EDITORIAL

Dying in the emergency room

Morir en urgencias

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The World Health Organization (WHO) defines palliative activities as active care applied to patients who are not dependent on curative treatment. The objective is to achieve the best quality of life for them and their families[1]. Patients associated with palliative activities who come to our emergency departments (EDs) in end-of-life conditions are patients who are often placed in beds that are not prepared for this purpose, focusing on illnesses that we believe require more rapid attention. We all know the sepsis code, the infarct or stroke code, which are well developed in our services. However, few have developed and implemented a patient care code for end-of-life situations. It is the Ombudsman itself who concludes: "Care in hospital emergency departments for patients in the terminal phase represents a failure of the system, since in these areas it is not possible to guarantee such patients a dignified death and to preserve the mourning of family members and loved ones[2]". Unfortunately, we seem to have forgotten the teachings of the classics. Epicurus, one of our first teachers, said: "The art of good living and the art of good dying are one".

The study published in this issue of EMERGENCIAS includes a record of patients who consecutively attended 11 Catalan EDs in a terminal situation and received palliative sedation (PS)[3]. It does not indicate whether any of the patients or family members did not wish to participate in the study, which the authors refer to as the only criterion for exclusion. On the other hand, it would have been interesting to define what the PS consisted of and the indications followed in the centres attached to the study to guide it. It is difficult to know whether this delay is due to the fact that the patient is not considered a candidate for PS or whether, as a candidate, there are other causes for the delay (lack of specific training, lack of protocols for managing these patients or the influence of the overload of the services involved). There are significant differences between level 2 centres (less delay) versus level 1 or 3 centres (greater delay in the PS pattern). A detailed analysis of these figures could be the subject of further work to find out whether the level 2 centres in the study have specific protocols and trained personnel or whether there is a lesser burden of care to explain the reduction in time.

Typically, when we think of terminal patients, we think of cancer patients. However, in the results of this study, we found that most patients to whom PS was applied were patients with heart failure (26.6% according to this series), neurological disease (25.7%) and respiratory disease (19%). This accounts for more than 70% of patients who received PS, while oncology patients represent 15.2%. These results could be due to better coverage of palliative units over cancer patients, which would mean fewer visits to the emergency department in an agonizing situation, or simply because the prevalence of non-oncological diseases is higher. In any case, these results open the door to create home support units, such as heart failure units, to help these patients and families consider the end of their lives at home. It would also be interesting, in order to promote the end of life in a familiar environment for the patient and family, to train the health personnel of the residences (assistants, nurses and doctors) in palliative care. In anticipation of the expected outcome, they should inform the patient and family of the existence of an end-of-life protocol and the possibility of avoiding an uncomfortable and unnecessary transfer to an ED.

To categorize the patient admitted to the ED and focus on short stay units, home hospitalization or palliative units interconnected with the ED, different studies performed in Spanish EDs show the usefulness of risk models in diseases such as acute heart failure or patients with infection and systemic inflammatory response syndrome, which predict mortality at 30-180 days[4-8]. These models develop scales that take into account comorbidity, polypharmacy or geriatric syndromes[9].

The development of automatic prediction models, associated with data entered in the electronic medical record, in different types of patients such as the frail elderly person at risk of falling[10] or the patient with end-stage heart failure[11-13] would help to automatically stratify risk and establish specific care plans (such as a fall prevention plan, used in the FALL-ER register[14]) that could enable these patients to be included in palliative care units or other home support resources. All this would avoid unnecessary and unwanted visits, as advised in previous studies on hyperfrequent ED patients (more than 10 visits/year)[15].

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On the other hand, specific training in end-of-life patient care is essential, as advised by the Academic Society of Emergency Medicine. This society offers emergency physicians various programs designed for this purpose, such as the education center for end-of-life resources, the "Project for End-of-Life Care by Emergency Physicians" (EPEC), and the "National End-of-Life Training Project"[1,10]. This indicates two things: first, the importance given in other countries to specific training for emergency physicians within the training programme for residents; and second, the need for a training programme of their own within a specialty that seems increasingly necessary.

We must congratulate Yuguero et al.[3] for addressing a topic that needs more attention. His work is an excellent initiative that shows that measures are needed to ensure that patients die with dignity in a known and familiar environment, strengthening palliative care units and extending them to groups of elderly people in terminal situations. On the other hand, we have to be prepared with agile and agreed protocols, specific training of multidisciplinary teams and spaces conditioned for this purpose for those patients who come to the ED in a final situation.

In summary, the growth and aging of the population, the prevalence of chronic diseases, the expectations and perceptions of citizens regarding the inevitability of death and the immediate accessibility to the ED will make it increasingly essential to introduce into our daily practice the philosophy that requires, first, early recognition of patients in a situation of agony, and second, to apply specific therapies like PS immediately, informing the patient (if possible) and family members of the application of the specific protocol of the end-of-life ED, and activating all parties involved in it. This requires the development of specific training programs that should be mandatory for all ED physicians, and which should make up the training program of the specialty of Emergency Medicine.

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