# Agnes S. (1918-2020): Great Grandma

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According to a 2018 study, over 90% of Americans prefer to die at home, but two thirds of seniors over 65 end up dying in a health care setting. The time to consider fulfilling this desire often arises in our clinical setting, the emergency department.

As emergency physicians in 2021, we need to talk to our elderly patients about end-of-life care. My strong belief in this commitment to our patients comes from my family's recent experience with the death of my mother-in-law, Agnes. The following is my own personal family story about hospice, a story about emergency physicians providing palliative and hospice care, and finally a call to action detailing how we provide palliative and hospice care in our emergency departments during the new year.

Agnes, my mother-in-law, died at 102 in November of 2020. She was born in a small rural community west of St. Louis in May 1918 during the Spanish flu pandemic. She was the youngest of nine children. She had outlived all of her brothers and sisters. Her vitality, humility, and generosity were always manifest. She loved all of her children, grandchildren, and great grandchildren; she was MOM, GMA, and GIGI to our family. My sisters-in-law gave her 24/7 care for nearly 10 years after a fall which resulted in a hip fracture and subsequent hip replacement. By March of 2020, I feared my mother-in-law would be isolated and have little contact with family if admitted to a hospital or skilled facility given her physical decline and frailty.

Thankfully, hospice was consulted around the same time and so began an end-of-life experience navigated cautiously at home 45 miles from where she was born. The experience was highly regarded by my sisters-in-law. The support from nurses, health care aides, social workers, was gratefully appreciated. "She got good care," "[The intense comfort measures and support through the final] six months of mom's life was fantastic" my sisters-in-law were pleased to report. I was relieved and thankful for the experience. My family felt informed and in control; they were supported by hospice as family caregivers.

When my family reflects on the home support my mother in law received, they realize more knowledge and information are needed by patients and their families about what palliative care and hospice can offer. Hospice did not make my mother-in-law a hostage, and her intense comfort care was not limited by an advanced directive or the "DNR" order. They felt empowered and relieved by the efforts made in response to their concerns for their mother and my dear mother-in-law.

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So, let us continue with a look at *our* story as emergency physicians in 2021. Our experiences vary but barriers to making early referrals to palliative medicine remain constant. Among these barriers may be our fears: what do I say? How much time will this take? Others may be uncertain about when the palliative service will be available to see the patient. Certainly, the limited availability of palliative consultants to the ED is a challenge as very few departments have ED-embedded palliative medicine or access to an emergency and palliative trained physician. The COVID-19 pandemic has added additional barriers dealing with prognostication challenges in those with chronic conditions affecting the heart or lungs, or cultural and racial disparities including social determinants of health.[1]

In 2021, let's change our STORY and overcome these barriers. As EM physicians, let's demystify and destigmatize palliative care implementation in the ED.[2] As we confront this pandemic, let's take advantage of the opportunity to focus on life giving, life changing, or life improving interventions.

As we distance ourselves from the binary mindset of "everything done" or "nothing," we offer ourselves and those we care for more options. What are the goals for the patient? Life prolonging? Limited intervention or comfort care? What helps most is planning, preparing, and practicing for the goals of care discussion.

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- Plan for the conversation by practicing and pre-procedural planning
- Prepare for an invitational approach and be open: what do you know, what is your understanding? Be willing to listen with soft eyes and ears.
- Practice being present with empathy and compassion so necessary for aligning with the patient and family to build trust and respect.

We overcome our fears and reticence through practice and simulation discussing withdrawal or withholding non-beneficial life/medical interventions. These discussions may be emotionally laboring and mentally stressful for us as clinicians, but the benefit to an aunt, a grandparent, or mother-in-law cannot be ignored.

In hopes of respecting life and the sacred ground, that encompasses a patient's last months or weeks it is important for us to provide opportunities for patients and families to express their wishes. We can promote and foster the connection to hospice by focusing on patient dignity, with goals to seek permission to engage the patient and family, so that we may partner to alleviate suffering, provide quality patient centered living and dying.

As health care leaders, let us advocate for and demonstrate patient centered assessments guided by patients and family wishes. Continually, let us advocate for the wide availability of palliative care interventions. We may enhance workflow and care delivery in the emergency department, with timely referrals for palliative and hospice support. As we broaden emergency disposition with early palliative care referrals,[2] let's also consider accelerating direct ED to hospice connection by engaging case managers. We can build electronic order sets to trigger and facilitate referrals. Let's participate in sectional interest groups in your health care systems and within AAEM.[3]

Palliative care initiated early offers patients and their families invaluable support. Be proactive and create paths to assist patients in gaining knowledge or access to palliative support and hospice. At this pivotal moment as physicians, we hold a unique presence in our systems and departments. Let us educate ourselves and let us offer prompt palliative care to patients who would benefit. Please set your intention to provide this desired care.

### Resources

- APPS: Vital Talk. Palliative Care fast facts
- Blogs: Geri Pal Nov 5, 2020
- Center to Advance Palliative Care
- *Common Sense* articles since 2018, with recent Nov/Dec *Create a LIFEMAP for Goals of Care* discussion Austin Causey, MD
- Palliative Care Interest Group

View all of the resources and more on the Palliative Care Interest Group website: www.aaem.org/get-involved/committees/interest-groups/palliative-care ●

#### References

1. Chidiac,C. Feuer,D. The need for early referral to palliative care for Black, Asian, and minority ethnic groups in Covid-19 pandemic: Findings from a service evaluation. *Palliative Medicine 2020*, vol 34(9) 1241-1248.DOI: 10.1177/0269216320946688
2. Wang DH. Beyond Code Status: Palliative Care Begins in the Emergency Department. *Ann Emerg Med*. 2017 Apr;69(4) 437-443. doi:10.1016/j.annemergmed.2016.10.027. Epub 2017 Jan 26. PMID: 28131488
3. George N, Bowman J, Aaronson E, Ouchi K. Past, present and future of palliative care in emergency medicine in the USA. *Acute Med Surg*. 2020 Mar 18;7(1):e497. doi: 10.1002/ams2.497. PMID: 32395248; PMCID:

# Board of Directors Election Opens April 1, 2021

- **Review the candidate statements:** Available online April 1, 2021 and will be printed in the May/June issue of *Common Sense*.
- **Join the Candidates' Forum** at the 27th Annual Scientific Assembly in St. Louis, MO. Tuesday, June 22, 2021 from 9:00am-9:45am.
- **Cast your vote:** Vote online at www.aaem.org/elections onsite at Scientific Assembly or from home. To learn more visit the AAEM elections website.

## www.aaem.org/elections

**Voting closes: June 22, 2021 at 11:59pm CT**

# 2021 AAEM Election

## Cast Your Vote Online

**Open Positions**

- At-Large Directors (5 positions)
  - Must be a Full Voting or Emeritus member
- Young Physicians Section (YPS) Director
  - Must be a YPS member