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Clinical Review

A SYSTEMATIC APPROACH TO COMFORT CARE TRANSITIONS IN THE EMERGENCY DEPARTMENT

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□ **Abstract—Background: Approximately 25–30% of Americans die within hospitals. An increasingly geriatric and chronically ill population arrive at emergency departments (EDs) for their terminal presentation. Many patients will not choose, nor are EDs obligated to deliver, futile care. Instead, aggressive comfort care may alleviate patient, family, and clinician distress. Objectives: To discuss best practice through a systematic approach to comfort care transitions for the dying ED patient. Methods: Authors utilized a structured literature search conducted via PubMed (MEDLINE), Embase, and CINAHL databases, including studies from 1998 onward focusing on symptom palliation and coordination of care for acutely dying patients. Discussion: Comfort care begins with the language used to introduce the transition. Frame choices to avoid creating feelings of familial abandonment. Prognostication in the dying process helps guide treatment planning and stewarding families. Symptom management in the actively dying patient involves diligent titration of medications as well as thoughtful ordering in de-escalation of life-support modalities. Compassionate extubation necessitates anticipation of postextubation dyspnea or airway loss, and therefore may require step-wise weaning of pulmonary support. Suffering at the end of life for patients and families is multidimensional, and is best approached with an interdisciplinary effort involving clinicians, social work, and chaplaincy. Conclusion: Comfort care deaths are a daily occurrence in the ED. A systematic approach to these transitions ensures optimal care for patients in their final hours and families' experience of these events.** © **2018 Elsevier Inc. All rights reserved.**

□ **Keywords—comfort care; palliative; dying; withdrawal; compassionate extubation; end of life**

INTRODUCTION

Case Report

An 88-year-old woman with dementia, dysphagia on gastrostomy feeds, and congestive heart failure status post pacemaker, was brought in by ambulance from a skilled nursing facility for hypotension and altered mental status. Upon arrival to the Emergency Department (ED), no advance directive or Physician Orders for Life Sustaining Treatment form was available. She was found to be in septic shock with profound dyspnea, likely secondary to aspiration pneumonia. Despite fluid resuscitation, she clinically deteriorated. She was intubated for respiratory failure and started sequentially on norepinephrine, vasopressin, and epinephrine infusions.

One hour after presentation the patient's son arrived; he was her legally authorized surrogate decision-maker (e.g., durable power of attorney, medical power of attorney). The emergency physician ascertained that the patient was now completely bedbound and nonverbal. After hearing a guarded prognosis, the son shared that he believed his mother would not value a worse quality of life than what she already had, which "she no longer enjoys." What are the emergency physician's next steps?

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BACKGROUND

Approximately 25–30% of Americans die within hospital settings (1,2). More than 50% of geriatric and 80% of metastatic cancer patients visit the ED within their final months of life (3). An increasingly geriatric and chronically ill population will arrive at EDs for their terminal presentation (4). Death is unavoidable in the ED. Patients with serious illness increasingly have advance directives delineating wishes to limit medical care. Moreover, when ED care approximates futility, either imminently or in anticipated downstream hospital course, emergency physicians have a responsibility to discuss comfort care as an alternate trajectory with patients and surrogates (5).

METHODS

This systematic review examines existing guidelines, practice models, and evidence behind the provision of comfort-based transitions in the acute and emergent care setting. We performed systematic searches of the PubMed (MEDLINE), Embase, and CINAHL databases for English-language journals using keywords in the domains of comfort care (e.g., *comfort, palliative, goals of care, hospice, dying, withdrawal*), with limiters for the acute care setting (e.g., *emergency department*, *intensive*). We utilized a search strategy combining key words with free text and Medical Subject Headings (MeSH) terms. We complemented electronic database searches with focused secondary review and subsequent exploration of article references. We included studies published from 1998 and onward, focusing on symptom palliation and coordination of care in the management of acutely dying patients.

DISCUSSION

In the presented case, the patient has end-stage dementia, which is a terminal illness, and is already hospice eligible. In advanced dementia, tube feedings do not decrease aspiration risk, decrease mortality, or lead to improved physical functioning (6). The emergency physician correctly identifies this as an acute exacerbation of a life-limiting disease.

Surrogate Decision-Makers

When a patient lacks capacity to speak for themselves, it is important to identify the most appropriate surrogate prior to engaging in goals of care conversations. When no health care surrogate has been legally appointed, decisional hierarchy law varies across states, ranging from rigid surrogacy ladders to undefined priority order for persons (7). Advance care planning documents that limit life-sustaining treatments (e.g., Physician Orders for Life Sustaining Treatment, Medical Orders for Life Sustaining Treatment, advance directives) are applicable in the ED, which is an outpatient level of care, and serve as effective conversation starters (8). The most recently notarized/signed document is most valid. Health care surrogates usually may not supersede a recent and valid document's instructions, however, there can be ethical ambiguity if surrogates appropriately act from a substituted judgment (what they think the patient would want) rather than best interest (what they think is best for the patient) standard (9). When there is irreconcilable discordance between documents and surrogates, hospital risk management consultation is essential. Given time constraints in the ED, the treatment course in these scenarios often leans toward full care. Lastly, irrespective of documented or surrogate wishes, emergency physicians are never obligated to deliver or continue medical care that they assess to be nonbeneficial (5).

Reframing Withdrawal of Care as Aggressive Comfort Care

Goals-of-care conversations should focus on presenting likely functional outcomes, not the resuscitative interventions themselves. If the minimum acceptable quality of life appears unrecoverable, the conversation pivots to introduce comfort care as a transition, not as "withdrawal of care" (10). The latter may suggest abandonment to families. Offering this transition to an alternative approach of "aggressive comfort care," meaning attentive medication titration for symptom management, may help families feel assured that their loved ones are receiving the best care possible. Similarly, there is never "nothing more that can be done"; emergency physicians and staff can always mitigate suffering, both physical and psychological, and for both patients and their surrogates. Families will remember that they pursued "aggressive care" instead of "pulling the plug." Word choice matters (Table 1) in creating the narrative of this memory that families will carry with them after the ED (10).

Prognostication

Prognosticating how long an actively dying ED patient will live is essential for anticipating symptom management needs as well as providing guidance to families. Some families may be unaware that stopping multiple vasopressors may result in death within minutes; others may be surprised that patients may live for hours after extubation.

Predicting death trajectories is challenging and imprecise even with clinical decision tools (11). When providers fail to recognize signs that indicate active dying,

Table 1. Word Choice Matters in Goals-of-Care Conversations*

Avoid These Phrases	Use These Phrases
We need to discuss code status. I wouldn't want this for my own mother.	Tell me about your mother. What was she like before she became ill? How has this illness affected her quality of life?
I don't believe resuscitation would be successful. It is highly unlikely that she would ever get off these life support machines.	It seems like this illness has already taken many of her joys away from her. From what I see today, I do not think she would be able to return to that quality of life that is meaningful to her, not even to her current state. This is the natural course of her disease, and she is now dying.
Do you want us to do everything? Would she want heroic measures? Do you want us to push on her chest or put in a breathing tube? You are making a hard decision today	Based on what you have told me about your mother, do you think she would want to die a natural death? You have fought hard for your mother, and now her body is making this decision for you.
There is nothing more we can do.	I wish things were different. I suggest that we shift our focus now to keeping her comfortable, and aggressively use medications to reduce any distress she may feel.

* Adapted from reference (10): Wang DH. Beyond code status: palliative care begins in the emergency department. Ann Emerg Med 2017;69:437–43.

but not imminent death, patients are at risk for inadequate treatment of symptoms (12). Specific physical examination findings (Figure 1) identified in dying patients may be useful in providing a general sense of hours to days (13).

Presence of pooling secretions ("death rattle") rarely implies imminent death within hours. Sagging of the jaw with breathing (respiratory mandibular movement) suggests likely death within the next 2 days. Pulselessness to palpation reliably indicates death within the next 12 h (14). When observed, Cheyne-Stokes respirations and apneic pauses are late signs of active dying (13). In contrast to subacute death trajectories, which usually spans days, dying patients presenting to the ED in extremis may follow an accelerated course, and thus not necessarily manifest these signs, especially if requiring respiratory and circulatory support.

Symptom Management

Regardless of specific terminal diagnosis, patients usually experience similar symptoms during active dying: pain, dyspnea, anxiety, terminal delirium/agitation, and secretions (15,16). Some or all of these may be present, and warrant vigilant pharmacologic attention.

Pain. Opioids are the mainstay of treatment for pain in patients who are terminally ill. Intravenous delivery is preferred for rapid onset of action. Alternatively, highly concentrated oral morphine (20 mg/mL) is also readily absorbed through the buccal membranes, and therefore effective even if the patient cannot swallow. Patients must be assessed for repeated doses given the short half-lives of intravenous opioids. The $t_{1/2}$ of i.v. morphine and i.v. hydromorphone is approximately 2–2.5 h.

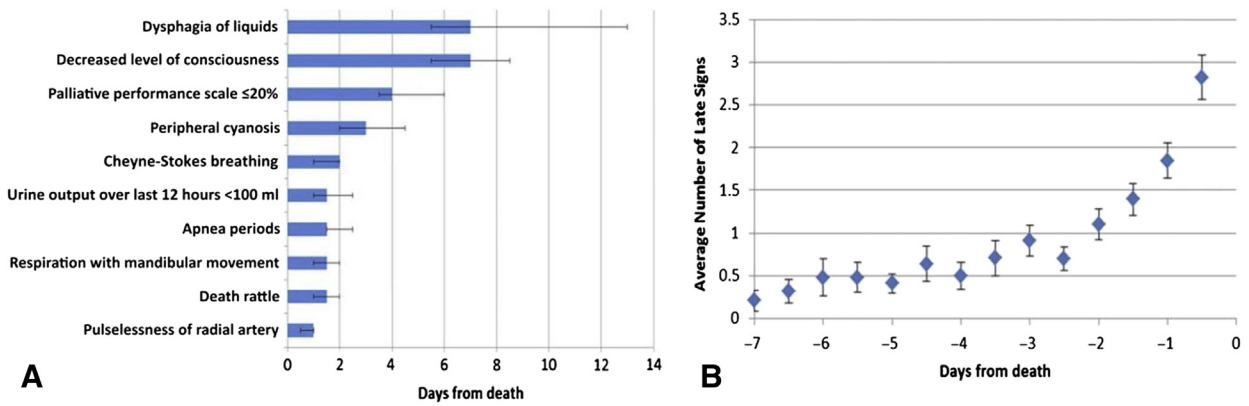

Figure 1. Correlation of physical examination findings to timing of death [from Hui et al. (13).]

Fentanyl has a duration of action of only 30–60 min, despite a long half-life given rapid redistribution from serum into muscle/fat tissue. When a prolonged prognosis is anticipated, hydromorphone is superior to morphine in the setting of impaired renal clearance given its slower accumulation of toxic metabolites.

Opioid or benzodiazepine infusions are often started in the ED but may take too long to be of benefit. Because they obey the pharmacokinetics of all infused medications, they require four to five half-lives to reach steady plasma concentration. For instance, a 4-mg/h morphine infusion will not achieve the same effect of giving a 4-mg bolus per hour until about 10 h after the infusion has begun. During that ramp-up period, the patient's symptoms are unlikely to be adequately treated from the infusion alone (17). Therefore, bolus doses are necessary, and infusions may supplement, but not substitute for them.

Dyspnea. Air hunger is best treated using opioid boluses as first-line medications. As with treating pain above, i.v. opioid bolus dosing may repeat every 10 min as needed after failure of the previous dose after peak effect. Start with low doses, and double each successive dose as needed. There is sometimes a negative feedback loop between dyspnea-anxiety that opioids alone cannot control. Intravenous benzodiazepines may be used as a second-line adjuvant. Midazolam and diazepam achieve peak effect (3–5 min) faster than lorazepam (30 min) (18). Although lorazepam is safer in the seting of hepatic impairment, this becomes less salient at the end of life.

In the ethics of medical treatments, the "Principle of Double Effect" permits some measure of harm to achieve an intended greater good. Many physicians believe that using opioids in comfort-care patients to reduce dyspnea is caveated by double effect, due to the theoretical possibility that it may depress respiratory drive and thus hasten death. There is now an abundance of research that dispels the notion of respiratory deleterious effects. Opioid use titrated to comfortable respiratory rates does not significantly alter $PaCO_2$, PaO_2, or overall survival, but does significantly increase comfort at the end of life (19,20). Furthermore, opioid-related toxicity first manifests as drowsiness, confusion, and loss of consciousness well before respiratory drive is significantly compromised.

One exception to note: For conscious patients with imminent airway loss, rapid and large boluses of opioids (and/or adjunct benzodiazepine, propofol, ketamine, barbiturate) are necessary to mitigate suffering. In this instance, the primary intent is to treat unusual and significant dyspnea, and an expected secondary effect from the medications would be loss of consciousness. Distinct from treating mild-moderate dyspnea for comfort, this is considered palliative sedation to unconsciousness (21). These cases fall on the aggressive end of the spectrum of medication use for comfort, and double effect dose operates here.

Discontinuing noninvasive oxygen and ventilator support is discussed in a later section.

Anxiolysis, agitation, and delirium. Anxiety and terminal agitation are common at the end of life. They are often difficult to distinguish, especially if the patient is nonverbal. In contrast to typical management of delirium, strategies for managing delirium in the acutely dying patient usually necessitate benzodiazepines (e.g. lorazepam) in addition to antipsychotics (22). Terminal delirium is often under-recognized and usually precedes the patient's ED presentation through the days beforehand.

Secretions. Anticholinergic agents (e.g,. glycopyrrolate, scopolamine, atropine) may assist with turbulent respirations secondary to retention of pooled secretions ("death rattle") (23). Glycopyrrolate is a quaternary amine and does not cross the blood–brain barrier to exacerbate delirium. Note that the expected benefit is likely greatest if given early, up to 1 h prior to planned extubation or anticipated symptoms. These medications only reduce new secretions; they do not clear existing secretions once present. Reassurance to distressed family members at the bedside that the patient is not experiencing discomfort from the secretions is often sufficient.

Order of Intervention De-escalation

Once symptoms have been adequately controlled with medications, the emergency physician should next turn to systematically discontinue life support. In general, circulatory support should be discontinued prior to ventilator support. The resulting cerebral hypoperfusion mitigates, or even circumvents, the experience of postextubation dyspnea.

Circulatory support. Discontinue pressor medications, and any mechanical circulatory support, and then within minutes thereafter proceed with extubation.

Discontinue intravenous fluids as they do not increase comfort and only serve to prolong the dying process (24).

If an automated implantable cardioverter defibrillator is present, the emergency physician should secure a ring magnet over the chest to deactivate the defibrillator function, or contact the manufacturer if time permits. The native pacemaker function will continue at its asynchronous rate; however, it will not keep the patient alive, and will keep firing unsuccessfully even after death.

Left-ventricular assist devices (LVAD) are increasingly seen in EDs. LVADs can be "turned off" by removing the battery source or disconnecting the driveline from the controller unit. Depending on native cardiac function and the presenting insult, the patient may live minutes to

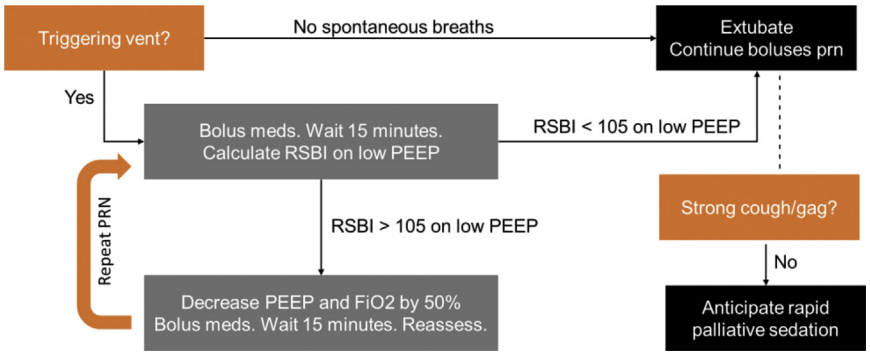

Figure 2. Stepwise compassionate extubation process to minimize dyspnea. PRN = as needed; RSBI = rapid severity breathing index; PEEP = positive end-expiratory pressure; FiO_2 = fraction of inspired oxygen.

days. Symptoms after LVAD deactivation may mirror those of acute heart failure exacerbation, including dyspnea and associated anxiety. Importantly, emergency physicians should bolus with comfort medications prior to deactivation because reduced drug circulation thereafter leads to unpredictable and delayed times to peak effect (25).

Compassionate extubation. Prior to compassionate extubation, it is essential to evaluate native respiratory function. Two important questions to ask are: Does the patient trigger breaths? And is there a cough or gag?

If the patient breathes autonomously but with low tidal volumes, expect that the patient will likely fatigue from increased work of breathing, and subsequently experience respiratory distress and failure (26). The rapid severity breathing index, calculated as respiratory rate divided by tidal volume, may be helpful in gauging this timeline and opioid requirements (27). If the patient is currently requiring significant positive end-expiratory pressure (e.g., acute respiratory distress syndrome, pulmonary edema), it is advisable to first bolus medications, wean pressure support gradually, readdress any worsening dyspnea after 15 min with additional medications, and then extubate once breathing without distress on minimal support (Figure 2).

In a conscious patient, an absence of a cough and gag indicates that the patient is likely to aspirate again, and thus will require close monitoring against asphyxiation. If sudden airway loss occurs, the treatment intent shifts to aggressive palliative sedation with rapid and large boluses, as outlined earlier.

Using an interdisciplinary checklist may help ensure that nursing staff and respiratory therapy coordinate next steps (28). These same principles apply to discontinuing noninvasive positive pressure ventilation and high-flow nasal cannula support as well.

Team-Based Support and Disposition

Although the patient's clinical outcome is certain, the ED staff may still have a significant impact on the family's experience. The long grieving process begins even prior to death, and suffering for both patient and families spans several dimensions, including physical, social, emotional, and spiritual (29). Although emergency physicians may expertly anticipate and manage symptom needs, they are neither able to nor expected to address this totality of suffering singlehandedly (Figure 3).

Invite Social Work, who will provide emotional support, bereavement resources, and a staying presence after the ED staff are pulled away to other duties. Offer chaplaincy and spiritual services to patient and family. Their expertise extends beyond prayers and Judeo-Christian frameworks; they often help address existential questions and pleas that arise irrespective of religious tradition (30). Moreover, they often are perceived as "non-medical," and may serve as an independent reassuring voice when there is discontent amongst some family members with the medical teams.

Liberalize visitation policy. Turn off monitors, vitals, and alarms. These rob the patient of their family's attention at a time when personal interaction may be crucial. Remote telemetry monitoring at the workstation may be used instead to monitor for time of death. Place signage on the door to minimize disturbances from all ED

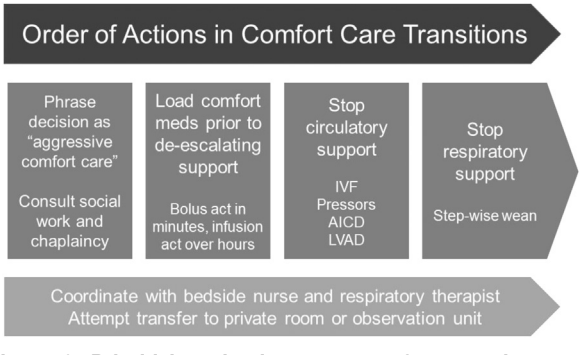

Figure 3. Prioritizing simultaneous comfort care interventions with de-escalation of support. IVF = intravenous fluids; AICD = automated implantable cardioverter defibrillator; LVAD = left-ventricular assist device.

personnel. If time permits, periodically reassessing patient and family prevents a sense of abandonment and is a significant driver of satisfaction with care despite the outcome of death (31).

Lastly, short-stay observation units may have private rooms that can be converted to use for the imminently dying comfort care patient. If awaiting arrival of more family, compassionate extubation may be delayed until after transfer to these quieter rooms that accommodate more visitors. Observation units may also operate under lean treatment protocols, which serves to minimize staffing resources as well as interprovider variation in symptom management (32).

CASE CONCLUSION

The patient's son agreed to the emergency physician's recommendation to pursue aggressive comfort care and allow his mother to rest. The son confirmed that no further family needed to arrive. He accepted an offer for chaplaincy, who came and provided a blessing and affirmation of his decision. Social Work provided emotional support throughout the ED stay as well. The emergency physician discussed the plan for compassionate extubation with the bedside nurse and respiratory therapist. The patient was noted to overbreathe the ventilator with a high rapid severity breathing index. Intravenous hydromorphone 1 mg was given for anticipated dyspnea. Pressure support was weaned to minimal settings, and her work of breathing increased. She was then given an additional 0.5 mg of hydromorphone and 2 mg of midazolam. Ten minutes later, the patient appeared comfortable. Inotropes and vasopressors were stopped, and minutes later she was extubated. One further dose of opioids was required. She died peacefully soon thereafter. An observation room was reserved but not needed. Prior to leaving, her son told the ED staff that he would never forget their compassion, attention, and care.

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ARTICLE SUMMARY

1. Why is this topic important?

Comfort care transitions occur daily in the emergency department (ED) and must be held to the same quality standards as any other ED procedures. A systematic approach to these transitions ensures optimal care for patients in their final hours and families' experience of these events.

2. What does this review attempt to show?

This review delineates a best practice approach to the ED comfort care transition, building upon diligent prognostication and medical management to further invite a multidisciplinary approach to address the multidimensional suffering experienced by patients and families.

3. What are the key findings?

Emergency physicians should begin the transition by rephrasing withdrawal of care instead as aggressive comfort care to avoid creating feelings of familial abandonment or guilt. Optimal symptom management in the actively dying patient involves accurate prognostication, recognition that i.v. medication boluses are superior to infusions given time to effect, thoughtful ordering in de-escalating life-support modalities, and circumventing postextubation dyspnea or airway loss. Early engagement of chaplaincy and social work support is essential. Protocols may minimize both interprovider variation in symptom management and team/family distress.

4. How is patient care impacted?

Although emergency physicians encounter death daily, patients will only die once and families remember the emotional legacy from these critical hours in the ED. Establishing a best practice systematic approach to comfort care transitions not only allows physicians to better leverage their medical expertise, but invites a multidisciplinary effort to holistically address physical, social, emotional, and spiritual needs.