The Case for Palliative Medicine in the Emergency Medicine Department – The Time is Now!

Emergency medicine (EM) is a relatively new specialty in our country, aimed at treating and stabilizing the acutely sick with life-threatening illnesses usually under constraints of time. EM training revolves around dealing with patients across specialties using structured protocols and resuscitation modules with the aim of preserving and promoting life. This would often include rapid treatment decisions such as the need for airway intervention like invasive ventilation, the use of vasopressors, and renal replacement therapy. Often, these decisions are unloaded onto the patient attenders in haste, and important decisions are to be made quickly in order to expedite better patient care. This becomes further complicated as Indian medical systems are often burdened with too many patients (average attendance in a private medical college EM department, emergency department [ED], can vary between 150 and 250, the number touches 500 in a government college ED) with an embarrassingly low number of health-care professionals.

The patients presenting to the ED can be of two types, acute, wherein the illness presents unexpectedly and rapidly (myocardial infarction, trauma, and sepsis) or, chronic, with patients presenting in “crisis” with a known illness such as chronic kidney disease, chronic liver disease, and malignancy. The principles of treatment for the two sets of patients remain the same; however, the requirements and expectations from the patient bystanders could vary. With the complexities of an ED as mentioned above, emergency physicians (EPs) seldom get adequate time to discuss with patients and relatives about their wishes and concerns, thereby compromising on holistic treatment decisions.

With improving health-care facilities and better public health access in India, the life expectancy has increased which has led to an increase in patients presenting with chronic illnesses to the ED often acutely and at times at unsalvageable scenarios. Three distinct chronic illness trajectories of dying are commonly described: advanced cancer, organ failure, and chronic frailty.[1] Patients with cancer usually start with a high-functioning state followed by a sharp decline as the disease progresses. The organ failure trajectory is marked with acute exacerbations of the underlying illness with multiple ED visits and a progressive decrease in function. Patients with chronic frailty have low baseline function which further reduces with time. The fourth trajectory described is that of sudden death in an otherwise healthy individual. An understanding of these trajectories by an EP would help in prognostication and guide the end-of-life treatment decisions better which would overall improve the quality of care.

Even though the ED is witness to death and the dying, core training in EM is still lacking in principles of care of the dying, and although the Royal College of Emergency Medicine does have a guidance document about end-of-life care (http://www.rcem.ac.uk, 2015), its use has not been translated into clinical practice.[2] There is evidence that shows the integration of principles of palliative medicine with EM could help achieve a more holistic approach to our patients in the ED and make interventions which not just prolong life but also gauge the quality.[3] Across the globe, there are no protocols in EM for the care of the dying and “judicious resuscitation,”[4,5] although the need has now been recognized with newer studies focusing on the barriers to the integration of palliative medicine and EM.[6] Some of the issues delineated include inherent EM training concerns such as the perception of staff that all patients require aggressive modes of resuscitation, with the focus on living and not dying,[6] and also that the staff perceives death as a failure.[7] Shearer et al. found that ED staff were confident in palliative symptom care but lacked the understanding of patients in whom palliative approach would benefit and sought training in better communication and ethical issues involved.[8] The usual suspects such as the lack of time, space, and resources have also been reported. However, one of the most significant and challenging barriers is the ideological change that an EP must incorporate in order to shuttle between aggressive resuscitation and providing good palliative care in the same setting. One of the proposed ideas to tackle this would be having robust treatment protocols; however, as acknowledged, the decisions would be complex and not a simple algorithm. There is evidence that more research is needed to fully integrate these initiatives into practice.[9]

EM has made rapid strides by incorporating several skill sets such as ultrasound, EM-critical care training, and even advance pain relief techniques such as nerve blocks and epidurals. With academic EM gradually finding its feet in medical education training, integration of palliative medicine principles would benefit the EP immensely. The new competency-based medical education curriculum for MBBS students will have an introduction to palliative medicine which is a step in the right direction. Furthermore, programs such as Education in Palliative and End-of-Life Care for EM trainees and consultants could help sensitize EPs toward the need for palliative care principles for the appropriate set of patients.

EM is a time-bound specialty, and institutional-level integration of both the specialties could not come fast enough. The time is now!

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

There are no conflicts of interest.
Letters to Editor

William Wilson
Department of Emergency Medicine, Kasturba Medical College, MAHE, Manipal, Karnataka, India

Address for correspondence: Dr. William Wilson, C/O, Department of Emergency Medicine, Kasturba Medical College, MAHE, Manipal - 576 104, Karnataka, India. E-mail: drwillwilson@gmail.com

Submitted: 02-Mar-20 Revised: 13-Apr-20 Accepted: 24-Mar-20 Published: 29-Aug-20

REFERENCES

1. Pal YR, Kuan WS, Koh Y, Venugopal K, Ibrahim I. Death among elderly patients in the emergency department: A needs assessment for end-of-life care. Singapore Med J 2017;58:129-33.
2. McCallum KJ, Jackson D, Walthall H, Aveyard H. Exploring the quality of the dying and death experience in the emergency department: An integrative literature review. Int J Nurs Stud 2018;85:106-17.
3. Lamba S, Pound A, Rella JG, Compton S. Emergency medicine resident education in palliative care: A needs assessment. J Palliat Med 2012;15:516-20.
4. Chan GK. End-of-life models and emergency department care. Acad Emerg Med 2004;11:79-86.
5. Chan GK. End-of-life and palliative care in the emergency department: A call for research, education, policy and improved practice in this frontier area. J Emerg Nurs 2006;32:101-3.
6. Wolf LA, Delao AM, Perhats C, Clark PR, Moon MD, Baker KM, et al. Exploring the management of death: Emergency nurses’ perceptions of challenges and facilitators in the provision of end-of-life care in the emergency department. J Emerg Nurs 2015;41:e23-33.
7. Bailey C, Murphy R, Porock D. Professional tears: Developing emotional intelligence around death and dying in emergency work. J Clin Nurs 2011;20:3364-72.
8. Shearer FM, Rogers IR, Monterosso L, Ross-Adjie G, Rogers JR. Understanding emergency department staff needs and perceptions in the provision of palliative care. Emerg Med Australas 2014;26:249-55.
9. Houben CH, Spruit MA, Groenen MT, Wouters EF, Janssen DJ. Efficacy of advance care planning: A systematic review and meta-analysis. J Am Med Dir Assoc 2014;15:477-89.

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

How to cite this article: Wilson W. The case for palliative medicine in the emergency medicine department – The time is now! Indian J Palliat Care 2020;26:395-6.