



It Takes Courage to Pause: Rapid Goals-of-Care Conversations in the Emergency Department

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He barely roused as the paramedics transferred him from the ambulance stretcher to the emergency department (ED) bed. Obtunded and breathing irregularly, he couldn't tell me his name. As our care team undressed him and started to establish IVs, I took 30 precious seconds to open his chart: late 60's, terminal cancer, no advanced directive. The most recent oncology note mentioned initiating conversations about hospice, but no formal decisions had been made. For an emergency physician (EP), this translates to "full code." I called for airway equipment and a respiratory therapist. A nurse from triage burst into the room, announcing that the patient's wife called and was several minutes away.

In this situation, the routine and indeed easiest thing to do is to intubate, connect him to the ventilator, and admit him to the intensive care unit (ICU). Tell his wife we had to act quickly to keep him alive. Call it a day and move on to the next patient. The relentless onslaught of ED patients awaits.

Many would argue that intubation is also the right thing to do. Nowhere in his chart did the language of "do not intubate/do not resuscitate" appear. In the absence of a clear directive, that makes intubation our default course of action, our standard of care, for a patient with respiratory failure.

Nonetheless, I felt morally ambiguous. My clinical gestalt whispered, "*he is dying and has hours to days left. Intubating him will prolong, but not restore his life.*" Indeed, 33% of older adults intubated in the ED do not survive hospitalization.¹ But this knowledge is not easy to act upon, particularly when the patient in front of you cannot voice their wishes.

In emergency medicine, we face unique time pressures. We care for patients with high acuity conditions, which demand immediate action. Our adages reflect this—e.g., "time is brain," "the golden hour" of trauma—as do our quality metrics, such as door-to-balloon time. Timeliness is the difference between life and death. It is the essence of emergency care. Simultaneously, unlike other parts of the hospital and health care system, the ED is open 24/7 to any patient, regardless of insurance status. There is no "cap" on the number of patients we receive, and they may arrive at any time. Under the constant threat of patient volume, time is incredibly valuable. Time spent on one task necessarily takes away from other tasks.

Given these features of our practice, a patient's disposition, or their destination after their ED presentation—home, the floor, the intensive care unit, transfer to a specialty hospital, or to whatever lies beyond life—is central to emergency clinician's mindset. "Dispo," as we abbreviate the term, is a crucial part of our initial evaluation of a patient, as it helps us anticipate how long a patient will remain in the ED and the types of resources they may require before the next patient can be seen. Rapid disposition is crucial to maintaining patient flow through the department, a domain that administrators evaluate through metrics such as patient length of stay or time from evaluation to disposition. Uncertain

disposition threatens not only an individual patient’s care advancement, but also the department’s ability to empty a bed and accommodate a new patient.

Our approach to time and “dispo”-oriented mindset can be at odds with a patient’s priorities during critical illness. Under immense pressure to make decisions and act quickly, EPs commonly approach patients with respiratory failure as follows. They review the chart for an advanced directive. In the majority of cases, an advanced directive is not available,² so they speak with family at bedside or by phone to clarify wishes, focusing the conversation on immediate action needed to preserve life. An example of typical language used in such “crisis communication”³ is: “Your relative is very ill. If their heart were to stop, would they want us do CPR? If they were to stop breathing, would they want us to place them on a ventilator?” This sequence is commonly modeled for trainees.^{3,4} Such communication prioritizes the ED’s need to make a quick decision rather than investigating the patient’s priorities.

In contrast, Ouchi et al. outline a value-based approach to rapid goals of care conversations in the ED that prioritizes concordance with a patient’s care priorities.⁴ It involves eliciting a patient’s baseline function and values prior to acute illness—including disabilities that a patient would consider worse than death—and using this information to make a goal-concordant recommendation about pursuing intensive treatment focused on comfort vs. recovering from illness. The physician and family members establish a path forward through shared decision-making.⁴ Identifying patient values to inform outcome goals and care preferences (patient health priorities) has empiric⁵ and normative⁶ support in chronic illness care as well.

While the value-based approach offers the potential benefit of honoring a patient’s wishes, deviating from common practice feels like it entails risks (see Figure 1). First, EPs may feel that spending extra time risks a patient’s further clinical decompensation while also taking the physician away from caring for

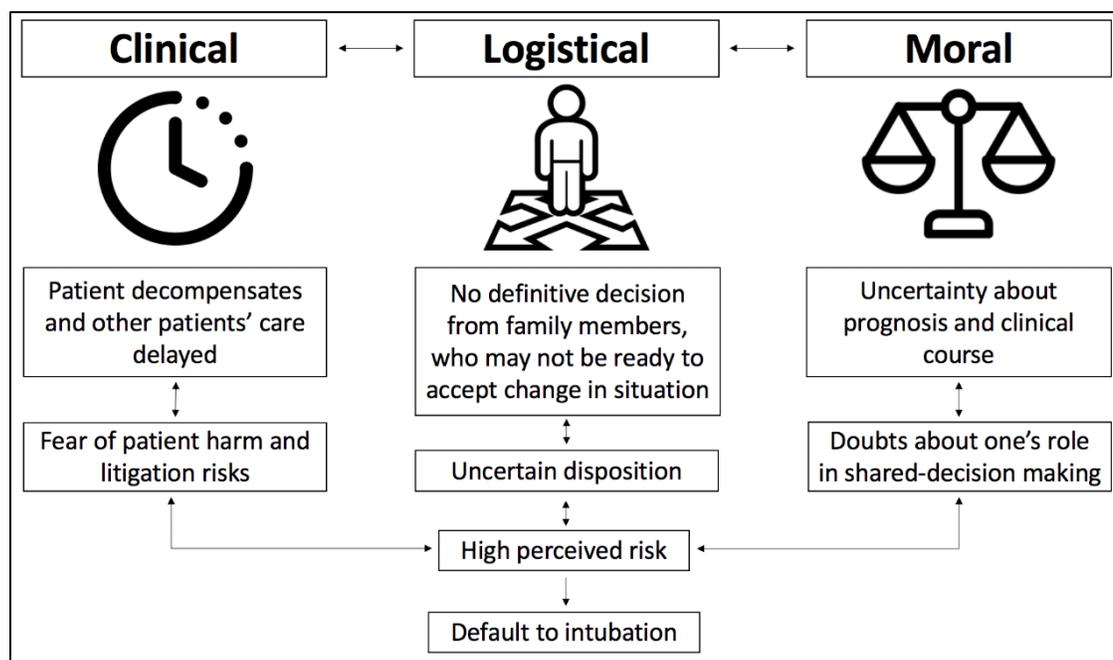


Figure 1: Perceived Risks of Value-Based Goals of Care Conversation for a Patient with Respiratory Failure

other patients. Second, there is a logistical risk that a more open-ended conversation will lead to a family not making a definitive decision, complicating disposition planning. A patient who needs intubation needs the ICU. A patient who transitions to comfort medicine only goes to the floor. The “dispo” that hangs in the balance goes against deeply entrenched norms in emergency medicine. Third, the value-based approach poses a sense of moral ambiguity and risk. When a physician recognizes their own fallibility in prognostication, they may experience emotional distress about making a recommendation in shared decision-making.

This is why it is hard to pause. In my patient’s case, however, further skimming the oncology note convinced me that pausing was the right thing to do. He valued his independence and expressed interest

in participating in a clinical trial only if he could maintain his activities of daily living and stay engaged with family at home.

I felt on edge, as if I was abandoning the room, as I asked the care team members to keep him on the non-rebreather and bag him if needed while I spoke to his wife for five to ten minutes. I asked the patient’s nurse to stat page me if the patient became apneic or lost pulses. In the triage area, the patient’s wife revealed that he woke up short of breath, expressing a premonition that he would die that day. He valued his role as the patriarch of his family, and he valued being able to help others and care for himself. Giving his wife my impression—that he was unlikely to survive the hospitalization, and if he did, it would be a long road to recovery—was not easy. Her sense was that he would not want to be intubated if it meant a long ICU course, discharge to a skilled nursing facility, and potentially never returning home. He would have wanted to spend his last moments surrounded by family members at home—not in the hospital with only one visitor allowed at a time, given COVID-19-related restrictions. “Based on what you say your husband values,” I told her, “I recommend intensive treatments to relieve his shortness of breath, rather than treatments that wouldn’t allow him to live the life he’d consider acceptable. We’ll work to get him home as quickly and safely as possible.”

Our care team worked tirelessly for several hours with palliative care and case management to control the patient’s symptoms while obtaining prior authorizations for opioids and benzodiazepines and arranging ambulance transport home. Just before the ambulance arrived, however, the patient expired with his wife at bedside.

I wondered if I did the right thing. It would have been easier to intubate. It would have been easier to not elicit the patient’s priorities, but rather leave that task for an inpatient team. It would have been easier not to dedicate ED staff time to end-of-life care. At the end of it all, what had I accomplished? I had perhaps given him a more merciful death, though not the one he would have wanted. By doing moral work for the whole health care team and system, by initiating an uncomfortable conversation and making a recommendation to transition to comfort medicine only, I had saved the hospital an ICU bed.

As I wallowed in self-doubt filling out the patient’s death paperwork, a physician colleague who was involved in the case put his hand on my shoulder and told me, “It takes courage.” What he meant was that it takes courage to pause, to go against the default system and its associated time and disposition pressures and elicit a patient’s values. It takes courage, despite the perceived clinical, logistical, and moral risks, to recommend emergency care that aligns with a patient’s priorities. In emergency medicine, applying palliative care principles, which have become increasingly relevant during the COVID-19 pandemic, can allow us to do right by our patients.⁷ We all must find the courage to take the time to honor our patients’ values at the end of life.

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emergency medicine; goals of care; serious illness; communication

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CONFLICTS OF INTEREST

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