

ACUTE GERIATRICS

Approach to death in the older emergency department patient

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Do not seek death. Death will find you. But seek the road which makes death a fulfilment.

– Dag Hammarskjöld, former UN Secretary General

Introduction

A total of 70% of older patients present to ED at least once in the last 12 months of their life, with maximal attendance rates in their final weeks and days.¹ End-of-life planning and care are skills that ED physicians employ everyday; however, the quality of this care is highly variable.^{2,3} Furthermore, ED clinicians have been shown to find end-of-life communication and ethical issues around death and dying difficult, and most of us can readily describe our involvement in the distressing deaths of vulnerable older people.^{4,5} How can we improve our quality of end-of-life care?

Terminology used in this area varies between jurisdictions. Table 1 outlines the terms used in this article. We provide discussions about three scenarios relevant to the care of the elderly ED patient nearing his or her end of life, where:

- The dying trajectory has been recognised and planned for.

- The patient is nearing the end-of-life and planning for death needs to commence.
- The patient is imminently dying and urgent decisions must be made.

The dying patient with an advance care plan (ACP)

An 89-year-old woman has end-stage chronic obstructive pulmonary disease (COPD). She is dependent on home oxygen and is only able to walk a few steps at a time. She has been under the care of a community palliative care team for the past 6 weeks. Over the last 2 days, she has developed fever and a cough with purulent sputum. She is febrile, tachypnoeic and distressed.

Not infrequently, we see misunderstandings when a patient receiving palliative care, or with an ACP setting limits on care, attends ED.⁶ Palliative care and emergency care are not mutually exclusive.⁷ A presentation to the ED might be desirable, and not incongruent with end-of-life care, where improved symptom control or emergent investigations or procedures unable to be accessed in the community setting are required. Viewing any presentation to the ED by such patients as a failure is wrong.

Instead, we suggest interpreting emergency care through the prism of the relief of suffering, which delivers care consistent with the patient's and her family's preferences and aligns with the intent of palliation. Key to this is understanding the patient's goals of care, what matters most to them and what they wish to prioritise in their life. An honest discussion with this patient is paramount to ensure that a shared understanding is developed of the management options for her symptoms and her prognosis with each of these options. This discussion should highlight that managing her pulmonary sepsis with intravenous antibiotics might have two consequences – unnecessarily prolonging life in a dying patient and/or contributing to symptom relief.⁸

There is very limited evidence regarding anti-microbial therapy at the end of life.⁹ One prospective study in patients with advanced dementia and pneumonia showed greater comfort but shorter life for those who were not given antibiotics.¹⁰ Nonetheless, here, it is reasonable to offer a time-limited trial of antibiotics, as they might help relieve suffering, provided that the patient is also aware of the potential consequences of (possibly undesired) prolongation of life. Similar considerations would need to be given were the patient to lack decision-making capacity. Here, if the patient has a valid Advance Health Directive (AHD), the primary intent of the directive should guide care: does the patient wish to have no life-sustaining treatment or only no futile

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TABLE 1. Terminology

Term	Abbreviation	Definition
Advance Health Directive (also known as Advance Care Directive)	AHD	A document, covered by legislation, made by a person to direct their future healthcare. Only comes into effect when the person is no longer able to make decisions
Advance Care Plan	ACP	A written record of conversations between health professional/s and a person (or their designated health decision-maker) regarding their current and future preferences for healthcare
Palliative Care		Care to improve the quality of life by relief of suffering for patients and families facing life-threatening illness. It utilises symptom relief, spiritual and psychosocial support, from diagnosis through death and bereavement
End-of-Life Care	EoL Care	An umbrella term, meaning care that assists those with advanced, progressive, incurable illness to live as well as possible until they die

treatment where the treatment is more burdensome than the condition? In the absence of an AHD, discussion with an alternate decision-maker should elicit what the patient's wishes would likely be in this setting (as distinct from the wishes of the decision-maker), taking into consideration her quality of life, values and priorities.

Case reports exist of living wills misinterpreted as 'Do Not Resuscitate' orders, compromising patient care.¹¹ This has led some to argue that the failure to aggressively resuscitate dying patients is a patient safety hazard because of the inherent complexities of ACPs in the often chaotic ED.¹² It is important to be mindful of these remote hazards when using documented care plans to guide management. Future palliative care research is needed to explore the fidelity of ACP interpretation in real-world settings, measuring both patient/family benefit and potential unintended consequences.

Initiating planning in the patient approaching end-of-life

An 89-year-old woman has end-stage COPD. She is dependent on home oxygen and is only able to walk a few steps at a time. She has had four presentations to the ED, with subsequent admissions in the last year. Today, she has fallen and has multiple skin tears. She reports anorexia and weakness.

It remains common to encounter patients with metastatic neoplasia, advanced dementia or end-stage chronic disease in the ED who have never discussed their impending death with their primary healthcare provider, family or inpatient treating teams.

Despite decades of research on prognostication, the 'gold standard' question for initiating palliative care remains 'would I be surprised if this patient died in the next 12 months?'^{13,14} Many emergency physicians feel ill equipped to answer this question because of gaps in our training around common dying trajectories (Fig. 1) and our limited contact time with any one patient.¹⁵ However, we find that meeting the 'gold standard' can be aided by lists that reference the concept of 'futility'.¹⁶ There are a number of these, one example is represented in Table 2.^{17–20} Recent research has shown that the use of one such list is acceptable and reliable in the ED setting.²¹

Emergency physicians have a critical circuit breaker role in: (i) identifying patients who would benefit from formal advance care planning; and then (ii) raising the issue at the appropriate time in a non-threatening way.²² Beyond this, it is generally impossible to complete such complex planning in the ED setting. The three biggest hurdles to formalising the planning for a patient's death, in our experience, are a lack of clear referral pathways to clinicians

that will assist the patient with planning; resistance from organ-specific subspecialists that see this as an admission of 'failure', particularly for patients they have treated for a long period; and the patient's complex cultural issues that traverse religious, family, philosophical, competence and health literacy domains and make it all appear 'too hard'.^{23,24} ED staff cannot solve these issues alone, nor can we ethically ignore the problem we face all too often, of lack of planning contributing to a bad death. Accordingly, as part of the Choosing Wisely Australia campaign, the Australasian College for Emergency Medicine advocates that clinicians, patients and families should have a common understanding of the goals of care for patients approaching the end of life.²⁵

If planning death is worth doing, it is worth doing well, and this takes time. In the ED, we are frequently asked to expediently complete a 'Do Not Resuscitate' order for a sick, bewildered older person about to be whisked off to the ward. The focus on the mechanics of resuscitation does not constitute planning for death, and should be only one of many goals of care discussed as part of a comprehensive plan.

Urgent end-of-life decisions in the imminently dying

An 89-year-old woman is brought into your resuscitation bay by ambulance as an ATLS1, having been found

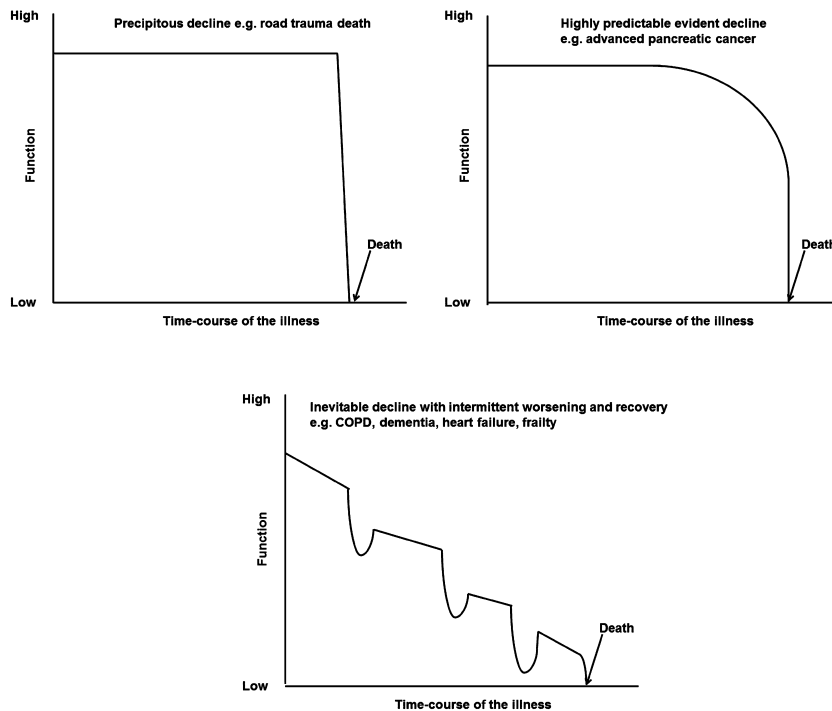


Figure 1. Dying trajectories (modified from Rogers and Lukin³⁰).

unconscious in her house by her neighbour who had not seen her for 48 h. Little is known of her medical or social history, except a statement from the neighbour sayings that 'she has been crook recently'. She is thin and cold, cyanosed, has a barely palpable femoral pulse and GCS 6.

Notwithstanding the views expressed in the prior section, research tells us that 88% of physicians do not wish to be resuscitated in the event of cardiac arrest, and more than 80% of patients say they wish to avoid high-intensity care at the end of their lives.²⁶ Many patients have a clear preference as to how and where they would wish to die, but too often, their wishes are not known, as in this scenario. Most readers will recognise that each day, older people die in the resuscitation bays of our EDs receiving unwanted, invasive and expensive care.²⁷

Does this patient receive intubation, IV fluid boluses, vasopressors? A warm blanket, analgesia and a reassuring voice? All of the above? There is no 'correct approach', for what is, at its heart, an ethical dilemma. What we can confidently say is that we see changes emerging in emergency medicine away from our deeply ingrained bias towards aggressive resuscitation as the default in such cases – default because 'we don't know what the patient/family wants', because 'there might be something reversible' or, most pointedly, because 'then it can be ICU's problem to sort out'.

The four pillars of medical ethics are beneficence (do good), non-maleficence (do no harm), autonomy (respecting patient wishes) and justice (allocation of finite resources). Superimposed on these ethical considerations is the fear of legal/coronial repercussions, which are more likely for sins of omission than of commission. It is important that emergency physicians know the legislative requirements for consent to provide or indeed withhold care in their jurisdiction of practice. With respect to this, Advance Care Planning Australia has useful online resources.²⁸ The clear difficulty in this case, no indication of patient

TABLE 2. Prompts to consider referral for advance care planning/palliative care

Consider referral for patients with features of life-limiting illness AND markers of unmet care needs, for example two or more ED attendances in past 6 months; uncontrolled symptoms; increased frailty and dependency; or carer stress

Life-limiting illness to prompt referral	Indicative features
Advanced dementia or other CNS disease (e.g. stroke and motor neuron disease)	Inability to walk, dependent on others for all care needs, six or less intelligible words
New York Heart Association Class IV heart failure	Symptoms at rest, often bedbound
End-stage renal failure where dialysis is not an option	
Advanced malignancy refractory to treatment or treatment options exhausted	
End-stage pulmonary disease	SaO ₂ <88% RA or on continuous home oxygen, evidence of RHF, unintentional weight loss >5 kg
End-stage liver disease	Refractory ascites, episodes of SBP/encephalopathy

wishes, does not in itself oblige us to act in a way that egregiously violates other principles of ethically sound clinical practice. Like all ethical dilemmas, consultation with trusted senior colleagues and a consensus view on the appropriate course of action is prudent. Whatever your decision and the care you provide, it is important to clearly document your rationale and communicate with your team and others outside it.

Summary

From the perspective of the patient, family, clinician and society, advance care planning is worth doing well. ED physicians must see themselves as having a role in this paradigm shift. It is worth ending with a cautionary quote from the abstract of a 2007 paper, to remind ourselves of the many excuses, against our better judgement, that we can use to avoid planning for dying with our older patients, and which need to be overcome to align patient comfort with healthcare delivery.

‘Although the majority of health professionals believed that patients and caregivers should be told the truth about prognosis, in practice, many either avoid discussing the topic or withhold information. Reasons include perceived lack of training, stress, no time to attend to the patient’s emotional needs, fear of a negative impact on the patient, uncertainty about prognostication, requests from family members to withhold information and a feeling of inadequacy or hopelessness regarding the unavailability of further curative treatment’.²⁹

Competing interests

None declared.

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