

Importance of End-of-Life Care in the Emergency Department (ED) is Growing as the Number of Persons with Terminal and Chronic Diseases Rises

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Introduction

It might be difficult to provide treatment for patients who are towards the end of their life in the emergency department (ED) due to the busy and sometimes chaotic atmosphere. The priority of addressing acute emergencies clash with the skills and time required for complete end-of-life care [1,2]. However, if a patient is terminally ill and has uncontrollable symptoms, financial difficulties, or restricted access to community services, the emergency department (ED) frequently serves as their entry point to such treatment [3,4]. Around the world, up to 80% of people passed away in hospitals even though the majority would have wanted to do it at home [5]. Even while more than 50% of cancer patients in Singapore stated that they would like to pass away at home [6], just 25% of all deaths in the general population took place in private homes, with the majority (60%) passing away in hospitals [7]. Singapore's healthcare system consists of open-access public hospitals with government-subsidized payment plans for residents [8]. Its emergency departments serve as entry points for terminally ill individuals who need accessible, round-the-clock medical care. In Singapore, patients who attend the emergency department (ED) pay a set price in Singapore dollars that ranges from \$116 to \$132 depending on the institution [9], which covers the consultation, preliminary investigations, necessary medical care, and common prescriptions. Charges for specialised treatments including diagnostic tests, surgeries, and prescription drugs are not included. As the world's population ages, end-of-life care in the ED is quickly increasing relevance [10]. However, there is little information in the literature currently available about patients' and families' experiences with end-of-life treatment in the emergency department (ED), as well as the views and challenges faced by ED and community healthcare professionals. In order to better understand these problems, we carried out a qualitative exploratory study grounded in the constructivist paradigm to explore and examine the perspectives and experiences of next-of-kin of patients needing end-of-life care in the ED; ED doctors and nurses in the provision of end-of-life care; and community palliative care providers regarding end-of-life care in the ED. It has been established that providing competent end-of-life care can enhance the quality of death. Its significance in ensuring minimal suffering for the patient and improving physical, psychological, and relational outcomes for next of kin and medical professionals cannot be emphasised. But while dealing with death on a regular basis, the ED hasn't been linked to providing good end-of-life care. Our study examined previously unstudied viewpoints from community healthcare workers and next-of-kin. As seen through the eyes of healthcare professionals working in the ED and the community as well as the next-of-kin, our study's findings revealed the expectations, flaws, and potential improvement areas in the delivery of ED end-of-life care. The themes that emerged from this study are supported by pre-existing theories thanks to the qualitative descriptive research technique. In accordance with the Theory of Planned Behaviour (TPB), a person's attitudes, subjective norms, and perceived behavioural control influence their underlying behavioural intentions and the likelihood that they would act in a certain way based

on their assessment of the advantages and disadvantages of the potential behaviour result. Patients' willingness to visit the ED is substantially influenced by their attitudes and behavioural intentions as well as those of their next-of-kin. For example, patients may find it difficult to deal with new or symptoms getting worse, feeling emotionally unprepared, or believing that hospitals may delay a fatal outcome.

The basic idea of Social Cognitive Theory (SCT) also explains how one's behavioural activity may be formed, as demonstrated by reciprocal determinism, social influences, and the individual's prior experiences. Participants spoke about their loved ones' excellent hospital end-of-life care experiences in the past, which encouraged them to seek out comparable treatment for themselves when they were terminally ill. Similar to the perceived power and behavioural control stated in TPB, the idea of self-efficacy as articulated by SCT is a significant additional aspect. Many of the next-of-kin admitted to lacking the knowledge, confidence, and abilities necessary to effectively manage symptoms like pain and dyspnea that occur at the end of life. Because of their perceived lack of self-efficacy, behavioural capacity, and control as well as their sense of helplessness, dying patients are often sent to a hospital rather than dying at home as they may have previously preferred. Subjective and societal norms (TPB), which imply that bringing ailing family members into a hospital is seen as helping them, further complicate this situation. The inability to execute operations and blood tests, the absence of 24-hour services, and insufficient financial subsidy programmes are all restrictions on community end-of-life care that prevent the care of the dying at home and act as negative reinforcing (SCT). For patients who are nearing the end of their lives, an effective home care plan includes educating the family about the expected course of events and the dying period, training the carers to manage symptoms, and giving access to neighbourhood resources. It can be difficult to provide end-of-life care in the emergency department (ED). A save-all approach is frequently adopted in emergency medical training. The ensuing attitudes and subjective norms lead to a negative assessment of the provision of end-of-life care in the ED. Stress and conflicting goals, along with a lack of rapport and confidence in starting end-of-life dialogues, were obstacles for ED doctors and nurses. It was recognised that the ED team needed to be given the information and abilities it

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needs to provide appropriate end-of-life care. To improve knowledge, abilities, and confidence in end-of-life care, suggestions included systematically integrating end-of-life care training for ED doctors and nurses. The ED team's ability to reach consensus on the care's objectives was also crucial. The patient and family should be talked to jointly by the ED doctor and nurse in order to convey a coherent message and a common knowledge of family dynamics.

Conclusion

The provision of end-of-life care in the EDs of three public hospitals in Singapore was noted to have issues, and key stakeholders indicated common expectations. ED visits were frequently caused by patient preferences, family decisions, a lack of community options, and ease of entry to the ED. Conflicting priorities, a confined space, a lack of confidence, poor communication, an absence of standardised procedures, and the laborious coordination of final discharge from the ED were among the obstacles. To best provide end-of-life care at the ED, multidisciplinary cooperation addressing environmental issues and ED procedures are crucial. To increase their expertise and confidence in the care of patients visiting the ED during the end-of-life phase, it is equally crucial to provide ED doctors and nurses with the appropriate information and abilities.

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Conflict of Interest

Author declares no conflict of interest.

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