Protocolli Multidisciplinari nel Fine Vita

ANTONIO LA GRECA

FONDAZIONE POLICLINICO UNIVERSITARIO A. GEMELLI IRCCS, ROMA
UNIVERSITA' CATTOLICA DEL SACRO CUORE

CHIRURGIA D'URGENZA E TRAUMA

FUTILITY ?

«do not operate a patient the day he's dying»

A. Leppaniemi, Pisa (Italy) 2023

OXFORD Leading Article

BJS, 2022, **109**, 1184–1185
https://doi.org/10.1093/bjs/znac313
Advance Access Publication Date: 6 September 2022
Leading Article

The virtual uncertainty of futility in emergency surgery

Hannah Javanmard-Emamghissi[1,*] and Susan J. Moug[2,3]

Futility is when 'there is a goal, there is an action and activity aimed at achieving this goal and there is virtual certainty that the action will fail in achieving this goal'.
Having been described initially by Hippocrates before his death in 370BC, the importance of futility remains today.

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The virtual uncertainty of futility in emergency surgery

Hannah Javanmard-Emamghissi[1,*] and Susan J. Moug[2,3]

Managing scenarios where you, as the surgeon, believe that a surgery will be futile is challenging.

The first step is to recognize that this is a balance of risk…

Futility «Quantification»: does it work?

Ramírez-Giraldo *et al. BMC Surgery* (2023) 23:21
https://doi.org/10.1186/s12893-022-01897-1

BMC Surgery

RESEARCH

Open Access

Surgical mortality in patients *in extremis*: futility in emergency abdominal surgery

Camilo Ramírez-Giraldo[1,2*], Andrés Isaza-Restrepo[1,2], Juan Camilo García-Peralta[2], Juliana González-Tamayo[2] and Milcíades Ibáñez-Pinilla[1,2]

Abstract

Background The number of older patients with multiple comorbidities in the emergency service is increasingly frequent, which implies the risk of incurring in futile surgical interventions. Some interventions generate false expectations of survival or quality of life in patients and families and represent a negligible therapeutic benefit in patients whose chances of survival are minimal. In order to address this dilemma, we describe mortality in a cohort of patients undergoing emergency laparotomy with a risk ≥ 75% per the ACS NSQIP Surgical Risk Calculator.

Futility «Quantification»: does it work?

Techniques in Coloproctology (2023) 27:729–738
https://doi.org/10.1007/s10151-022-02747-1

ORIGINAL ARTICLE

Check for updates

Quantitative futility in emergency laparotomy: an exploration of early-postoperative death in the National Emergency Laparotomy Audit

H. Javanmard-Emamghissi[1] · B. Doleman[1] · J. N. Lund[1] · J. Frisby[2] · S. Lockwood[3] · S. Hare[4] · S. Moug[5] · G. Tierney[6]

EmSurg futility = early postoperative death within 72 h

Futility «Quantification»: does it work?

"Only 4% of surgeries result in a quantitatively futile outcome strongly suggesting that appropriate decision-making is part of current emergency surgery practice in the UK"

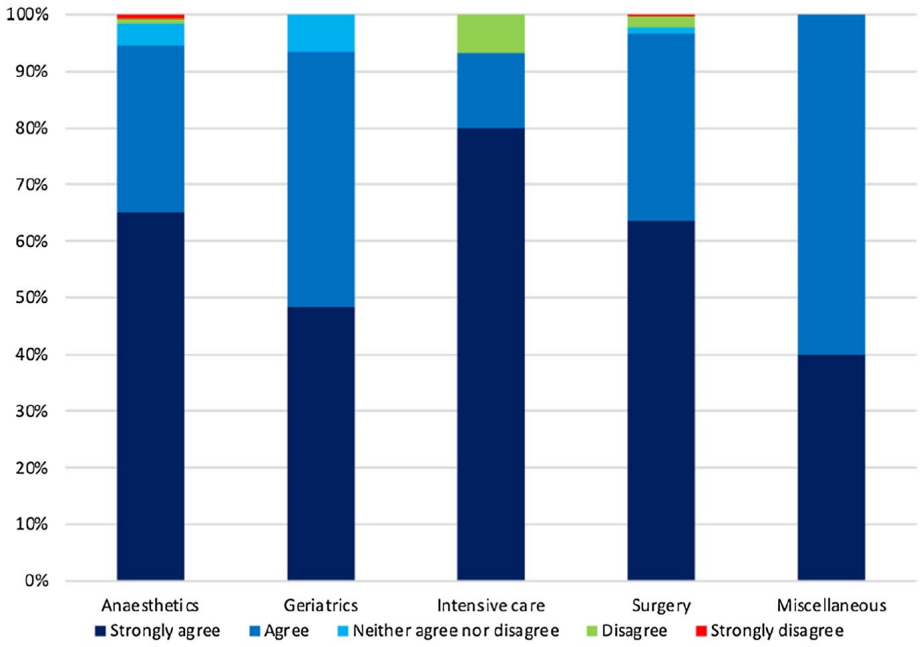

Fig. 1 Responses to the question can an emergency laparotomy be futile, by speciality

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«The differing responses from different specialties highlight the varying experiences and values that a multidisciplinary team can provide to these high-risk patients. Where a decision to operate or not may not be clear to a single surgeon, ***a multidisciplinary council assessment including anaesthetics, critical care and, if appropriate, geriatricians should be routinely considered***»

Futility «Quantification»: does it work?

ACS NSQIP® Surgical Risk Calculator — ACS American College of Surgeons

Home | About | FAQ | ACS Website | ACS NSQIP Website

Enter Patient and Surgical Information

Procedure 44143 - Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure) — Clear

Begin by entering the procedure name or CPT code. One or more procedures will appear below the procedure box. You will need to click on the desired procedure to properly select it. You may also search using two words (or two partial words) by placing a '+' in between, for example: "cholecystectomy + cholangiography"

Reset All Selections

Are there other potential appropriate treatment options? ☑ Other Surgical Options ☑ Other Non-operative options ☐ None

Please enter as much of the following information as you can to receive the best risk estimates. A rough estimate will still be generated if you cannot provide all of the information below.

Age (between 18 and 112): 79

Sex: Female

Functional Status: Partially Dependent

Emergency Case: Yes

ASA Class: Severe systemic disease

Steroid use for chronic condition

Diabetes: No

Hypertension requiring medication: No

Congestive Heart Failure in 30 days prior to surgery: Yes

Dyspnea: With Moderate exertion

Current Smoker within 1 Year: No

History of Severe COPD

ACS NSQIP® Surgical Risk Calculator — ACS American College of Surgeons

Home | About | FAQ | ACS Website | ACS NSQIP Website

Procedure: 44143 - Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)

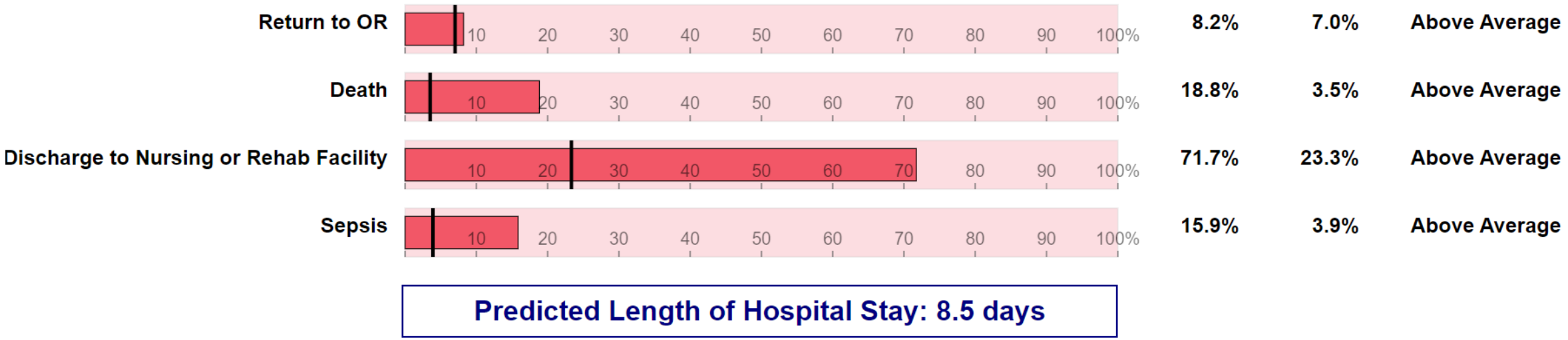
Risk Factors: Age (79), Female, Partially dependent functional status, Emergent, ASA Severe systemic disease, Chronic steroids, CHF, Dyspnea with moderate exertion, COPD, BMI (25.99)

Change Patient Risk Factors

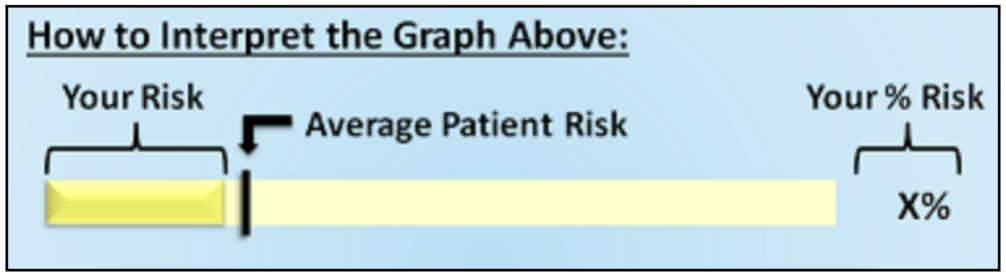
Note: Your Risk has been rounded to one decimal point.

Outcomes	Your Risk	Average Risk	Chance of Outcome
Serious Complication	39.2%	23.6%	Above Average
Any Complication	44.2%	29.7%	Above Average
Pneumonia	13.4%	5.0%	Above Average
Cardiac Complication	6.0%	2.4%	Above Average
Surgical Site Infection	12.7%	9.5%	Above Average
Urinary Tract Infection	8.5%	1.8%	Above Average
Venous Thromboembolism	6.1%	3.9%	Above Average
Renal Failure	2.6%	2.0%	Above Average
Colectomy Ileus	37.4%	30.5%	Above Average
Colectomy Anastomotic Leak	2.1%	2.3%	Average
Readmission	22.1%	11.5%	Above Average

Futility «Quantification»: does it work?



Appropriate Potential Surgical and Non-operative Treatment Options Are Also Available and Should Be Discussed



Surgeon Adjustment of Risks

This will need to be used infrequently, but surgeons may adjust the estimated risks if they feel the calculated risks are underestimated. This should only be done if the reason for the increased risks was NOT already entered into the risk calculator.

1 - No adjustment necessary

Futility «Quantification»: does it work?

Tilburg frailty index = 8 (cutoff >5)

A1	**Do you feel physically healthy?**	☐ Yes	☒ No
A2	**Have you lost a lot of weight recently without wishing to do so?** ('a lot' is: 6 kg or 13lbs or more during the last *six months*, or 3kg or 6½lbs or more during *the last month)*	☐ Yes	☒ No

Do you experience problems in your daily life due to:		Yes	No
A3	... difficulty in walking?	☒	☐
A4	... difficulty maintaining your balance?	☒	☐
A5	... poor hearing?	☐	☒
A6	... poor vision?	☒	☐
A7	... lack of strength in your hands?	☐	☒
A8	... physical tiredness?	☒	☐

Psychological components		Yes	Some-times	No
A9	Do you have problems with your memory?	☐	☐	☒
A10	Have you felt down during the last month?	☒	☐	☐
A11	Have you felt nervous or anxious during the last month?	☐	☒	☐
A12	Are you able to cope with problems well?	☐		☒

Social components		Yes	Some-times	No
A13	Do you live alone?	☒		☐
A14	Do you sometimes miss having people around you?	☐	☒	☐
A15	Do you receive enough support from other people?	☒		☐

EmSFI = 12 (high risk > 7)

Table 1 Variables for calculating emergency surgery frailty index (EmSFI), proposed by the ERASO group [21]

Variable	Absent	Mild	Severe
Age ≥ 80 years	0		1
Emergency	0		1 ⟵
SIRS	0		1 ⟵
Malignancy	0		1
Chronic cardiopathy	0	1	2 ⟵
Chronic pneumopathy	0	1	2 ⟵
Other comorbidities	0	1	2 ⟵
Altered autonomy	0	1	2 ⟵
Altered mobility	0	1	2 ⟵

Maximum score: 14 points

- First EmSFI risk Class with the maximum score of 3 points,
- Second EmSFI risk Class with total score between 4 and 7 points,
- Third EmSFI risk Class if scored more than 7 points.

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Futility «Quantification»: does it work?

Managing scenarios where you, as the surgeon, believe that a surgery will be futile is challenging. ***The first step is to recognize that this is a balance of risk*** …

… and that your experience and perception of risk using ***objective scores needs to work alongside the patient's values*** and their perception of risk according to those values.

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Home > Shared Decision Making

Shared Decision Making

B.R.A.N. Decision Making Framework

Comprehensive Futility Judgement

RESEARCH

doi: 10.1136/bmj.j4891 | BMJ 2017;359:j4891

A three-talk model for shared decision making: multistage consultation process

Glyn Elwyn,[1] Marie Anne Durand,[1] Julia Song,[1] Johanna Aarts,[2] Paul J Barr,[1] Zackary Berger,[3]

PATIENTS (and relatives) ENGAGEMENT

PERSPECTIVE

J Gen Intern Med 27(10):1361–7, 2012

Shared Decision Making: A Model for Clinical Practice

Glyn Elwyn, PhD[1,2], Dominick Frosch, PhD[3,4], Richard Thomson, MD[5],

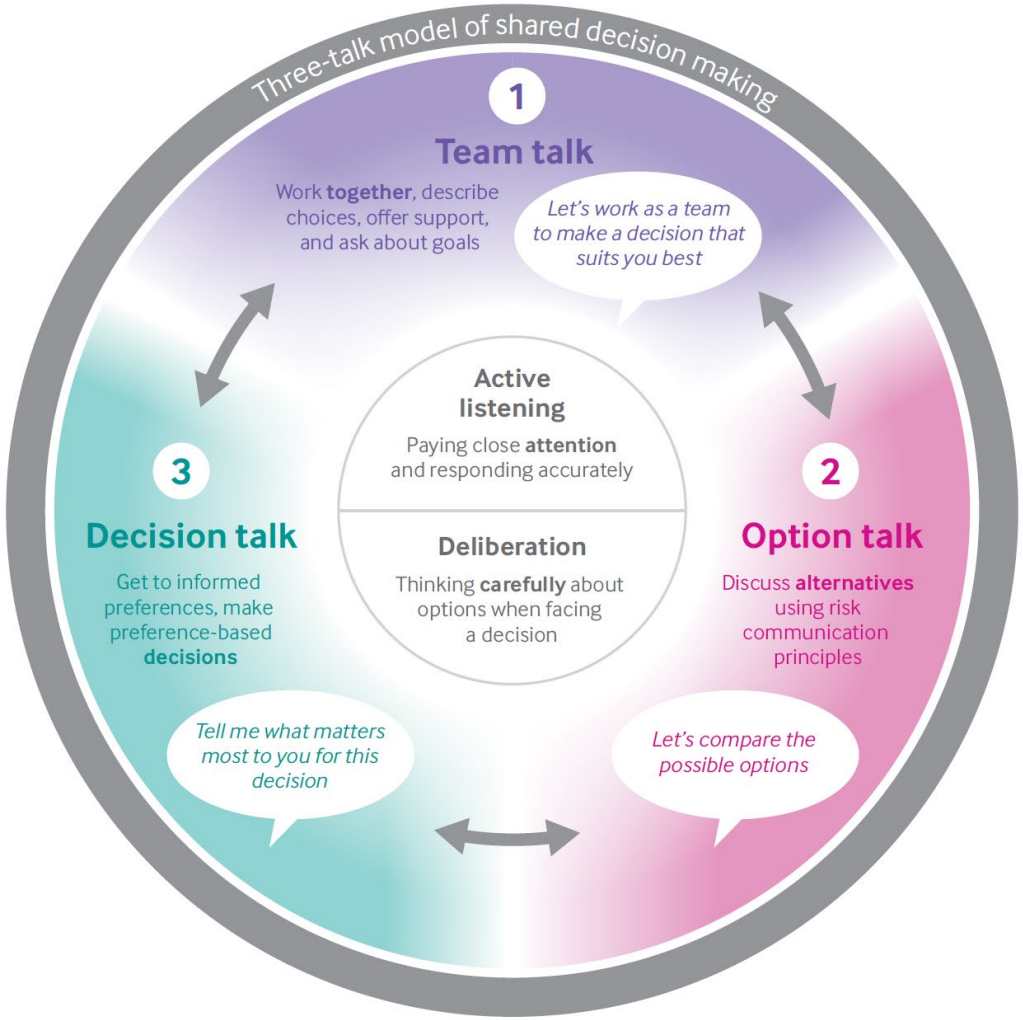
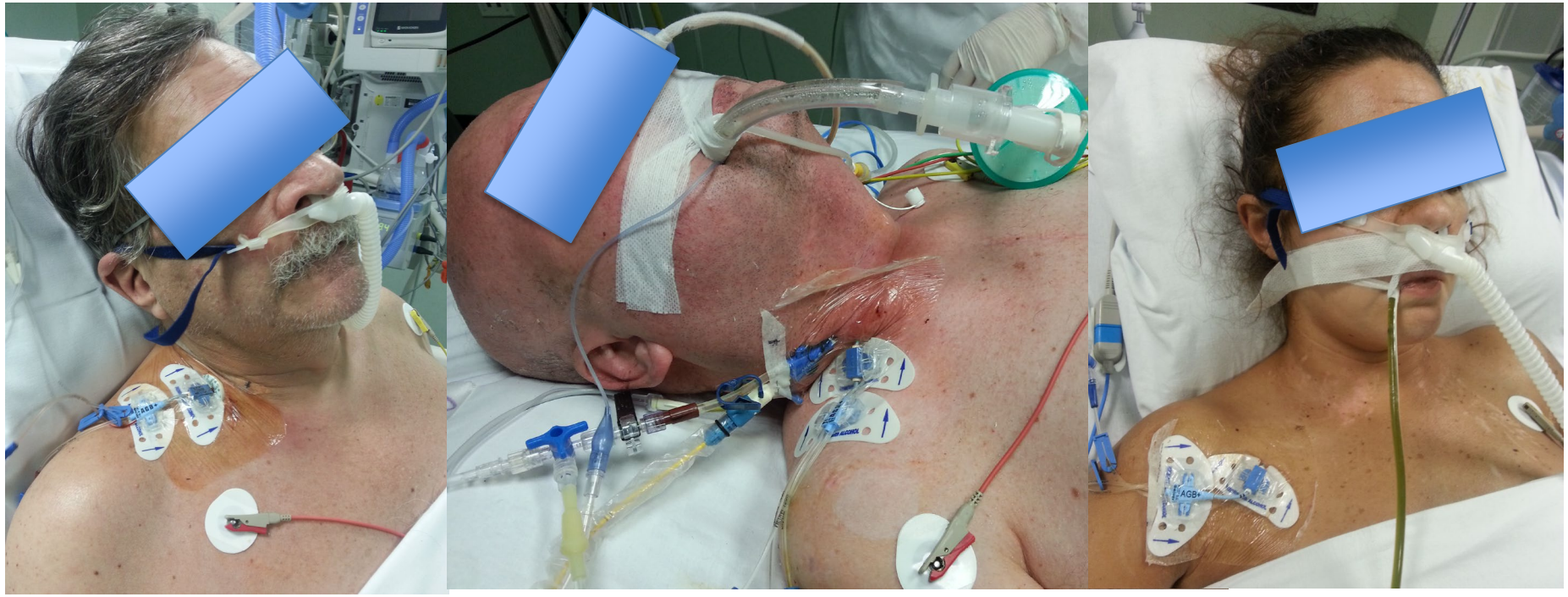


Fig 3 | Three-talk model of shared decision making, 2017

Futility «Quantification»: does it work?

What about patients engagement in emergency?



And what if

no advanced healthcare directives available?

Comprehensive Futility Judgement

Hornor M, *et al*. *Trauma Surg Acute Care Open* 2023;**8**:e001167. doi:10.1136/tsaco-2023-001167
Open access Review
Trauma Surgery & Acute Care Open

Futility in acute care surgery: first do no harm

Melissa Hornor [1,2] Uzer Khan,[3] Michael W Cripps [4] Allyson Cook Chapman,[5] Jennifer Knight-Davis,[2,6] Thaddeus J Puzio [7] Bellal Joseph,[2,8] AAST Geriatrics Committee

AN
*«ACS **FUTILITY TEAM**»?*

How can futile surgery best be avoided? The risk of early postoperative death is difficult to determine. Whether surgery is futile depends on the physiological and the patient-centered outcomes of the surgery within the framework of the patient's personal healthcare goals and preferences. There are currently no objective scoring systems that predict whether an emergency surgery may be futile. Since the evidence base informing perioperative emergency general surgery care in these patients is lacking, high-quality shared decision-making that incorporates the patient's ADs, surrogate decision maker, and overall healthcare goals is currently our best prevention method. The best case/worst case framework has helped improve surgeon communication by shifting the focus of surgical decision-making away from an isolated surgical problem ('fix-it' model) to a discussion about likely outcomes and alternative paths other than surgery.[35]

Antibiotic use towards the end of life: development of good practice recommendations

Seaton RA, *et al*. *BMJ Supportive & Palliative Care* 2021;**0**:1–6. doi:10.1136/bmjspcare-2020-002732

R Andrew Seaton,[1,2] Lesley Cooper ,[1] Jack Fairweather,[3]

- There was a recurring theme to 'avoid creating policy' and that, while guidance could be helpful, it should support but not replace a personalised approach to care and decision-making.

Sindrome infettiva addominale

12^ edizione

. da "una compressa per due" all'intelligenza artificia

Roma, 15 dicembre 2023
CNR - Aula Guglielmo Marconi

Coordinatori

gabriele sganga e francesco cortese

con la collaborazione di
massimo sartelli

14:30 - 14:50

Antibioticoterapia nei contesti di fine vita e palliazione

massimo fantoni

Gemelli

Fondazione Policlinico Universitario Agostino Gemelli IRCCS
Università Cattolica del Sacro Cuore

Policy
Cure palliative e paziente al termine della vita
PLC.008

Al fine di assicurare l'ottimizzazione dei percorsi di cura ed il setting assistenziale più appropriato nonché al fine di garantire una adeguata gestione dei sintomi si prevede quanto segue:

-Il **medico/equipe sanitaria del reparto di degenza**, una volta individuato un paziente potenzialmente in fine vita attraverso il soddisfacimento dei requisiti illustrati di seguito nel paragrafo 4.2.5 e suoi allegati, il cui esito è parte integrante della cartella clinica, dovrà contattare il team assistenziale di cure palliative tramite richiesta informatica di consulenza, accompagnata da una breve sintesi delle condizioni cliniche del paziente e dal motivo della richiesta.

La trasmissione della richiesta informatica di consulenza è effettuata dal personale medico.

Il **Team assistenziale di cure palliative** è composto da medici palliativisti e si avvale della collaborazione di rianimatori, anestesisti specializzati in terapia del dolore e psicologi.

Il Team dei palliativisti, afferente alla UOC Cure Palliative, è attivo dal lunedì al venerdì, dalle ore 08.30 alle ore 15:30 (DECT: 3704, 3706, 3536, 3563). Nella fascia oraria 08:30-13:00 è anche operativo un infermiere case manager dedicato (DECT 3579), afferente alla Centrale di Continuità Assistenziale. Fuori dal predetto orario e solo per le richieste che rivestono carattere di urgenza (gestione dei sintomi refrattari in pazienti già inseriti nel percorso e con piano di cura già stabilito, nuovi ricoveri con sintomi complessi e/o in imminente pericolo di vita), subentra il personale medico di guardia presso le unità di rianimazione dei settori adulto e pediatrico, contattabile sul rispettivo DECT (3112 adulto e 3125 pediatrico). In questi casi, al contatto sul DECT farà comunque seguito la richiesta informatica di consulenza sul servizio Guardia Attiva rianimazione.

Al fine di favorire la relazione di cura e fiducia nelle varie fasi [redacted] eventualmente avvalersi dell'ulteriore ausilio di altri specialisti: psicologo, assistente sociale, assistente spirituale, bioeticista, medico legale, nutrizionista, fisioterapista, mediatore culturale e/o di altre figure professionali di volta in volta individuate.

La consulenza di bioetica clinica è svolta con le modalità definite dalla PRO.968. Il supporto spirituale, nel rispetto del credo religioso del paziente, è garantito da FPG con le modalità definite dalla policy PLC. 002. L'assistenza spirituale, nel suo servizio allargato, è ulteriormente specificato e integrabile secondo quanto indicato in PLC.008.All.006.

In definitiva, il processo decisionale per l'erogazione delle cure di fine vita è definito «collettivo» e consta di tre fasi:

1. una individuale, in cui ogni figura professionale coinvolta forma la propria opinione in base alle informazioni sul paziente e sulla patologia;
2. un momento collettivo in cui i familiari, le persone di fiducia e gli operatori sanitari condividono il percorso di cura;
3. una fase conclusiva, in cui la decisione viene trascritta in cartella clinica. E' possibile in casi selezionati redigere un documento di pianificazione condivisa delle cure secondo PRO.968. Il paziente (o il suo rappresentante) deve sempre poter accedere alle informazioni che lo riguardano.

Si riporta di seguito la matrice delle attività/responsabilità degli operatori coinvolti nell'applicazione della policy.

ATTIVITA'	Medico/ Equipe sanitaria/ Medico di guardia	Case manager (Centrale di Continuità Assistenziale)	Team Assistenziale di Cure Palliativei	Altri specialisti	Paziente/ Fiduciario /Familiare/ Amministratore di sostegno/ Tutore legale	Direzione Sanitaria	U.O.S. Risk Management
Valutazione generale dei criteri per l'identificazione del paziente in fin di vita	R		C		I/C		
Valutazione costante dei sintomi	R	R	I/C	I/C	I/C		
Descrizione del processo valutativo in cartella clinica	R		I		I		
Richiesta informatica di consulenza	R	C	C				
Richiesta di valutazione urgente avanzata in orario di attività del team (chiamata sul DECT del Case Manager, associata a richiesta informatica)	R	C/I	C/I				
Richiesta di valutazione urgente avanzata fuori dall' orario di attività del team (chiamata sul DECT del rianimatore di guardia seguita da richiesta informatica)	R	C/I	C/I				
Comunicazione sui temi di fine vita	R/C		R/C	I/C	C		
Esecuzione consulenza di cure palliative	I/C	I	R	I/C	C		
Somministrazione delle scale di secondo livello per la valutazione dei sintomi	I/C		R	I/C	C		
Gestione farmacologica del dolore ed eventuale somministrazione della sedazione palliativa	R/C	I	R/C	I/C	C		
Relazione scritta di consulenza del team	I/C		R	I/C	I		
Realizzazione della PAC/DAT	R/C	I	R/C	R/C	R		
Individuazione percorsi in strutture di cure palliative	I/C	C	R	I/C	C		
Progettazione policy	I		R/C	C		R/C	R/C
Diffusione policy	C	C	R/C	C		R	R/C
Applicazione policy	R	R/C	R/C	R/C		I/C	I/C
Monitoraggio applicazione policy	I	I	I	I		R	C

R= RESPONSABILE; C= COINVOLTO; I=INFORMATO

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Comprehensive Futility Judgement

AN «ACS FUTILITY TEAM»

ROMA

Dipartimento di Sicurezza e Bioetica
Sezione di Bioetica e Medical Humanities

UNIVERSITÀ CATTOLICA del Sacro Cuore

Servizio di Consulenza di Etica Clinica

CORE
- ACS Surgeon
- Intensivist
- Palliativist
- Nurse

SPECIALIST ON DEMAND
- Bioethicist
- Oncologist
- Cardiologist
- Pneumologist
- …

Roma, [redacted]

DOCUMENTO CONDIVISO DI ORIENTAMENTO ETICO ASSISTENZIALE
per [redacted] di anni [redacted], Cod. San. [redacted]
ricoverato presso la UOC di [redacted]

Comprehensive Futility Judgement

Finally...NOT to treat

Day 15
treatment options disproportionate

Day 21 Death

Comprehensive Futility Judgement

TRAINING ?

4.12 LA FORMAZIONE DEL PERSONALE DI FPG E DEGLI SPECIALIZZANDI SULLE TEMATICHE DEL FINE VITA

Il personale sanitario di FPG e gli specializzandi sono sensibilizzati nei confronti delle tematiche del fine vita richiamate nella presente politica attraverso una formazione continua che prevede la partecipazione obbligatoria a corsi FAD.

La formazione e l'aggiornamento del team assistenziale di cure palliative sono garantiti mediante la partecipazione a periodici incontri autocondotti, sulla base del modello "Focus-Group", che prevedono la possibilità di invitare le figure professionali potenzialmente coinvolte nel processo decisionale ed eventuali partecipanti esterni, esperti delle specifiche tematiche trattate.

Al personale di FPG è offerta inoltre la possibilità di avvalersi, su richiesta, di supporto psicologico nonché di assistenza spirituale.

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Comprehensive Futility Judgement

FURTHER DEVELOPMENTS

Editorial

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Published online ■■
http://dx.doi.org/10.1097/JS9.0000000000002347

INTERNATIONAL JOURNAL OF SURGERY

OPEN

Ethical considerations on the role of artificial intelligence in defining the futility in emergency surgery

Valentina Bianchi, MD[a], Filomena Misuriello, MD[b], Edoardo Piras, MD[b], Carmen Nesci, MD[b], Maria Michela Chiarello, MD[c], Giuseppe Brisinda, MD[b,d,*]

CONCLUSIONS

- No standards available for futility judgement
- Presently, only multidisciplinary team working can relieve this hard job both for patients and relatives as well as for operators
- Policies are recommended, but still human judgement is the cornerstone
- Training in this field is simply non-existent

«the amateur pilot is surprised if one of the instruments fails,
but the professional is surprised if they work»

Old aviation saying

THANKS

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