



# Death, Dying, and End-of-Life Care Provision by Doctors and Nurses in the Emergency Department

## *A Phenomenological Study*

Oluwatomilayo (Tomi) Omoya, PhD, RN, GradDip(Emergency Nursing), BN(Hons), MCENA ○  
Anita De Bellis, PhD Flin, MN Flin, BN(Man) Flin, RN, DipN SACAE ○  
Katrina Breden, PhD, MN, BAppSc(Nursing), RN, GradCertEd(Higher Education)

There have been significant advancements in the fields of medicine, demography, and pathology. These disciplines have contributed to the classification and control of death and dying. People are now living longer with numerous comorbidities, and there is a significant aging population. Consequently, there have been increases in the numbers of people who present to emergency departments across Australia seeking access to care at the end of life. Emergency department staff must have the knowledge and skills required to provide end-of-life care in a setting that traditionally contradicts the goals of comfort care. With the increase in demand for end-of-life care in emergency departments, a gap exists in the experiences of how staff provide such care in this setting. As a result of this gap, it is important to understand the lived experiences of emergency department doctors and nurses who provide end-of-life care. The aim of this research is to understand the lived experiences of emergency department doctors and nurses concerning death, dying, and end-of-life care provision. Data were analyzed using Diekelmann's 7-step analysis to support Gadamer's phenomenological approach. Results indicate that

challenges exist in the decision-making process of end-of-life care in emergency departments.

### KEY WORDS

acute care, attitudes, barriers and facilitators, critical care, death and dying, ED, education, emergency department, end-of-life care, EOLC, experiences, knowledge, medical, nursing, palliative care, terminal care

The emergency department (ED) is generally the first point of contact for people who need health care services, serving as a specialty for critical conditions and traumatic events. Its primary aim is to provide curative treatment. The general public and ED staff often hold a misconception that death is not expected within the ED and that people who seek medical care from EDs are primarily seeking curative treatments.<sup>1,2</sup> Patients with incurable chronic illnesses and those who require end-of-life care (EOLC) often access EDs in a crisis for treatment and/or symptom management, and as such, EOLC is required for those who are dying and cannot be treated in an area designed to save lives.

According to the Australian Institute of Health and Welfare,<sup>3</sup> of the 7.5 million presentations to EDs in 2015, approximately 16% either died in the ED or were dead on arrival. People at the end of life (EOL) often have an acute crisis, and admission to the ED is a common pathway when a person may be dying.<sup>1</sup> Despite the significant amount of contact with dying patients, accepting death and the provision of quality EOLC within the ED remains difficult for staff and family.<sup>4,5</sup> Doctors and nurses who work in ED still lack the knowledge and skills required to adequately care for people at the EOL.<sup>6</sup> One reason for this lack is the focus of emergency education on saving lives and treatment with little or no emphasis on EOLC.<sup>1</sup>

In some cases, palliative care and ED staff work collaboratively to seek out ways of improving care for patients

**Oluwatomilayo (Tomi) Omoya, PhD, BN (Hons), RN, GradDip (Emergency Nursing), MCENA**, is associate lecturer (teaching specialist), College of Nursing and Health Sciences, Flinders University, Adelaide, Australia.

**Anita De Bellis, PhD Flin, MN Flin, BN(Man) Flin, RN, DipN SACAE**, is senior lecturer in nursing, College of Nursing and Health Sciences, Flinders University, Adelaide, Australia.

**Katrina Breden, PhD, MN, BAppSc(Nursing), RN, GradCertEd(Higher Education)**, is senior lecturer and teaching specialist, College of Nursing and Health Sciences, Flinders University, Adelaide, Australia.

Address correspondence to Oluwatomilayo (Tomi) Omoya, PhD, BN(Hons), RN, GradDip(Emergency Nursing), MCENA, College of Nursing and Health Sciences, Flinders University, GPO BOX 2100, Adelaide, SA 5001, Australia (oluwatomilayo.omoya@flinders.edu.au).

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with chronic life-limiting illnesses who will benefit from palliative care.<sup>7</sup> For example, in 2006, the American Board of Emergency Medicine announced palliative medicine was to be a sub-specialty of emergency medicine because of the increase in EOLC needs within the ED.<sup>4,7</sup> Although some progress has been made in the integration of EOL and palliative care into emergency medicine in some countries, there is a significant gap in the Australian literature as to how EOLC is delivered within the ED.<sup>8,9</sup>

The literature has shown that patients often present to access symptom management.<sup>1,2,8,9</sup> An exploration of EOLC in ED from both doctors' and nurses' perspectives has the potential to identify barriers and facilitators to the effective implementation of EOLC in the ED setting and to inform practice and education for staff, with the aim of improving outcomes for patients and families. Guided by Hans-George Gadamer's phenomenological interpretive underpinnings (hermeneutics), this phenomenological study explores the lived experiences of ED doctors and nurses concerning death, dying, and EOLC using qualitative methods of data collection.

**METHOD**

Purposive sample of participants in this study was composed of Australian ED doctors and nurses who provided EOLC in the ED. Participants responded to emails sent by the Australasian College for Emergency Medicine and the College of Emergency Nursing Australasia. A total of 16 participants (7 doctors and 9 nurses) responded and provided firsthand accounts of their experiences of providing EOLC in the ED. Of the 16 participants, 11 had worked in an ED for 10 years, whereas 4 had worked in an ED for more than 10 years. Most of the participants had engaged in postgraduate education and training after their university degrees. In addition, 13 of the participants had undertaken senior roles including ED consultants, triage, resuscitation, and team leader roles. Table 1 provides further information about the demographics and characteristics of the participants.

Data were collected for a period of 7 months. The semistructured interview (Appendix 1) times ranged from 30 minutes to 2 hours at a suitable location for the participant or via telephone. The recorded interview data were transcribed verbatim, and pseudonyms were used to ensure confidentiality.

Final ethics approval for the study was obtained from the Social Behavioral Research Ethics Committee of Flinders University (project: 7909). Approval to recruit ED doctors and nurses was sought and obtained from the Australasian College for Emergency Medicine and the College of Emergency Nursing Australasia.

A qualitative methodology has been used using Han-George Gadamer's hermeneutic phenomenology. The use of Gadamer's hermeneutic phenomenology has assisted the researcher

**TABLE 1** Overview of Participants

	Nurse	Doctor
Total = 16	56%	44%
Sex		
Male	4	2
Female	5	5
Age, y		
18–29	4	1
30–49	5	4
50–64		2
Education		
University graduate	2	2
Graduate diploma	6	
Master's degree	1	1
Doctoral degree		1
Professional degree		4
Years of working in ED		
<5	1	1
6–10	8	2
>11		4
Roles in ED		
Senior nursing roles (triage, resus, TL)	5	
Consultant		6
Intern		1
Registrar		1
Low-acuity team leaders	4	
Education on death and dying		
Yes	4	3
No	5	4

*Abbreviations: ED, emergency department; resus, resuscitation; TL, team leader.*

to establish an understanding and create meaning out of ED staff experiences. Data were analyzed using Diekelmann's 7-step analysis to support Gadamer's phenomenological approach (Table 2).<sup>10</sup> Gadamer's key phenomenological concepts of constant dialogue, fusion of horizons, language,



**TABLE 2 Diekelmann et al's (1989) 7 Stages of Data Analysis**

Stage	
1	All the interviews or texts are read for an overall understanding.
2	Interpretive summaries of each interview were written, and excerpts were provided.
3	A (team) of researcher(s) analyses selected transcribed interviews or texts.
4	Any disagreements on interpretation are resolved by going back to the text.
5	Common meanings and shared practices are identified by comparing and contrasting text.
6	Relationships among themes emerge.
7	A draft of themes and exemplars from texts are presented to the team. Responses or suggestions are incorporated into the final draft.

experiences, truth, prejudices, and hermeneutic questioning were used.

## RESULTS

From the data obtained, 4 major themes were identified: (1) providing for respect and dignity, (2) ethical dilemmas, (3) providing EOLC in the ED and the role of the participants, and (4) experiencing conflict. The findings showed that maintaining dignity throughout the dying process was a crucial aspect of EOLC provision. Participants often reported that the decision making on treatment and management were difficult and challenging. The themes are described hereinafter and illustrated by using quotes from the participants.

### PROVIDING FOR RESPECT AND DIGNITY

The participants believed that the provision of EOLC must be founded on both respect and dignity. They defined respect and dignity in EOLC as strictly adhering to the dying patient's wishes (lifesaving or comfort care). According to the participants, when the patient's wishes were respected, they had been given a voice in a situation in which they could easily become voiceless and disrespected and could end up having an undignified experience of death and dying. Participants described the importance of family members and loved ones in relation to respectful and dignified care. For example:

For the patient, obviously it's maintaining their dignity, so I would, before bringing the family in, especially if it's from a patient from a tragic circumstance, make sure blood is

washed off, a new gown is placed on the patient, clean sheets, things like tubes and lines are removed where possible, sufficient pain relief is given so the patient does not look like he or she is in pain, especially when the family members are in there. Yes, so just making sure that the patient looks presentable before we bring family members... (Nurse Abigail, p. 11, L 12-38).

The participants also revealed that their own personal culture, beliefs, and views influenced death, dying, and EOLC in the ED. The doctors' and nurses' beliefs and values varied considerably, ranging from Christianity to atheism.

Personally, I'm a Christian, so death and dying, I would say, means different to me than it would to someone who isn't a Christian...yes, personally as a Christian, for me there's hope after death and dying, ... (Nurse Abigail, p. 5, L 10-28).

Some participants believed that care was easier when the dying patient and their family held the same beliefs and views as them.

I think those situations were easier maybe because I felt like they [the dying patient and families] were behaving the way I would behave... (Dr Nnea, pp. 4-5, L 59-60, 1-6).

The participants reported that their ideas and beliefs enabled them to cope with death, dying, and the provision of EOLC.

### ETHICAL DILEMMAS

Ethical dilemmas occurred when the participants were presented with situations in which the available choices did not resolve the dilemma. Such dilemmas deepened when there were misunderstandings as to what a quality life and a quality death entailed. The participants believed that quality of life was often not determined by the dying patient:

I think we [ED doctors and nurses] assume quality of life as to what we would imagine it to be, as opposed to potentially what the patient would consider as quality of life, and that's a very big ethical question in itself. As soon as we hear that the patient is independent or was able to walk, ..., and they were 90, then you try a little bit harder, because you feel that they had a better life to go back to, even though you know that potentially it will be futile (Nurse Robert, p. 6, L 29-37).

Within the context of ethical dilemmas, issues about the provision of futile care were common. For example, the decision-making process on the futility of treatment was seen by the participants as contextual and heavily reliant on the circumstances of the dying patient:

Futility of treatment can be argued in lots of different ways and I think that it depends on the situation. If you have a 34 year old woman who wants to go to see her child's first birthday, and if you are 80, it is almost very futile treatment. But for that situation to give a woman another month of life—if she is prepared to accept the side-effects, that's



not futile—so I think with futility, you have to be very careful with the context which you say something is futile or not.... I think medical opinion as to count very highly about what is futile or not as well...from an ethical point of view, you should not be putting somebody and their family through something for very negligible positive outcome...a lot of the evidence showed that we {ED staff} know when what we are doing is futile, then what are we doing it for? ...we sort of feel legally obliged to do it (Dr Nnea, pp. 5, L 3-7; Nnea, p. 6, L 12-22).

Participants believed that “futility with flexibility” was required, because futile treatment decisions were often not “black and white.” Ethical dilemmas were also reported in regard to the relinquishing and neglect of care for the dying patient. In addition, many of the participants reported that when decisions about care were intentionally handed over to another clinician in an impromptu fashion, then care was said to be relinquished. The nurses reported that care was relinquished by doctors to nurses when EOLC was determined:

They {doctors} go away. They don't come back—I hardly ever see doctors come back and check until the nursing staff have notified them of something, not necessarily time of death, but of observations decreasing or family members wanting to speak to them. But even then, because it's an ED, the doctors are busy, and by the time they've come back, it just doesn't feel right (Nurse Teresa, p. 9, L 9-20).

In contrast to the nurses, the doctors did not believe they were relinquishing care; rather, they saw their role as one that was an extension of the nurses' role. They expected the nurses to be informants who would bring to their attention anything that was required to provide care for the dying patient:

They {Nurses} actually do the palliative care stuff. They {Nurses} are the ones who come and get me when the families have questions that they can't answer, or questions that need to come to the doctor. When they need more medication prescribed so that they can control nasal secretions, explaining what they are doing so it's the nursing staffs that actually do the hard part of that job (Dr Sam, p. 4, L 42-51).

Not all the nurses believed that the doctors leaving the care encounter was a relinquishing of their roles once death was imminent, but they did state that the doctors at that stage frequently had nothing more to offer. The participants believed that nurses had a clinical role to play initially but that much of the role played by nurses occurred once EOLC had been confirmed and emotional support was required. Thus, the doctors provided diagnoses and established goals of care and treatment options, but it was the nurses who cared for the dying patient.

The participants felt that the relinquishing of care also occurred between the ED and the wards:

Yes. I think the culture of ED—I think that there is a very bad culture within ED where once they've referred for admission, you relinquish your care of that patient. I think that's a very dangerous culture and one that, I know myself and many interns are very uncomfortable with...maybe more senior doctors being a bit jaded. And as somebody working in the ED, you do everything you can for the dying patient, but there are limits in the sense that once you've referred them for admission, I find that it's tricky for you to continue to provide for that patient as best you can, because you're expected to kind of move on to the next patient... (Dr AC, p. 4, L 1834; Dr AC, p. 12, L 31-38).

Junior doctors revealed that they were expected by the senior doctors to relinquish the care of the dying patient once a referral for admission had been made. They were expected to move on from the dying patient once they were referred for admission due to staff shortages and high workloads. Regardless of the dying patient physically remaining situated in the ED, junior doctors felt pressured to be quick with patient care and were uncomfortable at not being able to go back to care for the dying patient.

The relinquishing of care for the dying was justified by the participants with a resignation that the dying patient was going to be made palliative. So, along with the relinquishing of care, there was also an inclination for care of the dying patient to be neglected and given a lower priority in the ED. The participants emphasized that staff and resources tended to be directed toward acute emergencies and lifesaving procedures, while the dying patient may be left out:

Once the dying process begins, and heading towards the death trajectory, we often tend to neglect the patient in the cubicle, and yes, we put the monitoring on and we are watching and observing their deterioration, but we tend to forget that they could be scared and might just need someone to sit with them for that short period of time and touch them and reassure them, and overall, our presence is what counts more than anything else, making sure the patient don't feel alone (Nurse Eve, p. 2, L 26-36).

Generally, the culture of the ED, such as staff shortages and the fast-paced setting, was believed as the reason for relinquishing care and neglecting the dying patient. The participants reported that although the ED was not set up for EOL/palliative care, this still occurred.

## PROVIDING FOR EOLC IN THE ED AND THE ROLE OF THE PARTICIPANTS

According to the participants, doctors and nurses had a set of distinct tasks, some of which overlapped. The accounts





of the participants in relation to their understanding of each other's roles highlighted differences in how nurses perceive the role of doctors, and vice versa.

Doctors play a role in explaining very clearly in simple terms to the patient's family what exactly has happened and what is happening and what will happen. I think it's their role to really ensure that the family members understand and not just to, you know, kind of a give a—rattle on some clinical thing and then walk out. I think it's really important doctors {explain prognosis very clearly} because that goes a long way in ensuring that the family members are at peace and find it easier to come to acceptance... So, I think doctors play a very big role in this. Again, they have to be clear and they have to make it clear to the patient's family members that this is something the patient is not going to come back from and, therefore, any extra treatment is not going to prove beneficial and, therefore, end of life care should then commence for the patient (Nurse Abigail, p. 10, L 11-18; p. 13, L 20-24).

Both doctors and nurses stated that EOLC was often more intense for nurses due to their numerous responsibilities. The quote below demonstrates why the doctors believed that EOLC was so intensive for the nurses:

{End of life care}, it is often very intensive on the nursing staff. It is intensive in a different way, it is not in lots of machine, and there is not millions of drugs; the drugs used maybe half a dozen max probably 3 or 4. It is intensive on nursing staff for turning the patients, making sure their lips aren't cracked, making sure they are comfortable in bed, so they often cannot do anything for themselves, so it is very intensive from a nursing point of view to keep the patient comfortable, intensive emotional relationship that is built up and that is required, the intensive kind of communication, so to do {end of life care} well, it is intensive sometimes even in doing nothing (Dr Nnea, p. 3, L 10-13 and 32-37).

Overall, the ED doctors recognized that EOLC was "intensive" and "demanding" not only for nurses but also for doctors:

Because I'm the senior doctor, I have to care for my staff that are also caring for that patient and family. So, because dying patients are very demanding—emotionally demanding patients, and so all the staff are affected, the nursing staff, the junior doctors, the social worker, and sometimes, you know, people who you're not even aware of being affected, so the ward person or the radiographer who came in to do the chest X-ray. So, it's quite a big role because...you're thinking of everything that needs to be done for the patient... So, it can be very, very intensive caring for someone who's dying (Dr Cat, pp. 8-10; L 38-44, 15-43, and 1-29).

The next quote illustrates the clinical and emotional role according to a nurse:

But I think we are put in a fairly difficult position...for emergency nurses...during a resuscitation that's going to have a poor outcome, I think emergency nurses we try and switch off when things are going bad that we are actually dealing with a person...but as soon as their family walks in, I find that at least everyone have worked with, and myself included, you kind of shift gear...you go from completely separating yourself from the situation to been there as an emotional support... I honestly think we fulfill two different roles; ...one is we are very clinical; we separate ourselves to provide the best physical care we can, and then we also swap over and try to offer the best emotional care we can because it's very difficult to offer both of those {clinical and emotional roles} at the same time I find...but I think we are expected and should be both of those roles (Nurse Callij, p. 2, L 14-44).

The nurses stated that they initially left their emotional support role behind, especially when an unwell patient with the potential for deterioration or death presented for care. The clinical aspect (lifesaving measures) of care was initially the focus because it was the only way to "do the job." The clinical role came first, after which came the emotional role of EOLC.

### EXPERIENCING CONFLICT

The participants' experiences of conflict referred to the discord between groups of people such as dying patients, their families, and ED staff around EOLC. This stemmed from an inability to facilitate what they believed to be a "good death." The conflict experienced resulted from a constant attempt to provide good EOL and comfort care measures against a background of the ED environment, the lack of time, and the lack of information to guide appropriate treatment decisions:

The barriers are obviously the time pressures, you know, it takes a lot of time to talk to patients and or talk to their relatives...and I often feel conflicted in that sometimes I feel I am not spending enough time with the relatives in talking them through it and that sort of thing, just because there is time pressure of ED, so that to me, would be the greatest barrier to providing adequate palliative care (Dr Ahik, p. 3, L 27-31).

In addition, families were reported as a major source of conflict at the EOL, not only between family members but also between ED staff and family members:

Conflict by the family members, and conflict within the family. From experience, it's just fight between family with differences to each side between family...one of the family members that already decided that the dying patient would



be for palliative care, and another family member came in and said, "No, they should not be for palliative care," so there was a lot of fighting back and forth between the family, and there was a lot of threats made as well, like, we've got to get our lawyers involved, and, "Why won't you look after this patient?" ...but they didn't realize the extent of the condition the patient had. So, it becomes a back and forth where no decision is made... (Nurse Abebs, p. 5, L 3-36 and 37-40; p. 11, L 21-24).

Advance care planning (ACP) was reported to often cause conflict between families, patients, and ED staff members when there was disagreement about the advance directives. Some participants stated that an advance directive was not always helpful:

ACPs are not helpful, they don't help me decide what I am gonna do, and I don't just find them helpful...so it can help me to start a discussion, but it's extremely rare that it actually guides me as to what I should do.... They are helpful inasmuch as they tell me that the patient is very unlikely to want invasive therapies and will probably welcome a discussion about therapy limitations and that's a nice door to open for me. The advance care planning is simply patient's preference and values sometimes even two decades ago.... It's an awfully long way from so this person has now got a pneumonia, we think carefully about what we might do for them (Dr Turtle, p. 5, L 40-56).

Many of the participants believed that these conflicts were unavoidable and that conflict resolution was a necessary skill to have in EOLC.

Well, it's not really avoiding the conflict because it's often there; it's how to deal with it, because, you know, people have very complicated family structures and relationships, and you can't avoid it because that's part of who that patient is and who the family are, but...I think I identify conflict early in those situations, and I try to negotiate how best to deal with conflict.... I involve other staff members to help make them aware of what's going on so that they can help negotiate and care for the patient and their family, whilst dealing with conflict as best as possible. So, the other staff—when I say that I mean my junior doctors caring for the patient and family, my nursing staff caring for the patient and family, the social worker, at times security, if I think there might be a risk that the family might have a big fight or something. And I don't avoid it, and I do it early and I'm very inclusive (Dr Cat, pp. 17-19; L 10-22, 18-41, and 1).

The study participants all experienced conflict resolution very differently. One of the main techniques they used was effective communication by making sure the patient and their families were heard, with all questions being answered and clarified to prevent conflict. They emphasized that communication between multidisciplinary teams was used to prevent and resolve conflict. For example, agreement

for transfers to the intensive care unit was made, but with a view to a slow removal of all aggressive interventions, rather than an abrupt stop to all treatments in ED. The slow removal of treatment by the intensive care unit was achieved through the process of open and honest communication with the family so they could all agree and accept the inevitability of their loved ones' death. Conflict and disagreements were perceived as unavoidable, but suggestions were made to resolve conflicts in a timely manner, so that quality EOLC could be provided to patients and their families.

## DISCUSSION

These findings extended beyond the available current literature of ED staff members' experiences of death and dying, especially in terms of the constant complexities in the decision-making process that were reported by participants as they attempted to provide quality EOLC. The complexities experienced in ED staff's decision making were influenced by factors such as the level of understanding of the prognosis by the patient and his/her family, the experiences of the ED staff, and the uncertainty about who owned the responsibilities and roles of initiating EOLC conversations. Emergency department staff constantly reported navigating these complexities to ensure that the decisions made were in the best interests of patients and their families.

The participants' personal beliefs and values referred to privately held views about death and dying, and they seemed to have a significant impact on their experiences of providing EOLC. This finding ties in well with the previous research that has examined how health care professionals' personal religious beliefs, cultures, and values influence their attitudes and decision making about death, dying, and the provision of EOLC. Similar to this current study, the findings from these previous studies agreed that doctors' and nurses' personal religious beliefs, views, and culture concerning death and dying influenced their decision making and the provision of EOLC.<sup>11-13</sup>

Studies that examined the impact of religious beliefs on the provision of EOLC also explored the impact that the religion of doctors and nurses had on decisions to forgo life-sustaining treatments.<sup>11,12</sup> The findings from these studies showed that health care professionals who have religious beliefs were unwilling to withdraw lifesaving treatments and often wanted more extensive treatments.<sup>11,12</sup> These study findings were supported by this study, as participants' religious beliefs influenced how they provided EOLC to patients and their families. For example, some participants in this study reported feelings of sadness for those patients who were dying with no religious beliefs, because they believed these patients had no hope of an afterlife. This aspect of the data highlighted that the participants held a range of beliefs, but one common one was the need to



provide comfort. Their responses revealed that culture, beliefs, and views did not have to conform to a religious or popular belief system but that they held opinions that served as a coping mechanism when providing EOLC.

In this study, the participants' decisions on whether to give lifesaving treatment or comfort care were often guided by a combination of factors, such as the dying patient's quality of life, the patient's request to have life-prolonging measures for family reasons, and the participants' own moral understandings of what was ethical, moral, and legal. This finding ties in well with the previous research where the evidence has shown that the perceptions and the ethical and moral norms of the health care professional shape interventions provided at the EOL, whereas life-prolonging measures are provided based on factors such as quality of life and family requests, but often at the expense and dignity of the dying patient.<sup>14</sup>

As a result of the dilemmas faced in ethical decision making, some of the participants referred to the ethical standards that were available to guide their EOLC practices. The participants indicated that they were aware of the code of ethics and the professional standards that supported their EOLC practices.

These standards aim to facilitate best ethical practice for patients who are receiving EOLC for an advanced chronic or terminal condition in the last 12 months or so of their lives.<sup>15</sup> These standards support health care professionals' clinical judgment and the engagement of the dying patient in the decision-making process while taking into account the concerns of family members. Some of the research has found that the recommendations of health care professionals did not always determine the acceptance or lack of acceptance of aggressive treatments by the dying patient.<sup>15,16</sup> The factors that were considered as important determinants of the acceptance of aggressive interventions were different between the dying patient, their families, and the health care professionals.<sup>16</sup>

Evidence from the literature has shown that, for the dying patient and his/her family, decisions about accepting aggressive treatments or otherwise were based on hope, increased survival time, and quality of life, but some health care professionals' decisions were often driven by the financial consideration and burden.<sup>16,17</sup> In this study, participants who worked in private ED settings with patients that were categorized as affluent in a high socioeconomic status area with high literacy skills reported that decision making around EOLC goals was understood at a high level and was reported as being more effective with groups of privileged people. Regardless of the views of dying patients and their family members regarding the quality of life, the participants believed in their own views of what quality of life entailed and that these were important factors to be considered in relation to whether aggressive treatments were given or not.

Studies on emergency nurses' roles in ED EOLC have shown that nurses were significantly responsible for physical comfort, as well as spiritual and emotional care, and for supporting dying patients and their families.<sup>18,19</sup> Similar to the literature, findings in this current study also showed that the role of nurses was believed to be demanding because of the stressful, fast-paced environment, staff shortages, and time constraints, as well as the clinical and bureaucratic tasks.<sup>20</sup> The cost of the emotional care and support carried out by nurses was reported in this study as an "emotional burden." The literature on emotional burden revealed that there was a professional expectation that nurses should emotionally support the dying patient and his/her family.<sup>21,22</sup> In line with the previous research, nurses in this study felt that they were professionally obliged to provide clinical care and, at the same time, to provide emotional support. For example, evidence from the primary literature showed that nurses were often burdened by the professional expectation to manage the emotions of the grief and loss of the dying patients and their families as well as their own.<sup>23</sup>

Inconsistencies in the participants' expectations of each other's roles were also found in the current study. In some cases, the views of doctors as to what their roles were differed to what the nurses perceived to be the role of the doctor. Contradictions were discovered when the participants who were nurses reported that the role of the doctors was to communicate EOL goals of care effectively. However, doctors in the study perceived that their main role was to "figure out" and "work out" a dying patient's goals of care so that the decision-making process could be facilitated. Research studies that have explored how nurses perceive the role of doctors in EOLC and how doctors perceive the role of nurses in EOLC were limited. There is a significant gap in the research literature that has specifically explored how nurses perceive the role of doctors in EOLC and vice versa. The findings from this study have shown that common ground existed in the perceptions of the roles, but at the same time, differences were also present. Exploring this aspect was crucial because it highlighted the discord around the priorities of care that existed between ED staff (doctors and nurses). An awareness of these differences was important so that changes could be targeted at reconciling the differences, and improving the outcomes, for the dying patients and their family.

Much of the available research on EOLC in the ED has suggested that EOLC required a significant amount of collaboration between patients, their families, and ED staff.<sup>24</sup> However, from the findings of this study, the misunderstanding in expectations of each other's roles could affect the care of the dying patients and their families. For example, many of the nurses reported that when communication was not effectively undertaken by the doctors, a lack of acceptance of death in dying patients was often reported.



Like the findings in the current study, recent research has shown that the causes of conflict between the dying patient, the family, and staff members were often because of mismatched expectations in EOLC treatments and decisions, as well as poor communication.<sup>25</sup> In line with the results of previous studies, the participants in this study described that open, honest, and robust communication from the moment EOLC was determined were useful in avoiding conflict.<sup>26,27</sup>

In exploring the dying patients' best interests during such conflicts, many of the participants in this study reported that ACP was not instrumental in making decisions that were in the patients' best interests at the time of presentation. Most of the participants believed that ACP often caused conflict between families, patients, and ED staff when one or more of the parties disagreed with the ACP decisions. They stated that ACP documentation was often performed when the patient had a nonsignificant disease burden but was often irrelevant to their current situation. As opposed to ACP and not-for-resuscitation documents, which may already be in place, the "goals of patient care" discussions were designed to explore the values and preferences for medical treatment at the time of presentation and at the point of care.<sup>28</sup> The findings in this study were consistent with the previous research regarding the understanding that ACP was not beneficial for decision making at the EOL, and recommendations to change ACP to goals of patient care, which were made at the point of care and current prognosis, were emphasized.<sup>28</sup>

Limitations identified include the subjective nature of the research. The findings cannot be generalized; however, they may be transferrable to other ED settings. The small number of participants was sufficient for a qualitative study. A key strength of this study was that the sample was nationally representative of ED staff across Australia, including staff in rural, private, and public ED settings. Therefore, the findings can be transferred and generalized across Australian ED settings.

Future research could focus on determining the experiences of ED staff regarding their roles in EOLC. Similarities and differences were evident between ED doctors and nurses in the expectations placed on each other. It is important that a qualitative methodology be used to examine these differences, so that ED staff can become more aware of their own underlying assumptions. The knowledge of these assumptions will allow the roles to be redefined and will ensure that ED staff are aware of expectations and work to create a stronger collaborative approach to EOLC for patients and their families. In addition, further research is required to establish the benefits of the goals of care made at the point of care, as opposed to long-term advance care directives. The research on the benefits of the goals of care made at the point of care should be carried out to address the challenges associated with EOLC decisions through a multidisciplinary team. Further research to explore

interventions to facilitate EOLC in the ED would add to the body of knowledge in this area.

## IMPLICATIONS FOR PRACTICE

Nurses play a critical role in EOLC provision because they spend more time with the patients. It is important that nurses are part of the decision-making process. The inclusion of nurses in decision making would be beneficial, because they may be privy to information that other members of the health care team are not. End-of-life/palliative care training program is needed for ED doctors. The training program may assist ED doctors to be more confident in the areas of discussions about EOLC, decision making, management of symptoms, medication prescriptions, and community discharge planning.

## CONCLUSION

Australian EDs are generally the gateway to accessing health care, and therefore, patients with various disease processes seek interventions and include those who require EOLC. Four major themes were identified, illustrating that providing for respect and dignity, addressing dilemmas, the role of participants as they provide EOLC in the ED, and the experience of conflict were key concepts in EOLC. The provision of respect and dignity in EOLC was important for the doctors and nurses, regardless of the difficulties associated with decision making about what care is in the best interests of the patient, which would often lead to ethical dilemmas and conflicts. Dying patients and their families can potentially be at a disadvantage when there are mismatches between the ED staff, the dying patients, and their family in relation to the aims of care.

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## Appendix 1

## Interview Questions Death, Dying, and End-of-Life Care Provision by Doctors and Nurses in the Emergency Department—A Phenomenological Study

## Section 1: Demographic Questions

- 1.1 What is your age?
- 1.2 Are you male or female?
- 1.3 Are you a doctor or nurse?
- 1.4 What is your highest education level?
- 1.5 How many years have you worked in the emergency department?
- 1.6 Do you undertake any other roles within the emergency department?
- 1.7 Have you undertaken any specific additional study/educational programs on palliative care, end of life care, or death and dying? If yes, please describe the additional educational program you have undertaken: the level, content, and length.

## Section 2: Interview Questions

- Can you please describe your own values and beliefs about death and dying—your personal perspective?
- Can you please begin by describing what it is like to care for someone who is dying within the ED?
- What in your opinion is the role of doctors and nurses in ED concerning death and dying?
- Can you describe what care you are able to provide to people who are dying and their relatives?
- Can you describe any negative experiences of caring for a dying patient or their relatives in an emergency department?
- Can you describe any positive experiences of caring for a dying patient in an emergency department?
- What ethical issues have arisen for you when caring for a person who is dying and relatives in ED?
- What are the barriers to providing end of life care for people who are dying and their relatives in ED?
- What facilitates good end of life care for people who are dying as well as their relatives in ED?
- What do you believe can be improved concerning the care of dying patients and their relatives? Can you give me your views on the futility of treatment and decisions about withdrawing treatment or active treatment when a person is dying or elderly?
- Additional prompting questions as appropriate.