Changes in Emergency Room Communication to Improve the Patient Experience

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Introduction

The Emergency Room (ER) is the first point of contact for the most vulnerable patients in the healthcare system. Therefore, it is especially critical to maintain effective communication between clinicians and patients in this sector. Compassionate communication techniques are backed by a substantial body of research in their ability to improve the patient experience and clinical outcomes. The ER is also the fastest-moving department in any healthcare facility, which is a trait that is often used as an excuse for any lack of effective communication that may be present. It is important for those who would make such an excuse to understand that increasing patient-physician dialogue in emergency departments (ED's) does not hinder the efficiency of the system, but rather catalyzes the process. This paper will identify what is lacking in ER communication and suggest steps that healthcare workers can take to address these issues.

What is Lacking

Overview

It is difficult to unearth exactly what the issues are for patients in emergency departments because they cannot complain in real-time due to their typical critical condition upon arrival. Researchers can, however, interview past ER patients to try to grasp what they experienced during their visit and interactions with clinicians post-hoc. This is exactly what Natusi et al. did in 2018, when they conducted a "patient callback program" to investigate common themes in

patient-reported data. The objective of the study was to find areas for improvement in emergency departments by conducting phone interviews with patients who had visited the ER in a given year (2015). Their research indicated that the second most popular complaint among the participants in the study was communication, with 14.6% of participants reporting this issue. (Natsui, 2018). Statistics such as these are the basis for research in compassionate medical communication. Especially in a medical field that deals with disaster management, communication is key to providing the safest and most efficient treatment.

To understand non-effective communication in the emergency department, one has to understand the variety of patients that are being treated at any given time. While the classic image of an ER might include paramedics and surgeons rushing from an ambulance bay to an operating table, it is important to note that there are almost always patients whose illnesses or injuries have been deemed a lower priority[1] in terms of when they will be treated. Therefore, these patients are left in waiting rooms and have more in-depth, prolonged conversations with healthcare workers than the higher priority patients. In this section, two of the most glaring communication issues across all patients in emergency room departments will be presented.

(1) Reassurance

One example of the difference that effective communication can make to an emergency room patient can be found in the anecdote of Marcus Engel. In his book *The Other End of the Stethoscope*, Mr. Engel describes his traumatic car crash that left him blind and nearly dead at the age of eighteen. In recovery from this accident, he was dragged through over three hundred

[1] The system of determining patient priority in emergency departments is called the *triage* system. The triage system prioritizes patients based on serious of illness or ailment only (i.e. there is no prioritization based on outside factors such as citizenship, sex, ethnicity, socio-economic status, etc.).

hours of facial reconstructive surgery and years of torment. Mr. Engel has used his experience in the medical arena to provide insight into which communication techniques are effective and which are not. When recalling his initial experience after the crash, he states, "[e]verything below the neck aches…She [A young woman studying to be a paramedic] gives my hand a soft squeeze. Then, the most comforting words of all, 'I'm here'…Those two little words [were] a verbal embrace, a warm, safe place of protection" (Engel 23). Words of reassurance make a huge difference to a patient in the ER. As chronicled by Mr. Engel's example, it does not take much to comfort a scared, vulnerable person. Oftentimes, patients are looking for something to latch onto that they can understand. Phrases such as "I'm here" or "We're going to take care of you" provide a sense of comfort to someone who might not have any idea what is going on or what has happened in the first place.

When a patient relaxes, it is also more likely that they will have increased receptivity to treatment (e.g. moving them around, injecting them with medications, etc.) which can lead to improved outcomes. While the personal effect that simple words of reassurance can have might seem obvious, it is often forgone in favor of addressing physical issues. Bringing this type of communication to the forefront in emergency medicine is critical for the mental health of patients and health outcomes in general.

(2) Explaining the Situation

A 2008 article points out that the process of explaining ED procedures to patients is not as simple as it may seem. The article, by Slade et al., states that the typical ED clinician does not only lack the time to explain every step of the procedure to patients, but also the ability to translate the complicated medical jargon to layman's terms (Slade, 2008). As previously

mentioned, the efficiency of an ER is not hindered by implementing effective communication between the patient and the clinician. Instead, it is a necessary step to achieve good outcomes that can be done as the patient is undergoing change. As was noted in the Marcus Engel anecdote, simple phrases such as "I'm here" were effective for "reassurance" communication. Likewise, only simple statements are needed (and may even be better) to explain to a patient what doctors/nurses/other staff are doing to their body. For example, instead of saying something complicated like "We are going to give you a low-concentration dose of epinephrine[2] now," a healthcare provider in the ER could say "We're giving you something that will make your heartbeat a little faster."

While there is certainly a balance to be struck between relaying the information in an overly complicated manner to a patient and insulting the patient with simplified language, the point to be made is that it *is* possible to have explanatory conversations on the fly even with critical patients. The data presented in the overview for this section marks communication as a commonly lacked technique for ED employees and therefore professionals cannot make excuses in this department. This skill is enhanced in caregiving facilities for the well-being and safety of their patients.

What Can Be Done

Overview

The issue of communication between physicians and patients in the ED can be addressed on multiple levels: organizational/systemic action can be taken, clinicians can train themselves in

[2] Epinephrine is a neurotransmitter often used with critical care patients to effectively "jump start" the body. It is effective in cases where a patient is suffering from a drop in blood pressure, low heart rate, etc.

compassionate communication practices, etc. In this essay, the focus will be placed on changes that clinicians can make to their day-to-day, patient-to-patient techniques in order to address the needs this essay has previously identified. The two primary changes that are suggested in current literature include (1) increasing physicians' general knowledge of what it means to be empathetic, etc. during a crisis and (2) introducing formal training programs to emergency departments.

(1) Increasing Knowledge of Empathy and Like Terms

Terms such as empathy, compassion, sincerity, sympathy, etc. often get mistaken for one another. It is important to teach healthcare professionals the differences between these terms so as to dismiss the idea that the "soft science" of patient interaction is unstructured. In addition to ensuring that healthcare professionals can distinguish between the terms, it is a necessity that they properly act on things such as empathy, sincerity, etc.[3] A 2008 study by Nordby et al. investigates the role of communication and empathy in an emergency setting. Specifically, these researchers interviewed six paramedics and six parents who were involved in cases of Sudden Infant Death Syndrome (SIDS). The results of this study show that many of the parents were not satisfied with the paramedics' empathy towards themselves, the child, or the situation in general. Additionally, there was a high degree of disagreement between paramedics as to what the role of healthcare professionals such as themselves had in situations involving people in a crisis (Nordby, 2008). An important takeaway from this article is that while some healthcare professionals undoubtedly have a strong sense of the different facets of compassionate care noted

[3] The reason that compassion is not included in this short list is that compassion itself is an act based on empathetic resonance between one person and another. Therefore, it would be illogical to say that someone "acted on compassion."

earlier (empathy, sincerity, caring, etc.), many have trouble acting on them. Part of the reason for this, as mentioned earlier, is that their role in the situation is ambiguous.

The only way to correct the ambiguity that is present in this realm is through top-down work from the healthcare professionals' respective organization. It cannot come from the level of the healthcare professional because that is how the current problem arose. Instead, training programs need to be implemented to get employees on the same page. Additionally, clear and detailed mission statements are crucial to letting each employee of a healthcare facility understand his or her basic functions in their job.

In the book *If Disney Ran Your Hospital,* Fred Lee discusses the role of central authority in patient-employee interactions. Lee explains that it is beneficial to decentralize the authority to say "yes" (Lee 92). In other words, it should not be that healthcare workers feel like they cannot engage in emotional conversations with patients because that is not in their job description. By decentralizing the authority to say "yes," healthcare workers such as those paramedics detailed by Nordby would feel comfortable breaking the emotional wall and connecting with patients in conversation. This decentralization can begin with a wider mission statement (e.g. "We vow to provide holistic service to the patient at *each* level of contact"). This can continue with training sessions in which professionals are put in simulation scenarios that prompt them to display empathy skills. The next section on training programs will provide examples and give more detailed specifics.

(2) Training Programs

It is difficult to present one universal training program that will increase both knowledge of empathy and general communication skills within the emergency department. Instead, this

paper will present a number of exemplary training programs described in the literature as a reference for future, more customized courses for healthcare facilities and their employees. Since each emergency department is different in trauma level, surrounding population density, maximum capacity, number of staff, etc., individual systems will need to adapt to meet their own needs. Nevertheless, the general principles of the following programs should remain consistent and serve to improve communication and outcomes as a result.

The first exemplary program comes from the Department of Emergency Medicine at Maine Medical Center. Their program was called "Intern as Patient: A Patient Experience Simulation to Cultivate Empathy in Emergency Medicine Residents." Half of the interns in the emergency medicine program were brought into the hospital just as typical patients would be: professional ambulance service, cervical collar, evaluated in trauma bays, etc. The other half of the interns acted as the family members of the fake patients. The article describing the study states that "the complete simulation lasted three hours and included a full trauma assessment… time in the family waiting room, transport to radiology, splint placement…[etc.]" (Nelson 42). This program is outstanding for its experienced-based learning. Most training that medical school students and medical residents receive is not as realistic as Main Medical Center's program but instead relies on didactic learning. While lectures appeal to some students' learning preferences, including experienced-based learning forces students to be more involved. Being in the shoes of a patient can help one recognize the vulnerability that comes from being surrounded and touched by healthcare professionals following an accident. Conversations after this experience have the opportunity to reveal where the most obvious lacks in communication are. Specifically, the research would suggest looking for gaps in reassuring and explanatory communication, as mentioned in the first part of this paper.

The next exemplary practice comes from Gulhane Military Medical Academy. Sixteen emergency medicine nurses from Gulhane attended a 6-week psychoeducation program (90 minutes per week). Over the course of the six weeks, three sessions involved the traditional, theoretical education on empathy and communication while the rest involved awareness, active communication, role-plays, discussions, etc. The results of a study published on the program indicated that "[t]he number of undesirable events and complaints during nurse-patient interactions decreased 66%" (Ak 397). Where the "Intern as Patient" program excelled in its emphasis on participation, this program equally excels in the diversity of learning preferences that it appeals to. This type of program would be perfect for emergency healthcare facilities that have a wide variety of generations (age-related) working together in the same department. Different generations of emergency department employees come with their own unique set of preferences with regards to learning.[4] Older physicians tend to have a disposition towards less technology and more lecturing while younger physicians tend to prefer technology-based, interactive approaches to teaching medicine (and patient interaction techniques). The program at Gulhane is great because it not only excels in improving communication, which is the bottom line, but also does so in a way that appeals to not just one sort of learner.

In short, there is significant room for improvement in Emergency Room communication practices, and by turning to best practices, the industry can better address patient needs.

[4] See *Generational (Age) Differences in Nursing Students' Preferences for Teaching Methods* by Walker et al., 2006

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