What is the role of Pre Hospital Emergency Medicine (PHEM) teams in pre-hospital palliative care?

Introduction

In 2002, the WHO defined palliative care as an approach that improves quality of life of patients facing terminal illness through the relief of suffering and resolving issues such as pain and distress, as well as other problems encountered towards the end of life (1). In the United Kingdom, a multi-disciplinary approach is taken involving several members of health and social care, including but not limited to primary care physicians, palliative care specialist nurses, district nurses, palliative care physicians, healthcare assistants, and live-in carers to name a few. Nonetheless, situations arise whereby input from pre-hospital teams (comprising typically of a prehospital emergency medicine (PHEM) doctor and a critical care paramedic) is crucial in relieving the suffering identified in the definition above. This essay will explore the significant contributions of PHEM teams in palliative care settings in the community, as well as offer a balanced view of the contrary: limitations of PHEM teams in the palliative environment. Finally, in light of these limitations, possible future directions of PHEM involvement are discussed to improve patient's and families' experiences of end of life care.

Contributions

As generalists, PHEM teams are trained and expected to be equipped with a skillset to deal with all areas of medicine and surgery at the point of patient contact with health services. Retrieval, stabilisation, and transfer of critically ill patients is the cornerstone of PHEM clinical practice. PHEM practitioners are able to respond to and provide care at the beginning of life (for example neonatology) and the end (in palliative care – the subject of this essay).

- *Ethico-legal considerations*

In an ideal scenario, a patient with a terminal illness, and therefore considered 'palliative' would be known to their general practitioner, and usually a community palliative care team. Legal documents such as an advanced directive, a guidance document such as a RESPECT (recommended summary plan for end of life care and treatment) form or a lasting power of attorney, or indeed a combination of the three

can be put in place well before a patient reaches the last moments of life. These tools empower patients to choose how they will be looked after towards the end of life, and provide much needed guidance to clinicians (such as PHEM teams) who are unlikely to have a prior relationship with the patient when encountering these situations.

From a bioethics perspective, Beauchamp and Childress' four principles of autonomy, beneficence, non-maleficence, and justice first outlined in 1979 appear to have withstood the evolving specialty of palliative care (2). PHEM clinicians are expected to understand and apply these principles when responding to a palliative patient, as with any other callout. For example, patient autonomy may dictate how much intervention a PHEM team can provide in any given scenario, especially with respect to the withholding of treatment without consent. This, however, requires careful legal consideration in line with the Mental Capacity Act 2005, which empowers clinicians to carry out a dynamic assessment of a patient's competency in making such autonomous decisions. Just as in hospital, if a patient can understand, retain, weigh up, and communicate a decision about whether to consent to treatment, they should be deemed to have capacity.

- *Out of hours support*

Palliative patients often have a care plan in place. 74% of people on the community palliative care register have a documented key support worker (3). This is most often their GP or district nurse. Rapid response palliative outreach teams also provide essential support during distressing times for patients and their families. However, during times when these healthcare workers are not available, or in times of severe distress of patient's relatives, an ambulance may be called to the dying patient in a medical emergency. Common problems encountered are respiratory distress and seizures, both of which are common presentations PHEM teams are usually well equipped to deal with. However, the issue arises when there is no record of the patient's wishes, and there is difficulty clarifying the patient's background out-of-hours. As a result, an initiative by North East Ambulance Service (NEAS) Macmillan promotes information sharing between the ambulance service, primary care, and hospitals via a

"Special Patient Note" which can include details such as those shown in figures 1 and 2 below (4).

Fig 1. Reason for the special patient note

DNACPR ❒	Palliative care (Fig 2 must be completed) ❒	Emergency healthcare plan (Attach a copy) ❒
ADRT ❒	Advance statement ❒	Chest team referral ❒
Automonic dysreflexia ❒	Brittle asthma ❒	Awaiting transplant ❒
O_2 alert ❒	Hospital at home for COPD ❒	Caution needed (violence, aggression etc) ❒
Laryngectomy ❒	Temporary ❒	Permanent ❒
Tracheostomy ❒	Temporary ❒	Permanent ❒
Other ❒	Give details:	

ADRT = advance decision to refuse treatment; COPD = chronic obstructive pulmonary disease; DNACPR = do not attempt cardiopulmonary resuscitation.

Fig 2. Special patient note palliative handover details

Diagnosis:			
Patient understands their diagnosis/prognosis:	Yes ❒	No ❒	
Stage of illness:	Months ❒	Weeks ❒	Days ❒
Does patient have a preferred place of death? If yes, where:	Yes ❒	No ❒	
Is a community nurse involved? If yes, give name of nurse:	Yes ❒	No ❒	
Would this be an anticipated/expected death?	Yes ❒	No ❒	
In the event of expected death, will the GP issue the death certificate?	Yes ❒	No ❒	
Administer anticipatory medication in situ?	Yes ❒	No ❒	

- *Getting it right first time (GIRFT)*

Over the last few years, NHS England and NHS Improvement have been promoting the GIRFT strategy to improve patient flow within all settings of the healthcare system. As such, PHEM teams also have a responsibility in ensuring that decisions made in the pre-hospital environment are in the best interests of both the patient and the wider healthcare system within which we aim to operate. PHEM teams should question whether a palliative patient would benefit from hospital treatment. For instance, intravenous therapies (whether this is antibiotics, fluids or total parenteral nutrition), syringe pumps, or specialist input can all be considered as hospital-based interventions, however these may not always be a necessity. Patient controlled analgesia, regular prescribing of opioids by the general practitioner, and percutaneous

endoscopic gastrostomy (PEG) feeding are just some ways in which patients can remain at home for as long as possible. These however require early intervention from teams in the community to recognise and hopefully even anticipate that a patient will benefit, for example, from a PEG insertion prior to developing an acute need later on in their disease course.

Specifically for palliative care, the End of Life Care Plan Strategy unveiled in 2008 by the Department of Health in collaboration with the Gold Standards Framework, highlights key areas of palliative intervention early on, to help identify those patients with end of life care needs. The emphasis is on anticipating medical and social care issues and having plans in place for practitioners unknown to the patient (such as PHEM teams) to have specific instructions relevant to the patient's wishes.

Finally, in order to GIRFT, PHEM teams should attempt to recognise at what stage of illness the patient in front of them is presenting with. Figure 3 below shows how illness trajectories vary, and prompt recognition of the patient at the latter phases may inform decisions of whether or not referral to an acute service is necessary. If identified, just in case medications (often already prescribed by the GP) such as midazolam for agitation, opioids for respiratory distress +/- analgesia, and hyoscine for secretions are some of the options available to PHEM teams to ensure patients die with dignity in the comfort of their own home. Literature from Gomes et al suggests most people prefer to die at home, lending weight to the role of PHEM teams to consider this as a viable option for some patients (5) .

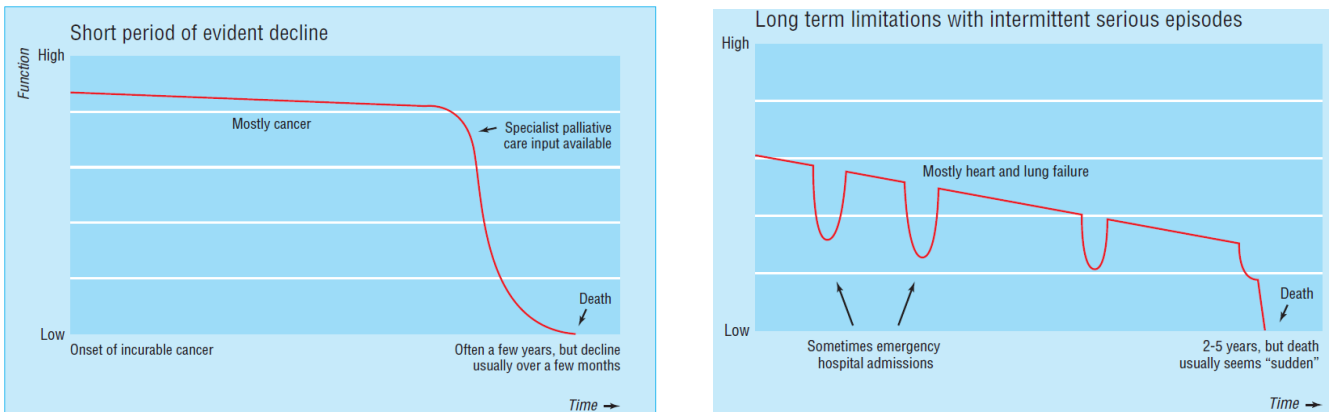

Figure 3

Limitations

Thus far, we have explored the considerable roles PHEM teams have in delivering palliative care in an acute setting. However, in the interests of balance, it is important to consider the limitations of PHEM involvement in palliative care.

- *Experience*

Palliative patients form a minor proportion of the caseload of the average PHEM team. For example, a retrospective analysis by Carron et al showed that over an 8 month period in urban Switzerland, 4/1586 callouts were to terminal patients (6). The old adage in clinical medicine that “common things are common” is reflected in the PHEM training pathway, with understandably more emphasis placed on management of trauma, respiratory distress, and other medical emergencies. As a result, the competence and confidence of PHEM teams may be somewhat hindered by the lack of exposure to these patients on a regular basis.

In hospital, the decision to deem a patient terminally ill occurs with senior input, and for inpatients often after several visits by a palliative care specialist. In the field, there is perhaps a fear of making a hastened decision and PHEM practitioners may feel more comfortable if a patient was assessed with more time and expertise in hospital. Another example is when terminating resuscitation in a cardiac arrest – PHEM teams should have senior decision makers who are able to make difficult decisions without immediate consultant input. This of course relies on constructing PHEM teams with appropriate levels of training to make such choices in stressful environments.

- *Patient preference*

Clear communication and treating patients with dignity and respect should be at the heart of medical practice. This is even more so during sensitive conversations at the end of life. The standard ambulance pathway in the ALS algorithm for refractory VF involves hospital admission, however should PHEM teams question this in the palliative setting? Taking a humane approach, if a patient without an advanced decision in place is deemed palliative, is the pre-hospital environment the right setting to initiate these conversations with distressed relatives? Or would justice be better served by giving the patient the best chance of survival by referring to hospital? These are questions which do not necessarily have a correct answer. An individual case by

case approach is perhaps the best way forward, whereby each patient, their circumstances, and the PHEM team's clinical judgement should be used to achieve an appropriate resolution.

Future considerations

Remote decision making support from senior clinicians, such as in an ambulance control room, may provide a solution to the experience limitations discussed above. In addition, several community initiatives have been introduced around the country to try and provide more experienced pre-hospital physicians to uphold the values of GIRFT. Some are outlined below:

- Barts emergency access community hub – single point of access to reach an emergency department
- Physician response unit in east London where doctors carry out the principles of GIRFT – the cumulative time, effort and quality of care conveyed in getting a patient to the right place is worth the extra time spent organising and liaising with several health and social care providers
- Lincolnshire integrated voluntary scheme – comprised of ED doctors and GPs

Finally, while it may not be possible to increase exposure to palliative cases, ongoing CPD and training in this area for PHEM trainees may prove useful in improving confidence, as it may challenge the innate dogma to err on the side of caution with a hospital referral.

Conclusion

In summary, the roles of PHEM teams in palliative care range vastly: non-technical skills such as communication, respecting patient preferences and wishes, providing out of hours medical support, and ensuring the patient is in the right place for their care needs are just some of the ways in which PHEM teams deal with palliative cases. Despite this, there are areas for improvement, and this really depends on what the expectation of PHEM practitioners is in these scenarios. PHEM teams can exert influence at a variety of points along the patient journey, and influencing education to paramedics, remote support, and on scene intervention are all possible avenues which could be seen as future considerations.

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