Palliative Medicine and Geriatric Emergency Care
Challenges, Opportunities, and Basic Principles

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KEYWORDS
- Palliative care • Geriatrics • Emergency medicine • Elderly • Hospice care

KEY POINTS
- Hospice and palliative medicine, a subspecialty of emergency medicine, concentrates on life-threatening illnesses, whether curable or not.
- Palliative care is not the same as end-of-life (EOL) care.
- Arrival of a patient under hospice care to an emergency department (ED) does not automatically equate to hospice care termination nor does it imply that patient seeks aggressive interventions.
- Challenges to implementation of pre-existing advance planning documents exist, including an unanticipated change in health status, interfamily conflicts, and issues with institutional protocols.
- Many eligible patients, if considered for hospice, are enrolled too late in the course of disease to realize the full benefit of hospice.

OPENING REMARKS
Before starting this article, it is important to have some perspective. Figs. 1–3 define the terms and summarize necessary concepts of care. On initial presentation of a disease, such as lung cancer or heart failure, the goal of care is curative but patients also receive noncurative symptom management. In cancer, this noncurative management may include nausea relief and relief of constipation. This noncurative symptom management is palliative. Palliative care is the relief of symptoms and pain that interfere with quality of life.

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Fig. 1 shows that as the disease progresses and curative treatment is less or no longer effective, the goal of care moves from curative to noncurative or palliative. When no curative treatment is available, then palliative care is the only treatment that is left to give. The disease course leads to death. This frequently is referred to as advanced end-stage disease. At this point, palliative care or hospice care remains as a treatment choice. Also at this point, life-prolonging interventions may be considered as prolonging suffering. Understanding a patient’s goals of care is important in all aspects of care but of utmost importance in this case. This is the point when all additional curative treatment is not life prolonging and may actually cause more unwanted symptoms.

The important point to make is the role of the emergency physician. Along the continuum that is shown in Fig. 2, a patient may present to an ED. The physician role is part curative, such as infection management, and part palliative, such as managing nausea. This article discusses symptom management but is not limited to physical symptoms and includes psychosocial as well as ethical issues.

Fig. 3 further defines the disease trajectories. As discussed in this article, there are 4: sudden death, terminal illness, organ failure, and frailty. All dying falls into these 4 domains. Palliative care is focused on all but sudden death.

- The best example of terminal illness is cancer. Patients undergo curative and noncurative treatment as they approach either death or cure.
- In the case of organ failure, examples include renal failure and heart failure. The classic pattern of dying is prolonged with frequent exacerbations and symptom
resolution but, eventually, the disease is progressive and life limiting. Each time the disease exacerbates, patients may present to an ED.

- Dementia and Parkinson disease are examples of frailty.

The dying trajectory is one of prolonged decline. Symptom management and prognostication, which is the prediction and communication of disease progression, are key to the long-term management of these patients. An example is the Seattle Heart Failure Model that can help predict survival in heart failure. There is even a smartphone application for many of these predictive tools.

An emergency physician may not need to know all the predictive tools but must be able to identify those patients who can benefit by a transition of care to a palliative service or hospice. For example, a 75-year-old man with class 4 heart failure has a 35% chance of dying in 1 year. It is important to realize that this patient is dying from his disease. Over the next year, this patient is likely to visit an ED multiple times. Identifying a disease trajectory and setting up appropriate palliative interventions is beneficial to the patient and helps with starting advance directives and other care planning. At minimum, an ED physician can help identify the patients who may benefit from discussion of palliative needs and make the transition of care to the appropriate resources. (Patients may see their ED physician more than they see their primary care physician in the last year of life.)

One last perspective: 100% of geriatric patients die. All die from one of these trajectories and all but sudden death has a role for palliative care. When President George Washington died of epiglottis, there were no hospitals. Most people died at home, usually without a nurse or physician present. When physicians were present, they had little therapy to offer (eg, Dr Benjamin Rush at Washington’s bedside was bloodletting him because bloodletting was the cure for all “moist, wet diseases”). Today, there are vast hospitals with a diagnostic and therapeutic armamentarium that our ancestors never dreamed possible, but overtesting and overdiagnosis are bankrupting our nation and patients too often die away from home and family in cold, sterile hospitals. This is neither financially sustainable nor idyllic for patients. Palliative care offers an opportunity to find the sweet spot—if health care providers accept the philosophy and if appropriate patients can be identified at the right time in the course of their disease process and health care pathway.
INTRODUCTION

Defining Palliative Care

The World Health Organization defines palliative care as “care which improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end-of-life and bereavement.”1 Hospice and palliative medicine, a subspecialty of emergency medicine, concentrates on life-threatening illnesses, whether curable or not.2 These may include terminal illness (eg, cancer), organ failure (eg, congestive heart failure), and frailty (eg, Parkinson disease). Palliative medicine represents the “physician component of the interdisciplinary practice of palliative care.”3

Palliative care is not the same as EOL care.4,5 EOL care, a component of a palliative care program, is the care provided during the last likely hospitalization. It is impossible to know when a person is dying, hence the difficulty in defining EOL, leaving the concept to regulatory interpretation rather than scientific evidence.6 EOL care, however, usually encompasses a chronic disease with a progressive downward trajectory.6 Palliative care should not be confused with hospice care, in which patients have less than a 6-month life expectancy.

Older adults with chronic illnesses often present to an ED several times in their last year of life. The ability to change the existing paradigm of care for chronic disease is an opportunity for palliative medicine—specifically, palliative care in EDs—to alter the in-house trajectory of care. Research supports the use of palliative care interventions early in the disease trajectory to promote quality of life as well as reduce costs associated with treatments.7-9 There is not a great deal of palliative care research related to quality of life and many of the available studies have weak methodology.9 Yet studies have consistently demonstrated that palliative care consultations and interventions result in reduced symptoms, greater emotional support, and improved patient and family satisfaction.10

There are many variables to consider when determining savings associated with palliative interventions in the acute care setting. For example, was the patient admitted to an ICU for several days before a palliative consult and subsequent change in treatment plan to a floor bed? Other considerations include physician practice patterns, timing of consultations, and length of stay, suggesting that the presentation of clinical outcome data with cost-saving data may be the best approach.11 With that said, researchers are concluding that hospital-based palliative care is associated with significant hospital cost savings.10,12 Penrod and colleagues8 compared palliative care admissions with regular hospital admissions and had significant findings. The investigators8 reported a savings of $464 per day for total direct hospital costs associated with palliative care patients compared with those patients receiving standard care (P<.001) and a decrease in ICU use of 43.7% for palliative care patients.

Making the Case for Palliative Care Integration

Emergency medicine providers already offer many interventions that are aspects of palliative care. For example, discussions with family and loved ones to help direct the plan of care, symptom management, and pain control are essential to palliative care medicine. Additional benefits of providing palliative care interventions while in an ED include the ability to manage diagnostics and interventions,12,13 improved satisfaction for patients and their families,14 improved outcomes, reduced length of stay,4,13,14 less use of intensive care compared with similar patients receiving usual care,8,12 cost savings,4,8,12,13 and direct referrals to hospice as appropriate.12

Patients with advanced and end-stage disease present to EDs every day, emphasizing the need for palliative care and EOL care in EDs.7,15-17 The older
adults in this cohort represent a complex and vulnerable population. EDs function as a safety net for these patients by offering a solution to the large gap in outpatient services. EDs provide access to multidisciplinary teams for assessments, plan of care, and interventions 24 hours a day, 365 days a year. Research focusing on patients who were at EOL found that these patients often did not receive the care they anticipated. They may present to an ED for assistance with pain management or other symptom relief with full intentions of being discharged. Once registered in an ED, EOL patients may find themselves overwhelmed by the chaotic environment and admitted to the hospital. Emergency physicians need to consider an alternate approach to treatment rather than the typical response of life-prolonging interventions. In this situation, clinical protocols may be used to facilitate palliative care interventions in the plan of care for the chronically ill elderly presenting to EDs.

Types of Programs

There are many ED palliative care delivery systems, based on provider experiences and the needs of the patient community. In general, there are 3 recurring models of palliative medicine/care in this area: ED–palliative care partnerships, ED palliative care champions, and ED hospice partnerships. An advocate of the palliative care program is needed (preferably an ED physician) who possesses the ability to work behind the scenes educating, recruiting, addressing barriers, and promoting inclusion and continuity of the program within the individual hospital structure. It is essential to know the staff and community as well as nuances of the hospital in terms of leadership, internal politics, and resources before designing an ED-based palliative care program.

RECOGNIZING UNMET PALLIATIVE NEEDS IN THE EMERGENCY DEPARTMENT

Elderly patients with serious, advanced illnesses comprise a particularly vulnerable population in EDs. A recent longitudinal study of patients older than 65 years examined the pattern of ED use in their last months of life: 75% (4518 decedents) visited an ED in the last 6 months of life and 51% in the last month, and repeat visits to an ED were common. This is not unique to the United States; a recent Australian study of patients with a known poor prognosis disease, such as cancer, also revealed that 70% of the cohort (1071) had at least 1 ED visit in the last few months of life. These visits may, therefore, present an opportunity to initiate early goals of care discussions that may help tailor future care plans. Many system-related, patient-related, and provider-related barriers to recognizing and addressing palliative needs in the ED elderly exist, however, for example, time-constraints, curative disease–focused approach to patient care, patient self-report limited by cognitive disabilities, lack of access to family or primary providers, chaotic environment, and lack of 24/7 availability of interdisciplinary support staff.

It is well recognized that identifying unmet palliative needs in EDs is vital. A geriatric competencies for emergency medicine residents consensus group identified palliative care competencies with respect to elders, including (1) rapidly establishing, documenting, and managing elders’ goals of care for those with serious life-threatening conditions; (2) assessing and managing pain and key nonpain symptoms; and (3) understanding how to access hospice care and how to manage elders in hospice care in ED. Clinical practice guidelines for quality palliative care in EDs also highlight that “The ED use explicit criteria to identify patients with unmet needs for palliative care.”
**Prognostication**

Predicting and anticipating the needs of patients in the near future requires determining a prognosis. Patients and families desire information about life expectancy so that they are able to plan for the future. The 5 D’s of determining prognosis (prognostication) have been discussed in the literature and are related to outlining (1) disease progression, (2) death, (3) disability and discomfort, (4) drug side effects, and (5) dollars (cost of care). Clinicians often find 2 aspects of prognostication challenging: the formulation and the communication of prognosis. Prognostication remains an essential first step, however, that leads to triggering a palliative needs assessment in the elderly. Many palliative prognostic scores and scales that identify patients with life-limiting prognoses exist. One such scale, the Palliative Performance Scale, takes into consideration the following domains (range 0–100%): (1) ambulation (bed bound to fully mobile), (2) activity and evidence of disease (no evidence of disease to extensive disease), (3) self-care (full to total assistance), (4) intake (normal to mouth care/sips), and (5) level of consciousness (fully alert to coma). Approximately 10% of patients with a score of 50% or less are expected to survive 6 months or more. Although such prognostication tools exist, support tools for ED palliative care consultation and reliable ED screening methods that identify patients (including the elderly) in need of palliative care services early have not yet been widely evaluated or adopted. Prognostication remains challenging in the ED setting when often the event is a terminal crisis can only be recognized retrospectively.

**Identifying Palliative Care Needs**

Some early identification programs proactively seek to identify the elderly at high risk for unmet palliative care needs through screening pathways, ED checklists, and standardized assessment tools. Examples include automatic triggering of palliative team consultation for preselected populations, such as those with admissions for placement of a gastrostomy tube; a case management approach; or Screen for Palliative and End-of-Life Care Needs in the ED for use in ED cancer patients. The Center to Advance Palliative Care convened a consensus panel of experts that selected criteria by which patients at high risk for unmet palliative care needs can be identified (Table 1). Similar checklists (with proper education) may assist hospital staff engaged in day-to-day patient care in identifying the majority of patients with such needs and addressing concerns.

**COMMUNICATION**

**Effective Communication when Caring for Seriously Ill ED Patients**

Optimal communication with shared decision making has been identified by patients and families as a crucial aspect of medical care, especially at EOL. Effective communication facilitates improved satisfaction with care and a reduction of anxiety and distress, often with even brief interactions. Although most patients and family members want to receive support and hope from clinicians, they also value clear and honest information about the medical condition and prognosis. Yet studies, mostly in ICU and inpatient environments, reveal that up to one-third of families of critically ill patients are dissatisfied with the lack of communication or conflicting information from different clinicians. EDs may have a disadvantage in communicating with patients and families due to the inherently fast-paced environment. If ED physicians identified the need for palliative care, however, a palliative care team can support the patient and family decision-making process. This transition is best initiated in EDs so goals of care and appropriate treatment are delivered.
The ED setting poses further significant challenges due to patient-related, physician-related, time-related, and environment-related factors. Three communication-related domains that are pertinent to caring for seriously ill elderly patients in EDs are as follows: (1) goals of care and patient-centered decision making, (2) advance care planning, and (3) transitioning patients to palliative care. Typically, these goals are initiated in the ED and are achieved as a process over a day or 2 with multiple coordinated conversations with the patient, family, and essential palliative care team members.

### Goals of care and patient-centered decision making

A patient-centered decision making approach requires a shared understanding of patient values and goals so as to tailor suitable treatment plans. Because goals may evolve with a change in health status or one patient goal (relief of pain and suffering) may take precedence over another (cure of disease), often these

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**Table 1**

Criteria for initiating a palliative care assessment at initial patient evaluation

<table>
<thead>
<tr>
<th>A potentially life-limiting or life-threatening condition(^a) AND</th>
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<tbody>
<tr>
<td><strong>Primary criteria(^b)</strong></td>
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<tr>
<td>1. The surprise question</td>
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<td>2. Bounce-backs</td>
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<td>3. Difficult-to-control symptoms</td>
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<td>4. Complex care requirements</td>
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<td>5. Functional decline</td>
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<tr>
<td><strong>Secondary criteria(^c)</strong></td>
</tr>
<tr>
<td>1. Admission from long-term care facility</td>
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<tr>
<td>2. Elderly patient, cognitively impaired, with acute hip fracture</td>
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<td>3. Metastatic or locally advanced incurable cancer</td>
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<td>4. Chronic home oxygen use</td>
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<td>5. Out-of-hospital cardiac arrest</td>
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<td>6. Current or past hospice or palliative care intervention</td>
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<td>7. Limited social support (eg, family stress, caregiver distress, chronic mental illness)</td>
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<tr>
<td>8. No history of completing an advance care planning discussion/document</td>
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</table>

\(^a\) Any disease or condition that is known to be life-limiting (eg, dementia, chronic renal failure, metastatic cancer, or cirrhosis) or that has a high chance of leading to death (eg, sepsis, multiorgan failure, or major trauma). Serious medical conditions for which recovery to baseline function is routine (eg, community-acquired pneumonia in an otherwise healthy patient) are not included.

\(^b\) Primary criteria: global indicators that represent the minimum standard of care that hospitals should use to screen patients at risk for unmet palliative care needs.

\(^c\) Secondary criteria: indicators of a high likelihood of unmet palliative care needs that should be incorporated into a systems-based approach to patient identification if possible.

discussions with the need to occur in real time in the ED setting with a palliative care advocate. Goals of care discussions are road maps that assist clinicians in clarifying where patients want to go and what they want to avoid so that treatments align with their objectives. Box 1 lists some key elements when negotiating goals of care.

**Box 1**

Goals of care discussions with the elderly patient in the emergency department

1. Communicating prognosis (key step so the patient/family have a basis to make future plans/decisions)
   a. Answer 2 key questions: “What is wrong with patient? What will happen to him/her?”
   b. Frame discussion as, “Hoping for the best while preparing for the worst.”
2. Eliciting patient values (open-ended questions are suggested)
   a. “What is most important to you in your life right now?”
   b. “What kind of results are you hoping for?”
   c. “What do you hope to avoid at all costs?”
   d. “Have you been with someone who had a particularly good death or a particularly bad death? Please tell me about it.”
3. Using appropriate language when describing goals of care
   a. Avoid negative statements (“Do you want us to stop aggressive care?”)
   b. Frame appropriately
      i. “We want to ensure that you receive the kind of treatment you want.”
      ii. “Let us discuss how we can work toward your wish to stay home.”
4. Reconciling goals of care
   a. Sometimes a time-limited trial of therapy is needed to help patient/family cope/decide. If so,
      i. Outline the proposed treatment plan.
      ii. State what the goals are that you are hoping the treatment plan will achieve.
      iii. Clarify how you will recognize and determine that these goals are being met.
      iv. What period of time will be used to see if the treatment plan “works or does not work”?

Unrealistic goals may need limits set without implying abandonment.

“I understand your goal is not to be a burden to your family and you want an assisted death. Unfortunately, I cannot do that. I can however help with the distressing symptoms and alternative ways to help you not be a burden.”

5. Recommending a care plan based on the established goals
   a. Any therapies that do not help meet the goals should be discussed for potential discontinuation.
   b. Appropriate diagnostic plans and disposition plans are best formulated/discussed with goals in mind.

In general, instead of the yes-and-no answers, it is more important to ascertain the why's behind patient decisions and it is best to first ascertain overall big-picture patient goals and then discuss specific treatments.\textsuperscript{59,60}

Eliciting goals is particularly challenging when patients lack decision-making capacity.\textsuperscript{58,59,61} Capacity is determined “based on the process of the patient’s decision making rather than the final decision itself.”\textsuperscript{62} Capacity surrogate proxy decision makers need guidance from a clinician to determine what the patient would have wanted given the clinical scenario and available information. It may be necessary to remind family or proxy that they should do their best to communicate the patient’s wishes, not their own, although concordance may not always be feasible.\textsuperscript{53,64} The ED environment may not be conducive to determining capacity and the process should be guided by the specific policies of the institution. Temporizing measures and/or a transition of care from an ED may provide the opportunity to establish goals of care, determine capacity, or guide a capacity surrogate through the decision-making process.

\section*{Advance care planning}

Advance care planning is usually a longitudinal process whereby patients, in consultation with health care providers and family/caregivers, make decisions about their future health care, should they become incapable of participating in medical treatment decisions.\textsuperscript{54,65} Advance planning documents usually fall into 2 categories: (1) instructional directives that usually provide guidance regarding single focused events, for example, do-not resuscitate, do-not hospitalize, or do-not intubate directives, and (2) proxy directives, which are those that involve the designation of a surrogate or substitute decision maker. Although completion of this process is important to document patient wishes, mere completion of such directives may not improve EOL care.\textsuperscript{16,19,34,66–68} As discussed in the Translating Research Into Action for Diabetes (TRIAD) studies,\textsuperscript{69,70} living wills and advanced directives are frequently misinterpreted because of a lack of understanding of intent and terminology. Many states are initiating new physician orders for life-sustaining treatment to help clarify the patient wishes and goals of care.

The availability of these documents in a crisis is variable; the applicability can be unclear and especially challenging in rapidly deteriorating elderly ED patients, often creating conflict, anxiety, and uncertainty.\textsuperscript{16,19,34,66–68} Therefore, real-time rapid goals of care discussions are usually needed in the ED setting.\textsuperscript{34} Again, prognostication is a key initial step and it is known that patients often vary their choices when informed about the likelihood and severity of outcomes, including those related to functional and cognitive disability.\textsuperscript{71,72} In general, it may be best not to use mechanistic terms (put on breathing machine) and approach advance directives in the context of the whole person–big picture as opposed to isolating discussions around cardiopulmonary resuscitation.\textsuperscript{34,58} The discussion and documents should be based on goals of care, not specific management decisions, such as “I do not want to be ventilator dependent” versus “do not put on breathing machine.”

\section*{Transitioning an elderly patient to palliative care}

Transition of elderly patients into palliative care may be one of the most confusing and traumatic transitions for patients and their loved ones.\textsuperscript{73} A family may face conflict due to the time needed to cope and adjust and due to the intrinsic nature of the transitions, the timing of the transition, and the lack of information surrounding this transition.\textsuperscript{73} In a discipline where the training focus is on life-prolonging care, the shift of a patient to comfort care may pose a philosophic challenge for ED clinicians as well, such that
support to family may be lacking at the time that they most need it. Therefore, when the issues are complex and difficult to manage, the ability to engage interdisciplinary staff (clergy, social worker, hospice case manager, and so forth) and/or consultation with a specialist palliative care clinician may be particularly helpful. Even if these services are not available in an ED, it is likely that some or all services are available in the hospital. Identifying the need and conveying the need is the domain of the ED team.

The availability to transfer a patient directly from an ED to a hospice or palliative care service or in-patient palliative unit may also assist in ease of transition to palliative care. Another significant and stressful transition for patients is when they are already in palliative or hospice care and seek care in a different setting (like the ED). Lack of communication between care teams during such hand-offs and settings may create conflict and hamper overall patient-centered care. A structured process of hand-offs with an emphasis on clear communication with caregivers and among the health care teams during the transitions (for example, when a hospice sends a patient to the ED and vice versa) assists to streamline care and decrease conflict and assures that the patient goals of care are consistently met.

PALLIATIVE EMERGENCIES IN THE ELDERLY

A palliative care emergency is an unexpected change in a patient’s medical condition in the context of an underlying known advanced or serious illness, and this emergency often triggers an ED visit. The recommended ED assessment and treatment plan should consider patients’ overall goals of care as well as the following:

- What is the acute medical issue and is it potentially reversible?
- What would most likely be the patient’s status after treatment?
- What is the person’s recent performance level, the extent of the underlying disease, and overall prognosis?
- What are the burdens of any treatments that could be offered?
- What are the patient’s/surrogate’s wishes when informed of the potential benefits and burdens of treatment plan?

Some common emergencies seen in the elderly with known advanced underlying disease (especially malignancy) are presented in Table 2.

SYMPTOM MANAGEMENT

The challenge faced by ED physicians who are managing patients with life-limiting illness, specifically EOL patients, is to provide relief of symptoms. Whether a patient is admitted to the hospital or discharged to home should not interfere with this management initiative. A partial list of common symptoms and complaints that may need to be addressed at EOL includes

1. Agitation/confusion/delirium—see Table 3
2. Anxiety
3. Constipation—see Table 4
4. Diarrhea
5. Dyspnea
6. Nausea and vomiting—see Table 5
7. Pain—see Table 6
8. Pruritus
9. Stomatitis
10. Terminal oral secretions—see Table 7
<table>
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<th>Emergency</th>
<th>Presentation</th>
<th>Cause</th>
<th>Therapeutic Plan</th>
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<tbody>
<tr>
<td>Cord compression</td>
<td>Underlying malignant disease with</td>
<td>Vertebral metastasis</td>
<td>• Dexamethasone when suspected (10 mg IV)</td>
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<td></td>
<td>• Worsening back/radicular pain</td>
<td>Edema after radiation</td>
<td>• Urgent imaging (MRI scan)</td>
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<td>• Progressive gait difficulties</td>
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<td>• Urgent referral for radiotherapy</td>
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<td>• Sphincter symptoms, such as urinary retention</td>
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<td>• Urgent surgical referral for decompression</td>
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<td>may occur late</td>
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<td>• Pain and temperature sensation are usually lost</td>
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<td>Superior vena cava</td>
<td>Early: periorbital edema, facial swelling, cough,</td>
<td>Extrinsic pressure or invasion of tumor</td>
<td>• Raise head of bed and diuretics (temporary measures)</td>
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<tr>
<td>syndrome</td>
<td>dyspnea</td>
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<td>• Radiation referral</td>
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<td>Late: engorged neck and chest veins, upper-</td>
<td>Intraluminal thrombus</td>
<td>• Intravascular expandable metal stent</td>
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<td>extremity edema</td>
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<td>• Lytic therapy if thrombosis</td>
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<td></td>
<td>• Severe: headaches, seizures</td>
<td></td>
<td>• Dexamethasone</td>
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<tr>
<td>Hypercalcemia</td>
<td>Nausea, change in mentation, constipation,</td>
<td>Multiple myeloma</td>
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<td>dehydration, cardiac arrhythmia</td>
<td>Malignancies</td>
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<tr>
<td>Bowel obstruction</td>
<td>Malignant bowel obstruction may present</td>
<td>Compression or intraluminal mass/</td>
<td>• Antisecretory medications (eg, octreotide) to reduce the fluid load–associated vomiting and distress</td>
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<tr>
<td></td>
<td>acutely or subacutely</td>
<td>tumors</td>
<td>• Anticholinergic drugs (scopolamine, atropine, and glycopyrrolate) may decrease spasm</td>
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<td>• Avoid stimulants and prokinetic antiemetic (metoclopramide) in complete obstruction because they may worsen colicky pain (these may assist in partial obstructions)</td>
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<td>• Steroids help in decreasing edema and can relieve nausea</td>
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<td>• Initial decompression with nasogastric tube may be helpful</td>
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<td>• For intractable symptoms, consider a venting percutaneous gastrostomy</td>
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<td>• Surgery to relieve obstruction (if good functional status)</td>
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<table>
<thead>
<tr>
<th>Emergency Presentation Cause Therapeutic Plan</th>
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<tbody>
<tr>
<td>Dyspnea or respiratory failure&lt;sup&gt;h,i&lt;/sup&gt;</td>
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<tr>
<td>Common at EOL</td>
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<tr>
<th>Delirium&lt;sup&gt;j,k,l&lt;/sup&gt;</th>
<th>Fluctuating mental state and disorganized thinking</th>
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<tbody>
<tr>
<td>An abnormal state of arousal—either hyperactive/agitated or hypoactive</td>
<td>Medications</td>
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<tr>
<td>Infections</td>
<td>Underlying cognitive impairment</td>
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<td></td>
<td>• Consider potentially reversible causes and screen early</td>
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<tr>
<td></td>
<td>• Antipsychotic may be tried: haloperidol or newer atypical antipsychotics (olanzapine or risperidone)</td>
</tr>
</tbody>
</table>


<sup>g</sup> Data from Navigante AH, Cerchietti LC, Castro MA, et al. Midazolam as adjunct therapy to morphine in the alleviation of severe dyspnea perception in patients with advanced cancer. J Pain Symptom Manage 2006;31:38–47.


Table 3
Delirium: treatment

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>(Common Brand Name)</th>
<th>Starting Dose</th>
<th>Dosing Interval</th>
<th>Max q24 h Dose</th>
<th>Formulations</th>
<th>EPS</th>
<th>Anticholinergic</th>
<th>Sedation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone</td>
<td>(Risperdal)</td>
<td>0.25–1 mg</td>
<td>bid or up to q6 h prn</td>
<td>6 mg</td>
<td>0.25-, 0.5-, 1-, 2-, 3-, 4-mg tablets Available as ODT</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>Caution with renal failure</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>(Zyprexa)</td>
<td>2.5–10 mg</td>
<td>Debilitated or elderly: 2.5 mg</td>
<td>Daily IM: q2 h (maximum: 3 doses daily)</td>
<td>20 mg</td>
<td>2.5-, 5-, 7.5-, 10-, 15-, 20-mg tablets Available as ODT and IM injection</td>
<td>+</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>(Seroquel)</td>
<td>12.5–50 mg</td>
<td>bid</td>
<td>800 mg</td>
<td>25-, 50-, 100-, 200-, 300-, 400-mg tablets</td>
<td>+</td>
<td>++</td>
<td>+++</td>
<td>Start daily at 4:00 PM for sundowning and then time subsequent, additional doses based on symptoms</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>(Ability)</td>
<td>5–15 mg</td>
<td>qam</td>
<td>30 mg</td>
<td>2-, 5-, 10-, 15-, 20-, 30-mg Available as IM and oral solution</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>Useful for hyperactive delirium. Can cause insomnia if given at night</td>
</tr>
</tbody>
</table>

Abbreviations: CNS, Central nervous system; IM, Intramuscular; ODT, Oral dissolving tablet.

Data from UPMC supportive and palliative care pain card. University of Pittsburgh Medical Center, Pittsburgh, PA.
When patient and family agree to comfort measures rather than aggressive resuscitation, the goal of treatment is symptom management. EOL patient symptoms require appropriate assessment and intervention. For example, the management of an EOL patient who declines intubation but has dyspnea and respiratory failure is challenging. It is an ED physician’s responsibility to keep that patient comfortable and permit the disease process to take its course. The treatment of dyspnea is not oxygen alone but a combination of therapies that includes opioids and benzodiazepines. Morphine works well in improving comfort, decreasing anxiety, and decreasing the feeling of breathlessness in the face of dyspnea.79

Knowledge and expertise in the management of these complaints is necessary to help patients meet their goals.80 Remember to treat the patient as a person not as an EOL complaint.

**ETHICAL ISSUES AT EOL IN THE EMERGENCY DEPARTMENT**

“Palliative care at the EOL involves meeting the physical, psychological, social and practical needs of patients and caregivers.”81 Ethical issues arise from time to time in EDs when dealing with palliative care patients at the EOL. Ethical dilemmas in the ED setting are likely to include matters related to the use of artificial airways, artificial nutrition, and surrogate decision makers. If available, state-approved advanced directives in the form of do-not-resuscitate (DNR) orders, living wills, or durable powers of
Table 5  
Nausea and vomiting: treatment

<table>
<thead>
<tr>
<th>Drug (Generic Name)</th>
<th>Receptor Activity</th>
<th>Common Clinical Indications</th>
<th>Dosage/Route</th>
<th>Cost</th>
<th>Comments/Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>D2</td>
<td>Opioid-induced N/V</td>
<td>0.5–4 mg po or sq or IV q6 h</td>
<td>$</td>
<td>IV has less EPS compared with po</td>
</tr>
<tr>
<td>Metoclopramide</td>
<td>Peripheral D2</td>
<td>Impaired Gl motility</td>
<td>5–20 mg po or sq or IV AC and HS</td>
<td>$</td>
<td>EPS, esophageal spasm, and colic in Gl tract obstruction</td>
</tr>
<tr>
<td>Prochlorperazine</td>
<td>D2</td>
<td>Opioid-induced N/V N/V of unknown etiology</td>
<td>5–10 mg po or IV every 6 h or 25 mg pr q6 h</td>
<td>$</td>
<td>EPS and sedation</td>
</tr>
<tr>
<td>Scopolamine</td>
<td>Ach, H1</td>
<td>Motion-induced N/V</td>
<td>1.5-mg transdermal patch every 3 d</td>
<td>$</td>
<td>Dry mouth, blurred vision, ileus, urinary retention, and confusion</td>
</tr>
<tr>
<td>Ondansetron</td>
<td>5-HT 3</td>
<td>Chemotherapy or radiation induced N/V</td>
<td>4–8 mg po as a pill or dissolvable tablet or IV every 4–8 h</td>
<td>$$$</td>
<td>Headache, fatigue, and constipation</td>
</tr>
<tr>
<td>Dexamethasone</td>
<td>Decrease ICP</td>
<td>N/V related to Increased ICP</td>
<td>4–8 mg qam or bid, po (as pill or liquid), and IV</td>
<td>$</td>
<td>Agitation, insomnia, hyperglycemia</td>
</tr>
</tbody>
</table>

Abbreviations: AC, Before meals; EPS, extrapyramidal symptoms; HS, hour of sleep; GI, gastrointestinal; ICP, intracranial pressure; N/V, nausea/vomiting.

Data from UPMC supportive and palliative care pain card. University of Pittsburgh Medical Center, Pittsburgh, PA.

Table 6  
Opioid conversions

<table>
<thead>
<tr>
<th>Opioid Agonists</th>
<th>Parenteral mg</th>
<th>Oral mg</th>
<th>Duration of Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>10</td>
<td>30</td>
<td>3–4 h</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20–30</td>
<td></td>
<td>3–4 h</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1.5</td>
<td>7.5</td>
<td>3–4 h</td>
</tr>
<tr>
<td>Meperidine¹ (not recommended)</td>
<td>75</td>
<td>300</td>
<td>3 h</td>
</tr>
<tr>
<td>Fentanyl⁴</td>
<td>0.1³</td>
<td></td>
<td>1–2 h</td>
</tr>
<tr>
<td>Codeine</td>
<td>130</td>
<td>200</td>
<td>3–4 h</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1</td>
<td>10</td>
<td>3–6 h</td>
</tr>
</tbody>
</table>

¹ Equivalency for a 1-time dose of IV fentanyl only.

Data from UPMC supportive and palliative care pain card. University of Pittsburgh Medical Center, Pittsburgh, PA.
attorney for health care and/or physician orders for life-sustaining treatment are valuable resources. In cases of advanced directives, ED physicians need to pay attention to the intent of the directive, not only the specific instructions. Specifically, a DNR order does not equal “do not treat.” If time permits, gathering information from family, significant others, friends, and previous medical records can provide additional insight when making EOL decisions in an ED. EDs must have specific procedures that address ethical issues as well as policies outlining how to request a consult with the ethics committee.

Physicians and their patients must evaluate the use of technology at their disposal, keeping in mind that the patient and/or surrogate has the right to decide on goals of care and treatment options. ED physicians need to confirm that the goals of care represent the patient’s wishes. If a treating physician cannot meet a patient’s goals of care because of personal beliefs, it may be appropriate to transfer care to another physician. The American College of Emergency Physicians provides additional policies and guidelines for ED physicians and EOL care.

ED physicians have a responsibility to help EOL patients attain comfort by managing symptoms, such as anxiety or pain. Palliative care EOL patients should be kept as pain-free as possible so that they may die comfortably and with dignity. In addition, every effort should be made to honor patients’ wishes concerning the place in which they wish to die. “Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person’s life so long as the intent is not to hasten death.” It is a goal of care to make patients comfortable.

Futility

The term, futility, continues to be controversial because there are inconsistencies in definition and interpretation throughout the literature. The American College of Emergency Physicians suggests using terms, such as nonbeneficial, ineffectual, or having a low likelihood of success, when referring to medical interventions that may be unnecessary or unsuccessful.

Disputes among family members, patients, and physicians regarding the medical plan of care for EOL ED patients should be resolved through increased communications, use of available institutional resources, and policies. Another consideration for EDs physician is that of determining treatment goals when “defining an absence of benefit.” For example, it may be agreed to maintain ventilator support until family members can arrive at the bedside or maintain other medical interventions that support

<table>
<thead>
<tr>
<th>Drug</th>
<th>(Trade Name)</th>
<th>Route</th>
<th>Starting Dose</th>
<th>Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyoscyamine hydrochloride</td>
<td>Scopolamine</td>
<td>Transdermal</td>
<td>1 (~1 mg/3 d)</td>
<td>12 h</td>
</tr>
<tr>
<td>Hyoscyamine sulfate</td>
<td>Levsin</td>
<td>Drops, tabs (oral)</td>
<td>0.125 mg</td>
<td>30 min</td>
</tr>
<tr>
<td>Glycopyrrolate</td>
<td>Robinul</td>
<td>Pills (oral)</td>
<td>1 mg</td>
<td>30 min</td>
</tr>
<tr>
<td>Glycopyrrolate</td>
<td>Robinul</td>
<td>Injection (SC IV)</td>
<td>0.2 mg</td>
<td>1 min</td>
</tr>
<tr>
<td>Atropine</td>
<td>Atropine</td>
<td>Injection</td>
<td>0.1 mg</td>
<td>1 min</td>
</tr>
<tr>
<td>Atropine</td>
<td>Multiple</td>
<td>Sublinguala</td>
<td>1 gtt (1%)</td>
<td>30 min</td>
</tr>
</tbody>
</table>

* Use atropine ophthalmic drops.

a patient’s goal of seeing a granddaughter get married in a few days. Ultimately, treatment decisions should be based on standards of care, evidence-based data, and the patient and family wishes and goals of care as well as professional judgment. 

**Palliative Sedation**

Palliative sedation is often framed in ethical terms and is defined as “the use of specific sedative medications to relieve intolerable suffering from refractory symptoms by a reduction in patient consciousness, using appropriate drugs carefully titrated to the cessation of symptoms.” The primary ethical responsibility of physicians is to provide relief from suffering in a way that is consistent with the wishes, values, and norms of patients, their families, and medical professionals. The goal of palliative sedation is symptom relief. Many palliative care patients reaching the EOL are unable to find relief from severe symptoms, such as pain or shortness of breath. The goals of care may shift from those of “prolonging life and optimizing function to maximizing the quality of remaining life.”

Palliative sedation requires continuous monitoring by physicians experienced with the medications and palliative sedation. The administration of palliative sedation needs to be guided by an institution’s specific policies and procedures. The National Hospice and Palliative Care Organization recommends that each institution’s policies should address (1) criteria for administration of palliative sedation; (2) specific procedures for the administration of palliative sedation; (3) concomitant use of life-sustaining therapies, such as dialysis; (4) continuous education regarding clinical evidence and best practices; and (5) continuous quality improvement to monitor the use of palliative sedation in the institution.

**MANAGING THE ELDERLY UNDER HOSPICE CARE IN THE EMERGENCY DEPARTMENT**

Patients under hospice care often present to EDs for crisis events, and emergency clinicians who are familiar with the hospice model of care may be better able to guide EOL care for such patients. Eligibility for hospice is primarily based on a prognosis of living 6 months or less if the disease were to run its natural course. Patients may have any diagnosis to qualify for hospice care, and noncancer primary diagnoses now comprise more than half of all hospice admissions.

Arrival of a patient under hospice care to an ED does not automatically equate to hospice care termination nor does it imply that patient seeks aggressive interventions. Often, caregivers activate the 9-1-1 emergency response system as an automatic response to an inability to cope with patient deterioration. Hospice providers may initiate patient transfers to an ED if they are unable to fully address a distressing symptom or imminent deterioration. It should not be assumed that a patient who embraced the comfort-based hospice philosophy would automatically choose a DNR directive (DNR is not a prerequisite for hospice). Such end-of-life conversations may take time and further discussions, even in patients under hospice care. An initial assessment on ED arrival is needed to ascertain the underlying reasons (if any) for a shift in goals of care and the trigger for ED visit (Box 2).

A general management approach to ED management of patients under hospice care is listed in Box 3. It is important to highlight a multidisciplinary approach to optimizing care with early collaboration with hospice staff, social worker, and palliative team, if available. Effective communication with all members of the team and caregivers is essential to emphasize ongoing commitment to patient. In general, it is best to avoid diagnostic/therapeutic modalities that do not match overall patient goals of care.
Box 2

Common triggers for an emergency department visit by an elderly patient under hospice care

**Triggers related to patient health care issues**
- Poor control of symptoms especially pain, dyspnea, and delirium
- Loss or malfunction of a key support device, such as a tracheostomy or gastrostomy tube
- Inability to fill a new prescription (for example, pain medication on a weekend)
- New symptoms that require work-up (for example, fall and hip fracture in a patient with bone metastases)

**Triggers related to other patient and caregiver issues**
- Anxiety, fear, and inability to cope with impending loss of life
- Conflict about life-prolonging treatments (begun in past and discontinued or never started, for example, chemotherapy)
- Conflict with caregivers regarding approach to care (caregiver may want more aggressive interventions)
- Caregiver fatigue
- Dialing 9-1-1 as an automatic response to a perceived distress

**Triggers related to hospice system**
- Failure or inability to communicate with or address patient needs in a timely manner
- Equipment failure unable to be fixed in a timely manner (for example, home oxygen or nebulizer machine)
- Call initiated by hospice (unable to provide a particular aspect of care or patient is a full code)


Patients under hospice care with imminent clinical deterioration present a major management challenge in EDs. Delineating patient wishes and underlying disease status in a life-threatening situation is difficult when a patient is unable to communicate and the family or primary provider is not readily accessible. In such scenarios, the least-invasive modalities should be used first; however, imminent life-prolonging measures (ventilator) sometimes need to be instituted until it is determined that such measures are not desired and can then be withdrawn.

Challenges to implementation of pre-existing advance planning documents exist, including an unanticipated change in health status, interfamily conflicts, and issues with institutional protocols. Therefore, discussion of all relevant decisions ideally occurs in real time in EDs, with a rapid delineation of patient goals of care. At minimum, EDs identify these needs and get a palliative consult or communicate the need in the transition of care the same as would be done with a bowel obstruction and surgical consult. Withdrawal of preinstituted life-prolonging interventions may sometimes be necessary in EDs if it is later determined that these measures are not desired or in conflict with patient goals.

**REFERRING AN ELIGIBLE EMERGENCY DEPARTMENT PATIENT TO HOSPICE CARE**

Elderly patients with declining health and functional status and advanced disease have frequent ED visits, particularly in the last months of life, presenting a window of
### Box 3
#### Approach to the management of a patient under hospice care in the emergency department

1. Notify hospice provider as soon as possible.
   a. Hospice providers have an ongoing understanding of patient-related issues.
   b. Hospice is legally finanziamentally responsible for the patient's plan of care as well as medical costs related to the hospice-qualifying disease diagnosis.

2. Determine the main trigger for the emergency department visit.
   a. Pay attention not only to the distressing physical signs and symptoms but also to the underlying emotional and psychosocial issues.
   b. Involve social service/chaplaincy and palliative care team early, if needed.

3. Optimize management of distressing symptoms.
   a. Promptly address and optimize management of common distressing complaints related to pain, nausea, shortness of breath, altered mentation, and so forth.

4. Rapid goals of care discussions, especially if clinical deterioration is imminent.
   a. If imminent decisions are needed regarding the use of life-sustaining treatments (eg, intubation for respiratory failure), a rapid discussion of goals of care must occur.
      i. Determine the legal decision maker and review any completed advance directives.
      ii. Complete a rapid overall goals of care discussion (palliative team involvement early as needed).
      iii. Make clear recommendations, for example, “According to what you want for [the patient], I would/would not recommend....”

5. Care for the actively dying patient.
   a. Assess for cultural/spiritual needs and assure privacy.
   b. Identify family/patient preferences related to locations where patient could be safely transferred to for the dying process (eg, home, long-term care residence).
   c. Involve bereavement, chaplaincy, and palliative team support, as needed.

6. Carefully consider laboratory tests and diagnostics.
   a. May need to be limited or withheld until discussion with patient's hospice care team.
      i. Tests should be based on patient-defined goals of care.
      ii. Low burden, noninvasive means to reveal reversible pathology, or clarified prognosis should generally be used first.

7. Carefully consider therapeutic modalities.
   a. Management is based on patient-defined goals of care. Ensure that automatic algorithms (eg, antibiotics for pneumonia) are used only if they also meet patient goals of care.

8. Consider disposition based on patient goals and preferences.
   a. Determine after a discussion with hospice staff (and based on patient's goals).
   b. Return home with additional support or a direct admission to an inpatient hospice facility may be the best disposition rather than hospital admission (24-hour home support for those with difficult to manage symptoms is feasible).

9. Communicate plans of care clearly to patient or surrogate and hospice.
   a. The inpatient palliative care service (if available) and hospice should be notified if the patient is to be admitted to the hospital.
   b. Patient/caregiver should be made aware of next steps in plan of care (for example, a discharge home on adjusted pain medications or in-patient hospice).

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Box 4
Approach to the management of a patient under hospice care in the emergency department

1. Assess patient eligibility for hospice care (Medicare Hospice Benefit guidelines).
   a. Does the patient have a prognosis that is 6 months or less if the disease runs its expected course?
   b. Ask the surprise question, “Would I be surprised if this patient died within the next 6 months?”

2. Discuss disposition to hospice care with the primary care provider for the patient.
   a. Discuss the current condition, prognosis, and prior goals of care conversations and proposed enrollment to hospice.
   b. Ask if the provider is willing to be the follow-up and continuing care physician of record for hospice.

3. Assess whether the patient goals of care are consistent with the hospice philosophy by asking clarifying questions:
   a. “What have you been told about the status of your illness and what to expect in the near future?”
   b. “Has anyone talked to you about your prognosis and how much time you likely have?”
   c. “Are there any plans for new treatments that will help you extend your life?”
   d. “What do you know about hospice?”

4. Introduce hospice as a care system to the patient and family.
   a. Discuss the core aspects of hospice and how some specific resources can help the patient (eg, 24/7 on-call assistance, home visits for symptom management, emotional, and chaplaincy support).
   b. Address concerns and clarify misconceptions.
   c. Phrase recommendations for hospice care in positive language, grounded in the patient’s own goals: “I think the best way to help you stay at home, avoid the hospital, and stay as fit as possible for whatever time you have left is to receive hospice care at your home.”

5. Make a referral to hospice.
   a. When calling a hospice agency, anticipate commonly asked questions:
      i. What is the terminal illness or hospice qualifying diagnosis?
      ii. Who will be the following physician? (see Step 2)
      iii. What equipment will be needed immediately (eg, home oxygen)?
      iv. Is there a caregiver at home?
      v. What is the patient’s code status?

   (A directive is not necessary for enrollment, but the hospice team needs to be aware of code status.)

6. Write orders.
   a. Sample ED-initiated hospice referral orders:
      i. Evaluate and admit/enroll Mr/Mrs________ in hospice care.
      ii. Terminal diagnosis: __________.
      iii. Expected prognosis: terminal illness with a less than 6-month survival likely if the disease runs its normal expected course, or more specific as needed.
      iv. Dr __________ will follow the patient in hospice.
opportunity to assess patient needs/goals of care and initiate discussions about hospice in eligible patients.\textsuperscript{35,96,100,103,106} Hospice may be considered in eligible patients when the pre-eminent care goal is relief of symptoms, such that they want therapy aimed at maintaining quality of life, without a major focus on life prolongation.\textsuperscript{103}

Studies demonstrate that hospice enrollment may (1) provide optimal support for terminal disease-related physical and psychosocial symptoms, (2) provide assistance to family and caregivers with improved well-being as well as bereavement outcomes, (3) lead to increase in overall patient, family, and physician satisfaction with care at EOL, and (4) have an impact hospital outcomes, such as reduction in hospital length of stay, total health care expenditures, and repeat ED visits.\textsuperscript{34,103,107} Hospice remains an underutilized resource, however.\textsuperscript{34,35,97,103} Of the 2.4 million deaths in the United States in 2007, 38\% of patients received hospice care. The median length of service under hospice is approximately 20 days with approximately one-third of patients receiving hospice care for 7 days or fewer.\textsuperscript{97} Thus, many eligible patients if considered for hospice are enrolled too late in the course of disease to realize the full benefit of hospice.\textsuperscript{34,97}

A stepwise approach to hospice referral is recommended, and assessing eligibility is the key initial step (Box 4). Effective communication about next steps with family and primary care provider is essential.\textsuperscript{34,35,96,100} Hospice care is preferably set up at a location the patient calls home (a private residence or long-term care facility) and direct admissions to some hospice facilities can also occur. Patients can usually be enrolled in hospice care within 24 to 48 hours of referral. If a patient cannot be discharged home safely, observation versus short inpatient admission may be needed.\textsuperscript{100}

### MANAGING THE ACTIVELY DYING PATIENT IN THE EMERGENCY DEPARTMENT

Two distinct death trajectories have been recently discussed in ED literature: the so-called spectacular death—a resource-intensive event, for example, a traumatic, sudden event in a young person where multiple personnel are involved, and the so-called subtacular death, for example, ED death of an older person with a DNR directive who enters the final actively dying phase after a prolonged chronic illness.\textsuperscript{106} Although it is important to give families a general idea of how long a patient might live, it is also necessary to advise them about the inherent unpredictability of the moment of death.\textsuperscript{107–109}

It is important for clinicians to recognize the many physiologic changes related to the syndrome of imminent death.\textsuperscript{107,109,110} An understanding of the underlying pathophysiology helps ED clinicians address each symptom effectively, support the family, and address concerns (Table 8). It may be helpful to reiterate that patient experiences may be different from what family perceives, for example, thirst issues may concern a family when oral intake declines but may not be distressing to the patient. Even though the loss of a loved one may have been expected for some time, family may

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7. Ensure patient and surrogates understand the plan and next steps.
   a. Communicate the next steps after discharge from ED.
   b. Provide the name and contact number for hospice agency.

## Table 8  
**Recognizing the signs and managing the actively dying patient in the emergency department**

<table>
<thead>
<tr>
<th>Changes as Death Approaches</th>
<th>Signs</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Fatigue</strong></td>
<td>Inability to move or to lift head off pillow</td>
<td>Need not be treated (medications to manage fatigue may be discontinued)</td>
</tr>
<tr>
<td><strong>2. Cutaneous ischemia</strong></td>
<td>Erythema or skin breakdown (pressure ulcers)</td>
<td>• Turn frequently, cushioning and air mattress</td>
</tr>
</tbody>
</table>
| **3. Decreased oral intake of food** | • Anorexia  
• Progressive weight loss (temporal wasting prominent) | • Dehydration/ketosis in the last hours may not cause distress, may stimulate endorphin release and promote sense of well-being
• Family support to explain the process |
| **4. Decreased oral intake of fluids** | • Dry mucous membranes | • Moisten oral mucosa often (artificial saliva, ice chips)  
• Lubricate lips/nose with petroleum jelly |
| **5. Cardiac and renal dysfunction** | • Tachycardia  
• Decreased blood pressure  
• Cool, clammy, and pale skin  
• Cyanosis  
• Livedo reticularis  
• Dark urine and oliguria | Parenteral fluids not usually indicated if patient death is imminent because they may not reverse circulation shutdown |
| **6. Neurologic dysfunction** | • Decreasing level of consciousness (drowsy, nonresponsive to stimuli)  
• Decreased communication (monosyllabic responses, nonverbal)  
• Loss of swallowing ability  
• Incontinence  
• Loss of ability to close eyes  
• Death rattle (gurgling oropharyngeal and endobronchial secretions) | • Encourage family to talk to patient as if patient were conscious  
• Frequent artificial tears to avoid dry eyes  
• Encourage family to give the patient permission to let go (“We will miss you but we will be OK”)  
• Oropharyngeal suction may not be helpful  
• Scopolamine or glycopyrrolate (0.2 mg SC every 4 h as needed) to decrease secretions |
| **7. Respiratory dysfunction** | • Increased or decreased rates  
• Abnormal respiratory pattern (Cheyne-Stokes or agonal) | Reassurance to family |
| **8. Pain** | Facial grimacing | • Discontinue routine dosing or continuous infusions of morphine when renal clearance decreases and administer when needed  
• Recognize that grimacing/agitation may be signs of delirium and added opioid doses may worsen same |

(continued on next page)
require intense support in these last hours; and allowing to be spent with the body may assist caregivers with acute grief.107,111

SUMMARY

It is impossible to put all aspects of palliative care into one article. The authors’ objective is to give readers a broad overview of general principles. Geriatric care in EDs, by the nature of the specialty, must include an understanding of disease trajectory, prognostication, and symptom management in EOL as well as the psychosocial needs of dying patients and their families.

An understanding of palliative medicine is important for several reasons: palliative and hospice medicine is a subspecialty of EM; patients have the need for clinicians to have this expertise; and most people want to die in familiar surroundings. With knowledge of this subspecialty, physicians can help patients be symptom-free and transition care to a more appropriate venue, whether home with visiting nurses or in hospice care. Clinicians’ knowledge of all aspects of palliative medicine helps patients better understand their disease and symptom and better meet their goal of care.

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103. Meier DE. Increased access to palliative care and hospice services: opportunities to improve value in health care. Milbank Q 2011;89:343–80.