The Integration of Palliative Care into the Emergency Department

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SUMMARY

Palliative care (PC) is a new and developing area. It aims to provide the best possible quality of life for patients with life-limiting diseases. It does not primarily include life-extending therapies, but rather tries to help patients spend the rest of their lives in the best way. PC patients often are admitted to emergency departments during the course of a disease. The approach and management of PC include differences with emergency medicine. Thus, there are some problems while providing PC in the ED. With this article, the definition, main features, benefits, and problems of providing PC are presented, with the primary aim of emphasizing the importance of PC integration into the ED.

Key words: Emergency department; integration; palliative care; training.

Introduction

Palliative care (PC) is basically the complete active care of patients who have life-limiting diseases.[1] It aims to provide relief from distressing symptoms and to achieve the best possible quality of life. It was defined by World Health Organization in 2006 as "(PC is) an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.[2]"

Historically, PC was developed for terminal stage cancer patients. The spectrum of diseases has widened, and it now includes cardiac, respiratory, metabolic, renal, and neurological (i.e. dementia) diseases.[3–5]

Main Features of PC

There are some main features of PC. First, it has a patient-centered culture.[6] This means that every patient is unique and, additionally, every situation about the patient is unique as well. The most important thing is to assess the whole patient and to include the patient and family while making decisions. It is designed to meet all the physical, psychological, spiritual, and social needs of the patient. PC has a multidisciplinary, collaborative, and team-based approach.[7,8] It is important to have good communication skills that include breaking bad news.[9] The aim of PC is not limited to the end of the disease, but rather it aims to support the patient in the early stages of the life-limiting disease. It begins in early stages of the disease but it doesn't end with death; it includes supporting families in bereavement.

Misconceptions about PC

There are some misconceptions about PC. First, it is not same as end-of-life care, although end-of-life care is a part of PC.[3,10] PC focuses on providing the best possible quality of life in patient's remaining time. It does not aim to prolong the life span. However, PC does not mean that the patient has to give up curative treatments such as chemotherapy

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and their access to intensive care units or hospital beds. Recently, early identification of patients has gained importance. Thus, patients can be considered as a PC patient while curative treatment continues.[4,9]

The Providers of PC

As PC is not an approach that one health care provider can ensure, it cannot be supplied by only one health care institution. To apply PC with its full meaning requires all the structures of the health care system of a country. All providers of PC should be determined, and the communication between providers should be maintained. There may be variations according to health care system of a country. They can be PC units, PC home care teams, and/or PC consultants in hospitals, hospices, primary health care providers, and emergency departments (ED).[7] Emergency physicians should know these providers of PC, especially to refer these patients from ED.

Hospice is planned for patients who can no longer be helped by curative treatment and are expected to live about 6 months or less, if the illness runs its usual course.[11] Hospice aims to celebrate, enable, and facilitate life and living by trained professional teams. It is designed to meet all physical, physiological, social, and spiritual needs.[12,13] Death is a part of life and is acceptable in the hospice approach.[14] The words of Cicely Saunders, who is the founder of the modern hospice movement, may explain the aims of hospice clearly: "You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die." [15]

Referring the patients to hospice care is important decision in ED. Four steps were suggested as assessing hospice benefits eligibility, discussing hospice as a disposition plan with the patient's physician, assessing whether the patient's goals are consistent with hospice care, and introducing hospice to the patient and family surrogates.[16]

PC in the ED

It is known that patients who need PC often visit EDs whether or not there are PC units, home care services and hospices, and ED visits will never lose importance due to the aging population and the increase in advanced diseases . It is obvious that adults with chronic illnesses often visit an ED several times in their last year of life. Unfortunately, high rates of ED visits in the last weeks of life are accepted indicators of poor-quality end-of-life care.[17]

In a study which was called 'the health and retirement study', number of emergency admissions were evaluated according to age variable in the last months of life for fourteen years. It was found that 75% of patients older than age 65 years visited an ED in the last six months of life, and 51% of patients visited an ED in the last month of life. They also found that repeated visits were common in these patients.[18]

McNamara et al. evaluated ED admissions in the 90 days before death. They reported that 65.8% of patients with malignancies were admitted to ED in the last year of life, and 47% of patients in the 90 days before death visited ED many times.[17] In a study, patients with advanced malignancy were evaluated according to ED admissions, and it was reported that 26% of patients with advanced malignancy were admitted to ED more than five times in a two-year period.[19]

There can be a lot of reasons for admission to ED. First, PC patients may have serious and variety of symptoms in a disease trajectory. Pain is the most common problem. In addition to pain, dyspnea, nausea, vomiting, nutritional deficiencies, fatigue, bleeding problems, and anemia may occur.[20–23] Moreover, acute function loss, acute anxiety, epileptic seizures, and delirium were reported symptoms of PC patients.[24] Shin et al. reported that pain, fatigue, nausea, and insomnia were the most common symptoms when referring acute PC patients from ED.[21] Also, they suggested that the patients who were referred from ED had more severe symptoms than other PC patients. In a study by Ahn et al., the reasons for ED admission for cancer patients were divided into four groups: disease progression (55.5%), infection (22.8%), treatment-related complications (14.7%), and non-cancer related problems (7%).[25]

The ED may be an option for PC patients for hydration or intravenous medication, as well as a quick reach for acute imaging. The symptoms that the patient suffers are often bothersome and distressing, and it may cause anxiety in patients and families. It is known that psychological distress includes symptoms such as depression and anxiety. It was suggested that the prevalence of psychological distress in cancer survivors ranged from 0% to 44%.[26]

It was found that many patients with advanced malignancy needed only simple procedures such as hydration, bladder catheterization, and oxygen therapy in ED in a study by Hjermstad et al.[27] They found the most common reasons for ED admissions were gastrointestinal problems (nausea, vomiting, diarrhea, etc.), lung problems (dyspnea, pleural effusion, pneumonia, etc.) and pain. It was suggested that somatic indications such as reduced performance status, frailty, loneliness, and psychological distress might be a reason for admissions to ED. Additionally, family distress and feeling safer in the hospital than at home were indicated as the causes of ED admission.[27] Next to those, the most common reason was the availability of EDs 24 hours a day and 7 days a week. The patients have access to physicians for all their needs.

EDs will always be essential for PC patients with or without

PC units, hospices, and PC consultants. The first important point for providing best care is to be aware of PC in ED. PC patients are on a long and distressed road. They are more vulnerable than other patients. Hence, symptom-oriented assessments cannot be enough for them.

Problems

There are some problems while providing PC in ED. Several studies from different countries report similar problems about these difficulties. According to a study by Grudzen et al., the limited knowledge and understanding about the main role of ED physicians in providing PC, problems in decision-making, a more defensive approach, and logistical challenges of ED were reported as difficulties while providing PC to patients in terms of the perspectives of ED physicians.[28] The thoughts of Australian ED clinicians were evaluated concerning problems while providing PC in ED. The free text responses were commented along three main headings The first one was about differences in expectations, and the most common response was 'family or patient do not understand or agree with prognosis'; the second was about challenges for staff, and the most common response was 'not enough experience to avoid the default treatment pathway'; and the last was about the challenges related to systemic issues, and the most common problem was 'limited information was available about the patients'.[29] Additionally, the barriers on PC initiation in ED were defined as communication problems, ethical and legal issues, aggressive symptom management, and lack of clear guidelines.[28]

Logistical Problems

The logistical problems of ED were reported by Bradley et al. and included lack of time and space; overcrowding and workload; alarms, buzzers, and the yelling of agitated patients; and poorly designed departments.[30] It was shown in the literature that patients spent considerable time in ED before being transferred to an inpatient unit or a PC bed, services that may not be immediately available.[5,29] Time itself can be a problem for providing PC in ED.

ED visits can distress and exhaust vulnerable patients at the end of life and their families, while being clinically challenging and time consuming for staff.[29] A study by Lamba et al., which evaluated differences between ED-initiated, intensive care-initiated, and floor-initiated PC consults, found that emotional and bereavement support was more required and communication with family was one of the major needs in ED.[31] Logistical problems, such as interruption to work flow, unclear whether ED can support this type of care, lack of patient follow-up, and lack of trust due to the lack of a long-term relationship were presented according to responses of ED physicians in Stone et al.'s study.[32]

Cultural Problems

The main problem is differences between the cultures of two medical approaches. Emergency medicine aims to provide stabilization of acute medical urgencies as quickly as possible, whereas it is not necessary to draw immediate medical actions in PC[33] and it is less invasive in critical situations. Nauck et al. suggested that aggressive resuscitation might be inappropriate for every critical situation in ED, such as PC patients[20] because death is an expected outcome for most PC patients. The cultural problems suggested by Stone et al. were language barriers, differing religious and spiritual beliefs about illness, death, and dying, patient education, family needs at odds with patient needs, and patient informed decision-making.[32] Grudzen et al. claimed that it was not easy to match two different cultures and approaches between EM and PC. Thus, they suggested that PC consultation in ED might solve the problems while providing PC.[34] Inversely, it was reported that EM culture should change to patient-centered culture as in PC. However, it is obvious that patient goal-centered care matches the wishes of patients and families.[9]

Training Problems

Training about PC core competencies is very important. It is specified in the literature that there is a lack of training about PC in ED residency programs. In a survey study about PC in ED, most of the ED physicians (72%) stated only a working knowledge about PC, and they indicated a need for education about end-of-life communication and ethical issues particularly.[3] One hundred fifty-nine emergency residents from USA participated in the survey study by Meo et al., and it was reported that residents recognized the importance of PC competence. Most of the responders had indicated an interest in greater formal training in PC topics, and they reported a lack in their training program about PC.[33] Similarly, training problems such as PC being at odds with medical training and lack of communication skills training in EM were reported in a survey study that 42 emergency physicians participated in. It was indicated that residents were aware of the importance of PC, and they would like to have more training about PC skills.[35]

Benefits of PC Integration into the ED

The creation of a PC pathway in ED provides a better match for patient wishes with the care received, and it may provide an improvement in patient-centered care and a decrease in the intensity and invasiveness of care when appropriate. It was suggested that initiating PC in the ED had a unique opportunity to support PC interventions early in a patient's disease trajectory, promoting quality of life as well as reducing costs associated with treatments.[5] Similarly, Wang et al. sug-

gested that PC intervention in the ED provided numerous benefits in terms of timely provision of care, improved outcomes, direct referrals to hospice, reduced hospital length of stay (LOS), improved patient and family satisfaction, less utilization of intensive care, and cost savings.[36] The evaluation of emergency physicians' perspectives on PC through a survey study presented the benefits of PC to patient and family as better pain management, better quality of life, and the preparation of family for death, and the benefits to ED physicians were broadened perspective in training and increased job satisfaction.[32]

The health care system should aim to reduce unnecessary ED admissions for PC patients. Wang et al. revealed that health services utilization was an important measure of palliative care effectiveness. Easier access to medical doctors outside the hospital and better lines of cooperation between hospitals and the primary healthcare services might reduce the need for ED admissions.[36] Similarly, Seow et al. reported that patients who spent more time with home care teams had reduced ED admissions.[37] It was suggested that patients who wished to die at home and patients who had advance directives with DNR orders had reduced ED admissions.[38,39] It was suggested that special PC programs in health care systems can reduce the psychosocial stress in families as well as the number of emergency calls, and it was reported that these programs make PC patients more likely to die at home.[40]

Studies have suggested that palliative care might lead to cost savings through reduced use of avoidable health care services.[5,36] As an example, a hospital-based palliative care program helped reduce the utilization of intensive care, laboratory services, and pharmacy.[41] Devader et al. suggested that reducing the use of avoidable health care services, unnecessary tests and treatments, and decreasing LOS provides cost savings.[11] Patients with in-home palliative care were found to be less likely to visit emergency departments (EDs) or to be admitted to hospitals, and more likely to die at home, than those with usual care.[42,43]

There are some studies that indicate the benefits of PC initiation in the literature. It has been found that early initiation of PC consultation in the ED was associated with a significantly shorter LOS for patients admitted to the hospital, and they indicated that the patient- and family-centered benefits of PC were complemented by reduced inpatient utilization.[5] Kandarian et al. suggested that early PC consultation in the ED impacted quality of life, health care utilization and survival, but not whether this was due to the supportive care aspect of PC teams alone.[8]

Identification of PC Patients in the ED

Early identification of PC patients is very important in ED. In the literature, there are some criteria in terms of defining PC patients on ED admission. The primary and secondary cri-

Table 1. The identification of PC patients

Primary criteria	Secondary criteria
Global indicators that represent the minimum that hospitals should use to screen patients at risk for unmet palliative needs	Specific indicators of a high likelihood of unmet palliative care needs
The "surprise question": Would you be surprised if the patient died within 12 months?	Admission from long-term care facility
Frequent admissions (e.g., more than one admission for same condition within several months)	Elderly patient, cognitively impaired, with acute hip fracture
Admission prompted by difficult-to-control (moderate-severe) physical or psychological symptoms	Metastatic or locally advanced incurable cancer
Complex care requirements (e.g., functional dependency; complex home support for ventilator/feedings)	Chronic home oxygen use
Decline in function, feeding intolerance, or failure to thrive	Out-of-hospital cardiac arrest
	Current or past hospice program enrollee
	Limited social support (e.g., family stress, chronic mental illness)
	No history of completing an advance care planning discussion/document

teria that were suggested by Lamba et al. are presented in Table 1.[44]

A basic model was suggested for identification of PC patients in ED. First, the patient should have a serious and life-threatening disease and additionally should have one or more of the following criteria: ED physician would not be surprised if the patient died in the next 12 months, or if a pediatric patient, will not survive to adulthood; more than one ED visit or hospital admission for the same condition within several months; ED visit prompted by difficult-to-control physical or psychological symptoms, decline in function, feeding intolerance, unintentional weight loss or caregiver distress; and lastly, complex long-term care needs requiring more support.[45]

PC integration models in the ED

The integration of PC into ED is a new area of expertise. Thus, the ways of integration are not completely identified. In a study by Lamba et al., four clinical integrations are suggested. The first is a traditional consultation model.[44] When a PC patient comes to ED, the emergency physician calls a PM expert consultant in hospital. The second is called basic integration. The ED and PC work together on some goals/objectives. The third, which is called advanced integration, requires that ED and PM work together on processes and protocols but ED locates in the forefront. The applicability of these models may be limited due to the availability of PM expert consultants in hospitals. In Turkey, PC is not a specialty and only a few physicians are interested in PC. The final model is an ED-focused advanced integration program. It needs a dual EM-palliative care board-certified physician. PC is a subspecialty of ED since 2008 in the USA, but in many countries including Turkey, PC is not a subspecialty, so the feasibility of this model is not possible for every country.[46]

The study by Wu et al. that evaluated the effects of PC integration may be an example for the third explained model. The benefits of this model were presented as decreased LOS, greater patient satisfaction, reduced costs, and less invasiveness.[5]

Some basic integration steps when getting started are presented by IPAL-EM. According to one, four steps are suggested. The first step is to convene an interdisciplinary workgroup to plan and lead the effort; the second step is to assess the needs and resources for improving PC in the ED; the third one is to develop an action plan to map out work responsibilities and a time line; and last step is to engage the entire ED team to create a supportive culture for palliative care improvement.[47] Additionally, a list that briefly includes what could be done in a week for initiation of PC into ED is reported. It includes identify your ED "champions," review the existing literature, identify local hospice and palliative care resources, and develop a plan to complete a needs assessment.[48]

In a study by Rosenberg, an integration model that is called 'LSMA (Life Sustaining Management and Alternatives)' is presented.[4] It is an emergency-based PC program that includes a core team of one ED physician and one nurse coordinator for the initial consult. Nutritionists, chaplains, psychologists, social workers, physical therapists, occupational therapists, and other disciplines as required to meet the needs of each patient and family are the other members of the team. They reported increased patient and family satisfaction, reduction of costs, decreased length of stay (LOS), and reduction of the intensity of care and resuscitation rates with the LSMA program.[4]

Every emergency department should find their own way on this issue. It should be organized according to the health care resources in the country, sources of hospitals with or without palliative consultants or units, and the circumstances of each individual ED. Thus, the methods might be different but the aim should be presenting high quality of care for PC patients.

The Management of PC Patients in the ED

The most important thing is to identify PC patients in ED and then to identify resources of possible health care facilities in terms of referral from ED. A PC team can be formed in ED that includes physicians and nurses.[49,50] It is not to be forgotten that to provide PC is only possible with a multi-disciplinary approach. This team can include social workers and chaplains in the hospital. If a team cannot beformed, the com-

Table 2. The first steps of assessment of PC patients in ED

A	Does the patient have any advance directives in place regarding life-sustaining measures? If so, what are they?
B	How can you make the patient feel better? This is the symptom-management phase of the acute resuscitation while the ED physician tries to ascertain what level of resuscitation he or she should perform.
C	Are there caregivers at the bedside or who can be reached by phone? If so, take their needs and desires into consideration.
D	Does the patient have decision-making capacity?

Table 3. The list of solution proposals for providing better PC in the ED

Proposed Solutions
Arrangements that include facilities to provide PC can be made in the existing health care system.
Training programs that include core competencies of PC can be added to ED residency programs.
Management guidelines that include PC emergencies can be prepared for ED staff.
Educational materials and courses from the ED perspective can be added ongoing medical education.
Arrangements intended to remove logistical barriers should be made in ED.
Special palliative care teams can be formed in the ED.
Arrangements that include providing legality of advance directives and DNR orders can be done in the existing health care system.

munication between ED physician and the rest of the team should be enabled. Also, the psychologist or psychiatrist can be ensured to contact or consult for PC patients and families. Devader et al. present the ABCD for rapid assessment of PC patients in ED.[11] It is shown in Table 2.

When a PC patient comes to ED, the question should be "what is the appropriate treatment for this patient in this particular situation?" It is not forgotten that every patient and every situation is unique, and rapid assessment and meeting the needs of patients should be done in the ED. After assessment and treatment, ED physician, patient, family, and the patient's primary physician should decide the best option among hospice, PC unit, hospital bed, or home care for the patient.

The Proposed SolutionsWhen it is considered globally, EM residency programs should be organized according to PC knowledge and skills, with or without the health care structure of PC. Emergency physicians should know core competencies concerning PC.[51] The core competencies are indicated in a study by Meo et al.[33] According to that study, they are: assessing illness trajectory, formulating prognosis, difficult communication with patients and families, pain and symptom management, withdrawing or withholding non-beneficial treatments, planning advanced care, PC systems referrals, and an understanding of ethical and legal issues. Additionally, Quest et al. added family presence during resuscitation, management of the imminently dying, spiritual/cultural competency, and management of the dying child to the core competencies.[14] These core competencies can be added to ED residency programs.

Additionally, some proposed solutions that are intended to solve the problems that occur while providing PC in ED are presented in Table 3.

Furthermore, the main point for initiating PC in the ED is suggested that clinical awareness, a multi-professional team approach, communication skills, ethics expertise, close contact with the patient and families, information and informed consent, and correct documentation can help manage crises in PC such that unforeseen and distressing acute emergencies should be rare.[24]

Finally, PC is a new and rapidly evolving area and is a good approach that every patient with life-limiting disease deserves. Although there are some developments in the existing health care system that are supported by Ministry of Health in Turkey, there is not enough clinical awareness and embodiment in EDs. It is known that there are not enough PC units, hospices, or consultants in hospitals in Turkey. As a result, there will be inadequacy while providing PC to its whole meaning. However, giving best care and meeting the needs of patients are the responsibility of emergency physicians. In the beginning, the deficiencies in the training aspects of PC may be remedied due to good management of PC patients. Next, changing the overall approach to PC patients may be chosen. An increase in patient-centered care and a decrease in invasive approaches may be tried for these patients by emergency physicians. Communication with the patient as well as families is more important. Thus, ED physicians can try to give more time to these patients. If EDs begin to solve their problems and create a system for providing PC in the course of time, Turkey can be a country that presents good PC to patients completely by opening new units and hospices.

Conflict of Interest

The authors declare that there is no potential conflicts of interest.

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