Blog of the Month

January 2020
Written by Anna Chisholm

End-of-Life Care in the Emergency Department

Like so many junior doctors, earlier this year the final rotation of my Foundation Programme was altered, and I found myself spending an additional 4 months in an area of medicine that I was not overly keen upon, accident and emergency. Despite enjoying my first few months of emergency medicine, gaining a vast amount of knowledge and skills, I was ready to move on and the prospect of spending another 4 months on a grueling 1 in 2 weekend rota, in the middle of a pandemic, was something that filled me with apprehension.

However, it is during these last few months I have been able to see a different side of a speciality I feel much more passionate about, palliative care. At a Clinical Educator meeting, my supervisor asked, 'what would you like to do as a future career?', I replied palliative care. They responded, as many clinicians do, that palliative care is an essential and very worth-while area of medicine, especially end-of-life care, something that can be very challenging in the fast-paced Emergency Department.

Prior to the Covid-19 pandemic, I did see unwell patients come into the Emergency Department. Some were elderly with multiple co-morbities who had been 'off legs' for a few days, others who had acutely developed pain (whether that chest, abdominal or little finger) needing urgent review, a few who were normally very well but due to being in the wrong place at the wrong time had ended up in trauma situations and many more in between. Most often, these patients were promptly shipped off to the relevant specialities, hoping to never have to attend the Emergency Department again.

However, Covid-19 brought a new set of unwell patients into the Emergency Department, many were pre-alerted (an act where paramedics contact a hospital ahead of time to ensure a medical team are awaiting the patient's arrival, often used in emergency and time critical scenarios) due to concerning vital signs such as low oxygen saturations or high temperatures. And with no visitors being allowed in hospital, these patients arrived into the busy, noisy environment of the Emergency Department alone.
As a junior doctor, I did my best to care for these patients, taking a history (when able), ordering investigations and providing initial management. Often, after discussing with a senior colleague, a patient would be reviewed by the Intensive Care Team who had to make very difficult decisions as to who it would be appropriate to offer invasive management to and who it would not be, evaluating a host of factors, including bed availability. But for some, who were very unwell, the most appropriate management was to acknowledge that the patient was dying and make comfort, along with symptom management, as part of end-of-life care, the priority.

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One particular patient that has remained in my thoughts for many weeks, is a lady who presented to the Emergency Department late one Friday evening, with a few days history of gradually worsening shortness of breath, dry cough and fevers. The lady had a recent diagnosis of colon cancer with lung metastases, to be managed conservatively and over the last few months had slowly become house-bound. It was apparent the lady was unwell when she arrived at the Emergency Department, scoring a 10 on her National Early Warning Score.
I reviewed the patient, gaining very minimal history. Throughout the lady lay still on a hospital trolley, appearing very tired and frail. I was aware the patient was very unwell and discussed the patient and their story with the senior registrar on shift who kindly reviewed the patient with me promptly. Despite our best efforts, it became apparent the patient was deteriorating quickly. With senior support, I contacted the lady's family and updated them on their loved one's condition. The patient's family were offered the opportunity to visit the hospital, to be with their relative as long as they wore Personal Protective Equipment (PPE).

When the lady's family arrived, a senior colleague and I updated them at the bedside. Although they were aware their loved one was unwell with a terminal cancer diagnosis they were shocked by how frail and small she looked in a hospital bed. The lady's family remained with her, until the time of her death, only but a few hours after entering the Emergency Department. The medical and nursing staff during this time did their best to care for the patient and their family. The lady was transferred to a hospital bed rather than a trolley, observation machines were moved out of the room to allow extra room for chairs, anticipatory medications given promptly when needed, unlimited amounts of tea and biscuits provided, chaplaincy contacted and asked to come in urgently and after the patient's death support and guidance given to the family in the form of a kind words and a care pack.

Being part of this experience, I could not be prouder to witness the end-of-life care provided by my colleagues in the Emergency Department. I had seen many manipulate limbs, perform life-saving chest compressions and cannulate even the most difficult of patients but it was these simple gestures to both the patient and their families in their time of needed which stood out. Prior to working in accident and emergency, I had not appreciated how much palliative care can take place in the Emergency Department, whether this be symptom management, helping to prevent a hospital admission, arranging extra support at home to prevent career burnout and end-of-life care, helping people to die in their preferred location.

Over the next few months, I would see this scenario enfold many more times and know there will be thousands of other examples up and down the country. The Emergency Department for the vast majority would not be where they would choose to die, but as with a lot of medicine, things can change very differently. When I started my Emergency Medicine rotation, I thought seeing death in the Emergency Department would involve a new wallpaper of blood after a large trauma case. More recently however, in these unprecedented times, this has not been the case. The Covid-19 pandemic has greatly affected all of our lives, has sadly took the lives of many loved ones and unfortunately is still ongoing, with the

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repercussions likely to be witnessed for many years. Regardless of this, experienced healthcare staff continue to provide excellent care, including end-of-life care, making the most undesired situations a little more bearable, even behind a facemask and gown.

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