Review Article

Medical and nursing care for patients expected to die in the Emergency Department

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ABSTRACT

The progressive ageing of the population, the increased survival of subjects with chronic disorders and the implementation of the welfare society have been the cause of an increased demand for emergency care for patients in their last few days of life. The aim of the present review is to present a series of multidisciplinary recommendations based on medical and nursing scientific knowledge, communication skills and ethical and logistic aspects for providing integral care to the patient who is expected to die in the Emergency Department.

Key Words: *Death. Emergency Department. Palliative care. Ethics. Nursing. Agony. Communication. Terminal disease. Care providers.*

RESUMEN

Asistencia médica y de enfermería al paciente que va a fallecer en urgencias

La progresiva longevidad de la población, el incremento de la supervivencia de los ciudadanos con patologías crónicas y la implementación de la sociedad del bienestar han provocado el incremento de la demanda de atención urgente de los pacientes en situación de últimos días de vida. La finalidad de esta revisión es ofrecer unas recomendaciones multidisciplinarias basadas en los conocimientos científicos médicos y de enfermería, comunicacionales, éticos y logísticos para asumir el tratamiento integral del paciente que va a fallecer a urgencias.

Palabras clave: *Muerte. Fallecimiento. Urgencias. Paliativos. Ética. Enfermería. Agonía. Comunicación. Enfermedad terminal. Cuidadores.*

INTRODUCTION

Social, psychological and medical dysfunctions in modern society as a whole are reflected in emergency departments (ED)[1]. A gradual ageing of the population due to the improvement in social conditions, a higher rate of survival among patients with chronic conditions due to technological advancements and the change in the social approach to death, perceiving the end of a life as a failure on the part of the patient and patient's family, have increased the number of terminal patients admitted into hospital[1-8].

The increase in quality and range of available services within the current health system is undeniable. However a health policy that is over-preoccupied with patient healing and the cost of processes, with deficient hospital bed planning and a slow implementation of extra-hospitalary supports [Home Care and Support Equipment Programme (PADES), Social and Health Care Interdisciplinary Functional Unit (UFISS), home hospital care, health care centres, etc] , has led to an increase in the number of patients at end-of-life situations (EOL) presenting at the ED seeking care and who should have been admitted into other care departments[1-9].

EDs are not a suitable environment for caring for patients in EOL situations. An ED is marked by a simultaneous patient flow, a fast work pace, a heavy emotional charge, limited time to make diagnostic and therapeutic decisions, physical

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space restrictions, a staff with a constant turnover of young people and in a continuous state of saturation during the winter months. As such, the ED is not the ideal place to care for a terminally ill patient[1-8].

The aim of this review is to present some recommendations for nursing and medical care based on scientific, communication, ethical and logistical knowledge, geared towards the overall care of the patient who is going to die in the ED. The aims are as follows:

- To identify patients in an EOL situation.
- To take steps towards patient comfort aimed at the pharmacological and non-pharmacological therapeutic handling of the various symptoms.
- To recognise indications for sedation during the death agony.
- To consider ethical implications.
- To provide effective emotional support.
- To adapt the care provision and physical space to patient needs.

PATIENT IDENTIFICATION

Knowledge in palliative care can benefit patients with advanced terminal illnesses, both of an oncological and a non-malignant etiology (such as coma due to various causes, CNS degenerative diseases, highly advanced dementia, or the terminal stages of pulmonary, cardiac, hepatic or nephrological conditions, etc). The higher number of oncological patients receiving palliative care compared with that of patients with non-malignant conditions[1-9] is probably due to the disparity of criteria on intervention limits between physicians and the trend in modern medicine towards fragmenting the patient according to speciality, with the ensuing loss of ethical, cultural and social values which make up the overall treatment. All of this renders ethical decision-making in emergency medicine more difficult[1].

By terminal illness we understand[10-14] the presence of an advanced, progressive and incurable disease, with no reasonable chances of response to treatment, with a survival prognosis under six months, along with multi-factorial and variable symptoms.

On the other hand, a terminal oncological condition[10] is a situation in which life expectancy falls below six months and in which the histology of the tumour has been found to have no impact on survival.

Lastly we shall define the EOL situation or death agony[11-15]. The term "agony" originates from the Greek word "agon", meaning struggle or combat. The EOL situation is the process identified by the therapeutic team, the relatives and the patients which appears during the end stage of many diseases, during which life is gradually extinguished. It lasts less than one week, and if there is also loss of consciousness it usually does not exceed three days. The specific characteristics of this stage are as follows:

– Physical characteristics[14]: increase in weakness and prostration, ingestion reduction with dryness of skin and mucosae, urinary and faecal retention, cognitive alterations with disorientation, agitation or delirium, variations in vital signs with lowering of blood pressure, irregular and fast pulse and superficial breathing with apnea breaks, as well as respiratory and functional index disorders [Karnofsky, Eastern Cooperative Oncology Group (ECOG)].

– Emotional characteristics: onset of hypoactive reactions such as resignation or silence and/or hyperactive reactions such as anxiety or distress crises.

– Socio-cultural characteristics: interdisciplinary communication between the various levels of care and the correct information given by the specialist and/or primary care physician on the patient's evolution should prevent the arrival of most EOL patients to ED upon the approach of death. Nonethless a considerable proportion of these patients present to ED upon the family's inability to provide care at home due to the clinical nature of the illness or the social environment. The family is informed of the patient's situation but does not accept it, does not have the material resources to assume patient care or psychological support to help them face the manifestations of the symptoms[1,5,11].

MEASURES FOR COMFORT

Comfort[14] is the subjective perception of wellbeing. It requires a number of specific, realistic, proportioned and adapted measures within the emergency environment, with particular emphasis on the control of situations causing discomfort. The various measures designed to achieve such comfort are described shortly.

Crisis prevention is very important. In fact, in order to achieve patient comfort, pharmacological treatment of the symptoms must begin early on and with guidelines set according to the onset of the different manifestations.

We shall deem a refractory symptom[16-18] to be any situation which cannot be suitably controlled, despite efforts to identify a tolerable treatment, without compromising patient consciousness.

On the other hand, the difficult symptom[17,18] is a situation

which requires the establishment of therapeutic measures beyond the usual means in order to achieve clinical control.

• Symptom control

1. The first action to be carried out upon patient arrival at ED is to transmit calmness and security to enhance patient trust levels.

2. Adaptation of pharmacological treatment[12-15]: Proven efficiency medication must be used at suitable doses, with simple and fixed guidelines designed to control all symptoms producing discomfort. If the patient is drowsy, non-verbal language must be assessed to detect pain or agitation; if the patient is conscious, he/she will communicate his/her own needs.

2.1. Selection of administration method[12-16]:

– Subcutaneous administration: patients in EOL present a considerable reduction in muscle mass secondary to the wasting syndrome and, in the case of oncological patients, veins can become sclerosed due to chemotherapy. For this reason, subcutaneous (SC) administration of medication by bolus or via a continuous infusion pump is recommended, in light of this method being well-tolerated and not very iatrogenic, except in the case of liposoluble drugs and large perfusions.

– Intravenous (IV) method: this is useful if there is a risk of anasarca or haemorrhage, rejection of other methods by the patient or the need to use drugs exclusively administered via this method.

– Spinal or transdermic method: these must be maintained if the symptom is under control.

2.2. Prescription of drugs of only immediate effect on comfort:

– Analgesics: any drugs of the first and second WHO analgesic levels (acetylsalicylic acid, paracetamol, non-steroidal anti-inflammatories, codeine and hydrocodeine) should be removed in favour of third level medications (morphine).

– Antiemetics: discard 5-HT3 antagonists, ortopramides and antihistamines in favour of haloperidol or levomepromazine.

– Anticonvulsants and tranquilizers: replace these with benzodiazepines (BDZ).

– Neuroleptics: replace these with haloperidol or levomepromazine.

– Corticoids: maintain them in endocranial hypertension given their proven efficiency on comfort.

2.3. Discard any drugs with no immediate effect on comfort such as insulin, oral antidiabetics, anti-arrhythmia medication, heparins, diuretics, antibiotics, antidepressants, laxatives, antihypertensives, bronchodilators (aerosols) etc.

2.4. Remove fluid therapy: hydration does not help control symptoms and can worsen respiratory secretions, oedemas, amount of vomiting, and resort to urinary catheterization in the event of urine retention.

2.5. Pharmacological control of symptoms[10-17]: the use of a common protocol for symptom control is designed to ensure continuity between home and hospital programmes, and thus it is important that a joint treatment protocol is in place.

– Pain: we must underline that to die with dignity means to die without pain. It is better to know a few drugs well than to have a superficial knowledge of all those available[11]. The right dosage to fight pain is the minimum dosage required to obtain the desired pharmacological effect. In the event of an acute pain crisis in patients with previous opioid treatment, their usual dosage must be increased by 33%/1/6 of the morphine dosage/24 h or the equivalent of half the dose of the fentanyl patch via SC-IV) with establishment of the new guidelines adding the basal dosage plus the rescue dosages. In patients with no previous opioid treatment, one should begin with low doses of morphine chloride (5-10 mg/4 h SC-IV), to be individually regulated (every 30 minutes) until the desired effect has been achieved. Several studies on large numbers of patients and correct methodology[19-21] have shown that treatment of intense pain with standard dosage (0.1 mg/kg) opioid analgesics fails to meet therapeutic criteria, as proven in the study by Aubrun et al[21] on a sample of 4,525 patients. These authors found that opioid requirements to alleviate pain were 0.173 mg/kg in men and 0.192 mg/Kg in women up to the age of 75, after which the differences balance out. As such, a progressive therapeutic adjustment in accordance with patient needs must be established in order to achieve comfort.

– Nausea and vomiting: for control of nausea and vomiting the use of neuroleptics such as haloperidol (2.5-10 mg/24 h by subcutaneous continuous infusion (SCCI) or in bolus every 6-8 h. SC) is recommended. If the cause of the symptom is endocranial hypertension, dexamethasone is the drug of choice.

– Myoclonia and convulsions[15]: in patients at ED with a history or presence of lesions, the onset of crises must be expected; therefore, treatment must be administered according to the symptom, bearing in mind that morphine can cause myoclonia as a sign of neurotoxicity. BDZs are the drugs of choice, midazolam (5-10 mg bolus followed by 15-30 mg/24 h SCCI-IVCI).

– Acute confusional syndrome (psychomotor agitation and hyperactive delirium)[16]: before beginning any medication regime other intercurrent processes, such as pain, presence of vesical globe or faecal impacting, must be discarded. The drug of choice is haloperidol due to its powerful antipsychotic effect and only slight sedative effect (2 mg at start followed by 2 mg every 20-30 min. until symptom is

controlled, followed by 1.5-2.5 mg/8 h SC-IV). If after the administration of three doses of haloperidol the symptoms are still not until control, one must resort to midazolam, a BZD with no antipsychotic effects but with a very powerful sedative effect (5 mg every 5 min until symptom has remitted, followed by administration of an infusion of 30-120 mg/24 h (SCCI-IVCI). If, despite administration of such drugs, the symptom should prove refractory, sedation must be considered.

– Dyspnoea[22-24]: this is a symptom which is difficult to manage and which generates a great deal of anxiety for the patient and relatives. The use of ancillary respiratory muscles is the most obvious sign of dyspnoea, for which the use of morphine is recommended (2.5 mg/4-6h SC-IV). In the event that the patient uses the abdominal muscles, administer midazolam (5-10 mg SC-IV). In the event of hypoxemia or anxiety, oxygen therapy on demand via nasal spectacles improves comfort (avoid using masks as they provoke a feeling of breathlessness). In the case of terminal refractory heart failure, furosemide has been used at a dosage of 20-40 mg SC or SCCI with improvement of dyspnoea[22]. If despite the medication, refractory dyspnoea persists, sedation must be considered.

– Rales and noisy breathing: this is a symptom which appears in most agonic patients and which causes great distress to the family. The use or anticholinergic medication- to be given despite improvement or disappearance of symptoms -is recommended. Scopolamine (0.5-1 mg/4-6 h SC-IV or SCCI-IVCI) combined with midazolam (10-15 mg/24 h) is recommended to prevent agitation associated with the use of scopolamine, or hyoscine butylbromide (20 mg/4-6 h SC-IV).

– Fever: this must only be treated when it produces discomfort. Warm clothing must be removed or lightened and avoid applying cold compresses as these cause discomfort. If applicable, administer antithermic non steroidal anti-inflammatories (Ketorolac 30 mg Sc-Iv)[22], metamizol (2 g. IV) or paracetamol (1 g IV).

– Haemorrhage: This is a difficult situation to handle as it is very overwhelming, particularly for the patient and relatives. Dark-coloured towels should be at hand, together with a syringe loaded with 15 mg of midazolam to be administered every 5 min. SC-IV until deep sedation has been achieved, with death arriving a few minutes later.

– Intestinal occlusion: in order to improve patient comfort, levomepromazine (50-150 mg/24 h SCCI-IVCI or in bolus 6-8 h SC) or hyoscine butylbromide (120 mg/24 h SCCI-IVCI or in bolus 20 mg/6-8 h SC) or scopolamine (0.5-1 mg/4-6 h SC or 3-6 mg SCCI) should be administered, together with midazolam (10-15 mg/24 h) to prevent agitation associated with the use of scopolamine.

3. Non-pharmacological steps[11-15,31,32]: respect of body image and privacy of the patient is essential.

– Postural changes: to be carried out gently, using pillows to obtain an antalgic position and prevent erythema due to pressure (between legs, elbows, etc). The most comfortable position for the patient is the lateral recumbent position with legs bent.

– Skin care: hygiene and linen changes must be carried out gently if patient is stable. After hygiene, dry well, especially in areas with skin folds, and rub moisturising cream (include relatives in providing this care). If the patient should have skin ulcers, the aim is the prevention of pain (topical application of local anaesthetic and postural change every 4-6 hours), of bad odour (2% metronidazol gel and activated carbon dressings) and of bleeding (topical adrenalin every 56 h. and compression with gauzes).

– Mouth care: non-adapted dentures must be removed to prevent displacement and clean with swab or children's toothbrush (include relatives in providing this care). In the event of plaque, moisten the swab with diluted hydrogen peroxide and, if there are erosions, lightly apply lidocaine at 2% or topicaine via aerosol. The mouth must be frequently cleaned out with water (teaspoon, syringe or gauze) as the suction reflex prevails until the end of life and dryness of the lips and oral mucosa causes pain. Do not use mouthwashes containing alcohol as these dry out the mouth; likewise, avoid using Vaseline as its hydrophobic quality causes more dryness if the patient is dehydrated.

– Control of dyspnoea: avoid use of tight garments, raise patient's head with neck slightly flexed and permeate airways cleaning nasal fossae with saline solution. If patient is conscious, the Fowler position encourages pulmonary ventilation; if patient is unconscious, semi-prostration prevents aspiration. In the event of pleural effusion, place patient in lateral recumbent position on affected side.

– Control of constipation: neither enemas nor laxatives should be used, as constipation does not cause discomfort to the patient at this stage of the process.

– Control of urinary incontinence or acute urine retention: if the patient is agitated, examine whether urine retention is the cause of the symptom. If the frequency in diaper changes or the presence of a vesical globe should cause pain, insert vesical tube despite imminence of death.

– Control of delirium[16]: this is the organic neurological change, with an acute beginning and changes in perception and attention, in which the roles of the nursing staff and rela-

tives are vital in reorienting the patient to time, space and person. Confrontation must be avoided. Contention is not advised under any circumstances.

Health care legends[11-15]

Table 1 includes a number of concepts which are mistakenly interpreted with some frequency.

Sedation during agonic stage[17,18,25-30]

Sedation during the agonic stage is a therapeutic decision to be made exclusively by the physicians, for treating a physical symptom (delirium, dyspnoea, pain and haemorrhage) or psychological symptom (anxiety or panic crises) which is refractory to other treatments. This is a therapeutic response to a demand for medical care, and it is therefore the physician who has the right and the obligation to make such a decision. The end goal is to lessen distress, although it carries with it the side effect of a foreseeable and irreversible reduction of consciousness ("doctrine of double effect")[18]. This is the fundamental difference from pharmacological coma or euthanasia, where the end goal is the death of the patient via administration of lethal medication.

– Indications for sedation: In order to administer sedation, four premises must be fulfilled: (1) there must be a refractory symptom which previous treatments have failed to improve; (2) respect patient wishes if the patient does not want to be informed, or if patient is not conscious or is not capable of deciding, a decision must be made by the patients's legal representative, the relatives or the physician; (3) the decision must be agreed with family and health care team, with the presence of at least two physicians and two relatives and (4) record this in writing in the medical history.

– Preparation before sedation: (1) use the Ramsay scale to reduce level of consciousness, given its simplicity of use and realiability[17] (Table 2); (2) select means of administration; (3) maintain analgesics; (4) simplify treatment; and (5) calculate the dosage of drugs to be used (Tables 3, 4 and 5).

ETHICAL CONSIDERATIONS

Ethics do not provide an answer to all questions[17,18,33-41], but it tries to bring together all the interests of the patient, the family environment, the physician and society[1,39]. Emergency Departments are made up of a heterogeneous team of professionals who originate from a variety of environments (cities,

TABLE 1. Ten "health care legends" compared with the current real care of EOL patients

Legend	Real care
1. "Patient must be given the medication he/she has taken all his/her life"	– Maintenance of medication with no immediate effect on comfort is incoherent.
2. "Administration of fluids must be carried out to show that all possible is being done"	– The administration of a treatment which can cause side effects leading to more discomfort is illogical.
3. "Placebos can be used to control pain"	– This is clinically and ethically unacceptable.
4. "Opioids have a ceiling effect"	– Dosage of opioids can be almost indefinitely increased, with continued efficacy.
5. "Opioids can be prescribed on demand"	– Only the administration of opioids at fixed intervals leads to maximum efficacy.
6. "Several opioids must be administered simultaneously to control refractory pain"	– Opioids can interact with one another reducing efficacy.
7. "Oral care is a second level skill"	– Care of the oral cavity has a large effect on patient comfort.
8. "Saline drip is necessary to reduce patient thirst"	– Localised care has been proven to be much more effective in reducing thirst than saline hydration.
9. "Repeated secretion aspiration is recommended to improve patient comfort"	– Secretion aspiration only achieves a short term effect at the expense of great discomfort, and is thus not a recommended technique.
10. "Explorations and diagnostic tests must be performed in order to show that all possible is being done"	– Performance of diagnostic tests, particularly if these require transport and displacement are very distressing for the patient; the suitability thereof must thus be carefully assessed.

TABLE 2. Ramsay scale

Level	
1	Anxious and agitated
2	Calm and cooperative
3	Awakens suddenly with verbal stimulation or glabellar tapping
4	Lazy response to glabellar stimulation
5	Response to painful stimuli
6	No response

communities, religions, etc) and specialties. The health care team has a significant component of young physicians who are marked by a pressing desire to acquire new experience in invasive techniques and a wide range of reactions. This can impair the identification of ethical problems, unless a common strategy of ethic coherence is in place[1]. The great emotional burden of having to work under the gaze of others, stress, handling a large number of emergencies, fear of responsibility and often the loneliness and vulnerability of patients at EOL, requires learning reasoning techniques based on the person [privacy and confidentiality), on respect for autonomy, on the proportionality of actions (limitation of therapeutic effort-LTE), maximum comfort and control of circumstances], all in agreement with the patient's family environment[42].

• Basic principles of clinical bioethics[38,39]: Urgent clinical situations require fast and coherent decision and as such, clinical practice will not be correct if it does not go hand in hand with an appropriate moral decision. Decisions made in health care are governed by four principles that are universally agreed upon in Western culture, although differences in interpretation may arise: no malefaction (no harming the other), benefaction (doing the best for the other), autonomy (respect for a person's freedom; for the patient, it means knowledge, understanding and lack of coercion, and for the medical professional it means appropriate information, knowledge of patient's cognitive capacity and understanding of the therapy to be administered) and justice (all must be treated equally). The patient must act in accordance with the principle of autonomy. Society and the institutions, in accordance with the principle of justice, and the physician, in accordance with the principle of benefaction and non-malefaction[39].

• Futile intervention[38]: this is any diagnostic or therapeutic action which does not benefit the patient.

• Limitation of therapeutic effort[18]: this is the gradual elimination (or non-initiation) of treatments or diagnostic tests

TABLE 3. Pharmacological doses of midazolam for sedation

Midazolam
- Hydrosoluble BDZ, two to three times more powerful than diazepam.
- Start of administration: 5-10 min. via SC and 2-3 min. via IV.
- Average plasma life: 2-5 h.
- Recommended maximum dose: 160-200 mg/day
- Presentation: ampoules (5 mg/mL), 5 mL: 25 mg.

Subcutaneous administration
- Induction bolus
- Intermittent sedation: only administer rescue dosage
- Continuous sedation: begin with SCCI and administer rescue doses
  - Patients who do not take BDZ or low weight (weakened)
    - Induction dosage: bolus, 2.5-5 mg.
    - Rescue dosage: bolus, 2.5-5 mg.
    - Initial SCCI dosage: 0.4-0.8 mg/h.
  - Patients who have taken BDZ previously:
    - Induction dosage: bolus, 5-10 mg.
    - Rescue dosage: bolus, 5-10 mg.
    - Initial SCCI dosage: 1-2 mg/h.

Intravenous administration
- Induction bolus to achieve Ramsay II or III: dilute 15 mg (3 mL) of midazolam in 7 mL of saline solution: 1,5 mg/mL.
  - Patients not taking BDZ or very weakened: 1.5 mg every 5 min.
  - Patients who have taken BDZ previously: 3.5 mg every 5 min.
- Rescue dosage= induction dosage
- Intermittent sedation: rescue dosages equal to induction dosages
- Continuous sedation: begin with IVCI and administer rescue dosage.
  IVCI= induction dosage x 6.

Note: in the event of requiring fast and deep sedation (Ramsay V or VI) double the dosage.

TABLE 4. Pharmacological doses of levopromazine for sedation

Levopromazine
- Agitated patients who require sedation for delirium.
- When midazolam has proven ineffective in patients who require sedation for other reasons than delirium.
- When BDZs are contraindicated (allergy, previously known paradoxical reaction).
- If no response to midazolam before beginning administration of levopromazine, reduce dose of midazolam by 50% during first 24 h. to prevent withdrawal symptoms, and subsequently by 33% of the total daily dose depending on evolution.

Subcutaneous administration
- Induction dose: bolus, 12.5-25 mg.
- Rescue dose: bolus, 12.5 mg.
- Initial dose SCCI: 100 mg/24 h.

Intravenous administration
- 50% of subcutaneous dosage.

which are futile in unrecoverable patients or those with a fatal prognosis in the short term.

• Doctrine of double effect[18]: the acceleration of death is only considered permissible if this is not the first treatment attempt. The application of actions which, in addition to having the desired effect can also accelerate death despite not being the first attempt, is ethically admissible provided the action is good, or at least, indifferent.

• Therapeutic obstinacy or stubbornness[36,39]: this is the initiation or continuation of medical actions that have no other aim but to prolong the patient's life when the patient is facing irreversible death. To insist on prolonging merely biological human life at all costs is a serious assault on a person's dignity[11]. Not everything which is technically possible is ethically admissible, and unjustified disproportionality , beyond what is medically reasonable, only prolongs the agony[1,33]. The appropriate individual and social approach to death avoids the performance of futile therapeutic measures, and supports LTE and proportionality based on palliative care.

• Advance directive or living will[34,36,39]: this term includes all regulations which enable a person of legal age, capable and free, to make an advance directive regarding decision-making, in the event of being unable to do so at the end of life. It must be signed before a notary or three witnesses, of whom at least two must not be related nor have any patrimonial interest with the party in question. The affirmant can prohibit that he/she be kept alive by artificial means, but cannot request an acceleration of death. If a document containing the will of the patient is in existence, this must be respected. In the absence of such a document, the relatives will be responsible for deci-

TABLE 5. Pharmacological dosage of propofol for sedation

Propofol
- Short-acting anaesthetic agent.
- Reduces cerebral flow, reducing intracranial pressure and has an antiemetic effect.
- Increases risk of convulsions in epileptic patients and can cause myoclonia.
- Therapeutic action begins after 30 secs. and lasts 5 min.
- Average plasma life: 40 min.
- Presentation: 1% (10 mg/mL), 20 mL ampoules = 200 mg.
  2% (20 mg/mL), 50 mL ampoules = 1000 mg.
- Indications: failure of midazolam and levopromazine, need for sedation with rapid recovery , allergy to BDZ or phenothiazine.
- Before beginning perfusion: stop administration of BDZ and reduce opioids to 50%.

Intravenous administration
- Can only be administered intravenously and cannot be combined with other drugs.
- Induction dose: 1-1.5 mg/kg/IV in 1-3 min.
- Rescue dose: 50% of induction dose.
- Initial dose: IVCI: 2 mg/kg/h.

sion-making. Should there be no document and relatives should abstain from decision-making, the decision shall be made by the physician.

• Principle of distributive justice[1]: In the event of insufficient knowledge (incomplete information) to elect the best option for the patient, therapeutic measures cannot be abandoned (therapeutic abandonment) until the overall decision has been agreed both at a medical level (other members of the same emergency team and/or referral team) and family level. To base a decision on a clinical impression is unacceptable, given that emergency is not synonymous with haste. Opinions among professionals may vary as there are many acceptable interpretations[15], but attempts should be made to reach a consensus on collective decisions[39]. To share ethical decisions with other emergency professionals with ethical training, as well as the availability of individual guidelines/protocols on situations which may pose dilemmas (LTE, advance directives, etc), contribute towards quality health care. Health care excellence is ensured by the ability to consult other experts on palliative care[2,34].

COMMUNICATION

Nowadays, the imminence of the death of a loved one means giving bad news. If this takes place in an ED, the handling thereof becomes particularly complex, and thus, continuous (changes in evolution), feasible (credibility) and confidential (privacy) information is recommended[42-48]. The following recommendations must be considered: to mention only what is essential in the person's usual language, at a moderate pace with no breaks; technical jargon must be avoided and, above all, one must be able to listen. If the relatives have never faced a similar experience, the process of death must be explained mentioning the types of symptoms which could manifest. Furthermore, one must attempt to alleviate any feelings of guilt among the relatives, and acknowledge their contribution to patient's care. The family should be advised to watch their comments around the patient and to keep up communication and physical contact. Finally, one must try to be tolerant when faced with inappropriate conduct or attitudes of distance by the relatives, as these are a consequence of personal immaturity or cultural habits.

Among the most frequent mistakes made in the communication with the relatives is the belief that they have understood everything at the first explanation, without checking their capacity for understanding. Likewise, to anticipate questions, to provide information that they have not requested, to express facts in an imprecise manner and to try to explain many ideas in one single sentence are also common mistakes.

Among the communication recommendations for nursing staff, the importance of keeping physical contact right to the end must be stressed. If the patient is confused or drowsy, try to communicate with him/her via short sentences and simple questions ("are you in pain?", "are you comfortable?", etc.) and avoid attitudes of haste or denial.

• Communication of bad news[48]: one of the basic elements in emergency clinical training is learning rational decision-making, both of a technical and ethical nature, and one must learn to face death in an individual and social way.

– Physician's attitude: a sitting position is recommended (readiness to spend time with the relatives) facing the relatives (increases degree of involvement) at the same eye level (readiness to communicate), leaning forward and closer to the relatives (a sign of involvement) without using defensive postures (arms or legs crossed) with a suitable appearance (a blood-stained surgical gown would foster mistrust). Both affection and formality must be shown (to encourage listening and empathy) and assurance to the relatives (all opinions expressed are based on sound knowledge).

– Message clarity: one must proceed calmly, be accompanied by another member of the medical team and if possible, by an intern (training), introduce oneself (name and surname) and address all family members as a group. The deceased should be mentioned by name and death of the patient should be communicated.

LOGISTICS

• Medical team: the patient at EOL requires a minimum care team made up of a physician, a nurse and auxiliary nurse, to be joined whenever possible by the referral team physician.

• Support team:

– Palliative care unit [(UFISS (Interdisciplinary Social-Sanitary Functional Unit), PADES (Home Attention Support Team Programme)][9]: communication with the home and hospital support teams enables consultations to be made on assessment of complex patients, as well as handling and referral to other units.

– Religious support[15,49-50]: the medical team must encourage patient contact with the various religious representatives, as a belief in the afterlife lessens anxiety and despair.

– Administrative clerks: in order to safeguard EOL patient privacy and confidentiality, the clerks who are responsible for information on patient location, must not disclose any

information without previously consulting the medical team.

• Other support groups which contribute to excellence: psychologist, social worker, etc.

• Documentation:

– Admission computer system: a field in the technical data file should indicate whether ethical provisions exist (advance directive or living will), as one of the main hindrances faced by society when consolidating patient rights is the lack of knowledge thereof by the citizens.

– Medical report: the medical history with treatment criteria and symptom control plan established by the referral team (primary care team, PADES or UFISS) avoids the risk of loss of data and dilution of responsibilities. In order to ensure the same action guidelines between the various shifts, the clinical sheets should include any action taken and/or decision made. If the patient returns home, the family must be given the medical report with the changes and interventions carried out to enable continuity of the therapeutic plan by the referral team.

– Architectural infrastructure: when death is to happen in the ED, the spatial and organisational structures are not ideal for treatment of a patient at EOL. In order to ensure maximum comfort and privacy, EDs should be adapted to the reality of demand and strategies of spatial adaptation should be sought[2,5].

– Information office: communication in a private office is a mark of respect[41]. It should be cosy, equipped with a table and enough chairs, and an alarm connected to the hospital security service to protect physicians from violent or aggressive outbursts.

– Individual box[2,3,44-47]: death occurring on a gurney, on a shared box or in a corridor should be avoided at all costs and thus individual boxes which preserve privacy and allow the presence of family members are essential. The number of relatives should be conditioned to the dimensions of each ED with flexible visiting hours, enabling respect for the patient and for the rest of patients in the ED[2].

CONCLUSIONS

The great attraction of hospitals for patients at EOL is related to immediacy of response, access at any time, and the safety and protection they convey due to the ready availability of medical personnel[1-8]. This is the case despite the tight working hours, the lack of training given to professionals in facing emotional reactions from the patient and family members (university training based on the preservation of life and not on facing death), as well as the lack of suitable spatial infrastructure conducive to privacy[1-8,15]. The high rate of deaths occurring in EDs is related to the impossibility of referral of EOL patients to hospital wards, which leads to the usual overcrowding and unsuitable location[1-8]. In order to prevent the passing of such patients through EDs, a "model for the end of life" should be established with home support ranging from symptom control therapy to preparation for death, gradual family support throughout the course of the disease (medically educated and informed carers who accept the prognosis), as well as alternative circuits with direct access from the home to the palliative care units[6,9,37]. Despite all the measures that can be established, death is currently not accepted -least of all at the home- as part of the cycle of life, which leads to many people spending their last days of life away from their family members, in a cold environment lacking the necessary privacy[2,3,6,9,37]. A long road must therefore still be travelled in order to dignify death once again and integrate it into daily life. If, despite the steps taken, EOL patients arrive at EDs, the training of emergency physicians in patient assessment, in strategies and therapy actions in palliative care, in ethical-therapeutic decision –making and in communication will help towards better treatment and attention for those patients who come to die in the ED[1-8].

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