The Integration of Palliative Care into the Emergency Department

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SUMMARY

Palliative care (PC) is a new and developing area. It aims to provide the best possible quality of life for patients with life-limiting diseases. It does not primarily include life-extending therapies, but rather tries to help patients spend the rest of their lives in the best way. PC patients often are admitted to emergency departments during the course of a disease. The approach and management of PC include differences with emergency medicine. Thus, there are some problems while providing PC in the ED. With this article, the definition, main features, benefits, and problems of providing PC are presented, with the primary aim of emphasizing the importance of PC integration into the ED.

Key words: Emergency department; integration; palliative care; training.

Introduction

Palliative care (PC) is basically the complete active care of patients who have life-limiting diseases.[1] It aims to provide relief from distressing symptoms and to achieve the best possible quality of life. It was defined by World Health Organization in 2006 as "(PC is) an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.[2]"

Historically, PC was developed for terminal stage cancer patients. The spectrum of diseases has widened, and it now includes cardiac, respiratory, metabolic, renal, and neurological (i.e. dementia) diseases.[3–5]

Main Features of PC

There are some main features of PC. First, it has a patient-centered culture.[6] This means that every patient is unique and, additionally, every situation about the patient is unique as well. The most important thing is to assess the whole patient and to include the patient and family while making decisions. It is designed to meet all the physical, psychological, spiritual, and social needs of the patient. PC has a multidisciplinary, collaborative, and team-based approach.[7,8] It is important to have good communication skills that include breaking bad news.[9] The aim of PC is not limited to the end of the disease, but rather it aims to support the patient in the early stages of the life-limiting disease. It begins in early stages of the disease but it doesn't end with death; it includes supporting families in bereavement.

Misconceptions about PC

There are some misconceptions about PC. First, it is not same as end-of-life care, although end-of-life care is a part of PC.[3,10] PC focuses on providing the best possible quality of life in patient's remaining time. It does not aim to prolong the life span. However, PC does not mean that the patient has to give up curative treatments such as chemotherapy

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and their access to intensive care units or hospital beds. Recently, early identification of patients has gained importance. Thus, patients can be considered as a PC patient while curative treatment continues.[4,9]

The Providers of PC

As PC is not an approach that one health care provider can ensure, it cannot be supplied by only one health care institution. To apply PC with its full meaning requires all the structures of the health care system of a country. All providers of PC should be determined, and the communication between providers should be maintained. There may be variations according to health care system of a country. They can be PC units, PC home care teams, and/or PC consultants in hospitals, hospices, primary health care providers, and emergency departments (ED).[7] Emergency physicians should know these providers of PC, especially to refer these patients from ED.

Hospice is planned for patients who can no longer be helped by curative treatment and are expected to live about 6 months or less, if the illness runs its usual course.[11] Hospice aims to celebrate, enable, and facilitate life and living by trained professional teams. It is designed to meet all physical, physiological, social, and spiritual needs.[12,13] Death is a part of life and is acceptable in the hospice approach.[14] The words of Cicely Saunders, who is the founder of the modern hospice movement, may explain the aims of hospice clearly: "You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die." [15]

Referring the patients to hospice care is important decision in ED. Four steps were suggested as assessing hospice benefits eligibility, discussing hospice as a disposition plan with the patient's physician, assessing whether the patient's goals are consistent with hospice care, and introducing hospice to the patient and family surrogates.[16]

PC in the ED

It is known that patients who need PC often visit EDs whether or not there are PC units, home care services and hospices, and ED visits will never lose importance due to the aging population and the increase in advanced diseases . It is obvious that adults with chronic illnesses often visit an ED several times in their last year of life. Unfortunately, high rates of ED visits in the last weeks of life are accepted indicators of poor-quality end-of-life care.[17]

In a study which was called 'the health and retirement study', number of emergency admissions were evaluated according to age variable in the last months of life for fourteen years. It was found that 75% of patients older than age 65 years visited an ED in the last six months of life, and 51% of patients visited an ED in the last month of life. They also found that repeated visits were common in these patients.[18]

McNamara et al. evaluated ED admissions in the 90 days before death. They reported that 65.8% of patients with malignancies were admitted to ED in the last year of life, and 47% of patients in the 90 days before death visited ED many times.[17] In a study, patients with advanced malignancy were evaluated according to ED admissions, and it was reported that 26% of patients with advanced malignancy were admitted to ED more than five times in a two-year period.[19]

There can be a lot of reasons for admission to ED. First, PC patients may have serious and variety of symptoms in a disease trajectory. Pain is the most common problem. In addition to pain, dyspnea, nausea, vomiting, nutritional deficiencies, fatigue, bleeding problems, and anemia may occur.[20–23] Moreover, acute function loss, acute anxiety, epileptic seizures, and delirium were reported symptoms of PC patients.[24] Shin et al. reported that pain, fatigue, nausea, and insomnia were the most common symptoms when referring acute PC patients from ED.[21] Also, they suggested that the patients who were referred from ED had more severe symptoms than other PC patients. In a study by Ahn et al., the reasons for ED admission for cancer patients were divided into four groups: disease progression (55.5%), infection (22.8%), treatment-related complications (14.7%), and non-cancer related problems (7%).[25]

The ED may be an option for PC patients for hydration or intravenous medication, as well as a quick reach for acute imaging. The symptoms that the patient suffers are often bothersome and distressing, and it may cause anxiety in patients and families. It is known that psychological distress includes symptoms such as depression and anxiety. It was suggested that the prevalence of psychological distress in cancer survivors ranged from 0% to 44%.[26]

It was found that many patients with advanced malignancy needed only simple procedures such as hydration, bladder catheterization, and oxygen therapy in ED in a study by Hjermstad et al.[27] They found the most common reasons for ED admissions were gastrointestinal problems (nausea, vomiting, diarrhea, etc.), lung problems (dyspnea, pleural effusion, pneumonia, etc.) and pain. It was suggested that somatic indications such as reduced performance status, frailty, loneliness, and psychological distress might be a reason for admissions to ED. Additionally, family distress and feeling safer in the hospital than at home were indicated as the causes of ED admission.[27] Next to those, the most common reason was the availability of EDs 24 hours a day and 7 days a week. The patients have access to physicians for all their needs.

EDs will always be essential for PC patients with or without