Palliative Care for the End-of-Life Cancer Patients in the Emergency Department in Iran

To the Editor:

A 35-year-old female with main diagnosis of advanced metastatic pancreatic cancer was admitted to the Emergency Department (ED) with severe pain and delirium. She was cachectic and extremely agitated. While she was in delirious situation she continuously asked for "a pill" to relieve her abdominal pain. The patient spent 48 hours in the ED and underwent various tests and consultations:

1. From ED to Internal Medicine Department (IMD): They ordered regular lab tests and some prescription for hyperkalaemia.
2. From ED to Anaesthesia department: They recommended ICU admission as soon as possible and also suggested 2-4 lit/min oxygen with mask in the sitting position.
3. From IMD to Communicable disease department: They asked for a fever chart, vital sign record every 2 hours, cardiac monitoring, chest X-ray, chest and abdominopelvic CT Scan, transfusion of 2 bags of packed cells and 3 litres of fluids per day. Ordered IV antibiotics and recommended ICU admission ASAP.
4. From IMD to Oncology Department: She was not fit for any further chemotherapy.

Is this what patient/family want from the health care system?

There is only one referral public hospital which provides palliative care services to cancer patients in the emergency department in Iran. The statistical analysis showed that in 2012 between one-third to half of admissions in the ED in Imam-Khomeini Hospital were patients with advanced or end-stage cancer. They normally stay in the emergency department for days to manage their symptoms (commonly pain and respiratory distress) or to receive terminal care. The unlucky ones will be entrapped on emergency beds and remain intubated and dependent on ventilation machines, while their tired relatives wish them a peaceful death.

What's wrong?

- Futile interventions and inappropriate use of limited health care resources [1]
- Poor physicians-patients communications and discussion about the goals of care, prognosis and end-of-life care [2]
- Poor support for caregivers
- Poor physician-physician communication of different departments [3]

There are potential barriers for delivering an efficient palliative care service in the ED that are noted below:

- Traditional attitude among the ED staff that practice life-saving approaches for every patient regardless of their disease [4]
- Ambiguous medical rules to protect the ED staff from legal action against them if they refuse to provide futile treatments to satisfy the unrealistic demands of the patients' family
- Lack of knowledge about palliative care philosophy regarding the better symptom management and terminal care
- Insufficient number of palliative care teams, community care services and hospices as compared to the number of the patients who need them [5]
- To see the mortality rate as a failure of the health care system even for advanced incurable cancer patients

Some suggestions for overcoming the barriers of palliative care in the ED:

- Look at the palliative care as a necessity in the national health care system that should be addressed urgently.
- Integration of the basic concept of palliative care in all medical fields and specialties particularly in the emergency medicine [6]
- Creation of community care services as a priority
- Allocation of an oncology unit in the ED for an organized attention to the needs of this group of patients
- Regular emergency department visits by palliative care team with or without the oncology specialists to help for better symptom control, decision-making and future planning
- Education of the ED physicians and nurses on weekly meetings about palliative care topics and case presentations
- Collaboration between the ED and palliative care unit for transferring patients who are clearly in terminal phase

- Referring advanced cancer patients to the palliative medicine clinic after discharging them from the ED [7]

To shift a "Terminal" cancer patient care from the ED to the hospice simply based on an easy memorable criterion is tempting but not rational. Indeed, many terminal cancer patients might still benefit from emergency attention. For example, for conditions such as severe hypercalcemia, an active ED management might significantly enhance the quality of life of the patient. On the contrary, integration of palliative care into routine ED operations can result in:

- Less ED crowding
- Less overuse of limited ED resources
- Fewer readmissions in ED
- Fewer deaths in ED
- Reduced ED days of stay
- Better symptom management
- Better care of patients based on their goals of care

Clinicians should always ask themselves about the CURRENT GOAL OF TREATMENT [8], and whether it contributes to prolongation of life or it provides comfort care with goals of increasing peacefulness, dignity and comfort for the patients. Each option needs to be justified with good reasons and understood by other clinicians, nurses and family members.

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