Trajectories of End-of-Life Care in the Emergency Department
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Study objective: The emergency department (ED) is the gateway to the hospital setting. Despite the intentions from the end-of-life care strategy in the UK to improve care provision, the ED has increasingly become the access site for end-of-life support. Little attention has been given to this aspect of the work of the ED, even as the quality of end-of-life care in hospitals has become the subject of increasing concerns. We explore end-of-life care in the ED and provide an understanding of how care is delivered to the dying, deceased and bereaved in the emergency setting.

Methods: Observation was carried out in a large urban ED during 12 months. This was complemented by detailed interviews with emergency staff, patients diagnosed with a terminal condition, who had visited the ED in the previous 6 months, and their relatives. Data were analyzed thematically, following the normal conventions of ethnographic research.

Results: Two distinct trajectories of end-of-life care were identified in the ED; the spectacular and the subtacular. Patients and family members experiencing end-of-life care in the ED have distinctly different care because of the nature of these 2 trajectories, frequently resulting in dissatisfaction for staff and distress and frustration for patients and their relatives.

Conclusion: The ED is priority driven, focused on resuscitation and the prolongation of life. As a result of the consuming nature of the spectacular death, a reluctance to build relationships with the dying, and a lack of educational support, the care needs of patients in the subtacular trajectory are somewhat neglected. These trajectories can be used to identify the shortfalls in end-of-life care in the ED and raise serious concerns for policy in regard to staffing, resources, and professional development. [Ann Emerg Med. 2011;57:362-369.]

Please see page 363 for the Editor’s Capsule Summary of this article.

INTRODUCTION

Background

Brian,* a 25-year-old male driver, is brought to the emergency department (ED), having crashed at 60 miles per hour with a stationary vehicle. Despite the heroic efforts of many physicians, nurses, and technicians to resuscitate the patient, his head injury is irreversible and death imminent. Noise is kept to a minimum, lights within the bay are dimmed, and monitoring is removed. Nurses remove the blood-stained evidence and cover him with clean linen. His family, accompanied by a nurse, sits with Brian until his death is confirmed. The nurse is vigilant and remains with them throughout.

In the opposite bay, Glennys grips her mother’s fingers. Mara is 92 years of age. She was brought into the ED by an ambulance from a care home, caregivers having found her with reduced consciousness and dyspnea. Her eyes are closed. Her mouth is dry. She has an oxygen mask on and an intravenous infusion connected but switched off. The monitor is on but not connected; its alarm sounds repeatedly. Mara’s breathing is erratic, followed by periods of stillness. A blanket half-covers her body, exposing her mottled ankles. There is a lingering smell of urine. Glennys remains anxiously by her mother’s side, her eyes red and swollen.

Both Mara and Brian died in the ED, but the care they received at the end of life was very different. In the ED, care is prioritized toward resuscitation even when the potential for death is far greater than the potential for life. This article defines 2 distinct trajectories of end of life in the ED and presents an argument that patients who are dying in the ED need to receive priority care whether or not they are candidates for, or have been recipients of, resuscitative interventions.

Importance

Despite the widespread assumption among policymakers and professionals that people prefer to die at home, 66% of people

*Pseudonyms are used to protect patient and staff anonymity.
in the United Kingdom die in hospitals.\textsuperscript{1} With a third of these individuals dying in the first few hours of admission to the hospital\textsuperscript{2} and many being admitted through the ED, knowledge of end-of-life issues in the emergency care setting is fundamental. Standards of hospital care have been brought into question. Such concerns relate to inadequacies in provision, communication, and the quality of end-of-life care,\textsuperscript{3,9} with some suggesting that the care of dying patients is a sadly neglected aspect of hospital life.\textsuperscript{10,11} Within an ED, where time and information are limited, the magnitude of these problems can be very high. The end-of-life care strategy in the United Kingdom\textsuperscript{12} has raised awareness within service provision in other areas of the health care system, such as the implementation of care pathways in hospital ward settings. Death, dying, and bereavement are daily occurrences in the ED, but despite more than 22,000 people dying in EDs annually,\textsuperscript{13} it is a sadly neglected area of research, professional development, and practice.

**Goals of This Investigation**

This article draws on detailed qualitative empiric research that explores end-of-life care delivery in an ED. With a very large quantity of observational data and a series of interviews with emergency staff, patients, and their relatives, 2 distinct trajectories of end-of-life care in the ED emerged. These trajectories are an important contribution to examining the multifaceted nature of end-of-life care delivery and are used to identify shortfalls in care delivery in the emergency setting.

**MATERIALS AND METHODS**

**Study Design**

Drawing on ethnographic methods, the study was organized in 3 phases. First, observation was conducted during a 12-month period, supported by informal field interviews with ED staff. The observation was progressively focused during the course of the research period,\textsuperscript{14} commencing with a thorough observation of all areas of the ED and then gradually focusing on the specific areas in which end-of-life care was provided for patients. After 4 months of observation, the second stage of the study comprised 15 detailed interviews with emergency nurses (11), physicians (2), and technicians (2). After a further 2 months, patient recruitment commenced and interviews were carried out with 7 patients who had been diagnosed with a terminal illness, concerning their experiences of visiting the ED in the previous 6 months. Seven relatives, who had accompanied the patients during the emergency admission, were also interviewed. As the study progressed, the observation and the interview phases began to complement each other in terms of the inquiry and the analysis. The study received ethical approval.

**Setting**

The study was carried out at an urban academic teaching hospital ED that treats approximately 140,000 patients each year. The department was typical of UK EDs in that it has 3 treatment areas: minors, majors, and resuscitation. As the study progressed, observations were focused within the resuscitation room, where the majority of patients at the end of life were located. Observations and informal interviews were also carried out “backstage”\textsuperscript{15} in the staffroom, offices, and communal spaces.

**Selection of Participants**

The ED staff were informed about the study through meetings and individual information sheets and asked to return a form indicating their agreement to be contacted. Information posters were displayed, and a reminder was sent to all ED staff before commencement of the observation phase. Consent for the observational work was ongoing and was obtained verbally at the beginning of each observation. Separate written consent was obtained for the formal interviews.

Patients who had been admitted to the ED in the previous 6 months and their relatives were recruited at the Specialist Palliative Care Unit. They were all identified by unit staff and confirmed by examination of medical records. They were given information about the study and arrangements were made for interview. The process required flexibility and understanding on the part of the researcher considering the patient’s individual needs. Although no patients refused an interview, patient attrition was high because of deterioration and, frequently, death.
Data Collection and Processing

The researcher spent approximately 3 shifts each week in the ED, collecting observational data. These comprised early, late, and night shifts, including weekends. Field notes in the form of “jottings,” including a description of events, were digitally audio-recorded away from the clinical area to avoid loss of information and to minimize invasiveness. Field notes were written up in more detail, within 24 hours, and combined with analysis and reflection. The researcher (C.B.) conducted all of the observations, adopting a “participant as observer” role.17

C.B. is an experienced emergency nurse, but she did not wear a uniform. Early in the study, all areas of the ED were observed, and this led to a subsequent focus on 2 areas where patients at the end of life were streamed for assessment: the resuscitation room and the major treatment area.

The observations added a further vital dimension to the research findings, complementing the interview data. It particularly enabled a greater rapport to be developed with the staff participants.18 It also led to the identification of phenomena worth further exploration and as such influenced subsequent data collection19 while also providing a greater depth of understanding of the “unsaid” data. As McCall and Simmons20 caution, participants may not want to tell the researcher everything when disclosing information or emotive explanations about the death of a patient or about their professional care or that of their colleagues because they may believe that such disclosures are insensitive or impolitic. The full period of observations enabled us to develop considerable insight into these unsaid data and provided us with greater clarity in observing systematic distortions or discrepancies that are less obvious from interviewing alone.21 It also provided a platform on which spontaneous interviews occurred naturally between the researcher and the emergency staff. These “natural interviews,” which were more akin to informal conversations, provided a considerable amount of valuable additional data.22

The semistructured approach to the formal interviews enabled a fluid, 2-way, conversational style of communication known to be more conducive to dealing with sensitive issues.23 Staff interviews commenced with a broad opening question such as, “Can you tell me about your experience of caring for a patient in the ED who was dying . . . ?” They were conducted in a private room in the hospital. Patient and relative interviews began with an explanatory question about their condition and ED admission. Patients who had attended the ED in the previous 6 months were interviewed at the Specialist Palliative Care Unit and were invited to recall their care in the ED. These formal interviews explored their experience of care and care delivery, their attitudes toward the end of life, and other issues arising from the ED admission. These interviews were audio-recorded with the participant’s consent. The development of the “researcher-participant relationship”24 before the interviews helped to reduce anxiety and facilitate open dialogue, thus increasing the credibility of the data.

### Table 1. Characteristics of participants in staff interviews (n=15).*

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Years Qualified</th>
<th>Years Worked in ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elizabeth</td>
<td>SN</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Margaret</td>
<td>SN</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Jane</td>
<td>SN</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Annette</td>
<td>SN</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Catherine</td>
<td>SN</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Ellen</td>
<td>CN</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td>Frances</td>
<td>CN</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>John</td>
<td>SN</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>Rob</td>
<td>SN</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Anthony</td>
<td>SN</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Taylor</td>
<td>St N</td>
<td>Student</td>
<td>Placement (6 wk)</td>
</tr>
<tr>
<td>Richard</td>
<td>EDA</td>
<td>N/A</td>
<td>3</td>
</tr>
<tr>
<td>Will</td>
<td>EDA</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>James</td>
<td>SPR</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Ray</td>
<td>SPR</td>
<td>8</td>
<td>5</td>
</tr>
</tbody>
</table>

SN, Staff nurse; CN, charge nurse; St N, student nurse; EDA, ED assistant; N/A, not applicable; SPR, specialist registrar.

*Numbers are representative of staff group.

Primary Data Analysis

Data collection and analysis of the data occurred simultaneously. Interviews and field notes were audio-recorded, transcribed verbatim, and organized for analysis with NVivo (QSR International PTY Ltd, Victoria, Australia) by C.B. Given the iterative process of the research, thematic analysis25 was used to identify a series of codes deriving from observational field notes, reflective notes, and interview transcripts. The codes were then used to identify themes by drawing on a priori issues derived from the observation data and initial research questions. The research study aimed to explore how emergency staff care for patients who are at the end of life; present the experiences of care from the perspectives of emergency nurses, patients with terminal and life-threatening illnesses, and their relatives; and describe the trajectories of end of life in the ED in relation to the care of the patient, their relatives, and through the nurses’ response to death and dying. Coding and analysis was checked further (D.P.), and where differences of opinion arose, a consensus was reached by mutual discussion and reflection. “Prolonged engagement,”26 “member checks” with clinical staff,27 and interdisciplinary critique achieved by examination of the data by the 3 authors28,29 were measures taken to ensure trustworthiness.26

RESULTS

Characteristics of Study Participants

More than 100 ED staff were observed during the study period (totaling approximately 960 hours). The characteristics of the ED staff are presented in Table 1. The characteristics of the patient and relative study subjects are presented in Table 2.

Main Results

Two trajectories of end-of-life care situations in the ED were identified; the spectacular and the subtacular. These trajectories
are based on the care of the patient, management of the relatives, and the overall response to dying, death, and bereavement. The spectacular involves a sudden, often traumatic loss of life. The care of patients in this trajectory is prioritized, to a great extent acting to consume the attention of ED staff members. It is this death that society in general most associates with the ED, and not necessarily the slow process of dying: the subtacular, which appears to command a lower priority in emergency care compared with patients whose problems can possibly be fixed by rapid intervention. The differences between spectacular and the subtacular death were highlighted in the ways in which ED staff cared for the patient and their relatives. Staff attitudes toward dying and the death of patients were also evident in how they care for the deceased and the bereaved and in how they responded to one another. The nature of the spectacular death occupies the attention of the ED staff, and therefore the needs of patients in the subtacular trajectory are often neglected when a spectacular death is occurring concurrently. The ED focus is on saving life, and reluctance exists among emergency staff to concede that nonemergency death and dying constitute a large part of emergency work. This, along with the distancing behaviors, which some staff exhibited to avoid getting involved with the dying and bereaved, means that palliative and supportive care needs are often not provided in the ED. Overall care was found to be poor for patients within the subtacular trajectory, who often have complex needs associated with terminal illness and who are admitted to the ED near the end of life.

The spectacular death, as illustrated in the introductory case of Brian, is an elaborate display that is full of the activity of emergency care. All spectacular deaths that took place during the 12-month observational period involved a resuscitation attempt, in which efforts were directed toward saving the patient despite any previous preconceptions of the severity of the emergency presentation. The performance of the resuscitation attempt draws on the ED as if it were an audience because during the resuscitation the patient is considered living, as heroic attempts are carried out to save life. During the ED is organized around the production and consumption of images, commodities, and staged events. It is this death that is most commonly portrayed in films, television dramas, and the media more generally. As Debord’s notion of the spectacular implies, the passive subject, in this case the patient subject to the resuscitation attempt, and even the deceased body, consumes the attention of the ED staff over all other aspects of emergency work.

The high potential for death in this trajectory demands high levels of staff attention directed at the patient, and the resuscitation attempt regularly takes precedence over other work in the department, including care of other patients who may also be at the end of life. Staff nurse Anthony said that “your attention has to go to the resuscitation so the patient that is dying will be left and will be checked on intermittently and that’s not how it should be, that’s not how you want it to be.” The notion of the resuscitation patient taking precedence over other dying patients was observed in the fieldwork and reflected in many of the nurses’ interviews. Staff nurse Annette also sensed the consuming nature of the spectacular death and said, “If I was looking after a patient who was dying and a resuscitation came in, I would have to leave what I was doing and go to the resuscitation.” Among emergency staff, there was a consensus that end-of-life care could be improved, but external pressures exist that staff believe are out of their control. As charge nurse Frances conveyed, “We are the emergency department and we are governed by what comes in the door.”

The spectacular death involves an unexpected acute medical illness or a sudden and often traumatic event that results in death. Patients observed in the study in this trajectory included those with cardiac arrests, cardiac emergencies (in young people), multiple traumas, leaking abdominal aortic aneurysm, gunshot and stabbing wounds, suicide attempts, neurologic emergencies (head injury, neurologic bleeding, overdose), and severe burns; this trajectory also included a variety of pediatric resuscitations. There is rarely spectacular dying in the ED because during the resuscitation the patient is considered living, as heroic attempts are carried out to save life. During the

### Table 2. Characteristics of participants in patient and relative interviews (n=13).

<table>
<thead>
<tr>
<th>Name</th>
<th>Relative or Patient</th>
<th>Age, Years</th>
<th>Sex</th>
<th>Patient Diagnosis</th>
<th>ED Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe</td>
<td>P</td>
<td>72</td>
<td>M</td>
<td>Lung cancer/heart failure</td>
<td>Chest pain/dyspnea</td>
</tr>
<tr>
<td>Maria</td>
<td>P</td>
<td>52</td>
<td>F</td>
<td>Ovarian cancer</td>
<td>Pain</td>
</tr>
<tr>
<td>Elsie</td>
<td>P</td>
<td>92</td>
<td>F</td>
<td>Bowel cancer</td>
<td>Fall=fractured clavicle</td>
</tr>
<tr>
<td>Lewis</td>
<td>P</td>
<td>46</td>
<td>M</td>
<td>Glioblastoma/multiple sclerosis</td>
<td>Overdose</td>
</tr>
<tr>
<td>Murray</td>
<td>P</td>
<td>50</td>
<td>M</td>
<td>Esophageal cancer/bone metastasis</td>
<td>Fall=fractured femur</td>
</tr>
<tr>
<td>Annie</td>
<td>P</td>
<td>78</td>
<td>F</td>
<td>Cancer of bladder/COPD</td>
<td>Deterioration</td>
</tr>
<tr>
<td>Bill</td>
<td>R; Annie’s husband</td>
<td>80</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carolyn</td>
<td>R; Annie’s daughter</td>
<td>44</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olivia</td>
<td>R; Annie’s granddaughter</td>
<td>18</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gillian</td>
<td>R; Daughter</td>
<td>53</td>
<td>F</td>
<td>87-year-old mother with renal failure</td>
<td></td>
</tr>
<tr>
<td>Rose</td>
<td>R; Joe’s wife</td>
<td>71</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phillipa</td>
<td>R; Elsie’s daughter</td>
<td>67</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helen</td>
<td>R; Daughter</td>
<td>35</td>
<td>F</td>
<td>60-year-old father with prostate cancer</td>
<td></td>
</tr>
</tbody>
</table>

R, Relative; P, patient; M, male; F, female; COPD, chronic obstructive pulmonary disease.
The spectacular death yields a public display of the end of life in the ED, involving additional nurses, physicians, technicians, and often a variety of specialties within the hospital. Even in the aftermath, when the deceased’s body is no longer visible in the ED, the spectacle of what has happened remains in the conversation and reflections of those who have been involved. The spectacular death is worthy of special notice, and as a result, it is this death that is most commonly discussed informally among the staff. There is a “need to tell” among the nursing staff who have been involved with the bereaved and deceased. During the interviews, it was the spectacular deaths that participants discussed first. Although the spectacular death presents many stressors to the emergency team, informal support and guidance observed in discussions among staff are more freely available to those involved.

The neologism subtacular, coined here as the second trajectory of end-of-life, is used to denote a lower status in terms of care than the spectacular. Unlike Debord’s30 concept of the spectacular, the subtacular does not consume the attention that the spectacular yields. Although it can be emotionally intense, it does not evoke the heroic, elaborate reaction of its witnesses. The subtacular trajectory refers to end-of-life patients, who are viewed as less than spectacular. Patients here command a lower priority, and therefore their care is generally of a lower intensity compared with the spectacular. Subtacular dying occurs with patients who attend the ED for symptom management as their underlying condition deteriorates or they experience a “periodic crisis,” as described in the Lunney et al31 trajectories of dying.

The opening case of Mara illustrates the lower priority for attention given to patients and their relatives, once the discussion to discontinue treatment has taken place and a do-not-resuscitate order has been written. To the ED staff, Mara’s dying was subtacular, low priority, and their actions reflected this. Her monitoring leads had been taken off, but the monitor was still on, her intravenous infusion was switched off but not taken down, and her cannula was no longer needed but was still in situ. No explanation was given to Mara or Glenns about why the cannula remained in place. Mara had been moved to the corner bay with the curtains drawn, concealing the space in which she was dying. From the point that her active treatment was stopped and the do-not-resuscitate order written (a period of 3 hours 20 minutes), Mara was checked on only once by a staff nurse during shift handover. During this observation, the rest of the ED was at its usual busy state, but most of the staff attention was focused on Brian in the trauma bay. Brian received constant nursing presence and comfort care, but Mara did not.

Mara’s case was not an unusual occurrence during the study period. From clinical experience and from the observational data, the care of patients dying a subtacular death formed a considerable part of emergency admissions. Patients in this trajectory were most frequently brought into the ED by ambulance from their homes or care homes. Presentation complaints on arrival to the ED included collapse, dyspnea, gastrointestinal bleeding, fall with associated injury, or acute symptoms associated with terminal conditions such as pain. Joe, a 67-year-old man with terminal lung cancer, fitted our observations that patients in the subtacular trajectory are, although often segregated to less visible areas in the ED for privacy, effectively hidden away. He described being “stuck in a corner and left there.” Joe, like other patients in this trajectory, had complex needs because of additional heart failure, but the lack of attention to his needs on admission to the ED had implications later, resulting in a prolonged hospital stay on an acute medical ward. Similarly, other patients in this trajectory described their individual care in the ED as “poor” and revealed their anxieties of being “uncared for,” confirming the observations that once the emergency presentation had been stabilized or treated, there was a general lack of regard for the wider end-of-life care needs.

In another instance, Elsie, a 92-year-old patient who lived alone, was sent home after sustaining a fractured collarbone from a fall. Despite being frail from end-stage bowel cancer, she was discharged and told to return to the fracture clinic the following day. Unable to dress herself, prepare a meal, or access further support, she failed to return and was instead admitted 3 weeks later, spending the last days of her life in a busy hospital ward, a far cry from the “dignified death” Elsie had wished for. As Chan32 points out, the nature of the ED puts pressure on staff to “be productive and focus primarily on outcomes, de-emphasizing process and being with people who need care.” Although “being with patients” is regarded as highly important by the nurses and by the patients themselves, this is only possible when the ED environment affords nurses the time and resources to care. Subtacular dying can bring with it a series of complex demands, and consequently the admission of the dying patient into the ED brings with it further challenges for the emergency team, in contrast to the spectacular death, which is more prescribed and often more efficiently managed in relation to meeting individual care needs.

Unlike the spectacular death, there is the potential for the patient-practitioner relationship to develop in the subtacular...
and a space in which end-of-life choices can be discussed and implemented. However, this is frequently not carried out because some staff distance themselves from the patients and their relatives, apparently in an attempt to protect themselves from the potential loss or upset they may experience when death occurs. This had implications for patients and relatives in regard to communication and information giving. As Helen recalled after her father’s admission to the ED with cancer-related pain, the distancing behaviors among the ED staff created a negative impression of care delivery.

“We found a great lack of communication to be quite honest because they [the ED staff] were very busy . . . so the information wasn’t very forthcoming. It wasn’t until Dad got here [the Specialist Palliative Care Unit] that answers started to become apparent. I think from our point of view, purely from the frustration as a family member, I wanted to know what was going off. The lack of information was infuriating. I think they look at him and think what is the point of giving that person a bed when we are going to have another emergency come through the door that is going to benefit [from it]? We all know that costs come into decisions a lot of the time, and it shouldn’t, but they do, so whatever the reason he has often been classed as a lower-class citizen in regards to emergency medicine.” (Helen, daughter; italics the authors’)

Generally, the ED staff did not feel prepared for caring for the dying in the ED. Nursing staff relied on learning from others and experience. As Annette recalled, “No one actually knows what they should be saying. There is no practical advice. It is just from experience, really, and a lot of the time I worry I am going to say or do the wrong thing.” They described not having the space and resources to care for patients and revealed their anxieties about talking to the dying patient and the family, as well as managing their emotions during the care of a patient who was suffering. As staff nurse John highlights, “There is something different between [death from] an accident and people who die slowly in the department. It still can be as difficult to deal with. I think the real pressure comes from being with the relatives or dealing with someone who is dying slowly [as] you’re there with them.” As John indicates, death in this trajectory can be more difficult for the practitioners because they may also experience a greater sense of loss when the patient dies. Coping mechanisms, which staff adopt, seem to prove detrimental to their practice. This is sometimes expressed by nurses displaying avoidance behaviors and withdrawing from situations and, in some cases, from nursing altogether. More notably, the behaviors that staff adopt to cope have a detrimental effect on the patients’ experience of care. Patients reported how distancing behaviors made them feel “uncared for,” “forgotten about,” and “neglected.”

LIMITATIONS

The qualitative approach used within this study has enabled a richness and depth of meaning and understanding to be brought to the fore about the delivery of care at the end of life in the ED. The data collected throughout the study, though from a variety of sources, was nonetheless gathered from just 1 ED in the United Kingdom. For this reason, it may not reflect the views of emergency staff and patients in other regions, in particular from hospitals that may have an active palliative care team working within the ED. Further research will be required to establish whether the trajectories identified in this study also exist in other EDs outside the National Health Service and, indeed, the emergency field more generally.

This type of qualitative research study did not seek generalizability, and the small sample size for the supporting interviews means that we are unable to transfer these findings to all staff within the ED. The majority of the data were collected from nurses, whereas the physician data are from specialist registrars and may not therefore be reflective of the whole medical team. However, with observations being conducted consistently during 12 months, patterns and types of data could be identified. This provides the opportunity to generate a number of hypotheses for future research.

DISCUSSION

This article has set out the primary findings of a qualitative study, exploring the end-of-life care in the ED, and introduces 2 end-of-life care trajectories, the spectacular and the subtacular, which were confirmed by staff and patient interviews. In the ED, the individual care needs of patients in the subtacular trajectory are frequently neglected. One of the reasons for this is that the spectacular patient commands the most attention and takes priority in the emergency management of the patient, which can be observed to result in the subtacular patient receiving a subordinate level of care. The patients and relatives associated with the subtacular trajectory of dying and death are more likely to experience less attention in the ED, which results in a poor experience of care. Patients equated feeling cared for with the level of attention they received by the emergency staff. Although they did not measure satisfaction by how many interventions or treatments were administered, they valued the presence of the nurses. In an emergency environment that is priority driven, fulfilling these demands is challenging but essential to provide quality end-of-life care.

Many ambiguities exist around subtacular dying, where a clear prognosis is not easy to provide. This can lead to problems in communication and appropriateness of active or therapeutic care. Although the medical needs of patients in each trajectory may differ, the supportive care needs of the patient and their relatives remain high in both. A more detailed description of these needs can be found in the thesis by Bailey. Nevertheless, supportive care for the spectacular ranks most highly in emergency work, and therefore the care of these patients and their relatives was more highly justified among the ED staff.

The spectacular death is associated with the norms and practices of the ED, whereas the subtacular is not. Emergency staff are trained in resuscitation but not in palliative care. Page and Komaromy examine how death is constructed in both a care home and an acute hospital setting. They describe how death in the care home was not an unexpected or even
unwanted event, but one that was constructed as “timely” and “natural,” coming as it often did at the end of a long life.35 Considering the study by Page and Komaromy34 in light of “natural,” coming as it often did at the end of a long life.35
of these study findings, it could be argued that, although the subtacular may seem natural in community settings, death in the acute hospital environment can be perceived as being out of place, and therefore it is often not constructed as a “natural” or “timely” event. Consequently, the ED is not viewed as the appropriate place for the subtacular death to occur. The ED focuses on saving life, and reluctance exists to accept that patients in the subtacular trajectory constitute a large part of emergency work. The neglect of patients in the subtacular trajectory reinforces the commodified spectacle of the ED. With an increasingly aging population, more people are living longer and dying more slowly from chronic illness. The promotion of healthy aging brings with it a gradual decline in health, thereby increasing the potential for comorbidities, resulting in the subtacular death becoming more prevalent in society. Although the community setting is currently the focus for end-of-life care service provision, it is negligent to ignore the fact that patients within the subtacular trajectory are likely to access the ED for advice, treatment, and supportive care as death nears. This is concerning, given that this study has revealed that the care of patients in the subtacular trajectory is often neglected and regarded as poor by both patients at the end of life and nurses who feel responsible for their care.

The implications arising from this study will need to be addressed at local and national levels through education, service development, and further research. These findings have important considerations in terms of future service provision. There is a need for policymakers and key organizations such as the National Health Service and Department of Health to focus on the primary—acute secondary care interface in regard to improving end-of-life care. Currently, EDs do not staff for the “caring” aspects depicted in this study. The findings identified here go one step farther than previous trajectories identified by Timmermans,36 Chan,37 and Lunney et al31 because they are based on the processes of care at the end of life in the ED. The trajectories identified in this article are specific to the ED and consider the role of the ED staff through the perspectives of staff and directly out of the experiences of patients and their relatives. These trajectories offer an insight into end-of-life care giving for all emergency professionals and can be used within undergraduate and continuing education to identify the shortfalls in end-of-life care within the ED. Implications for practice require a willingness to acknowledge and confront what are emotionally challenging and sometimes professionally difficult issues of care delivery.

Within education there are implications at both undergraduate and postgraduate level. The current lack of consistency within nursing and medical curricula needs to be addressed, focusing on the effect of end-of-life care delivery in critical care areas and building awareness of the nonphysical needs of the subtacular dying to ensure a positive effect on those providing the care and consequently those receiving it. At postgraduate level, the focus needs to turn to supportive practice for trained staff in relation to end of life. Emergency staff need to be able recognize and acknowledge their role in end-of-life care delivery and clearly define the parameters of their work to manage the emotional impact of end-of-life care to ensure the delivery of excellent care at the end of life for all patients. Collaborative effort between policymakers, educationalists, and health care professionals is needed in light of these research findings to improve the practices of those providing end-of-life care, consequently improving the experience for patients and their families. Further research is being conducted to investigate interventions that are currently being implemented to improve end-of-life care in EDs across England. Understanding of how organizational structures and practices that assist with higher-quality end-of-life care will help us to implement changes to ensure high-quality care for all.

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