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ISBN 978-3-662-46020-7
ISBN 978-3-662-46021-4 (eBook)
DOI 10.1007/978-3-662-46021-4

Library of Congress Control Number: 2015938575

Springer Heidelberg New York Dordrecht London
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Preface

This book presents the findings of our research on communication in hospital emergency departments. Our 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 (EDs). We present here a detailed picture of the critical importance of communication in the delivery of effective and patient-centred care, and 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. Due to the complex, high stress, unpredictable and dynamic work of EDs, these healthcare environments pose particular challenges for effective communication.

Over a 3-year period, the emergency communication project investigated communication between patients and clinicians[1] (doctors, nurses and allied health professionals) in five representative emergency departments. Combining qualitative ethnographic analysis of the social practices of each ED with discourse analysis of the spoken interactions between clinicians and patients, this project describes the communicative complexity and intensity of work in the ED and, against this backdrop, identifies the features of successful and unsuccessful patient–clinician interactions.

In conducting this research, a team of seven researchers with disciplinary backgrounds in applied linguistics and health sciences spent over 1093.5 h inside the

[1] 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 book uses the word ‘clinician’ to refer inclusively to doctors, nurses, social workers and all the other healthcare professionals/practitioners working in ED. We use the broader term for brevity and simplicity. When referring to a ‘junior doctor’, we are referring to an intern (JMO, junior medical officer) or resident medical officer (RMO). The term ‘registrar’ refers to a doctor who is in specialist vocational training. The terms consultant, staff specialist and emergency physician refer to senior medical practitioners with specialist qualifications (e.g. in oncology, neurology, emergency medicine, etc.).

five EDs. Of these hours, 242.75 were spent directly observing ED practices. Eighty-two patient trajectories through the ED were audio recorded and critically analysed, from the patients' first presentations in the ED to the point when a decision was made about their admission, discharge or referral elsewhere. The audio recordings consist of 629,436 words of patient–clinician interactions: affording rich and relevant insights into the links between the overall patient experience and communication practices and breakdowns in the ED. The medical records of each participating patient were also examined and follow-up interviews were conducted with participating patients and staff. In addition, the research team interviewed, and conducted focus groups with, 150 ED staff including administrative staff, nurses and medical practitioners and allied health workers—exploring how these frontline staff perceived the role of, and what they identified as potential barriers to effective, communication within their work. The extensive data collection and the detailed analyses make this one of the most comprehensive studies internationally on clinician–patient communication in hospitals.

The communicative challenges and risks in EDs arise directly from the unique contextual demands of the ED environment. As such, while the focus of this work is on communication, this is integrated with detailed descriptions of the environment, observations, staffing, teamwork and networks of the ED as a means of setting the context for communication encounters.

Communication (whether spoken, gestured, written or electronic) underpins ED practice. 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 therefore begin our account of the communication demands by a detailed description of the context of EDs. These contextual factors impact directly on the quality of communication in the ED and pose a series of communicative risks, where information can be lost and patient safety compromised. By presenting a series of vignettes and case studies, we demonstrate the complex communicative networks that exist and illustrate key risk moments within the ED consultation. We then present our analysis of the communication patterns and conventions we observed and recorded: identifying features of effective and ineffective 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.

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.

In presenting a series of case studies and clear and comparative language examples, we demonstrate how effective patient-centred communication can be achieved within the emergency healthcare context. Drawing on authentic examples of communication patterns within the ED, this book delivers comprehensive communication strategies for the healthcare professional that can be readily imported and integrated into everyday practice.

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November 2014

Acknowledgements

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, Eloise Chandler, Roger Dunston and Nicole Stanton (Faculty of Arts and Social Sciences) and Jane Stein-Parbury (Faculty of Nursing Midwifery and Health); Christian M.I.M. Matthiessen from the Department of English at the Hong Kong Polytechnic University; and Maria Herke from the Linguistics Department, Macquarie University, NSW.

In particular I would like to thank and acknowledge Nicole Staunton who was the project manager for the entire period of the project. Without Nicole this research could not have happened—she was responsible for the administrative organisation of a very complex project. She also undertook many research tasks with great competence.

I would also like to thank Suzanne Eggins and Bernadette Hince from Textwork for their extraordinary editing and layout skills and taking on the job at such short notice.

The team would like to thank all those ED 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 ED and, in particular, to discuss the communication that occurs between patients and clinicians. 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 recommendations were developed in consultation with them.

The rich and authentic recorded data collected as part of the research has enabled us to undertake a unique analysis of the language of ED healthcare. We trust our observations and findings will be useful to ED staff, to hospital management and to patients who attend an emergency department.

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.

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November 2014

A Note on Transcription Conventions

We have transcribed clinician–patient interactions using standard English spelling. Nonstandard spellings are occasionally used to capture idiosyncratic or dialectal pronunciations (e.g. *gonna*). Fillers and hesitation markers are transcribed as they are spoken, using the standard English variants, e.g. *Ah, uh huh, hmm*, *mmm.*

What people say is transcribed without any standardisation or editing. Nonstandard usage is not corrected but transcribed as it was 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 that the transcriber could not hear or guess what was said. For example:

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

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Chapter 1
The Role of Communication in Safe and Effective Health Care

1.1 Introduction

Effective communication, both among clinicians and between clinicians and patients, is critical in the provision of safe and quality health care. Over the last two decades, poor communication practices have consistently been identified as a major cause of critical incidents—adverse events leading to avoidable patient harm—in hospitals around the world (Wilson et al. 1995; Kohn et al. 1999; Hong Kong Hospital Authority 2014; US Joint Commission 2014; NSW Clinical Excellence Commission 2013). The complex, high-stress, unpredictable and dynamic work of emergency departments means that these departments pose particular challenges for effective communication.

In this book, we describe the communicative complexity and intensity of work in emergency departments and, against this backdrop, identify and describe the features of patient–clinician interactions most likely to lead to patient involvement, patient satisfaction and positive health outcomes. We also detail the communication practices that restrict patient involvement and are susceptible to misunderstandings and breakdowns in communication, which in turn affect patient satisfaction and safety. We then identify ways in which clinicians can enhance their communicative skills to improve the quality and safety of the patient journey through the emergency department. The strategies clinicians use need to simultaneously communicate medical knowledge and build up rapport and empathy with the patient. We argue that to deliver care effectively, clinicians must communicate care effectively.

Conducted in Australia over a 3-year period, our qualitative study investigated communication between patients and clinicians (doctors, nurses and allied health professionals) in five representative emergency departments[1] in New South Wales and the Australian Capital Territory. The study involved 1093 h of observations,

[1] Also known throughout the world as Accident & Emergency Departments or Emergency Rooms. Throughout the book we will use the term Emergency Department.

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D. Slade et al., *Communicating in Hospital Emergency Departments,*
DOI 10.1007/978-3-662-46021-4_1

150 interviews with clinicians and patients, and the audio recording of patient–clinician interactions over the course of 82 patients' emergency department trajectories from triage to disposition. Our research therefore represents one of the most comprehensive studies internationally on patient–clinician communication in hospitals, and specifically within emergency department care. This book documents our research findings, and presents a detailed analysis of the way communication occurs and sometimes fails in the high stress and time-critical context of emergency health care.

Emergency departments are becoming increasingly challenging health care contexts for clinician–patient communication. A defining and universal characteristic of emergency department care is the unpredictability of patient presentations and the lack of familiarity between patients and clinicians. Patients will typically present as strangers to emergency departments, with no readily accessible medical records or established relationships with the clinicians who will be treating them (Hobgood et al. 2002; Chung 2005). As a result, perhaps more than at any other site within the healthcare system, emergency medicine relies heavily on effective spoken communication between patients and clinicians as the former articulate their symptoms and concerns, and the latter draw on this to complement physical examination and diagnosis, and subsequently negotiate treatment (Redfern et al. 2009). Increasing patient demand for emergency department services around the world often results in overcrowding and 'access block' (the inability of a hospital to admit new patients due to a lack of available beds). These pressures have placed severe time constraints on clinician–patient interactions.

It has been recently estimated that the number of presentations to emergency departments increases annually by 3–6 % around the developed world (Lowthian et al. 2012). In England, the National Health Service now estimates that there are over 21 million emergency department attendances each year (National Health Service 2014). The latest statistics published by the US Department of Health and Human Services showed that in 2011, there were more than 131 million presentations to emergency departments in the USA. In Australia, more than 6.7 million emergency department presentations were reported in 2013, representing a 2.5 % increase from the previous year (National Health Performance Authority 2014; Australian Institute of Health and Welfare 2013). This high demand has resulted in emergency departments around the world frequently becoming subject to patient overload, and exceeding staff capacity to provide timely care. This can create serious obstacles to effective clinician–patient communication, obstacles which, if not overcome, can result in serious patient harm.

What is unique about this book is that it studies hospital communications as they unfold. It explains, describes and analyses actual communication between clinicians and patients in real time. The focus is on the patient, and on how the clinician–patient interactions within the emergency department are created, modified and shaped by the complexity of emergency department work. By observing, interviewing and audio recording, we have been able to produce greater insights than would be gained by a single method. Our book is about communication, but