



End-of-Life Care in the Trauma Bay: Six Key Points

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INTRODUCTION

The dominant culture across North America, Europe, and Australia has been characterized by workers in hospice and palliative care as “death-denying” or “death-phobic.”^{1,2,3} Our shared societal cultures do not encourage consideration of our own death or the deaths of those around us. Coupled with this, people often assume that trauma predominantly affects young people and that mortality from trauma is most likely to affect younger people.

The last two decades have seen a significant increase in the number of trauma patients with complex background co-morbidities due to advanced age.^{4,5} Paradoxically, patients and families can become focused on the acute effects of trauma and fail to understand the role of pre-existing medical comorbidity in trauma mortality. They often see comorbid conditions as chronic and stable and may be ill-prepared to understand the poor prognosis associated with trauma in older adults with poly morbidity.

Effective end-of-life care in trauma requires physicians to begin careful, balanced, and sensitive conversations encompassing goals of care and expectation-setting in the trauma bay. The following six pointers will help the reader communicate the principles of these clinical decisions clearly to patients and their families.

1. An End-of-Life Care Discussion is not an Advance Care Planning discussion.

Advance Care Planning is a theoretical exploration of what the patient “might want” in the event of future illness or incapacity. It doesn’t consider the specifics of illness or the limitations of medicine in a particular clinical scenario but focuses on patient wishes and their desired outcome in general circumstances. It is a discussion about meaning, purpose, and how the patient sees “quality of life.” It is a discussion to ensure the patient can trust someone to make decisions on their behalf, in accordance with their understanding of meaning, purpose, and quality of life.

An End-of-Life Care discussion involves an explanation of the current clinical situation, the likely prognosis including the impact of comorbidity, and the limitations of medicine within these circumstances. An End-of-Life Care discussion occurs at the point that the medicine has failed the patient (and us) and betrayed its implicit promise to restore the patient to physical health. This is a discussion about dealing with that betrayal. It is a discussion around “what is possible” rather than a discussion of “what you would want.”

2. Be clear in your own mind about the likely therapeutic benefit of any intervention or course of therapy to the specific patient in front of you.

Only offer medicine that is likely to be of benefit. This requires you to be honest with yourself about those therapies that are unlikely to be of benefit. This may leave you feeling personally vulnerable and betrayed (as there may be very little medical therapy left to offer).

3. *When you know that aggressive therapy has little or nothing to offer, speak clearly about the risks, benefits, and limits of therapy.*

Don't imply that the patient is going to miss out on effective, restorative therapy because they are too weak to withstand the unpleasantness of treatment. The family needs to know that the medicine has failed, rather than the patient. That will help you steer away from statements that unintentionally intimidate people into refusing therapy:

"They do a lot of distressing things to people in ICU... If your heart was to stop, do you really want us to break all your ribs?"

4. *Do not offer the illusion of choice if you know that the choice will not change the outcome.*

Make it clear that the decision not to proceed with ineffective therapy is a medical decision. If the patient's outcome will not be altered by a treatment, then the decision not to proceed with that treatment is not a matter of the patient's choice. Do not burden the patient or family with the belief that they have the responsibility to make a choice that will influence the disease trajectory if it will not. Asking a family to choose not to use ineffective or futile therapy can complicate their grief and contribute to ongoing psychological morbidity.

5. *When the medicine fails you, it is important to draw near to the bedside and be present as a compassionate human being, and a sympathetic witness to the distress of others.*

Dying is not about medicine, it is about being human. Often, when there is no useful medicine to alter the course of the disease or prevent the dying, there is still significant therapeutic benefit to the patient and family in providing your calm presence, your time, and your compassion. The steady presence of an experienced Emergency Physician to navigate through the emotional turbulence of mortal injury in an unfamiliar environment is of great value.

6. *For action-oriented physicians, death and dying will create additional psychological burdens.*

Often the older trauma patient will not die as a 'failed resuscitation', but some hours or days after a decision to manage conservatively. This can create a different type of psychological burden for healthcare professionals. The betrayal of the medicine and the personal vulnerability that arises when there are no restorative interventions can be particularly challenging for highly trained, action-oriented doctors who are personally invested in and focused on resuscitative and restorative healthcare.

CONCLUSION

The increased frequency of chronic disease in an aging population will increase presentations of frail, comorbid older people with major trauma, and the need for decisions about conservative management within this group. Many of these people will not have considered the implications of chronic illness and trauma. Emergency Physicians will continue to play a pivotal role in helping patients and families navigate a fatal combination of frailty and trauma. The emergency room is our familiar environment, but it can seem uncontrolled and confusing to our older patients and their families. Our steady and compassionate presence is therapeutic. When confronted with patients dying, the Emergency Physician's skills in triage, coordinating management, and effectively communicating complex medical concepts, with the willingness to speak difficult truths, gently and clearly will support them in achieving a "good death" when medicine cannot restore "good health."

KEYWORDS

Geriatric Trauma, End-of-Life Care, Communication, Older Adult

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