Palliative Care in the Emergency Department

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KEYWORDS

• Palliative care • Emergency department • Delirium • Pain control • Quality of life

KEY POINTS

- Palliative care (PC) initiated in the emergency department (ED) is an innovative idea that is now incorporated more frequently across health care settings.
- The ED typically treats immediate symptom and pain relief and historically does not initiate PC.
- Different models of PC in the ED can deliver services in consultation with the PC team or with PC champions in the ED.
- Barriers to the implementation of PC in the ED include a lack of research on this topic, which inhibits informed policy making.

BACKGROUND

The emergency department (ED) is a fast-paced environment in which patients seek immediate relief of pain and other distressing symptoms. Emergency physicians are trained to provide care that focuses on disease-directed treatment of acute illnesses.[1] In an effort to stabilize patients and preserve life, emergent procedures and treatments for medical conditions are often provided. Despite this, many patients with chronic or end-stage diseases seek treatment and assistance for their conditions in the ED each year. Thus, the ED is frequently the point of entry into the health care system for acute episodes of illness in a patient's life.

In 2004, more than 90% of Medicare beneficiaries were hospitalized in the year before death; more than 50% of those with serious illness in the United States died in the hospital.[2] Surveys of healthy adults suggest that most would like to die at home; however, most Americans still die in the hospital. Care in the ED is traditionally aggressive in nature; conversely, it is also episodic. Therefore, this environment is not

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usually considered a place to initiate palliative care (PC). The opposing nature of emergency care has placed it at odds with the traditional PC culture.[3]

The ED sees a variety of patient populations, and the decisions within the ED greatly impact the patients' hospital stay and goals of care. As health care resources become more strained and inpatient PC has gained more recognition, literature has emerged calling for the presence of PC in the ED. EDs are seeing older and more complex patients who are in need of PC for relief of exacerbations of a chronic condition. Older patients or patients with end-stage cancer may not desire aggressive treatments in the ED but may seek palliation of symptoms that are more in agreement with their goals of care and the patients' interpretation of quality of life. Chronic diseases are now the leading causes of death (**Table 1**).[4] These diseases have a high prevalence of physical, psychosocial, spiritual, and financial suffering associated with complex illness.[1] Other patients seeking care in the ED may be patients with cancer who are either receiving or have received chemotherapy and are having side effects of the treatment for which outpatient management has failed. Residents of long-term care facilities (nursing homes, rehabilitation facilities) can be medically complex and require the ED physician to have a discussion on the goals of care or review an advanced directive with patients and/or the families. These roles are ones in which the ED physician may not be well versed.

When discussing PC it is important to note that there is a distinction between hospice care and PC. PC is focused on communication, comfort, and quality of life and can be used at the same time as life-prolonging treatments. This approach to care is conducive to the treatment of chronic serious diseases and conditions whereby the goal is to decrease suffering and in doing so achieve the best quality of life possible for the patients.[5] Hospice care typically begins as restorative or curative care is finishing and end of life is near; however, it continues after the death of the patients in the form of bereavement support for the family.

PRESENTING TO THE EMERGENCY DEPARTMENT FOR PALLIATIVE CARE

The absence or presence of PC in the ED largely depends on the extent of a PC program at the individual hospital. A greater number of patients receiving PC in the

Table 1
Chronic diseases in the top 10 causes of death in the United States

Rank	Disease	Deaths Per Year	Percentage Total Deaths (%)
1	Heart disease	596,577	23.71
2	Cancer (malignant neoplasms)	576,691	22.92
3	Chronic lower respiratory disease	142,943	5.68
4	Stroke (cerebrovascular diseases)	128,932	5.12
5	Accidents (unintentional injuries)	126,438	5.02
6	Alzheimer disease	84,974	3.37
7	Diabetes (diabetes mellitus)	73,831	2.93
8	Influenza and pneumonia	53,826	2.13
9	Kidney disease (nephritis, nephrotic syndrome, and nephrosis)	45,591	1.81
10	Suicide (intentional self-harm)	39,518	1.57

Data from Nichols H. What are the top 10 leading causes of death in the US? Medical News Today. Available at: http://www.medicalnewstoday.com/articles/282929.php#top_10_leading_causes_of_death. Accessed March 16, 2015.