



Communicating in  
> *hospital*  
.....  
emergency  
departments



*Final Report — Executive Summary*

*August 2011*

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*We try to make visible the passion and commitment of staff to providing high quality health care in the fast-paced and challenging context of the Emergency Department.*

*We argue that to deliver effective care, clinicians must also communicate care effectively.*

*Positive interpersonal relationships between clinicians and patients result in more collaborative interactions, which in turn produce better clinical outcomes.*

**The Emergency Communication Project was carried out with funding from:**

Australian Research Council (ARC Linkage Projects)

ACT Health

NSW Health: Northern Sydney and Central Coast Area Health Service and South Eastern Sydney and Illawarra Area Health Service (Health Service Partnership Fund)

NSW Adult Migrant English Service

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# Contents

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|  |           |
|--|-----------|
| <b>List of tables and figures</b> .....  | <b>4</b>  |
| <b>Transcription conventions</b> .....   | <b>5</b>  |
| <b>Foreword</b> .....  | <b>6</b>  |
| <b>Section 1 Recommendations</b> .....   | <b>7</b>  |
| 1.1 Preamble.....  | 7         |
| 1.2 Recommendations.....   | 7         |
| <b>Section 2 Introduction to the study</b> .....   | <b>13</b> |
| 2.1 Aims and background .....  | 13        |
| 2.2 Overview of the EDs in the five hospitals.....   | 16        |
| 2.3 Methodology .....  | 16        |
| 2.4 Methods .....  | 16        |
| <b>Section 3 Setting the scene: one busy day in an ED</b> .....  | <b>17</b> |
| <b>Section 4 The context of communication in EDs</b> .....   | <b>20</b> |
| 4.1 Material complexity — the physical demands of the ED context .....   | 20        |
| 4.2 Competing priorities in the ED context.....  | 20        |
| 4.3 Structure of the ED consultation: activity stages .....  | 21        |
| <b>Section 5 The communicative challenges of EDs</b> .....   | <b>23</b> |
| 5.1 From context to language: the key communicative risks .....  | 23        |
| 5.2 Disruptions to continuity of care due<br>to complex communication networks.....  | 24        |
| 5.3 Risks to knowledge/information transfer.....   | 26        |
| 5.4 Different effectiveness of senior and junior communication styles .....  | 28        |
| 5.5 Discipline boundaries and barriers to communication.....   | 31        |
| 5.6 Communication burden on patient .....  | 31        |
| 5.7 Casting the patient as passive.....  | 31        |
| 5.8 The need to create interpersonal rapport .....   | 33        |
| <b>Section 6 Effective clinician–patient communication</b> .....   | <b>35</b> |
| 6.1 The role of questions in the ED .....  | 36        |
| 6.2 Bridging the information gap—effective strategies for<br>developing shared medical knowledge and decision making ..... | 37        |
| 6.3 Bridging the interpersonal gap—effective strategies<br>for developing rapport and empathy with patients.....           | 38        |
| 6.4 Conclusion .....   | 41        |
| <b>References</b> .....  | <b>42</b> |

# *List of tables and figures*

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|             |   |    |
|-------------|---|----|
| Table 1.1:  | Strategies for developing shared medical knowledge and decision making .....    | 9  |
| Table 1.2:  | Strategies for developing rapport and empathy with patients .....               | 10 |
| Figure 2.1: | Issues raised in inquiries and in written complaints received in 2009-10 .....  | 14 |
| Figure 2.2: | Proportion of issues in the category communication/information 2009-10 .....    | 14 |
| Figure 2.3: | Issues raised in complaints received by most common service areas 2009-10 ..... | 15 |
| Figure 2.4: | The rising demand for EDs.....  | 16 |
| Figure 5.1: | Network of care for Patient 52, Dulcie (Manidis et al 2010b) .....              | 24 |
| Figure 5.2: | Encounters for Dulcie (Manidis et al 2010b) .....                               | 25 |
| Figure 5.3: | Network of care for patient 38, Denton (Manidis et al 2010b) .....              | 26 |
| Figure 5.4: | Sequence of communications with and by Denton (Manidis et al 2010b) .....       | 27 |
| Figure 5.5: | Analysis of questions and statements for Patient 1, Fahime .....                | 32 |

# Transcription conventions

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Clinician–patient interactions are transcribed using standard English spelling. Non-standard spellings are occasionally used to capture idiosyncratic or dialectal pronunciations (e.g. *gonna*). Fillers and hesitation markers are transcribed as said using the standard English variants, e.g. *Ah, uh huh, hmm, mmm*.

What people say is transcribed without any standardisation or editing. Non-standard usage is not corrected but transcribed as said (e.g. *me feet are frozen*).

Most punctuation marks have the same meaning as in standard written English. Those with special meaning are:

... indicates a trailing off or short hesitation.

== means overlapping or simultaneous talk. For example:

*P Um—oh, just trying to think. Well I suppose you could put my folks down, == yeah.*  
*Z1 == OK, so.*

This shows that Z1 started saying *OK, so* when P was saying *yeah*.

— indicates a speaker rephrasing or reworking their contribution, often involving repetition. For example:

*P Ah, no. No, you can take—take him off.*

[words in square brackets] are contextual information or information suppressed for privacy reasons. Examples:

*[Loud voices in close proximity]* contextual information  
*Z1 And your mobile number I've got [Number].* information suppressed

(words in parentheses) were unclear but this is the transcriber's best analysis.

( ) empty parentheses indicate the transcriber could not hear or guess what was said. For example:

*P Abright then.*  
*Z1 ( ).* Transcriber could not hear Z1's comment.  
*P OK, thank you very much.*  
*Z1 ( ) you ( ).* Transcriber could hear only the word *you*.

# Foreword

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The Emergency Communication Project was conceived in response to the increasing realisation of the central role of communication in effective healthcare delivery, particularly in high stress contexts such as emergency departments. The project presents a detailed picture of the critical importance of communication in the delivery of effective and patient-centred care, and provides a detailed analysis of the way in which communication occurs and, at times, fails. Failures in communication have consistently been identified as a major cause of critical incidents—that is, adverse events leading to avoidable patient harm.

Over the last three years, this project investigated communication between patients and clinicians<sup>2</sup> in five representative emergency departments. It involved 1093 hours of observations, 150 interviews with key staff and patients and 82 patients recorded from triage to disposition. Only patients in triage categories 3 to 5 (i.e. initially assessed as non life-threatening) were approached for participation. Researchers recorded, analysed and described spoken interactions between clinicians and patients and identified the features of both successful and unsuccessful interactions. The project therefore represents one of the most comprehensive studies internationally on clinician–patient communication in hospitals.

The Emergency Communication Project consists of individual hospital reports and this final report, which consists of two volumes—an executive summary and a full report that details the overall findings and summarises the hospital-specific communication practices.

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<sup>2</sup> Where possible we use the terms ‘nurse’ or ‘doctor’ or ‘social worker’ when it is clear from the context who we are talking about. At other times, this report uses the word ‘clinician’ to refer inclusively to doctors, nurses, social workers and all other healthcare professionals/ practitioners working in the Emergency Department. We use the broader term for brevity and simplicity. When referring to a ‘junior doctor’, we are referring to an intern or resident medical officer (RMO). The term ‘registrar’ refers to a doctor who is in specialist vocational training; a ‘specialist doctor’ is a consultant or a staff specialist or an emergency physician (in the case of an emergency specialist doctor), a senior medical practitioner.

I would like to thank the cross-disciplinary team of researchers who worked on the project—from the University of Technology, Sydney, Marie Manidis, Jeannette McGregor, Hermine Scheeres, Roger Dunston, Nicole Stanton, Eloise Chandler (Faculty of Arts and Social Sciences) and Jane Stein-Parbury (Faculty of Nursing Midwifery and Health); and Christian Matthiessen from the City Polytechnic of Hong Kong and Maria Herke from Macquarie University.

In particular I would like to thank Marie Manidis and Jeannette McGregor for their dedication to the project. The original work of Marie Manidis is evident in the construction of the diagrams for the encounters and networks for patients, first presented in Manidis et al 2009. I also thank Suzanne Eggins for editorial assistance in preparing the final report.

The team would like to thank the senior staff in the five hospital emergency departments who supported our research endeavours. We would also like to thank all those emergency department staff and patients who agreed to be interviewed, observed and recorded. At all times staff and patients were remarkably open, prepared to share their experiences, insights and concerns about the work of the emergency department and, in particular, to discuss the communication that occurs between patients and clinicians. The rich and authentic recorded data collected as part of the research has enabled us to undertake a unique analysis of the language of emergency department healthcare. We trust our observations and findings will be useful to emergency department staff, to hospital management and to patients who attend the emergency department.

We look forward to presenting and discussing these findings.

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August 2011

# Section 1

## Recommendations

### 1.1 Preamble

This Executive Summary, designed to stand alone, provides an overview of the project's full report, referred to throughout as *The Emergency Communication Report*. The Executive Summary includes our recommendations, an abridged version of the introduction, methodology and context of emergency departments sections of *The Emergency Communication Report*, and longer sections that summarise our findings about communicative challenges and effective clinician–patient communication in emergency departments.

Our research focused on communication in five hospital Emergency Departments (EDs) in NSW and the ACT:

- The Prince of Wales Hospital (POW), Sydney, New South Wales (NSW)
- The Hornsby Kur-ring-gai Hospital (HKH), Sydney NSW
- The Gosford Hospital, Gosford, NSW
- The Canberra Hospital (TCH), Canberra, Australian Capital Territory (ACT)
- The St George Hospital, Sydney, NSW.

Understanding the context of emergency communication is an essential prerequisite for understanding and describing effective communication within that context. Our description of the context is based on ethnographic observations by researchers and interviews with staff members. The analysis of the communication is based on authentic recordings of clinician–patient consultations in the five emergency departments.

All patient and staff names have been changed and any identifying comments deleted from the data in order to guarantee confidentiality.

We have tried to capture the culture and practices of the EDs as they occurred, with no attempt to alter them in any way. We have maintained respect for the context and its effect on the communication process in an effort to uncover how communication is shaped by and shapes the ED. While the focus of our study was communication, we have integrated this with

descriptions of the environment, observations, staffing, teamwork and networks of the ED as a means of setting the context for communication encounters.

This research study was carried out in collaboration with the staff of the EDs, and in particular with the collaboration of Directors of the ED and Nursing Unit Managers. The implications of this study for all the EDs and recommendations for professional development will be developed in consultation with them.

We would like to stress that, given the extreme pressures ED staff work under, we were at all times profoundly impressed by their dedication, skill and professionalism—qualities also identified by many patients.

### 1.2 Recommendations

Our research shows that communication (whether spoken, gestured, written or electronic) underpins what is done in the ED. From handovers to taking blood, to giving medications, to talking to patients, to listening to colleagues, to reading computer screens, to doing resuscitations—clinicians engage in speaking, listening, reading and writing on a continual basis. The ways the communicative, social and clinical practices work *together* in the complex context of the ED define the overall quality of the experience for patients and the ultimate work satisfaction of clinicians.

We found that both the quality of the patient's care and the patient's experience of care are negatively affected by two interlinking factors:

- Contextual complexity: The complex, discontinuous and fragmented nature of ED consultations can result in loss of knowledge transfer, inadequate and confusing explanations and interpersonal insensitivity to the patient.
- Foregrounding of the medical over the interpersonal: The failure of clinicians to build rapport and create relationships with patients can inhibit patients' understanding of and compliance with clinicians' diagnoses.

We now outline our seven recommendations.

## 1. Achieve a balance between medical and interpersonal communication

Our research shows that two broad areas of communication have an impact on the quality of the patient journey through the ED: (1) how medical knowledge is communicated; and (2) how clinician–patient relationships are established and built. We argue that to deliver care effectively, clinicians must communicate care effectively. To do this, clinicians must create an interpersonal relationship and build rapport with the patient. We therefore propose that strategies and skills in both communicating medical knowledge and in building interpersonal relationships be a required component in the training and assessment of ED clinicians. We summarise and exemplify these communication skills in Tables 1.1 and 1.2. Section 6 of this report discusses each strategy in more detail.

## 2. Provide explicit explanations to patients about processes and procedures in the ED

Patients are strangers to the ED environment, yet they receive very little information about what is going on and what will happen to them. To improve clinician–patient communication, we recommend the following four actions.

### 2.1 Develop an orientation protocol

We suggest the development of an ‘orientation protocol’ to guide clinicians in conveying both clinical and process information (such as more general information about the ED). The patient remains an outsider to the institutionalised language and patterns of behaviour practised by ED staff. Patients’ outsider status can result in anxiety, incomprehension and/or interpersonal alienation. While patients are often given key information and explanations about the processes of the ED, they often do not understand these fully because they are ill and anxious and because clinicians present the information in complex institutional and medical language. While we were collecting our data at one of the EDs, one of the project nurses introduced a ‘green sheet’, which included information to help patients understand where they might be in the particular stage of an ED consultation. We understand that this initiative was later withdrawn as a result of poor implementation by staff, which led to low use by patients. In principle the idea is an excellent one as patients are frequently confused and unaware about the timing of processes, the part of the ED they are in or where their health care is up to, but the *in situ* demands on everybody made it difficult to implement.



*Patients are strangers to the ED environment, yet they receive very little information about what is going on and what will happen to them.*



### 2.2 Explain triage categories

We suggest that staff make explicit the triage category that they have allocated to the patient and the expected waiting time. The patient is then in a position to make an informed decision about whether to wait in the ED or to seek other medical attention. We are aware that the government has target waiting times for each triage category and that these may be unrealistic but patients continually state that not knowing how long they might wait is a major frustration. We found that once patients understood why they might face delays (e.g. because staff need to deal with more critical patients, such as cardiac arrests), their anxiety and frustration reduced.

### 2.3 Explain ED processes

We recommend that staff explain to patients what is likely to happen next. For example, staff should inform patients that they are likely to be visited by different doctors at unpredictable times and that they may be sent for X-rays or tests. In particular, clinicians should tell patients that although shifts may change while they are in the ED, handover processes ensure that the oncoming personnel will be fully briefed and that patients will receive continuity of care.

### 2.4 Provide clinical explanations

We recommend that clinicians provide clinical explanations of the ED patient’s diagnosis and treatment plan. Wherever possible, we suggest that staff also explain the reasoning processes behind these. Evidence from patient complaint statistics suggests that providing useful explanations is vital to meeting patients’ expectations of quality care (see the discussion of the *NSW Health Care Complaints Commission Annual Report 2009–10* in section 2).

**Table 1.1: Strategies for developing shared medical knowledge and decision making**

| Aim: To enable and encourage patients to be informed and to be part of the decision-making process about their own health. |   |  |
|--|---|--|
| Communication strategies   | Description   | Examples   |
| 1. Make space for the patient to tell their story  | Initially open up the space for patients to talk by asking open, neutral questions.   | <i>'Now what seems to be the problem?'</i><br><i>'And how can I help you today?'</i>   |
| 2. Seek and recognise the patient's knowledge and opinions about their condition.  | Facilitate the knowledge-building process by eliciting and valuing patients' knowledge about their case and prior treatments. | <i>'So it was yesterday afternoon you were passing these big clots. Were they red, or did they look black like that?'</i>  |
|  | Normalise patients' medical symptoms and concerns about what is happening to them.  | <i>'There's a few things that can cause bleeding out the bum. I think in you the most likely thing is that it's coming from some diverticular disease. And sometimes little pockets on the wall of the bowel can bleed from time to time and they can get infected.'</i> |
| 3. Explain medical concepts clearly by moving between technical (medical) and commonsense (everyday) language.             | Limit technical language or jargon and explain terms that patients might not understand.                                      | <i>'What we have there is what we call epididymo-orchitis. That's just our fancy way of saying infection.'</i>   |
| 4. Spell out explicitly the rationale for management/ treatment options and decisions.                                     | Provide patients with clear reasons for ongoing treatment or management plans.  | <i>'Now, we need to rule out a problem with the aorta, which is the big blood vessel coming in the top of your heart. And the only way to do that is to do a CT scan.'</i>   |
|  | Wherever appropriate, make the reasoning process available to patients.   | <i>'Hopefully we won't have to do the x-ray again. But we may have to because the situation changes on different days.'</i>  |
|  | Explain the sequence and priority of treatments.  | <i>'Alright, but for now the priority is treating the infection. Make sure there is nothing nasty with the biopsy and then we can talk about how to get the waterworks better in the long term.'</i>   |
| 5. Provide clear instructions for medication and other follow-up treatment, appointments, etc.                             | State instructions clearly and repeat or ask patients to repeat to confirm comprehension.                                     | <i>'I wouldn't use anti-inflammatory tablets at the moment because they could make you bleed from the prostate, so take Panadol- two tablets every four hours. So that's a maximum of eight tablets per day. OK?'</i>  |
| 6. Signpost the hospital processes the patient will need to go through.  | Set out the steps the patient is likely to go through and the different demands that will be made of him/her.                 | <i>'I'll send you up to the next window just to give your Medicare details and things. And then one of our doctors is going to call you through the house doctor section today, so they'll bring you through and have a chat to you ...'</i>                             |
| 7. Negotiate shared decision making about treatment.   | Encourage patients to debate, clarify and discuss their treatment options.  | <i>'If the bandage falls off you might want to try something simpler? So we could try the one you used last time, if you like.'</i>  |
|  | Encourage patients to comply with recommended treatment plans by negotiating preferred treatment plans with them.             | <i>'If the bleeding continues then we'll consider doing something else. OK? So what are our options? Well, the definitive option is radiotherapy.'</i>   |
| 8. Repeat key information, check comprehension and offer clarification throughout.   | Continually check that patients have understood and offer the opportunity for them to ask for clarification.                  | <i>'When you fell down onto that bone, the coccyx bone it's a very thin area and it's going to be sore. The bruising is going to be...the pain itself will probably last for at least a week. It's going to be very, very sore.'</i>                                     |

**Table 1.2: Strategies for developing rapport and empathy with patients**

| Aim: To establish a 'human' connection with the patient in order to facilitate the patient's collaboration in the management of their condition and to improve the quality of the patient's experience in the ED. |  |   |
|---|--|---|
| Communication strategies  | Description  | Examples  |
| 1. Introduce yourself and describe your role.   | Alleviate patient anxiety by introducing yourself and explaining your role in order to clearly establish your medical expertise.                                     | 'Good morning. My name's ( ) and I'm one of the surgical registrars here. I work with Dr ( ). He told me you were coming in.'   |
| 2. Use inclusive language   | Put patients at ease and create an atmosphere where the patient feels more included in the decision-making process by using the patient's name and the pronoun 'we'. | 'We'll get you through as soon as we can, George. We're just going to have another look down your throat with a camera, and because you can't drink, we probably need to do that today.'            |
| 3. Use colloquial language and softening expressions to put patients at ease.   | Minimise the strangeness of the ED context by using colloquial language.   | 'Have you noticed any blood from your bottom at all?'<br>'Just pop up on there for me.'   |
|   | Soften commands and requirements of the patient with just and expressions of probability, e.g. I think, probably.  | 'And because you can't drink, we probably need to do that today.'<br>'With that low a blood count and with your history of heart attacks, I think it's very likely that we need to transfuse you.'  |
| 4. Give positive, supportive feedback.  | Establish empathy and alleviate patient anxiety by expressing interest, approval and engagement with the patient.  | P: I'd say it's probably about a month, probably about — I had a haemorrhoid.<br>D: Yeah.<br>P: And I had that lanced a couple of weeks ago.<br>D: Yeah.<br>P: And, um...<br>D: I'm feeling for you |
|   | Mirror patients' comments regarding symptoms, attitudes or concerns.   | P: They were really big clots like that.'<br>D: Yeah, so really big clots.'   |
|   | Express personal attitudes and values to show support.   | 'Because you are absolutely right. I don't blame you. I don't blame you. But you've done all the right things.'   |
| 5. Recognise the patient's perspective.   | Express a positive attitude to patients' thoughts and feelings about their medical conditions or their responses to treatment.                                       | 'No. You're not going crazy. I can appreciate how uncomfortable it must feel. It's not a very nice test.'   |
| 6. Intersperse medical talk with interpersonal chat.  | Put patients at ease and reduce the professional distance between you by chatting to them about aspects of life that are unrelated to their medical conditions.      | 'You play Rugby Union do you? So who do you think is going to win the World Cup this year?'   |
| 7. Share laughter and jokes.  | Alleviate anxiety and lighten the atmosphere by sharing jokes and laughter that express solidarity and inclusiveness.  | 'You've got to have another needle, have you? Ooh! You're the lucky one!'   |
| 8. Demonstrate intercultural sensitivity  | Elicit and listen to details of patients' cultural background and don't make cultural generalisations or assumptions based on cultural stereotypes.                  | N1 How long have you been in [City]?<br>P About seven, eight years?<br>-----<br>N1 So country of birth, where were you born?<br>F [European country].   |

### 3. Develop effective interdisciplinary teamwork

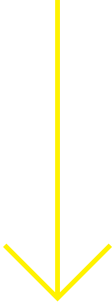
EDs are multidisciplinary worksites but the care they provide is not always interdisciplinary. Although we observed strong teamwork at one ED, at the majority we saw nurses sharing information with nurses, doctors with doctors—and very little cross-disciplinary interaction or collaboration. This lack of multidisciplinary culture and behaviour can lead to failures to exchange vital patient information. It can also be associated with poor levels of respect between the disciplines and therefore a working environment that is less harmonious and less cooperative than would be ideal in the ED context. We therefore recommend that ED training and handover procedures take into consideration ways to improve multidisciplinary collaboration.

### 4. Develop cross-cultural communication awareness and strategies


Australia's population is culturally diverse and this diversity is reflected in presentations to EDs. This fact, compounded by most EDs' reliance on overseas-trained staff, ensures that modern day healthcare is a multilingual and multicultural reality. In addition, EDs have to use agency and locum staff on a regular basis, which increases staffing variation and unfamiliarity of team members. Older patients, many of whom attend EDs, may also be seen as a specific cultural group with values, expectations and specific healthcare communication needs which differ from younger patients. While several staff demonstrated significant awareness of cross-cultural factors and communication strategies when dealing with patients of different backgrounds and ages, the findings from the research highlighted the many and remaining challenges of communication between culturally-diverse patients and clinicians. Patients and clinicians often experienced difficulty understanding overseas accents and intonation patterns. Local and overseas-trained clinicians can also sometimes have trouble understanding each other's medical framing and explanations.

Many doctors we recorded and interviewed did not have English as a first language. On occasion, patients referred to the difficulty they had understanding what overseas-trained clinicians were saying or asking, but patients did not suggest they had less faith in their clinical skills.

One nurse said that when patients did not fully understand what they were told by a doctor whose first language was not English, emergency nurses felt called on to clarify the information.



*...clinicians should tell patients that although shifts may change while they are in the ED, handover processes ensure that the oncoming personnel will be fully briefed...*



We suggest it would be useful to orient all staff to the difficulties associated with dealing with diverse population groups. For example, staff could be coached in the need to avoid cultural stereotyping, to give clear (possibly written) follow-up instructions, to avoid complex questions and culturally-specific references to pain and to manage reporting histories with older patients.

We recommend that all staff receive training or support in ways of dealing with the difficulties associated with treating and working with patients from diverse population groups, as well as with overseas-trained doctors and nurses.

### 5. Introduce more effective and durable forms of patient records

Communicating in the ED will always involve a combination of spoken and written exchanges, with the role of written documentation playing a significant role from both a medico-legal and a clinical perspective (Eisenberg et al 2005; Hobbs 2007; Slade et al 2008). Although our study focused on spoken language in EDs, our data indicated that patients' written records were a potential source of miscommunication and risk.

In clinician–patient interactions, our consultation transcripts demonstrate that successive clinicians continually re-question patients, seeking information that has been previously documented in their notes. In clinician–clinician interactions, usually, senior clinicians have been 'told' about the patient's illnesses (Coiera et al. 2002) by junior clinicians, but often they do not have the time to read notes and case histories before they approach the bedside, and even if they have read them, they prefer to ask the patient for the information themselves. However, our transcript data (and interviews with patients) suggests that this is taxing and confusing for patients, especially if the information is already available in the patient's notes and/or has been provided by the patient earlier on in the consultation.

Our interviews with clinicians and our examination of patients' medical records highlighted ongoing 'disconnects' between the ways that spoken and written communication were meant to support or complement each other in the ED. Particular problems included the legibility, accuracy, equivalence and accessibility of written documentation.

To reduce the mismatch between what is said and what is written down, we recommend the introduction of some form of electronic patient records. In developing e-record systems, Australian EDs should build on international best practices.

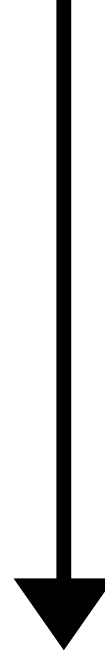
## 6. Provide training with authentic materials

Effective clinical communication is recognised by medical and nursing accreditation bodies as a core skill and essential for ensuring quality and safety in health care. While teaching and learning clinical communication features in most health education courses, the quality and extent of the content, resources and teaching methodologies can vary greatly. Medical and nursing students are rarely exposed to authentic materials or teaching and learning approaches that address communication in high-risk settings such as emergency departments. We recommend that the teaching of clinical communication skills be based on research that analyses and describes real clinician–patient communication, such as the data presented in our research.

To this end, the Communication for Health in Emergency Contexts (CHEC) Project, funded by the Australian Learning and Teaching Council, has drawn on the authentic materials in the Emergency Communication Project to develop an innovative multimedia learning resource for nursing and medical students. Materials and activities in this educational resource reflect the cultural and linguistic diversity clinicians will encounter in emergency contexts. Details of CHEC are available at <http://www.chec.meu.medicine.unimelb.edu.au/>.

## 7. Examine communication in clinical handovers

Our research in EDs recognised that although effective clinician–patient communication is essential for quality patient care, handover communication between clinicians is also critical. Substantial international research has identified problems in clinical handover, and in Australia, failure to achieve effective clinical handover is recognised as one of the five leading sources of clinical incidents (ACSQHC 2010; WHO 2008).



*Medical and nursing students are rarely exposed to authentic materials or teaching and learning approaches that address communication in high-risk settings such as emergency departments.*



Since completion of the Emergency Communication Project, the University of Technology, Sydney (UTS) has begun coordinating a national ARC-funded research project (2011–2014) into effective clinical handover communication. The project's objectives are to improve patient safety, experiences and outcomes by producing research outputs that are transferable across the multiple contexts of the Australian health system and internationally.

The partner organisations include the Health Departments of NSW, WA, SA and ACT and the University of Queensland, University of Melbourne, University of Adelaide, Curtin University of Technology and Flinders University of South Australia.

## Section 2

### Introduction to the study

#### 2.1 Aims and background

The major aim of this project was to describe communication encounters between patients and clinicians in five emergency departments (EDs) in NSW and the ACT. Ineffective communication has been identified as a major cause of critical incidents in public hospitals (Australian Institute of Health and Welfare and Australian Commission on Safety and Quality in Health Care 2007; Kohn, Corrigan and Donaldson 1999; NSW Department of Health 2005). Critical incidents are adverse events leading to avoidable patient harm. Due to the complex, high stress, unpredictable and dynamic work of EDs, they pose particular challenges for effective communication. Our project sought to describe the communicative complexity and intensity of work in the ED and, against this backdrop, identify the features of successful and unsuccessful patient–clinician interactions.

This report documents our findings from research conducted in five EDs in NSW and the ACT. Our research is unique in both its scope and cross-disciplinary focus. A team of seven researchers with disciplinary backgrounds in applied linguistics and health sciences spent a total of over 1,093.5 hours inside five EDs conducting the research. Of these hours, 242.75 were spent directly observing ED practices; we recorded 82 patients from their first presentation in the ED to the point when a decision was made about their admission, discharge or referral elsewhere. We interviewed 150 staff and we examined the medical records of all the patients we followed throughout their ED Admission and conducted follow-up interviews with participating patients and staff.

The extensive data collection and the detailed analyses make this one of the most comprehensive studies internationally on clinician–patient communication.

The broad aims of our research were to:

- describe communication encounters that occur between clinicians and patients in the ED in order to identify the features of both the successful and unsuccessful interactions

- analyse the breakdowns in communication that occur in these spoken interactions
- identify ways in which clinicians can enhance their communicative practices to improve the quality of the patient journey through the ED.

This project is located against the backdrop of current broader agendas in acute care services in NSW. These include the Clinical Redesign initiatives (NSW Department of Health 2005) and outcomes of the ‘Garling Inquiry’ (Garling 2008), which have paid increasing attention to the relationship between communication (in particular communication breakdowns) and patient safety.

There is mounting evidence that providing quality care is challenged by the pressures of communication in high-stress work areas, such as EDs. Different cultural, linguistic and socio-economic backgrounds and experiences can result in increasingly serious communication problems between patients and clinicians.

Communication in hospital EDs is particularly complex. Emergency medicine has traditionally been a predominantly spoken discipline, dependent on the oral transfer of information. However, spoken interaction now carries an even greater burden because of time pressures, increasing presentation loads and the expectation that clinicians work in multidisciplinary teams. The time available to do the work of the ED has been substantially reduced, particularly at critically busy times.

Even in the time-pressured environment of the ED, the goal of contemporary hospital practice is to ensure the quality of the patient journey by providing ‘continuity of care’. Continuity of care stands for well-organised, planned and appropriately communicated care processes. A lack of continuity of care raises uncertainty for all involved: clinicians, patients and family members. This uncertainty can be mitigated with targeted communication but the complexities of emergency work make it very challenging for clinicians to organise their work to achieve continuity and to communicate explanations to patients, family members and colleagues when discontinuities occur.

Documented evidence shows that effective spoken communication produces positive outcomes for patients' understanding of treatment (for example as described by Elwyn et al. 2003) and compliance with treatment plans (Haynes, McKibbin and Kanani 1996b). In addition, patient satisfaction is directly related to spoken communication (O'Keefe 2001). Garling (2008, Vol.2, p.551) emphasised the importance of effective communication in health care: *improved lines of communication between patients and hospital staff can reduce the number of problems a patient experiences during a stay in hospital. Good communication between patients and health professionals leads to fewer errors and better treatment outcomes.*

Figure 2.1, from the NSW Health Care Complaints Commission (HCCC) Annual Report 2009–10, shows what patients formally complained about in that period, listed by complaint area. A total of 3,515 complaints raising 5,841 issues were received by the HCCC in 2009–10. Of these, communication between practitioner and patient accounted for 15.4% and was the second most common complaint (897). (The largest number of complaints—42.9%—related to treatment).

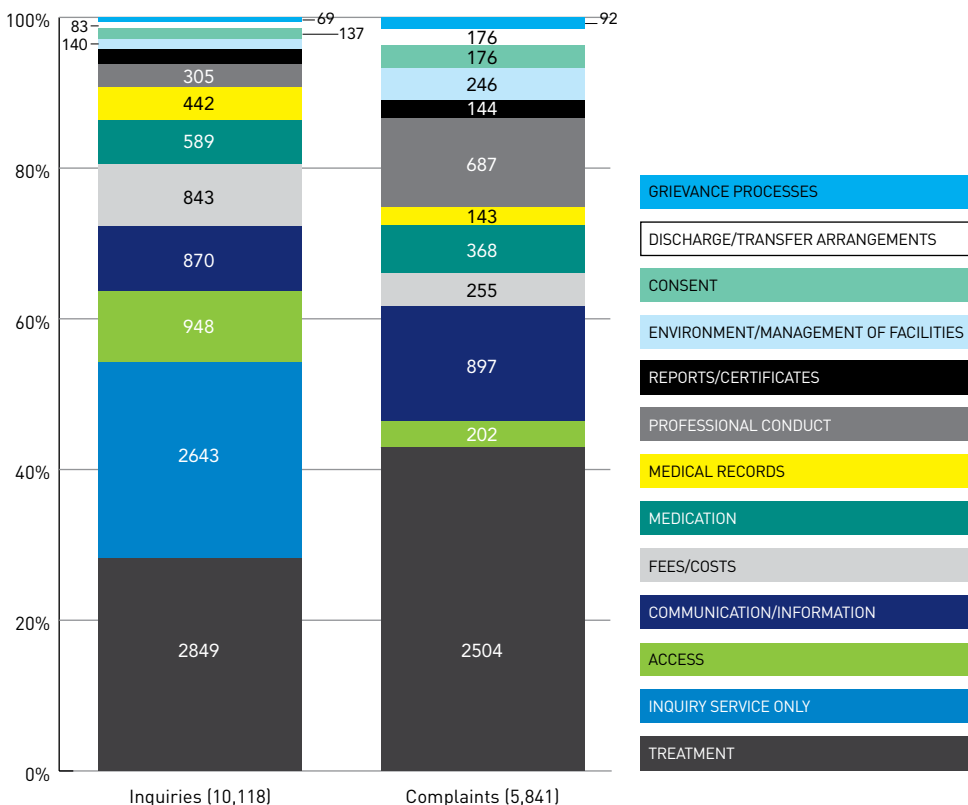


Figure 2.2: Proportion of issues in the category communication/information 2009-10

Source: adapted from NSW Health Care Complaints Commission Annual Report 2009–10, p20

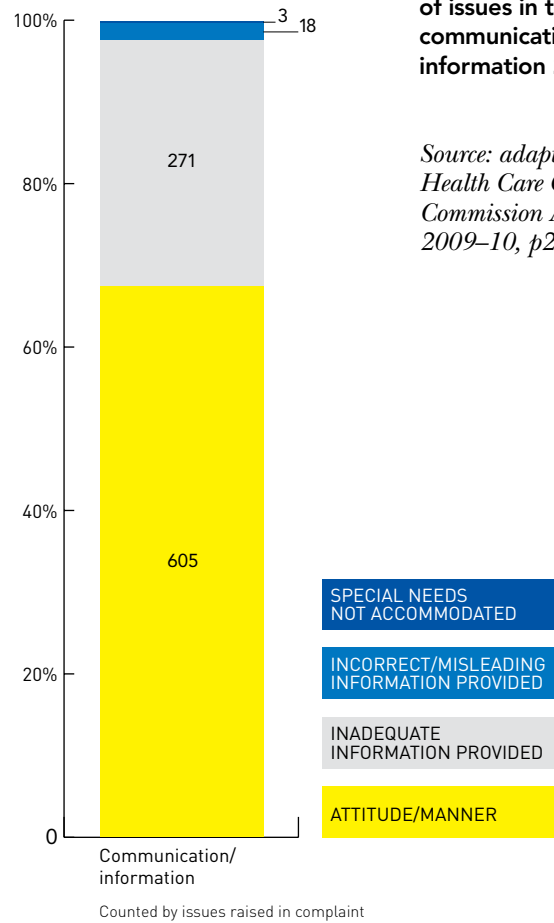


Figure 2.1: Issues raised in inquiries and in written complaints received in 2009-10

Source: adapted from NSW Health Care Complaints Commission Annual Report 2009–10, p19

**Figure 2.3: Issues raised in complaints received by most common service areas 2009-10**

Source: adapted from NSW Health Care Complaints Commission Annual Report 2009-10, p25

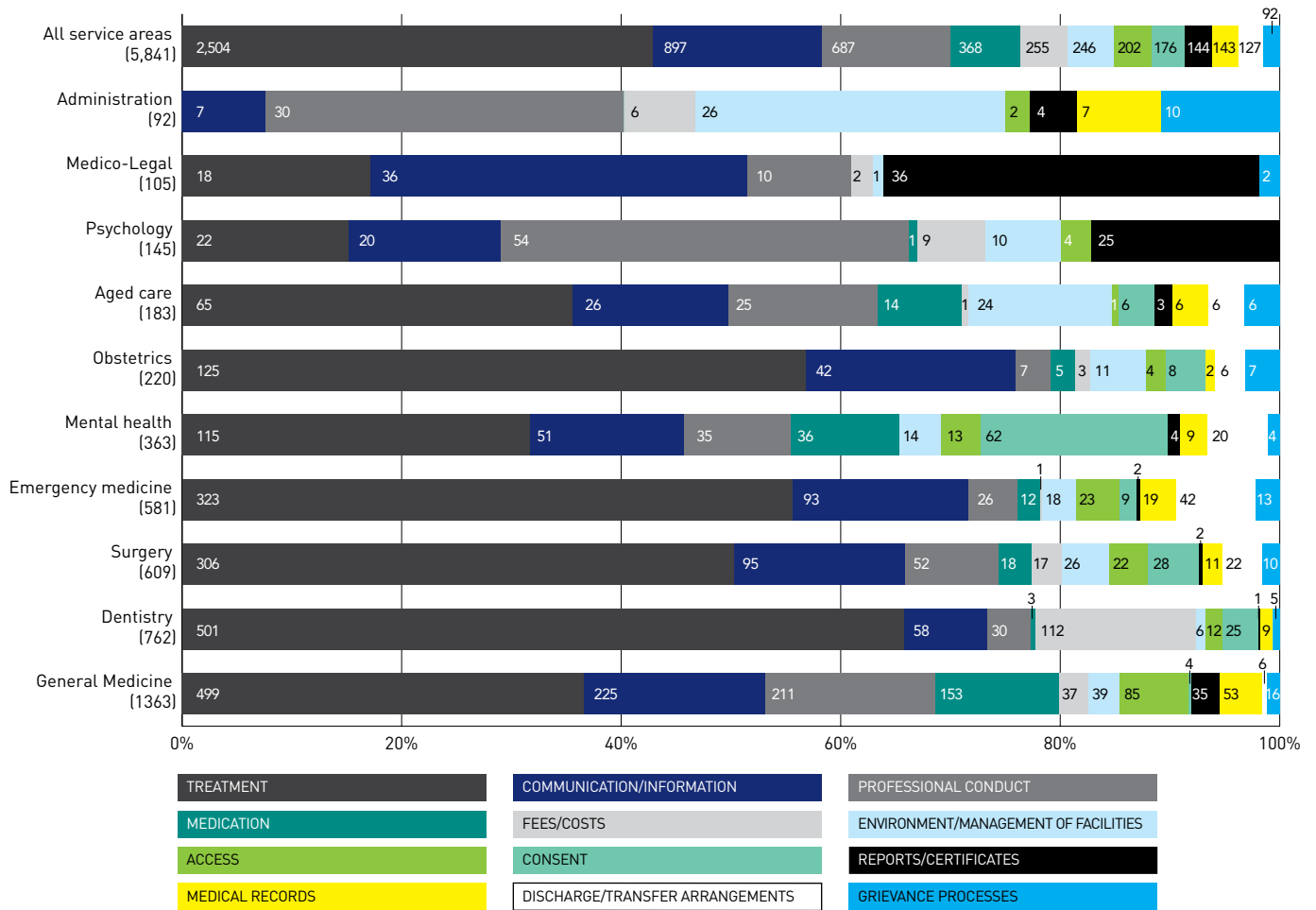


Figure 2.2 shows the HCCC’s communication complaints broken into the categories of attitude (605 complaints), provision of inadequate information (271), and the provision of incorrect or misleading information (18). A smaller proportion of cases involved complaints that special needs were not accommodated (see HCCC Annual Report 2009-10, p20).

Analysis by service area shows that EDs are the most frequently complained about named location beyond the general category and dentistry. Complaints about communication and information made up the second largest category (after complaints about treatment), and was proportionally higher than for communication complaints in all areas except surgery. See Figure 2.3.

The reason for the high number of complaints about EDs could be the extraordinary increase in the demand for this service. Figure 2.4 below shows the increase in the numbers of people going to the ED as well as the rate of attendance per capita.

The demand for ED services has grown 6.9% annually since 2004/05 for the 59 hospitals that were included in the HCCC study, with a remarkable figure

of 7 million presentations to public hospital EDs in Australia in 2008. The five EDs we researched recorded a total of 235,037 presentations in 2009.

By 2006/07 the number of presentations to the ED as a percentage of the population had reached 30%, up from 26% in 2004/05. Of all the patients visiting the ED, 26% had visited on multiple occasions. This indicates the general population’s growing tendency to use the ED (Booz Allen Hamilton 2007).

The number of critical incidences that have been reported in the media over recent months have highlighted the increasing stress that ED clinicians are working under. The Garling report highlighted the pressure on EDs:

*On a typical day for NSW Health across the state of NSW, there will be: an ambulance responding to an emergency 000 call every 30 seconds; 6,000 patients arriving at Emergency Departments seeking treatment; 4,900 new people being admitted as an in-patient at a hospital; 17,000 people occupying a hospital bed of whom 7,480 are over 65 years old; 7,000 separate procedures performed.* (Garling 2008, p. 1)

## 2.2 Overview of the EDs in the five hospitals

Our study is based on data collected in the EDs at the following five hospitals: Prince of Wales; Hornsby Kurin-gai; Gosford; St George; Canberra. *The Emergency Communication Report* details the patient presentation statistics for each hospital and other areas of service delivery. Below we provide a brief overview of each ED. Individual hospital reports provide further details (Prince of Wales: Manidis et al 2009; the Canberra Hospital: Manidis et al 2010a; Gosford Hospital: Manidis et al 2010b; Hornsby-Ku-ring-gai Hospital: McGregor et al 2010).

## 2.3 Methodology

Our research combined two complementary modes of analysis: qualitative ethnographic analysis of the social practices of each ED (extensive observations and interviews with staff and patients) and discourse analysis of the spoken interactions between clinicians and patients. This report presents core findings from:

- analysis of 1,095 hours of non-participant observation of work in the EDs, with over 242 hours of direct observation and 1,411,238 transcribed words
- analysis of audio-taped interviews with 150 staff (administrative staff, nurses and medical practitioners, allied health workers)
- analysis of audio-recordings of interactions during consultations between 82 patients and their attending clinicians. The audio recordings consist of 629,436 words of patient-clinician interactions. These recorded interactions are a unique resource. They have afforded rich and relevant insights into the links between the overall patient experience and communication practices and breakdowns in the ED.

## 2.4 Methods

### 2.4.1 Ethnographic data

Our researchers collected a cluster of ethnographic data from the five EDs, detailed in *The Emergency Communication Report*:

- non-participant observation of the EDs
- semi-structured interviews and focus groups with key clinical staff and patients
- staff shadowing
- semi-structured interviews with patients
- photographs of signage, written notices and informal notes displayed throughout the ED.

### 2.4.2 Discourse data

Researchers collected and analysed a range of spoken language material and supporting documentation.

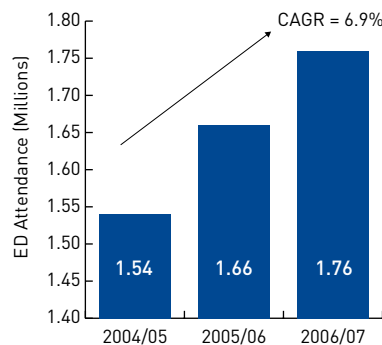
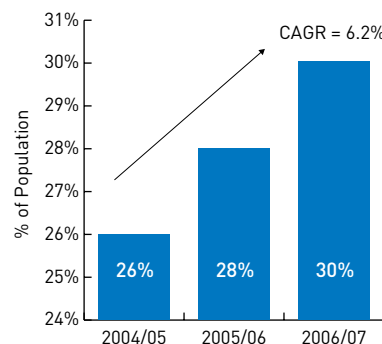


Figure 2.4: The rising demand for EDs

Source: NSW Health (Booz Allen Hamilton 2007, p.52)



Source: NSW Health, Australian Bureau of Statistics (Booz Allen Hamilton 2007, p. 52)

### Analysis of audio-recording of patients and clinicians in the ED

Researchers audio-recorded clinician-patient interactions of 82 patients from the time they were triaged (assessed and categorised for emergency care) to the time of their disposition (when a decision was made to either admit them or send them home). Patients were approached and asked if they wished to participate in the study in consultation with triage staff or separately. Only patients in the less serious triage categories (3, 4 and 5) were approached. Once patients had consented, all their interactions with clinicians were audio-recorded. On some occasions clinicians were recorded discussing consenting patients with other clinicians. We transcribed these clinician-patient interactions in detail, checked them for accuracy and then analysed them linguistically.

### Analysis of the communication used in handovers

A small number of handovers were observed and we analysed the communication of these exchanges.

### Analysis of relevant ED documentation

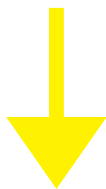
After the audio-recordings were completed, researchers reviewed the ED records of patients who had consented to obtain documented details of their ED admissions.

## Section 3

### *Setting the scene: one busy day in an ED*

Our ethnographic observations in the EDs reveal a picture of busy, overstretched worksites with constant movement, talk and clinical action. This complexity is compounded for patients and carers who arrive as outsiders to the ED environment.

We conducted a total of 1,093.5 hours of ethnographic observations in the different sections of EDs. These yielded a rich, graphic account of the activities, people, stories and interactions that take place daily in the triage room, the ambulance bay, the acute, sub-acute, EMU<sup>2</sup> and resuscitation areas and in the waiting room.



*A senior nurse working in the ED complains that staff cannot even see the patients—there are just too many of them, piled up and out of view.*



It was a bad weekend. The Director of the ED has been called on Sunday at 2am and has been told that the situation is quite critical. On Monday at 1.45pm it is still critical. The primary problems are bed space and acuity. Patients are spilling into the corridors and out of the exits. A senior nurse working in the ED complains that staff cannot even see the patients—there are just too many of them, piled up and out of view. At around 1:50pm ‘another’ level 3 page goes out, notifying the hospital that the ED is in a situation of overcrowding and in need of the wider hospital’s support. Already over the ambulance threshold (with seven patients queued up in the bay), ambulance officers have begun to queue around the entry to the department.

A bed manager comes down to allocate beds among the waiting patients but gets nowhere. The access to beds is not there, creating further queues. The queue for beds at 2pm is nine people long. A senior doctor suggests that they start doing the rounds to find people who are better and ‘to see who we can get rid of’. The senior nurse on duty replies that there is no-one who can be moved. A young girl has been in an ED bed since the night before. The orthopaedic ward refuses to take her until her neck is formally cleared and documented. The orthopaedic registrar had been on his way down to do this but has been called away to do something else.

Two staff specialists are ‘trapped’ in the ambulance bay. Although this is a non-treatment area they have started treating patients anyway, taking patient bloods, getting ECGs. With every patient there is an ambulance officer—sitting around, waiting to hand over his or her patient when a bed becomes available. They monitor their patients, although regulations prevent them from administering any care. Mostly, they just have to ‘sit there’ and wait. Another ambulance turns up making the queue ten patients long.

A senior nurse goes to call the hospital bed managers but is informed that all bed managers

<sup>2</sup> Emergency Medicine Unit

are unable to come down as ‘they’re in meetings’. She calls them anyway, informing them that it ‘is critically unsafe down here’. The researchers are told that those words ‘critically unsafe’ get a response. The senior doctor and nurse try to work out whether they can send any of the patients down to EMU to free up a bed. They agree that five can go; however, in the end they only manage to free up one bed. Another ambulance arrives. There are now 11 patients in the ambulance bay and the ED ‘does not have resusc capacity’<sup>3</sup>. Non-resusc patients occupy beds dedicated to this level of care. The senior nurse, still having received no response from the bed managers, writes to the program executive, pleading for managerial staff to support them.

A further admission is declared by one of the doctors in the ambulance bay. A senior nurse does a round of the ambulance bay getting briefed on the waiting list—several patients have been sitting in this area since 10am. It is now almost 2pm. No-one has been treated. Meanwhile, the ambulances have begun to queue behind the doors at the entry to the ED. The doctors have ‘no visual line’ to those patients. One of these patients is diagnosed as being critically unwell with a pericardial effusion. It needs to be tapped urgently. Another patient has a severe allergic reaction. Another has had a severe epileptic seizure. A ‘psych’ patient occupying one of the beds is asked to move into a seat to make space for the patient with the allergic reaction. Another mental health patient, who has been in the ED for an inordinate number of hours without a bed, is moved into the corridor. Meanwhile, the patient with the allergic reaction still goes untreated—it is predicted that she will lose an airway if she is not addressed shortly.

The senior nurse walks to the EMU and finds there are five beds there. She decides to override the department’s own policies and assigns five non-urgent patients beds down there. Instantly, the ED beds that were freed up are filled again. It is now 2.20pm and there are still six people waiting in the ambulance bay. The girl waiting for the orthopaedic registrar has still not been moved and there has been no sign of the bed managers. A nurse explains to the researchers that three beds in the ED are being blocked because the patients cannot be transferred into wards. One of these patients is a 98-year-old woman who has been in the ED since 2pm the day before—she cannot be moved because there is simply no bed for her to go to. Staff attempt to clear the beds in ‘resusc’ so that they can regain

<sup>3</sup> ‘Resusc’ refers to a reserved bed where patients who need resuscitation can be put.

resusc capacity. Every patient they approach is waiting for a bed to be freed in a ward. None can be moved. There are no clinical beds and no mental health beds in the hospital. Further, despite three mental health admissions, only one nurse ‘special’ has been provided—they have been given one third of what is required for safety.

Two beds become free in EMU and resusc capacity is temporarily regained. The Acting Director of Nursing comes down to sort out the ward blocks. Just as the staff begin to regain control, the computer board refreshes itself and sends out the message that the ED can take two more patients. This is anything but the case. A new patient who has arrived is suspected of having Legionella and needs to be isolated. Seconds later a mental health patient arrives without a ‘special’ nurse in attendance. Staff attempt contact with the Mental Health Unit to clarify whether they have beds. At 3pm, the second bed manager comes down. Moments later the orthopaedic registrar arrives to make a decision about the girl’s neck. He clears the spine immediately and the girl is moved. Doctors remain in the ambulance bay, attempting to provide whatever care possible to those patients not yet able to be placed in a clinical area in the ED. A nurse comments to the researchers: ‘This is where it gets unsafe. Doctors in the ambulance bay with trolleys and with needles. All you need is a psychotic patient in there to go off and all hell will break loose.’

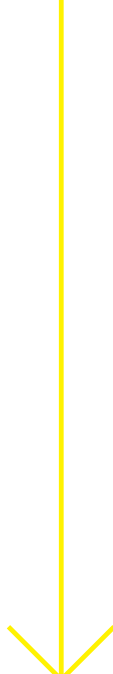
The senior nurse does another round of the bay and finds a ‘potential SBE’<sup>4</sup> in need of urgent antibiotic treatment. She also meets a man with myocardial infarction who has had his ECG delayed. He needs to go on a bed immediately. Meanwhile, the patient suspected of having Legionella has still not been isolated. As predicted by ED staff, the man with infarction has an abnormal reading on his ECG and is an admission. Behind him, staff frantically make phone calls trying to free up beds and create

<sup>4</sup> SBE: Shortness of breath on exertion


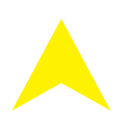
movement for patient flow. The ambulance bay is still spilling with patients and trolleys and it is virtually impossible to walk freely around the department. A senior nurse asks the ambulance officers to attempt to make a clear way. Finally a man with hypoglycaemia who arrived at 11.30am is offloaded from the ambulance bay onto a bed at 3.15pm.

There is a woman in the corridor waiting on a trolley and obstructing the path to resusc. One staff member, on seeing her, groans: 'If they have a cardiac now, how do they run through there?' She is moved onto a seat in the main area so that she can be watched by staff. Minutes later the radio announces that a cardiac arrest is on its way in. There is no bed empty in the resuscitation rooms but staff manage to clear an empty space in one by putting all occupied beds in the one resuscitation room. One of the patients in Resuscitation 2 has been there all day. Around six minutes after being announced, the cardiac arrest arrives and is rushed into resusc. Her heart stops beating; they 'call it'—they are not able to bring her back. The senior doctor and the social worker go to see the family of the cardiac patient, who have been waiting in a nearby room, to explain that the patient has died.

Meanwhile, outside, the patient who had an epileptic seizure still sits in the ambulance bay waiting for treatment. The staff believe he will have another seizure soon. Nine more patients are about to arrive at the ED by ambulance. There is still nowhere to offload them. Waiting to be seen are a young man with a dislocated shoulder with pain at 8/10 and 'a febrile old lady'. A nurse re-categorises them as Category 2 'so someone can just start seeing them'. It is decided that at least two patients who have been in the department all day will be held overnight—there are no beds to accommodate them ...



***Nine more patients are about to arrive at the ED by ambulance. There is still nowhere to offload them.***



***On a day when presentations were relentless the situation reached a critical point.***

Comments made by staff on the day also highlight the lack of resources and inadequate staffing in EDs, presenting a work environment that is cumulatively and increasingly challenging.

In the next section we try to make visible the passion and commitment of staff to providing high quality health care in the fast-paced and challenging context of the ED.

## Section 4

### *The context of communication in EDs*

The way we use language is always shaped by and reflects the context in which we are communicating. The communicative challenges and risks in EDs arise directly from the unique contextual demands of the ED environment.

We therefore begin our account of the communication demands of the ED by describing the three main categories of context that impact on the ED:

1. material or practical factors that characterise the ED
2. ED participants' different priorities
3. the conventional staged structure of ED consultations.

#### 4.1 Material complexity—the physical demands of the ED context

Factors contributing to the immediate practical complexity of EDs include:

- **Schedules:** EDs operate 24 hours a day, 7 days a week. This means they must be staffed by changing shifts of personnel. Patients are likely to be cared for by many different doctors and nurses during their time in ED. Up to six different doctors and even more nurses may see the same patient.
- **Workplace conditions:** All ED staff work in conditions characterised by frequent interruptions, shortages of space, inadequate staffing, less than ideal resources and equipment failure.
- **Access:** EDs are open to all and it is impossible to predict who is going to come through the door. The linguistic, social and cultural diversity of patients reflects the multicultural demographics of modern Australia.
- **Multicultural workplace:** Australia is experiencing a shortage of locally trained medical practitioners. An increasing number of the doctors working in EDs are overseas trained, often with English as a second language.
- **Spoken communication:** EDs are predominantly a spoken language context. Clinicians talk—to patients, to each other, to healthcare and hospital staff—with written records playing a very secondary role. Pressures of time and tradition mean that a lot

of what is spoken is not recorded in the patients' written records.

- **Training facilities:** EDs are a training ground for student doctors and junior doctors so patients are seen by clinicians with varying degrees of expertise and experience.
- **Multidisciplinary:** EDs are multidisciplinary workplaces, with the major disciplinary division between nurses and doctors. Patients will encounter clinicians who have different roles and priorities within the ED.
- **Time:** Both ED staff and patients are constrained by time in ways not common in other professional or private contexts. Few of the participants (clinicians and patients) in EDs have any real control over their own time and the time taken for medical analyses. Staff are pressured to move, talk and think quickly, while patients can spend long periods in holding patterns, waiting on results, diagnoses, X-rays and returning staff.

These material factors make EDs unique workplace contexts. Individuals and teams with very different disciplinary, cultural and experiential backgrounds are expected to somehow work together in a coherent and systematic way in a high-paced, stressful and uncontrollable environment.

This complexity does not mean that the ED's are chaotic. On the contrary: we found that the patient trajectory is complex but highly systematised, although these systems are not made transparent to the public or to patients.

#### 4.2 Competing priorities in the ED context

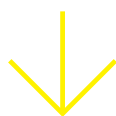
As well as these material contextual factors, communication in EDs is also shaped by competing priorities or different views about what matters most in the context. Three distinct agendas underpin the institution of the ED—those of the organisation, the clinician and the patient. Each has different priorities and expectations.

#### 4.2.1. Organisational priorities

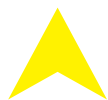
For the organisation, the principal priority is to move the patients through the ED as quickly as possible. Continual pressure comes from policy requirements to account for the time that the patients have to wait and to manage issues of bed block. The organisation expects that junior and overseas-trained doctors will be supervised by senior local doctors but that they will also exercise autonomy and make the clinical decisions required by circumstances. Organisational structures are complex and governed by protocols and procedures that are often difficult for staff to manage when priorities compete or the ED is overtaxed.

#### 4.2.2. Clinician priorities

For the clinician, the priority is to reach a medical diagnosis as quickly and as efficiently as possible. However, clinicians are a heterogeneous and multidisciplinary group. Nurses, doctors and allied health clinicians all have different roles and priorities—one group to manage ongoing care; the other group to diagnose and establish a treatment plan. Within each discipline, seniority introduces a further difference in priorities. Senior doctors must provide guidance and feedback to ensure that their junior colleagues are diagnosing and treating accurately. Junior doctors must focus on following the organisation's protocols and demonstrating their technical competence to their seniors. Although all clinicians share the priority of patient care, our research suggested that the organisation and traditions within EDs provide few structured ways for the groups of clinicians to collaborate in achieving their shared objective. For example, while some EDs do have interdisciplinary handovers, many do not.



***The patient can therefore experience the ED as a journey to a foreign land—disorienting, confusing and alienating.***



#### 4.2.3. The patient's perspective: journey to a foreign land

For the patient, the priorities are to have their anxiety alleviated and to feel that they are receiving expert and informed advice. Often clinicians did not introduce themselves or explain their level of seniority or specialty. From the patient's point of view, the journey through ED is physically stressful because of their presenting medical condition, with the added psychological and emotional stress of finding themselves in the unfamiliar and often incomprehensible environment of the ED. Often patients do not have a clear understanding of how long a procedure will take, how long an absence will be or what will happen to them next. The patient can therefore experience the ED as a journey to a foreign land—disorienting, confusing and alienating.

### 4.3. Structure of the ED consultation: activity stages

The third main contextual influence on communication in EDs is the conventional structure of the ED consultation. Institutionally, ED consultations are organised systematically, with every patient moving through a similar sequence of activities. Each stage can be associated with predictable and often highly constrained communication choices, summarised below and discussed in detail in *The Emergency Communication Report*.

#### 4.3.1 Triage

This is the patients' first contact with the ED process. A nurse assesses the urgency of the presentation and assigns patients a triage category that determines their position in the queue to be treated. The triage nurse must balance competing priorities: the medical priority of patient care, the organisational priority of allocating the correct category and identifying the most appropriate assessment/treatment area and the professional priority of performing discipline-specific practice.

The communication between the triage nurse and the patient is framed by uniform criteria designed to make the process thorough and efficient. Patients are asked to provide limited information in response to a very specific series of questions. They are not given an outline of what to expect during the overall ED journey and patients consistently fail to ask. What information they are given is usually related to approximate waiting times or a general reference to who will see them next.

#### 4.3.2. Nursing Admission

For patients ill enough to require admission into the ED, the nurse takes the patients' personal details,

monitors basic observations and manages pain when necessary. Communication in this stage is challenged by three needs: nursing staff need to manage and adapt their priorities according to changing demands; clinicians need to communicate effectively with the multidisciplinary team; and all staff need to attend to the disorientation patients experience in the ED.

Effective communication strategies in this stage would recognise the patient's transition to the institutional setting of the ED and allay fears about illness or injury. The potential communication problems are that less experienced clinicians will not provide the feedback and information that ease the patients' transition to the ED and that the members within the multidisciplinary team will not collaborate to resolve and share essential information about patients.

#### 4.3.3. Initial Assessment and Stabilisation

A doctor—often junior—completes initial history taking, examination and formulates a treatment/management plan. Both doctors and nurses perform clearly prescribed parallel roles in this stage.

This is the stage when the communication load on both patients and doctors is considerable and often problematic. The gravity of the responsibility for the medical outcomes of the consultation appears to constrain doctors from engaging with patients at an informal level. Doctors tend to maintain a greater professional distance from patients than nurses do. This is evident in their choice of words and the degree to which they respond to patients at a personal level.

The doctor must balance competing medical and organisational priorities. Because of limits on the resources of time and medical expertise, patients are often positioned as passive co-agents in the history-taking process. They are not always given the opportunity to offer an opinion or to ask questions about their own medical condition.

Effective communication strategies in this stage would be those that maximise the exchange of information between the clinicians and the patient about the patient's illness and/or injury and those that establish trust. If treatment is commenced, it would also be important for clinicians to negotiate treatment and explain the reasoning processes for testing and treatment. This is the stage in which doctors and nurses have the best opportunity to develop an interpersonal relationship with the patient as this is the longest stage of the consultation. Paradoxically, it is mostly junior doctors who are responsible for this stage.

#### 4.3.4. Management, Diagnosis and Disposition

The final Management, Diagnosis and Disposition stage is the responsibility of a senior doctor who can make conclusive decisions about the diagnosis and patient disposition (admission, referral or discharge). The stage may involve a multidisciplinary team.

Effective communication strategies in this stage would recognise the patient's need to fully understand their treatment and plan. These include negotiating treatment, explaining the reasoning process behind treatment, repeating key information, checking patient comprehension, providing clear instructions for medication and follow-up treatment. It would also be important for clinicians to allow room for the patient to seek further information.



***The gravity of the responsibility for the medical outcomes of the consultation appears to constrain doctors from engaging with patients at an informal level***



## Section 5

### *The communicative challenges of EDs*

#### 5.1. From context to language: the key communicative risks

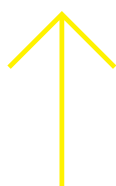
The material, discourse and activity stage factors make the ED a highly complex context in which to be communicating. Our data indicates that communication challenges in the ED carry the risks of the following negative impacts:

##### **Negative impact on continuity and safety of care**

- A patient's continuity of care can be challenged by the complex communicative networks in the ED as patients are attended by multiple clinicians and as consultations are interrupted and affected by space, staff and equipment constraints.
- Information and knowledge about patients can be lost because of the number of clinicians who deal with any one patient and because of poor quality and unsystematic written records.



*Clinicians may lose sight of the patient's human needs for rapport and reassurance.*



##### **Negative impact on clinicians**

- Senior and junior staff can be communicating with patients and other staff in different ways, with the communicative strategies of junior staff sometimes less effective than those of their more experienced senior colleagues.
- Discipline boundaries between nurses and doctors can inhibit the effective exchange of information and collaborative care and can constrain opportunities for team and individual professional development

##### **Negative impact on the patient's subjective experience**

- The patient can be subjected to a significant communication burden because clinicians change frequently and make limited use of written records.
- Clinical and nursing staff can fail to treat patients as agentive co-interactants, instead treating them as passive recipients of the actions and decisions of ED staff.
- Clinicians may lose sight of the patient's human needs for rapport and reassurance. Clinicians who fail to construct an interpersonal relationship with the patient risk not being able to elicit important information from the patient and not gaining patient compliance and understanding for treatment plans.

As a result of these challenges, the quality of the patient's journey through the ED can be compromised significantly and the patient can be exposed to risks. We now discuss some examples of these communication challenges.

## 5.2. Disruptions to continuity of care due to complex communication networks

Our research at the patient's bedside reveals the complexity of communicative practices in ED consultations. We found that between 8 and 15 staff were involved in the care of each patient we recorded. The complexity of the communication is not only due to the number of different clinicians a patient sees but also to the number of interruptions and extraneous interactions around the patient.

For example, one patient, Dulcie (experiencing difficulty breathing), had 326 encounters involving two doctors, five nurses, three ambulance officers, one patient services attendant, one clerical staff member (although the clerical person spoke to the researcher, not Dulcie), one tea lady, one researcher, a wardman, a radiologist, a radiographer, a radiology nurse and a

number of other people who engaged with her in the bedside space. Figure 5.1 shows the network of care around Dulcie.

Dulcie spent 8 hours in the ED before being admitted. We recorded her interactions over a period of 2 hours and 16 minutes, which means she had an encounter every 25 seconds. Dulcie initiated many of the encounters herself—101 in all. She was a trained Assistant in Nursing and said she had learnt:

*that one needed to ask in order to find out what was happening: 'I do [ask a lot of questions], 'cause I've—with the course [AIN], I mean, if you don't ask you don't get—well they can either tell you to shut up == or ( )'.*

Figure 5.2 opposite shows the encounters that Dulcie had. The sheer number of encounters over the four-hour period as well as the environmental and contextual dynamics of the consultation are immediately visible.

**Figure 5.1: Network of care for Patient 52, Dulcie (adapted from Manidis et al 2010b)**

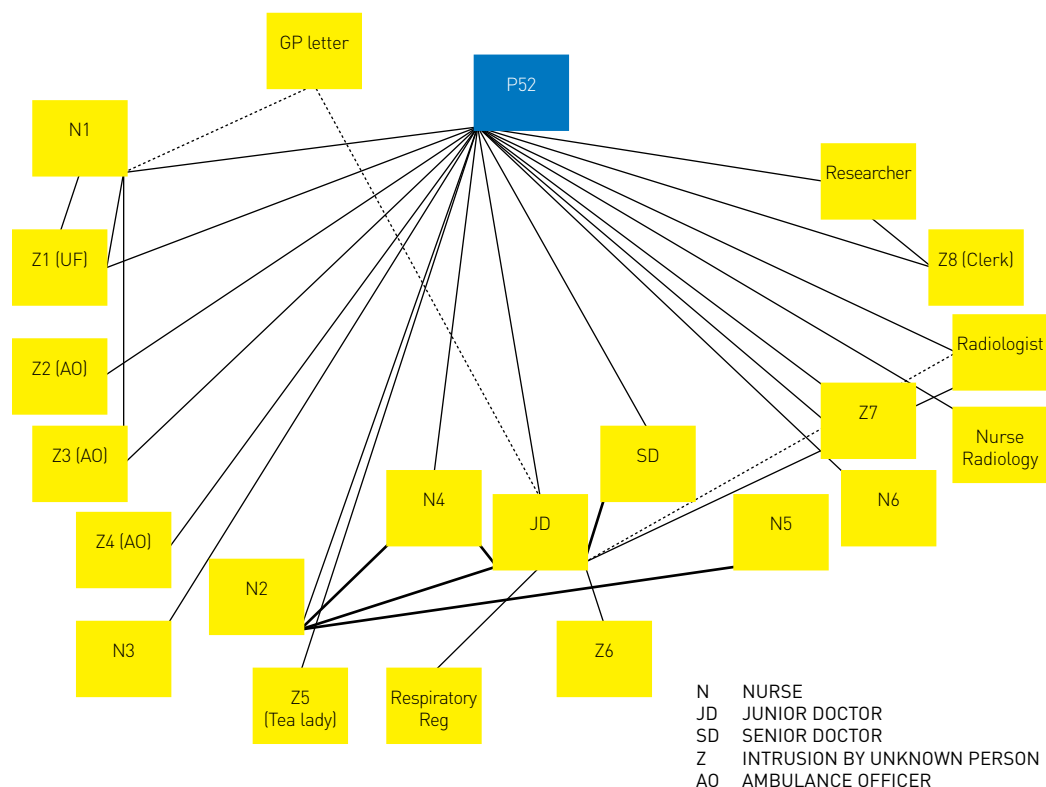


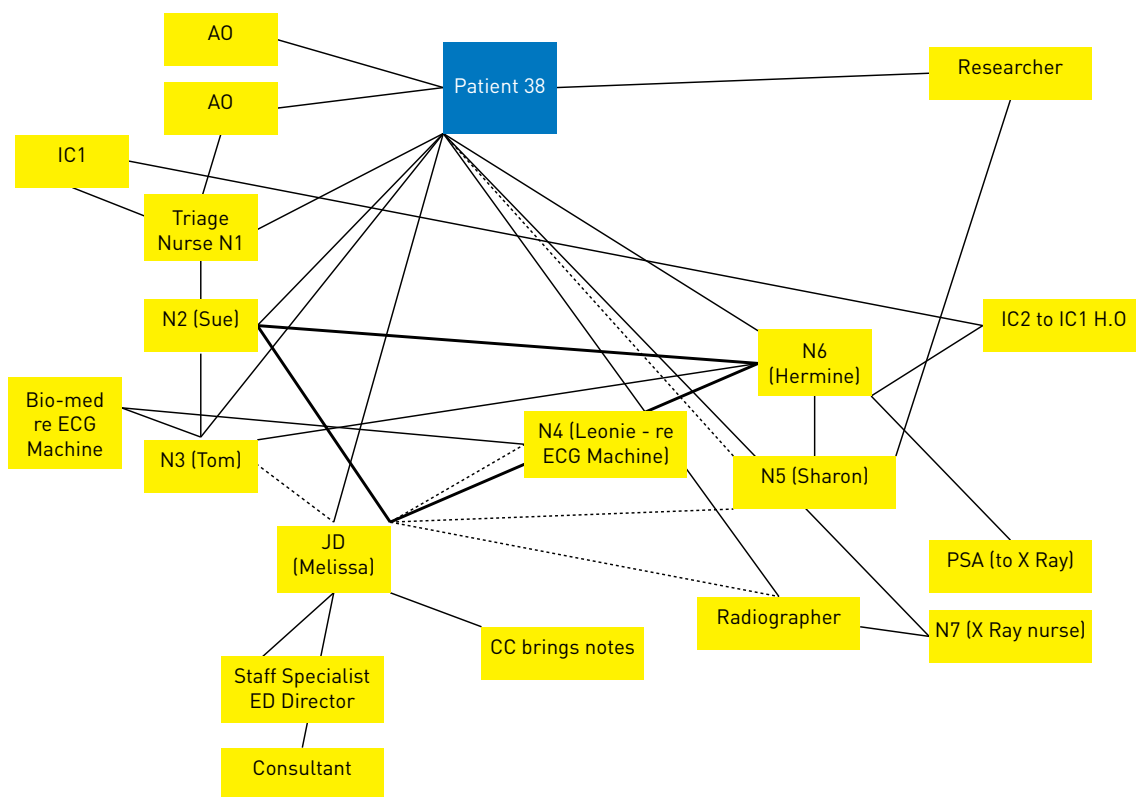
Figure 5.2: Encounters for Dulcie (adapted from Manidis et al 2010b)



Each box represents a new conversation with the patient or between interactants about the patient. Code in box shows who initiated the conversation.

- N = NURSE
- D1, D2 = DOCTORS
- R = REGISTRAR
- P = PATIENT
- DIST = DISTURBANCE AROUND PATIENT
- Z = UNKNOWN PERSON
- EXCHANGE BETWEEN CLINICIANS WITHIN EARSHOT OF PATIENT
- MOVEMENT OF PATIENT TO X-RAY, AMBULANCE, ETC

Figure 5.3: Network of care for patient 38, Denton (adapted from Manidis et al 2010b)



### 5.3. Risks to knowledge/ information transfer

As Dulcie’s example suggests, with so many different people involved in each patient’s care, there are real risks that knowledge and information about patients will be lost in the complex care network. In the words of one communication clerk at one ED, the everyday reality of managing knowledge about patients (in this case patient notes) is a time-consuming task:

- R Do you spend any time looking for patient notes?
- C Probably more than anybody else.
- R How much time? [Laughter]
- C I would probably spend two and a half to three hours of my shift chasing up patient notes.

An example of the failure to share and transfer knowledge occurs with patient 38, Denton, who presented with shortness of breath and a fever. When he first presented to the ED, Denton’s old notes were not with him. Figure 5.3 is a graphic representation of all the staff involved in Denton’s care.

During his 120 minutes of recorded interaction (out of a total four-hour stay in ED), Denton had 225 communicative encounters with clinicians. Figure 5.4 captures these interactions in sequence, with a square marking every time someone spoke to him or about him at the bedside. Is it any wonder that at one point Denton asked, “Who are my specialists?”

Throughout Denton’s stay, one of the questions about him that the clinicians were trying to solve is whether he was a CO<sub>2</sub> retainer (i.e. whether he retains carbon dioxide and should therefore not be given pure oxygen). When he was first admitted to the ED, Denton’s old notes were not with him. They were brought in to the ED relatively early in his stay, but at a number of points the notes went missing, presumably taken away by one or other clinician. Equipment was also a problem on the day, with a faulty ECG machine going offline.

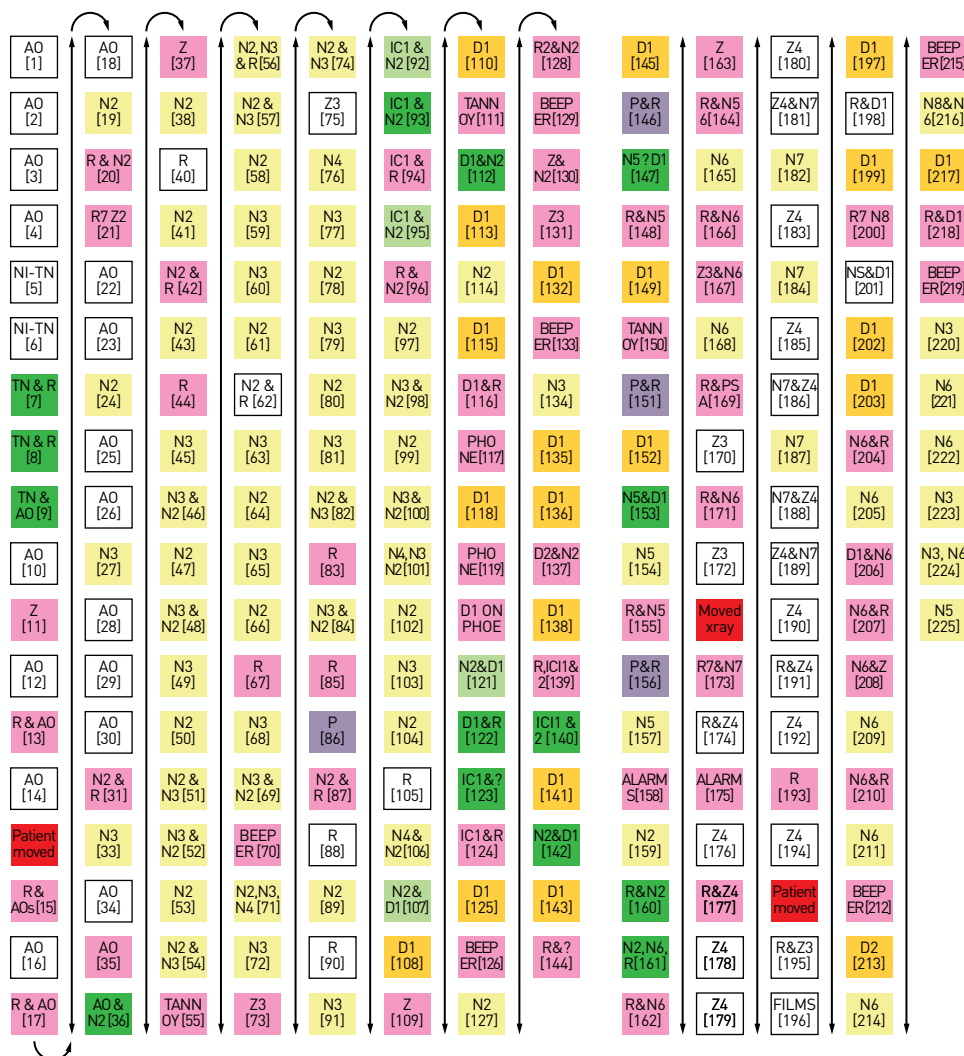
On six separate occasions between 12:55 pm and 16:15 pm, clinicians displayed confusion about this information. Here are extracts from Denton’s interactions:

**Figure 5.4: Sequence of communications with and by Denton (adapted from Manidis et al 2010b)**

Each box represents a new conversation with the patient or between interactants about the patient. Code in box shows who initiated the conversation.

AO = AMBULANCE OFFICER  
 TN = TRIAGE NURSE  
 N = NURSE  
 D = DOCTOR  
 R = REGISTRAR  
 Z = UNIDENTIFIED PERSON

□ AO; TN  
 ■ NURSES  
 ■ EXCHANGE BETWEEN CLINICIANS ABOUT PATIENT WITHIN EARSHOT OF PATIENT  
 ■ EXCHANGE BETWEEN CLINICIANS ABOUT WHAT THEY ARE DOING  
 ■ MOVEMENT OR LOCATION OF PATIENT  
 ■ INTRUSION ON THE CONSULTATION, FOR EG SOMEONE MOVING EQUIPMENT  
 ■ PATIENT CONTRIBUTION  
 ■ D



- (1) 12:55 pm N2 *We don't know if he's a CO<sub>2</sub> retainer?*
- (2) 14.00 pm IC1 *Don't know too much about him.*
- (3) 14.25 pm N5 *I don't know much about him but collapse, wasn't it?*
- (4) 14.30 pm N5 *Is he—he's not a retainer, is he?*
- (5) 16:08 pm D1 *Yes, I think he's a CO<sub>2</sub> retainer ...*
- (6) 16:15 pm D2 *No, because he's not a CO<sub>2</sub> retainer. So remember the gases. Got his old notes there? Remember I said if you look at the bicarb, that tells you what he's a CO<sub>2</sub> retainer. He's got normal bicarb so ...*

Example 1 is Nurse 2, talking to the Ambulance Officer. She admits staff do not know if Denton has this condition, which would suggest the need to find out but it doesn't get followed up on. Nor does the Nurse in Charge (example 2) follow up. In examples 1, 2 and 3 the three different clinicians all use the same expression (*don't know*) to register their lack of knowledge about the patient's history and condition.

This is further queried by Nurse 5, the temporary relief nurse covering the lunch shift, in example (4), when she now presumes that he's not a retainer. The first doctor to see Denton (three hours into his ED stay), the JMO, picks up on this lack of knowledge but makes no definitive comment (*I think he's a CO<sub>2</sub> retainer*).

To this point, then, every clinician has expressed a lack of certainty but no-one has tried to establish whether the patient is in fact a CO<sub>2</sub> retainer or not. It is only when the senior staff specialist, D2, comes in at 4:15 pm that a definite opinion is given and he directs the JMO to the patient's notes. The question is why for three hours no-one tried to find out if the patient was or was not CO<sub>2</sub> retainer. The most likely answer is that because so many different staff were involved in this patient's care, no-one accepted the responsibility to locate and check his notes.

This example demonstrates not only the risks to patients of discontinuous care by so many different clinicians but also the failure of the clinicians to collaborate: no-one resolves the issue and no-one provides this key information to subsequent clinicians.

## 5.4. Different effectiveness of senior and junior communication styles

Seniority emerged as an important communication variable. Our data indicates that junior and senior doctors display different patterns of talk in their interactions with patients. For example, junior doctors may be responsible for the longest stage of the ED consultation for triage categories 3 to 5, that of Initial Assessment and Stabilisation. Junior doctors are often so focused on performing this challenging and difficult task that they concentrate on medical aspects and do not always develop an effective interpersonal relationship with the patient. One senior doctor told us that junior doctors avoid getting involved interpersonally in case patients want medical information that the junior doctors feel too inexperienced to provide. By contrast, in the final Management, Diagnosis and Disposition stage, senior doctors are more likely to attend to the interpersonal needs of the patient and to negotiate compliance with treatment.

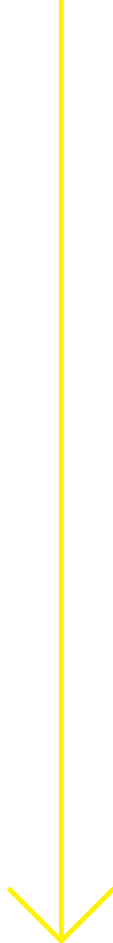
Junior doctors are still learning about their situational practice and of course they vary in experience, training and clinical skills as well as in cultural approaches or differences, all of which can impact on care as the example below indicates.

A junior doctor offers Patient 76, Zahara (abdominal pain) stronger pain relief. Zahara had earlier told the junior doctor that she was allergic to codeine, but the junior doctor appeared to have forgotten this piece of information:


- [Early in the history taking]
- D1 Um, and any allergies to any medications?
- P Um nuro- not nurofen, codeine.
- D1 Codeine?
- [About ten minutes later after the physical examination]
- D1 Do you want to try some Panadeine forte?
- P Am I allowed to?
- D1 Hmmm hmm.
- P Panadeine forte. Has that got codeine in it?
- D1 Yes. Oh I'm sorry.
- P ( )
- D1 ( ) your allergies.

When the junior doctor offers Panadeine forte the patient has a choice either to challenge the doctor or to trust the junior doctor's judgement. The patient tentatively challenges the junior doctor's choice. The junior doctor replies in the affirmative but the patient persists and questions the use of Panadeine. The junior doctor replies in the affirmative and then suddenly remembers the allergy.

While the previous example suggests that the junior doctor finds it difficult to retain important information



***While ... the junior doctor finds it difficult to retain important information under the stressful demands of his role, seniority is also associated with different patterns of talk when interacting with patients.***



under the stressful demands of his role, seniority is also associated with different patterns of talk when interacting with patients.

The following examples are taken at different times in the consultation with the same patient, Patient 37, Nola (PR bleeding). In the consultation, Nola has two rectal examinations, the first conducted by the junior doctor, the second conducted by the gastroenterology registrar. In the lead-up to the junior doctor's examination we know that Nola was very embarrassed about the rectal examination she had undergone earlier at the GP, relaying how she had reacted when her GP said he wanted to examine her in his rooms, to which she had exclaimed *'Here and now?'* When the junior doctor then said *'I'm going to have to do an examination of*

| Senior practice   | Junior practice   |
|---|---|
| D3 <i>Could I get you to roll on to your side?</i>  | D1 <i>Just gonna pop the bed down.</i>  |
| P <i>Yeah, but what about the thing-ohs, are they OK? These.</i>  | P <i>Now, what's gonna happen?</i>  |
| D3 <i>The drip?</i>   | D1 <i>(.), So what I'll get you to do is to roll over on to your side.</i>                            |
| P <i>Yeah.</i>  | P <i>Ooh, what about this? Is that OK?</i>  |
| D3 <i>Yeah, the drip'll be alright.</i>   | D1 <i>That's OK. Yep, just shuffle across and tilt towards me. That's right.</i>                      |
| P <i>OK.</i>  | P <i>(.). [Background noise, Distant from mic]</i>  |
| P <i>I've got a ...</i>   | D1 <i>OK.</i>   |
| D3 <i>That's it.</i>  | D1 <i>Now can you bring your knees up? Bend your knees up for me. Do you think you could do that?</i> |
| P <i>Now, I've got this horrible old pad still on from this morning.</i>  | P <i>Yes, how's that one. Oh excuse me, Doctor (.) [Distant from mic]</i>                             |
| D3 <i>Don't you worry about that. I'm just going to have a bit of a--sneak a bit of a look around it, OK?</i>             | D1 <i>It's alright. [Background noise and Voices]</i>   |
| P <i>OK.</i>  | D1 <i>I'll just pop your pants down.</i>  |
| D3 <i>That's it. Roll over. Good-oh. Anyone in your family had bowel cancer at all Mrs [Patient's surname]?</i>           | P <i>Patient groans.</i>  |
| P <i>No.</i>  | D1 <i>Now first of all I'm just going to have a look at the outside of your bottom, OK?</i>           |
| D3 <i>Have you lost any weight recently?</i>  | D1 <i>Right.</i>  |
| P <i>No.</i>  | D1 <i>I'm just going to pop one finger into your bottom, OK? Patient groaning</i>                     |
| D3 <i>Oopsy-daisy. Just see if you can roll right on over. That's the way. Had any trouble with tummy pains recently?</i> | D1 <i>That's it all over. (.) [Distant from mic]</i>  |
| P <i>No.</i>  | P <i>Pull up my pants (.)"</i>  |
| D3 <i>Just relax, I'm going to have a little feel.</i>  |   |
| P <i>Right.</i>   |   |
| D3 <i>All done."</i>  |   |

## Senior Practice

In this example, the senior doctor has a very different approach to Nola's rectal examination than the junior doctor's alongside. He is not as explicit about the step-by-step process and this may be less confronting. He also combines the examination with a history taking; he does not spell out the procedure; he uses more fluent procedural language, which accompanies his actions. He uses everyday colloquial language such as 'sneak a bit of a look' (as opposed to 'I'm just going to put my finger up your bottom') and 'oopsy daisy', 'Good-oh' and 'Just relax, I'm going to have a little feel'. In the senior doctor's examination, Nola, who has also been schooled by the earlier examination, does not display her embarrassment or discomfort once. The senior uses more instructive language than the junior doctor: 'Don't you worry about that' and 'Roll over'.

## Junior Practice

In this example, the junior doctor uses very procedural language e.g. 'Can you bring your knees up I'll just pop your pants down' and so on. The junior doctor follows what they are taught to do, the protocol, which is to explain and spell out each step of the examination process. This makes the procedure somewhat laboured and maybe even a little more daunting. On a number of occasions Nola is heard to groan during the examination. She was discomfited and embarrassed. Although the junior doctor instructs the patient early on 'Yep, just shuffle across and tilt towards me', she subsequently asks Nola gently to comply: 'Now can you bring your knees up? Bend your knees up for me. Do you think you could do that?'

*your bottom. OK?* she replied 'That's gonna be horrible...'. She was also embarrassed about the pad she was wearing for the bleeding, and concerned about unhooking the drip that was attached to her. Both doctors use a comfort statement about the drip before the examination: the junior doctor says 'That's OK'; the senior doctor says 'Yeah, the drip'll be alright'. Below we see the language differences in the way the two doctors went about the examination.

Seniority was also a variable among nurses, with more experienced nurses providing more information and taking more time to establish rapport with patients than their junior colleagues, who were inclined to focus on procedures and protocol.

The examples following with Patient 71, Wilson (sore toe), and Patient 52, Dulcie (difficulty breathing),

occur at slightly different points in their Admission stage, but the more experienced nurse in Wilson's case has a good grasp of what patients want to know, whereas the new graduate nurse who interacts with Dulcie provides very little information about what will come next in her care. We contrast the two examples to illustrate how a senior nurse has developed both awareness of what patients want to know and skills in how to let them know what is happening. She combined this awareness and skill with a systematic approach to explaining to patients what the ED process was about. In the less effective example, with Dulcie, the new graduate nurse focused intently on his own protocols, provided very little future-signposted information and forgot to follow up on Dulcie's request for a bed warmer.

| More effective   | Less effective  |
|--|---|
| <p>N2 <i>[Siren in background while Nurse 2 is talking]. Yes. I've got a form here for you. It's to enable you to understand what's going on with you while you're here. OK? So you fill it out when you know who your nurse is and what your doctor's name is, what tests you've had or what tests you're waiting for or what medication you're waiting for, things like that so you know ... so you're not just sitting there going 'What's going on?' [Family member laughing at the siren] Alright? Whether you can eat and drink, you know, those sorts of things. So they're the sorts of things that you ask, and you can fill that out if you want. [Fire alarm is tested—this happens as N2 is talking]</i></p> <p>P OK.</p> <p>N2 <i>Or the nurse will fill it out.</i></p> <p>P <i>Alright.</i></p> <p>N2 <i>So ask her what her name is.</i></p> <p>P OK.</p> <p>N2 <i>And just so you know what's going on so you're not sitting here==</i></p> <p>P <i>==Yup==</i></p> <p>N2 <i>==Going 'I wonder what's happening?'</i></p> <p>P <i>[Chuckles]. Alright, then.</i></p> <p>N2 <i>So what is happening is that you're waiting for your nurse to come over and introduce herself but she's a little bit tied up so she'll be with you as soon as == she can.</i></p> | <p>N2 <i>Hi I'm Sandy, I'm a nurse.</i></p> <p>P <i>How are you?</i></p> <p>N2 <i>Good thanks.</i></p> <p>N2 <i>OK. So your full name please?</i></p> <p>P <i>Dulcie [surname].</i></p> <p>N2 <i>Lovely. And your date of birth please?</i></p> <p>P <i>[DOB].==</i></p> <p>N2 <i>==Terrific. Alright. Just lie down on the bed for me please, Dulcie. [Patient coughs] .....[Nurse leaves to get armband]</i></p> <p>N2 <i>OK. So I'll just ask you again, Dulcie, for your full name please.</i></p> <p>P <i>Dulcie [surname].</i></p> <p>N2 <i>And your date of birth please?</i></p> <p>P <i>[DOB]</i></p> <p>N2 <i>Thank you.</i></p> <p>P <i>I'll get the six out yet. Twice I've had a shot at that.</i></p> <p>N2 <i>Alright.</i></p> <p>.....</p> <p>N2 <i>You in any pain at all Dulcie?</i></p> <p>P <i>No. Me feet are frozen, I don't know why.</i></p> <p>N2 <i>OK.</i></p> <p>P <i>Oh, gawd.</i></p> <p>N2 <i>I'll keep that in mind. [Chuckles]</i></p> <p>P <i>Need a bed warmer.</i></p> <p>N2 <i>Be back soon. [N2 leaves at 12.03pm] returns at 12.35pm</i></p> |

### More effective

In this example, Nurse 2, one of the admitting nurses, explained to Patient 71, Wilson (sore toe), how to complete a 'patient progress' form. After explaining this to Wilson, which took a considerable time, she then proceeded to tell him (in bold) where he was up to in his care and importantly, what would happen next.

A little while later Nurse 5 who also looked after Wilson, was impressed to see the sheets were being of some, but limited use:

N5 *You know Wilson, you're one of the very few that have actually filled one of those out, I'm very impressed."*

### Less effective

In this example, Nurse 2 has a very different approach to his experienced counterpart in the more effective example. He is a new graduate nurse and comes into the room with a pad and writes notes as he speaks to Patient 52, Dulcie (difficulty breathing). Nurse 2 is very focused on protocols (institutional knowledge—getting the patient's name and date of birth correct etc.). His introduction is very different to the norm of what we have recorded. Nurse 2 gives his professional role without any institutional affiliation, 'I'm Sandy. I'm a nurse'. Shortly after that he has to get an armband—and when he returns two minutes later, he focuses again on the protocols of rechecking Dulcie's name and date of birth and re asks her for these details. A little later on, he does not explain why he wants Dulcie to lie down, and when Dulcie says her feet are cold, he says 'I'll keep that in mind'. He leaves without any explanation of what processes will come next, does not bring the bed warmer and returns half an hour later. He gives Dulcie no explanation about what will happen next. He leaves her confused about whether or not he is coming back. Dulcie said after he left 'Ah, well I think he's coming back isn't == he?'

In the less effective example with Dulcie, the new graduate nurse's focus was on institutional protocols and his communication was formulaic, using rote expressions (e.g. 'OK, so your full name please. And your date of birth please?').

In section 6 we examine some of the more effective communication strategies that junior clinicians could be encouraged to use.

## 5.5. Discipline boundaries and barriers to communication

Our research suggested there is inadequate cross-talk between doctors and nurses in the ED. Medical and nursing staff rarely worked together or communicated with each other around the patient bedside. For the most part, consultations were made up of (several) doctors and (several) nurses individually and asynchronously attending to the patient. The high pace of work and increasing demands on their time mean they have few opportunities for cross-disciplinary handover, briefings or professional development. Many

EDs hold no joint handovers or meetings and nurses often complain about not being able to find doctors' notes. Separate care meant segmentation of patient information. This translates to a potential risk to patient safety.

While such practices reflect the well-defined and distinct role delineations of medical, nursing and allied health staff, they fail to capitalise on the benefits of active interdisciplinary communication, including the risk reduction that comes from sharing knowledge and information, and the opportunities for team and collegial development. The example with the patient Denton, discussed above, where nurses and doctors do not raise with each other the need to clarify Denton's CO<sub>2</sub> retainer status, is one example of a potentially serious failure of staff to take an interdisciplinary approach to the patient.

## 5.6. Communication burden on patient

Because clinicians change frequently and make limited use of written documentation, patients may be questioned repeatedly by different clinicians. For example, here is the same patient being questioned by three ED staff:

### Triage Nurse

*N1 My name's Lorraine. Now tell me what's actually happened.*

*P On Friday I was picking up the kids from my sister's place at about 4:00 or 5:00 and I tripped on, it was one step, and I tripped on the outdoor rubber mat cause I had heels on.*

### Doctor

*D1 My name is Tatiana, one of the doctors here. How can I help you?*

*P I've hurt my ribs ... that's all.*

*D1 Ah-hm. Do you remember how and when was that?*

*P It was on Friday.*

### Nurse 4

*N4 Did you have a fall or something or what happened?*

*P On Friday I fell down—tripped on a mat, outdoor mat.==*

*N4 ==OK.*

We understand that the benefits of recursive questioning are that clinicians can check information straight from the source and can jog the patient's memory if required. Further, we recognise that asynchronous bedside attendances and recursive questioning are systemic and historical in origin and a feature of the way the ED is set up physically. They are

a part of the way care takes place across space and time, rather than being indicative of ineffective practice by individual clinicians.

The benefits of this historical approach may outweigh the communication burden this creates for the patient as they respond several times to the same or similar questions in one consultation.

However, patient reports indicate that this recursive questioning can be seen as redundant and may even undermine patient confidence in clinicians. The exhausted and anxious patient can be left wondering why there appears to be no shared knowledge between clinicians. Most patients are not aware—and are not made aware by staff—that the ED is a training ground. Patients therefore do not appreciate the need for different clinicians to ask the same questions. Clearer explanations to patients, plus better quality written notes so that the senior doctor does not need to start the examination completely from scratch, would reduce this burden on the patient.

## 5.7. Casting the patient as passive

In the interests of getting a quick diagnosis or managing the patient efficiently, clinicians may constrain the patient's ability to be heard and may limit the explanations they give the patient about their illness and about the ED system.

The dominance of the medical script in doctor and nurse communication reflects the medical and institutional priorities of the ED context. It also reflects normative practice: the bio-medical imperative of finding out in the quickest possible way what is wrong with the patient. But the risk is that the patients' concerns can be overlooked or not responded to empathetically.

Perhaps one reason clinicians discourage patients from contributing is that patients and clinicians have different goals in the consultation. Our data shows that while the clinician's interaction was commonly geared towards diagnosis and treatment, the patient's interactions indicate that they desired something more—a sympathetic reaction, a sign of understanding, the opportunity to direct the information flow.

In many of the consultations we identified divergent trajectories between a doctor's line of questioning and the patient's desire to foreground other information, from the intensity of pain they are feeling, to various details surrounding their illness or complaint. Sometimes the doctors did not pick up on the patient cues as they focused solely on the medical diagnosis.

In the following example, the junior doctors fail to pick up on signals provided by a family member about the patient's condition. Patient 1, Fahime (dizziness, feeling stressed), spends about three hours in the ED. The patient is of Middle Eastern background and the

junior doctors are of English-speaking background, in their mid-twenties:

D1: *Have you been eating and drinking sort of reasonably normally?*  
P: *I drink but I haven't been eating.*  
F: *==She hasn't been eating well because she's just had a recent death in the family.==*  
D1: *OK*  
F: *== A couple of days ago.==*  
D1: *OK.*  
F: *==Which is her grandmamma.==*  
D1: *OK.*  
F: *So she's been spending a lot of time at her mother's house and no she hasn't been eating well obviously distressed because of that.*  
D1: *OK. Sure but you've been keeping up your fluids and drinking and==?*

The junior doctor fails to establish any rapport with patient. He also does not pick up on a vital clue provided by a family member (*a recent death in the family*), repeated later: *she hasn't been eat well obviously distressed because of that.*

The second junior doctor was similarly insensitive and missed further clues:

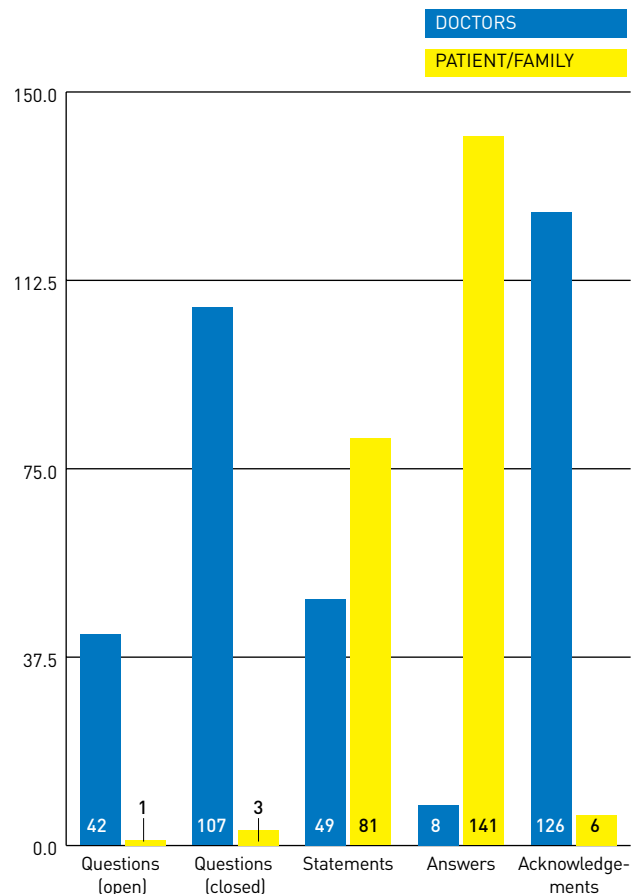
D2: *And is – what's wrong with your son?*  
F: *He's just stressed he's and==*  
D2: *==OK.==*  
F: *==And the situation was inflamed and she became stressed because of that and it added ==to her.*  
D2: *==Sure.*  
F: *Yeah.*  
D2: *OK. OK. So you—so does the room spin round or is it that you just feel ==light-headed?*  
P: *==Last night I felt like the room spin out for two minutes, one minute I think.==*  
D2: *Uh huh.*

In fact, Fahime's son had tried to commit suicide and was in the ED at the same time. The patient was finally diagnosed with depression. This diagnosis could have come much more quickly if the patient cues had been picked up on and an attempt made to establish a relationship with the patient. Instead, the junior doctors appeared wedded to a particular question protocol.

Figure 5.5 shows the different contributions made by doctors and Fahime and her family while in the ED. The figure shows the striking difference between questions asked (149 by doctors; 4 by Fahime and her family) and answers given (141 by Fahime and family; 8 by doctors).

It is reasonable to expect that in the initial history taking stage the junior doctors might ask many questions and make few statements about the patient's illness. However, this same pattern continued

**Figure 5.5: Analysis of questions and statements for Patient 1, Fahime**



throughout Fahime's stay in the ED. In addition, most of the questions asked by the doctors across the consultations were closed (yes/no) questions. There were very few open questions (e.g. 'How often do you get dizzy like this?'), which would have given the patient more scope to expand on her information.

Our analysis of the interactions with Fahime show that at no stage did the patient get the opportunity to tell her story. As a result, the 'real' reason why Fahime was in the ED was not diagnosed until the last senior doctor came in. She was finally diagnosed with depression and advised to see her GP. This analysis suggests that either the patient did not feel that it was appropriate for her to ask questions or she felt too intimidated by the context to do so.

## 5.8. The need to create interpersonal rapport

As the previous example shows, the discordance between what the patient wants to say and what the clinician wants to hear is associated with a very limited focus by some clinicians on the interpersonal dimensions of interaction. The impact of this medical concentration is that effective relationships between clinician and patient are not established, which in turn creates the risk that the quality of care will be compromised.

In the following lengthy extract, we see a repeated lack of empathy and rapport, or acknowledgement of the patient's pain, by the clinical staff, possibly because the patient's illness was due to a breast augmentation. This first exchange is between Patient 15, Natasha (post-op infection) and the triage nurse:

- N: *And what brings you into the hospital?*  
P: *Bloody agonising—agonising pain. I had a breast aug ... I had a breast augmentation three weeks ago.*  
N: *Yes.*  
P: *And I felt pains in my chest. I think they are a normal part of the==(.).*  
N: *OK.*  
P: *And then today I started to really feel unwell and I feel like it's a heart attack actually. Just really sharp pains in my chest and my left breast is swollen ( ) fever, gone down my arm, you know ...*

The nurse concentrates on details of the medical condition, providing no recognition of the patient's repeated expressions of pain:

- N: *OK, so it's particularly the left one.*  
P: *It's the = right one ...*  
N: *And = = ( ) swollen, or ...*  
P: *Yep, yep, and that's where all the pain is.*  
N: *OK. And how long has that been like that for?*  
P: *The pain has been since I had the op, but it's ...*  
N: *OK, but the swelling and the ...*

***Our analysis of the interactions with Fahime show that at no stage did the patient get the opportunity to tell her story.***

- P: *Probably since early this evening, this afternoon.*  
N: *So it's just today that it's come?*  
P: *Well no, you've had pain for a while.*  
P: *I've had pain and it's got progressively worse but the real temperature and the agonising pain was tonight, today.*  
N: *And sorry, you said three weeks ago?*  
P: *Three weeks ago, yup.*  
N: *You had it done, OK. And have you had a follow up appointment or anything?*  
P: *I have, yes, I did.*  
N: *Yes. When was that?*  
P: *When did I have that? Last week? It was fine.*

When the patient said:

- P: *I actually am in such pain, I can't tell you.*

The nurse still offered no words of comfort:

- N: *It looks, yeah, it looks bigger than that one.*

And this continued:

- P: *Very sore, even that is killing me.*  
N: *Yeah.*

Even when the nurse explained that such infections were relatively common, she avoided making any overt interpersonal gestures. However, she did attempt to reassure the patient by explaining that such infections were relatively common and could be treated easily:

- N: *==Yeah, look, you know, they are—they are relatively common. Um, and it's—you know, it's not due, not due to anything, such as hygiene or anything like that. It just happens sometimes. And certainly not remarkable, but easily treated most of the time.*

The nurse's later comments to a fellow nurse seemed to sum up her approach to the case:

N: *I think—I think it might be alright. She seemed quite—she's got a—she had a boob job done ( ) got infected.*

After a three-hour wait, the patient was seen by a (male) doctor. The patient was concerned, as with the triage nurse to discuss her pain which was not picked up on by the doctor:

D: *Right. So what happened? You had the operation and ...*

P: *And I've just been in terrible pain.*

D: *Only on the left side?*

P: *On the left side, yeah.*

The doctor then asked a series of specific questions:

D: *Any discharge from the area? Right. It's not oozing? It's got no oozing?*

When the patient described her pain explicitly, the doctor continued to focus on the medical:

P: *But it's definitely an infection I'm in agony and it's there, and just down my arm...*

D: *Have you had temperature == ( ) and all of that?*

P: *== Yeah, my temperature is high, yeah. Absolutely.*

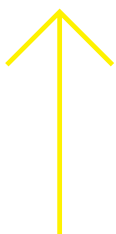
D: *So the operation was about three weeks ago? ==*

P: *==Three weeks ago.*

D: *Who did it?*



***By giving patients agency (i.e. power) in the process, clinicians help patients become involved and gain a sense of control over their own health care***



The doctor then examined the patient, and continued questioning her in order to establish a diagnosis, and begin the process of treatment. The doctor prescribed medication to bring the patient's temperature down, but did not mention her pain. Even when the patient reminded him about the pain, the doctor did not respond empathetically:

D: *And no allergies, any medications or anything? OK. Let's have a look at it. We'll give you something in a minute to bring the temperature down.*

P: *And the pain.*

D: *Yeah. What sort of thing did they give you for pain normally?*

It was only when the patient cried out in pain following an injection that the doctor made his first interpersonal gesture; however, the focus quickly returned to the medical:

D: *I'm putting in a drip so we can give you some access, that will give you the pain relief through that, we take the bloods through that as well. Just a sharp [], going one, two, three.*

P: *Oh. Jesus Christ. Ow, ow.*

D: *Sorry.*

P: *Ow. Ow.*

D: *Sorry. Oh, that's fine, that's the worst bit. You haven't been vomiting have you?*

This example shows a repeated failure to build an effective relationship with the patient.

Establishing a positive interpersonal relationship with the patient has implications beyond making the patient 'feel good' about his or her experience in the ED, although as one of the roles of EDs is to provide satisfactory public service, this subjective experience is also important. The evidence we have from the many recorded interactions is that positive interpersonal relationships between clinicians and patients result in more collaborative interactions, which in turn produce better clinical outcomes, such as mutually agreed treatment plans and better patient compliance.

By giving patients agency (i.e. power) in the process, clinicians help patients become involved and gain a sense of control over their own health care. Reassuring patients, alleviating their anxiety and acknowledging their personal experiences of illness and injury are other ways that clinicians can make the ED experience a more positive one. That is, we argue that to deliver effective care, clinicians must also communicate care effectively.

In the next section we identify the strategies that promote effective communication.

## Section 6:

### *Effective clinician–patient communication*

Our analysis of how clinicians and patients spoke, listened and responded to each other in ED interactions shows that two broad areas of communication have an impact on the quality of the patient journey through the ED:

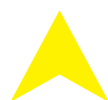
1. how medical knowledge is communicated
2. how clinician–patient relationships are established and developed.

It is our proposition that patient-centred care should reflect both these aspects.

We argue that in order to improve the effectiveness of the medical care delivered, clinicians must find more accessible and empathetic ways to communicate medical information and they must establish a more individual, ‘human’ connection with patients.



*...the most effective clinicians sought to integrate medical knowledge and expertise with a concern for establishing a positive interpersonal relationship with their patients*



Many doctors told us that they believe that the heavy patient load and the intensity of ED work means there is no time to build a relationship with the patient or to establish rapport and empathy. However, we have sufficient evidence from the transcripts (for example, the Fahime interactions discussed in section 5) to indicate that without developing this relationship and leaving space for the patient to tell their story, an effective diagnosis is likely to take longer to achieve and patient understanding and compliance with treatment is less likely to occur.

We identify two strong rationales for clinicians to build an interpersonal connection. Firstly, the interpersonal aspects of the communication between clinicians and patients help to personalise medical knowledge, making it relevant to individual patients, which in turn makes it more likely that patients will understand it. Secondly, building relationships with patients also promotes the patient’s agency through a process of collaborative knowledge-building and shared decision-making. This makes it more likely that patients will comply with treatment and advice.

Recorded clinicians at the five EDs varied significantly in the degree to which they established effective relationships with their patients, with factors such as experience and seniority influencing this process. Our analyses indicated that the most effective clinicians sought to integrate medical knowledge and expertise with a concern for establishing a positive interpersonal relationship with their patients, a relationship that encouraged—or at least allowed—the patient to collaborate in the process.

The key communicative strategies to achieve these two essential tasks and their subcategories have already been set out in tables 1.1 and 1.2. *The Emergency Communication Report* presents and discusses examples of each category. Here we highlight the main points that can help clinicians bridge the information and interpersonal communication gaps. First, however, we briefly review the important role of questions in ED communication.

## 6.1. The role of questions in the ED

Asking and answering questions is one of the principal ways that clinicians and patients communicate within the ED. Typically, clinicians use questions to uncover the medical aspects of the patient's condition, while the patient's main contribution is to provide information in response. Although meanings are co-constructed through this question and answer process, clinicians clearly dominate the talk and set the agenda for the consultations.

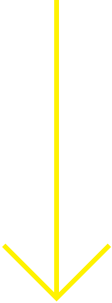
The kinds of questions asked by clinicians vary according to the type of information they want to establish. We identified a number of different types of questions in our recorded data. These are the ones clinicians most commonly use:

### Direct questions

These are of two kinds: **open questions** (such as *'How can we help you today?'*; *'Have you got any pain anywhere?'*) and **closed questions** (such as *'And have you um ... have you got a history of angina or anything like that?'*). **Open questions**, which give patients discretion in relation to their responses, are used throughout the consultation to encourage patients to provide background information relevant to the diagnosis. **Closed questions**, which tend to limit the patient's response to a 'yes' or a 'no', are used to probe for more specific information. These kinds of questions show no presuppositions by the clinician and are easily recognised as requests for information.

### Assumptive questions

These are questions in statement form (such as *'So you're totally pain free at the moment?'*; *'So you came in this morning with a bit of chest pain?'*). They are used to clarify information, or to check the clinician's understanding of a specific piece of information. Assumptive questions are often constructed from the words or meanings conveyed by patients in their answers to previous questions. That is, a clinician picks up on something a patient has just said (*'I felt a bit of pain in my chest'*) and forms an assumptive question to probe for more details (*'So you came in this morning with a bit of chest pain?'*). Assumptive questions are useful when a clinician wants to focus the patient's attention and narrow the field of responses that patients can give. They also demonstrate that the clinician is listening to and building on what the patient says. The reply can be limited to a 'yes' or a 'no' but unlike closed questions, assumptive questions implicitly invite patients to provide a more expansive response, e.g. *'Yes, and ...'* or *'No, but ...'*



*...clinicians' use of questions can position patients as passive participants, whose only role is to respond as briefly as possible to the clinicians' requests for information*



### Information command questions

These are questions in the form of imperatives or commands to provide information, e.g. *Tell me about that*. These questions directly ask for information without prescribing limits on the patient's response.

Although there is certainly more to effective clinician communication than asking questions, our analysis shows that how and when clinicians use these question types is often the difference between more effective and less effective communication. Questions can be used to encourage patients to contribute relevant information and become collaborators in their diagnosis and treatment, perhaps through asking questions of their own. Alternatively, clinicians' use of questions can position patients as passive participants, whose only role is to respond as briefly as possible to the clinicians' requests for information. We now review the strategies clinicians used to achieve the dual goals of communicating medical knowledge and constructing relationships with patients. These strategies are summarised in Table 1.1 on page 9.

## 6.2. Bridging the information gap—effective strategies for developing shared medical knowledge and decision making

### 6.2.1. Make space for the patient's story

Many clinicians are aware that it is an effective diagnostic strategy to give the patient the space to tell their story of their illness and injury. After all, patients are the most valuable source of information about themselves. However, less confident (often more junior) clinicians often do not give the patient the opportunity to discuss their anxieties and state their concerns. We were surprised to find very few examples across all five EDs of interactions that started with a doctor asking the patient what they thought was wrong with them, what they were most worried about and/or why they had come to the ED.

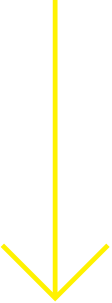
While we acknowledge that clinicians are under pressure to set the agenda in the ED, our data indicates that allowing patients a greater opportunity to contribute to building shared knowledge may be a way of making the patient journey more efficient as patients may provide crucial medical information themselves. At the same time, patients have the satisfaction of knowing that they have been given the opportunity to express themselves.

### 6.2.2. Recognise the patient's knowledge and opinions about their condition

Giving the patient space includes not just asking for but also respecting the patient's opinion of his or her condition. The most effective clinicians listen actively to their patients' accounts and validate the patient's contribution to the consultation.

### 6.2.3. Explain medical concepts in commonsense language

One of the challenges clinicians face is that they must diagnose using scientific understandings and terminology but communicate with patients who do not 'speak' the bio-medical discourse. Effective clinician-communicators learn to translate complex medical concepts and terminology into vernacular language that patients can understand. Clinicians can help patients register and retain information firstly, by considering what information is important from the patient's point of view; secondly, by ensuring they use everyday terminology where appropriate; and thirdly, by repeating key facts at different times.



*Clinicians can help by setting out clearly the steps the patient is likely to go through and the different demands that will be made of him/her along the way*



### 6.2.4. Spell out explicitly management/treatment rationales

An important role of ED clinicians is to provide patients with clear information about their medical conditions and their ongoing testing, treatment and management plans. Some clinicians make their reasoning processes available to the patient. By including patients in this way, clinicians can provide patients with crucial knowledge, which gives them the opportunity to participate in the decision-making process.

### 6.2.5. Provide clear instructions

Part of providing patient-centred care through talk in the ED involves making sure the patient has clear instructions about medication and other follow-up treatment or appointments. This has a direct relationship to patient safety.

### 6.2.6. Signpost the hospital process

Most ED patients feel anxious, disoriented and confused by what's happening to them in the ED. While clinicians often explain the ED processes, patients do not always fully grasp or retain this information. Clinicians can help by setting out clearly the steps the patient is likely to go through and the different demands that will be made of him/her along the way.

### 6.2.7. Negotiate shared decision making about treatment

Earlier, we argued that effective communication recognises the patient's agency in the interaction. If clinicians have allowed space to the patient to tell their story, have found out what the patient knows and have ensured the medical information has been communicated clearly, then they are likely to have already put the patient in a relatively empowered position. The next step—usually reached during the Management, Diagnosis and Disposition stage—could be to include the patient in decisions about treatment. As Cordella (2004) noted, if the patient disagrees with the recommended treatment plan, it is likely that they will attempt to renegotiate or refuse to comply.

However, in our data, we have little evidence of patients being given the space to negotiate recommended treatment plans. Possible reasons for this include patients' lack of familiarity with the consulting doctor, the patient's limited information about his/her medical condition or about other options, and the intimidating nature and experience of the ED itself. Yet, even in this context, we would argue that it is important that patients be able to debate, clarify and discuss their treatment options.

In our data, patients do ask questions if they are unclear about their diagnosis and treatment but generally they do not debate or question the doctors' advice.

### 6.2.8. Repeat, check and clarify throughout

Patients can be overwhelmed with different kinds of information and it can be difficult for them to register the different levels of importance of what they are told or asked. Repeating key information is a way to check and confirm that patients have understood, and repeating questions is a way of ensuring that all clinicians involved in a patient's care understand the problem. These practices are more relevant when patients are elderly, distressed or do not have English as a first language.

## 6.3. Bridging the interpersonal gap—effective strategies for developing rapport and empathy with patients

A key finding of our study is that good clinical care depends on clinicians establishing an effective and respectful interpersonal relationship with the patient. Rapport and empathy are integral to the development of interpersonal relationships between clinicians and patients. Empathy means being able to vicariously imagine and share another's subjective experience. In the clinical context, Brock and Salinsky (1993) define empathy as 'the skills used to decipher and respond to

the thoughts and feelings passing from the patient to the physician'.

Factors influencing rapport and empathy include time constraints, situational constraints, language barriers, intercultural differences and other variables such as socio-economic background, field specificity of the consultation environment (e.g. Emergency Medicine versus General Practice), the patient's age and gender. Other factors include the purpose of the patient's visit and the patient's expectation of what the relationship should be. However, the willingness of the doctor or nurse to engage with the patient on a personal level is also very important.

As doctors and nurses are generally perceived as experts in health care, patients are sometimes less inclined to assert or involve themselves in healthcare decisions. To encourage patients to take a more active role, clinicians need to reduce the professional distance between themselves and patients. In our study, we observed clinicians attempting to do this in a variety of ways, including addressing the patient by their first name, using informal and colloquial language, giving supportive feedback, valuing the patient's concerns, initiating and responding to interpersonal chat and using humour and laughter. According to our data, when clinicians incorporated personal strategies into their medical expertise and practice, patients' subjective experiences of the ED were affected in a positive way.



*To encourage patients to take a more active role, clinicians need to reduce the professional distance between themselves and patients*



However, resources of time, space and medical expertise in EDs are limited. In prioritising their activities so that they can provide ‘the greatest good for the greatest number of patients’ (Nugus 2007:206), clinicians often prioritise the medical over the interpersonal.

The artistry involved in communicating with patients and the importance of developing good rapport with the patient cannot be underestimated. Although doctors bring considerable scientific knowledge to bear on diagnostic decisions when treating patients, what they obtain from patients themselves is crucial to good diagnostic practice. Earlier research on diagnosing angina shows that ‘agreement [between doctors] rises if they base their judgements on what patients say about their chests, whereas it falls when diagnosis is based solely on the ‘hard’ data of ECG tracings’ (Sackett et al 1991).

Next we outline effective interpersonal communication strategies based on our findings. These strategies are summarised in Table 1.2 on page 10.



***When clinicians use inclusive language they help put patients at ease in the interaction and create an environment where the patient feels more included in the decision-making process***



### **6.3.1. Introduce yourself and describe your role.**

In the NSW Health Patient Survey (2008) one of the communication strategies that patients consistently stated helped alleviate their anxieties was when clinicians introduced themselves and explained their role. By doing this, clinicians clearly established their expertise. One of the recommendations of the Garling Inquiry (2008) was that clinicians wear name and position badges at all times. Our data showed that while clinicians regularly introduce themselves to patients, they do not always specify their status or their role in the ED.

We established earlier that clinicians can help alleviate patient anxiety by introducing themselves and explaining their particular roles to patients. Apart from needing to feel reassured in what can be a bewildering context, patients also need to know who is questioning them and to what end if they are to cooperate fully with the process. Patients have encounters with many people, not all of them clinicians, during their stay in the ED.

### **6.3.2. Use inclusive language**

When clinicians use inclusive language they help put patients at ease in the interaction and create an environment where the patient feels more included in the decision-making process. Effective inclusive language techniques include using the patient’s first name and using the inclusive pronoun ‘we’ to include the patient in the actions and decisions of the clinical staff.

Using the patient’s first name allows patients to feel personally identified in what can be a very intimidating environment. Some clinicians, more typically nurses, use terms of endearment as a way of making patients feel included, although these may be interpreted as patronising, particularly when used with elderly patients.

The inclusive pronoun ‘we’ can be used to co-opt the patient into the healthcare team. Clinicians also used ‘we’ when referring to the medical procedures that would take place in the ED. The use of ‘we’ draws in the patient as an active agent in the consultation.

### **6.3.3. Use colloquial language and softening expressions**

When presenting or requesting medical information, most clinicians are careful to re-present their technical terms in more everyday and sometimes quite colloquial terms so that their patients can understand what they are saying:

*D1 Have you noticed any blood from your bottom at all?*

The use of these everyday words not only ensures comprehension but also helps to put patients at ease in what is in reality a very formal context.

The strangeness of the ED context, and the patient's relative disempowerment within it, can also be minimised by the use of two common 'softening' expressions:

- *just* or *only* to mitigate commands
- expressions of probability rather than certainty to temper statements, e.g. *probably*, *I think*.

Nurses in particular use the mitigating word 'just' frequently, to soften what are in effect commands with which patients need to comply.

Another way of softening the effect of obligations on the patient is for the clinician to phrase them as not completely certain. In the following example we see one of the junior registrars explaining the next steps to Patient, 8, Mara (oesophagus blockage). Mara will be required to endure further tests, but the doctor softens the blow with several expressions of probability as well as one mitigating just:

D1 *And you need to have someone have another look down with a camera. Just probably like they did last time.*

P *Yes.*

D1 *And because you can't drink, we probably need to do that today.*

P *Yeah.*

D1 *Going to have to put, try, I think to put a drip into you.*

P *Mhmm.*

D1 *With that low a blood count and with your history of heart attacks, I think it's very likely that we need to transfuse you.*



***Nurses in particular use the mitigating word 'just' frequently, to soften what are in effect commands with which patients need to comply***



### 6.3.4 Give positive and supportive feedback

Clinicians can establish positive relationships by using feedback cues that express support for the patient.

These cues include: evaluative expressions such as *excellent*, *good*, *great*, *that's terrific*, *well done*; exclamations of surprise and support (e.g. *Wow! Fancy that!*); open questions that encourage the patient to say more; and mirroring of the patient's comments, which both implies support and invites further comment. Clinicians often repeat back what patients say as a way of checking the information but this strategy is also a useful way of demonstrating the clinician's validation of the patient's interpersonal experience.

Doctors generally maintain a greater professional distance from patients than nurses do. Doctors provide patients with supportive, empathetic and reassuring feedback. However, their responses tend to be more measured. Nurses are more directly involved with managing patients within the hospital system and are less concerned with gathering information about the medical aspects of the case. Potentially they have a better opportunity to establish more personal relationships with patients. Expressing support and empathy through feedback is one way they do this.

### 6.3.5 Recognise the patient's perspective

Another empathetic strategy is to reassure the patient that they are justified in feeling worried about their condition.

### 6.3.6. Intersperse medical talk with interpersonal chat

Some clinicians seek to put their patients at ease during the consultation by interspersing their medical talk with informal chat. Used with care, this strategy can contribute positively to building interpersonal rapport, provided the patient perceives the 'chat' as somehow relevant to them.

Demonstrating an interest in the patient's experiences outside of the ED is another way of creating rapport and a human connection.

Relevant and constrained personal disclosure can also help to express empathy.

### 6.3.7. Share laughter and jokes

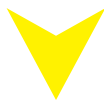
Several patients commented on the inappropriate use of humour in the ED. However, we observed that the judicious use of humour during clinician-patient consultations seemed to help ease the patient's anxiety.

### 6.3.8. Demonstrate intercultural sensitivity

Cross-cultural awareness is a basic requirement for clinicians who are dealing with our multi-cultural population.

## 6.4 Conclusion

We believe that by drawing on the communicative strategies we have reviewed in this section, clinicians can improve their effectiveness in both conveying medical information and in establishing interpersonal relationships with patients. The authentic data collected for this Emergency Communication Project has recently been adapted to develop a multimedia learning resource for nursing and medical students. The materials and activities in this resource reflect the cultural and linguistic diversity of real EDs and aim to prepare clinicians for authentic emergency contexts. Details of the resource are available at:  
<http://www.check.meu.medicine.unimelb.edu.au>



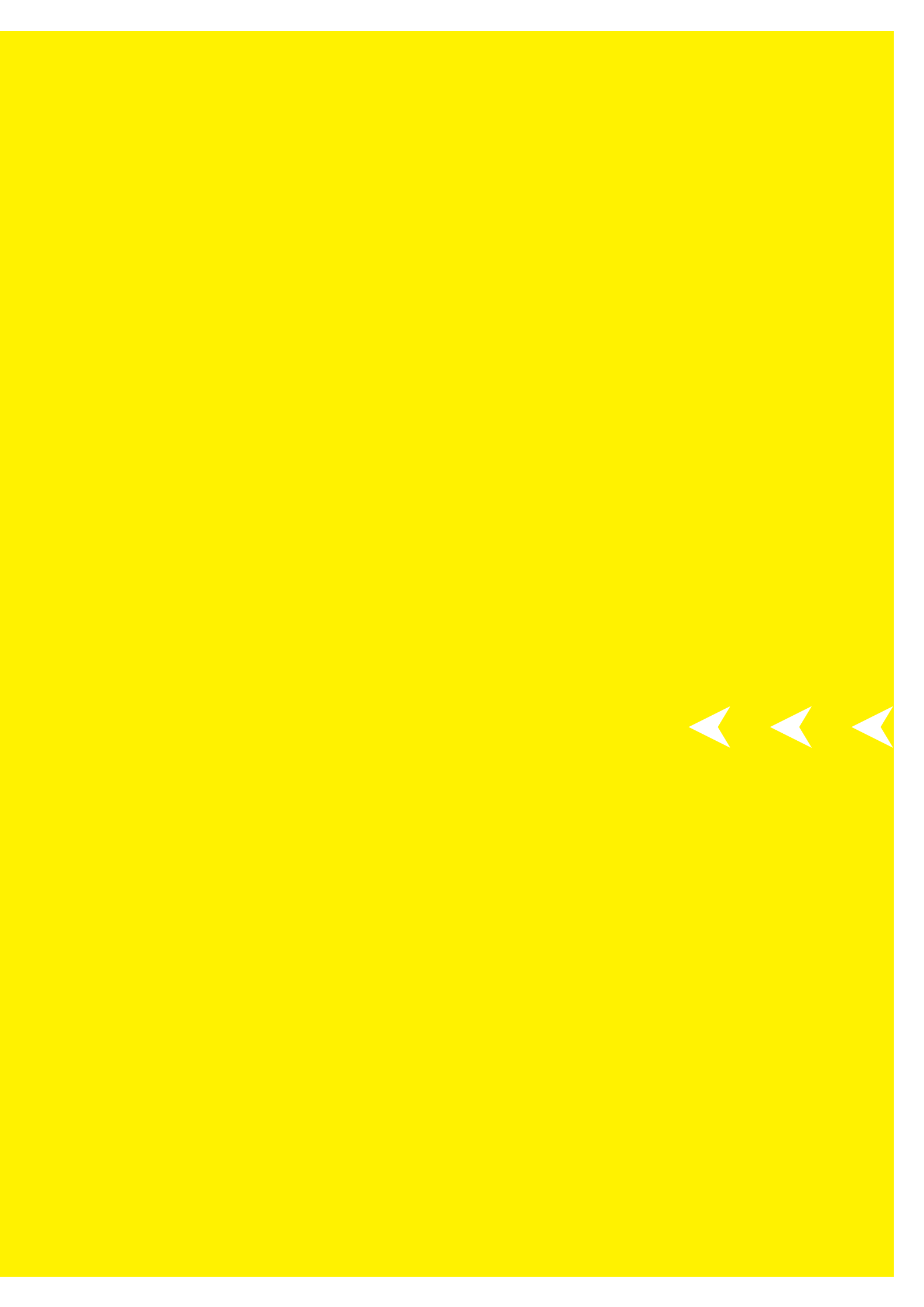
*...by drawing on the communicative strategies we have reviewed in this section, clinicians can improve their effectiveness in both conveying medical information and in establishing interpersonal relationships with patients*

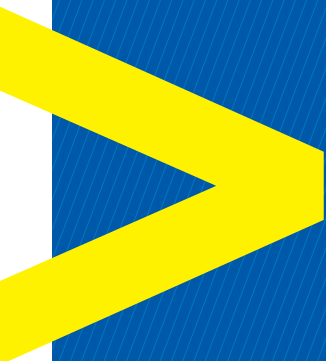


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*My participation in the UTS Emergency Communication project provided an extraordinary insight into the complexities and subtleties of communication encounters of a patient's emergency department journey. Personally I found the discussion and feedback fascinating and rewarding. This project, driven by the dedication and expertise of Diana's team, has made a lasting impact on my daily work, and I hope will improve emergency patient care into the future.*

Dr Nick Taylor  
Emergency Medicine Specialist  
The Canberra Hospital

*The Emergency Communication project is important qualitative research. The captured clinical conversations between doctors, nurses and patients are captivating. The analysis of the communication is informative and relevant to everyday practice. The discussion and conclusions provide a rare insight into an integral and critical component of Emergency Medicine practice. Moreover, being a participant in one of the research hospitals, I experienced no interference or slowing of my work. The team, led by Professor Slade was truly unobtrusive, professional and personable.*

Dr Marian Lee  
Emergency Physician  
Director of Emergency Medicine Training