

ORIGINAL RESEARCH

Aotearoa New Zealand emergency medicine specialists on the provision of care at or near the end of life: A survey

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Abstract

Objectives: The ED is an increasingly important venue for the initiation of palliative care. We sought to characterise the opinions, experience, training and education of ED staff in Aotearoa/New Zealand (NZ) with regard to specific aspects of palliative care in the NZ ED setting.

Methods: All NZ FACEMs were personally emailed a simple unstructured 16-part survey asking questions about initiating palliative care, goals of care, initiation and availability of advance care plans, frailty screening, availability of palliative expertise, training and education, cultural safety and pastoral care of staff. All EDs were contacted and a link provided for non-FACEM ED staff who wished to participate. Free-text comments were analysed for dominant themes.

Results: All NZ EDs had at least one participant. There was a high level of senior medical staff engagement with 60% of NZ FACEMs participating. More than 300 free-text comments from this group were available for theme analysis. A total of 93% of NZ FACEM respondents agree that palliative care should be able to be initiated in the ED. Only 25% of this group knew of training in serious illness conversations in the ED while only 34% felt culturally

competent when providing end-of-life care for Māori and their whanau (family). Pastoral care for ED staff appears to be *ad hoc*. Time and privacy limitations were common themes.

Conclusions: There is significant opportunity for quality improvement in the initiation and provision of palliative care from the ED. Attention to how departments provide pastoral care to their staff is needed.

Key words: *advance care plan, cultural competency, goals of care, palliative care.*

Introduction

Despite lower death rates and increased life expectancy, total annual mortality for Aotearoa/New Zealand (NZ) is projected to rise by about 50% over the next 20 years. As the general population ages, people 80 years and older will account for the majority of this increase. Between 70% and 80% of older patients are seen in NZ EDs within the last year of life. Hospital remains the single most common place of death for this group.¹⁻³ EDs can expect to become increasingly involved in providing care and helping to navigate treatment choices for people with life-limiting illness who are at or near the end of life (EoL).

Key findings

- There are low levels of self assessed cultural competence among NZ FACEMs.
- NZ EDs provide minimal training in palliative care including training in serious illness conversations.
- Pastoral care is *ad hoc* in NZ EDs.

The need to rapidly identify those who are unlikely to benefit from the emergent, resuscitative or a restorative model of care requires a well-trained and agile ED workforce. Patients may not have had the opportunity to discuss their goals of care previously. Offering care appropriate to the phase of life-limiting illness at hand necessitates skilled assessment and communication.

The Australasian College for Emergency Medicine (ACEM) has an EoL and palliative care policy (P455), which promotes training, frailty screening, shared care planning and the availability of senior expert decision-makers.⁴ The COVID-19 pandemic has prompted ACEM to produce a palliative care framework augmenting this policy. It points out that ED specialists are experts in complex ethical decision-making where resource stewardship is likely to increasingly influence the balance between autonomy and the risk/benefit of interventions.⁵ Since 2015 the college has also developed a detailed EoL care section in its fellowship curriculum.⁶ Finally, ACEM, in its Choosing Wisely statement for patients approaching the EoL sets an

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expectation that shared goals of care (SGoC) be established as part of the package of care.⁷

To our knowledge there have been no studies scrutinising the initiation of EoL care in NZ EDs. Two small Western Australian studies examining perceptions and attitudes towards palliative care in the ED showed high levels of self-assessed confidence in palliative care. However, patients with life-limiting illnesses other than cancer appeared less likely to be identified for early initiation of palliative principles of care.^{8,9}

The level of availability of expert palliative care advice and/or education in NZ EDs has not been described. Additionally, there is no literature available on cultural safety, advance care planning (ACP) or SGoC training or of the utility of existing ACPs/advance directives (ADs) within the ED. Finally, there is no collective information on the pastoral care offered to clinicians across NZ EDs.

This quality initiative uses a simple survey of NZ ED staff to gauge and describe attitudes and experiences of ED clinicians about palliative or EoL care in the ED.

Methods

A 16-part questionnaire was designed by the lead investigator in collaboration with the Clinical Director of the Integrated Palliative Care Service Christchurch Hospital and the Medical Director of the Nelson Tasman Hospice (both in NZ). The survey was intended for all medical, nursing and allied health staff in NZ EDs to complete.

The survey included questions on initiating a palliative approach in the ED, ACP, frailty screening, cultural safety at the EoL and palliative care education. It also used two brief scenarios to enquire about specific issues such as honouring an AD and the role of active treatment for patients known to palliative care or hospice.

Using a commercially available survey tool (<https://www.surveymonkey.com/>) two methods for distribution throughout NZ EDs were used.

1. Potential participants were emailed including all NZ-based

FACEMs (contact email addresses were permitted through the NZ faculty of ACEM).

2. A link to the survey was sent to local ‘champions’ (mainly ED Charge Nurse Managers) for distribution.

There were multiple opportunities for voluntary free-text comments throughout the survey. These were examined using Braun and Clarke’s method of reflexive theme analysis where appropriate.¹⁰

Iwi Health Board consent was formally confirmed on 3 June 2021.

Results

The survey was open for participants during the 4 weeks, between 13 April and 12 May 2021.

A total of 661 clinicians (ED nurses, ED allied health, ED non-specialists) participated from 26 of the 27 EDs surveyed. It took an average of 3 min 20 s to complete. Despite the short time it took participants, there were more than 800 free-text comments, 300 of which were from the NZ FACEM group ($n = 221$). There was a 60% participation rate from the FACEM group (contact email addresses were permitted through the NZ faculty of ACEM). The participation rate for ED nurses was only 8% (Nursing Council of NZ estimates that there are 3280 registered nurses with ED credentials). The clinical roles of all respondents are shown in Figure 1.

Because of the high rate of NZ FACEM participation, most of the results shown in the remainder of this paper are from this group.

Cultural identity

All participants were asked about their cultural identity. Only seven (3%) of the FACEM group identified as Māori, 65% of FACEMs identified as NZ European/Pakeha; 35% were international medical graduates while remainder preferred not to say.

EoL care as a core ED activity

A five-part question covered a range of issues relating to EoL care. Clinicians were asked if they agreed with the statement, ‘caring for the imminently dying patient is a core ED activity’. A total of 79% of the FACEM group agreed.

Free-text responses were not able to be specifically analysed in relation to each of the five-part question. Statements that appeared to relate to this subsection are as follows:

ED should facilitate prompt palliative care. End-of-life discussions are too often deferred ... and ED has to have them. (FACEM)

While I am a strong believer in palliative care, I don’t think ED is the right place for proper, dignified, holistic, comfortable end-of-

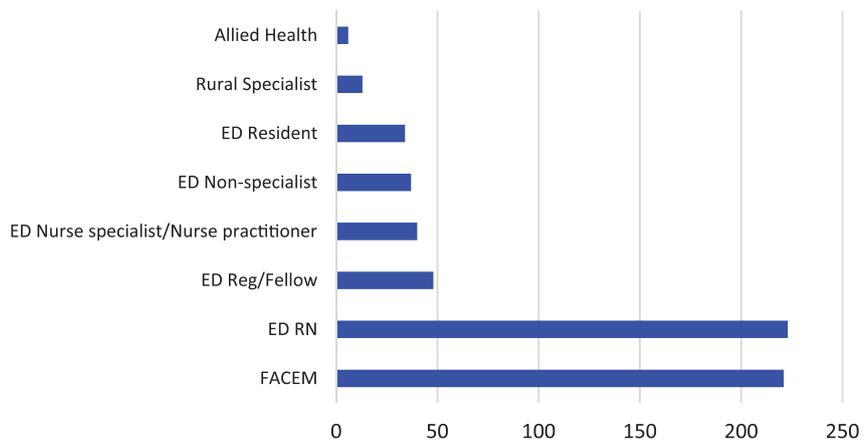


Figure 1. A total of 661 ED clinical staff responded to the survey, specialised roles are shown.

life for patients and the relatives accompanying them... (ED Nurse)

I think patients in ED receive at times a negative approach by some doctors and even perhaps nurses because there is no other form of treatment that will be given... (ED Nurse)

The only thing would be to be honest with families about our shortcomings and request they come in and help care for their relatives as it is unlikely to happen otherwise. (ED Nurse)

Advance care planning

Clinicians were then asked about their understanding of ACP. The scenario detailed an AD indicating a non-resuscitation pathway. A total of 73% of FACEM respondents indicated that a patient with acute delirium because of sepsis and an AD against ‘resuscitation’ should not receive antibiotics.

Ordinarily, if there is no reason to doubt the validity of the AD, it should in fact be honoured. Sometimes this can be hard to determine and 28 of 42 of the comments made to this five-part question indicated there was too much nuance, essentially saying that it was difficult to provide a definitive answer on the information provided.

...these questions require discussion with patient and whanau as to what they consider life-prolonging treatment or symptomatic treatment.

...unless I feel that this will resolve the delirium and so ease their suffering.

Initiating palliative care in the ED

The next question explored the issue of whether more patients could benefit from a palliative approach in the ED; 206 (93%) of the 221 FACEM participants agreed.

Some themes emerged from the free-text comments. Representative extracts are as follows:

We absolutely need to embark on ‘palliation only’ treatment pathways in ED and yes this is core EM.

Trainees are poorly prepared for this type of patient...

...managing end-of-life care is a frequent activity in our ED, especially now that ICU have...

I think we sometimes give up too early due to the ICU mentality running the culture of medicine.

Initiating an ACP conversation in the ED

Given the increasing prevalence of patients seen in EDs with life-limiting illnesses, participants were asked if they agreed with the statement. Figure 2 shows FACEM responses to the statement, ‘There are times when ED should initiate an ACP discussion’.

The three most prominent themes from analysis of the 26 comments provided were:

1. ED can or should initiate the conversation.
2. There are greater resource implications for undertaking ACP than for acute care planning in the ED.

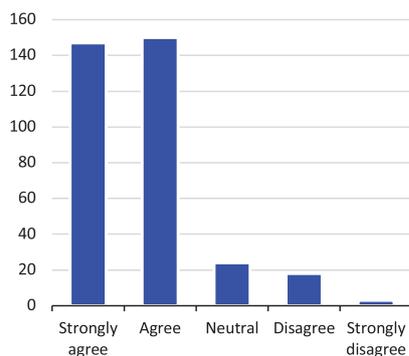


Figure 2. A total of 221 New Zealand FACEMs show their agreement or otherwise to the statement, ‘There are times when the ED should initiate advance car planning’.

3. Primary care is a better place for ACP discussions.

...frequently (EDs) are the first place when this conversation is initiated.

Yes, as an introduction ‘In this hospital we ask everyone ... the next team will discuss this in more depth with you...’

...workload makes the ED not the ideal place to start these discussions.

Unfortunately, this many times has not been done, even on severely at-risk people, including those clearly at end of life.

...inability of primary care and community services to have this discussion...

...can be a discussion to get the thinking along the lines of full discussion in primary care...

Frailty screening

Frailty is increasingly prevalent, and these patients present commonly to the ED. Frail patients are less likely to benefit from an aggressive treatment approach so respondents were asked whether elderly patients should be routinely screened for frailty. A total of 82% of FACEMs agreed.

Most respondents answered ‘yes’ but some felt strongly that this can railroad patients away from active management.

...I don’t think frailty relates to end-of-life care for those with life-limiting illness and is a slippery slope to withdrawal care for vulnerable elderly.

Thirty-two percent of FACEMs answered yes to the question ‘does your ED routinely screen for frailty?’ However, free-text comments indicated that screening was often sub-optimal. Examples follow:

We are meant to but does not happen routinely.

Not convinced it is acted on well...

Would like to but we are not resourced to.

Cultural safety

Cultural safety is key to providing equitable care to minority groups. Figure 3 shows FACEM self-reflected cultural competency when providing

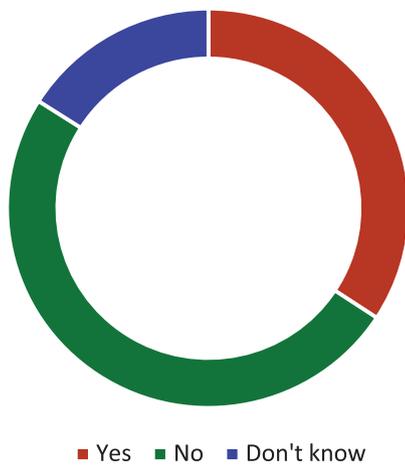


Figure 3. A total of 219 New Zealand FACEMs self-report their feeling of cultural competency when caring for Māori who are nearing the end of life.

care for Māori who might be nearing the EoL.

Interestingly, the proportion of FACEMs who felt 'cultural competent' did not significantly alter when filtered by experience (10 years or more in their current role) or age (≥45) or by tertiary *versus* other ED (36%, 39% and 37%, respectively). It should be noted that the ED nursing and allied health groups showed much higher rates of self-reported cultural competency (55%).

Accessing ACPs in the ED

A key requirement for ensuring patient-centred care is ensuring that any prior expressions of wishes such as an ACP is readily available to view when needed. Figure 4 shows that documented EoL wishes are often useful but are generally hard to find.

Free-text comments in this section were dominated by those with a dissenting view:

...lack of 'do not transport to hospital' orders from nursing homes.

...documents are often ambiguous...

...family remains the main source to indicate an advance directive...

...it's a mixed bag...

...(Care plans) can be out of date or seem clinically inappropriate.

...wish there were more and more readily available.

Palliative care expertise, education and training in the ED

Participants were asked if expert palliative care advice was available to their ED, 35% of FACEMs reported that there was none.

Thirty-four of those who answered yes to this question indicated that expert palliative care advice was available only during business hours. Eight reported that it was often difficult to obtain timely advice.

When asked if palliative care education is delivered in their ED, only 29% answered yes.

There were 19 comments, 17 of which indicated that palliative care education was either occasional or rarely occurred. Three comments directly stated that more education was needed.

Talking about serious illness in the ED

Serious illness conversations encompass more than just breaking bad news. Participants were asked if training in delivering serious illness conversations was available in their ED. Seventy-five percent either did not know or answered no.

Of the 17 responses, 12 referred to the availability of training, poor uptake and no available time were referred to in four comments. One respondent felt that because of the lack of ED trainees, it was a low priority.

Pastoral care for ED staff

Death in the ED can be stressful, emotional, traumatic and sometimes felt to be a failure of care. Not uncommonly, staff may have had to deal with many deaths in a short period of time. Figure 5 shows the support that FACEMs consider is available to ensure staff well-being

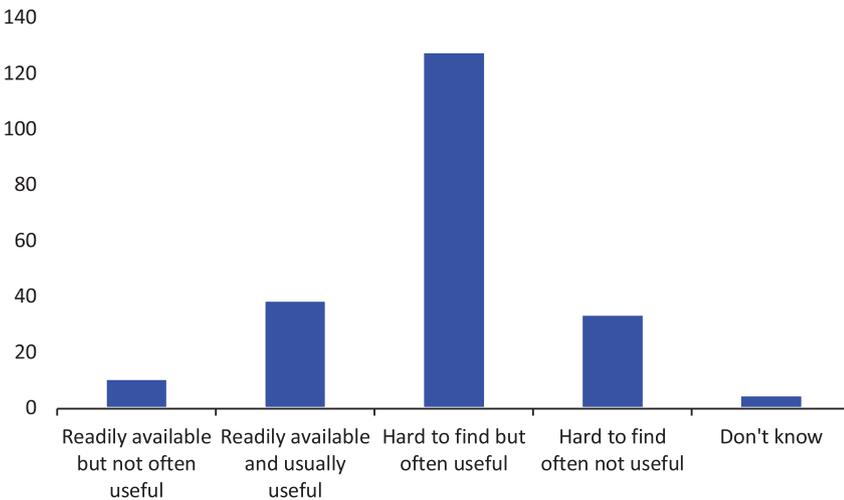


Figure 4. A total of 217 New Zealand FACEMs state how difficult (or otherwise) it is to locate, and how useful (or otherwise) documented wishes around end-of-life care is.

following a traumatic death or series of deaths in the ED.

Twenty-three (62%) of the 39 comments reported that debriefing was *ad hoc*, 15 participants report that no allocated time available or allocated while 13 comments reported that debriefing and support was dependent on the clinical lead. There were also reports that delays in debriefing often occurred and that there was potential for harm from this.

Additional comments

Participants were asked for additional comments at the end of the survey, there were 29 from the FACEM group.

Nine FACEM participants acknowledged the importance of this work while others pointed the need for community-based teams to increase ACP activity and visibility; there were concerns about stretching limited resources to doing more in the area of EoL care and serious illness conversations.

Discussion

The expected rise of total deaths in NZ (and Australia) has important ramifications for emergency medicine. This unstructured NZ ED survey examines some quality measures around palliative and EoL care shows that there are model of care, training and educational gaps and opportunities. The high participation rate by NZ FACEMs in this survey is

compelling and provides strong evidence of a need for improvement.

Less than one third of NZ FACEM participants reported their ED provided education in palliative care. Sixty-five percent answered either ‘no’ or ‘did not know’ to the availability of training in serious illness/SGoC/ACP conversations while more than one third of FACEMs report that there is no availability of palliative care expertise in their ED. This is likely to negatively impact on the quality of care offered to ED patients and whanau at or near the end of their lives possibly delaying their journey to palliation or worse, missing the opportunity altogether.

Cultural competency is recognised as a critical component in addressing healthcare inequity and forms an important part of the Medical Council of NZ requirements around cultural safety.¹¹ However, in this survey, a minority of FACEMs felt they were culturally competent when caring for Māori at or near the EoL. Higher rates of self-reported competency among ED allied health and the ED nursing groups, point to a valuable resource for NZ FACEMs.

The Health Quality and Safety Commission (HQSC), in its deteriorating patient programme, promotes the use of SGoC documentation in the acute setting and is supporting the roll out of training in the use of the serious illness conversation guide.¹² The main purpose of this evidence-based guide is hearing and listening to what is important to patients and the families.¹³⁻¹⁵ It

helps staff elicit the person’s views and preferences about their health and this is used to inform their goals of care.

Identifying risk groups is central to the initiation of serious illness discussions where necessary. This survey asked both: ‘Should your ED screen the elderly for frailty?’ and ‘Does your ED routinely screen for frailty?’ A total of 84% of FACEM respondents thought that the elderly should be screened for frailty, while only 32% reported that their ED routinely screens for frailty. Free-text comments commonly cited resource limitations (privacy, time and personnel) with some reservations around what happens in the community for those who meet the definition of frailty.

Existing ACPs are considered useful by most FACEM participants; however, the accessibility of completed plans appears problematic. The HQSC is actively promoting ACP, and in some District Health Boards primary care funding is available for practitioners to help create and digitally record plans for patients who fulfil the surprise question – Would you be surprised if this patient died within the next 12 months?

Pastoral care offered to ED staff following a traumatic death or series of deaths appears patchy, *ad hoc*, personality dependent and informal. Barriers to debriefing include limited available time, the asynchronous nature of shift work and the lack of scheduling formal debriefing time. Potential barriers not uncovered by this survey may include lack of training in debriefing.

Limitations

A major strength of the present study is the high participation rate from FACEMs. There are potential limitations related to definitions and to the nature of surveying as a research tool. Working definitions for palliative care, SGoC and frailty were not offered. For example, palliative care is sometimes taken as terminal care, while the ‘term goals of care’ does not appear to have a collective understanding among Australasian Emergency Specialists.¹⁶ However, the work done in Western Australia suggests that palliative principles of care are well understood by the ED clinical

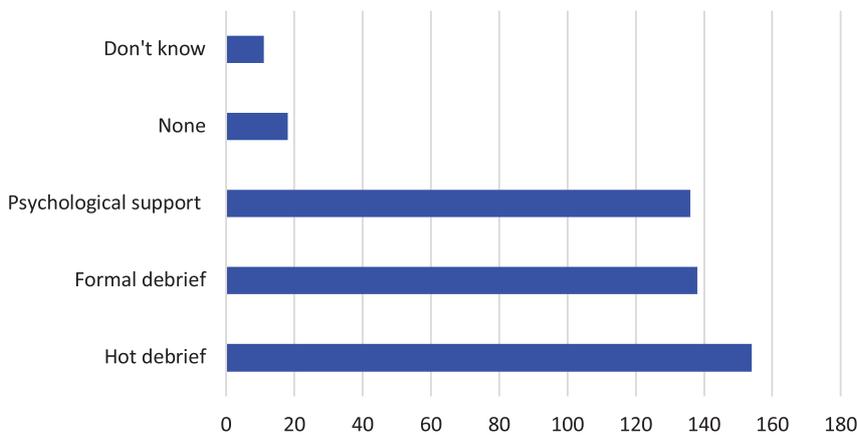


Figure 5. A total of 217 New Zealand FACEMs state the type of pastoral support that is made available to ED staff following a traumatic death or series of deaths in the ED.

community.^{5,6} The results in the present study indirectly suggest the case is similar especially with regard to many of the free-text comments.

Likewise, the use of the term 'resuscitation' can represent a spectrum of care even by senior clinicians, and participants were not expected to outline their definition.

Priming bias may be a problem, the survey was sent to all recipients in the same question order. Random sequencing of questions may have adjusted for this possibility.

Reporting bias, where respondents are more motivated than non-respondents, could be a factor. This may be further magnified by placing weight on free-text analysis as the themes described may not represent the entire group of participant opinions.

The scenario-based questions elicited a significant proportion of participants who felt that some scenarios were too nuanced for them to provide a meaningful answer.

The relatively low participation rate of non-specialist staff was a result of difficulties personalising the distribution of the survey and renders comparisons between craft groups as potentially misleading.

Conclusions

There is a high level of engagement of NZ FACEMs in thinking about EoL care in the ED but there are large gaps in training, education and cultural competence.

Overall, the quality of EoL care in NZ EDs needs to improve. Links to expertise in palliative care also need to be established and strengthened.

Additional barriers to the initiation of ACP and SGoC in the ED include poor ED design/no privacy, staffing and limited community follow up.

Pastoral care for ED staff is haphazard.

Competing interests

None declared.

Data availability statement

Data will be made available upon reasonable request to the corresponding author.

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