HHS Public Access

Author manuscript

J Pain Symptom Manage. Author manuscript; available in PMC 2015 November 24.

Published in final edited form as:

J Pain Symptom Manage. 2012 January ; 43(1): 1–9. doi:10.1016/j.jpainsymman.2011.03.022.

Does Palliative Care Have a Future in the Emergency Department? Discussions With Attending Emergency Physicians

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Abstract

Context—Palliative care focuses on the relief of pain and suffering and achieving the best possible quality of life for patients. Although traditionally delivered in the inpatient setting, emergency departments (EDs) are a new focus for palliative care consultation teams.

Objectives—To explore attitudes and beliefs among emergency care providers regarding the provision of palliative care services in the ED.

Methods—Three semistructured focus groups were conducted with attending emergency physicians from an academic medical center, a public hospital center, and a community hospital. The discussions were digitally recorded and transcribed to conduct a thematic analysis using grounded theory. A coding scheme was iteratively developed to subsequently identify themes and subthemes that emerged from the interviews.

Results—Twenty emergency physicians participated (mean age 41 years, range 31–61 years, median practice time nine years, 40% female). Providers acknowledged many benefits of palliative care presence in the ED, including provision of a specialized skill set, time to discuss goals of care, and an opportunity to intervene for seriously ill or injured patients. Providers believed that concerns about medicolegal issues impaired their ability to forgo treatments where risks outweigh benefits. Additionally, the culture of emergency medicined—to provide stabilization of acute medical emergencies—was sometimes at odds with the culture of palliative care, which balances quality of life with the burdens of invasive treatments. Some providers also felt it was the primary physician's responsibility, and not their own, to address goals of care. Finally, some providers expressed concern that palliative care consultation was only available on weekdays during daytime hours. Automatic consultation based on predetermined criteria was suggested as a way to avoid conflicts with patients and family.

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Disclosures

The authors report no conflicts of interest.

Conclusion—Emergency providers identified many benefits to palliative care consultation. Solving logistical problems and developing clear indications for consultation might help increase the use of such services.

Keywords

Palliative care; palliative medicine; emergency medicine; geriatrics; end-of-life care; goals of care; defensive medicine

Introduction

Emergency medicine developed as a procedural specialty to stabilize patients with acute illness or injury for definitive care. Emergency physicians are trained to provide acute treatments for emergency medical conditions that are aimed at preserving life. The specialty has traditionally focused on intervention for emergent conditions, and less attention has been paid to palliation of burdensome symptoms. Nonetheless, there is an increasing emphasis on using a patient-oriented approach rather than a disease-oriented approach; as such, competencies have been developed for geriatrics that include a section on pain and palliative care,[1] and a palliative care curriculum has been designed specifically for emergency providers, called Education in Palliative and End-of-Life Care for Emergency Medicine.[2]

Hospice and palliative medicine, whose goal is to relieve the pain and suffering associated with serious illness, is now an official subspecialty of the American Board of Medical Specialties. Even so, the challenges of integrating palliative care practices across care settings are real and well recognized. The integration of palliative care concepts and consultation teams into emergency care may help to avoid unnecessary and burdensome treatments, tests, and procedures that are not aligned with patients' goals of care. In the hospital setting, palliative care has been shown to decrease burdensome symptoms,[3,4] improve quality of life,[5–7] increase patient and family member satisfaction,[6,8–10] and decrease costs.[7,11–14] Most recently, early palliative care consultation was shown to improve quality of life for patients with metastatic non-small cell lung cancer and may even lengthen their survival.[15]

Because hospice and palliative medicine is a relatively new subspecialty, little is known about how to adapt the current model to the environment of the emergency department (ED), rendering further research crucial. The ED environment and culture is unique. EDs are increasingly crowded, and rapid triage and disposition are increasingly important. Any successful palliative care intervention requires consideration of the differences from the inpatient environment. Building support among the emergency staff and understanding their concerns and beliefs are imperative.

The goal of this study was to explore attitudes and beliefs among attending emergency physicians regarding palliative care in the ED. We chose to use qualitative methods to elucidate the various barriers and facilitators to the integration of palliative care for emergency patients from the emergency physician perspective. We believe this type of approach is superior in areas where there has been little prior research, as this method is more likely to be hypothesis generating than more quantitative lines of inquiry.

Methods

Study Design and Sample

Board-certified or board-eligible emergency physicians were recruited to participate in semistructured focus group discussions conducted by telephone conference call from three sites: a tertiary academic medical center, a public hospital, and a community hospital. All participants were attending emergency physicians purposively chosen to represent varying ages, institutions, and years in practice. The discussions were facilitated by an experienced focus group moderator with a doctorate in medical anthropology and lasted on average 90 minutes. We intentionally designed the focus groups to mix physicians by hospital type to facilitate the exchange of ideas from different practice types. A focus group discussion guide was prepared in advance (Table 1) by the principal investigator and the focus group moderator and covered two hypothetical case-based scenarios, as well as the following topics: decision making, communication, and the role of palliative care in the care of seriously ill older adults. The cases were used to ground the discussion in shared experiences and set up topics that would be brought up later in the conversation. The cases and topics were selected based on a literature review on palliative care in the ED, as well as review and discussion with two senior clinician investigators in emergency medicine and hospice and palliative medicine. Participants did not receive an incentive for participation.

Data Collection

All physicians provided oral informed consent, and this and all other procedures were approved by the Mount Sinai School of Medicine Institutional Review Board. The sessions were digitally recorded and transcribed by a professional medical transcription company. The facilitator began by asking each person to identify the most rewarding and most frustrating aspects of providing care for seriously ill older adults in the ED. Subsequently, the moderator outlined two hypothetical situations that highlighted communication and decision-making issues commonly encountered in the ED.

The moderator defined palliative care, and then participants were asked to explain their use of palliative care consult teams. The moderator probed to understand various opportunities and barriers present for delivering palliative care in the ED. The discussion concluded with participants' thoughts on how palliative care interconnects with the mission of emergency medicine and their roles as emergency physicians.

Data Analysis

Each focus group discussion was digitally recorded and transcribed verbatim by a professional transcription company. The transcripts were reviewed to identify themes and subthemes using grounded theory methodology.[16] Three of the coauthors—the principal investigator, a research coordinator with experience in qualitative research, and a research assistant—coded the transcriptions individually by analyzing them line by line to elucidate core concepts that describe and influence the attitudes and beliefs of emergency physicians regarding the role of palliative care in emergency medicine. No analyses were shared until all three coauthors independently completed their task. New codes were incorporated as new themes and subthemes emerged. This procedure was repeated iteratively until all emerging

concepts were redundant. Representative quotes were identified for each theme and subtheme and later revised for grammatical accuracy. Subsequently, the resulting codes were shared, and the rare discrepancies were reconciled by discussion among the three coauthors. The coauthors all reviewed the final coding scheme for clarity.

Results

Characteristics of Study Participants

Three focus groups were conducted with 20 attending emergency physicians (range 6–8 per group) from an academic medical center, a public hospital center, and a community hospital. Mean age was 41 years (range 31–61 years), 40% were female, and the median practice time was nine years. Other participant characteristics are listed in Table 2.

Rewards and Challenges

Attending physicians reported the most rewarding aspects of their job were “being able to connect with the patients and families,” “to assuage fears,” or “to educate or explain something.” One physician expressed particular satisfaction with “being able to transition a family from an aggressive course of care to a mode of comfort care.” Attendings’ greatest frustra- tion was when this could not be achieved because of cognitive deficits, family conflict, or when they felt they had to “provide futile care.” One described a situation in which “a lot of people are involved and trying to bring them to consensus can be a challenge” other times, this occurred because of a “patient’s or a family member’s lack of appreciation that they are at the end of life.”

Reactions to Case-Based Scenarios

The first case-based scenario described an elderly patient with dementia who needed surgery to repair a hip fracture. Emergency physicians responded to this scenario with a number of actions they would perform, including involving “social work,” other consultants, or the “primary care physician;” assessing “capacity;” and “drilling down to find out exactly what the patients’ wishes would be.” The second scenario in which the family hid the diagnosis from the patient was described as common:

> I’ve had similar cases and it always gets to me when the family tells me that the patient does not know about their disease because then everybody else is making the decision without the patient’s involvement.

All physicians felt strongly that “the patient has a right to know.” One physician described feeling “torn sometimes because I grew up in that culture; I’m also obligated to make the patient aware of their disease.”

Themes That Emerged

Qualitative analysis using grounded theory methodology yielded five themes that explain physicians’ attitudes and beliefs regarding palliative care and the care of seriously ill patients with advanced disease: (1) limited understanding and knowledge of palliative care, (2) fixed view of the role of the emergency provider, (3) complexity inherent in decision

making, (4) practice of defensive medicine, and (5) logistical challenges. Table 3 displays each theme with its associated subthemes and representative quotes.

Limited Understanding and Knowledge of Palliative Care—Some emergency physicians expressed uncertainty about the components of palliative care, and many admitted that they had little training in the palliative care skill set. ED physicians described feeling unready to tackle all the emotional responsibilities because of limited training in handling sensitive end-of-life situations. An attending physician trained in a tertiary academic center expressed this opinion:

> I'm very concerned about End-of-life issues that need sensitivity and time and caring, none of which are my strong suits. I'm relieved to get the palliative care team down to help me with these things.

Emergency physicians' lack of training can be viewed as an opportunity for training in primary palliative care skills as well as consultation by palliative care teams for more complex cases. One physician expressed the need for palliative care teams when patient and family issues become more complex:

> We have a very scattered role in terms of keeping everybody on a plane of going toward better health. This needs a lot of sensitivity, which takes time and finesse, a little bit of the ability to understand where a family and a patient are coming from. And you cannot get that in a five-minute interaction.

However, many physicians also expressed uncertainty regarding how to integrate palliative care into their practice of emergency medicine.

Fixed View of the Role of the Emergency Provider—Emergency physicians often meet their patients and families for the first time during the ED encounter. For this reason, some physicians felt that it was not their responsibility to address goals of care, and that these are best discussed ahead of time by the primary provider. One physician from a community hospital stated:

> The primary care physicians or oncologists often fail their patients and families because they haven't raised the issue and I'm forced to do so in the extreme situation.

Another physician from a community hospital explained that he was "not always clear what the expectation is or what my role is" when hospice patients come to the ED.

There was also a feeling among some emergency physicians that patients and families expect aggressive care in the ED. One emergency physician expressed this notion with the following sentiment:

> As an emergency physician, people look to us to be heroic and all gung-ho; every orifice probed, everything possible done.

Conversely, poor communication among providers and failure to address goals of care in advance could present an opportunity for emergency physicians and palliative care teams to intervene for such patients. Some saw this as an opportunity for palliative care:

> Activating palliative care consult in the ED could be useful, especially because a lot of our patients tend to be noncompliant with follow-up or go to many different providers. So if you were able to activate the palliative care team in the ED, they may have at least one consistent person that they can talk to.

This physician sees opportunities for palliative care teams to provide ongoing care for seriously ill patients without good access to care, provided there is access to outpatient palliative care.

Complexity Inherent in Decision Making—Goals of care discussions for seriously ill emergency patients are often complex and time consuming, and these complexities are magnified in the ED, where there is an increased urgency, a lack of private space, and where providers are unable to give their undivided attention to patients for prolonged periods. Nonetheless, important decisions must be made regarding potentially life-sustaining interventions. An attending physician in practice six years at a tertiary academic center describes complex family dynamics:

> The family members don't give patients enough credit, and if the patient is competent, they have some idea of what's going on, then you have to deal with the family dynamics and the lack of communication.

When the patient is cognitively impaired, physicians must consult the health care proxy or family member to make the best decision for the patient. A physician with three years' experience as an attending expressed his frustration with how to address cognitively impaired patients and health care decision making:

> A lot of the time, when these patients come in, they may not be medically in a position to be able to have a conversation with you. In those cases, it is important to contact the family and figure out *exactly what the patient wishes.*

A physician in practice 10 years noted the "conflicting rights of the patient versus the rights of their family members." As a physician, he claims that he is "responsible for the patient and their rights supersede everyone else's." In such cases, it is common for families to react to physicians' decisions: "Here is this new person confronting them with the reality of the situation. They do get mad. They do get irritated."

Some providers also saw this as an opportunity. One in particular suggested that automatic palliative care consultation based on predetermined criteria would be one way to avoid resistance from family, using an "opt-out [rather] than an opt-in system for a palliative-care consult."

Practice of Defensive Medicine—Emergency physicians described how medicolegal concerns play an integral role in decision making for patients with life-threatening illnesses. Participants expressed the tension that exists between doing what they feel is right for the patient and protecting themselves from lawsuits. One attending physician described this tension and the pressure for more aggressive care:

> In the vast majority of cases, the family wants more aggressive therapy than the practitioner thinks is reasonable. The challenge is to bring the family to what we consider to be a more reasonable place.

Whereas this could be seen as a limitation for the integration of palliative care, it also could present new opportunities. A 35-year-old attending physician with three years' experience expressed the following:

> I think the biggest help for us in the ED would be when there's a crashing patient and you feel it's not in the best interest of the patient to be aggressive, but for medicolegal reasons, you're stuck doing everything. If we could have a palliative care team that could come in and intervene quickly insituations like that, I think that would be beneficial for the patient.

Participants equated a more palliative approach with higher medicolegal risk but being of greater benefit to patients.

Logistical Challenges—Participants identified three major logistical challenges to providing palliative care in the ED, which included frequent interruptions to care, the competing needs of caring for other patients with time sensitive conditions, and the lack of availability of palliative care teams at night and on the week ends. An attending physician in practice 10 years at a tertiary academic center commented:

> In reality, when a patient finds out they have a terminal illness, we simply don't have the resources to be there for them, the time, the energy to be holding their hand. They are clearly suffering, so to have somebody that we were able to call who came in and was a surrogate for us, that would be great.

The time pressure of the ED prevents physicians using palliative care consultation teams, even when they are available. One physician described how other time-sensitive conditions often took priority:

> The lack of time pressure to get this consultation, when we have so much time pressure for everything else, probably limits the extent to which we take advantage of our palliative care colleagues.

Another physician expressed the view that palliative care needs are lower priority when compared with other actions they must perform in a busy ED: "It isn't the logistical lack of availability. From my perspective, this isn't the top of the list of things that I must accomplish."

Discussion

Our study describes the attitudes and beliefs of attending emergency physicians at three different hospital types regarding the care of seriously ill emergency patients with advanced disease. We also describe some of the most challenging patient and family encounters. To delineate the potential barriers and facilitators to palliative care service delivery, we identified five core issues that influence the emergency physicians' perceptions regarding the delivery of palliative care: a limited understanding and knowledge of palliative care,

fixed view of the role of the emergency provider, complexity inherent in decision making, practice of defensive medicine, and logistical challenges. Each theme presents both opportunities and challenges for providing palliative care in the ED.

Hospice and palliative medicine is a new subspecialty of emergency medicine; thus, some emergency providers are acquiring their own knowledge and skills as well as learning how and when to use palliative care specialists.[17] Despite this, emergency physicians in our study overwhelmingly acknowledged the many potential benefits of enhancing their own palliative care skills, as well as having a palliative care team provide services for more complex cases. Consultants were described as having a more specialized skill set, having more time to discuss goals of care, and providing an opportunity to intervene for seriously ill patients with advanced disease. This finding is similar to that of Smith et al.,[18] who also showed that emergency providers appear receptive to using consultants to fill current gaps in care for certain patients. Although this and other ground-breaking qualitative research has been conducted only recently in the ED,[19,20] we chose to focus specifically on attending emergency physicians in our study, as they are the main obstacles to and facilitators of palliative care.

Although interest in palliative care among emergency providers continues to grow, our study shows that some aspects of emergency medicine culture make it difficult to reconcile the two specialties. Emergency care is inherently time sensitive and discussions regarding goals of care may be time consuming. Emergency physicians also face the challenge of meeting many patients for the first time, and medicolegal concerns and a reimbursement system that favors procedures over conversations are additional obstacles. The primary focus of emergency medicine—to provide stabilization of acute medical emergencies—can appear to be at odds with a goal of palliative care, which is to balance quality of life with the burdens of invasive treatments. Emergency physicians who have a more rigid view of their role may view palliative care as outside their own practice and better relegated to the primary care provider. Developing the primary palliative care skill set of the emergency physician and clear criteria for consultation might help circumvent these obstacles.

However, many physicians in our study would welcome an opportunity to avoid aggressive interventions that they may feel are not in their patients' interests but feel compelled to do because of pressure from family members or medicolegal concerns. Providers believe that legal issues impair their ability to forgo certain treatments, even when the potential for harm outweighs the potential for benefit. This is consistent with other studies of emergency physician attitudes and beliefs regarding the practice of defensive medicine. Most emergency physicians admit to ordering more tests than medically indicated because of fear of liability;[21] in another study, emergency physicians with greater fear of litigation were less likely to discharge patients with low-risk chest pain.[22]

Logistical issues also must be addressed. Some providers expressed concern that pallia- tive care coverage was only available on week days during daytime hours. In addition, providers were concerned with the slow response of palliative care teams when called for consultation on emergency patients. In fact, the palliative care community has recognized the need for rapid response to such consults[23] but may not be staffed to provide such services. Several

limitations of our study deserve mention. First, our attending physician participants were drawn from a large and diverse urban area on the east coast of the U.S. and thus may not represent the views of emergency providers in rural or other geographic areas. In an attempt to achieve as diverse a sample as possible, we chose to include attending physicians from three hospital types, including a smaller community hospital. Second, although our results accomplished our aim of identifying the attitudes and beliefs of the participating emergency providers, we did not triangulate our findings with other important players, such as palliative care consultants, primary providers, patients, or families.

Despite its limitations, we do believe this work provides important insights into the challenges facing emergency providers in caring for seriously ill patients with advanced disease who might benefit from palliative care. Understanding providers' views of the potential barriers and facilitators to delivering care in this setting is vital to forging successful palliative care-emergency medicine partnerships in moving forward.

Emergency physicians identified many benefits to increasing their own palliative care skills and knowledge as well as to using palliative care consultation for complex seriously ill patients. Solving logistical problems and developing clear indications for consultation might help increase the use of such services.

Acknowledgments

This study was funded by a Brookdale Foundation Leadership in Aging Fellowship and a Mentored Research Scholar Grant from the American Cancer Society (Dr. Grudzen). Dr. Morrison received support from a Mid-Career Investigator Award in Patient Oriented Research (K24 AG022345) from the National Institute on Aging.

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Table 1

Focus Group Discussion Guide

1	How long have you been an emergency physician, and can you describe the most rewarding and most frustrating aspect of providing care for elderly patients with many medical problems?
2	An 83-year-old woman with mild dementia and multiple other medical problems presents with a broken hip after a fall. Her eldest daughter is present and is a health care proxy and tells you her mom never wanted surgery. Orthopedics is at the bedside telling the daughter her mom needs to have surgery, or she will never walk again.
	a. Is this a common case in the ED?
	b. What problems do these cases cause? How do you handle it?
	c. How do you deal with the patient and the family?
	d. Did you turn to other resources, such as a primary doctor, social worker, or nurse? If so, how was the conversation between the specialist, the family, and yourself? Were there challenges in such conversations?
3	A cachectic 66-year-old Chinese male with diffusely metastatic stomach cancer who speaks no English is brought in by his daughter who tells you he has had persistent vomiting and has been moaning in pain. But the daughter emphasizes that her father is unaware of his diagnosis (refer to 2. questions a–d).
4	Palliative care is focused on the relief of pain, and suffering and is not limited to end-of-life care. It can be delivered at the same time as curative and life-prolonging therapies.
	a. Have you ever called a palliative care consultation or other kinds of consultants for cases such as the ones we've mentioned?
	b. What has been your experience with palliative care consultation teams?
5	Where do you see opportunities for your hospital's ED and palliative care service to work together? When can palliative care be helpful? For what kinds of cases could a palliative care consult help you with patients and families?
6	If ED physicians want to consult with a palliative care physician or team at your hospital, what are the challenges that need to be addressed? In your hospital, where do you see barriers or problems?
	a. What about the role of the primary doctor: could a palliative care consult take place in the ED without notifying them? What about the specialists, for example, if the patient is being cared for by oncology?
	b. What about administration? What other people would need to agree to support these consultations?
	c. What about medical-legal issues?
	d. What about the logistics of a palliative care consultation, availability of consultants, or other logistical challenges?
7	When you think of the mission of the ED and your role as an ED physician, how, if at all, does palliative care fit in? As more older adults with multiple medical problems visit EDs, how, if at all, do you see your role changing?

Table 2

Provider Characteristics (*n* = 20)

Characteristic	***n* (%)**
Age (years), mean (range)	41.1 (31–61)
Time in practice (years), mean (range)	9 (1–25)
Male gender	12 (60)
Hospital type	
Tertiary care	12 (60)
Public	6 (30)
Community	2 (10)
Race	
White	13 (65)
Black	2 (10)
Asian	5 (25)

Table 3

Key Themes: Selected Quotes

Themes		Representative Quotes
Limited Understanding and Knowledge of Palliative Care		
Barrier	Limited understanding of palliative care role	"I was over at _____ Hospital where they have more easily accessible palliative care teams. It would be helpful if they could define exactly what their role is, what they can do for us, and in what time frame they could do that for us."
Opportunity	Recognized need for medical provider education	"I was treating a patient for pain and when the house staff came to see him, they also felt very uncomfortable with his care because they're used to treating a patient for a disease and not for pain. They're not used to dealing with these patients, so I think that palliative care consultation services would be very helpful in educating the staff."
Fixed View of the Role of the Emergency Physician		
Barrier	Primary care's role to discuss goals of care	"If we're the ones who have to activate a palliative care team, then that's suboptimal. We do it because we're in a situation where it hasn't been done."
	Patients and families expect aggressive care	"Even the label, 'palliative' – temporize – the moment we introduce it as an emergency physician there are going to be families that feel you aren't doing everything in your power to help or cure or fix something."
	Little sense of patient ownership	"It's a very difficult situation for us because we're only caring for the patient for a very short period and then we usually give the patient's care to someone else. It could be a specialist whose plan of care we don't agree with, which is difficult for us."
Opportunity	Emergency patients have true palliative care needs	"Palliative care in the ED is one way to make up for what I perceive as failures in the outpatient setting."
Complexity Inherent in Decision Making		
Barrier	Need for explicit criteria for consultation	"Unless the family opts-out, there should be certain criteria and a screening process to decide whether palliative care should get involved."
Opportunity	Including family is complex and time consuming	"A lot of the time with elderly patients, there are a lot of people involved because they're unable to make their own decisions and trying to bring them all to consensus can be quite a challenge."
Practice of Defensive Medicine		
Barrier	Aggressive care decreases risk of lawsuits	"Am I doing what is right for the patient? Or am I doing what is medico-legally right?"
Opportunity	Palliative approach is right for patient	"We're all stuck feeling like if we aren't aggressive in our treatment, fingers will be pointed at us when it's abundantly clear that the most aggressive medical care isn't the best care for the patient. That's where palliative care can be really helpful. Once they've involved, a lot of people relax their medicolegal concerns and you can actually begin to treat the patient the way they ought and want to be treated."
Logistical Challenges		
Barrier	Slow palliative care response time	"You can call the palliative care service and arrange for something over time, but their response time is not typically helpful for patients in the ED."

Themes		Representative Quotes
Opportunity	Time constraints hinder ability to provide supportive care	"Purely from a time perspective, if you have a palliative care team that can clarify goals of care, which is generally a very time-consuming process, especially on a busy day when you're caring for 50 patients, that could be immensely useful."