Received: 23 January 2023 | Revised: 6 April 2023 | Accepted: 20 April 2023

DOI: 10.1002/emp2.12962

JACEP OPEN
JOURNAL OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS OPEN
A GLOBAL JOURNAL OF EMERGENCY MEDICINE
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ORIGINAL RESEARCH

Ethics

Recommendation-making in the emergency department: A qualitative study of how Canadian emergency physicians guide treatment decisions about resuscitation in critically ill patients

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Funding and support: By *JACEP Open* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist.

Abstract

Study Objective: Emergency physicians are frequently responsible for making time-sensitive decisions around the provision of life-sustaining treatment. These decisions can involve goals of care or code status discussion, which will often substantially alter a patient's care pathway. A central part of these conversations that has received relatively little attention are recommendations for care. By proposing a best course of action or treatment via a recommendation, a clinician can ensure that their patients receive care that is concordant with their values. The objective of this study is to explore emergency physicians' attitudes toward recommendations about resuscitation in critically ill patients in the emergency department (ED).

Methods: We recruited Canadian emergency physicians via multiple recruitment strategies to ensure maximum variation sampling. Semi-structured qualitative interviews were conducted until thematic saturation occurred. Participants were asked about their perspectives and experiences with respect to recommendation-making in critically ill patients and to identify areas for improvement in this process in the ED. We used a qualitative descriptive approach and thematic analysis to identify themes around recommendation-making in the ED for critically ill patients.

Results: Sixteen emergency physicians agreed to participate. We identified four themes and multiple subthemes. Major themes included identification of the roles and responsibilities of the emergency physician (EP) with respect to making a recommendation, the logistics or process of making a recommendation, barriers to making a recommendation, and how to improve recommendation-making and goals of care conversations in the ED.

Conclusion: Emergency physicians provided a range of perspectives on the role of recommendation-making in critically ill patients in the ED. Several barriers to the inclusion of a recommendation were identified and many physicians provided ideas on how to improve goals of care conversations, the recommendation-making process, and ensure that critically ill patients receive care that is concordant with their values.

Supervising Editor: Lauren Black, MD, MPH.

1 | INTRODUCTION

1.1 | Background

Emergency physicians are frequently responsible for making time-sensitive decisions around the provision of life-sustaining treatment. Given the ever-increasing advances is biomedical technology, and the fact that a significant proportion of North Americans will die in hospital, people are being confronted with difficult decisions about how much medical care they want to receive when they are critically ill.[1,2] Because of inherent limitations in reliable prognostication and the heterogeneity in individual values about medical care, these decisions are extremely difficult. Further complicating this difficulty is the fact that a high proportion of emergency department (ED) patients have not previously engaged in advanced care planning (ACP).[3–6]

1.2 | Importance

A central part of making these tough decisions is the patient–physician interaction and discussion about the patient's illness, values, and preferences for medical care, referred to a goals of care conversation.[7] These conversations are optimal when a patient is not at imminent risk of deterioration or death. However, in the ED, such conversations must occur when a patient requires immediate stabilization and critical care interventions in order to prevent death. In this context, a goal of care conversation has been referred to as a form of crisis communication.[8] Decision-making and communication in this specific context has not been well studied, with much of the literature on goals of care conversations looking at patients for whom immediate life-or-death decisions do not need to be made (eg, serious illness or chronic illness).[9–11]

Guidelines for how to have goals of care conversations, such as the Serious Illness Conversation Guide or REMAP Framework, explicitly suggest that physicians provide patients or substitute-decision makers (SDMs) with a recommendation.[12–13] Recommendation-making is an important part of shared-decision-making and if done properly, has the theoretical potential to enhance informed consent, improve patient autonomy, ensure that care received is concordant with patient values, and minimize harms of overtreatment.[14,15]

1.3 | Goals of this investigation

Little is known about how physicians incorporate recommendations in the context of crisis communication. In this qualitative study, we sought to understand emergency physicians' perspectives and self-reported practices around making recommendations about resuscitation when treating critically ill patients in the ED.

The Bottom Line

This qualitative study of goals of care conversations in the emergency department (ED) used semi-structured interviews of 16 emergency physicians in Canada. Four major themes were idenitified, including the roles and responsibilities of emergency physicians, logistics of making a recommendation, barriers to making a recommendation in the ED, and improving recommendationmaking in the ED.

2 | METHODS

2.1 | Study design and setting

We undertook a prospective qualitative descriptive study, conducting semi-structured interviews with Canadian emergency physicians. Data was analyzed and interpreted using thematic analysis, outlined below.

We received approval from the University of Toronto Research Ethics Board. The consolidated criteria for reporting qualitative research was used to ensure appropriate reporting of our results.[16]

2.2 | Selection of participants

We recruited attending emergency physicians working in Canada. We sought to include participants with a range of years of experience, practice setting, gender, and geographic location. As such, several recruitment strategies were used including departmental listservs, targeted emailing, and snowball sampling. As recruitment proceeded, we realized that community physicians from outside of major cities were under-represented, so we sought out these physicians via targeted requests. All participants provided written consent to participate in the study and were able to withdraw their data at any time. Based on experience with similar studies, we estimated a sample size of 15–20 participants and continued with recruitment and interviewing until thematic saturation was reached by consensus with the research team.

2.3 | Interview guide development

An interview guide was developed and refined by all authors (see Appendix S1). It was modified after the initial interview to ensure the clarity of questions. The guide also included questions around moral distress in the ED, which sought to address a separate research question not covered in this article.

Planning for our study was carried out before COVID-19. We recognized that the pandemic could impact our participants' perception of recommendation-making in several ways. To account for this, we incorporated questions about COVID-19 in our interview guide.

2.4 | Data collection

Data was collected using semi-structured, 1-on-1 interviews conducted with videoconferencing software (Zoom) over the course

of 6 months. Initial interviews were carried out by both K.N.D. and H.A. to ensure standardization and appropriate performance of the interview guide and subsequent interviews were performed by H.A. Once thematic saturation was reached, 2 additional interviews were conducted to further ensure no new information was missed.

All interviews were audio-recorded with participants' permission. Interviews were transcribed verbatim by a third-party transcription service. Field notes were handwritten by the interviewers and used during the analysis. All interview transcripts were anonymized.

2.5 | Data analysis

Coding was done independently by all authors for the first three interviews and after initial codebook development, subsequent coding was done (H.A.). Interviews were conducted until thematic saturation had been reached. This was an iterative process and involved concurrent data collection and transcription analysis. We broadly utilized a process of thematic analysis as outlined by Braun and Clarke.[17] After transcription of recorded interviews, the data were reviewed and coded in an open fashion to generate an expansive list of concepts and ideas. Subsequently, this list was organized into categories and formed the basis of a codebook. This codebook was applied to all transcripts and refined in an iterative manner. The data was analyzed to look for the emergence of themes. A final list of themes was defined and organized into a manuscript. Thematic saturation occurred after 16 interviews.

3 | RESULTS

3.1 | Characteristics of study subjects

See Table 1 for demographic information. We interviewed 16 emergency physicians. In Canada, emergency medicine has several possible training pathways, including a 5-year residency to become a Fellow of the Royal College of Physicians of Canada (FRCPC), a 1-year training program added to a 2-year family medicine residency via the Canadian College of Family Physicians (CCFP), and lastly, some physicians begin work immediately after a 2-year family medicine residency (CCFP) without any formal fellowship. Of our participants, 7 of 16 were FRCPC-trained, 7 of 16 had a CCFP plus a fellowship year, and 2 of 16 had CCFP training with no formal fellowship. Our sample was balanced between males and females (8 of 16). Most (12 of 16) worked at academic hospitals in Ontario.

3.2 | Main results

Four major themes with multiple sub-themes emerged from our research. They are described below and in Table 2. Representative interview excerpts from Themes 1–4 are included in Boxes 1–4, respectively. Note that each participant was assigned a number as part of the anonymization process.

TABLE 1 Participant demographics.

Demographics	No. (%)
Gender	
Male	8 (50%)
Female	8 (50%)
Years in practice	
0–10	7 (44%)
11–20	5 (31%)
21–30	2 (12%)
31–40	2 (12%)
Mean	15.1
Training	
FRCPC	7 (44%)
CCFP plus emergency medicine year	7 (44%)
CCFP without emergency medicine year	2 (12%)
Practice setting	
Academic	12 (75%)
Community	4 (25%)

Abbreviations: CCFP, Canadian College of Family Physicians; FRCPC, Fellow of the Royal College of Physicians of Canada.

3.3 | Theme 1: Role of the emergency physician with respect to making recommendations

Emergency physicians held varied perspectives on their own role in making a recommendation about critical care interventions. Physicians found it important to strike a balance between a patient's autonomy and a responsibility to guide them to a decision that would lead to medical benefit. Some felt strongly that it was their responsibility as the physician to provide a recommendation. Other physicians believed that making a recommendation to patients about critical care interventions was not their place. The reasons provided for this included violating the patients' autonomy, not having appropriate prognostic information, and medicolegal ramifications.

Physicians described that whether or not they make a recommendation in a particular case is dependent on several variables, and most do not universally include a recommendation as a part of their code status discussion. Physicians said they were more likely to make a recommendation when they believe that a patient would be harmed by critical care interventions, and in these cases they advise against escalation of care. Commonly cited examples were the recommendation against intubation, CPR, or transfer to the ICU. Where patients have poor functional baselines, comorbidities, or non-survivable injuries (e.g., intracranial bleed), recommendations against care are easier to provide. Physicians felt that when patients' prognosis was good or ambiguous, treatment is the presumed course of action and no explicit recommendation is provided. Regardless of prognosis, many physicians found it easier to provide resuscitative measures than to recommend against the escalation of care.

TABLE 2 Themes and subthemes.

Theme	Subtheme
Theme 1: Roles and responsibilities of the emergency physician with respect to making a recommendation	Balancing paternalism and patient autonomy
	Recommendations are not universally part of the conversation
	Recommendation-making is more likely when a physician feels that the patient is clearly unlikely to benefit from care
	Starting the conversation and deferring a decision to a consultant
	Unburdening family
	Default is to provide aggressive care or "do everything" and stopping escalation is often harder
Theme 2: Logistics of making a recommendation	Finding substitute decision-makers
	Eliciting patient and family values
	The importance of framing clinical status and treatment options on decision-making
	Recommendation-making as an iterative process
	Fully informing patients of the risks associated with life-sustaining therapy as an alternative to making a recommendation
Theme 3: Barriers to recommendation-making in the ED	Conflict around decision-making
	Lack of advanced care planning among ED patients
	Limited ability to prognosticate in the ED
	How COVID has changed recommendation-making
	Time and acuity limit fulsome goals of care conversations
	Lack of relationship with patient or SDM
Theme 4: Improving recommendation-making in the ED	Improve education around goals of care conversations and recommendation-making in undergraduate and postgraduate medical education
	Standardized and province-wide electronic medical records
	Widespread use of ACP conversations and documentation in primary care
	Use of clinical prognostication scoring systems to improve prognostic ability
	Institutional support in not offering medical treatments that are deemed to be non-beneficial

Abbreviations: ACP, advanced care planning; ED, emergency department; SDM, substitute-decision makers.

Physicians who routinely incorporate recommendations into their practice felt that it is important because it helps to alleviate the psychological burden on the patient or SDM of deciding alone.

Physicians sometimes focused on starting the goals of care conversation rather than making a recommendation or obtaining a decision. This often leads to temporizing the patient with interventions like vasopressors or non-invasive ventilation.

3.4 | Theme 2: Logistics of making a recommendation

Physicians described the process of making a recommendation. Many explained that it was frequently impossible to speak with the patient because their critical illness rendered them incapable, so their first step was to identify a SDM. Subsequently, most sought out any pre-existing wishes with respect to resuscitation. Physicians found it helpful when there was a pre-existing ACP document or the family could convey the patients' wishes.

Physicians described that they frequently present critical care interventions as options and used the patient or SDMs' response to help them develop a recommendation that incorporated the patient's values.

Physicians unanimously believed how they framed the conversation was important to the code status discussion and impacted how their recommendation was received. Physicians felt that it was their responsibility to share potential negative outcomes associated with critical care interventions. By framing interventions in a way that highlights the negative outcome, they were making an implicit recommendation not to escalate care. This style of communication was more comfortable for many participants than an explicit recommendation.

BOX 1

Theme 1: Role of the emergency physician with respect to making recommendations

I have always lived my life asking for recommendations from my financial advisor, or my contractor…. I really don't care about the details of what you do with my money, or my house, as long as you know what I want, and then maybe give me two or three choices that make sense to you first, but I need their opinion and expertise. And I think that's how I view my job too, that I do have something to add and my expertise to offer to the patients. (Participant 11)

[Did you make a recommendation?] I try not to do that. It makes me feel really uncomfortable, what I will do though is we'll arrive at the decision and then I'll support them in their decision. So I'll say. "I think that is in keeping with what your loved one would have wanted based on our discussion." (Participant 7)

Based on their medical history and the progression of their disease, I have become a bit firmer in terms of recommending against things like intubation where it will likely lead to significant morbidity and likely death. (Participant 2)

In the timeframe in which we need to make decisions, family members aren't prepared to make that decision… so we can't have a realistic conversation about risks and benefits that does justice to a consent conversation. So, in general, it's safer and better for the patient, it's better for the family to err on the side of being a bit more aggressive. (Participant 2)

But those patients where it's very obvious that they're not going to benefit from an ICU, most families are actually relieved when you're more directive. When you give it as an option, I think most people, it stresses them out, because then it puts the onus [on them]… (Participant 16)

I think it's a responsibility that we have in the emergency room to at the very least initiate those discussions. I think we do a disservice to patients by leaving it for someone else. (Participant 3)

BOX 2

Theme 2: Logistics of making a recommendation

And so… we talked about what the patient would have wanted. I remember asking distinctly, is there anything that they would not have wanted? What was really important to them? And it was living independently and doing things. So then we got to a point… where it was quite clear and frank that they did not want to pursue life-sustaining interventions. (Participant 7)

But I do try to get as much family input as I can in these things because if I know what their basic wishes might be, then I can adjust my, not prescription, exactly, but my description of what I think is available, what I think it's possible benefits might be, what the downsides would be. Without trying to make them into intensivists overnight, I try to get them to understand what the likelihood of these things being useful is or what use they might offer. (Participant 15).

I usually present the most aggressive treatment option and [then] comfort measures only or allow natural death, and then I sort of see if they are anywhere in there. (Participant 4)

It's all framing. I think it truly is all framing… I think it is all in the language you choose and how you frame things. I mean, it's in the same way that we can almost coerce a patient to agree to a CT scan for a PE or not. It's all in how you word it, right? Same thing with LPs, you can coerce people into doing what you want. (Participant 3)

The way that the information is framed to people absolutely will influence the response that you get… if the first option that we give people is that they're going to have full aggressive resuscitative care, I think people are more likely to choose that option… (Participant 10)

I think … you shouldn't describe CPR in horrible terms or shoving the tube down your throat. Because… the physician really doesn't believe in this care, so they're presenting it as this horrible option…In some ways it is disingenuous. I think it is better to give your opinion and just say, "I don't think your loved one would benefit from this intervention," but not reframe the intervention to make it sound so horrible. (Participant 16)

3.5 | Theme 3: Barriers to recommendation-making in the ED

Recommendation-making was perceived to be a difficult task that is not suited to the ED. The majority of participants found it difficult to engage in meaningful conversations and build rapport given a lack of prior relationships with the patient or SDM. Patient acuity and the need to act quickly often prevents emergency physicians from being able to elicit patient values. Rural physicians found that they more commonly knew the patient and this allowed them to have more productive conversations.

Patients commonly present with a lack of any ACP and this was a common point of frustration, especially when it involved patients who had pre-existing serious illnesses such as cancer. Physicians stated that patients or SDMs were sometimes reluctant to acknowledge how critically ill they or their loved ones' were, or had unrealistic expectations of recovery. As described by Theme 1, physicians found it easier to make a recommendation if the prognosis was clear.

Physicians were asked about conflicts between themselves and patients or SDMs when there is a difference of opinion about what level of care is appropriate for that patient and most said that outright conflict was rare. If there was discordance between the physician's recommendation and patient or SDMs' wishes, physicians try to ensure that the other party is fully informed of the potential harms associated with an escalation of care. However, they reported that they would not

BOX 3

Theme 3: Barriers to recommendation-making in the ED

And it's really hard, right? Because sometimes they never had that conversation. They weren't expecting to have a conversation. They don't feel comfortable because you're a stranger… (Participant 1)

It's amazing to me how many patients… with the diagnosis of cancer have never had a code discussion and there's nothing documented on the computer by oncology, who has been following them for ages. (Participant 6)

I think it's hard if the family members have never had a discussion with their loved one about goals of care to initiate that conversation when someone's critically ill and, basically, an acute intervention needs to be done in a time-sensitive manner, I think it really puts them in a really difficult position. (Participant 16)

We're just not great at prognosticating. (Participant 5)

And so, I think where it's very clear cut, [for example a] really massive subarachnoid with a patient who's decerebrate [or] decorticate, this is a situation that we can speak with some confidence about. But for other situations where I'm not as confident, then I try not to be absolutely dogmatic about it. (Participant 15)

I don't think it's appropriate for me to try and redirect them when they're feeling quite strongly. Sometimes you can also tell that they have very strong beliefs of some sort, religious beliefs…they still want aggressive care and you're like, well, I'm not going to make a dent in this, so I'm not going to make another enemy. (Participant 4)

I think… with COVID, what's been really difficult too, is that the family members aren't there. It is, awful, right? So, sometimes you talk to them on the telephone, you get the family to be on speaker phone, but it's just not the same. (Participant 1)

One of the positive effects of COVID is being more comfortable with not providing. Or when not providing CPR or intubation, making a… professional decision that this is not something [we are] going to provide. I think I'm much more comfortable with that right now. (Participant 3)

BOX 4

Theme 4: Improving recommendation-making in the ED

I do not remember getting any training on advanced care discussions other than just observing what stuff people did, and I think that it is necessary and would be highly valuable (Participant 6)

And I think the more we can normalize the discussion, the more we can have this discussion… like not necessarily the critically ill patient. I feel it just makes it easier for someone else to continue the discussion. Because it plants a seed, it gets in there, I think maybe from a philosophical perspective allows people to reflect on mortality…. I think it is incumbent on us to have these discussions or at least open these discussions. (Participant 3)

"push back" (Participant 3) too much as it was not productive, may lead to medicolegal ramifications, and would also place undue emotional stress on SDMs.

Another common theme was that the inherent difficulty of prognostication made it challenging to formulate an accurate recommendation for the patient or family.

Physicians were asked about how the COVID-19 pandemic had changed their practice. Many found that visitor restrictions made communication difficult with patients' families and important conversations were more difficult to have over the phone. Some physicians stated that their recommendations were changed by perceived resource scarcity though none had formally enacted triage protocols in their hospital. These physicians felt that the limited resources available increased their comfort with recommending against escalation of care.

3.6 | Theme 4: Improving recommendation-making in the ED

Emergency physicians reported that in general they received little to no formal training on how to have goals of care conversations in medical school or residency, and no one reported learning how to make recommendations. Many had attended departmental rounds or simulations on how to have rapid goals of care conversations in the context of the COVID-19 pandemic, and found this extremely helpful. Physicians felt that more could be learned from palliative care or ICU physicians. Physicians believed that better training at an undergraduate and postgraduate level would be helpful.

Improving the electronic standardization to document ACP was cited as a way to ease decision-making in times of crisis. Physicians with experience in provinces where there was a provincial electronic medical record and standardized levels of resuscitation found that it was helpful, and thought this should be employed in all provinces.

Some physicians stated that it would be easier to make recommendations if they had better clinical tools to help them prognosticate. Examples given were the Clinical Frailty Scale or APACHE II.[18,19] The idea that uncertainty of diagnosis and outcome is one of the most difficult parts of practicing in emergency medicine was frequently raised.

One physician wanted more institutional support from their college or professional society to empower them not to offer medical treatments (i.e., withhold care) they did not think would benefit the patient, which would decrease a fear of legal repercussions.

Many physicians said that it would be easier to make a recommendation if patients had already had an ACP conversation with their primary care provider, specialist, or even with an emergency physician at an earlier date.

3.7 | Limitations

Our study has several limitations. We attempted to minimize selection bias by seeking out physicians with alternative opinions, balancing gender, and finding physicians from both community and academic sites. However, most of our cohort work in urban areas. There is also likely a self-selection bias, whereby physicians who are interested in end-of-life care or ACP are more likely to participate. We did not specifically recruit for ethnicity or race.

Interviews for this study were conducted during the COVID-19 pandemic. Although we addressed this by asking about how COVID-19 impacted practice, it is difficult to fully know how participants' perspectives were affected by the pandemic.

Our study assesses physicians' own perspectives. It does not assess all the factors that may play into how recommendations are made or formulated, some of which the physicians' may not even be aware of (e.g., ageism, racism).

Last, the efficacy of recommendation-making as a means of impacting outcomes has not been established empirically.[20] This questions the importance of recommendation-making generally and calls for more research in this area.

4 | DISCUSSION

There has recently been a groundswell of interest in goals of care conversations. Research has sought to identify where and when they occur,[21,22] why they are frequently not done,[23] and how education can improve provider comfort with them.[24,25] What is less well studied is the structure or content of these conversations, and how this can influence decision-making. Specifically, little attention has been paid to recommendation-making in the ED. This study fills a gap in the literature by exploring emergency physicians' perspectives around recommendation-making.

Several frameworks and position statements on code status discussions suggest that physicians should make a recommendation to patients and their SDMs.[13,15,26] Most patients and SDMs prefer a model of shared decision-making rather than deferring to their physicians or acting independently.[14,27–29] A central part of shared decision-making is ensuring patients and SDMs are fully informed of the natural history of their disease as well as likely outcomes of different interventions. Providing facts and figures is not sufficient however and will often leave patients at a loss on how to proceed. A recommendation, which is a formulation of a physicians' expert opinion, fills this void, and is thus a necessary part of shared decision-making. It does not only promote autonomy, but it can psychologically unburden SDMs who feel that they may be abandoning their loved ones if deciding on a less aggressive resuscitation strategy.[15]

Previous studies have reported numerous perceived barriers to code status discussions in the ED, including physicians' own uncertainty with respect to prognosis, discomfort in communicating with SDMs, lack of relationship with patients, lack of prior ACP, and the perception that physicians lacked the training to have end-of-life conversations.[9,23,30] Our study shows that many of these factors also apply to recommendation-making. This overlap may indicate that the difficult aspect of code status discussions is in fact the recommendation.

The current literature around recommendation-making focuses primarily on non-crisis communication, and generally has looked at settings outside of the ED. These studies show that several variables impact whether a physician will make a recommendation, what that recommendation is, and how it is delivered. Physicians are more likely to make a recommendation to limit care when they believe a patient has a poor quality of life[31] or a clearly poor prognosis.[32,33]

The ED is a wholly unique environment. Our study demonstrated that there is no universal practice with respect to making recommendations for critically ill patients in the ED. Physicians described an internal tension between balancing the patients' autonomy and a responsibility not to inflict harm on them by providing them with invasive critical care interventions which often do not improve outcomes.

Many participants stated that they received no training during residency on code status discussions or how to make a recommendation to patients, but several stated that departmental rounds by a palliative care physician or a simulation session was useful and changed their practice. This may indicate that there is a need for more education around code status discussions and the role of recommendation-making at undergraduate and postgraduate levels.

Physicians provided arguments for and against why they would or would not provide a recommendation, few of which are evidence-based. For example, physicians argued that providing a recommendation could unburden SDMs of a difficult decision. Although we tend to agree with this based on our experience, there is little empirical evidence to support it. This suggests that much more research needs to be done around the impacts of recommendation-making in critically ill patients.

Last, our study identifies several barriers to making recommendations in the ED. Many of these are modifiable factors that can be addressed with systems-level change. These include improving rates of ACP, developing regional or provincial electronic health records or do-not-resuscitate forms, incorporating prognostic tools to predict mortality, and clarifying college or regulatory body policies on withholding care. We believe that recommendation-making is an important part of goals of care communication and one of the ways in which physicians can ensure the care patients receive is concordant with their values.

AUTHOR CONTRIBUTIONS

HA conceived the study. HA, KND, and EO designed the study and participated in recruitment. HA and KND conducted interviews. HA, KND, and EO performed data analysis. HA drafted the manuscript, to which KND and EO made substantial revisions. HA takes responsibility for the article as a whole.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to report.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Ajzenberg H, Dainty KN, O'Connor E. Recommendation-making in the emergency department: A qualitative study of how Canadian emergency physicians guide treatment decisions about resuscitation in critically ill patients. *JACEP Open*. 2023;4:e12962. https://doi.org/10.1002/emp2.12962