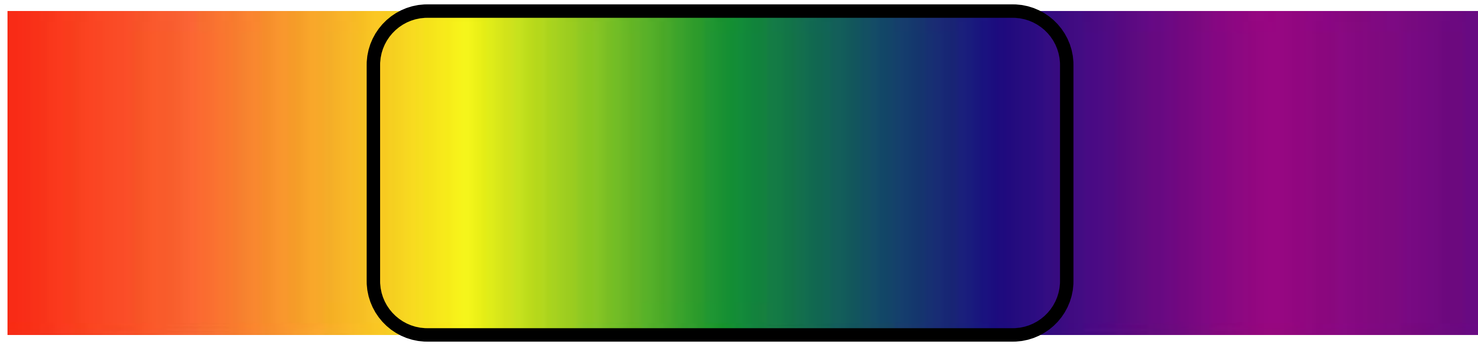
- Oferecer os tratamentos médicos adequados de acordo com os valores e preferências do paciente

OMS, 2002

Crane, Am Fam Physicians 2005

ArnOld, JAMA 2005

Siegel, Clin Chest Med, 2009



Decisões médicas

Objetivo:

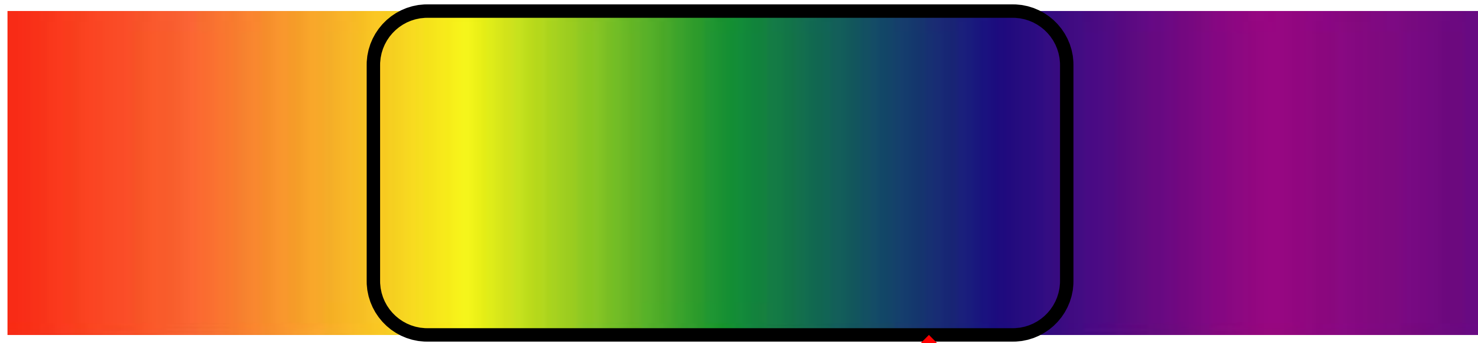
- **Oferecer os tratamentos médicos adequados** de acordo com os valores e preferências do paciente

OMS, 2002

Crane, Am Fam Physicians 2005

ArnOld, JAMA 2005

Siegel, Clin Chest Med, 2009



Decisões médicas

Objetivo:

- Oferecer os tratamentos médicos adequados **de acordo com os valores e preferências do paciente**

OMS, 2002

Crane, Am Fam Physicians 2005

ArnOld, JAMA 2005

Siegel, Clin Chest Med, 2009