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

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Pre-hospital emergency medicine (PHEM) has only recently been recognised as a subspeciality of emergency medicine and anaesthetics[i]. It primarily involves caring for patients in urban, rural or remote environments before transfer to hospital. Significant physical and emotional resilience is required to manage the challenging conditions and upsetting situations experienced. As the UK, and global, population ages, emergency care departments are likely to have an increasingly higher caseload of elderly patients[ii] – many of whom have co-morbid conditions, and potentially terminal diagnoses. It is likely therefore that interaction between the emergency (ED) and palliative care departments will need to become regular, and the training and equipment for those in PHEM needs to reflect this to ensure that units across the country are able to manage such patients effectively.

The World Health Organisation emphasises that palliative care is a 'global ethical responsibility'[iii] to relieve people of serious health-related suffering – be it physical, psychological, social or spiritual. The recognition of the importance of good palliative care during the terminal stages of illness is arguably more established than the field of PHEM, yet worldwide inequities and inequalities in healthcare mean that only 14% of people who require this vital service are able to access it[iv]. Thus, it is paramount that palliative care services are improved on a local, national and international level. Through my clinical experiences in primary, secondary and tertiary care, and reflections during University seminars, I have gained a strong insight into palliative medicine - arguably one of the most important specialties in healthcare.

Up to 5% of PHEM workload may involve dealing with palliative care emergencies[v]. Whilst the ED is traditionally a place for diagnosis of acute conditions, units are increasingly burdened with managing deteriorating patients – in those with a terminal illness this may include sudden dyspnoea, haemorrhage, and seizures. Outside of normal working hours, patients and their families may access care through the emergency services. Patients must be quickly and effectively managed – and

treated, if necessary – to return them to their preferred place of dying, which is most commonly the home[vi]. Ultimately, a balanced multidisciplinary approach must be sought between the PHEM team and palliative care team. The ability of PHEM teams to provide high quality care in a range of environments places them in an excellent position to aid those suffering from terminal illness – despite this not being what they are trained for. In order to resolve and minimise the burden placed on PHEM clinicians to manage palliative care emergencies[vii], we should act from four differing, yet overlapping angles.

Prevention through anticipation of events and implementing strategies, such as an advanced care plan (ACP), is crucial. ACP should involve a conversation between the patient and their families, as well as anyone involved in their care as to their future wishes and priorities. Documenting such wishes is crucial as it means should circumstances mean the patient cannot be visited by their normal care team in their hour of need, care can be transferred and the wishes and decisions of the patient respected. We should encourage written notes as to any legal refusal of treatments, or delegations of lasting power of attorneys. Effective symptom control is the mainstay of palliation, so it may be prudent for patients to have an emergency supply of anti-emetics, analgesias, anti-epileptics, anti-secretory and anxiolytics[viii] which an emergency practitioner could administer if required.

Emergency care centres must adopt and follow protocols[ix] when managing palliative patients, and staff members must be adequately trained – particularly with respect to dealing with cultural, emotional and spiritual aspects of palliative care[x]. Discussions with PHEM trainees and paramedics suggest many have experienced uncertainties when confronted with end-of-life decisions, particularly pertaining to psychosocial care. Training should involve assessment of palliative patients and how to communicate effectively with regards to end-of-life decisions. Clinicians should be educated in the implications of DNACPR orders[xi] and the balance of respecting the patient's best interests, and acting in accordance of the principles of palliative care[xii]. There is no doubt that specialised training would provide individuals with valuable and transferable skills. For example, in mass casualty events where resources are scarce and allocated accordingly to clinical need, PHEM doctors may need to provide palliative care to patients who cannot be saved[xiii]. The COVID-19 pandemic

has brought such issues into the spotlight, with a significant burden of disease and death, exacerbated by systemic barriers placed to halt spread of the virus. This has impacted how palliative care is delivered[xiv].

Development of an on-call palliative service available to patients 24-7 will ensure management by clinicians highly knowledgeable in the field who manage end-of-life scenarios on a daily basis and have experience with supporting bereaved families. However, the rarity of palliative care emergencies may mean demand is minimal at present. Prompt review of difficult cases and transfer of care from PHEM/ ED teams at the earliest instance may be a more realistic and achievable goal. I noted the success of such procedures when speaking to a patient admitted to a DGH following a mechanical fall. Following retrieval from the PHEM team, subsequent imaging showed evidence of a pathological fracture which warranted further investigation, resulting in a diagnosis of metastatic lung cancer. Whilst the PHEM team were unaware of the patient's terminal diagnosis, the acute medical team ensured prompt involvement of oncologists and the palliative care team in order to manage the patient's expectation of illness and inform her of the likely trajectory of disease.

Collaboration must be encouraged between the prehospital emergency team and community-based palliative care networks[xv]. During a GP placement, I saw the interaction between the GP and a paramedic who was dispatched to review a young gentleman with brain cancer with declining GCS. Upon arrival, the paramedic had reservations about the suitability of the patient for ambulatory transfer and subsequent hospital care. The GP was able to inform the paramedic and the patient's family that due to nature of the condition any attempts of transfer to hospital were likely to be futile, whilst reassuring the family that their loved one was unlikely to be in pain. The interaction and coordination between both primary care and pre-hospital services ensured a comfortable and dignified death – one of the main priorities of end-of-life care. I admired the resilience of all involved and the decision making processes that took place to maximise the patient's palliation and improve their experience of dying.

It is evident that the contribution of PHEM teams to palliative medicine is significant and diverse. To improve services and ensure a comfortable, dignified death with

minimal distress, communication and collaboration between the specialities is required.

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