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Providing end of life care in the emergency department: A hermeneutic phenomenological study

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ABSTRACT

Background: Registered nurses report the experience of delivering end of life care in emergency departments as challenging. The study aim was to understand what it is like to be a registered nurse providing end of life care to an older person in the emergency department.
Methods: A hermeneutic phenomenological study was conducted in 2021, using semi-structured interviews with seven registered nurses across two hospital emergency departments in Queensland, Australia. Thematic analysis of participants' narratives was undertaken.
Findings: Seven registered nurses were interviewed; six of whom were women. Participant's experience working in the emergency department setting ranged from 2.5–20 years. Two themes were developed through analysis: (i) Presenting the patient as a dying person; and (ii) Mentalising death in the context of the emergency department.
Conclusions: Nurses providing end of life care in the emergency department draw upon their personal and aesthetic knowing to present the dying patient as a person. The way death is mentalised suggests the need to develop empirical knowing about ageing and supportive medical care and ethical knowing to assist with the transition from resuscitation to end of life care. Shared clinical reflection on death in the emergency department, facilitated by experts in ageing and end of life care is recommended.

Introduction

Internationally, the population aged 65 years and over (often referred to as 'older persons') is growing faster than any other age group and are predicted to reach over 1.5 billion persons by 2050 [1]. Older persons are increasingly using emergency departments across Australia, accounting for 21% of emergency presentations in 2020–2021, despite making up 16% of the population [2]. Limited access to community services and hampered continuity of care is internationally recognised as a contributor to increased emergency department demand [3,4].

For many older persons, the emergency department represents a 24-hour gateway for access to acute care and specialist medical services to address exacerbation in chronic disease [5,6]. With the increased prevalence of chronic diseases and the ageing demographic, the registered nurse's role in the emergency department context encompasses more chronic disease management, and increasingly end of life care [7]. A registered nurse is an individual that has completed the relevant educational preparation, demonstrates competence in the provision of safe nursing care and is registered as a nurse in Australia under the Health Practitioner Regulation National Law [8]. End of life care refers to the period when a person is living with, and impaired by a life-limiting illness [9]. While the end of life phase of chronic disease may last months to years, in the emergency setting, the end of life care phase is considered the time directly preceding death [9].

A key challenge to providing end of life care is the emergency department's medical-hegemonic model that focuses primarily on aggressive resuscitation measures to prevent death, not facilitate it. The emergency department is primarily designed to preserve life, perform invasive procedures, and maximise visibility to monitor unwell patients [10]. A recent Australian survey of emergency nurses highlighted the emergency department environment as a prominent barrier to providing end of life care [11]. Indeed, emergency nurses

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are educated, trained, and accustomed to recognise and stabilise acute illnesses [12], not necessarily provide end of life care [11]. The shift to non-emergent end of life care focused on patient comfort and the minimisation of invasive therapies, contradicts the emergency nurses' conventional training on aggressive resuscitation measures [13]. Despite these barriers, the emergency department has become a pivotal location where trajectory discussions are held, and end of life care plans are discussed, initiated, and implemented [7].

Several guidelines and tools exist to assist health professionals in the delivery of end of life care in Australian hospitals [7,14–16]. However, these strategies are not specific to older persons, registered nurses, or the emergency department. A recent Australian study reported how the absence of contextually appropriate guidelines and policies for end of life care in the emergency department creates a barrier to emergency nurses' engagement in end of life care [17]. In a scoping review of end of life care in the emergency department, authors noted the limited research that exists regarding how end of life care guidelines are applied and whether they are effective [18].

A recent qualitative study of nurses' and doctors' roles in end of life care in the emergency department reported on the emotional burden of the work but did not explore how this burden was experienced [19]. Understanding emergency nurses lived experiences of providing end of life care to an older person in the emergency department can provide important contextual information, necessary for guideline implementation. The aim of this study was to better understand what it may be like being a registered nurse working in an emergency department providing end of life care to an older person.

Methods

Design

A hermeneutic phenomenological approach to human science [20] guided the study. This design was relevant to address the study's aim as it focused on the individual emergency nurse's lived experiences [21].

Setting

The study was conducted across two mixed (adult and paediatric) emergency departments in public hospitals located in Queensland, Australia. Hospital 1 is a large hospital, with approximately 100,000 patient presentations in 2021–2022. Hospital 2 is a level six tertiary facility with approximately 160,000 patient presentations in 2021–2022.

Participants and recruitment

The inclusion criteria for this study were: Registered Nurses with lived experience of providing end of life care to an older person aged 65 years and over in the emergency department (within the six months before the study advertisement). Invitation occurred in several ways: (i) an email from the emergency department administration officer to all emergency nurses with attached study information; (ii) information sheets posted throughout the emergency department's common rooms; and (iii) advertising the research during clinical handover. Purposive sampling was used as a recruitment strategy to explore and gather rich descriptions of emergency nurses' experiences [22]. Participants were not immediately forthcoming in volunteering, so snowballing techniques were subsequently implemented at the end of participants interviews to identify further suitable participants and ensure sufficient recruitment [22]. For instance, the researcher encouraged participants to share the research project with other emergency nursing colleagues.

Data collection

In-depth semi-structured face-to-face or online interviews (as preferred by participant) were used to explore and gather experiential narrative. Online interviews via Microsoft Teams were utilized as the data collection period was impacted by the 2020 COVID-19 Pandemic and subsequent restrictions to hospital entry. Interview questions were based on van Manen's [20] hermeneutic interviewing style to gather rich narrative. Examples of questions asked in the interview included: "Could you tell me about the last time you provided end of life care to an older person in the emergency department?". To stay as close to the experience as lived, re-orientation questions were asked, for example: "Can you tell me more about that…". The participant accepted the active role in the interview, with the researcher listening as the participant described their experience.

Interviews were conducted (by EB) in a private room in the hospital or online via Microsoft Teams. The interview length of time ranged from 30 min up to one hour, were audio recorded and transcribed using a professional transcription service. The corresponding author conducted the interviews between May 2021 and November 2021. Another author (JR) experienced in hermeneutic phenomenology provided guidance and feedback for the initial interviews.

Data analysis

Data were analysed using a thematic approach led by (EB) and supported by the other authors. The process of thematic analysis moved from the individual interviews to developing an inter-subjective lived experience description [23] and is outlined in Table 1. Recruitment, interviewing, and thematic analysis continued until new participant's narratives produced minimal or no new findings and the research team had a rich understanding of the participants' lived experience. The details provided in the brackets after each quote provide a pseudonym for participants, represented by an anonymised participant number and their anonymised hospital. For instance, Hospital 1, Participant 1 is the first participant in this research, and they were from Hospital 1 (of 2) in this research.

Phenomenological validation

The validation criteria for phenomenological human science [20] were used to ensure the phenomenological texts were orientated to the phenomena, in-depth, rich, and strong. A fundamental component of achieving this was the hermeneutic circle, enabling the researcher (EB) to engage in the reciprocal activity of pre-understanding and understanding while analysing the data [20,27]. The hermeneutic circle enabled the researcher (EB) to gain depth beyond what was immediately experienced. To ensure the strongest interpretation, the inquiry process was opened to the research team for their interpretive insights and contribution, for instance (JR) providing guidance and feedback on the initial interviews. Findings were presented to the research team multiple times as the analysis progressed.

Protection of human participants

Approval to conduct this research was received from the health service (HREC/2019/QGC/53211) and university (2020/529) Human Research Ethics Committees. A member of the research team (KM), assisted by informing interested participants about the project

Table 1
Thematic Analysis.

Thematic Analysis Process	*Rationale*
The researcher listened and reflected upon the participant's narrative as the participant described their story.	Promotes the participant to gather recollections and proceed with their narrative. Enables the researcher to ask re-orientation questions [20].
The researcher listened concurrently to the audio recording while reading transcribed narrative.	Enables interpretive depth and holistic perspective [20,24].
Key moments identified.	Illustrates the key structures of the phenomena [20,24].
Themes grouped under van Manen's[20] four life world existentials.	Uncover and navigate disparate moments, while clarifying methodological significance [20].
Steps in the above three rows were repeated until no new themes could be established. Findings presented to research team.	This ongoing process (hermeneutic circle) immersed the researcher into the findings, enabling the researcher to explore the key moments further and ensures validity [20]. Enables the interpretive insights of the research team [20].
Phrases that exemplified the phenomena were extracted. Findings presented to the research team for review.	Uncovers and clarifies key moments of the lived experience [20] Facilitates collaborative analysis [20].
The researcher listened concurrently to the audio recording while reading transcribed narratives. For each moment and exemplar, the researcher asked: "What is occurring here and why is this moment unique to end of life care?".	Researcher continues to seek the true meaning and essence of the identified key moments [20,25].
Individual narratives compared against identified themes.	Researcher continues to seek meaning [24].
Theme headings established, and key moments and exemplars were re-read.	Ensures exemplars and key moments exemplify a rich description of the phenomena [25].
Findings presented to the research team for review.	Ensures key moments of the phenomena under investigation are identified [26].

verbally, providing them with an information sheet and gaining written consent before the interview. Participants voluntarily participated in this research with no renumeration. Interviews were de-identified using a study identification number. The researcher (EB) undertaking interviews had no prior relationship with the participants.

Findings

Seven registered nurses were interviewed; six of whom were women. All registered nurses interviewed were adults over 18 years of age. Participant's experience working in the emergency department setting ranged from 2.5–20 years, four participants role involved education, research, or management, two had previous experience working in palliative care, and all had a post-graduate qualification. Additional details regarding participant characteristics are presented in Table 2. This study identified two key themes associated with the registered nurses' experience: (i) Presenting the patient as a dying person and (ii) Mentalising death in the context of the emergency department.

Theme i: Presenting the Patient as a Dying Person

Participants were attentive to the holistic needs of the dying person and their family/close friend(s) present, describing how they wanted to ensure positive memorable experiences for family members/close friend(s). One participant described this:

Table 2
Participant's Characteristics.

Demographical Information	Number (%)
Gender (self-identification):	6 (85.7%)
Women	1 (14.3%)
Men	
Employment Status:	2 (28.6%)
Full-time (> 32 h/week)	5 (71.4%)
Part-time (≤ 32 h/week)	
Emergency Nursing Experience (years):	3 (42.8%)
1-5	1 (14.3%)
6-9	2 (28.6%)
10-19	1 (14.3%)
≥20	
Post-Graduate Qualifications:	7 (100%)
Role in the emergency department includes:	
Education, research or management	4 (57.2%)
No additional role	3 (42.8%)

> *"The family coming in, that's their last memory of their mum. Like, you'll always remember. And it wouldn't be a memory I would want."* (Hospital 1, Participant 1).

Participants expressed their desire to perform practices that ensured the dying person appeared well-cared for and comfortable to the family/close friend(s) viewing them in their final moments. For example:

> *"You want to present the patient as best you can for the family, so their last memory of that patient isn't messy, and dishevelled. You want them to be at peace and calm."* (Hospital 2, Participant 4).

To do this, participants described their exhaustive efforts to overcome the perceived environmental barriers in the emergency department to achieve a 'home like' and less clinical environment through practices such as decanting clinical equipment out of the patient's room. In this work, participants implemented thoughtful gestures, such as making family/close friend(s) a cup of tea. One participant described these environmental constraints:

> *"The procedure room had all machines. There were beds that weren't made, it wasn't tidy. There were buckets in the procedure room that hadn't been cleaned. One of which had blood in it. It's like, oh my God. There was [rubbish] on the desk. It was just horrible. Even the cords and the ECG [electrocardiogram] machine."* (Hospital 1, Participant 2).

Recognising the limitations of the emergency department setting for end of life care, participants recommended admitting the dying person to a hospital ward, where comfort could be optimised. One participant described this:

> *"I think ideally it's getting the patients [dying person] out of ED [emergency department]. It's not the best place to be."* (Hospital 2, Participant 3).

Participants outlined the conscious activity of connecting and associating the dying person with a family member/close friend of their own which enabled them to better empathise with the patient and their family/close friend(s). One participant described this:

> *"Whenever I see someone dying, you always relate it to someone that you know. So, in my head I'm like oh God, my dad is older than this guy. You know? He drinks a lot and he's got a belly like that. You start thinking about oh my God, what would I do if something happened to my parents? I think that also makes you better managing the situation because you can kind of go what would I want if it was me. You know?"* (Hospital 2, Participant 3).

However, upon narrating their experiences, it was evident that associating patients with a family member/close friend of their own involved a multiplicity of feelings that could affect participants' vulnerability as health professionals. For example:

> *"You can relate it [the dying patient] to your grandfather now or your dad or anyone you've ever known that was like him. I guess the closer you get to people, the more it hurts."* (Hospital 2, Participant 2).

Notably, as participants shared their experiences of caring for older people near end of life, there were no accounts of the unique needs of older persons or providing medically related care for palliation, such as symptom management.

Theme ii: Mentalising death in the context of the emergency department

The transition from resuscitation to end of life care was challenging for participants. Participants recalled periods of uncertainty when transitioning from curative measures to end of life care focused on comfort. One participant described this:

> *"Transition from treating to end of life care is we sit in this middle ground, where we're not fully treating, but we're sort of still sort of treating."* (Hospital 1, Participant 1).

The decision to continue with emergency medicine or commence end of life care was described as a pivotal milestone in their experience. These moments of uncertainty became significant moments of self-awareness for participants. For example:

> *"The room was in such suspense of, how far are we going to go with this guy? We all knew that he's got a type of cancer. It has metastasised. So, at what point are we going to stop? We were waiting for the doctor to come back and give us that all-clear. I think the feeling in the room – I can only speak for myself – was that we don't want to do any CPR [cardiopulmonary resuscitation] or any of those kinds of things. I remember looking at my colleague and them looking at me. I was very adamant that we're not going to drop an adrenaline infusion. I just wouldn't have agreed with it."* (Hospital 2, Participant 2).

Participants described various coping mechanisms that they adopted to manage the transition from resuscitation to end of life care. Participants described distraction-type techniques such as focusing on the next task to 'lighten the situation' or de-briefing with colleagues. One participant described this:

> *"I went home, had a cup of tea. I cried and spoke to the same staff the next day."* (Hospital 1, Participant 1).

Pragmatism was apparent among the participants' narratives, with a matter-of-fact approach to the dying process and end of life care. One participant highlighted this:

> x*"He's seventy-something, he's had a good life."* (Hospital 2, Participant 4).

Gallows humour was another way participants mentalised the emotional element of the work:

> *"I may have sung to the Registrar: 'another one bites the dust'. In that moment of just, oh, this is so [messed] up."* (Hospital 2, Participant 4).

Participants emphasised how the process of knowing the patient's life story, usually told through the eyes of family/friend(s) present, impacted their own vulnerability as human beings. One participant described this vulnerability:

> *"You feel a bit more vulnerable in that moment. Because you are now relating to him. I guess it's sometimes easier if you don't relate."* (Hospital 2, Participant 2).

Participants exercised caution while treating the dying person, avoiding communication and interaction with the patients' family/close friend(s). Participants questioned their own value in supporting grieving family members/close friend(s), with one participant suggesting other health professionals, such as social workers were more suited to providing the emotional support required. For instance:

> *"I could walk in there and give them as much sympathy as they want. But, realistically, is it going to help? I've never felt like I would improve what happened. I feel like we have social work for that reason. They're trained people."* (Hospital 2, Participant 2).

Discussion

In this study, a registered nurse providing end of life care to an older person in the emergency department consisted of two core themes: (i) Presenting the patient as a dying person and (ii) Mentalising death in the context of the emergency department. These themes resonate with, and extend, earlier research into the challenges of delivering end of life care in the emergency department.

Like intensive care unit nurses who worked to provide a 'good death' for dying persons and their families at the end of life in an Australian setting [28], emergency nurses in this study focused on their personal knowledge of death and dying in presenting the patient as a dying person. How the patient is presented, with care focused on removing technical equipment, creating a homely environment, and imagining the patient as a family member/close friend, is consistent with international research. For example, in a qualitative study conducted in Thailand, emergency nurses worked to create a private space for families [29]. In another qualitative study conducted in Spain, presenting the body was a strategy to promote dignity in a chaotic emergency department setting [30].

In nursing theory, personal knowing is one of four ways that nurses work, with the patient valued as a person [31]. Personal knowing is highly unique, and as such carries the risk of inherent and unacknowledged biased views about the world [31]. In this account of emergency nurses' experience of presenting the patient as a person, personal knowing is combined with aesthetic knowing. Aesthetic knowing consists of those actions exercised in an artful way that are essential for human being [31]. In this case, aesthetic knowing is used to transform the process of dying to create a 'good death', as perceived by the nurse.

Interestingly, emergency nurses in this study focused on the initial medical management of the older person presenting at the end of life, with participants recalling advanced resuscitation practices such as adrenaline infusions. This focus on resuscitation medicine highlights the rescue culture embedded within emergency medicine and is well reported in the literature [13,32]. These clinical decisions may be influenced by uncertainty in anticipating the need for life-or-death supportive measures. However, in this study, even with a clear end of life trajectory, there was still an absence of medical supportive care activities reported; those that can support comfort near end of life, indicating a gap in empirical knowing. Empirical knowing is the foundation of nursing science, providing explanatory concepts and theory to support the prediction of phenomena and develop plans for these [31]. Limited empirical knowing about medical supportive care activities in end of life in this study resonates with international findings from a qualitative study conducted in a United Kingdom emergency department, where the specific supportive medical end of life care needs were overlooked [33]. Researchers call for further education on end-of-life care for emergency nurses [17,34] and this research suggests a specific focus may be on pharmacology, theories of ageing and end of life. This education could be formally delivered in post-graduate courses or informally delivered

during educational in-services [35]. Further research with emergency doctors, exploring their knowledge of supportive medicine at the end of life may be beneficial to better understand the extent of these identified knowledge gaps.

Mentalising death in the context of the emergency department was associated with uncertainty about the transition of care from resuscitation to end of life, using gallows humour to manage intimate moments, and feeling hesitant to support the dying person's family/close friend(s). Researchers consistently report that the transition to end of life care in the emergency department setting is a significant challenge [29,33,34]. While the decision to transition from resuscitation to end of life care is often based on fact, managing the transition requires strong ethical knowing, which Carper [31] defines as an understanding of service to people and respect for human life. Ethical knowing requires an understanding of different philosophical positions, different ethical frameworks to manage the complexities of moral judgements, and the ability to provide justification for one's actions [31]. Emergency nurses may benefit from opportunities to critically reflect on their experiences of transitions in care in collaboration with other team members, including doctors and social workers. Critical reflection on practice situations, where learners work closely with more knowledgeable staff, supports the development of the perceptual acuity and clinical imagination required [36].

The use of gallows humour is recognised as a strategy to communicate honestly about death, especially when honesty is uncomfortable [37]. It is a form of death humour that fosters coping when people feel threatened and can create a feeling of belonging [37]. In this study, nurses also reported hesitancy in approaching the dying person's family members/close friend(s), which is consistent with findings of a recent integrative review [17]. The difficulty in communicating with dying persons and their family members/close friend(s) in this study may have been compounded by their empathic approach of associating a dying person with a family member/close friend of their own.

These two partially effective coping mechanisms, gallows humour and avoidance, become insufficient over time, with burnout and emotional detachment increasing [38]. They are an indication of limited personal knowing [31]. There is concern with such trivialisation of death, that the true significance of this phenomenon in human existence is overlooked, which may lead to long-term ramifications for emergency nurses and the dying persons' family members/close friends [32]. For emergency nurses, the loss of emotional connection raises a significant risk for burnout and retention [39]. To improve psychological and clinical outcomes, interdisciplinary structured debriefing also known as hot debriefing following a clinical event is recommended [40]. Hot debriefing in the emergency department is common after unexpected events such as a paediatric death, [41] however rarely integrated in the expected death of the older person. Death at any age is a confronting experience regardless of if the death constitutes the natural course of life [42]. Structured debriefing should be considered as a routine continuing education practice in emergency departments for all deaths, regardless of age.

Limitations

This study was conducted across two emergency departments within the same health district, impacting the transferability of findings to hospitals outside of this health district. Participants in this study self-selected based on pre-determined criteria. Those nurses who met the criteria but chose not to participate may have held other views about the care of older people near end of life in the emergency department and this is recognised as a limitation of the study. However, the seven nurses that did participate provided rich, insightful experiences that facilitated a greater understanding of the context of their practice. As with other qualitative studies, the findings should be used to inform further work in this area. Empirical knowing about ageing and supportive care was notably absent in emergency nurses' accounts of their experiences, requiring further investigation regarding whether this is a genuine knowledge issue or taken-for-granted knowledge that was not voiced.

Conclusion

The provision of end of life care in the emergency department is a complex and challenging task for an emergency nurse. Emergency nurses in this study drew upon their personal and aesthetic knowing to present the dying patient as a person. The ways that death in the emergency department was mentalised indicates that personal knowing may be insufficient; the ramifications of which may be subsequently reflected through burnout and retention. To promote empirical and ethical knowing, nursing staff require opportunities to debrief about their death experiences with more knowledgeable clinicians through learning circles or other structured shared reflective activities. Further education on end of life care for emergency nurses focusing on pharmacology, theories of ageing and end of life is needed to enable care delivery improvements. Further research with other emergency health care professionals, exploring their knowledge of supportive medicine and pharmacology at the end of life would be beneficial to explore the identified nursing knowledge gaps.

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CRediT authorship contribution statement

Ellie Burnitt: Study conception and design, methodology, investigation, analysis, writing – original draft preparation. Final approval of version submitted. **Laurie Grealish**: Study conception and design, methodology, analysis, writing – review and editing, supervision, final approval of version submitted. **Julia Crilly**: Study conception and design, methodology, analysis, writing – review and editing, supervision, final approval of version submitted. **Katya May**: Study conception and design, resources. **Jamie Ranse**: Study conception and design, methodology, investigation, analysis, writing – review and editing, supervision, final approval of version submitted.

Declaration of Competing Interest

Prof Julia Crilly is a reviewer for AUEC.

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