

SAVED – a mnemonic to facilitate palliative care integration in the Emergency Department

SAVED – uma ferramenta para facilitar a integração do cuidado paliativo em situações de emergência

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Patients with advanced disease often visit the Emergency Department for multiple reasons, ranging from uncontrolled symptoms to acute conditions such as pneumonia and pulmonary embolism. A cohort study showed two-thirds of patients visited the Emergency Department in the 6 months preceding their death, and half of them in the last month.¹

These patients often do not have a living will² or a nominated family member to aid with health issues and, in critical situations the decision to initiate or forgo life support in the Emergency Department is as crucial as it is complex.

This manuscript describes a simple mnemonic to aid decision-making for emergency physicians faced with critically ill patients that suffer from advanced, chronic illness or are extremely elderly and frail.

The mnemonic is composed of five variables that contemplate both chronic health status and acute illness:

S – surprise question: would you be surprised if this patient died in 1 year/in this admission?

A – acute situations: is the acute situation that brings the patient to the Emergency Department potentially reversible?

V – values: what does the patient value the most? What does he consider to be suffering?

E – Eastern Cooperative Oncology Group (ECOG) scale: what is this patient's previous functional status?

D – does this patient have decision-making capacity?

The surprise question “Would I be surprised if this patient died in one year?” is a simple and practical tool that has already been studied in elderly patients³ and in the emergency critical care unit.⁴ A positive answer should trigger assessment for palliative care needs. Palliative care can be provided either in conjunction with disease-modifying treatments or as a comfort-care only strategy.

Diagnosing the acute condition that brought the patient to the Emergency Department helps us establish prognosis and most important:

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reversibility. If a patient presents with progression of an irreversible, terminal disease, life support is potentially inappropriate, since it might only prolong the inevitable dying process.⁵ On the other hand, a patient presenting with decreased consciousness can have a diagnosis as serious as multiple brain metastasis or as “reversible” as hyponatremia from chronic use of thiazides and might recover, returning to baseline status with simple and noninvasive interventions. In rarer situations, looking for a diagnosis can be too invasive and/or incompatible with goals of care. In these cases, symptom management must be optimal and the patient and their family reassured that they will not be abandoned.

Patient’s values should always be part of the decision-making process. At the same time, situations that bring suffering must be avoided. Values and concepts of what is suffering vary from patient to patient and are best expressed by the patient himself. When the patient lacks decision-making capacity, family members or loved ones can help with the decision-making process, which should be centered in patient’s values (not family’s) and focused on what the patient would prefer in that specific situation. More than half of hospitalized patients in a single-center study⁶ considered being incontinent, totally dependent on others, dependent on mechanical ventilation or artificial nutrition to be states worse than death.

Functional status is an independent predictor for both prolonged hospitalization and death. The patient’s baseline functional status is an important variable for an accurate prediction of prognosis. Critically ill patients with ECOG 3 and 4 had worse outcomes after acute hospitalization, even with less severe organ dysfunction. Other scales such as Palliative Performance Scale (PPS) and Karnofsky Performance Scale (KPS) can also be used, however for this mnemonic we utilized ECOG because of its simplicity.

Finally, critically ill patients often lack decision-making capacity⁵ and are unable to participate in the decision-making process. If the patient has previously appointed a friend or family-member as a proxy decision-maker, this person should represent the patient and participate in shared decision-making as the person who can collaborate in the understanding of what would be the patient’s priority in a given situation.

Sometimes, even taking all of these variables into consideration, it is impossible to have a clear view of what the best decision is. In these situations, a time-limited trial of intensive care can be appropriate.

Decision-making in the Emergency Department is one of the most challenging tasks emergency physicians face in their routine. Patients that make an option for comfort-directed care often receive interventions that are not compatible with their values.⁶ We hypothesize that incorporating a structured assessment can help physicians to better estimate prognosis, avoid futile care and refrain from interventions that are incompatible with patient’s values and priorities.

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