Chapter 4
End of Life Care in the Emergency Department

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Key Points
- End of life (EoL) care is aimed at patients with chronic or terminal illnesses and can be initiated in the emergency department.
- Religious and cultural beliefs often influence the type of EoL care the patient wishes for.
- Communicating bad news is a useful skill for all physicians and should be done with empathy.

Introduction

Emergency department visits are increasing each year, and studies have shown that 51 % of patients aged 65 years or older visited the emergency department in the last month of life and about 75 % in the last 6 months of their life [1]. This study also showed that 77 % of 51 % of patients were admitted to the hospital and 68 % of those admitted died there. In many of these cases, patients would actually prefer to die at home with their family around them [2].

Emergency medicine physicians have a unique opportunity to discuss end of life (EoL) care and help the patient understand their illness and articulate their needs, thus setting the path for the high-quality care that they deserve. The emergency physician can refer patients to palliative care or hospice directly, and this has shown to reduce ED visits and hospital admissions and also improved patient satisfaction [3, 4].

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Definition

End of life (EoL) care aims to relieve suffering and provides appropriate medical, physical, psychological, legal and cultural/spiritual help to patients with terminal illnesses and enables them to live their final days with dignity. Emphasis is placed on patient autonomy and shared decision-making.

EoL involves a multidisciplinary team approach, consisting of doctors, nurses, palliative or hospice team, pharmacist, nutritionist, social worker, home health nurse, spiritual counsellor and the family.

Consider the Following During EoL Conversations

- Initiate discussion by assessing patient's understanding of the disease.
- Discuss the disease course, treatment options and prognosis.
- How effective is the current treatment and does it meet the patient's expectation?
- Check who is coordinating their medical care and refer them to palliative care or hospice care as needed.
- Discuss patient's wishes regarding resuscitation measures (chest compression, intubation, medications to prolong life and defibrillation) and about withdrawing care.
- Ask about advance directives, living will and a surrogate medical decision maker.
- Do involve family and spiritual advisor/priest in discussions.

Levels of Care (Fig. 4.1)

In some countries, there are set pathways and models in place for EoL care, while in others EoL care is still an emerging specialty with limited resources. In countries with limited resources, the family physician often provides pain control, the home health nurse provides help to families and their temple priest provides the spiritual support.

In Eastern countries, the patient's family plays a vital role in the EoL decision-making and the patient is not the primary decision maker. This often determines or changes the level of care that the patient needs. Often, hospice care and palliative care are used synonymously and are not based on life expectancy.

Palliative Care

- Palliative care improves the quality of life for patients with chronic debilitating or terminal illness and for their families.

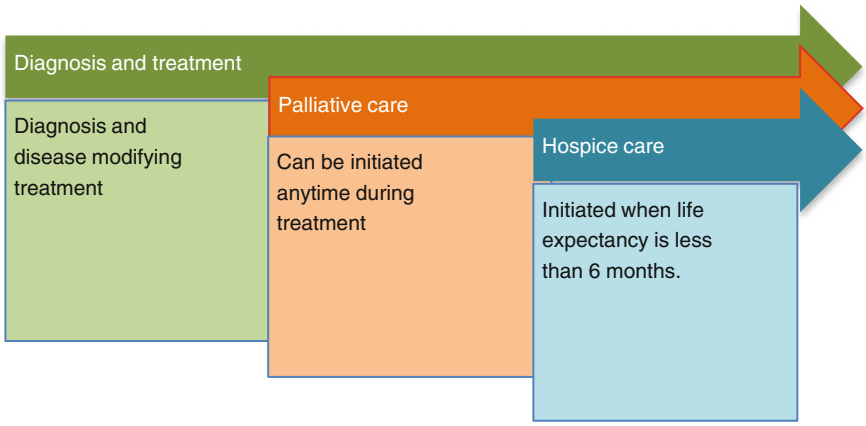

Fig. 4.1 EoL: levels of care

- A patient can be referred for palliative care at any stage of the illness regardless of their age and the outcome of their illness.
- Patients that may benefit are those with chronic CHF, severe COPD, HIV/AIDS, end-stage renal disease (ESRD), end-stage liver disease (ESLD), Alzheimer's, Parkinson's, strokes, advanced cancer, etc.
- They coordinate care between the various specialties involved and are a point of contact for the families.
- They provide pain relief, medical decision-making, home care, childcare, physical and occupational therapies and also help with transport to and from clinic appointments.

Hospice Care

- The hospice team provides comprehensive care to terminally ill patients whose expected life expectancy is less than 6 months.
- This can be provided either at the hospital, nursing home, hospice centres or even in the patient's home.
- They help with:
  - Symptom control and pain management
  - Providing medical equipment like home ventilator, oxygen, wheelchair, etc.
  - Performing required procedures like paracentesis, thoracentesis and dialysis
  - Counselling and psychological support
  - Legal EoL planning – advanced directives or living will
  - Any ancillary help that family members require – like childcare, respite care and even transport to and from appointments
  - Funeral arrangements and bereavement support

Common Symptoms and Their Management

Pain

- This is the most frequent presenting symptom to the ED.
- Treatments include NSAIDs, muscle relaxers, opioids, bisphosphonate (bone pain), steroids and regional blocks.

Respiratory System

- Dyspnoea is secondary to increased secretions, recurrent pleural effusion, cancer spread and spontaneous pneumothorax.
- Mainstay of treatment is to treat the underlying cause.
- Control secretions with glycopyrrolate or a scopolamine patch.
- Adjuvant treatments include home oxygen, non-invasive ventilation, home ventilators and opioids.

Gastrointestinal System

- Nausea and vomiting are usually treated with ondansetron (5-HT3 blockers).
- With loss of appetite or inability to swallow, treat with parenteral nutrition, PEG-tube placement, intravenous fluids or protein shakes.
- Constipation commonly causes abdominal pain and is due to medications and dehydration. Correct underlying cause and treat with either stool softeners, laxatives, polyethylene glycol or osmotic agents.

Renal and Genitourinary System

- Symptoms include bladder/bowel incontinence and urinary retention. Treatment options include diapers, intermittent or long-term bladder catheterisation.
- Some patients may require dialysis.

Central and Peripheral Nervous Systems

- Involve neurosurgery and neurology teams early in the treatment.
- Increased intracranial pressure and cerebral oedema – consider corticosteroids.
- Neuropathy and paraesthesias – tricyclic antidepressants and gabapentin.

- Paraneoplastic syndromes – treatments includes steroids, high-dose intravenous immunoglobulin, irradiation or plasmapheresis.

General

- Infections – treat with antibiotics.
- Anaemia and blood loss require blood transfusions.
- Anxiety – treat with anxiolytics and psychotherapy.

Opioids

Pain and dyspnoea frequently bring patients to the hospital. Opioids are used to treat these symptoms and also for comfort care closer to the end of life. In low- to moderate-income countries, there are regulatory barriers that limit narcotics prescriptions, and this interferes with appropriate patient care [5].

- Opioids act on μ-receptors in the brain and inhibit the respiratory drive by decreasing responsiveness to hypoxia and hypercapnoea. This along with its anxiolytic properties decreases dyspnoea. Nebulised opioids can also be used with similar benefits [6–9].
- In the community setting, a low-dose, sustained release morphine can be used safely. Start at a lower dose and titrate up until the patient's symptoms are controlled, especially in opiate naïve patients.
- When prescribing opioids, take into consideration the patient's age, prior opioid use and other coexisting illnesses (renal, hepatic, cardiac or pulmonary) and modify dose as needed.
- Calculate the total oral opioid dose requirement by calculating the total intravenous opioid used in the last 24 h and converting that to an equivalent total daily dose for the desired oral opiate. Then divide that number by the number of doses/day. Morphine equivalents are given in Table 4.1.
- For example, if the total dose of IV morphine used in 24 h is 30 mg, then an equivalent oral morphine dose for 24 h is 90 mg. So the patient may be prescribed 30 mg of oral morphine three times/day.

Social, Psychological and Cultural Needs of the Patient

- Many patients experience anxiety, depression, anger and sense of hopelessness as they approach the end of their illness. Recognise these symptoms and involve the psychiatrists, psychologists and social workers in the patient's care.
- Patients have not usually made plans for when they die; they will need guidance with regard to their finances, funeral arrangements, writing their wills and appointing a medical surrogate decision maker.
- Be empathetic and respectful of the patient's cultural and religious beliefs.

Table 4.1 Opiate equivalent doses

Opioid agonist	IV/IM/SQ dose	Equivalent oral dose	Frequency
Morphine	10 mg	30 mg	Q4 h
Hydromorphone	1.5 mg	7.5 mg	Q3–4 h
Oxymorphone	1 mg	10 mg	Q3–6 h
Oxycodone	N/a	15–20 mg	Q4–5 h
Hydrocodone	N/a	30 mg	Q4 h
Codeine	100–120 mg	180–200 mg	Q4 h
Fentanyl	100 mcg (0.1 mg)		Q2 h
Methadone	5 mg	10 mg	Q6–8 h
Meperidine	75 mg	300 mg	Q4 h
Buprenorphine	0.3 mg slow iv	N/a	Q6 h

- Encourage patients to talk openly about their wishes with their family and spiritual advisor.
- Be cognisant of some of the following cultural practices:
  - Mentioning death is taboo, as it brings bad luck and hastens death.
  - Patients are often not informed of their diagnosis in case the patient becomes depressed and gives up hope.
  - Asking for pain medicines is considered a sign of weakness.
  - Physicians are held in high regard and patients believe that asking questions about their care is disrespectful.
  - Families often make EoL decisions on the patient's behalf.
  - Some believe that it is the will of God and may decline medical care in favour of faith healing.
  - Jehovah's witnesses will refuse blood transfusions.

Legal and Ethical Details

Emergency medicine physicians skilfully manage the critically ill patients and yet find asking patients about their resuscitation wishes challenging. This discussion becomes easier if there are legal documents stating the patient's EoL wishes.

Advance Directives (Fig. 4.2)

- This states the patient's EoL wishes that are to be followed in the event that the patient loses his or her decision-making capacity. The advance directive can be made at any point in the patient's life and includes a living will, name of the patient's medical power of attorney and do not resuscitate (DNR) wishes.

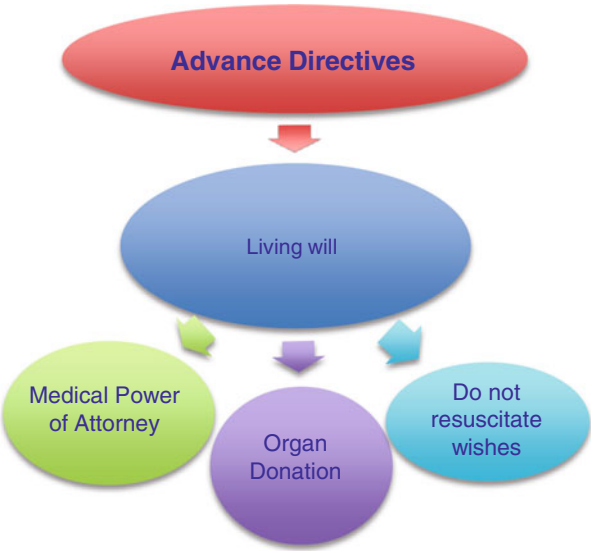

Fig. 4.2 Advance directives

Living Will

- The living will addresses the medical treatment the patient would like to receive as part of their EoL care. This also addresses life-sustaining treatment vs. withdrawing care and organ donation. The medical power of attorney or the court of law executes this living will when the patient is critically ill.

Medical Power of Attorney (MPA)

- The patient can elect a person, either temporarily or permanently, as their 'medical surrogate' or 'health-care agent' to make decisions on his/her behalf when he/she is too ill to communicate their wishes. The physician should deem a patient incapable to make his/her own medical decisions for this document to go into effect. The MPA can also make decisions regarding life-sustaining or withdrawing treatments.

Organ Donation

With each passing year, there is a widening gap between the number of patients on the transplant list and the number of organs being donated. In recent years, the emergency department has been under focus to identify potential organ donors.

Studies have shown an increase in the number of organ donors when patients are referred from the ED, as compared to when they are referred from the ICU – 19.3 % vs. 5.2 % [10].

- Ethically, the emergency medicine physician, who is treating the patient, should not discuss organ donation with the family.
- Once a potential donor is identified, the physician should call the organ donation team, and only that team should speak to the family or the patient's medical surrogate decision makers. This applies to all patients treated in the ED, be it trauma patients, out of hospital cardiac arrests, terminally ill or children alike [11–13].

Communicating Bad News

Communicating bad news is a daily occurrence in the emergency department. How the physician communicates bad news plays a critical role in how the patient perceives the physician and the care they are receiving. There are several effective protocols available for breaking bad news like the SPIKES [14, 15] and the GRIEV_ING [16] protocols. Below is a simple PIEE protocol (Fig. 4.3).

Preparation

- Switch off all pagers and cell phones.
- Take a nurse and the spiritual counsellor with you for the interview.
- Invite the patient, their significant other and family to quiet interview room.
- Have a phone available for them to use in the room.

Interview

- Sit down, make good eye contact, introduce yourself, state your role and also introduce everyone else with you in the room.
- Enquire if they would like anyone else to be present during the discussion and offer to call them.
- Determine how much the patient understands about their condition.
- Explain the condition, treatment options and prognosis.
- Assess how much the patient understood of what was discussed.
- Give enough time for the patient to ask questions.
- Be empathetic and avoid using medical jargon during the discussion.

Fig. 4.3 Communicating bad news – PIEE

EoL Care

- Ask if they would like to pursue the treatment or focus on symptoms control.
- Discuss cultural and religious beliefs.
- Give them information about advance directives and living will.
- Give patient time to come to their decision.
- Tell them that they are allowed to change their mind at any point.

Exit

- Check first if patient has any further questions.
- Confirm and summarise the agreed treatment plan.
- Provide your name and contact details and state that you are available for any further questions.

Barriers to End of Life Care in the ED

- Time constraints in the ED
- Physician and nurse perception of palliative care [17]
- Unaware of the availability of EoL care and how to access it
- Not informing patient of the disease progression and outcome
- Talking to the family instead of the patient
- Difference between patient's and family's wishes
- Not treating pain or undertreating pain
- Financial barriers
- Religious and cultural barriers
- Lack of availability of legal documents that support the patient's wishes

Conclusions

Emergency physicians frequently treat critically ill patients. It is important that they help their patients make a shared decision with regard to how they would like to be managed in their final days. The subject of dying is a very sensitive issue and many people avoid discussing it. It is necessary for the physicians to start these conversions and provide treatment options without using medical jargon. As religious and cultural views often dictate how the patient perceives end of life care and death, the emergency medicine physician must remain empathetic and respectful to these views. There is a need to educate physicians and public health policymakers to make EoL care a public health concern. As emergency medicine physicians, we can make a difference in improving EoL care.

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