

When End-of-Life Care is the Emergency: A Case-based Portrayal of End-of-Life Care in the Emergency Department

Karen Jubanyik*

Department of Emergency Medicine, School of Medicine, Yale University, USA

When one thinks of the Emergency Department (ED), one usually thinks of teams of providers hustling to save lives. And while that is often what is done in the ED, sometimes the situation calls for a different approach. ED providers may provide a new set of objective eyes and ears for a chronically ill patient with or without a change in their condition or the team may be presented with a patient suffering an acute catastrophic condition for which curative therapy is not possible or indicated. This article will review the reasons why ED's are a necessary and important place for end-of-life (EOL) discussions and management and highlight real-life cases in which the ED team played an integral role in identifying appropriate patients for EOL care and providing these services.

Why End-of-Life Care in the ED?

The ED is a place of transition, crisis and opportunity. Though the ambience and pace of the ED can prove to be a challenging care environment in many ways, there are a number of situations in which the ED is a suitable place for identifying patients in need of end-of-life (EOL) care and providing that care and the ED staff need to be comfortable and skilled at identifying and managing these patients. Of the 2.5 million people who die each year in the US, about 10% or slightly more than 200,000 die in the ED, so the volume alone makes the ED a place of opportunity [1]. In addition, the ED is often the only medical care setting in a community that is open 365 days a year, 24 hours a day. And, ED's are open to everyone, regardless of prior establishment of care in the community or insurance status. And for patients who are already in a health care system, when these systems fail, or patients develop physically, emotionally or spiritually distressing symptoms at any time of day or night, the ED is available to assist the patient and family.

Even when access to care is not a barrier, there are times when the ED still proves to be the place for EOL goals of care to be established. The objectivity that a fresh set of eyes can provide may prove valuable in establishing goals of care as patients near EOL. Patient's long term health care providers tend to overestimate survival time and the closer a person is to the patient, and the sicker a patient becomes, the more inaccurate these estimates tend to be [2]. In addition, in a multi-center cancer hospital study, only 37% of patients with life-threatening cancer diagnoses with a life expectancy of less than 6 months reported having these discussions with a doctor [3]. And even when best practices are observed and these discussions are had with patients, there are situations when the patient's condition changes, and decisions made based on parameters that were true last month or last week no longer apply. Therefore, there are many occasions in which the ED care team is presented with opportunities to work with patients and families to establish or re-establish treatment goals and for the team to provide care that relieves pain and other symptoms of suffering at end of life.

The ED, fast-paced as it is, in some ways an ideal place for delivering EOL care. Most importantly, suffering at EOL is an emergency for the patient and/or family and the ED staff is equipped and trained to provide a range of services on an emergent basis, from rapid bedside testing to other laboratory and diagnostic imaging studies, to procedures and medication administration. Moreover, similar to palliative care teams, virtually all ED's already rely on an

interdisciplinary team-based approach to provide patient care, and this team, which typically includes nurses, technicians, social workers, care coordinators, chaplains, and pharmacists, is readily available in many ED's throughout the country. The ED is also the front door for most admissions in the vast majority of hospitals in the US and therefore patients who require or desire inpatient care can access these services through the ED.

Case 1 "The World Traveler"

Presentation

Mrs. S, a 70 y.o woman presents to the ED by ambulance, with 3-4 days of intractable abdominal pain and vomiting and reports turning yellow on the day of admission. She is noted to be awake and alert, but is hypotensive with a fever to 102.5, and is found to be in acute renal failure and in early septic shock. She speaks little English, but with the help of a phone-line translator, you learn that she has traveled from her homeland in the Middle East, in search of curative therapy for an advanced metastatic pancreatic cancer that had been diagnosed in her home country just 4 weeks earlier. She was told that there was no medical or surgical therapy available for her cancer and that her life expectancy was less than 3 months. She was given advice to get her affairs in order and to spend her remaining days with her family. Her two daughters, upon hearing this news, made travel arrangements for her to come to the US to see a cousin who works at the hospital in order to seek "better" medical care. They made no advance arrangements with any particular medical providers in the US, but reasoned that there would be better treatment available in the US. The daughters had young families and were not able to come to the US, so the patient traveled alone and was met at the airport by the relative whom she had never met. The EMR reveals that the patient has an Oncology clinic visit scheduled for the next week, but there are concerns entered by the scheduler about a lack of insurance. What can and should the ED providers do?

Case 1 outcome

Mrs. S. was clearly in dire straits and needed an interdisciplinary team of providers to address her many medical, social, emotional, and spiritual issues. In addition, cultural differences could present unpredictable challenges. She was awake and alert at the time of the ED visit, but given her tenuous medical condition, the ED physician realized that this could change abruptly, so an in-person medical translator, who turned out to be a local college student from the patient's home

*Corresponding author: Karen Jubanyik, Department of Emergency Medicine, School of Medicine, Yale University, USA, E-mail: karen.jubanyik@yale.edu

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city, was brought to the bedside. It was clear that the female translator established an immediate rapport with patient and the two shared more than a few laughs. The ED physician outlined the seriousness of the acute medical problems, in the context of a new, but rapidly progressive, incurable chronic medical condition and specifically said that it was unlikely that she would survive to return to her home country. The patient expressed that her goals were to see her two daughters again, and she would want a short-term trial of intubation, but that she would not want attempts to restart her heart if she died. The social worker was notified and with the help of the translator, the daughters were called and the patient, though getting weaker, even spoke to them. A Muslim chaplain was called in to see the patient. The patient was transferred to the ICU, and later that day, intubated for worsening sepsis, and died a week later with her daughters, the Muslim chaplain, and the translator at her bedside. Though it is hard to say that this was a “good” death, it was one in which the patient’s wishes were elicited by the ED physician within a narrow window of opportunity between the onset of serious disease and the loss of decision-making ability and a team of providers played important roles in honoring her wishes.

Case 2 “Shakespeare in the Emergency Department”

Presentation

Mr. Z. is a 93 y.o former high school English professor, with a history of atrial fibrillation, hypertension and high cholesterol presenting with diffuse abdominal pain worsening over 2-3 days. He has driven himself to the ED after spending the day at the local zoo; he is a board member there and many of his daily activities revolve around his volunteer work with this charity as well as several others. He has a primary care doctor who has taken care of him for the past 25 years. A widower for the past decade, he has a son and a daughter who both live on the west coast, 3000 miles away. Upon arrival, though awake and alert, it is clear that he is quite ill, as he is hypothermic, tachycardic in atrial fibrillation to the 130’s, with a blood pressure of 102/48, a respiratory rate of 26, and a room air saturation of 94%. His vital signs begin to improve with some oxygen via nasal cannula and aggressive fluid resuscitation. His abdominal exam is significant for diffuse tenderness. Labs reveal a WBC of 10.3, with 15% bands and a serum lactate of 14. An abdominal catastrophe is suspected and an abdominal X-ray shows pneumatosis intestinalis consistent with mesenteric ischemia. He returns from the radiology suite somewhat confused and a bit more hypoxic and now moaning in pain. Intravenous morphine is given which appears to improve his pain, but additionally depresses his mental status so that he is no longer conversant and Mr Z. now requires a 100% non-rebreather mask, which he keeps removing. A check of the EMR reveals that the advanced-directives section has never been completed by the primary care doctor and a call to this primary care doctor yields no additional helpful information as to the patient’s expressed EOL wishes.

Case 2 outcome

Mr. Z. has an acute life-threatening surgical condition that has rapidly progressed during his ED stay. Unfortunately, he is no longer capable of making his own EOL decisions and there is no information available to document any prior expressed wishes. It is unlikely that he would survive an emergent laparotomy at this point in his illness, but he is rapidly declining and decisions need to be made as to the aggressiveness of care. The choices seem to be dichotomous - either a “full court press” including intubation, pressors, and laparotomy or admit for comfort care. One would hope that a primary care physician who cared for this man for 25 years would have engaged in discussions about end of life care and documented these in the community-based EMR. Though this 93 y.o man had few serious medical problems, it

is predictable that his life expectancy was not terribly long and likely only a few years at most, merely based on his age, so it is curious that the primary doctor had not thought it important to address this issue, particularly in light of the fact that surrogate decision makers were not readily available. In this case, the ED physician made a phone call to the daughter and son on the west coast, and they fortuitously revealed that Mr. Z had turned down gallbladder surgery earlier that year. Apparently, while visiting those 8 months earlier, he had an attack of right-sided abdominal pain, went to a local ED and was diagnosed with gallstones. When presented with his options, he had been vocal and clear that he did not ever want any surgery as he felt that he had led a rich, full life and did not think that he would recover quickly from even minor elective surgery. The family was given the information that the patient would likely only survive hours and their only request is that he not be left alone during the dying process, as he had stayed by his wife’s side for days on end as she died at an inpatient hospice. The ED physician initiated aggressive comfort care measures, which included a continuous warming blanket, removal of all monitors, administration of PRN morphine and lorazepam, and substitution of nasal cannula oxygen for the poorly-tolerated non-rebreather oxygen mask. The care coordinator was called to investigate a possible transfer to an inpatient hospice facility, but since the death trajectory was thought to be only hours, the patient was not accepted. Because a transfer to an inpatient medical ward bed for comfort care would likely result in the patient being alone while dying, the ED team, including the social worker, chaplain, nurses, technicians, and physicians all agreed to take turns sitting at the patient’s bedside, reading Shakespeare (downloaded from the internet) to him. He died four hours later, with the ED chaplain at his side. This might not have been “the death” that the patient would have chosen for himself, but in the dying process, the wishes he had expressed to his family were honored by the ED staff working as a team.

Case 3 “A Cautionary Tale”

Presentation

Mrs. D. is an 88 y.o woman with mild anxiety since the death of her husband two years earlier, COPD and hypertension, as well as a remote history of breast cancer. She reports no recent changes in her medications. She lives alone, but has good social support from her daughter who is a registered nurse and lives nearby, checking in on her multiple times each day. On the day of presentation, the daughter had dropped off some groceries at 11 am and found that her mother is at baseline. She subsequently called her mother at 1 pm and found her to be slurring her speech, so the daughter called 911 to bring her mother in to the ED for an evaluation. Upon arrival to the ED, Mrs. D. is sleepy, but arousable to verbal stimuli. When awakened, she is oriented x 3, knows her primary doctor’s name and address and though she is slurring her words, she does not have any focal neurological deficits. When asked about advance directives, Mrs. D. and her daughter report that she has an advance-directive that will “allow natural death” (AND) and the EMR confirms that her primary physician has documented extensive conversations with the patient about her EOL goals of care, which was to die at home, without ACLS measures such as intubation and chest compressions. The daughter is not in total agreement about this decision, but comprehends that her mother has been failing to thrive particularly in the past few months, and understands that it is her mother’s decision to make. A medical workup, including CT scan of the head, urinalysis, chest X-ray and laboratory studies, all return normal. While in the ED, Mrs. D.’s condition worsens; she becomes more obtunded, hypotensive and hypoxic. An arterial blood gas additionally reveals moderately severe hypercarbic respiratory failure. A trial of bipap is initiated but poorly tolerated by the patient and

the daughter reluctantly agrees that even bipap would go against her mother's expressed wishes. In an effort to respect patient autonomy, Mrs. D. is booked for admission to the medical floor for comfort care, but the daughter remains upset by her mother's pre-expressed wishes to not receive aggressive care.

Case 3 outcome

The patient remains in the ED for several more hours, awaiting transfer to the medical floor. The daughter leaves the ER briefly to get her kids at school and soon after, calls the ED, frantic, because she says she has found an empty bottle of lorazepam in her mother's trash. The bottle, containing a 30-day supply of 1mg tablets, was dated 2 days earlier, and had apparently arrived by mail that morning. Because this was presumed to be a suicide attempt, the daughter instructs the new attending, who has just arrived, to override the AND/DNR/DNI order and the patient is intubated and transferred to the Medical Intensive Care Unit. Mrs. D. never regains her mental status, proves to be difficult to wean from the ventilator and develops multiple hospital-acquired infections while in the ICU over the next several weeks. Ultimately, when faced with the need to have a tracheostomy tube and percutaneous gastrostomy tube placed, the daughter requested that aggressive measures be withdrawn and the patient died in the ICU shortly after the endotracheal tube was removed.

Conclusion

The cases presented in this article highlight situations in which the ED and its staff can be places of opportunity to identify patients with EOL care needs and in some cases, to actually provide this care. However, as the third case illustrates, there are certainly limitations, cautions and concerns. The lack of longstanding relationships with patients can make it difficult to truly understand the particular disease trajectory in a specific patient. In addition, it is often difficult to

appreciate family dynamics in highly time-sensitive situations, and it may not be clear who the surrogate decision-makers are in the family and how their own limitations may play a role in their thought processes. The ED also can prove to be a difficult environment, due to the sheer volume of new patients appearing at unpredictable intervals, not to mention the overall lack of privacy for patients and families. Moreover, because identifying appropriate patients and providing EOL care can and should be time-consuming, the fact that the average ED physician is interrupted 9.7 times per hour, (compared to 3.9 times per hour for PCPs), represents another challenge [4]. And finally, though EOL care is ideally delivered by interdisciplinary teams, which typically already exist in ED's, it is critical to realize that integral components of this care may only be available in the ED during certain hours. But as long as significant numbers of primary care physicians and specialists avoid having EOL conversations with their patients, the ED will continue to serve as a safety net for patients with EOL needs when the other systems fail. Recognizing this safety net role that EM physicians play, and that EOL conversations and care are more often a process than an event, it is necessary for EM physicians and staff to educate them and gain experience on best practices in having EOL conversations and providing EOL care when appropriate.

References

1. Miniño AM (2013) Death in the United States, 2011. NCHS data brief, no 115. Hyattsville, MD: National Center for Health Statistics.
2. Christakis NA, Lamont EB (2000) Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study. *BMJ* 320: 469-472.
3. Wright AA, Zhang B, Ray A, Mack JW, Trice E, et al. (2008) Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA* 300: 1665-1673.
4. Chisholm CD, Dornfeld AM, Nelson DR, Cordell WH (2001) Work interrupted: a comparison of workplace interruptions in emergency departments and primary care offices. *Ann Emerg Med* 38: 146-151.