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VIEWPOINT

The Emergency Physician and End-of-Life Care

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The scene is now familiar. The dying patient is rolled into the emergency department in cardiac arrest. The emergency team rushes to the patient's side and begins medical treatment. A tube is placed in the patient's trachea, lines are started, medications are given, and a defibrillator shocks the patient. Valiantly, the medical team snatches the patient from the jaws of death back into the realm of the living. The patient has made it through the cardiac arrest and will survive.

The reason this scene is now familiar is that a number of medical shows commonly portray this course of events, getting a lot of the details right, even though they get one important thing wrong: resuscitation is usually unsuccessful, even with today's advanced technology. For every 6 patients for whom resuscitation attempts are begun, only 1 survives to be discharged from the hospital. (But there's no reason for the TV shows to be accurate; it would make for boring and depressing television to see 5 out of every 6 attempts at resuscitation fail.)

Even if the television shows don't portray the outcome of resuscitation accurately, they do convey the sense of failure that emergency physicians feel when resuscitation is not successful and the patient dies. Traditionally, emergency physicians were trained to save lives and to stave off death at all costs. The technique of cardiopulmonary resuscitation (CPR) was originally developed to treat unexpected and reversible cardiac arrest -- those cases where the patient was still relatively healthy, but the heart had stopped due to an electrical abnormality that could quickly be reversed. The technique was soon extended, however, to everyone who experienced cardiac arrest, which, of course, meant all dying patients. Nonetheless, many patients still die in the emergency department, despite our best efforts. (Emergency physicians see the second highest number of patient deaths, fewer than oncologists, but more than cardiologists.)

The Real-life ED

In general, there are two broad categories of dying patients in the ED -- those with unexpected sudden death and those who have a terminal disease and are inevitably dying. The former cases are the stuff of valiant and sometimes heroic efforts, e.g., reviving a child with hypothermia in cardiac arrest, or saving the life of a middle-aged patient with heart disease who has an arrhythmia by using the defibrillator to shock the heart back to a normal rhythm. The latter types of cases, e.g., an elderly patient who is dying from cancer because nothing more can be done, or a patient

with amyotrophic lateral sclerosis (ALS) who requests that life-sustaining medical treatment not be attempted, were not well-handled or well-taught in a field where intervention and action were the orders of the day.

Emergency physicians were reluctant to discuss these latter cases of expected death, since the emergency department was for saving lives, not letting them end. The old emergency department rules were simple: (1) when in doubt, resuscitate and (2) always doubt. That is, always err on the side of life and resuscitate. CPR was applied to almost all patients in cardiac arrest, even in cases when family members told physicians that the patient should not receive it or would not want it. Emergency physicians, though trained in resuscitation, were not trained in the care of the patient who is dying. This resulted in their attempting to resuscitate a patient who was imminently dying, whether or not it would work, or in spite the fact that this patient's own wishes may have been to forgo resuscitation. The patient was often placed on life support and admitted to the hospital, where he or she may have lingered on life support until the inevitable death occurred.

Under the best circumstances, a dying patient's primary physician might arrange that the ambulance or family transporting the patient bypass the emergency department and admit the patient to a bed in the hospital where compassionate care could be administered and life-sustaining medical treatments withheld. But more often, family members who experienced the distress of their loved one dying called the emergency medical system, and paramedics, by standard protocol, transported the patient to the nearest emergency department where the cascade of interventions began. Some emergency physicians were even known to admonish families with, "if you didn't want an emergency response, you shouldn't have dialed 911."

Sometimes patients were allowed to die in the emergency department without attempts at resuscitation, but emergency physicians often did not understand how to provide appropriate comfort care to those patients. Maren Monsen, an emergency physician, produced a documentary called "The Vanishing Line," which portrayed, among other things, her distress when a patient who was dying (and was not going to be resuscitated) was brought to the emergency department and placed in a room alone to die without any comfort measures. Her distress motivated her to consider how physicians should treat patients at the end of life.

Emergency physicians were also reluctant to prescribe and administer narcotic pain medication to patients who were dying. They had not been trained to distinguish those for whom large doses of pain medication were appropriate because of their suffering at the end of life from those not facing death who were merely addicted to pain medications and using the emergency department to obtain the drugs. They were also afraid that if they gave enough medication to relieve the patient's pain, they might also inadvertently hasten the patient's death.

Important Changes in ED Customs

Two important developments have changed these customs. The first was the development of do-not-resuscitate (DNR) orders and pre-hospital DNR orders. DNR orders recognize that some patients -- whether because of the uselessness of attempting resuscitation or because of the patient's wishes to forgo resuscitation -- should not receive CPR. DNR orders were also developed which apply beyond the hospital, to the pre-hospital arena of the emergency medical system.

Patients are now able to express their wishes to forgo resuscitation and other life-sustaining medical treatment, either verbally, or in written directives to their physicians before they become incapacitated and can not communicate. The most common types of these "advance directives" are the living will (a direction to the physician to forgo life-sustaining medical treatment if the patient has a terminal condition or is in a persistent vegetative state) and the power of attorney for health care (an appointment of an agent to act as health care decision maker when the patient is incapacitated).

The second important development was the emergence of palliative care as a field of special expertise. With its emphasis on care rather than cure, this field has changed the way medicine and emergency physicians approach end-of-life care. Palliative care principles identify methods of comfort care and means for conferring adequate pain relief, including the principle of double effect, which recognizes that appropriate pain relief in end-of-life care (which may, on occasion, inadvertently hasten a patient's death), can and should be differentiated medically, ethically, and legally from intentionally hastening a patient's death.

Educating Emergency Physicians to End-of-life Care Needs

Important outreach efforts have been made, such as the Education for Physicians on End-of-Life Care (EPEC) Project, originated at the American Medical Association, funded by the Robert Wood Johnson Foundation and now sponsored by Northwestern University Medical School. This 16-module program has been educating physicians, including emergency physicians, on medical, legal, and ethical aspects of end-of-life care around the country.

With training, emergency physicians can now identify those for whom comfort care is more appropriate than attempts to resuscitate or other life-sustaining measures. And they now have the ability to care for these patients and to consult and collaborate in their treatment with their colleagues in palliative care. Emergency physicians are also learning that expected death is not necessarily an impending failure but rather an opportunity to successfully care for the patient at the end of life.

Emergency physicians' treatment of patients at the end of life has thus broadened. Trained in the past to work exclusively toward saving lives, they are now being trained to care with comfort and compassion for those who face expected death.

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