

Treating Cancer Patients who Are Near the End of Life in the Emergency Department

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KEYWORDS

- End of life • Cancer • Palliative care • POLST
- DNR • Decision-making capacity

Lydia is a 42-year-old woman with a diagnosis of metastatic leiomyosarcoma who comes to the emergency department with 1 week of increased fatigue. This fatigue is now so pronounced that she states, "I can no longer take care of myself." She is currently receiving palliative chemotherapy. Her hematocrit on presentation is 18. She is markedly pale, thin, tachypneic, and short of breath with any movement. She has a POLST form and does not wish to have resuscitation attempted, but she does want other limited interventions. How should the emergency care team proceed?

Patients with cancer seek care in the emergency department (ED) every day with a variety of symptoms and clinical presentations. These range from life-threatening events, such as impending respiratory failure, to fever, falls, medication side effects, or the always troublesome constipation.

Although cancer deaths, in general, have declined over the past years, ED visits for cancer-related emergencies are increasing. The 2005 National Hospital Ambulatory Medical Care Survey noted a decrease in cancer diagnoses from 0.8% in 1995 to 0.5% in 2005 but a 20% increase in ED visits.¹ The aging of America may be one of the reasons for the increase in both overall ED visits and visits related to cancer. The visit rates for patients aged 50 to 64 years increased 13%, and those aged 65 to 74 years increased by 11%. The Centers for Disease Control and Prevention estimates that by 2030 the number of Americans aged 65 years and older will more than double and represent 20% of the population!² Daniel Murphy in "The Tsunami: Neither Hasten nor Postpone Death"³ equates this increase in the baby boomer population as an incoming tsunami for the ED. This tsunami is set to overtake us with a tidal

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wave of patients, many of whom will have subspecialists involved with their care but no single individual practitioner responsible or knowledgeable about the entire person who can help in making decisions about end-of-life care. Patients with cancer, too, may arrive in the ED without a primary care provider who has been actively involved in their end-of-life planning. Unfortunately, at times, the goals of care will have to be determined at the time of the ED visit.

Efforts are underway to improve the care of patients near the end of life and honor their wishes in the emergency setting. In this article, we discuss some of the end-of-life issues related to patients with cancer coming to the ED, including those of legal documents, transmission of patient wishes, limiting factors in implementing those wishes, and the new horizon of palliative care in the ED.

THE NEED FOR IMPROVED END-OF-LIFE CARE PLANNING

In 1995, the results of the study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT) trial were published. This observational study followed by a controlled clinical trial was designed to improve end-of-life decision making and reduce the frequency of a prolonged process of dying.⁴ It documented many shortcomings of end-of-life care. Although patients were seriously ill and their dying proved to be predictable, frequently discussions and decisions about do-not-resuscitate (DNR) status were not written until the last 2 days of life. In the controlled trial, an intervention was performed in which physicians were provided with reliable prognostic information as well as a nurse who initiated contact with the family, arranged meetings, provided forms so that the patient and family could participate in collaborative end-of-life decision making with the physician. The intent of the intervention was to initiate DNR discussions earlier, reduce pain and discomfort, as well as assist with resource use. This study revealed that despite the time of intensive intervention, there was no statistical change in these parameters.

Since the SUPPORT trial was reported, there has been increased discussion about end-of-life issues, with notable attempts to intervene, which vary from state to state and community to community. Although this article focuses on patients with cancer, the issues are not specific to a particular comorbidity or diagnosis. In the ED, we can anticipate that terminally ill patients will suddenly present at an end-of-life decision moment without preplanning.

Many, but not all, patients with cancer are in the later decades of life. Hamel and colleagues⁵ reviewed previously published findings about how patients' age influenced their pattern of care. This study found that although older patients preferred less aggressive care than younger patients, many did want cardiopulmonary resuscitation (CPR). In contrast, their families and medical providers underestimated their desire for aggressive care. This was evidenced by lower hospital costs, decreased resource intensity, and higher rates of decisions to withhold life-sustaining treatments.⁵ This study raises many societal and ethical issues with regard to the treatment of elders. There is no evidence that this large difference in cost was based on informed decisions by elders to decline treatment. In this study, patients aged 80 years and older had no difference in survival from that of their younger counterparts and were more likely to have a stable view of their desire for aggressive treatment.

ETHICAL BASIS FOR END-OF-LIFE CARE

Modern medicine has endorsed the ethical principles of beneficence, non-maleficence, autonomy, and justice.⁶ In most cases, Lo states the provider should follow 2 fundamental ethical guidelines: respecting patient autonomy and acting in the

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