

Palliative Care Interest Group

Identification of the Hospice vs. Palliative Care Patient in the ED

Deniece Boothe, DO



The terms “hospice” and “palliative care” remain synonymous for many health care providers. Despite the intertwined relationship, it is important that we understand the differences in an effort to provide appropriate resources for our patients facing serious, life-limiting illness. Palliative care, also known as palliative medicine, is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.¹ Hospice care is designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure. Those with a prognosis of six months or less meet criteria for hospice. A Center to Advance Palliative Care survey found that most health care professionals erroneously equated palliative care with end-of-life (EOL) care.¹ This lack of understanding leads to ineffective communication between the provider and patient or health care proxy.

Let us look at two cases where hospice vs. palliative care is appropriate.

Case 1

Mrs. A, a 35-year-old female with recent diagnosis of ovarian cancer is your next patient to be seen. You review her vital signs and note that she is tachycardic: HR 116BPM, BP 124/80, RR 16, O2 sat 100% on room air, temp 98.4. The patient states that she has persistent abdominal pain despite using her short acting morphine 5mg every four hours over the past two weeks. She admits to nausea and constipation as well. Her overall functional status is fair. She recently started chemotherapy and has tolerated treatment thus far with minimal symptoms. Her workup in the ED reveals progression of disease in the liver, a negative study for pulmonary emboli and labs are within normal limits. She receives a total of 2mg of Dilaudid in the ED and reports that her pain has subsided from a level 10 to level 4. The patient is discharged home and advised to continue with morphine prn, to follow up with her PCP and oncologist as soon as possible.

Case 2

Mr. B is an 89-year-old male with hx of HTN, CVA, and advanced dementia. He presents to the ED from a long term care facility in respiratory distress. The documents accompanying the patient state that he was found to be less responsive today, hypoxic - sat's 70's, improved with oxygen prior to arrival. You note that the patient had three prior visits resulting in admissions over the past six months for sepsis secondary to pneumonia, UTI. On exam the patient is contracted, with noted bi-temporal wasting and is minimally responsive to painful stimuli. Respirations are labored, oxygen saturation remains at 90% on venti mask. Additional vitals: BP 80/40, HR 120 - irregular, RR 30, temp 103.4. You sift through the documents from the facility and note that the patient does not have

an advanced directive or POLST document. Family members arrive at bedside. You identify his wife as his legal next of kin and inform her that the patient will require intubation due to respiratory failure as well as a central line to administer pressors. You express concern for septic shock and explain that the patient will be admitted to the intensive care unit for further management.

Hospice or Palliative Care?

Patient A is an appropriate patient for palliative care services. Patients with a serious illness often experience substantial physical burden due to pain and symptoms such as fatigue, anorexia, nausea, and dyspnea. Anxiety and depression are also common after the diagnosis of a life threatening illness. Any of these symptoms may alter a person's ability to fulfill roles critical to self-identity.² Early integration of palliative care services in the emergency department will allow for improved quality of life. The patient requires appropriate pain management i.e., incorporation of a long acting opiate vs. adjuncts for adequate pain control. A bowel regimen should be instituted and persistent nausea should be addressed. Additional palliative care services should incorporate symptom management, support and establish the patient's goals in the setting of advanced disease.

Patient B is appropriate for hospice services. It is essential that the treatment goals are established in the ED setting prior to aggressive interventions if possible. Further discussion with the patient's health care proxy or legal next of kin may lead to a decision directed towards comfort care vs. initiating life sustaining measures. An understanding of advanced dementia and the trajectory of illness will serve as an important foundation for the physician when addressing the goals of care.

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In both cases the conversation should incorporate the following:

1. Eliciting the understanding of illness
2. Assessing willingness to hear information
3. Provide information and options of care
4. Respond to emotions
5. Review and summarize

Proper identification and disposition of the hospice vs. palliative care patient is essential to our practice in the field of emergency medicine. ED providers may serve as the sole source of information for patients facing serious illness. The primary goal when meeting with these patients is to ensure quality of life. "Quality" is defined by the patient, health care proxy or legal next of kin. Each has an ideal definition of quality of life. One that is specific to that individual. It is important that this is recognized as this definition will be what drives the conversation and ultimately define the goals of care. ●


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