Nursing Ethics

A phenomenological approach of the management of Advance Directives in Emergency Services

Journal:	*Nursing Ethics*
Manuscript ID	Draft
Manuscript Type:	Original Manuscript
Keywords:	Qualitative research < Empirical approaches, advance directives, ethical conflicts, barries, emergency services

Abstract:

Background: In hospital and out-of-hospital emergency services, professionals experience situations in which they face difficulties or barriers to know patient's advance directives and implement them.
Objectives: To analyse the barriers, facilitators, and ethical conflicts perceived by health professionals derived from the management of advance directives in emergency services.
Research design, participants, and context: This is a qualitative phenomenological study conducted with purposive sampling including a population of nursing and medical professionals linked to hospital and out-of-hospital emergency services. Three focus groups were formed, totalling 24 participants. We performed an inductive-type thematic discourse analysis.
Ethical considerations: This study was approved by ethical committees. The participants received information about the purpose of the study. Patients' anonymity and willingness to participate in the study were guaranteed.
Findings: There were four types of barriers that hindered the proper management of patients' advance directives in emergency services: personal and professional; family members; organisational and structural; and those derived from the health system. These barriers caused ethical conflicts and hindered professionals' decision-making.
Discussion: These results are in line with those of previous studies and indicate that factors such as sex, professional category, and years of experience, in addition to professionals' beliefs and the opinions of colleagues and family members, can also influence the professionals' final decisions.
Conclusion: The different strategies described in this study can contribute to the development of health policies and action protocols to help reduce both the barriers that hinder the correct management and implementation of advance directives and the ethical conflicts generated.

A phenomenological approach of the management of Advance Directives in Emergency Services

Abstract

Background: In hospital and out-of-hospital emergency services, professionals experience situations in which they face difficulties or barriers to know patient's advance directives and implement them.

Objectives: To analyse the barriers, facilitators, and ethical conflicts perceived by health professionals derived from the management of advance directives in emergency services.

Research design, participants, and context: This is a qualitative phenomenological study conducted with purposive sampling including a population of nursing and medical professionals linked to hospital and out-of-hospital emergency services. Three focus groups were formed, totalling 24 participants. We performed an inductive-type thematic discourse analysis.

Ethical considerations: This study was approved by ethical committees. The participants received information about the purpose of the study. Patients' anonymity and willingness to participate in the study were guaranteed.

Findings: There were four types of barriers that hindered the proper management of patients' advance directives in emergency services: personal and professional; family members; organisational and structural; and those derived from the health system. These barriers caused ethical conflicts and hindered professionals' decision-making.

Discussion: These results are in line with those of previous studies and indicate that factors such as gender, professional category, and years of experience, in addition to professionals' beliefs and the opinions of colleagues and family members, can also influence the professionals' final decisions.

Conclusion: The different strategies described in this study can contribute to the development of health policies and action protocols to help reduce both the barriers that hinder the correct management and implementation of advance directives and the ethical conflicts generated.

Keywords: advance directives, ethical conflicts; barriers; emergency services

Introduction

Studies indicate that the most common causes of patient referral by emergency services to hospital emergency departments are acute or critical health problems, such as conditions of cardiac/neurological origin, or accidents with traumatic sequelae (1,2). However, an important and growing aspect of the frequent use of out-of-hospital and hospital emergency services is the worsening of symptoms in pluripathologic patients of advanced age, or with an already known terminal pathology that, on many occasions, lead them to die as a result of these conditions in these services (1–3).

These cases, in which the high vulnerability of patients raises questions about the limitation of life support treatment, are complex and difficult to handle. Health professionals often encounter the moral conflict of 'establishing', 'maintaining', or 'withdrawing of treatment' (4–7).

It is known that health professionals are guided by the principles of non-maleficence, beneficence, and respect for the dignity and autonomy of patients' choices and decisions (8,9). Even so, at a practical level, the complexity of healthcare in these services, in which the time factor is decisive and there is no possibility of delay in decisions, professionals perceive difficulties or barriers to know or implement patients' advance directives (AD) (10,11). Studies on this topic have pointed out that some of these barriers would be related to: the difficulty of access to computer services, in which there may or may not be evidence of those AD (10,12,13); the perception of lack of time to consult them (14–16); the lack of an organisational and institutional view that encourages their application (17,18); and the low proportion of AD documents filled out by the population (19). Also, the lack of knowledge on the part of the professionals and the lack of skills for the management of these patients' AD should be added (20,21). Undoubtedly, these obstacles end up complicating decision-making and can generate ethical conflicts among professionals working in emergency services (22–25). In addition, there may be a potential negative impact on healthcare when making decisions that may not meet the wishes of patients who cannot manifest them (26).

Some studies, especially those of a quantitative design, do not allow us to know in a sufficiently precise manner the difficulties or barriers perceived by the professionals involved in such decision-making, such as nurses or physicians (18,25,27,28). However, knowing these issues in greater depth would allow knowing the patients' preferences and respect their autonomy and the right to decide on how they want to be cared for. These aspects are protected by current health regulations, thus improving healthcare in emergency services.

In order to close this knowledge gap, the present study considered answering the following two research questions: (1) According to the perception of health professionals in emergency services, what are the barriers that impair the management of patients' AD? (2) Does the presence of these barriers generate ethical conflicts among the health professionals of these services?

Objective

The goal of the present study was to assess the barriers, facilitator aspects, and ethical conflicts derived from the management of AD in out-of-hospital emergency services perceived by the health professionals.

Methods

Design and scope of study

This is a qualitative phenomenological study conducted in May 2019, in the Emergency Service of (deleted for review) Hospital and in the unit of the Medical Emergency Service (MES out-of-hospital) of (deleted for review). This type of philosophical line, according to Edmund Husserl, aims to explain how individuals interpret and give meaning to social phenomena through their own experiences (29).

Participants and sampling

We performed purposing sampling including a population composed of nursing and medical professionals linked to hospital and out-of-hospital emergency services.

In order to obtain different perspectives concerning the perception of barriers in the implementation of patients' AD in the two types of services, we determined representativeness and exclusion criteria for the sample (Table 1). These criteria were determined by the research team, which subsequently recruited the participants of the study through the corporate email of both health institutions.

Based on the representativeness criteria, participant profiles were developed and intra-group heterogeneity criteria were determined based on the following variables: sex; age; years of experience; and, in the case of MES, geographical area of work.

Two separate groups were formed by professional category, namely: G1 - nurses of the MES; and G2 - physicians of the MES. Subsequently, a third group (G3) was formed with nursing and medical professionals from the MES.

Data collection

Information was collected using the focus group technique. The three groups were formed by a maximum of 10 participants, and the sample was composed of 24 participants (G1 = 9; G2 = 5; and G3 = 10). The duration of each session was approximately one hour and thirty minutes. They were held in the classrooms of the participating hospital made available for the meetings, on three different days.

The sessions were recorded with a digital recorder and then transcribed for later analysis. In order to ensure the confidentiality of the participants, we used pseudonyms instead of their names. The debate was facilitated by using the questions of a script with the topics to be explored previously established and agreed by external experts (Table 2).

All the focus groups were moderated by the leader and another member of the research team, who performed as observer. There was no professional or personal relationship between the moderators and the participants of the groups. A report was generated from each group taking into consideration nonverbal language, which was included in the discourse analysis.

Data analysis and rigor criteria

We performed an inductive-type thematic discourse analysis, guided by the six-phase method proposed by Braun and Clarke (30). In the coding process, we obtained the discourses of the participants that contributed information to the study. Subsequently, these discourses were labelled forming the initial codes or categories. Once grouped, these discourses facilitated the search, the review, and determining the final topics (Table 3).

In order to maintain scientific rigor, triangulation was carried out by three researchers (deleted for review) in the analysis of the discourses, and subsequent sessions were held for sharing. Disagreements were resolved with the consensus of a fourth researcher (deleted for review). We used the criteria established by Guda and Lincoln (31) concerning transferability, credibility, reliability, and confirmability of the results. The criteria were checked using the COREQ tool (32).

Results

Of the total of 24 subjects who participated in the study (Table 4), 11 were women and 13 men, with an age range between 25 and 61 years, and an average professional experience of 16 years in emergency services. Only one medical professional from the out-of-hospital emergency service had completed a course on AD. Data saturation was reached within the sample, so it was not necessary to recruit more participants.

The thematic analysis of the content provided four main categories of barriers detected in the emergency services: they were: (1) personal and professional; (2) family members; (3) organisational and structural; and (4) those derived from the health system. Two other secondary categories were the strategies or facilitators in the management of AD, and the ethical conflicts generated among the professionals.

Personal and professional barriers

The discourse analysis of the participants revealed that one of the main barriers in the management of AD was the professionals' lack of knowledge about the topic. However, the discourses showed that they considered the incorporation of AD as a tool to ensure respect for the moral autonomy of the patients, a procedure that improved the decision-making process and should be performed with the collaboration of the family members and close friends.

[…] I don't know them, although I consider them very necessary, especially when patients want to make a decision in their last moments of life. It is very important to have everything in writing [...] (G3_Jose_Nurse_H_ES).

[...] The patients should perform them together with their families [...] (G2_Gonzalo_ Physician _OU_ES).

In order to respect patients' wishes and preferences, the participants considered essential that the AD should be reflected in the computerised medical histories, especially concerning those patients in an end-of-life situation. They also pointed out that these databases should be updated periodically to evaluate the possibility of changing patients' opinions.

Regarding the identification of responsibilities relating to the information and demand of the AD, differences were found in the discourses of the nursing and medical professionals. Two emergency physicians considered that the patients had the major responsibility in the demand

of AD. It is worth mentioning that this fact contrasts with all the opinions of the nursing professionals, who considered the role played by health professionals in the promotion of AD, especially in primary care.

[...] I don't think it is the responsibility of health professionals to inform more, in fact it should be a demand from society [...] (G2_Sofía_ Physician _H_ES)

[...] Community healthcare should help the population to do it [...] (G1_Jose_Nurse_H_ES).

One of the issues of which professionals were most fearful, especially male nurses from two of the focus groups, was the one concerning the legal repercussions that could derive from a clinical position contrary to that expected by family members, more inclined towards initiating or keeping futile treatments. On the other hand, women's concern was performing against the patients' own interests. This last positioning was very supported by the male physicians of two of the focus groups.

[...] We perform defensive medicine; we try to cover our backs for fear of legal problems with the families [...] (G1_Rubén_Nurse_OH_ES).

[...] A physician friend of mine one day told me that he was going all out for his father who had Alzheimer's disease and was in an end-of-life situation. This opinion is completely contrary to the one we could have […] (G3_Sergio_Nurse_OH_ES)

With regard to training, the participants reported that it was oriented towards teaching physical healing. It did not develop communication and coping skills in a proper manner, given that they are considered necessary to help professionals in the management of situations in which death is inevitable.

[...] We have to change our 'chip', we are always trained to save lives [...] (G1_Pedro_Nurse_OH_ES).

[…] We never talk to patients about their will […] (G2_Pablo_ Physician _H_ES)

Family barriers

MES professionals reported that the relatives of patients in end-of-life situations were relieved when the health professionals made the decision to refer the patients to emergency services. This fact was related to the lack of time that family members have to assimilate the situation in

an out-of-hospital context. On the contrary, they may have more time in an emergency unit, where the situation is more predictable.

[...] In the out-hospital MES, when you have been five minutes performing resuscitation and consider that the patient will not survive, you inform the family members. This is the time when the family members assimilate that their relatives will die; however, in emergency units, they can have up to a few hours […] (G3_Martín_Physician_OH_ES).

Another perceived barrier was the population's lack of knowledge about AD, and reduced compliance with them. This fact hinders patients' decision-making, given that, in many occasions, the relatives end up making the decisions. The participants stated that society lacked awareness and acceptance of the natural processes of death and end of life.

[...] If the patients had AD performed, families would be allowed to generate an assimilation process and it would not happen that, in an end-of-life situation, the families want to go all out for their relatives [...] (G1_Sara_Nurse_H_ES).

[...] We really don't start from a cultural context that favours talking about this matter [...] (G2_Bárbara_ Physician _H_ES)

[...] I think that formalising patients' AD before a public notary makes the process not very dynamic [...] (G1_Pedro_Nurse_OH_ES).

Organisational and structural barriers

According to the participants, these types of barriers arise when the demand for healthcare is high, and time is limited.

[...] When patients go to the emergency service and we have the service collapsed, we have enough by looking at their medical histories, we can't start searching whether they have AD or not; we would have to be very trained [...] (G1_María_Nurse_H_ES).

With respect to the available computing resources, the participants considered that the lack of unification between computer programmes and the clinical histories that they used in the healthcare centres was one of the main barriers that hindered the rapid verification of whether or not AD had been registered by the patients. In this sense, the MES professionals showed special concern about not being able to access the specific information about the AD of the patients treated on some occasions. In spite of these difficulties, they have tried to solve them

with the professionals that worked in the central coordination body that carried out an informative work concerning patients' wishes and preferences.

[...] I think that, for the MES, it would be essential to have access and know the AD of the persons, because when we arrive, if we do not know anything we end up going all out for outcomes. [...] (G2_Gonzalo_Physician _OH_ES).

[...] It would be ideal that, before arriving at the patients' homes, MES professionals get to know whether they patients require aggressive measures [...] (G3_Sergio_Nurse_OH_ES).

Different approaches were found among emergency service professionals regarding structural barriers. In the out-of-hospital setting, it was considered positive that family members witnessed the actions performed by health professionals in order to favour grieving processes. In the hospital setting, an emergency physician negatively evaluated the use of those closed boxes as a method of professional isolation from families.

[...] In the emergency room, you close the curtain and, therefore, you can do anything, at the patients' homes it is more complicated [...] (G3_Leo_ Physician _OH_ES).

Barriers in the health system

The professionals highlighted the lack of information campaigns addressing AD on radio and television promoted by the Ministry of Health. Also, they mentioned the need for: a paradigm shift placing the patients in the centre of attention; reducing the medicalisation processes in the end of life; respecting the right to autonomy of decision; and adapting the resources based on bioethical principles of non-maleficence, beneficence, and justice.

[...] The health sector should carry out information campaigns on how to meet AD, in the form of an announcement, for example, to give a series of instructions on where to go and how to complete this document [...] (G2_Sofía_ Physician _H_ES).

[...] I believe that institutional campaigns similar to those of the Directorate-General for Traffic (DGT) should be carried out [...] (G2_Bárbara_ Physician _H_ES).

Ethical conflicts related to the management of advance directives

The discourses indicated that the main barriers that generated a greater degree of ethical conflicts among the health professionals, understood as very problematic, were: the uncertainty caused by the lack of knowledge about whether the patients had previously expressed their wills; the responsibility to decide for others and the difficulties experienced in making decisions alone; opposing opinions among professionals, motivated by their own beliefs and values; the concern of 'not harming' the patients; and the fears that professionals perceive when adopt behaviours contrary to those of the family members.

[...] If I don't have AD done, I'm charging the physician in charge of the unit with my problem, since he has to decide for me in a very limited time [...] (G2_Héctor_ Physician _H_ES)

[...] Personally, it bothers me when a patient comes in his palliative phase and the physician tells you that we have to reach the end, sometimes you leave with the moral feeling of thinking what the patient would have wanted [...] (G1_Maria_Nurse_H_ES)

[...] Although you knew that the patients won't survive, we perform to cover our backs and all we get is the patients' suffering, knowing that the final outcome will be the same [...] (G3_Martín_ Physician _OH_ES)

When these conflicts arise, professionals experience feelings of helplessness and moral anguish from performing under organisational and social pressures. In these services, professionals are required to make quick decisions, based on their values and preferences, and on what they consider best for their patients, even though, in some cases, this fact could be against the patients' own interests.

These feelings were experienced more intensely by professionals of emergency services. They considered the out-of-hospital context as the greatest generator of ethical conflicts due to those barriers—especially organisational ones—that had greater frequency and magnitude.

[...] This happens every day, several times ... [...] (G1_Pedro_Nurse_OH_ES)

When the participants mentioned the most experienced type of ethical conflict relating to AD management, some professionals agreed that these situations generated moral distress, because they knew what was morally correct but could not carry it out due to obstacles propitiated by third parties, whether they were other professionals or the patients' families. Others, on the other hand, mentioned moral indifference, claiming in their favour that the ultimate goal of emergency services was curing the patients.

[...] I am not really worried whether they have AD, I think we have to do everything; we are going to cure [...] (G1_Jose_Nurse_H_ES).

Strategies or facilitators to overcome barriers

The participants considered a number of factors that could help resolve difficulties related to the management of patients' AD. First, specific healthcare provided to complex chronic patients in palliative services and home care was essential. This way, the collapse of emergency services would be reduced. In addition, healthcare provided during the end-of-life processes would be improved.

[...] The cost of referring patients at the end of life would be invested in improving palliative services and home care, in order to provide them with better home care [...] (G1_Pedro_Nurse_OH_ES).

The professionals of the coordination body of the MES were considered to have the primarily responsibility for investigating the existence or not of patients' AD. The adequacy of resources should be subject to the severity and the fact of having or not such AD.

All the participants showed concern about the difficulty in accessing AD records, and gave possible solutions that would help visualise them from any service or unit, for example the creation of an alert system for patients with the AD registry, which could be consulted from any tablet and/or computer with access to the medical record.

[…] If there is no alert that informs you that the patient has AD, it is not noticeable to health professionals […] (G1_Loli_Nurse_H_ES).

Among the factors that would help overcome the barriers related to AD management, the professionals highlighted: improvements in the communication of AD between healthcare centres and in the specific (ethical-legal) training of professionals; the inclusion of AD in the algorithms of urgencies and emergencies in order to facilitate their consultation; and, finally, the possibility of consulting experts in ethically conflicting situation.

[...] It would be convenient that, when the MES professionals come to the emergency room inform us that the patients have AD. This way, at the same time, you will check it out on the computer [...] (G1_María_Nurse_H_ES).

[...] AD consultation could be included in the algorithms of the healthcare itself, for example, in those of cardiopulmonary resuscitation [...] (G1_Pedro_Nurse_OH_ES)

Finally, with respect to other favourable factors, they highlighted the importance of primary/community care centres and residential centres in the promotion of AD and the preparation of the families in an end-of-life context.

Discussion

It was observed that the health professionals of hospital and out-of-hospital emergency services perceived obstacles that hindered the proper management of AD. These barriers that generate ethical conflicts can be grouped into four categories, namely: personal and professional; family members; organisational and structural; and those derived from the health system.

Although the professionals knew about AD and their practical application, and had a positive opinion about them, there was some lack of knowledge about registration methods, regulation, and information regarding the procedure (9,10,33,34). The participants did not know who was responsible for initiating the conversations about these wills. Rather than proactively offer information concerning AD, the physicians preferred to wait for such demand to come from patients and family members. Several studies have suggested that these behaviours were related to the lack of training on the ethical and legal aspects that regulate AD, given that they cause great discomfort in health professionals and, therefore, make ethical decisions become a difficult task (35–38).

There was some controversy regarding decision-making and the consideration of AD among health professionals working in out-of-hospital emergency services. In this sense, women of this professional category exhibited greater concern about ethical issues, prioritising patients' interests. Unlike male nurses, the physicians had an opinion similar to that of women, given that they related decision-making from an ethical perspective with more satisfactory outcomes for the patients, in accordance with the findings of Moore et al. (14).

In addition to sex and professional category, there were other determining aspects that could condition the final decisions of the professionals, such as experience, and personal and contextual factors. Professionals with more experience in the services felt more comfortable in resolving conflict situations. A study conducted by Erbay et al. indicated that the experience of the professionals could be an influential variable that might anticipate the resolution of the

different ethical conflicts. This way, more appropriate decisions could be made in critical situations (9). Personal and contextual factors can contribute to the performance of different actions depending on each health professional (6,37,39–41). Thus, some professionals provided care focused on healing and salvation, whereas others prioritise respect for patients' autonomy. Previous studies have described that these factors were barriers that impacted negatively and broke the ethical obligations assumed by the professionals, thus producing conflicting situations (42–45).

Different authors have also pointed to the lack of time that professionals had to consult patients' AD (17,46). In the present study, the perception of not having time to inquire about AD was greater in out-of-hospital emergency services, thus representing one of the areas with the greatest degree of exposure to ethical conflicts (10,33,34,47).

Although barriers were detected in the management of AD, the professionals identified strategies that could help overcome them and reduce the ethical conflicts generated. In order to improve the management of AD, there is a need of effective communication between services and care levels in terms of patients' values and preferences (48). There is also need of unifying computer programmes (49–51), in addition to create an alert system that allows the professionals to obtain a quick and effective visualisation of the patients' wishes. These results reinforce the findings of Busquets et al., who indicated that the ease of access to AD by professionals influenced the number of occasions in which they were consulted, and was the only variable that correlated in a significant manner with good healthcare provided at the end of life (52).

At the same time, in order to facilitate the implementation of AD in out-of-hospital emergency services, it is essential to incorporate ethical and legal consultants that help professionals in the resolution of the generated ethical conflicts (40,53,54). In addition, there should be training programmes aimed at health professionals and the inclusion of AD in all the guidelines and action protocols (33).

Finally, the dissemination of AD through campaigns of the Ministry of Health to promote their implementation, as well as their strengthening in the context of primary care, community care, and residential centres would be essential to improve their management. These centres can follow up patients with chronic diseases and those in an end-of-life situation (46,48). With these measures, the number of referrals and deaths in hospitals might be reduced (55).

Conclusion

We observed four types of barriers that hindered the management of AD in hospital and out-of-hospital emergency services, namely: personal and professional; family members; organisational and structural; and those derived from the health system. These barriers hinder and violate the recognition of the fundamental bioethical principle, i.e., the autonomy of choice and decision on the part of the patients. In addition, they cause ethically conflicting situations among health professionals. The results of the present study suggest that sex, professional category, and years of experience in the services can also influence the final decisions of the professionals.

The different strategies described in this study can contribute to the development of health policies and action protocols aimed at reducing the barriers that hinder the correct management and implementation of AD, and the ethical conflicts generated.

Limitations

One of the main limitations of the present study was the difficulty in recruiting participants, more specifically the physicians from the out-of-hospital emergency services, due to two factors, i.e., travelling to different locations and work schedules.

Ethical considerations

The present study was approved by the respective ethics committees of (deleted for review), code 1. Each participant received oral and written information about the purpose of the study and the dynamics to be followed. Their confidentiality was assured and they signed an informed consent form. The participants were also informed about the audio recordings for purposes solely related to the investigation, and that they could leave the study at any time. The professionals who participated in the focus groups were not part of the research team.

Funding

The present study was funded by (deleted for review) through a research grant awarded for Bioethics 2018. The authors, who performed independently of the funder, are entirely responsible for this research.

Conflicts of interest

The authors declare that they have no conflict of interest.

Acknowledgments

The authors are grateful to: all healthcare professionals who agreed to participate altruistically in the present study; and for the collaboration provided by (deleted for review).

References

1. Vinton DT, Capp R, Rooks SP, Abbott JT, Ginde AA. Frequent users of US emergency departments: Characteristics and opportunities for intervention. Emerg Med J. 2014;31(7):526-32.
2. Moe J, Kirkland S, Ospina MB, Campbell S, Long R, Davidson A, et al. Mortality, admission rates and outpatient use among frequent users of emergency departments: A systematic review. Vol. 33, Emergency Medicine Journal. BMJ Publishing Group; 2016. p. 230-6.
3. Chiu Y, Racine-Hemmings F, Dufour I, Vanasse A, Chouinard MC, Bisson M, et al. Statistical tools used for analyses of frequent users of emergency department: A scoping review. Vol. 9, BMJ Open. BMJ Publishing Group; 2019.
4. Frost DW, Cook DJ, Heyland DK, Fowler RA. Patient and healthcare professional factors influencing end-of-life decision-making during critical illness: A systematic review.1. Crit Care Med [Internet]. 2011;39(5):1174-89.
5. Torabi M, Borhani F, Abbaszadeh A, Atashzadeh-Shoorideh F. Experiences of pre-hospital emergency medical personnel in ethical decision-making: a qualitative study. BMC Med Ethics.2018;19(1):95.
6. Torabi M, Borhani F, Abbaszadeh A, Atashzadeh-Shoorideh F. Ethical decision-making based on field assessment: The experiences of prehospital personnel. Nurs Ethics. 2019;26(4):1075-86.

7. Boladeras M, Akrich M. Bioética del cuidar, ¿que significa humanizar la asistencia? Tecnos; 2015.
8. Johnson SB, Butow PN, Kerridge I, Tattersall MHN. Patient autonomy and advance care planning: a qualitative study of oncologist and palliative care physicians' perspectives. Support Care Cancer. 2018;26(2):565-74.
9. Erbay H, Alan S, Kadioglu S. Attitudes of prehospital emergency care professionals toward refusal of treatment: A regional survey in Turkey. Nurs Ethics [Internet]. agosto de 2014 [cited 4 January 2020];21(5):530-9.
10. Jezewski M. Emergency nurses' knowledge, attitudes, and experiential survey on advance directives. Elsevier [Internet]. [cited 2 October 2019]; Available: https://www.sciencedirect.com/science/article/pii/S0897189707000584
11. Fanta L, Tyler J. Physician Perceptions of Barriers to Advance Care Planning. S D Med 2017 ;70(7):303-9.
12. Skinner I, Smith C, Jaffray L. Realist Review to Inform Development of the Electronic Advance Care Plan for the Personally Controlled Electronic Health Record in Australia. Telemed e-Health. 2014;20(11):1042-8.
13. Walker E, McMahan R, Barnes D, Katen M, Lamas D, Sudore R. Advance Care Planning Documentation Practices and Accessibility in the Electronic Health Record: Implications for Patient Safety. J Pain Symptom Manage 2017 [cited 18 October 2017]; Available: http://linkinghub.elsevier.com/retrieve/pii/S0885392417304979
14. Moore N, Detering KM, Low T, Nolte L, Fraser S, Sellars M. Doctors' perspectives on adhering to advance care directives when making medical decisions for patients: an Australian interview study. BMJ Open. 1 October 2019;9(10).
15. De Vleminck A, Houttekier D, Pardon K, Deschepper R, Van Audenhove C, Vander Stichele R, et al. Barriers and facilitators for general practitioners to engage in advance care planning: a systematic review. Scand J Prim Health Care 2013;31(4):215-26.
16. Hayes SA, Zive D, Ferrell B, Tolle SW. The Role of Advanced Practice Registered Nurses in the Completion of Physician Orders for Life-Sustaining Treatment. J Palliat Med 2017;20(4):415-9.
17. Borhani F, Jalali T, Abbaszadeh A, Haghdoost A. Nurses' perception of ethical climate and organizational commitment. Nurs Ethics. 2014;21(3):278-88.
18. Bashkin O, Caspi S, Haligoa R, Mizrahi S, Stalnikowicz R. Organizational factors affecting length of stay in the emergency department: Initial observational study. Isr J Health Policy Res. 15 October 2015;4(1).
19. Mignani V, Ingravallo F, Mariani E, Chattat R. Perspectives of older people living in long-

term care facilities and of their family members toward advance care planning discussions: A systematic review and thematic synthesis. Clin Interv Aging. 2017;12:475-84.

20. Kellogg E. Understanding Advance Care Documents: What the Nurse Advocate Needs to Know. J Emerg Nurs 2017;43(5):400-5.
21. Booth AT, Lehna C. Advanced Directives and Advanced Care Planning for Healthcare Professionals. Ky Nurse. 2016;64(2):7-10.
22. Shahriari M, Mohammadi E, Abbaszadeh A, Bahrami M, Fooladi MM. Perceived ethical values by Iranian nurses. Nurs Ethics. 2012;19: 30-44.
23. Trautmann J, Epstein E, Rovnyak V, Snyder A. Relationships among Moral Distress, Level of Practice Independence, and Intent to Leave of Nurse Practitioners in Emergency Departments: Results from a National Survey. Adv Emerg Nurs J. 2015;37(2):134-45.
24. Wiegand DL, Funk M. Consequences of clinical situations that cause critical care nurses to experience moral distress. Nurs Ethics. 2012; 19:479-87.
25. Borhani F, Abbaszadeh A, Mohamadi E, GhaMESi E, Hoseinabad-Farahani MJ. Moral sensitivity and moral distress in Iranian critical care nurses. Nurs Ethics 2017:24(4):474-82.
26. Pavlish C, Brown-Saltzman K, So L, Wong J. SUPPORT: An Evidence-Based Model for Leaders Addressing Moral Distress. J Nurs Adm 2016;46(6):313-20.
27. Bravo G, Arcand M, Blanchette D, Boire-Lavigne AM, Dubois MF, Guay M, et al. Promoting advance planning for health care and research among older adults: A randomized controlled trial. BMC Med Ethics. 2012;13(1).
28. Moshtagh M, Mohsenpour M. Moral distress situations in nursing care. Clin Ethics. 1 September 2019;14(3):141-5.
29. Christensen M, Welch A, Barr J, Christensen M. Husserlian Descriptive Phenomenology: A review of intentionality, reduction and the natural attitude Peer Support in clinical and non-clinical suicide prevention services View project Facilitating student practitioner criticality View project Husserlian Descriptive Phenomenology: A review of intentionality, reduction and the natural attitude. Artic J Nurs Educ Pract. 2017;7(8).
30. Braun V, Clarke V. What can «thematic analysis» offer health and wellbeing researchers? Vol. 9, International Journal of Qualitative Studies on Health and Well-being. Co-Action Publishing; 2014.
31. Fourth Generation Evaluation - Egon G. Guba, Yvonna S. Lincoln - Google Libros [Internet]. [cited 18 January 2020]. Available: https://books.google.es/books?hl=es&lr=&id=k_zxEUst46UC&oi=fnd&pg=PA7&dq=Gub

a+G,+Lincoln+S.+Fourth+generation+evaluation.+1990&ots=__9erghODZ&sig=6RV7jscdzEeoEZDgvyyRC5rFV80#v=onepage&q=Guba G%2C Lincoln S. Fourth generation evaluation. 1990&f=false

32. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. Int J Qual Heal Care. 2007;19(6):349-57.

33. Cruz-Carreras MT, Chaftari P, Viets-Upchurch J. Advance care planning: challenges at the emergency department of a cancer care center. Support Care Cancer [Internet]. 16 de septiembre de 2017 [cited 18 October 2017]; Available: http://link.springer.com/10.1007/s00520-017-3870-x

34. Beckstrand RL, Wood RD, Callister LC, Luthy KE, Heaston S. Emergency nurses' suggestions for improving end-of-life care obstacles. J Emerg Nurs. 2012;38(5):e7-14.

35. Erbay H. What if the patient says «No!» in the ambulance: An ethical perspective for assessment of capacity in the prehospital emergency setting. El Mednifico J. 26 July 2014;2(3):304.

36. Sandman L, Nordmark A. Ethical conflicts in prehospital emergency care. Nurs Ethics. 2006;13(6):592-607.

37. Erbay H. Some ethical issues in prehospital emergency medicine. Vol. 14, Turkiye Acil Tip Dergisi. Emergency Medicine Association of Turkey; 2014. p. 193-8.

38. Brady M. Death anxiety among emergency care workers. Emerg Nurse [Internet]. 10 de julio de 2015 [cited 2 October 2019];23(4):32-7; quiz 38. Available: http://journals.rcni.com/doi/10.7748/en.23.4.32.e1448

39. Borhani F, Abbaszadeh A, Mohamadi E, GhaMESi E, Hoseinabad-Farahani MJ. Moral sensitivity and moral distress in Iranian critical care nurses. Nurs Ethics. 2017;24(4):474-82.

40. Denniss DL. Legal and ethical issues associated with Advance Care Directives in an Australian context. Intern Med J. 1 December 2016;46(12):1375-80.

41. Ebrahimian A, Seyedin H, Jamshidi-Orak R, Masoumi G. Exploring Factors Affecting Emergency Medical Services Staffs' Decision about Transporting Medical Patients to Medical Facilities. Emerg Med Int. 2014;2014:1-8.

42. McCarthy J, Gastmans C. Moral distress: a review of the argument-based nursing ethics literature. Nurs Ethics. 2015;22(1):131-52.

43. Bremer A, Herrera MJ, Axelsson C, Martí DB, Sandman L, Casali GL. Ethical values in emergency medical services: A pilot study. Nurs Ethics. 2015;22(8):928-42.

44. Torabi M, Borhani F, Abbaszadeh A, Atashzadeh-Shoorideh F. Experiences of pre-hospital

emergency medical personnel in ethical decision-making: A qualitative study. BMC Med Ethics. 2018;19(1).

45. Falcó-Pegueroles A, Lluch-Canut, MT, Martínez-Estadella G, Zabalegui-Yarnoz A, Delgado-Hito P, Via-Clavero G, Guàrdia-Olmos J. Levels of exposure to ethical conflict in the ICU: correlation between sociodemographic variables and the clinical environment. Int Crit Care Nurs 2016;33:12-20.
46. States U, Accountability G. Information on Federal Oversight, Provider Implementation, and Prevalence Why GAO Did This Study. Rep to Congr Requesters. 2015;(April):1-26.
47. Lakin JR, Isaacs E, Sullivan E, Harris HA, McMahan RD, Sudore RL. Emergency Physicians' Experience with Advance Care Planning Documentation in the Electronic Medical Record: Useful, Needed, and Elusive. J Palliat Med 2016;19(6):632-8.
48. Griffiths D, Morphet J, Innes K, Crawford K, Williams A. Communication between residential aged care facilities and the emergency department: a review of the literature. Int J Nurs Stud 2014;51(11):1517-23.
49. Skinner I, Smith C, Jaffray L. Realist Review to Inform Development of the Electronic Advance Care Plan for the Personally Controlled Electronic Health Record in Australia. Telemed e-Health. 2014;20(11):1042-8.
50. Tully J. Advance care planning: Meeting a crucial need. Nursing (Lond). 2018;48(11):63-6.
51. McGlade C, Daly E, McCarthy J, Cornally N, Weathers E, O'Caoimh R, et al. Challenges in implementing an advance care planning programme in long-term care. Nurs Ethics. 2017;24(1):87-99.
52. Busquets JM, Hernando P, Font R, Diestre G, Quintana S. Los documentos de voluntades anticipadas. La opinión de los representantes. Rev Calid Asist. 2016;31(6):373-9.
53. Schuchter P, Heller A. The Care Dialog: the «ethics of care» approach and its importance for clinical ethics consultation. Med Heal Care Philos 2018;21(1):51-62.
54. Anderson-Shaw L, Ahrens W, Fetzer M. Ethics consultation in the emergency department. JONA's Healthc Law, Ethics Regul 2007;9(1):32-5.
55. Klingler C, in der Schmitten J, Marckmann G. Does facilitated Advance Care Planning reduce the costs of care near the end of life? Systematic review and ethical considerations. Palliat Med 2016;30(5):423-33.

Table 1. Representativeness and exclusion criteria of the sample.

Representativeness criteria	Exclusion criteria
- Professionals with more than one year of experience. - Professionals with graduate training in emergencies. - Fixed or substitute professionals of the services. - Coming from different regions of the Province of (deleted for review)	- Nursing and/or medical students. - Professionals licensed or graduate in nursing during refreshing training or internships. - Professionals who were not part of the usual staff of paediatric emergencies.

Table 2. Questions guide for the focus groups.

Study area	Questions
Emerged experiences related to AD management.	Do you know the AD? Would you know how to perform in case that a user has registered AD?
Barriers and facilitators in AD management.	What difficulties/barriers do you consider to exist in your services that hinder the consultation of AD? What facilitating elements do you think can promote/follow AD in your services?
Ethical conflicts in AD management.	
Decision-making in ethically conflicting situations.	Do you consider that on some occasion you could have violated the will of a patient? What was it due to? Did you generate any kind of conflict of an ethical or moral nature? How often have these ethically conflict situations arisen?
	What do you rely on to make decisions? Who do you usually consult in a situation of ethical conflict?

Table 3. Summary of the coding matrix.

Units of meaning	Groups of common meanings	Topics
Ignorance about AD Information and demand of AD Legal repercussions Lack of training in communication and coping skills Positioning diversity	Professionals' lack of knowledge, fears, and insecurities.	Personal and professional barriers
Poor implementation of AD by the population Pacts of silence among family members Ignorance of the AD by the population Complex and little dynamic processes for meeting AD.	Patients and relatives' lack of knowledge, fears, and insecurities.	Family barriers
Lack of unification of computer systems. Lack of time to consult the AD Service oversaturation Lack of ethical-legal references Lack of confidence to talk about AD Lack of transfer of information between services	Organizational pressures and lack of resources.	Organizational and structural barriers
Lack of information about AD in the media. Biomedical paradigm	Mission and vision of the health system.	Barriers in the health system
Increase of resources in palliative and home care. Knowledge about AD in out-of-hospital emergency coordination bodies Alert system Chip card based medical information systems Improve communication between healthcare centres Training programmes (ethical-legal) Consultant and/or ethical-legal consultants.	Improvement proposals.	Strategies or facilitators to overcome barriers
AD promotion in primary care, community care, and residential centres. Information campaigns in the media	Ethical problems in emergency services	Ethical conflicts related to AD management
Feelings of anguish, uncertainty, dilemma, and indifference		

Table 4. Sociodemographic data of the participants.

	Code	Pseudonym	Gender	Age	Group	Professional category	Service	Experience (years)	Training on AD
1	(G1_Jose_Nurse_H_ES)	Jose	Male	27	G1	Nurse	Hospital_ES	5	N/A
2	(G1_Rosa_Nurse_OH_ES)	Rosa	Female	43	G1	Nurse	Out-Hospital_ES	10	NO
3	(G1_Flor_Nurse_ OH_ES)	Flor	Female	37	G1	Nurse	Out-Hospital_ES	7	NO
4	(G1_Rubén_Nurse_ OH_ES)	Rubén	Male	37	G1	Nurse	Out-Hospital_ES	18	NO
5	(G1_Matías_Nurse_H_ES)	Matías	Male	40	G1	Nurse	Hospital_ES	20	NO
6	(G1_Pedro_Nurse_ OH_ES)	Pedro	Male	42	G1	Nurse	Out-Hospital_ES	18	NO
7	(G1_Sara_Nurse_H_ES)	Sara	Female	43	G1	Nurse	Hospital_ES	18	NO
8	(G1_María_Nurse_H_ES)	María	Female	29	G1	Nurse	Hospital_ES	5	NO
9	(G1_Loli_Nurse_H_ES)	Loli	Female	53	G1	Nurse	Hospital_ES	25	NO
10	(G2_Bárbara_Physician_H_ES)	Bárbara	Female	60	G2	Physician	Hospital_ES	36	NO
11	(G2_Gonzalo_ Physician _ OH_ES)	Gonzalo	Male	53	G2	Physician	Out-Hospital_ES	20	NO
12	(G2_Sofía_ Physician _ H_ES)	Sofía	Female	37	G2	Physician	Hospital_ES	12	NO
13	(G2_Héctor_ Physician _ H_ES)	Héctor	Male	61	G2	Physician	Hospital_ES	25	NO
14	(G2_Pablo_ Physician _ H_ES)	Pablo	Male	61	G2	Physician	Hospital_ES	35	NO
15	(G3_Laia_Nurse_ H_ES)	Laia	Female	29	G3	Nurse	Hospital_ES	9	NO
16	(G3_Sergio_Nurse_ OH_ES)	Sergio	Male	56	G3	Nurse	Out-Hospital_ES	15	NO
17	(G3_Didac_Nurse_ OH_ES)	Didac	Male	57	G3	Nurse	Out-Hospital_ES	25	NO
18	(G3_Leo_ Physician _ OH_ES)	Leo	Male	46	G3	Physician	Out-Hospital_ES	10	NO
19	(G3_Martín_ Physician _ OH_ES)	Martín	Male	40	G3	Physician	Out-Hospital_ES	18	YES (course)
20	(G3_Cristina_Nurse_ OH_ES)	Cristina	Female	35	G3	Nurse	Out-Hospital_ES	10	NO
21	(G3_Ainhoa_Nurse_ H_ES)	Ainhoa	Female	25	G3	Nurse	Hospital_ES	3	N/A
22	(G3_Miguel_Nurse_ H_ES)	Miguel	Male	25	G3	Nurse	Hospital_ES	2	N/A
23	(G3_Cecilia_Nurse_ H_ES)	Cecilia	Female	53	G3	Nurse	Hospital_ES	33	NO
24	(G3_Aitor_ Physician _ H_ES)	Aitor	Male	39	G3	Physician	Hospital_ES	6	NO

Hospital_ES: Hospital Emergency Services (H_ES); Out-Hospital_ES: Out-Hospital Emergency Services (OH_ES)