Published in final edited form as:

Ann Emerg Med. 2016 July ; 68(1): 40–42. doi:10.1016/j.annemergmed.2015.11.006.

Resuscitating End-of-Life Care

Eric M. LeFebvre, MD and Timothy F. Platts-Mills, MD, MSc*

Department of Emergency Medicine (LeFebvre, Platts-Mills) and Department of Medicine (Platts-Mills), University of North Carolina, Chapel Hill, NC

If your problem is fixable, we know just what to do. But if it isn't?

—Atul Gawande, *Being Mortal*

This year in the United States, approximately 2.5 million people will die. Individuals aged 65 years and older will account for approximately 70% of these deaths, and among these older adults, 42% will die in the hospital.^{1,2} In most of these 700,000 cases, the physician caring for the patient will have known the patient less than a week.³ However, physician attitudes toward these older, dying patients shape the experience of patients and families during their final moments, so much so that patients identify trust and confidence in their physician as the most important factor during end-of-life care.⁴ The Institute of Medicine's 2014 report *Dying in America*⁵ identified a number of structural factors that negatively affect end-of-life care, including limited access to palliative care and social services and a fragmented care delivery system with misaligned financial incentives. Physician education in palliative care was a core recommendation of the Institute's report. But little was said of the underlying attitudes of physicians toward dying patients, perhaps because attitudes are hard to characterize or change or perhaps because so little is known.

In this month's *Annals*, Fassier et al⁶ present a methodologically sound qualitative study of the attitudes and thought processes of French emergency and critical care physicians caring for critically ill older adults. Through more than 300 hours of interviews with 24 physicians, linked to direct observation of decisionmaking, the authors provide a broad description of how physicians perceive these patients and interact with one another and how these perceptions and interactions influence care. The results are not pretty, but the problems identified provide a starting point for improving how we care for critically ill older adults.

One group of problems involves poor relationships between emergency physicians and other providers. Methods of increasing access to geriatrician and palliative care specialists for emergency department (ED) patients have been described, and, where available, these partnerships may help define goals of care and suggest ways to achieve them.⁷ Improving the quality of communication between emergency physicians and admitting physicians, particularly critical care physicians, also makes sense. Echoing findings from both medical error and aviation safety research, Fassier et al⁶ find that failures in communication during the admission of dying patients are not simply a failure to exchange information but are complicated by tensions caused by perceived or real hierarchic relationships.^{8,9} As

---

*Corresponding Author. tplattsm@med.unc.edu.

elsewhere in medicine, these tensions must be recognized and resolved to optimize patient care. Although not observed in this study, contacting primary providers can be helpful as a way to reach consensus around an appropriate care plan and as a way to communicate to the patient and family that the emergency physician and the primary provider care about the patient and want to honor his or her values.¹⁰

A second problem is the lack of access to information about end-of-life preferences for critically ill patients when they arrive in the ED.^{11,12} Even in Oregon, where the Physician Orders for Life-Sustaining Treatment form was developed, only approximately 30% of people who die of natural causes have a registered form.¹³ We need to increase uptake of this essential communication tool.^{14,15} Substantive conversations with patients about their mortality are difficult for physicians and, when the prognosis is poor, are likely to be perceived by patients as lacking compassion.¹⁶ Recent approval of a Medicare plan to reimburse discussions about end-of-life care should help physicians find the time to engage in these important conversations.^{17,18} Opening this reimbursement mechanism to all physicians, including emergency physicians, would presumably be a useful extension. A shift to a value-based health care system may provide further impetus for physicians to work with older adults to define and honor care goals.¹⁹

A third problem, and perhaps the most difficult to resolve, is the frustration that Fassier et al⁶ observe among emergency providers caring for these older, dying patients. One of the most striking representations of this frustration is this line from an emergency physician: “Another old woman?! And with Parkinson’s disease? I’m fed up with resuscitating these old sticks!” Further, Fassier et al⁶ find evidence that negative attitudes toward dying older adults sometimes result in poor decisionmaking, such as the hasty and incorrect diagnosis of a brain stem stroke in a patient with a decreased level of consciousness because of sepsis.

This frustration appears to come from several directions. Sometimes we are frustrated because the patient or family wants life-prolonging care and we know that this approach is likely only to increase suffering. Perhaps we are right to be frustrated by this situation, but we should not let that influence our attitude toward the patient. Rather, we should show compassion, earn the trust of our patients, and look for an opportunity to gently educate about prognosis and care options. Sometimes we are frustrated because we do not know what the patient and family want. This is a time to listen and, if forced to act, to do our best to make a decision that is respectful of the patient. Sometimes we are frustrated because the patient simply wants to die, and we have a hard time shifting from our usual image of ourselves as physicians who save lives to physicians who hold hands, turn off the monitors, and start a morphine drip.²⁰

In all of these cases, our work will be easier and our care better received if we take pride in the important responsibility of supporting dying patients and their families. One way to cultivate this pride may be to borrow the approach used for other critically ill patients. Trauma activations, code STEMI, and early aggressive therapy for sepsis have been embraced by the emergency medicine community because the protocols for evaluation and treatment are well defined and the potential benefit to the patient is large. Perhaps what we need now is a “code comfort.” Admittedly, deciding when to initiate such a code is going to

be more difficult than interpreting an ECG or measuring a lactate level. And once initiated, the care path probably will not follow a simple algorithm, and the resources mobilized will likely vary, depending on the needs of the situation. Perhaps a code comfort would not depend on external resources at all, but rather serve simply to make explicit for the physician and nurse the understanding that caring for this dying patient is important work. The value of a code comfort would be the potential to improve the final hours of a chronically ill or frail patient, as well as the much longer-lasting memories of the family. In the age of ECMO, IATPA, TXA, and IABP, we need to be mindful that caring is essential even when curing is no longer possible or appropriate. No person receiving care in a modern ED should have to die alone, without dignity, or without a physician equipped with the tools to demonstrate compassion.

Acknowledgments

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist and provided the following details: Dr. Timothy Platts-Mills is supported by a career development award from the National Institute on Aging (K23 AG038548).

References

1. Kochanek, KD., Murphy, SL., Xu, JQ., et al. Mortality in the United States, 2013. NCHS data brief, no 178. Hyattsville, MD: National Center for Health Statistics; 2014. p. 1-8.
2. Broad JB, Gott M, Kim H, et al. Where do people die? an international comparison of the percentage of deaths occurring in hospital and residential aged care settings in 45 populations, using published and available statistics. *Int J Public Health*. 2013; 58:257–267. [PubMed: 22892713]
3. Redinbaugh EM, Sullivan AM, Block SD, et al. Doctors' emotional reactions to recent death of a patient: cross sectional study of hospital doctors. *BMJ*. 2003; 327:185. [PubMed: 12881257]
4. Heyland DK, Dodek P, Rocker G, et al. What matters most in end-of-life care: perceptions of seriously ill patients and their family members. *CMAJ*. 2006; 174:627–633. [PubMed: 16505458]
5. Institute of Medicine. Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. Washington, DC: National Academies Press; 2015. Committee on Approaching Death: Addressing Key End of Life Issues.
6. Fassier T, Valour E, Colin C, et al. "Who am I to decide whether this person is to die today?" Physicians' life-or-death decisions for elderly critically ill patients at the emergency department/ICU interface: a qualitative study. *Ann Emerg Med*. 2015 ■■■:■■■.
7. Quest T, Herr S, Lamba S, et al. Demonstrations of clinical initiatives to improve palliative care in the emergency department: a report from the IPAL-EM Initiative. *Ann Emerg Med*. 2013; 61:661–667. [PubMed: 23548402]
8. Sutcliffe KM, Lewton E, Rosenthal MM. Communication failures: an insidious contributor to medical mishaps. *Acad Med*. 2004; 79:186–194. [PubMed: 14744724]
9. Gladwell, Malcolm. *Outliers*. New York: Little, Brown and Company; 2008. The ethnic theory of plane crashes; p. 177-223.
10. Shenvi CL, Tintinalli JE. Dr. Tintinalli on end-of-life decisions. *GEMCAST: Geriatric Emergency Medicine Podcast*. 2015
11. Bakitas M, Lyons K, Hegel MT, et al. Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: the Project ENABLE II randomized controlled trial. *JAMA*. 2009; 302:741–749. [PubMed: 19690306]
12. Phipps E, True G, Harris D, et al. Approaching the end of life: attitudes, preferences, and behaviors of African-American and white patients and their family caregivers. *J Clin Oncol*. 2003; 21:549–554. [PubMed: 12560448]

13. Fromme EK, Zive D, Schmidt TA, et al. Association between physician orders for life-sustaining treatment for scope of treatment and in-hospital death in Oregon. *J Am Geriatr Soc*. 2014; 62:1246–1251. [PubMed: 24913043]
14. Jesus JE, Geiderman JM, Venkat A, et al. Physician orders for life-sustaining treatment and emergency medicine: ethical considerations, legal issues, and emerging trends. *Ann Emerg Med*. 2014; 64:140–144. [PubMed: 24743101]
15. Hickman SE, Keevern E, Hammes BJ. Use of the physician orders for life-sustaining treatment program in the clinical setting: a systematic review of the literature. *J Am Geriatr Soc*. 2015; 63:341–350. [PubMed: 25644280]
16. Tanco K, Rhondali W, Perez-Cruz P, et al. Patient perception of physician compassion after a more optimistic vs a less optimistic message: a randomized clinical trial. *JAMA Oncol*. 2015; 1:176–183. [PubMed: 26181019]
17. Centers for Medicare & Medicaid Services. Dept of Health and Human Services. Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016. Washington, DC: Daily Federal Register; 2015. p. 41685-41966.
18. Belluck P. Medicare plans to pay doctors for counseling on end of life. *The New York Times*. 2015 Jul 9.:1. Section A.
19. Schenker Y, Arnold R. The next era of palliative care. *JAMA*. 2015; 314:1565–1566. [PubMed: 26334719]
20. Bailey C, Murphy R, Porock D. Trajectories of end-of-life care in the emergency department. *Ann Emerg Med*. 2011; 57:362–369. [PubMed: 21131103]