Emergency Medicine and Palliative Care

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KEYWORDS

• Emergency • Resuscitation • Hospice • Stabilization • Critical care

KEY POINTS

- The emergency department cares for patients during sentinel events in their care trajectory.
- Emergency clinicians should not delay hospice or palliative care referrals in patients for whom there can be a benefit.
- Palliative care consultation services can integrate with the emergency department in a collaborative manner to improve access to hospice and palliative care services.

INTRODUCTION: THE NATURE OF THE PROBLEM

The primary focus in emergency medicine (EM) is the identification and stabilization of acute conditions with an emphasis on rapidly intervening and initiating necessary procedures and treatments. However, the emergency department (ED) has evolved beyond this to serve as the gateway to the resources of the hospital in many situations and is the entrance point for patients who have presented to the hospital in distress. The ED is a critical place of care delivery for seriously ill patients and families in need of a response to physical, spiritual, and psychological distress. For some, unfortunately, it is the site of their death.

Despite the perceived need, the evidence is lacking regarding the prevalence of seriously ill patients in need of palliative care support in the emergency setting.[1] In Ontario, more than 81% of patients with cancer visited an ED in the last 6 months of life, with 34% of the visits in the last 2 weeks of life. In the last 2 weeks of life, 70% of the visits resulted in a hospital admission. The most common reason for visits include pain and symptom management as well as failure of caregivers to cope with distress at home.[2] Nearly 400,000 persons will die in a US ED.[3] Up to 25% of patient

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visits with advanced cancer may have been avoidable.[4] Palliative care approaches and interventions in the ED may present an opportunity to initiate optimal physical, spiritual, and psychological support. Consistently, studies that assess the palliative care needs in cancer and noncancer populations show that patients and families can benefit from physical, spiritual, psychological, and social support during the emergency crisis.

The ED often serves as a key branch point from which health care plans are determined. Patients present to the ED when they have acute distressing symptoms, such as pain or dyspnea, that their care support system cannot meet; when they do not know how to access the health care system; when they lack access to primary care or have been lost to follow-up; when they require diagnostic interventions like advanced imaging; or when they require acute interventions, such as intravenous fluids or medications. Despite optimal palliative care, patients will present to the ED when their distressing condition cannot be managed. The ED stop on patients' health care journey makes the ED an area ripe with opportunity for initiation of palliative care and continued linkage to support when patients are receiving comprehensive palliative care services.[5] Seventy-seven percent of patients who visited the ED during the last month of life were hospitalized, and 68% ultimately died in the acute care setting, demonstrating an opportunity to identify and redirect these patients to a setting that may be more in alignment with their goals.[6]

Despite this opportunity, historically, palliative care with its emphasis on multiple domains of comfort (physical, emotional, spiritual, and social) has been considered by some as incongruous with the culture of EM.

Included in these distressed patients are people with life-limiting diseases, such as terminal cancer, severe congestive heart failure, dementia, or renal failure, who are presenting to the ED with the goal of symptom management. A disconnect between the patients' goals and the provider's goals may then exist when the ED provider is working on stabilization, evaluation, and intervention of an acute event while the patients' goal is one of palliation of their distressing condition. Recognition of this possible disconnect is the first step necessary to take advantage of this checkpoint on a patient's journey with the health care system.[7–9]

The importance of palliative care in EM has been demonstrated when the American College of Emergency Physicians (ACEP) participated in the American Board of Internal Medicine's Choosing Wisely campaign in 2012. ACEP chose a palliative medicine domain for emergency providers to implement.

Don't delay engaging available palliative and hospice care services in the ED for patients likely to benefit. Palliative care is medical care that provides comfort and relief of symptoms for patients who have chronic and/or incurable diseases. Hospice care is palliative care for those patients in the final few months of life. Emergency physicians should engage patients who present to the ED with chronic or terminal illnesses, and their families, in conversations about palliative care and hospice services. Early referral from the ED to hospice and palliative care services can benefit select patients resulting in both improved quality and quantity of life.[10]

THERAPEUTIC OPTIONS

Determining the prevalence of palliative care needs in the ED is largely unknown.[1] However, general guidelines regarding patients that might benefit from both primary and/or subspecialty palliative care interventions in the ED have been identified (**Table 1**). Primary palliative care skills critical to the practice of the ED have also been identified (**Box 1**). Rapid assessments of the clinical scenario with key elements