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Geriatric Psychosocial Issues in the Emergency Department

My mother was blessed. For the last few years of her life before she died of breast cancer, she was lovingly cared for by my father. Friends would come and visit. So, despite being housebound and eventually bedridden, she had companionship and connection with others. She had little to no pain. How? I don't really know, but I think it was that she felt alive and involved with others. Even when she became confused, the confusion and delusions were pleasant, almost happy. She would talk about places she had been and people she had met when, in fact, it had not happened. She was enrolled in a hospice program for the final months of her life. A few years before, she had established her desires about how she wanted to spend her final days. Her passing was peaceful. We and our loved ones should be so fortunate.

When I see some of the elderly patients in my emergency department (ED), from home where they live alone, or from extended care facilities or nursing homes, I can't help but think about my mother. So many elderly patients in the ED are lonely, often troubled by depression, victims of abuse, or facing end-of-life decisions. The emergency physician often is called upon to handle these concerns. This issue will hopefully provide some guidance when seeing these patients.

— J. Stephan Stapczynski, MD, FACEP, Editor

Depression and Suicide

The prevalence of depression in the elderly varies widely depending on their situation. Anywhere from 1-4% of older adults living in the community are estimated to suffer from depression,[1] but 5-10% of elders who visit a primary care physician are diagnosed with depression.[2] These rates compare to 2.5% of children, 8% of adolescents,[3] 2-4% of adult men, and 4-6% of adult women.[4] However, the rates climb for the elderly as they become ill or lose their independence. Older patients who end up hospitalized have rates between 10-12%, and the rates for residents of nursing homes are from 12-20%.[1] Depression has been shown to be even more common in patients with certain medical conditions. For example, depression in seen in 40% of patients with coronary artery disease, 25-50% of patients hospitalized for cancer, and 40% of patients after a stroke.[5] Thus one would expect a high rate or depression for older ED patients, and one study found at least 27% of geriatric ED patients had depression.[6] Another study found that ED physicians were not very good at identifying depression in older patients. Physicians identified 41% of patients with depression, but also considered 46% of non-depressed patients to be depressed.[7] They referred only 13% of patients whom they identified as depressed for further mental health evaluation. Given that older adults have the highest risk of death from suicide (nearly 6 times that of younger people), one must not ignore depression in older ED patients.

Like many other conditions, the elderly may present with typical symptoms such as loss of interest in activities, depressed mood, and changes in appetite and sleep patterns. Many other elderly patients will present atypically instead, with somatic complaints or cognitive changes. Generalized anxiety frequently

Executive Summary

- Depression is common in elderly ED patients, often associated with cognitive impairment or nonspecific somatic symptoms.
- The risk of suicide increases with age and the number of physical aliments, so have a low threshold for directly asking elderly patients about suicidal thoughts or ideas.
- Neglect is the most common form of elder abuse, particularly if the patient is demented, functionally impaired, and financially dependent on the caregiver.
- Use appropriate doses of opioids to control pain and suffering to create a less disturbing environment to discuss end-of-life care with the family while in the ED.

accompanies depression in the elderly, and somatic complaints from anxiety can easily be confused with organic conditions. Dyspnea, chest pain, epigastric discomfort, frequent urination, muscle aches, dizziness, and headache are all common complaints with anxiety, but all of those complaints also have other possible causes that should be considered before concluding anxiety is the cause. In addition, loss of memory and cognitive function can easily be caused by dementia or infection as well as depression. In the ED, it is unlikely that one will be able to rule out all the other causes of somatic complaints in every case. But, one should keep depression in mind and refer patients appropriately in cases where no physical causes are found for the patient's vague constellation of complaints. Often, simply questioning the older patient about depression when other tests do not yield an explanation for their symptoms can be helpful. A simple three-question screening tool can be used by asking the patient the following: Do you often feel sad or depressed, do you often feel helpless, and do you often feel downhearted or blue?[8] A "yes" answer has a sensitivity of about 80% and a specificity of about 66% when compared to the more extensive Geriatric Depression Scale. Therefore, a positive response is reason for further mental health evaluation. While some patients will readily admit to depression, other older patients may resist having a "mental illness." Concerns of depression should be passed on to relatives, caregivers, and the patient's primary physician when possible.

One of the primary reasons to identify the older patient with depression is the higher risk of successful suicide. Older adults have the highest risk of death from suicide of any age group, and suicide was the 11th leading cause of death in the United States in 2006.[9] The risk actually goes up significantly with age. While the overall rate of suicide for those older than 65 years is double that of the rest of the population, the rate for those older than 85 years is six times higher (21 per 100,000). While the elderly do not attempt suicide as often as younger people, they are much more likely to be successful when they do attempt it. Nearly 1 of every 4 older people succeeds compared to only 1 of 200 of the general population.[11] In addition, 75% of the elderly succeed on their first attempt.[12] Thus, about 25% of all suicides in the United States are committed by people older than 65 years. Further, they are also less likely to voice suicidal ideation. In other words, when elderly patients admit to suicidal ideation, they should be taken very seriously.

Risk factors associated with suicide in the elderly tend to be obvious. The presence of physical illnesses, such as HIV/AIDS, multiple sclerosis, renal disease, spinal cord injury, lupus, and cancer, all tend to increase risk. Further, the risk is additive. A Canadian study of older patients who committed suicide found a three-fold increase in suicide risk in patients with three physical illnesses, and a nine-fold increase in patients with seven or more illnesses.[13] Other risk factors associated with suicide include financial problems, job loss, family discord, and living alone.[14] Substance abuse, in particular alcohol dependence, is the second most common psychiatric disorder associated with suicide, behind depression. One study found that up to 44% of elders who committed suicide had an active substance abuse problem.[15] In terms of race and sex, although women attempt suicide three times more often, white men have the highest risk for success. Native Americans are the only other race with similar suicide rates compared to whites, with the rates in African-Americans and Hispanics being half that of whites.[16]

A striking 70% of older people who commit suicide saw their primary care provider less than 30 days before their suicide.[17] In 33% of these cases, the visit was in the last week before, and in 20% it was less than 24 hours before.[17] It is unknown how many visited EDs in this time period, but the number is likely considerable. Roughly 72% of suicides among the elderly are committed with a firearm, followed by overdose (11%) and hanging/suffocation (11%).[9] One study of men who killed themselves with firearms found no link between owning a gun and suicide risk, but there was a link for those who purchased the weapon in the week preceding suicide.[18] Other studies do find a link between guns in the home and increased risk of suicide.[19] It seems that storing a weapon loaded and unlocked is an independent risk factors for suicide, as some argue that most suicides are impulsive acts and that easy access to a gun increases the risk.[19] One needs to keep the increased risk of suicide in the elderly in mind when evaluating them in the ED for depression.

Elder Abuse in the ED

Unfortunately, elderly people are often victims of abuse or neglect, and in some cases the ED may be the best opportunity to detect and intervene in these problems. Elder abuse is generally defined as "intentional actions that cause harm/serious risk to a vulnerable elder by caregiver or failure of the caregiver to provide for the elder's basic needs."[20] Public awareness of elder abuse began in 1975, and lagged behind child abuse (1960s) and domestic violence (1970s). Precise numbers on the prevalence of elder abuse in the United States are difficult to obtain, as the National Center on Elder Abuse states that only 1 of every 14 adult domestic abuse cases is reported.[21] Even so, research suggests a rate of elder abuse between 2-10%, which translates to 32 of every 1000 adults or roughly 2 million elderly people each year.[21]

Abuse of the elderly can take many forms, from physical or verbal abuse to taking financial advantage. One study tried to assess the frequency of different types of elder abuse and found the following. Neglect was actually the most common form of abuse and was seen in 49% of cases, followed by verbal/psychological abuse (35%), financial abuse (30%), physical abuse (25%), abandonment (4%), and sexual abuse (0.3%).[22] Although there are many variations, the typical victim is 75 years old or older, suffers from dementia or mental illness, and is not able to perform his or her activities of daily living. (*See Table 3.*) The victim also lives with his or her caretaker, is isolated socially, and often is a minority.[23] Women are more commonly victims of physical abuse than men. The most consistent finding of all studies of elder abuse is that the abuser is a close relative, in most cases a male adult child (47%) or spouse (19%).[24] The presence of substance abuse in the caregiver is strongly associated (35% of cases) with elder abuse, and most often is alcohol abuse.[20]

Detection of abuse in the ED is challenging, as the patient often is a vague historian at best. In addition, in many cases injuries from a simple fall and those from abuse can be indistinguishable. The American Medical Association has created screening questions that are similar to those asked when screening for domestic violence. The best advice is to be aware of how frequently this occurs and to remember the risk factors associated with elder abuse. As with other aged patients, when injury patterns do not match the story given, one should act to protect the patient from further harm. At least 43 states have some form of mandatory reporting for suspected elder abuse in private homes, but all 50 states mandate reporting for institutionalized elders.[25] ACEP has a policy statement against mandatory reporting of all forms of family violence to law enforcement.[26] Instead, the organization recommends reporting to social workers, victim's services, as well as law enforcement based on what seems appropriate in each case as well as taking the patient's preferences into consideration.

Table 1. Depression in the Elderly

- Common, seen in about 1/4 of geriatric emergency department patients
- Often present with somatic complaints as opposed to depressed mood
- Depression may cause loss of memory and cognitive function
- Three-question screening tool is useful:
    - Do you often feel sad or depressed?
    - Do you often feel helpless?
    - Do you often feel downhearted or blue?

Table 2. Suicide in the Elderly

- The suicide rate increases with age: twice for individuals older than 65, and six times for those older than 85.
- White males and Native Americans have the highest rates.
- Suicide in the elderly is associated with physical illness, and the rate increases with number of co-morbid conditions.
- Medical care provider visits are common within the week preceding suicide and suicide attempts.

End-of-Life Decisions and Care in the ED

As the number of elderly people increases with time, ED physicians will increasingly find themselves dealing with decisions surrounding end-of-life care for geriatric patients. One can compare end-of-life care decisions with notifying a patient's family of his or her death. Few physicians undergo any specific training in medical school or residency for these situations. Both of these experiences are emotionally difficult and require instruction with examples for most physicians to be comfortable performing this task. Numerous papers have been published on the lack of education given to medical students and residents on delivering bad news to family members when a loved one has died.[27,28]

Yet, while death notification is usually a brief encounter in the ED that consists of telling family members about what has already occurred, helping family members face the inevitable when a loved one is dying is a much more complex and challenging process. The responses from families and friends can be as varied as when one performs death notification. Some people will have already prepared themselves that death was coming and will be relieved that their loved one is no longer suffering, while others will become very emotional and may be unable to

Table 3. Risk Factors for Elder Abuse[20,23,29]

Victim Risk Factors
• Age > 75
• Low income
• Social isolation
• Minority
• Financial dependence on caregiver
• Cognitive impairment
• Substance abuse
• History of family violence
• Caregiver stress
• Low level of education
• Previous psychological problems
• Functional impairment
Perpetrator Risk Factors
• Primary caregiver (adult child or spouse)
• Substance abuse (often alcohol)
• Male more often than female

converse further with the physician. Emergency physicians encounter the latter response often when family members adamantly state, "Do everything!" when their dying loved one arrives in the ED. Perhaps even more so than death notification, helping guide a family member through the dying process can have great impact and lasting effects on both the family and the physician. In reality, death notification cannot be avoided in the ED. However, dealing with end-of-life decisions can always be passed on to the admitting physician even if it should be approached and in some cases finalized in the ED.

Death in America has slowly transitioned in the past 100 years from an event that always occurred in the home to one where, in 2004, an estimated 67% of people died in institutions.[30] It is hard to imagine that the experience of death in institutions is more comfortable in most cases for the patient or family. A recent survey of 1578 cases of death in various locations found that 32% of families thought pain was not controlled in nursing homes compared to 19% in hospitals and 18% with home hospice care.[30] Likewise, 32% of families at nursing homes thought the patient was not always treated with respect vs. 20% in hospitals and only 4% in home hospice care.[30] The concept of death has also transitioned from an expected end to life to a "failure" of modern medicine to keep people alive. The recent case of Terry Schiavo, whose husband's attempt to remove a feeding tube triggered national debate in 2005, demonstrates how polarized views in the United States can be concerning end-of-life decisions.

The reality, though, is that death has not changed, but our approach to it has. Families of patients ultimately know and accept that death comes for all of us, but they may not be ready to accept the timing when death actually arrives. When the ED physician is ready to help family members accept that "this is the patient's time," in many cases, the process again can be viewed as a natural ending of life, and we can help ease the relatives' pain instead of adding to it. Unfortunately, physicians can be reluctant in some cases to address these decisions when heroic care measures have become obviously futile. More often than not, physicians put the entire decision in the family member's court by asking, "What do you want us to do?" without offering their treatment recommendations. This is the wrong approach to take in dealing with end-of-life decisions. While a minority of relatives may want to shoulder the responsibility for treatment decisions completely on their own, most are expecting the treating physician to give them guidance on what should be done next. Otherwise, they may feel they are being put in the position to make the decision to "pull the plug on grandma." Just as it would be bewildering for families to be given sole responsibility on deciding whether to remove a loved one's appendix or stent a culprit lesion during a STEMI, they are looking for recommendations from the physician on what to do at this critical time. It is much easier for them to feel later that the "doctors said there was nothing more they could do" rather than feel they "chose" for their loved one to die.

In some cases, it will be unclear that further treatment is likely futile, but these are not the ones being discussed. The cases being referred to now are long-term nursing home residents or those with defined terminal illnesses such as cancer. Long-term nursing home residents often no longer walk, speak very little if any, and usually receive nutrition only via gastrostomy tube. Most of these patients suffer from some form of dementia and are victims of slow, lingering decline that can last years. They are frequently transported to the ED for respiratory distress from aspiration pneumonia or urosepsis. While relatives do not always accompany these patients, there is nearly always a list of contacts in their charts. In many cases, the nursing home has already informed them that their relative is being transported to the ED. In these situations, the ED physician should approach the decision maker in the family about restricting care to measures that make the patient comfortable (IV morphine) and not pursuing aggressive treatment (intubation, extensive blood work, CT scans) that in reality may just prolong the patient's suffering. The recent quality of the patient's life should be defined, and the relative should be gently asked if the patient

Table 4. Summary of Recommendations to Help Relatives with End-of-life Care and Decisions

Care Directed at the Patient
Patient comfort is the primary goal. • Give opiates generously for pain. • Double the dose given until pain is controlled. • Opiates also help with air hunger. • When the patient is no longer suffering, the family will be more apt to listen to reason. When possible, ask patients about their desires for end-of-life care. Follow advance directives when they are available. AMA and ACEP current policy guidelines clearly support the physician's choice not to perform interventions or resuscitation that is deemed futile or unlikely to benefit the patient.
Care Directed at the Family
Strategy to deal with the "do everything" statement • It is an emotional reaction, not a rational command that must be blindly followed. • Do not hesitate to state, "This is not in the patient's best interest," when you believe that is the case. • You can state, "Everything has been done, and this is where we are now — it is your loved one's time." • Alternatively, you can point out that "everything" is not possible, i.e., the patient is not a candidate for heart transplant, etc. Focus the family back on the patient and away from their reaction • My goal is to keep the patient comfortable now. • Doing lots of invasive procedures is not in the patient's best interest. • Have the past few months been comfortable/enjoyable for the patient? Would the patient want to continue living like that? • Is this what the patient would have wanted now? Reassure family members that comfort care or DNR orders do not mean that the patient will no longer be treated. Initiate palliative care consult or hospice consult when available.

would have wanted to live like this. Point out that their best possible outcome from current illness would be to return to the nursing home in the same state of health they were in previously. If this was not a comfortable or enjoyable existence, then it is not the best thing for them to be aggressively resuscitated in hopes of returning to it. One may be surprised to find that the relative agrees with a subdued approach focusing on comfort, and that this may not have been discussed with him or her in the past. Obviously, others will want "everything done," but it should be stressed that this course may increase the patient's suffering and may not be what's best for him or her at this time. (*See Table 4.*) Given the legal system's reluctance to override a family's desire for continued care, it is not realistic in most cases to withhold care that a family member demands.[31] One should make honest attempts to help families accept the inevitable, but when this does not happen, it is usually the best course to proceed in a standard fashion. It may be helpful in these cases to encourage the family to be present for resuscitation.

Another scenario that occurs in the ED is when a patient nears the end of life from a terminal illness such as cancer. In some cases these patients have been under hospice care, and the ambulance is summoned as the end actually draws near and relatives begin to panic. They can arrive in the ED with the ambulance and dramatically tear up the patient's DNR directive, stating, "Do everything!" In other cases the decisions on end-of-life care have not been made by the patient or family, and they arrive in the ED in a terminal state with a "full code" status. If it is unclear that the patient is at the end stage of an illness, then reasonable efforts to reach a diagnosis of the event prompting the sudden decline should be performed. However, the first step should be to administer appropriate doses of morphine (5-10 mg) or dilaudid (1 mg) to ensure the patient is not in undue pain/distress. Do not be hesitant to give additional doses and titrate upward until the patient's tachypnea/pain is improved. Fears that adequate analgesia may hasten death should be balanced by the obligation to relieve the patient's pain and suffering, which is supported by the AMA Council on Ethical and Judicial Affairs.[32] Just taking this step can greatly ease the relative's discomfort, because it is very stressful to see a loved one in distress. Once the patient has been made more comfortable, and it is clear that he or she is near death, then one should focus on helping the family accept what is happening. Help the family understand that this is "their loved one's time" and that he or she will be cared for appropriately.

Taking family members from an emotional "do everything" statement to acceptance that their loved one is going to die is not always possible in the ED, but it can be done more often than one might expect. (*See Table 4.*) The first step is to recognize that the statement "do everything" is an emotional statement of pain, not a rational, well-thought-out decision on care. The relative is emotionally pushing away the pain of a loved one's death and hoping to delay it. Although it is actually a

relatively selfish approach to have the patient undergo painful procedures to keep the relative from having pain, this is happening on a subconscious level. The "do everything" statement does not mean that the ED physician has no choice but to admit the patient to the ICU on full pressor support either. One can state that everything has been done already and this is where we are now; it is your loved one's time. A more assertive statement would be to ask the relative what "everything" means. The patient is unlikely to survive dialysis, is not a candidate for heart transplant, may not be helped by bilateral leg amputation, etc. In some cases this may help them understand that "everything" is not possible and that focusing on keeping the patient comfortable is the only real option.

Some relatives may be afraid that reducing care will mean the patient will be left without care. Reassure them that keeping their relative comfortable will be the primary objective; very few family members will disagree with this. Others may think they are getting reduced care because of no insurance/money, or they have seen unrealistic outcomes on television and equate them with reality in the ED. Surveys find that laypeople believe the survival rate for CPR is 40-60%.[33] The point is to try to understand what the relative's main fears are and address them appropriately. Ultimately, one should be aware that the AMA Council on Ethical and Judicial Affairs clearly states that CPR can be withheld, "when efforts to resuscitate a patient are judged by the treating physician to be futile," even if requested by the patient.[34] The current ACEP policy also states, "physicians are under no ethical obligation to render treatments that they judge have no realistic likelihood of medical benefit to the patient."[35]

As the numbers of elderly patients in the ED inevitably climb in the coming years, ED physicians will be faced with these situations more and more often. Just as one has a plan in mind for other critical situations (airway compromise, bleeding trauma patients), one needs to have thought about guiding older patients and families through this critical time when they arrive in the ED during their last hours. While it may be tempting to silently ignore these duties and pass them on to an admitting physician, it is our responsibility to address them in the ED. Emergency physicians regularly encounter dying patients more often than nearly all other specialties, and one needs to be comfortable with these events. Although the standard approach of ED physicians to a dying patient is to try to save him or her, the impulse to "save life at all costs" must be relinquished when treating terminally ill patients.[36] Complex questions may not always be solved while the patient is in our care, but the process will have been started, and families will appreciate having our opinion that the end is near for this patient. Lastly, many hospitals have palliative care services or hospice services, and one can initiate consult in the ED to help deal with these intricate issues.

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Physician CME Questions

101. Which of the following statements concerning depression in the elderly is *not true*?
    A. The rate of depression is generally higher in the elderly.
    B. Depression in the elderly can be associated with cognitive changes.
    C. Depression in the elderly can be associated with somatic complaints.
    D. Directly asking elderly patients if they feel sad or depression is not a useful approach.

102. Which of the following statements concerning suicide in the elderly is *false*?
    A. Older adults have the highest risk of death from suicide of any age group.
    B. One of every 4 older adults succeeds in his or her suicide attempt.
    C. The elderly are less likely to voice suicidal ideation compared to younger patients.
    D. Seventy-two percent of elderly suicides were committed with a firearm.
    E. All of the above

103. According to studies, which of the following is the most common form of elder abuse?
    A. verbal abuse
    B. neglect
    C. financial abuse
    D. physical abuse

104. Which of the following factors is *not* associated with victims of elder abuse?
    A. independent financial income
    B. age older than 75
    C. physically dependent
    D. dementia

105. Which feature is the most consistent in people who commit elder abuse?
    A. alcohol abuse
    B. the person is a relative of the patient (child or spouse)
    C. female more often than male
    D. low education level
    E. financial dependence on the older person

106. Which of the following statements concerning end-of-life pain management is true?
    A. Pain management in nursing homes is more effective than that provided in hospitals.
    B. Because of potential respiratory depression, only small doses of morphine, 1-2 milligrams, should be used initially.
    C. Opiates will help with the symptom of air hunger or dyspnea.
    D. Pain management in home care hospice is as effective as that provided in hospitals.

107. When a relative of a dying elderly patient says to "do everything" in the ED:
    A. The physician has no choice but to comply.
    B. This is an emotionally based statement as the patient's death becomes imminent.
    C. It is usually in the patient's best interest to comply.
    D. In the ED most relatives are not amenable to gentle guidance toward a comfort-based treatment plan.
    E. None of the above

108. The primary objective in end-of-life care in the ED should be:
    A. comfort of the relatives because they are the ones who can bring lawsuits
    B. to let the admitting physician solve this problem
    C. to ensure the patient's pain and suffering are controlled
    D. to not follow advance directives when they are available in the ED

109. Following cardiac arrest, what percentage does the lay public believe will be successfully resuscitated with CPR?
    A. 40-60%
    B. 90%
    C. 20%
    D. 5%

110. Which of the following statements regarding CPR at end of life is true?
    A. CPR can only be withheld if the patient has the appropriate advance directive.
    B. CPR is required if the family specifically requests it be done.
    C. Physical presence of a family member is required to start or stop CPR.
    D. CPR can be withheld when efforts to resuscitate a patient are judged by the treating physician to be futile, even if requested by the family.

CME Answer Key

101. D; 102. E; 103. B; 104. A; 105. B; 106. C; 107. E; 108. C; 109. A; 110. D

Emergency Medicine Reports

CME Objectives

Upon completion of this educational activity, participants should be able to:

- recognize specific conditions in patients presenting to the emergency department;
- apply state-of-the-art diagnostic and therapeutic techniques to patients with the particular medical problems discussed in the publication;
- discuss the differential diagnosis of the particular medical problems discussed in the publication;
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Emergency Medicine Reports
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Geriatric Psychosocial Issues in the Emergency Department

Depression in the Elderly

- Common, seen in about 1/4 of geriatric emergency department patients
- Often present with somatic complaints as opposed to depressed mood
- Depression may cause loss of memory and cognitive function
- Three-question screening tool is useful:
  - Do you often feel sad or depressed?
  - Do you often feel helpless?
  - Do you often feel downhearted or blue?

Suicide in the Elderly

- The suicide rate increases with age: twice for individuals older than 65, and six times for those older than 85.
- White males and Native Americans have the highest rates.
- Suicide in the elderly is associated with physical illness, and the rate increases with number of co-morbid conditions.
- Medical care provider visits are common within the week preceding suicide and suicide attempts.

Risk Factors for Elder Abuse

Victim Risk Factors

- Age > 75
- Low income
- Social isolation
- Minority
- Financial dependence on caregiver
- Cognitive impairment
- Substance abuse
- History of family violence
- Caregiver stress
- Low level of education
- Previous psychological problems
- Functional impairment

Perpetrator Risk Factors

- Primary caregiver (adult child or spouse)
- Substance abuse (often alcohol)
- Male more often than female

Summary of Recommendations to Help Relatives with End-of-life Care and Decisions

Care Directed at the Patient

Patient comfort is the primary goal.

- Give opiates generously for pain.
- Double the dose given until pain is controlled.
- Opiates also help with air hunger.
- When the patient is no longer suffering, the family will be more apt to listen to reason.

When possible, ask patients about their desires for end-of-life care.

Follow advance directives when they are available.

AMA and ACEP current policy guidelines clearly support the physician's choice not to perform interventions or resuscitation that is deemed futile or unlikely to benefit the patient.

Care Directed at the Family

Strategy to deal with the "do everything" statement

- It is an emotional reaction, not a rational command that must be blindly followed.
- Do not hesitate to state, "This is not in the patient's best interest," when you believe that is the case.
- You can state, "Everything has been done, and this is where we are now — it is your loved one's time."
- Alternatively, you can point out that "everything" is not possible, i.e., the patient is not a candidate for heart transplant, etc.

Focus the family back on the patient and away from their reaction

- My goal is to keep the patient comfortable now.
- Doing lots of invasive procedures is not in the patient's best interest.
- Have the past few months been comfortable/enjoyable for the patient? Would the patient want to continue living like that?
- Is this what the patient would have wanted now?

Reassure family members that comfort care or DNR orders do not mean that the patient will no longer be treated.

Initiate palliative care consult or hospice consult when available.

Supplement to *Emergency Medicine Reports*, May 10, 2010: "Geriatric Psychosocial Issues in the Emergency Department." *Author:* **Gary Hals, MD, PhD**, Attending Physician, Department of Emergency Medicine, Palmetto Richland Memorial Hospital, Columbia, SC.

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	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After completion of this program, I am able to:						
2. Recognize specific conditions in patients presenting to the emergency department.	○	○	○	○	○	○
3. Apply state-of-the-art diagnostic and therapeutic techniques to patients with the particular medical problems discussed in the publication.	○	○	○	○	○	○
4. Discuss the differential diagnosis of the particular medical problems discussed in the publication.	○	○	○	○	○	○
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