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.[3] 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!

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Conflicts of interest

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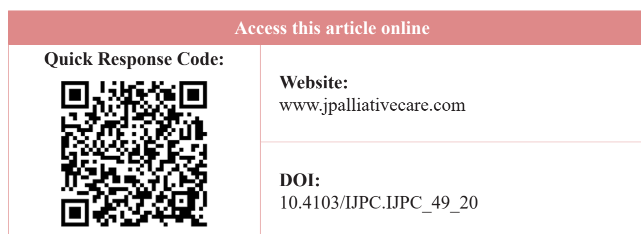
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