International Emergency Nursing xxx (2017) xxx–xxx

Contents lists available at ScienceDirect

International Emergency Nursing

journal homepage: www.elsevier.com/locate/aaen

Promoting dignified end-of-life care in the emergency department: A qualitative study

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ARTICLE INFO

Article history:
Received 31 October 2016
Received in revised form 11 May 2017
Accepted 28 May 2017
Available online xxxx

Keywords:
Dignity
Emergency department
End-of-life care
Experiences
Nurse
Doctor

ABSTRACT

Background: Preservation of a dying person's dignity in the emergency department (ED) is fundamental for the patient, his/her relatives and healthcare professionals. The aim of this study was to explore and interpret physicians' and nurses' experiences regarding conservation of dignity in end-of-life care in dying patients in the ED.
Methods: A qualitative study based on the hermeneutic phenomenological approach, was carried out in the emergency department of two general hospitals. A total of 16 nurses and 10 physicians participated in the study. Data collection included 12 individual in-depth interviews and 2 focus groups.
Results: The findings revealed that two themes represent the practices and proposals for the conservation of dignity in the emergency department: dignified care in hostile surroundings and the design of a system focused on the person's dignity.
Conclusion: Dignifying treatment, redesigning environmental conditions, and reorienting the healthcare system can contribute to maintaining dignity in end-of-life care in the ED.

1. Background

A human being's dignity lies in the autonomy of a rational being capable of giving him/herself rules of action. For Immanuel Kant [1], this implies recognizing an internal value that makes one susceptible to treat him/herself, and all human beings, as an end and not as the means. The respect towards the dignity of human life is also extended to the process of death, modifying the clinical relationship [2]. The hospitalization of a dying person in the Emergency Department (ED) has implications for maintaining his/her dignity, which can be a challenge for healthcare professionals [3,4]. In light of technological developments, the ED focuses on healing and maintaining life but this care framework is changing with regard to the dying patient [5]. Virginia Henderson has already stated that the nurse contributes to the patient's health or recovery, or to a dignified death [6]. Concepts such as quality of life [7], the economic cost of the end-of-life care [8,9], or public awareness of matters relating to death [4], are modifying the care of these patients so, with a focus on saving lives, the ED must now also provide end-of-life care [10].

Our framework is supported by H.M. Chochinov's model of dignity preservation [11]. The model establishes three categories which define the problem of conserving dignity: 1) Illness-related concerns, 2) Dignity conserving repertoire, 3) Social dignity inventory [12]. Adapted to end-of-life care [13] it covers individuals' physical, psychological, social, existential and spiritual concerns [14]. Caring for dying patients is part of physicians' and nurses' daily work in the ED, who equipped with the latest technology to save lives, must also redirect their attention towards end-of-life care [15]. Clinical factors inability to recognize imminent death [16], lack of good-quality palliative care [17] or the overburden of the caregiver [18], can lead to the terminally-ill patient being admitted to the ED. As the access gate to in-hospital care, the ED is not designed for providing palliative care or looking after a dying

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http://dx.doi.org/10.1016/j.ienj.2017.05.004
1755-599X/

person [19,20]. A dying person's dignity implies treating him/her as an end in itself [21], recognizing his/her value as a person, as well as his/her self-esteem and autonomy [22]. Currently, there is a mounting body of evidence to guide palliative and end-of-life care in the ED [23,24]. However, communication problems [25], loneliness, exposure to cold surroundings, and medical or family obstinacy continue to represent a constant threat to the dying person's loss of dignity in the ED [22]. In a technological environment, patients, family members and professionals face palliative sedation, futility of treatment [7] and the physician orders for life-sustaining treatment (POLST) [26,27]. The preservation of a dying person's dignity in the ED is fundamental for the patient, his/her relatives and healthcare professionals [28]. Understanding physicians' and nurses' point of view is key in preserving the dignity of a terminally-ill patient in the ED.

1.1. Aim

The aim of this study was to explore and interpret physicians' and nurses' experiences regarding conservation of dignity in end-of-life care in dying patients in the ED.

2. Methods

2.1. Study design

This study used a qualitative focus based on Gadamer's hermeneutic phenomenological approach. The study took place in two southeastern Spanish hospitals. The total population was comprised of 205 individuals working in both EDs – of whom 98 were nurses, 31 were physicians and 71 were physicians in training.

2.2. Participants

The participants met the following inclusion criteria: to be a physician or a registered nurse, have a minimum of two years' experience working in the ED and give consent for participation. The exclusion criterion was having suffered a personal loss within a year before starting the study.

2.3. Data collection

The data collection took place between October 2013 and June 2014. After receiving the approval from the ethical committee, two focus groups (FG) were carried out. The two FGs were respectively comprised of 6 physicians and 8 nurses, and lasted 45–57 min. For greater convenience, the FGs took place in a room adjacent to the ED. Furthermore, 8 nurses and 4 physicians from the ED who hadn't participated in the FGs took part in in-depth face-to-face interviews (lasting between 60 and 90 min). The interviewer was a member of the research team and worked as a nurse in the ED. An interview guide was used for both the FGs and the interviews (Table 1). The interviews were carried out in Spanish.

2.4. Ethical considerations

This research was approved by the Research Centre Ethical Committee (Andalusian Health Service, reference number 04/06/12). The participants received an Information Sheet to explain the nature of the study, the voluntary nature of their participation and the guarantee of confidentiality and anonymity, and signed an informed consent.

Table 1
Interview guide.

Stage of interview	Subject	Content/Example questions
Introduction	Motives	The belief that their experience offers information which should be known to everyone.
	Aims	To carry out research in order to make the lived experience known.
Start	General introductory question	'If you don't mind, we'll start with you telling me about your experience of dignity in end-of-life care in the Emergency Department."
Development	Guide for conversation	'When do you feel your patients conserve their dignity in end-of-life care?' 'What do you think about dignity in end-of-life care in the Emergency Department?'
Finish	Final question	'Is there anything else you would like to say on the subject?'
	Thanks	Thank them for taking the time to talk to us.

2.5. Data analysis

All the FGs and in-depth interviews were audio-recorded with consent. The audio-recordings were transcribed and analyzed. After completing the analysis, the participants' quotes were translated following a forward-backward procedure. Firstly, an independent native Spanish translator (proficient in English) translated the participants' quotes from Spanish to English. Secondly, an independent native English translator (proficient in Spanish) translated the English version of the participants' quotes back to Spanish. Thirdly, both translators and the researchers reviewed the English translation, the Spanish backward translation and the original version of the participants' quotes. It was agreed that the English version of the participants' quotes presented in this manuscript respected the original meanings. The analysis of the FGs and interviews was performed by using a modified form of the stages developed by Valerie Fleming [29]: (1) to decide if the research question was pertinent according to methodological assumptions; (2) to identify the researchers' pre-understanding of the study subject (reflexivity) – In this study, the researchers' pre-understanding was derived from their clinical experience in the ED and critical care, and their teaching and research experience in end-of-life care; (3) to gain an understanding through dialogue with the participants via the text, the coding was performed by three members of the research team; (4) to establish reliability – the researchers have tried to be faithful to the text and the context. The final list of themes, subthemes and units of meaning was subsequently confirmed by the participants. Computer-assisted qualitative data analysis software (ATLAS.ti. version7.0) was used to analyze the data.

3. Results

The final sample comprised 26 participants with an average age of 38.12 years old and an average experience of 14.3 years in looking after patients in the ED. The sociodemographic characteristics of the sample can be seen in Table 2. From the analysis, 150 open codes emerged and 203 quotes were selected. After an interpretation process, these codes were reduced to 12 units of meaning grouped into four subthemes and two main themes (Table 3).

3.1. Theme 1. Dignified care in unfavorable surroundings

The participants reported pro-active efforts in the search of dignity preservation in an unfavorable environment. Those efforts were directed to both making the act of providing care an element of dignity preservation, and minimizing the effects of the

Please cite this article in press as: Díaz-Cortés MdM et al. Promoting dignified end-of-life care in the emergency department: A qualitative study. Int. Emerg. Nurs. (2017), http://dx.doi.org/10.1016/j.ienj.2017.05.004