Palliative Care in the Emergency Department

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KEYWORDS

• Palliative care • Geriatric • End of life • Emergency medicine • Surrogate • Communication

KEY POINTS

- Shared decision making between physicians and patients/surrogates should be the framework for all conversations and decisions involving palliative and end-of-life care.
- Patient autonomy is the gold standard for decisions pertaining to care. If patients are unable to communicate; focus on prospective autonomy through substitute decision makers and written directives.
- Alleviation of suffering owing to end-of-life symptoms, whether physical or existential, is the responsibility of the emergency physician.
- Familiarity with evidence-based recommendations about symptom management at end of life is essential.

INTRODUCTION

Emergency medicine (EM) is generally thought of as a resuscitative specialty, one that revolves around the identification of life-threatening conditions and swift intervention with the goal of curative treatment. The American College of Emergency Physicians defines the specialty of EM as "a medical specialty dedicated to the diagnosis and treatment of unforeseen illness or injury."[1]

The inherent culture of EM makes discussion revolving around impending death and associated symptoms incongruous with some emergency physicians, because the mere acknowledgment of this discussion may be perceived as failure. "Emergency medicine physicians are trained to save lives, not to manage death" is a statement that resonates with some emergency physicians in training.[2] Statistically, EM residents place training in palliative care to be at a lower priority than do residents in other specialties such as pediatrics and internal medicine.[2]

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The reality is that, although the majority of people wish to die at home, a significant number of patients in the final stages of their life visit the emergency department and are under the care of an emergency physician.[3] This number is continually growing as the aging population increases. According to the World Health Organization (WHO), between 2015 and 2050, the proportion of the world's population over 60 years will double. By 2050, there will be more than 400 million people aged 80 and older worldwide.[4] Experts are acutely aware of this fact and structure is in place for addressing this. In 2006, hospice and palliative medicine was recognized as an EM subspecialty by the American Board of Medical Specialties.[2] In 2007, Education in Palliative and End-of-life Care for Emergency Medicine was implemented to teach clinical competencies in palliative care to EM professionals.[2]

The groundbreaking Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) Trial (*JAMA* 1995) raised awareness of many of the shortcomings of care for seriously ill and dying hospitalized patients. The principal investigators concluded through their research that the care of seriously ill or dying patients is far from ideal and that "One would certainly prefer to envision that, when confronted with life-threatening illness, the patient and family would be included in discussions, realistic estimates of outcome would be valued, pain would be treated, and dying would not be prolonged."[5]

COMMUNICATION WITH PATIENTS AND SURROGATES

Being comfortable with conversations pertaining to end-of-life and palliative issues is imperative for all physicians working in the emergency department. It has even been proposed that that training in communication skills should be integrated with mandatory resuscitation training.[6]

To adhere to best practice communication skills, it is useful to understand the concept of shared decision making and decision frames, and to be aware of certain tools for embarking on a discussion with a patient and/or their surrogate.

Shared Decision Making

End-of-life discussions should be centered around a shared decision making model. This approach is often the crux of patient-centered medicine.[7] Shared decision making was first coined in 1988 by the Picker Institute and introduced as one of the fundamental approaches to improving health care delivery in the United States.[8] The Institute of Medicine defines shared decision making as "care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."[9]

Decision Frames

The way information is presented by the physician can have a significant impact on the decisions patients and their surrogates make. This phenomenon of "decision frame" was described by Tversky and Kahneman in 1981 in their landmark publication on the psychology of choice. People often demonstrate preference reversal, depending on how the physician frames the information. When choices are presented in terms of gains, people are risk averse and when choices are presented in terms of losses, people are risk seeking.[10,11]

A 2013 Barnato study demonstrated this effect with a randomized simulation experiment exploring the effects of surrogate emotional state and physician communication strategies on surrogate code status decisions. One of the only factors that had an effect on the cardiopulmonary resuscitation choice was how the physician framed