Resident Issues

Where do goals of care conversations belong? A case for the emergency department

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INTRODUCTION

Emergency medicine developed as a specialty to provide life-sustaining and disease-oriented care for patients with acute illness.[1] However, some life prolonging measures offered in emergency departments (EDs) to patients with advanced disease may not be in keeping with patients' goals or wishes at the end of life. We commonly define goals-of-care conversations to involve both a discussion about resuscitation preferences or "code status," in addition to making decisions about treatment, the intensity of care, and planning for future care needs. An encounter I had during my first year of residency allowed me to reflect upon the importance of engaging in goals-of-care conversations early in presentation to hospital – most often in the setting of the ED.

A 91-year-old female with advanced dementia presented to the ED with fever, bilious, non-bloody emesis, and diffuse abdominal pain. She had not had a bowel movement in 48 hours, with decreased oral intake and urine output. The patient lived with her appointed power of attorney (POA), her daughter, and was dependent for both basic and instrumental activities of daily living. When assessed in the ED, the patient was febrile, alert, however disoriented to person, place, and time, which was representative of her baseline level of confusion. Her abdomen was soft, with diffuse tenderness, greatest in the right lower quadrant. The patient had a lymphocytosis with a white blood cell count of 12, elevated lactate of 2.1, hemoglobin of 104. A computed tomography (CT) scan revealed a closed loop, small bowel obstruction, and the acute surgical service was consulted.

Admitted under surgery, the patient was monitored over the course of the weekend with nasogastric tube insertion. Due to comorbidities, advanced cognitive disease, and high surgical risk, conservative medical management later became the definitive plan. Early in her admission, the patient became more acutely confused, frequently removing the nasogastric tube in agitation. Subsequently 48 hours following, with no signs of clinical improvement, the surgical team met with the patient's daughter and POA to address Do-Not-Resuscitate status. As POA, the daughter expressed that her mother's primary request was to be made comfortable and allow for a natural death, with minimal interventions. At this stage, a consultation to the palliative care team was made for optimization of pain management and fulfillment of the patient's original care goals. The patient succumbed to her illness on the Palliative Care Unity in the days shortly thereafter.

Working with the palliative care team, I had the benefit of analysing this case in the rear-view mirror. I could appreciate how a case like this could slip through the cracks: a common surgical complaint referred to surgery and lost in the shuffle over the course of a busy weekend with multiple attending physicians. Despite this, it remains clear that the patient's course in the hospital could have been altered had a conversation surrounding goals of care been had in the ED.

GOALS OF CARE IN THE ED

Although not typically seen as an ideal environment to discuss goals of care, the ED represents an important

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point at which healthcare providers can guide patients in navigating their further management and personal goals related to care.[1] In Canada, the experience of dying most often occurs in the hospital, commonly involving a substantial number of interventions and investigations.[2] One fifth of deaths occur in an intensive care unit[3] while rates of cardiopulmonary resuscitation (CPR) prior to death continue to increase among the elderly population.[4]

QUALITY OF LIFE OVER QUANTITY

Because patients presenting to EDs are increasingly advanced in age and more medically complex, greater clinical skill is required of the ED physician in symptom management and end-of-life care. While hardwired to provide heroic measures in an efficient manner, emergency physicians must also recognize and respect illness presentations where further efforts may not be futile or in keeping with a patient's goals of care. A recent Canadian study found that 80% of older adult patients in the hospital with a serious illness prefer a less aggressive and more comfort-oriented end-of-life care plan that does not include CPR.[5] For many patients, the focus will shift towards maximizing general well-being and comfort, with the value of quality of life outweighing that of quantity.[6]

Patients with dementia are at a heightened risk for in-hospital death, and an increasing proportion of the population is dying from advanced dementia. Physicians often under-recognize the terminal nature of the gradual loss of cognition and function seen in dementia, as research demonstrates that dementia patients frequently receive suboptimal end-of-life care, and often burdensome interventions.[7]

Early palliative care can benefit both patients and healthcare systems. At a systems level, incorporation of palliative care into EDs can limit healthcare spending without compromising quality of care. Recent evidence demonstrates that early integration into palliative care can reduce ED visits and hospitalizations by up to 50%.[8]

> Initiating a palliative care consultation directly from the ED shortens length of stay by an average of 4 days, resulting in fewer in-hospital deaths (Wu et al., 2013) while significantly increasing quality of life without reducing overall survival (Grudzen et al., 2016).[9,10]

Table 1. A systematic, 5-minute approach to ED goals-of-care conversations.

Time	Action
Minutes 1–2	Elicit patient and family's understanding of underlying illness and recent acute events. Build on previous advanced directives or documented conversations if established. Increase awareness of patient's wishes and values to guide further interventions and how to frame prognosis. Identify and validate patient's objectives, hopes, and fears.
Minutes 2–4	Discuss further treatment options. Continue to incorporate patient's wishes and values. Advise further course of action.
Minute 5	Summarize and discuss next steps. Incorporate additional resources of potential benefit (e.g., hospice, social work, chaplain).

USING EFFECTIVE COMMUNICATION STRATEGIES

A number of barriers make engaging in goals-of-care conversations with patients challenging for emergency physicians. Limited time, privacy, and a lack of an established therapeutic relationship compound an already difficult conversation.[11] Research indicates that emergency physicians also cite challenges in predicting illness trajectory during a brief encounter in the ED.[12] Despite some prognostic uncertainty, emergency physicians can rely upon effective communication strategies to convey important messages to patients and their families about disease outlook and viable symptom management options. Wang et al.[11] highlight a method to approach a brief goals-of-care conversation in the ED setting (Table 1).

Palliative care in emergency medicine offers patients and families support along the entire continuum of care and is best if instituted as early as possible.[11] Using a simple framework to engage in goals-of-care conversations can make the process more accessible for emergency physicians. Often deferred and addressed later during an admission, it's important to recognize that palliative care can begin in the ED and successfully bridge into inpatient and outpatient services. It can radically improve the way that patients interact with the healthcare system, while enhancing comfort and dignity at the end of life.

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