



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



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Final Report
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*Diana Slade, Marie Manidis, Jeannette McGregor,
Hermine Scheeres, Jane Stein-Parbury, Roger Dunston,
Nicole Stanton, Eloise Chandler (University of Technology,
Sydney), Christian Matthiessen (Hong Kong Polytechnic
University) Maria Herke (Macquarie University)*



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.

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Research team:

Diana Slade, Marie Manidis, Jeannette McGregor, Hermine Scheeres, Jane Stein-Parbury, Roger Dunston, Nicole Stanton, Eloise Chandler (University of Technology, Sydney), Christian Matthiessen (Hong Kong Polytechnic University), Maria Herke (Macquarie University)



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Transcription conventions

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 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*.

Foreword

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 clinicians¹ 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.

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.

Diana Slade

Director, Emergency Communication Project,
Professor of Applied Linguistics,
University of Technology, Sydney.
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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 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.

Section 1 Recommendations

1.1 Preamble

This Executive Summary provides an overview of the project's full report—referred to throughout as *The Emergency Communication Report*—and is designed to stand alone. It 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 the 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 healthcare is up to, but the in situ demands on everybody made it difficult to implement.

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?' '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 probable 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?' '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.' '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. D: Yeah. P: And I had that lanced a couple of weeks ago. D: Yeah. P: And, um... D: I'm feeling for you
	Mirror patients' comments regarding symptoms, attitudes or concerns.	P: 'They were really big clots like that.' 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]? P About seven, eight years? ----- N1 So country of birth, where were you born? 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:

I think it's—it is very hard, they [overseas-trained doctors] do—they do well but they [patients] also do need a lot of—um—a lot of hand holding and explaining from someone who does speak English better. And I reckon that's probably—would be a huge issue in this hospital. Yeah. 'Cause they [patients] might sit there and go "Yes I understand" but they probably have no idea of what they're really answering. 'Cause they [overseas-trained doctors] tend to word—um—word things in a different way as well. So you and I would say, "Hi, how are you". They might say, you know, "You look well today." (Enrolled nurse)

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, as explained by one senior registrar:

'No, I mean, this occurs frequently that notes are so poorly written that they're of no help at all. Because we often try and get an idea looking back to the previous notes, you know, what they came in with last time, that sort of stuff. Or, or even handing over from shift to shift, so the night resident hands over and we go look and often they're so useless you have to go back and take your notes again. And that may be for different reasons, it may be because they're completely illegible. Maybe because they're so short. We were taught in medical school a particular way to write notes, most people follow that. Some people choose not to follow that and that makes it very difficult. Some people are very scanty with their notes, they'll take a big history and have a lot more information and if you ask them the question they'll tell you but they don't write them down. And so it becomes very difficult. And sometimes you've got no idea from the notes what's actually gone on. And I think other people write their notes, not that they're sort of lying but they want their notes to fit a picture so actually they'll write something that's not quite actually as it happened. And I think that the notes should be a true representation of what happened. Even though it's never true because things get lost with every, every step of communication, but I think they should be aiming to be a true representation of what happened. If you want to then sum it up into something that fits a picture, that's fine but you need, you need to [have a record].'

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).

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: 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

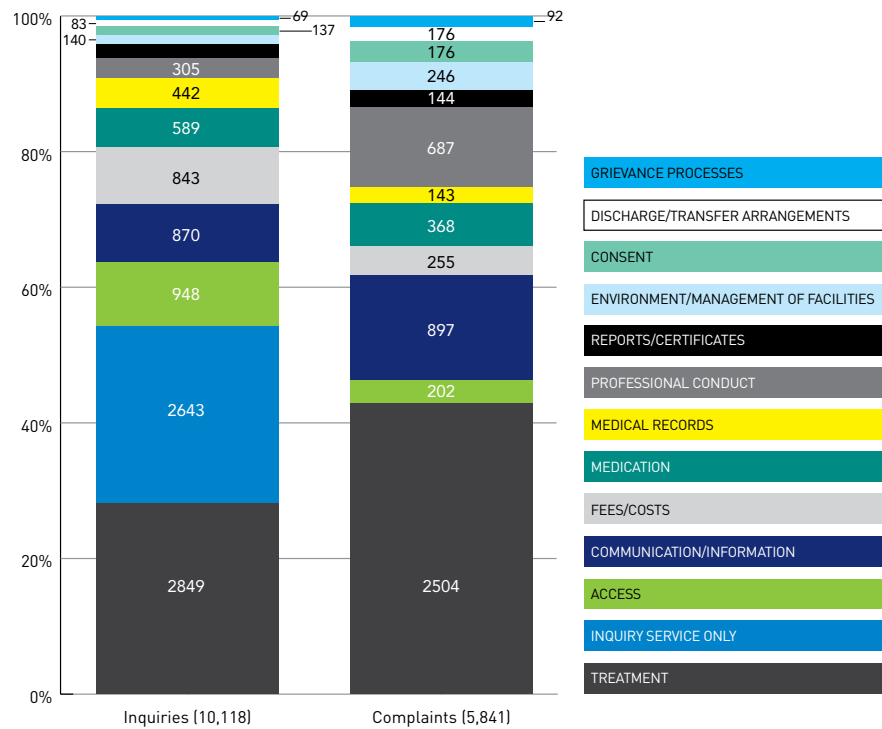


Figure 2.2: Proportion of issues in the category communication/information 2009-10

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

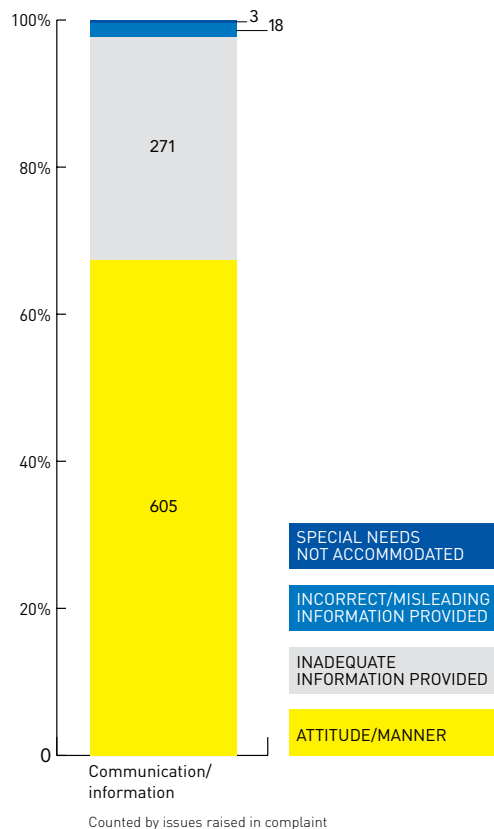


Figure 2.3: Issues raised in complaints received by most common service areas 2009-10

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

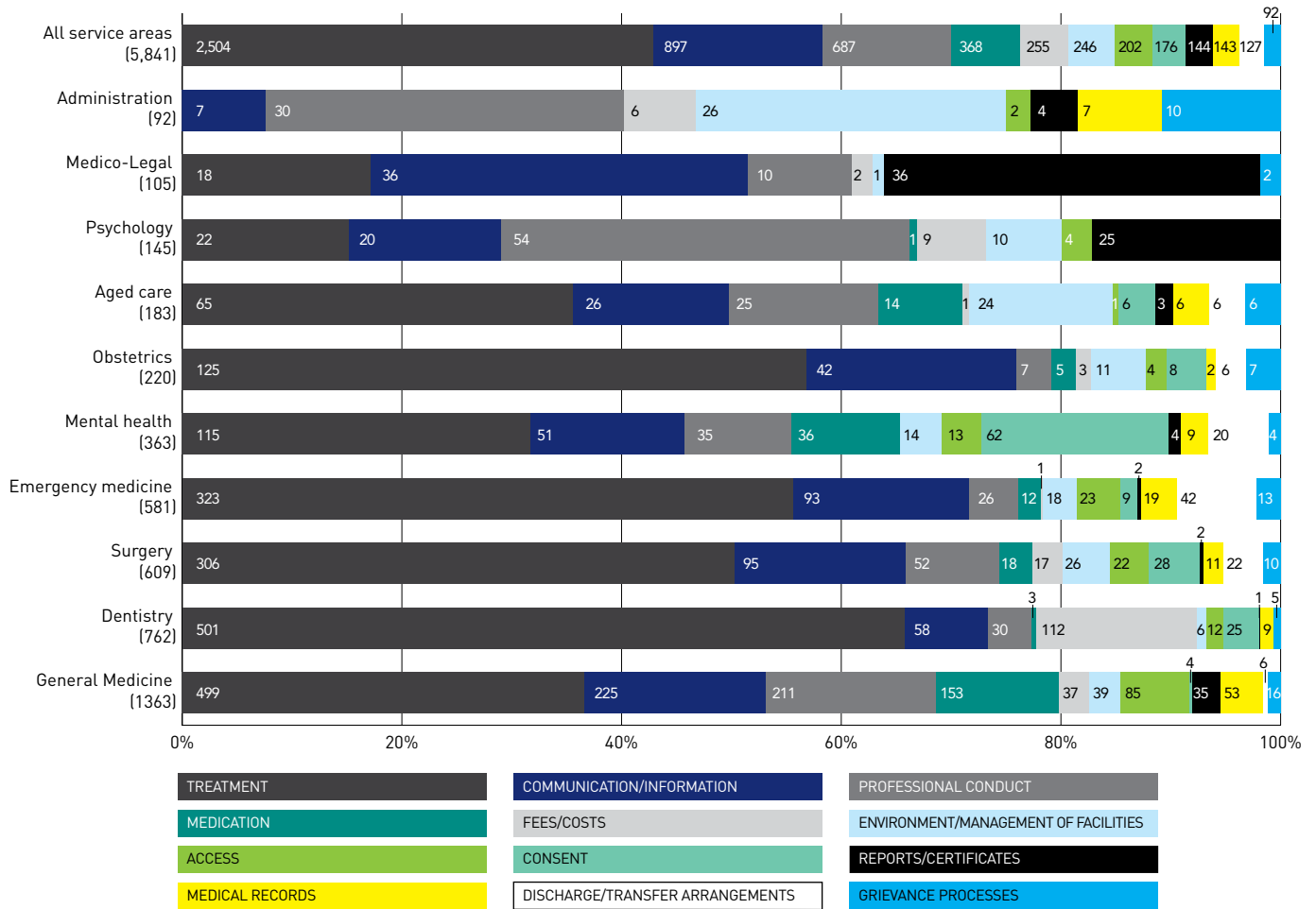
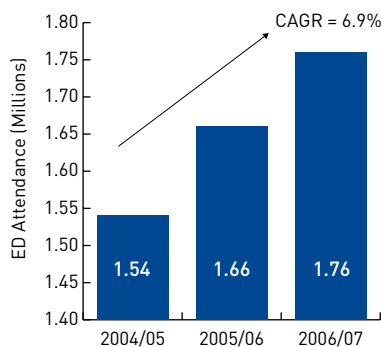
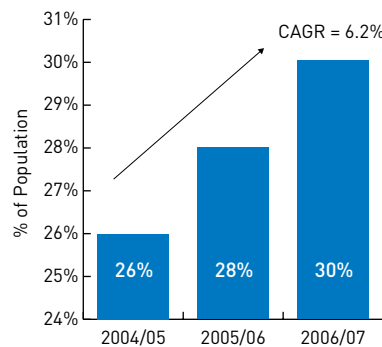


Figure 2.4: The rising demand for EDs



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



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

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 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 Ku-ring-gai; Gosford; St George; Canberra. Appendix 1 and Appendix 2 provide details of patient presentation statistics for each hospital. 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).

We are aware that some of our research findings reflect each hospital's unique demographic, historical and geographic profile as well as their size and level of service differences, and do not necessarily indicate differences in performance.

2.2.1. Prince of Wales Hospital Emergency Department (POW ED)

The Prince of Wales Hospital Emergency Department is in the northern section of the South East Sydney and Illawarra Area Health Service (SESAHS). Like all the hospitals we studied the POW ED is a complex, high-speed, high-pressure, critical workplace, offering wide-ranging treatment to a community with complex psycho-social issues as well as health problems. The ED provides a number of differentiated emergency care services including an Acute; Sub Acute and EMU facility; a Psychiatric Emergency Care Centre (PECC) and three resuscitation beds. On an average day the POW ED will treat between 120 and 130 patients, with an estimated 46,000 patients treated in 2007 when we conducted our research there between 21 August and 20 November 2007.

The patient demographic is varied, with patients of all ages and from many cultural and linguistic backgrounds. Although the annual statistics indicate that 91.9% of non-admitted patients who accessed the ED in 2007 spoke English at home, many patients were born overseas and spoke other languages. Males made up 45.8% of non-admitted patients and females made up 54.2%.

At POW ED we recorded a total of 19 patients and their journeys through the ED. Of the patients we audio-recorded three were over 80 years old, one was over 70, three were in their sixties, two in their fifties, four were over 40,

three over 30 and three in their twenties. All were English speaking although several were born overseas including Sri Lanka, Croatia, Spain, the United Kingdom, Lebanon and Iran. Of our 19 patients, 14 were female and 5 were male.

In addition, we interviewed 30 POW staff and undertook 65 hours of observation in the ED.

The Prince of Wales ED had undergone a number of changes to the medical leadership just prior to our time in the ED, while the nursing leadership had been stable. Although many senior staff had been in the hospital for a period of time, the ED director still had difficulty resourcing medical and nursing staff and on many occasions locums and agency nurses worked there.

2.2.2. Hornsby Ku-ring-gai Hospital Emergency Department (HKH ED)

The HKH ED, located in the northern area of Sydney, part of the Northern Sydney and Central Coast Area Health Service (NSCCAHS), offers wide-ranging treatment to its community. The HKH ED is not a major trauma ED—patients with very serious injuries are taken to Royal North Shore hospital instead. The ED provides a number of differentiated emergency care services including a Fast track (House Doctor) option for cases where straightforward procedures can be carried out and no treatment is required (e.g. a change of bandages); a trainee nurse practitioner service; an Acute and Sub Acute facility and there is a Psychiatric Emergency Care Centre (PECC) facility very close by. The ED has two resuscitation beds.

On an average day the ED will treat between 61 and 100 patients, with an estimated 9,088 patients treated between 21 August 2007 and 17 April 2008—the time during which we collected most of our patient data at the hospital in 2007/8. During our study, there were 65 ED presentations on average in every 24-hour period. The patient demographic range is varied with patients of all ages and from many cultural and linguistic backgrounds but Hornsby ED sees a proportionately large number of elderly patients with multiple co-morbidities, many of whom are of English speaking background. Data collected in our patient group included four patients over 80, seven over 60, ten females and seven males with a range of presentations.

It was clear from our time at the hospital that significant efforts had been made in the past five to seven years at HKH ED to deliver a co-ordinated team-based emergency care service and improve communication between patients and the ED and between doctors, nurses and patients. Improved communication began at the front desk where the clerical staff were now being managed by the Nurse Unit Manager. Clerical staff perceived themselves and their communication with patients as an integral part of the care process of the ED.

2.2.3. Gosford Hospital Emergency Department (Gosford ED)

The Gosford ED, located north of Sydney, part of the Northern Sydney and Central Coast Area Health Service (NSCCAHS), provides the full range of ED services, including a trauma ED. However sometimes patients with very serious injuries are taken to Royal North Shore hospital instead. The ED provides a number of differentiated emergency care services including a House doctor option; an Acute; Sub Acute; with a mental health team based in ED and three resuscitation beds. On an average day the ED will treat between 120 and 137 patients, with an estimated 12,666 patients treated in the three months we collected most of our patient data at the hospital in 2008. Of those, 10,734 were born in Australia, 108 were born in New Zealand, 42 were born in Ireland, six were born in Czechoslovakia, and four were born in Yugoslavia. Others were born in Fiji or the Solomon Islands, Tonga etc. and a small number were from Indonesia, Thailand, Germany, The Netherlands and the Philippines. Patients presented with a range of presentations.

Large proportions of people who live in the Gosford area are over 65. During the time we were there in June, July and August 2008, 31% of patients were over 60, 23% were over 70 and 13% were over 80. Of our patients, three were over 80, eight were over 60, two were over 50, three were under 50 and all were of English-speaking background. During our study, there were 137 presentations on average in every 24-hour period. The patient demographic range is varied with patients of all ages and from many cultural and linguistic backgrounds but Gosford ED sees a proportionately large number of elderly patients with multiple co-morbidities, many of whom are of English speaking background. The age factor adds another layer of complexity to the general 'unknown' of patient presentations.

The Gosford ED had just been placed under new medical and nursing leadership prior to our arrival there. As a result there were change processes in place in the services of both disciplines. The medical leadership was to change once more during the period of our stay but the hospital does have a stable pool of senior staff it can draw on.

2.2.4. The Canberra Hospital Emergency Department (TCH ED)

Canberra Hospital (TCH), located in the suburb of Garran, ACT, is the region's major public hospital, providing specialist and acute care to more than 500,000 people. TCH is a tertiary level health facility, and a teaching hospital

of the Australian National University (ANU) Medical School. TCH ED Canberra Hospital ED is a trauma ED. The ED provides a number of differentiated emergency care services including a Fast Track option; a nurse practitioner service; an Acute; Sub Acute and EMU facility; provision for mental health patients and three resuscitation beds. Compared with other EDs we have visited, this one had a community-based feel.

On an average day the TCH ED will treat between 130 and 180 patients. During our study, there were 151 presentations on average in every 24-hour period. The patient demographic range is varied with patients of all ages and from many cultural and linguistic backgrounds. During our stay, of the 6,645 patients treated, 5,324 were born in Australia but many different nationalities were represented as well. The ED sees patients from a wide range of national backgrounds, including patients born in Ireland, England, the United Kingdom, Italy, Germany, The Netherlands, Portugal and Spain amongst others. The patients we recorded included those born in Australia, The Netherlands, Greece and Italy. For additional demographic details on these patients, please see Appendix 1. Of our patients, one was over 85, two were over 70, two were over 60, three were over 50, four were over 40, three were over 30 and four were in their twenties. All but three, were of English-speaking background.

TCH ED had undergone a change of leadership in medicine and nursing prior to our arrival in the ED and from our perspective one of the key aims of the new leadership was to improve both the teamwork and delivery of service.

2.2.5. St George Hospital Emergency Department (St George ED)

The St George Hospital is in the southern section of the South East Sydney and Illawarra Area Health Service (SESAHS) and is one of the busiest Emergency Departments in New South Wales. The hospital under study sees approximately 59,017 trauma presentations annually of which 20% are less than 16 years of age. The admission rate for adults is 35-40%, and is the trauma centre for southern Sydney. Based on our data, between 2006 and 2009, we recorded a 19% increase in presentations to the ED. The ED provides a number of differentiated emergency care services including a Fast track option; a House doctor option; an Acute; Sub Acute and EMU facility; a nurse practitioner; a Psychiatric Emergency Care Centre (PECC) and three resuscitation beds.

The average daily number of presentations towards the end of 2009 was 162 patients compared with 134 in 2006. This means that the hospital has experienced a 19% increase in presentations in three years. The demographic of the patients includes a high proportion of Arabic speakers as well as elderly English-speaking patients. In 2006, three of our patients did not have English as their first language. In addition in 2006, 25% of the staff were from non-English speaking backgrounds. Of the patients we audio-recorded in 2006 one patient was over 20, three were in their thirties, two were over 40 and five were over 80. In 2009 we had one patient over 40 and one over 30, and both were English-speaking. We had an almost equal number of male and female patients on both occasions.

The Emergency Department has a well-earned reputation for innovation. It was the first in NSW to trial the Emergency Medicine Unit and clinical initiatives nurse position. In addition, the team has frequently won honours at the prestigious Baxter NSW Health Awards for improvements including the Trauma Case Management model of care, nurse-initiated intravenous pain relief and early diagnosis and treatment for suspected heart attack patients. A significant focus of the staff and the hospital is on the efficient and timeliness of fast tracking patients in while they are in the ED. The St George ED has a well-established team of clinicians, many of whom have worked together for a long period of time.

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.

Our ethnographic approach involved situating the patient experiences and communication exchanges within the professional and institutional practices of each ED. The researchers immersed themselves in the context of each ED by observing and interviewing key staff and patients. This approach provided a backdrop for understanding the

subsequent recorded interactions between clinicians and patients. The recorded patient–clinician interactions were transcribed and analysed in detail. The language was analysed for discourse and grammatical features.

By the term ‘discourse’ we refer to any stretch of spoken or written language that is meaningful within its context of use. Discourse features include how explanations and instructions are given and how they are received and acknowledged; how information is sought and clarified; how disputes and differences are negotiated; how breakdowns are repaired; and finally how empathy and rapport are displayed. From this analysis we were able to develop explanations for the forms of talk used by participants in the context of the ED.

2.4 Methods

2.4.1 Ethnographic data

Our researchers collected a cluster of ethnographic data from the five EDs.

Non-participant observation of the EDs

A team of seven researchers recorded what they observed in the EDs using observation sheets that could document both structured observational information for collation and comparison, as well as general commentary and description: what happened to patients, bedside practices, the work of clinicians (their interactions with each other and with patients), particular events and the layout of the spaces. We observed and noted what clinicians, patients, organisational staff and carers were doing and saying during the time of care, where they were located and who they spoke to.

Semi-structured interviews and focus groups with key clinical staff and patients

Researchers conducted semi-structured interviews with key informants (clinicians, hospital and ED managers and relevant administrative staff) in order to build an overall picture of the numbers and types of interactions, problems and issues related to communication, and the clinical and communicative ‘traffic’ of the ED. We also focused on themes and issues in relation to communication; how work and care were organised; how clinicians saw their professional roles and how they spoke about their practices.

Staff shadowing

Researchers followed a small number of clinicians and audio-recorded them as they went about their work. Audio-recordings of interviews and shadowings were transcribed in full.

Semi-structured interviews with patients

Researchers interviewed and recorded patients by telephone after their discharge from the ED.

Photographs of signage, written notices and informal notes displayed throughout the ED

Researchers took photographs of some of the spaces in the EDs including waiting rooms, triage desks, consultation room and clinicians’ stations.

2.4.2 Discourse data

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

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 to determine, amongst other features:

- the functions and language patterns of different stages of the consultations (what we are calling Activity Stages, discussed in section 4)

-
- how patients and clinicians exchanged information, including how clinicians communicated medical information while building an interpersonal relationship with the patient
 - how diagnoses were delivered
 - differences in nurse and doctor talk
 - differences in junior–senior talk
 - how (or whether) patients understood what was happening to them during their stay in the ED.

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.

2.5 Data collection

Table 2.1 summarises the data collected from the five hospitals:

	Prince of Wales	Hornsby Ku-ring-gai	Gosford	Canberra	St George	Total
Staff interviewed	30.00	20.00	37.00	34.00	29.00	150.00
Patients recorded	19.00	17.50	15.50	19.00	11.00	82.00
Patients declined	1.00	1.00	6.00	8.00	23.00	23.00
Total time in ED (hours)	294.00	196.00	215.00	237.50	151.00	1093.50
Direct observations (hours)	65.00	20.25	42.25	47.75	67.50	242.75

Table 2.1: Data collection summary for the five EDs

Participant consent was obtained verbally, followed by in writing. Only patients in triage categories 3, 4 and 5 were approached. Patients with immediately or imminently life-threatening conditions (triage categories 1 and 2) were not approached. Participant confidentiality was an important feature at all stages of data collection and analysis. Patient and clinician identities have been strictly protected. Strict ethical guidelines have been adhered to in the collection, storage, analysis and discussion of data throughout the project.

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.

Patients experience many sites when they present to the ED—the waiting room, the ambulance bay, triage, the acute and sub-acute sections and the ‘bridge’. The bridge is the colloquial name given to the central communications hub in the ED. It is always full of action, with staff standing and sitting, moving into and out of the area. There are many communication and electronic artefacts (computer terminals, equipment). The bridge is the communal centre of activity through which all clinicians move at some time during a shift. The purpose of the elevated platform that underpins the area and gives it its name is to provide a ‘watchtower’ view of the ambulance bay, resuscitation beds and a good view of a number of the acute beds. It is also a central point for communication, both written and spoken.

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, EMU² and resuscitation areas and in the waiting room. Here we present a description of one typical day in ED.

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 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’³. 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

2 Emergency Medicine Unit

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

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 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’⁴ 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 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 ...

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.
- **Multidisciplinarity:** 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.

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. 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, discussed below.

- **Triage:** this is the patients' first contact with the ED, via the waiting room, ambulance bay and triage room, and the point at which they are assessed and categorised by nursing staff.
- **Nursing Admission:** in this stage nursing staff take the patients' personal details, monitor basic observations and manage pain when necessary.
- **Initial Assessment and Stabilisation:** during this stage a resident doctor—often junior—completes initial history taking, examination and formation of a treatment/management plan.
- **Management, Diagnosis and Disposition:** this final stage may involve a multidisciplinary team in delivering the treatment and deciding on the 'disposition' (admission, referral or discharge) of the patient.

Each stage of the ED consultation is associated with different communicative goals, characteristics, challenges and risks for the participants involved. At various points in the sequence of activity stages:

- Clinician roles change and the focus of the activity shifts.
- Doctors and nurses have distinct, often competing, immediate priorities, varying levels of responsibility and focus on achieving different short-term goals.
- Patients are treated differently and have different expectations made of them.
- Particular patterns in the communication between patients and clinicians occur.

In the following sections we present a brief summary of what goes on behaviourally and linguistically in each activity stage and the particular challenges and risks involved. Appendix 3 provides a more detailed analysis of the activity stages.

4.3.1 Triage

Triage is the first stage of the patient's medical journey in ED. It begins either in the waiting room or in the ambulance bay.

Waiting room

In all of the five EDs we visited the observations of goings-on in the waiting room were similar. At peak times (between 11am and 11pm), many of the seats in the waiting rooms were taken. At other times (for example, 8am to 9am in the morning), the waiting rooms were virtually empty. In most cases signs directed patients to the triage nurse for assessment. More urgent cases were taken straight into the ED, and the rest were asked to register their

details (name, date of birth, marital status, etc.) with the clerical staff outside in the waiting room, and then to take a seat until a doctor could see them.

The amount of information available to patients to inform them about the ED process and how long it could take was variable across the five EDs. However, in those EDs where information was available, we noticed that patients did not spend a lot of time reading it. In all EDs patients tended to return to the triage nurse to get updates on waiting times. The waiting room could get extremely busy and noisy, as the following field notes show:

Over 30 people are in the waiting room. One person with a suspected DVT goes up to the window at 14.05pm. She says she's been waiting for four hours. She wants to go home, her husband says, "No, we're not going home". An ED doctor brings out a letter and gives it to a patient. People are reading absent mindedly, turning pages. Hospital staff walk through. One man returns to the waiting room from an outside call at 14.10pm. Someone drops a radio, checks it's still working. A wheelchair is wheeled through at 14.14pm. A sleeping elderly woman wakes up when a trolley is banged next door. A man in a wheelchair is wheeled through. Another man is trying to sleep on a wheelchair. At 14.18pm a new person is called in to the ED. A man with his arm in a sling accompanied by two people, walks through. A woman on crutches walks through. At 14.27pm someone places a blanket on a girl in a wheelchair. People pick up books, babies are squealing; the ED doctor calls in a new person to see at 14.37pm. One woman is on a mobile phone; some are flipping through magazines; some are just looking; one young man is balancing on crutches; a patient exits from Fast Track. The carer with the woman who has suspected DVT goes up to the window at 15.08pm to say "We're not going to wait".

Observation field notes in a waiting room, 2pm

From the moment they enter the waiting room, patients need to manage a number of tasks: they must register themselves with the institution (give name and details to the clerical staff) and experience and manage the waiting system in order to be seen by a doctor. The clerical process can be a drawnout matter, especially if one is not well. For Patient 39, Powell (severe shingles), this is what ensued at the reception desk:

- Z1 *And do you have your Medicare card with you? == Thanks*
P *== Sure do. [Papers rustling].*
Z1 *Have you been to Emergency here before? [Loud overhead announcements]*
P *Um, a while ago. It was a couple of years ago. And I came for, um, I'd injured my left leg. [Loud voices in close proximity]*
Z1 *Now your date of birth?*
P *[DOB].*
P *That's right. [Loud voices and typing]*
Z1 *Now are you still living at [Address]?*
P *No, no.*
Z1 *Is your address on here? It's not on here.*
P *Oh, not on == there.*
Z1 *== [] address.*
P *Ah, 35 ...*
Z1 *Yes?*
P *[Address].*
Z1 *And what's your new telephone number at home?*
P *Ah, [Number].*
Z1 *And your mobile number I've got [Number].*
P *That's right, yup.*
Z1 *Still correct? OK. Now I've got [Partner's name] down as next of kin == for you.*
P *== That's correct, yes.*
Z1 *So—so == () ...*
P *== And have you got his mobile number?*
Z1 *I've got [Number].*
P *That's right, yep.*
Z1 *OK. And also [Name].*
P *Ah, no. No, you can take—take him off.*
Z1 *OK. Is there anybody else you'd like me to put in his place?*

P Um—oh, just trying to think. Well I suppose you could put my folks down, == yeah.
 Z1 == OK, so.
 P Um ...
 Z1 Mum and dad's first names?
 P Ah, mother or father?
 Z1 Either.
 P Either? Ah, that's correct, yes. But I've been referred here by Dr [First name Last name].
 Z1 That's OK, but the local doctor, but == you're still [] are you?
 P == Yes. Yes, that's right.
 Z1 Now (you born in) Australia?
 P Pardon?
 Z1 Born in Australia?
 P Born in Australia, yes.
 Z1 You not from Aboriginal descent?
 P No.
 Z1 And any religion that you'd like me to note?
 P No, just ... no.
 Z1 Abright, that's fine. Sir, just take a seat.
 P Abright then.
 Z1 (.).
 P OK, thank you very much.
 Z1 (.) you (.).

Care of the patient begins at Triage. In the EDs we studied, Triage assessments were usually made in a small consulting room specifically for that purpose or at the triage window, using a uniform set of criteria. Triage nurses often worked in pairs or were assisted by others who liaised with other clinicians, categorised patients for treatment into one of five triage categories according to urgency and acuity and sometimes went into the waiting room to administer treatment.

In some EDs, patients with obvious injuries such as broken bones were sent for an X-ray before a doctor saw them. If a patient was identified at Triage as needing a bed, the triage nurse(s) negotiated with the nursing team leader who allocated beds in the ED when they became available. Each hospital ED had slightly different approaches to Triage, summarised in Table 4.1.

	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Triage system	Two work in tandem in two different rooms; triage interviews can be audible from the waiting room; can get very busy	One works with an AIN or junior 'runner'; Triage response generally good	Two work in pairs in one space; Triage queues can be lengthy at times; Triage response generally good but occasionally triage nurses don't 'see' patients	Two or three work in pairs in one space; sometimes 3 at a time, very busy; triage nurses sometimes 'blind' to waiting patients	Work in pairs; one in ambulance bay other at window; very small room; triage nurses responsive to patients

Table 4.1: Triage systems for the five EDs studied

Some patients were extremely nervous about entering the 'visual space' of the triage nurse; triage nurses themselves were frequently so busy that they chose not to (or did not) 'see' patients. Many triage interviews were audible from the waiting room or the triage window.

Ambulance Bays

Patients who arrived at the ED by ambulance were triaged while they were still on the ambulance trolley. The ambulance officer gave medical details of the presentation to the triage nurse, who then categorised the patient for treatment, following the same uniform set of criteria used for walk-in patients. Triage nurses occasionally initiated treatment (in the form of pain relief for example) while patients were still on the trolley. Ambulance bays could get extremely hectic, as the following observation notes show:

There is a very elderly, frail patient on a trolley. A female ambulance officer is handing over to the triage nurse. The patient has recently increased medication to help with cramping and is not able to communicate normally. His elderly wife (hunched with a walking stick) is with him. Two male ambulance officers are standing by. The triage nurse knows the patient and the ambulance officers. We can hear a baby crying from one of the cubicles. The patient is taken to bed 6. The baby is still crying. A man is wheeled into Triage, speaking to the triage nurse who is taking 'obs'. An elderly female patient is wheeled from bed 19 to ? There is laughter from the 'station'.

Another male at Triage is being given 'obs' and he then goes back to waiting room. A woman with a baby arrives at the triage window who then comes through into Triage; we overhear the word 'diarrhoea'.

The male patient in a wheelchair leaves Triage to return to the waiting room.

A male patient, 54 years, is brought in by male and female ambulance officers. They check his pulse and blood pressure. They hand over to the triage nurse—suspected anaphylactic reaction to medication (penicillin). The patient has previously had pleurisy and pneumonia. The patient has had shaking, shortness of breath and redness to body. The triage nurse says, "We'll get you seen to straight away". The patient is taken to bed 4.

Another ambulance arrives and then another. An elderly female patient has had a fall at the hostel this morning and then came over all hot and clammy. She felt fine to go out for lunch at the RSL with her husband where she took a turn for the worse. She appears to be very disorientated. The triage nurse asks her what month it is which she knows but not what year it is. The ambulance officers are told to take her to bed 16 but someone is already there. She is wheeled to the corridor. She smells as if she has defecated.

An elderly male patient, Sam, aged 99, arrives. He lives at home alone; had a fall this morning and cut his head. The triage nurse feels his arm, "You're cold darling". Sam doesn't take any medication except two lite beers a day. The triage nurse, "You're amazing, you've got ages to go yet". Sam used to be a butcher.

Now there are seven ambulance officers standing around laughing and joking. There seems to be a real camaraderie with the ED staff.

Another ambulance arrives with a 61-year-old man who dropped his hands into 90° hot wax.

Another ambulance arrives with an elderly male in a wheelchair. All the ambulance officers know him; he seems to be a regular to the ED. A drinker. Apparently he had rung an ambulance several times the previous night; it seems they only pick him up if they aren't too busy.

Observation field notes from the ambulance bay, 1.30pm

Communication in the Triage stage

In the Triage stage, the major communicative responsibilities fall to the triage nurse who must find out what she needs to know from the patient in order to triage accurately. The importance of the triage nurse in the ED communication network is highlighted by the following comment from a member of the clerical team:

'Good communication, that is when the triage nurse and us are on the same wavelength. If the triage nurse is happy then we're happy, then the doctor's happy. Everything's running smoothly.' (Communication Supervisor)

The Triage stage is characteristically brief and the role of the triage nurse is clearly prescribed. The triage nurse must balance a number of competing priorities during the assessment, including the medical priority of patient care, the organisational priority of allocating the correct category and the most appropriate assessment/treatment area and the professional priority of performing discipline-specific practice, which includes being accountable for these decisions.

Triage nurses are senior nurses who are specially trained to assess patients. They need particular skills to be able to sift out information from what is being presented to them but which may not be accurately communicated. As one advanced practice nurse pointed out:

'Because often what the patient says to Triage and what they've actually got wrong with them are two totally different things.' (Advanced practice nurse)

The communication between the triage nurse and the patient during the triage assessment is framed by a uniform set of criteria designed to make the process both thorough and efficient. During the brief encounter, patients are asked to provide limited information in response to a very specific series of questions, and are not encouraged to ask questions of their own. The information patients receive is usually limited to what they can expect to happen up until the end of this particular activity stage. In other words, patients are not given an outline of what they can expect to happen during the overall ED journey, and patients consistently fail to ask for information about the overall journey.

It is likely that patients initially find the Triage/ED context bewildering, especially if they are in distress. The information triage nurses provide usually relates to approximate waiting times or refers, in general terms, to the

staff members who will follow. Occasionally, staff provide a clearer indication of what patients can expect to happen in the next stage of the journey as shown with Patient 23, Bertha (knee gave way while shopping; had a fall):

NI We'll pop you out into the waiting room.

P OK.

NI And one of the doctors will see you. They may decide to do an X-ray just to make sure that you haven't damaged anything.

P == Mmm.

NI == in that knee replacement at all.

P OK...

NI OK, if you want to take another seat over here we'll get you in there and we'll have a look at that very shortly for you ...

The language patterns we found in most triage consultations were very similar to one another, despite the differences in the levels of medical complexity. The agenda was clearly set by the triage nurse and interactions were characteristically short.

For example, in the case of Jean (who presented with minor leg trauma) the triage nurse asked nine questions: four were about the patient's presenting condition and five related to the hospital system. The nurse made three statements during the assessment process and all related to the hospital system. Jean asked no questions, and her contribution was limited to providing short, concise responses to the nurse's questions.

The Triage stage provides us with the first evidence of the multidisciplinary nature of care in the ED and its communicative implications. Across the ED consultation, clinicians attend to patients in sequence, and patients are asked to provide consecutive information to a number of clinicians, each of whom has a clearly defined role in the process. A strong emphasis on discipline-specific practice and communication is evident in the Triage stage. The information gathered by the triage nurse—the first input to this sequence—is written into the patient's notes, and may also be shared through a verbal handover with following clinicians, but the developing knowledge can become fragmented and key information can appear to be ignored.

Consider, for example, the case of Patient 39, Powell (severe shingles), which illustrates how well-intended communication efforts in the Triage stage can be confounded by organisational constraints, creating risks for patients:

Powell was HIV positive. He needed intravenous treatment and was referred to the hospital by an HIV Specialist due to severe shingles. Powell was a 35-year-old male who arrived at the ED one day at 15.12pm. He was triaged at 15.30pm and had a letter from his physician addressed to the ED Director, explaining that he was concerned to make sure the patient was attended to as soon as possible as he had a highly infectious condition. The letter referred to an earlier conversation between the GP and the ED Director (at 13.30pm that day) about the patient. Powell showed the letter to both the ED receptionist and then to the triage nurse on arrival.

The triage nurse assigned Category 4 to the patient and he was told to wait in the waiting room where there were a number of other people waiting, including young children and elderly people. The letter apparently had little effect on the speed with which the patient was attended to, and there was no indication that sitting with other (sick) people might be a problem.

Powell waited for two and a half hours, when a nurse appeared and began the process of taking him through to the ED with some urgency to the family room for assessment. This room was being used by police who were escorting a violent patient. The patient then waited in the ambulance bay for another ten minutes until the family room became free. The ambulance bay was also quite busy with patients on trolleys waiting to be placed in a clinical area in the ED. Finally, Powell was shown into the room and the rapid assessment nurse began his history taking, carrying out an examination, and concluding that the patient did have a highly infectious disease (shingles). The nurse then put a sign on the interview room door advising others not to enter the room. He explained to Powell that his condition was infectious to the elderly, to those with suppressed immune systems, and to young children in particular.

The patient, having been made to wait in the waiting room and the ambulance bay for three hours that day may have placed a number of people at risk. Because of extended waiting times to enter the ED on that day, neither the receptionist nor the triage nurse could act on the import of the letter from the patient's GP regarding his condition. Despite attempts made through communicative channels to pre-empt risk as the GP had done, relying on both a spoken (the phone call) and a written (the letter) alert, the most appropriate and safest medical response did not eventuate.

Observation field notes one day in an ED waiting room, 12.30pm

In addition to the health risks that may accrue when information is missed or cannot be acted on, the communication burden on the patient increases as the ED consultation proceeds and the patient is repeatedly asked questions he or she has already answered several times.

4.3.2 Nursing Admission

In this second stage in the sequence of consecutive care in the ED, patients are admitted by nursing staff who are allocated to patient beds in teams. Junior nurses may be supervised at the bedside by more senior nurses, as part of the process of situational learning.

The nurses perform their own discipline-specific practice and are answerable to the hierarchy within their own discipline. Nurses responsible for the admission of patients have a clearly defined role in this stage: firstly, admitting patients into hospital, which involves getting patients changed into hospital gowns and recording their personal details; and secondly, making sure that patients are medically stable by doing basic observations, recording information in patient notes and managing pain when necessary. Handover to consecutive nursing staff is both written (patient notes) and verbal. Throughout this stage, nurses need to balance the competing priorities of the organisation of the ED with the priority of patient care.

During Nursing Admission team members, including nurses and junior and senior doctors, may be present at the bedside at the same time—or may simply be passing through—creating the hectic and stressful environment observed in the following field notes:

On this day 36 people have walked past the bed in a space of fifteen minutes, the fire alarms have been tested twice; on 24 occasions the noise was so high as to interfere with audible communication with the patient; there were 10 overhead announcements and/or code calls; and 180 patients have fronted up to the ED in the previous 24 hours resulting in a very stressed set of interactions for all the clinicians concerned as well as for the patient. People going past the bed one after the other include one team leader, one carer, one person in a bed, one person in a wheelchair, two staff nurses, four doctors and two people with IV drips.

Observation field notes from bed 3 in acute, 3pm

The level of noise in the different EDs varied considerably and impacted on the audibility of the consultations. In some instances clinicians needed to repeat themselves for patients to hear; very often consultations in all EDs were clearly audible from the next-door beds. It is well understood that the ED is *'a terrible environment for people to sit in for 24 hours, there's no doubt about that. Our beds aren't designed for people to stay, we don't have enough showers, we don't—we're not meant to be that'* (Senior staff specialist). Table 4.2 summarises the physical aspects of each of the EDs we studied.

	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Layout space	Crowded; cluttered walls; white; bright; few windows; cubicles defined by curtains	Beige; brown; clinical; ordered; windows; clean walls; cubicles defined by curtains	Windowless; ordered; antiseptic; bright yellow; cubicles defined by curtains	Has some windows; bright; antiseptic; cubicles defined by curtains	Windows in one part of acute; none in sub acute and EMU; walls are green; cubicles defined by curtains

Table 4.2: Layout and space in the five EDs studied

Once a bed is allocated, patients are either escorted or wheeled down the corridor into the acute or sub-acute sections of the ED. The acute sections are usually large open areas with cubicles (each defined by curtains) lining a number of sides of the room. Generally the acute and sub-acute sections are visible to staff on the 'bridge'. Table 4.3 summarises the available surveillance in each ED.

	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Surveillance	Raised 'bridge'; minor watchtower role; good view of resuscitation and ambulance bay	Central watch from the 'hub'—good view of acute and sub acute; minimal view of ambulance bay and resuscitation beds	Divided room; good view of ambulance bay from one side of 'flight deck'; not all patient beds visible from certain parts of the 'flight deck'	Central watch from 'station' especially in acute; view from 'station' in EMU somewhat restricted	Good view to most beds from front desk (but not from doctors' room) in acute except for view of two isolation rooms; good view in sub acute from 'station'; good view in EMU from 'station'

Table 4.3: Surveillance in the five EDs studied

Communication in the Nursing Admission stage

Communication in the Nursing Admission stage is challenged by three requirements: the need for nursing staff to manage and adapt their priorities according to changing demands, particularly in very busy times; the need for all clinicians to communicate effectively with the multidisciplinary team; and the need for nursing staff to attend to the disorientation patients experience in the ED.

In one of the EDs a senior nurse summed up the priority for the nursing teams in the admission process:

'I like to package people to a degree. Like I like to get all their observations done and make sure they're settled, and their pain's under control, and all the pieces of paper that go along with it and my documentation. And then I can sort of think, "Well, Mrs Smith, this is wrong with—I just think this is what's happening". I know everything that I could possibly know right now, until something [else happens]. I like to sort of go right, I know if I walk away for the next 10 minutes, it's all kind of sorted for you.' (Clinical nurse specialist)

When the department is under pressure, nurses have to prioritise their work differently, and they often need to spread themselves across the needs of several patients simultaneously:

'Often there's a time factor where if the department's really busy and we're short staffed or you know the level of staffing isn't as it should be, then you start to run into problems where you need to just do the basics for one person and then move on to the next one because they're just isn't time and if you sort of get three new patients all at once, you sort of have to prioritise what your duties are. So I personally just go back to my basic nursing, make sure they've got observations, ECG and you know make sure they're stable for the moment, then I'll move on and then come back, if there's time to do the more, you know, the higher skills, I guess.' (Staff nurse)

Occasionally, when the pressures reach a critical point, nurses have to compromise their practice to some extent:

'Sometimes it's very organised and things go well. Sometimes I think we try to rush our patients through and not that we miss things, but sometimes I don't think we take a holistic approach. I think we just hone in on what's wrong with them, get them in, get them out and let someone else do the definitive care. I think sometimes we forget that we do actually complete definite care here sometimes.' (Transitional nurse practitioner)

The communication impact of this need to work at maximum pace can be that patients are given less time to ask and respond to questions and less information than many would like about what will happen to them next ... and when.

The interdisciplinary communication demands arise from the 'team care' that operates in EDs. Most staff we interviewed stressed the importance of the team management structure at their EDs. As one senior nurse manager put it to one of our researchers at one ED:

DN An effective ED is an ED that provides an optimum patient flow in a team environment... (What) Supports (the ED) are its management structure, its team focus, and they are made very explicit in this ED.

R ... When you say management structure, is that like the organisation of care, the fact that seniors are put with juniors etc, etc.?

DN Yeah. The teaming model of care that they have in there.

In this ED, the team management structure appears to have a positive effect on the communication between doctors and nurses. Everyone knows whom they are working with, and junior staff can consult with senior members of their team, or nurses can consult with doctors, when problems arise. A senior nurse explained the advantages:

'Again as a whole I think it [multidisciplinary team communication] works really well. I think there's always going to be in workplaces some personalities clash and that sort of thing. But yeah, I think as a whole, we do the handover round, the nurse in charge, joins in on the doctors handover and, so the doctor in charge can then convey messages to the nursing staff and vice versa and the doctors write their names next to the patient so you always know who's looking after a particular patient, you can go straight to them to find out. I've found working in emergency you're more as an equal than say working on the ward 'cause I did work on the medical ward for three years and I was a junior nurse then but there it was more of a doctor telling the nurse what to do. Whereas here, we sort of get to discuss a patient rather than the doctor say "This is what you're going to do ..." You've got to say "Oh do you think Mrs So-and-so needs some more morphine"? So it's more of a—you're on the same level, I guess.' (Staff nurse)

At this ED we observed strong evidence of effective interdisciplinary consultations, handovers and training. However, at other EDs team communication was not as effective and did not seem to be embedded in training and cultural practice. Doctors talked to doctors; nurses talked to nurses; but there was very little collaborative pooling of information and expertise. In other words, care was multidisciplinary (involving clinicians from different disciplines) but it was not interdisciplinary (involving collaboration and sharing of information and resources).

An example of the failures to share and transfer knowledge occurs with the patient 38, Denton, who presented with shortness of breath and a fever. During his 120 minutes of recorded interaction (out of a total four-hour stay in ED), Denton had 225 encounters with clinicians. Throughout Denton's stay, one of the questions about the patient that the clinicians were trying to solve is whether he was a CO₂ retainer (i.e. whether the patient retains carbon dioxide and should therefore not be given pure oxygen). 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:

12:55 pm	N2	<i>We don't know if he's a CO₂ retainer?</i>
14.00 pm	IC1	<i>Don't know too much about him.</i>
14.25 pm	N5	<i>I don't know much about him but collapse, wasn't it?</i>
14.30 pm	N5	<i>Is he—he's not a retainer, is he?</i>
16:08 pm	D1	<i>Yes, I think he's a CO₂ retainer ...</i>
16:15 pm	D2	<i>No, because he's not a CO₂ retainer. So remember the gases. Got his old notes there? Remember I said if you look at the bicarb, that tells you that he's a CO₂ retainer. He's got normal bicarb so ...</i>

This example—discussed further in section 5—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. It is a potentially serious failure to take an interdisciplinary approach to the patient.

A notable feature of the communication between nurses and patients during the Nursing Admission stage is the focus on developing rapport and empathy. It is during this stage that patients become part of the hospital system, and many experience a sense of vulnerability and a loss of personal control. Pain and distress contribute to the feeling of powerlessness, and this can be emphasised by other factors such as gender, age and socio-economic circumstances. Nurses do try to keep patients informed about what is going on, as a way of addressing patients' anxiety, but time is often severely limited and patients may not always be well or confident enough to ask questions or understand information provided.

Most clinicians we interviewed were aware of the impact of hospitalisation on patients. As the Nursing Unit Manager explained:

'No one wants to come to an emergency department so you're dealing with consumers who are distressed. So every single patient that we deal with has some form of stress and so that makes it a particularly different area to work in, yeah.' (Nursing unit manager)

Another member of the nursing staff commented in a very empathetic way on the experience that patients have in the ED:

'I think it can be a very daunting experience. I think it can be quite scary sometimes and because they come in to what can be a foreign environment 'cause people don't come to hospital every day and so what concerns me is how they perceive how we treat other patients sometimes because, especially with our mental health patients who might need to be sedated and that sort of thing. I quite often think about what other patients may think what we're doing to these patients.' (Staff nurse)

Important aspects of language and communication in the Admission stage are therefore those that recognise the patient's transition to the institutional setting of the ED. Effective communication strategies are those that might allay fears about illness or injury. These include providing supportive and reassuring feedback, responding to patients' anxiety about their medical condition, developing shared knowledge and explaining processes regarding what is happening then and there and what will happen next. The risks in the Nursing Admission stage are, firstly, that less experienced clinicians will not provide the feedback and information that ease the patients' transition to the ED and, secondly, that the multidisciplinary team members will not collaborate to resolve and share essential information about patients.

4.3.3 Initial Assessment and Stabilisation

This is the stage during which the consulting doctor (often a junior doctor, under the supervision of a senior doctor, as part of a situated training program) takes a comprehensive medical history and examines the patient. The doctor may order necessary tests (bloods, CT/X-ray scans, etc), establish an initial diagnosis (or hypothesis) and initiate treatment, if required. In Fast Track, patients' illnesses or injuries may be examined, diagnosed and/or treated by doctors with varying levels of seniority.

During this stage, there is more evidence of multidisciplinary care. Nurses and doctors (especially student and junior doctors) are more often present at the bedside at the same time, although this depends on the how busy the ED is and the way teams are structured. Nurses are usually geographically allocated to beds whereas doctors work across the ED.

In some EDs, the Fast Track or House Doctor sections of the EDs have a number of consultation rooms where patients are seen. There are also plaster rooms, procedure rooms, and eye and ear–nose–and–throat rooms so treatment procedures can be done on the spot.

In most acute sections of the ED cubicles (each defined by curtains) line a number of sides of the room.

In this stage there is constant monitoring of patients. Some low level interventions are carried out, but clinicians also check to see that patients are stable and comfortable. The curtains are closed when clinicians examine or treat patients, to provide visual (not aural) privacy, but are generally left open.

There are usually comfortable spaces between each bed, with very little furniture apart from the beds and an occasional chair. Most medical equipment is mounted on the wall behind the beds.

Most patients lie quietly in their beds. Some sleep, some talk to clinicians or family members, others watch. While patients wait, the activity and noise of the ED go on around them, as these field notes show:

Six people are present on the 'station': one nurse, five doctors, two on the phone. There is still lots of noise coming from the X-ray area, separated from sub acute only by a cotton curtain. A doctor knocks on examination room 1, and says "Oh, sorry. I was just looking for Dr X". He closes door. Another doctor is on the phone. A nurse is standing by. Another doctor is unpacking some equipment (saline drip) and she then goes into room 4. There is the sound of someone coughing. There is a general sound of activity. Someone's buzzer keeps going off. Someone is typing on a computer. Another doctor gets on the phone. There is the sound of a blood pressure trolley being pushed down the corridor. The phone rings. It is answered by a nurse, "Yep, thanks so much".

Observation field notes in sub acute area, 6pm

In the acute areas, doctors, nurses, wardsmen and clerical staff constantly search for people, equipment and information:

- N *Has anyone seen the ultrasound machine?*
- D *Where has patient 10 gone?*
- D *Are you OK? [Doctor to patient walking down corridor]*
- D *Do you know where you're going? [Doctor to patient as patient enters the ED doors]*
- D *Somebody ought to answer that phone. Where is our Katie [Clerical assistant]?*
- N *Did you do an Admission for X?*
- WM *I've come to collect Patient 11. Does anyone know where he's gone?*
- CC *Has anyone taken the notes I left here?*
- D *Now where's Simona? Have you seen Simona? She had an elbow she wanted me to look at.*

Constant activity is the theme of the acute section, as seen in these field notes:

11.15am—A patient in EMU rustles a tobacco pouch. Voices can be heard. Three beepers go off. A nurse goes to bed 10, she then looks at the ‘station’ and speaking loudly says “We’re just going to move you. Just around the corner.” A patient coughs. Two nurses go past. A mental health nurse goes past. He talks to the patient at bed 10. A nurse opens a drawer. Two nurses walk past again. One nurse keeps walking past with a glass of water. The doctor talks to the patient in bed 10. One nurse goes past. The cleaner sweeps the floor.

11.20am—A doctor is at the side of ‘station’ with gloves. The cleaner sweeps. The doctor at the ‘station’ is organising tests. Two wards men plus the radiographer bring back the patient from bed 8. Silently. The cleaner sweeps. There is a carer at the end of bed 9. The cleaner sweeps. The doctor washes her hands. A woman talks to the patient in bed 8. A patient coughs. A patient goes past bed 10. Two beepers go off. A nurse says to a patient “So Mr X tell me why you came in today”. A doctor walks past. A doctor comes off the ‘station’ and the level of voices rises. A doctor says to the patient in bed 12—“I’m one of the doctors. Which medication are you taking? Is it the tablet or the injection? But this bottle is very old. Is this from last year? How many did you take? When?” “5pm”. “You told the nurse midnight. You took 80. You told the nurse 50.” The level of voices is rising. Two doctors come off the ‘station’.

11.25am—The Nursing Unit Coordinator walks past. A patient walks past. Two doctors go past, talking to each other. Bed 10 curtains are opened. Two nurses are talking to each other. Then they talk to the doctor. A senior doctor is helping other doctors doing exams. “Apparently pharmacy rang and said the dose was too high for her weight.” A wardman goes past with someone. A doctor talks to the nurse at the end of bed 8. He gives a verbal instruction. The doctor asks about the patient in bed 8 “if she’s had breakfast at all. If she’s diabetic she will have to eat something.”

Observation field notes in acute, one morning, 11am

Communication in the Initial Assessment and Stabilisation stage

This is the stage when most communication work is done in the ED consultation and the communication load on both patients and doctors is sometimes considerable. Both doctors and nurses perform clearly prescribed, parallel roles here and it is during this stage that we see the focus clearly on the medical aspects of the case. The ultimate responsibility for diagnoses, treatments and decisions rests with the medical team.

In the Fast Track/House Doctor sections of some of the EDs, the first part of this stage can be managed by senior nursing staff. At one of the EDs, a senior nurse describes the limits of her role here in detail. She also refers to the sequential nature of practice in the ED:

‘If you’re working say in fast track or the treatment areas you’re doing things like giving out medications, pain relief, checking observations, blood pressures, temperatures, that sort of thing and then acting on them. So if something’s abnormal then you need to report to the doctor that there’s an abnormal blood pressure for example, and what are you going to do about that. And also documentation. So if something’s not right, then you need to write it down and what you’ve done about it. And what else [do] we do? We are able to nurse-initiate some treatment. So there’s standing orders for analgesia and certain medications. So some nurses can, if you’re accredited, we could give a first dose of morphine, say. Yeah, so there’s standing orders for particular patients that we could do that. And we do cannulation and venepuncture so we can get things started in that respect. So quite often by the time a doctor gets to see the patient, we’ve gone through certain procedures that you know. There’s things in place already. Like the bloods have been sent off and we’ve done ‘obs’ and ECG, that sort of thing so the doctor can come along and look at a better picture of the patient.’ (Senior staff nurse)

In our interviews with clinicians, we found that doctors and nurses were very clear about the limits of their own discipline-specific roles and, at the same time, they were also aware of the roles and responsibilities of others. Below, a junior doctor describes firstly the role of the nursing staff in the care of a new patient; she follows this with a description of her own role and responsibility. She alludes to the kind of interdisciplinary care that was a feature of practice in one ED—but not in all. She is also explicit about the crucial role of the senior doctor in the overall management of the patient’s care:

‘So when they come I, for example, if I’m dealing with a Category 3 patient ... when they come in, the nursing staff do their stuff. They do their nursing bit, observations and depending on what sort of things that they need to do, they will do that and do the paperwork. At the same time, sometimes there are nurses who are credited should get some blood sample and then they can put in cannulas and take some blood samples and send them away. But if I’m only seeing at the same time when nurses are doing their nursing bit, I can start taking history and do ordering appropriate investigations. And then after I’ve got all history, examination, initiated my management plan in

terms of what sort of medication I should start on and what sort of investigation and bloods that I've done, I'll get a senior, tell them my story and you know they'll come and review the patient to double-check whether I'm in the right way. And then—yeah, take it from there. Wait for bloods, for all investigation results to come and then we can piece things out and then find out what's going on and then we decide whether that patient is staying in hospital or that you're going back home.' (Resident)

A registrar then describes the patient journey in this stage, taking account of the patient's perspective and emphasising the importance of keeping the patient informed about what is going on. He suggests that the nurses assigned to the patient also play a part in this process, which confirms the emphasis in this ED on the practice of interdisciplinary care:

'Well, 'cause what I do is when I see them initially and then examine [them]—do a history and then examine them, I have some sort of an idea of what's going on and right there and then I explain to them already what I'm thinking, what I'm going to do because it may take a while before I come back to them and review them. Because it takes a while for the bloods to come out, the results of the X-rays and I don't want them to like think that I've—or I don't want them to be in a loss. So it's very important that even during that very first time that I see them, I let them know that it's going to be a wait. 'Cause they would also see me to—doing other things and other patients and all that. And most of the time that's a complaint that they have you know if they— "Oh the doctor saw me" but then "I don't know what's going to happen or anything", you know? There would be lots of times when you wouldn't be able to get back to them right away because you're trying to sort out other patients or a new patient comes in and all that. So it's good if your nurses would be able to let them know that yeah, "We're just waiting for the results" and help you also explain to the patients about what's going on in that time.' (Registrar)

The Initial Assessment and Stabilisation Stage therefore provides us with ongoing evidence of the sequential, multidisciplinary nature of ED care. In some of our recorded data at one ED, we found evidence of interdisciplinary collaboration between senior nurses, junior doctors and patients, which provide a useful benchmark for effective team practice. However, this was not a universal finding across the EDs. In most cases, clinicians attend the bedside by themselves and work alone, undertaking discipline-specific tasks and care.

There is more evidence of team knowledge building (between doctors, nurses and patients) during this stage. However, there can be tensions between doctors and nurses relating to tasks as well as information seeking and giving, as outlined below:

JD Do you do lines?
N Not on him, he's got terrible veins. Technically it's your job doctor.
JD I know.
N I don't do lines, because I'm very good at blowing them.

And in another ED:

JD Are you looking after the patient in bed 10?
N I'm a float nurse.
JD Is that a 'yes' or a 'no'?
N That's a 'no'.

The gravity of the responsibility for the medical outcomes of the consultation appears to constrain doctors from engaging with patients at an informal level to some extent. Hence doctors tend to maintain a greater professional distance from patients than nurses do, evident in their choice of words and the degree to which they respond to patients at a personal level. This means that in the communication between doctor and patient, the medical is often prioritised over the interpersonal.

Nurses are not usually medico-legally responsible for patient's diagnoses although they may explain the patient's medical condition to them, and summarise what the diagnosis means in terms of consequences or treatment. In specific cases, when patients are directed to the Fast Track/House Doctor, this activity stage can be managed, in part or in total, by a senior nurse with advanced training (such as an advanced nurse practitioner). Primarily, however, nurses have responsibility for ongoing patient management, which requires them to interact frequently with patients, for short periods of time. Frequent interactions can contribute to familiarity, and this generally makes building empathy and rapport easier for nurses than it is for doctors.

In our data, we found that patients were more likely to respond to nurses in an informal way, and they asked nurses for explanations more often than they asked doctors. We acknowledge that traditional attitudes to the

perceived differences between the nursing and medical professions in terms of social hierarchy do play a role in the way patients behave with clinicians. This is particularly the case in relation to elderly patients, who are conditioned to believe that it is not appropriate to question the doctor.

The consulting doctor responsible for the Initial Assessment and Stabilisation stage must balance competing medical and organisational priorities. Because of a limit in the resources of time, space and medical expertise, patients are often positioned as passive co-agents in the history taking process and are not always given the opportunity to offer an opinion, or to ask questions about their own medical condition.

The important aspects of language and communication in the Initial Assessment and Stabilisation Stage are 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. These include clinicians greeting patients and introducing themselves and their roles, finding out what the patient already knows, allowing the patient to tell their story, and valuing issues that are important to the patient. If treatment is commenced, it would also be important for clinicians to negotiate treatment and explain the reasoning processes for testing and treatment. In some EDs this stage also sees the collaborative, interdisciplinary exchange of information between clinicians (nurses and doctors). However, this did not occur often.

4.3.4 Management, Diagnosis and Disposition

This is the final stage of the ED consultation, during which the senior clinician delivers a final diagnosis and decides on the treatment plan and whether the patient should be admitted to a ward or sent home. What happens and who is involved in this final stage differs in the following ways from the previous stage:

- Usually a senior doctor or an in-house registrar comes to see patients and most of the patient time is spent waiting for these doctors.
- While patients wait for the doctors, they are constantly monitored; nurses frequently check with patients.
- Sometimes junior and senior doctors attend the bedside together. Some senior doctors use the final history taking as a teaching opportunity for their more junior counterparts. They may ask them for their opinions to see what they are thinking: D2: 'OK. So after talking to her, what do you think? Vertigo or pre-sync? D1: 'Um—it sounds a bit more like vertigo'. D2: 'No, I don't think so. I think it's presyncope.' Alternatively, senior doctors may just have junior doctors there to observe, as part of their situational training.
- If patients are going to the ward, all their notes, X-rays and other test results are gathered on the bed.
- If patients are going home, after their diagnosis doctors bring final letters of recommendation for patients' GPs or specialists and talk to patients about treatment plans and follow-up regimens. Sometimes going home is not a straightforward matter as the case of Patient 23, Bertha, demonstrates:

Bertha's knee had given way while shopping. She arrived by ambulance. From the ambulance bay, the nurse educator watching her from behind the window said 'She's been shopping in Westfield's and she's fallen over.' This was 100% accurate. After checking Bertha's knee, the doctor told Bertha there was nothing wrong and she could go home. However Bertha was unable to walk without her walker (which had been taken home in the interim). Bertha could not get a taxi home as she needed support to walk at the other end. Bertha was then assessed by ASET⁵ as well as the physio⁷ to check her mobility.

Her mobility was not an issue; the lack of her walker was. The hospital was unable to lend her a walker. Hospital records state Bertha left the ED at 13.45pm, but in fact she sat in the corridor with the researcher from 13.45pm until 14.30pm. In that time, the researcher took her to the toilet twice. After the researcher spoke to one of the staff about the fact that she couldn't move from the corridor without assistance, they rang Bertha's neighbour and the neighbour and the neighbour's daughter offered to come and get her and bring the walker with them. Bertha left with them at 14.30pm.

Observation field notes, ED corridor 2.30pm

If patients need to be assessed for special care after they leave the hospital, the ASET and acute and post-acute care (APAC) nurses also see the patients during this stage to check home living arrangements.

If patients have been in the ED for some time, shift handovers may take place around them, close to the bed or at the whiteboard. Sometimes they watch the nurses or doctors who are clearly talking about them but they do not engage with them.

5 An ASET nurse is part of the aged-care services in emergency team.

Communication in the Management, Diagnosis and Disposition stage

This final stage follows the same broad clinical process and communication patterns as the Initial Assessment and Stabilisation stage, but there is a crucial difference: the Management, Diagnosis and Disposition stage is the responsibility of a senior doctor, who can make conclusive decisions about the diagnosis and patient disposition. Only more senior doctors, or junior doctors under their supervision, can negotiate with in-patient teams if patients need to be admitted to hospital, which they usually do in this activity stage. A senior doctor explains his role:

'Alright so they get seen by a doctor. That doctor may or may not be senior enough to make a decision about what should happen next. Let's say it is a doctor such as myself that's senior enough to make decisions. So I'll see the patient, take a history, examine the patient, have some ideas in my head about what could be wrong, arrange some tests probably to test the hypotheses and evaluate the extent of their disease. In the meantime, start some initial treatment and then depending on the results of tests, once I've made a decision that we've gone as far as we can in the Emergency Department or gone as far as we should then we'll make a decision about whether the patient needs to be admitted to hospital or needs to go home. If they get discharged, I need to make sure that they're—whether the treatment plan is a realistic plan to be carried out at home and if they need follow-up either with a GP or with some other healthcare provider, that a plan is in place for that. If they need to be admitted to hospital I need to negotiate with the in-patient team which in-patient team they're going to be admitted under and what should happen thereafter. Now if a junior doctor sees the patient and they're not senior enough to make those decisions then I'll guide them through the process.' (Staff specialist)

Communication with the admitting doctors and inpatient teams is more straightforward when there is a clear-cut diagnosis for a patient who needs to be admitted, a situation which is improved by a patient's age as they are less likely to have multiple co-morbidities:

SS ==Because there is a—because there is a clear, clear diagnosis, a clear path of action, no-one argues, I mean, they know exactly it's their case, they're (also) keen because they know there is a clear, even when they accept them in the ward there's a clear case of what's going to happen. So, all those cases tend to work fairly well. Be it, be it fractures, be it heart attacks, be it anything. ==Major trauma.

R

SS ==Oh yeah. Yeah. The clearer the diagnosis, the clearer the communication. Dare I say it, the younger the patient.' (Staff specialist)

Unlike junior doctors, senior doctors must take both a macro and a micro perspective on ED activities. In the words of one staff specialist, senior doctors have a dual responsibility to both patients and to the smooth operation of the ED and to the training of junior doctors. Also, they are often responsible for the simultaneous management of a number of ED cases with varying degrees of urgency. Despite the challenges of competing priorities, senior doctors still have a responsibility to the individual patients in their care, and part of that responsibility is to communicate effectively with them:

'I've got to take a big picture of what's happening elsewhere in the department so it may be that I'm seeing a patient who's got a minor illness while simultaneously ... in-between trying to manage a patient with a major illness. So in that case I need to for instance consider that the major case I'm handling is not being neglected while I'm looking after the minor case. But at the same time I've got a responsibility to any individual patient that I see to listen to them, be polite and courteous to them but come to a plausible diagnosis and provide a suitable plan of action. So ... yeah I have a dual responsibility both to the patient and to the overall running of the Emergency Department simultaneously.' (Staff specialist)

According to several staff specialists, one of the biggest challenges for senior doctors in the ED is to manage these competing priorities, to respond to the needs of many different people, including patients and to develop the ability to multi-task. The communication challenge is to do all this in face-to-face interactions, in 'real-time':

'The multi-tasking in the Emergency Department is one of the major differences in that you get requests from all sorts of different people at all sorts of different times simultaneously to do things ... it's mostly in a real-time basis. So in other words mostly when there's a problem ... somebody goes and addresses that with somebody else ... a direct face-to-face communication or phone call.' (Staff specialist)

The ED presents a particular challenge to clinicians because they have no control over time and the demands of the ED can stretch the capacity of the ED staff to respond:

'Again you don't have any control over the time course of things so stuff can—patients can come in, stuff can happen. You don't have any control over when that might be and at times it may be not that busy whereas at other

times there may be a lot happening that stretches the capacity or exceeds the capacity of the staff to do it all at once.' (Staff specialist)

At another ED, one of the staff specialists in charge of training outlined the real difficulty of the shortage of time: *'Um, the time thing is really hard. The ability to function in a chaotic environment is impaired dramatically by the constant interruptions that happen and that's not a criticism of anybody it's just the way that we work. I tracked it one shift and you know, one shift—I think I answered the phone 20 times, I saw eight of my own patients, I reviewed 20 of the interns' (junior) patients in person and discussed another 15 or 20. If you sort of divide 60 or 70 little work tasks into an eight or ten-hour day you realise that's why you never get to concentrate. And that's very difficult—to concentrate on one, to force yourself to concentrate on one thing when there are other things going on. Or to multi task and be able to manage all those things at once and that's a really hard skill.'* (Senior staff specialist)

Senior doctors communicate with a large number of people on any given day, and this adds to the overall communicative burden:

'I will talk to patients, I talk to patients' families, I would talk to all the other members of staff, both nursing and medical staff and also the various Allied Health staff such as physiotherapists. I would talk to the diagnostic support infrastructure such as having negotiations with the pathology department, the X-ray department. I would talk to the ambulance staff. I would talk to the clerical staff and I would talk to representatives of the in-patient teams. And many days I have gripes about various things and I talk to the administration as well. So I would talk to quite possibly 100 given people in a day.' (Staff specialist)

As one ED Director pointed out, patients are a critical factor in ED communication, and they do contribute to poor communication, especially if they are elderly or if they are in distress. This means that clinicians have no choice but to repeat the same questions over and over again, even though this can be stressful for patients. Not all clinicians explain this need to repeat the questioning process to their patients:

'They ... don't, you know, they can't remember. They don't know. And so you rely on getting a lot of extra sources of information. You see patients don't hear you, patients don't hear what you say and they may answer questions but they're not really thinking because they've got too many other things that they're worried about. I think you make an assessment always about somebody's reliability. So you do that first of all. And the second thing that you do, we all do is that key points have to be asked over and over and over and it drives patients crazy. But that's why you have to do it, because the answers change and what you tell me, I may make a mistake when I write it down, or you may change your answer. And we hear that over and over again from patients. "Well you know you've asked me that 50 times and I keep telling you." And yes, most patients will give you the same answer, but there's lots of patients who give you a totally different answer when you ask them again.' (Director of one ED)

One ED Director also expressed the view that clinicians often make the mistake of thinking that patients understand all the explanations they are given and underestimate the effect that the ED context can have on individual patients' ability to comprehend what is happening to them—on younger patients because the ED is generally unfamiliar, and on older patients because they may have hearing or cognitive difficulties, or else they are seriously ill:

'I think that one of the key things with communication in the Emergency Department is a realisation of how little patients can actually retain, even though we seem to think that they really have got it. And they think—and in fairness, they think they really have got it. But they haven't and I think we make that mistake over and over and over again ... for many people it's overwhelming partly because it's complex but because people are pretty generally healthy. There's not—you know, young people under the age of 65 are not overly familiar with medical care, hospital care and the older people that we see who are very familiar, they have other issues. They have cognitive issues, they have hearing issues. And they have more severe medical illnesses.' (Director of one ED)

Finally, the responsibility of supervising junior doctors who are still learning about their situational practice adds yet another communicative burden for senior doctors. Ultimately, it is senior doctors who are responsible for the overall safety and well-being of the patient. This is made more difficult because there are relatively few senior doctors in the ED and junior doctors vary in experience and clinical skills, and in aspects of care that are non-medical, but which nevertheless impact on patient care:

'... junior medical staff, I mean they're learning so you have to teach, but they're going to make mistakes. And that's just part of the—trying to direct and teach without being overly critical and realising they're making mistakes is the name of the game. And we are understaffed with consultants here. So when you're on the floor you've got everybody

coming at you all the time for 10 hours looking for direction. But I mean that's what you're supposed to be doing, that's your job. The younger doctors, the inexperienced doctors tend to be slower, there is a variation in the actual clinical skills of medical staff that are essentially at the same level. And also depending on the patient because the realm of experience may be very good in an area and you can whip through a bunch of patients 'cause you are very comfortable in that area, versus there are some patients which you're not terribly familiar with their illness or diagnosis, doctors in training have a lot of medical knowledge, but they may not have a lot of knowledge about other things, the social, and the kind of things they don't teach you in medical school.' (Director of one ED)

In summary, then, the important aspects of language and communication in the Management stage are those that recognise the patient's need to fully understand their treatment and plan. These include negotiating treatment, explaining the reasoning process behind treatment and advice to patients, repeating key information, checking patients have understood it and providing clear instructions for medication and other follow-up treatment. It would also be important for clinicians to allow room for the patient to seek further information.

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.

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, ask the same questions many times 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 can fail to provide opportunities for patients to contribute and can fail to hear them when they do.
- 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 wardsman, a radiologist, a radiographer, a radiology nurse and a number of other people who engaged with her in the bedside space. Figure 5.1 (next page) 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 (page 43) 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)

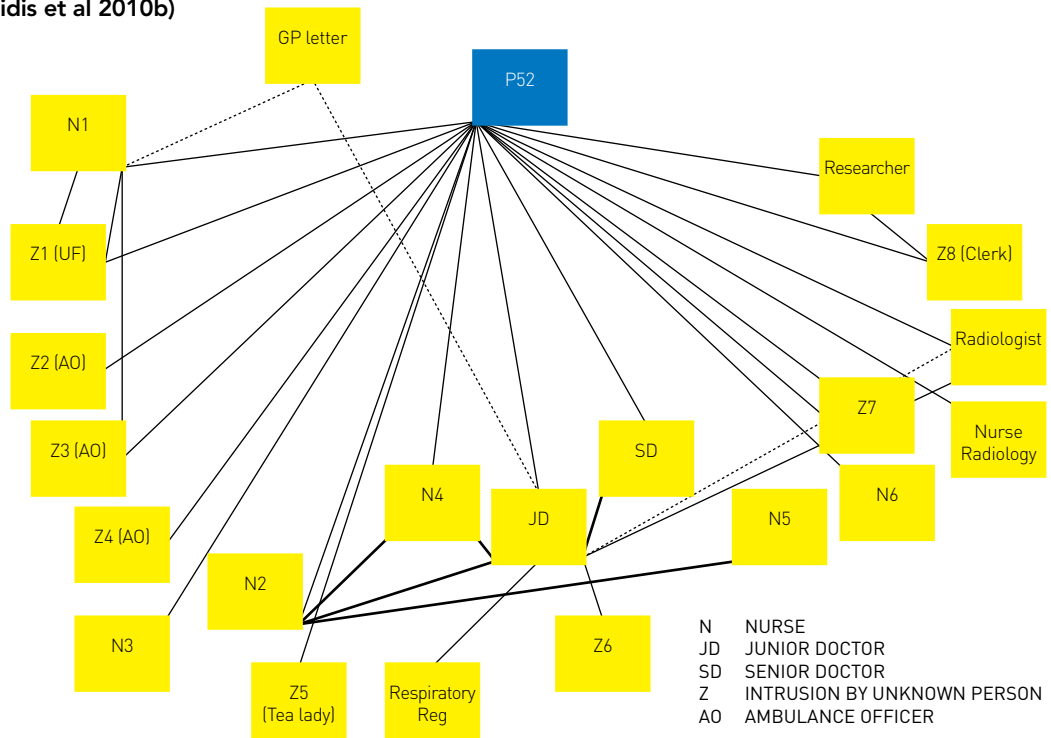


Figure 5.2: Encounters for Dulcie (adapted from Manidis et al 2010b)



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

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?”

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

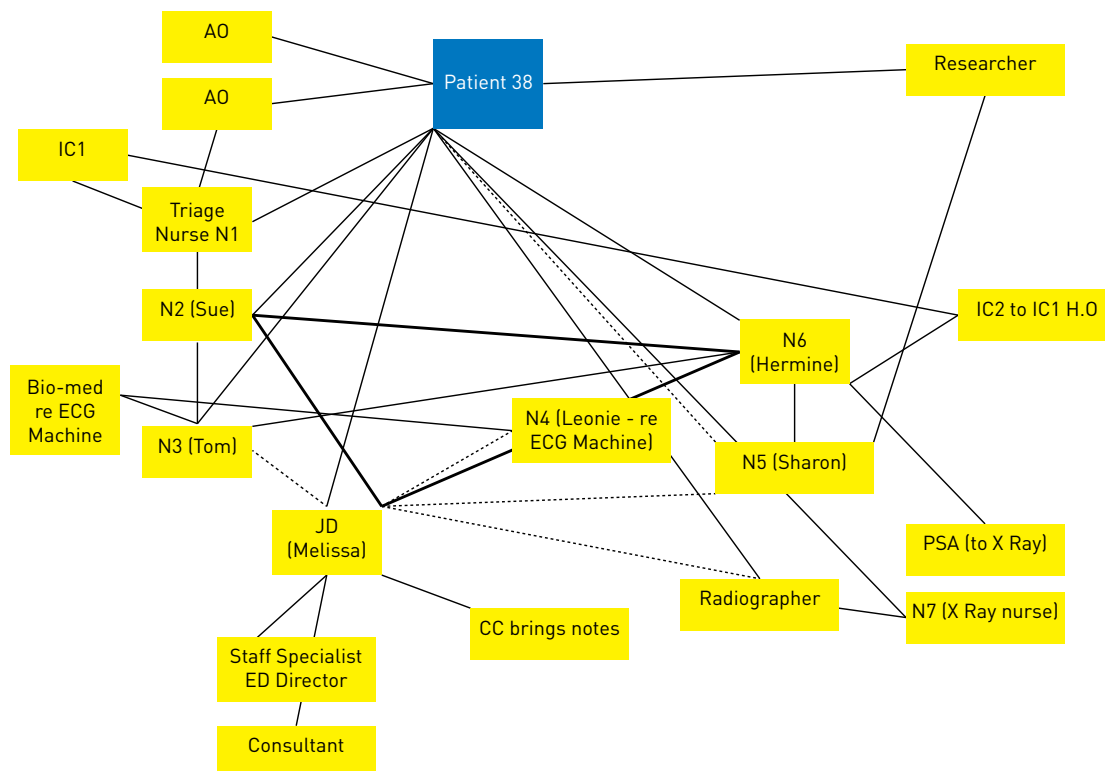
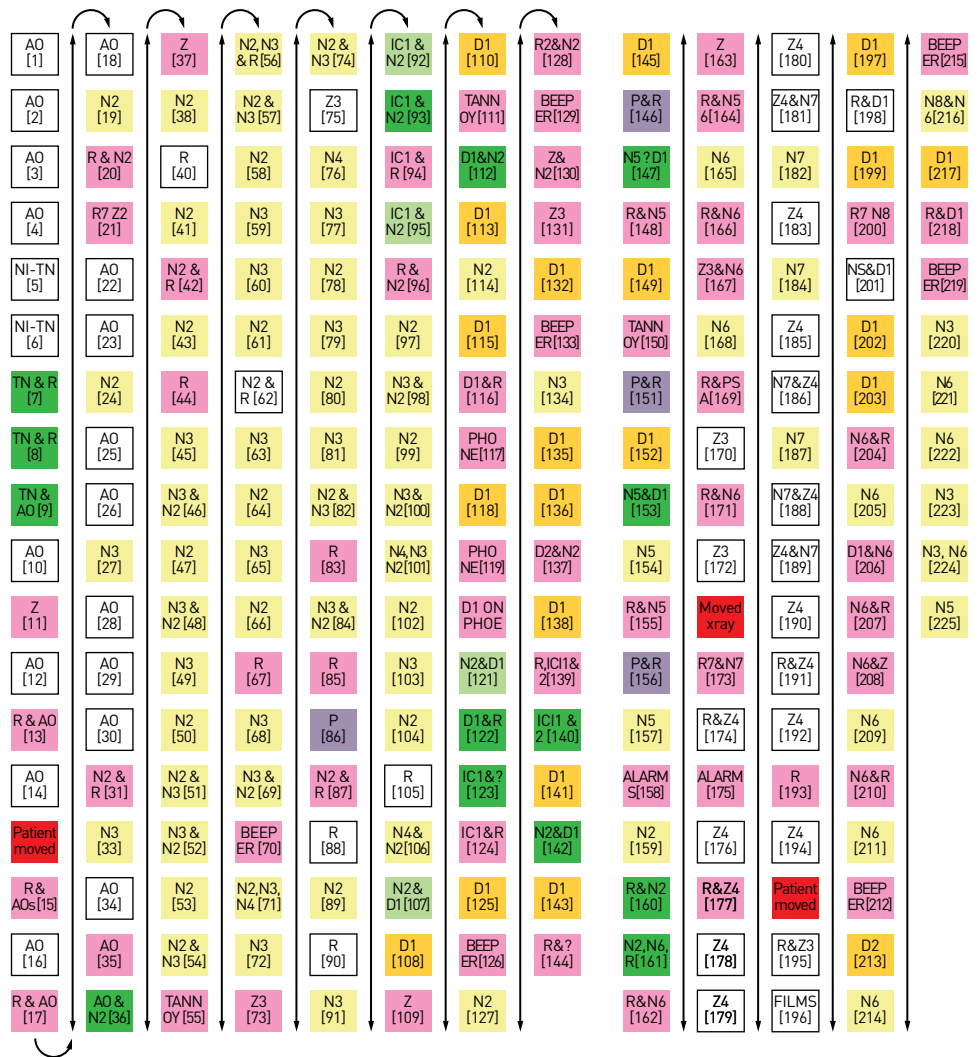


Figure 5.4: Sequence of communications with and by Denton (adapted from Manidis et al 2010b)

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



Throughout Denton's stay, one of the questions about him that the clinicians were trying to solve is whether he was a CO₂ 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.

As we pointed out when we introduced this example in section 3, clinicians expressed confusion about Denton's status as a CO₂ retainer on six separate occasions between 12:55 pm and 16:15 pm. Here again are the key extracts from Denton's interactions:

- | | | | |
|-----|----------|-----|---|
| (1) | 12:55 pm | N2 | <i>We don't know if he's a CO₂ retainer?</i> |
| (2) | 14.00 pm | IC1 | <i>Don't know too much about him.</i> |
| (3) | 14.25 pm | N5 | <i>I don't know much about him but collapse, wasn't it?</i> |
| (4) | 14.30 pm | N5 | <i>Is he—he's not a retainer, is he?</i> |
| (5) | 16:08 pm | D1 | <i>Yes, I think he's a CO₂ retainer ...</i> |
| (6) | 16:15 pm | D2 | <i>No, because he's not a CO₂ 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 CO₂ retainer. He's got normal bicarb so ...</i> |

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 Junior Medical Officer (JMO), picks up on this lack of knowledge but makes no definitive comment (*I think he's a CO₂ 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 CO₂ retainer or not. It is only when the senior staff specialist, D2, comes in at 4:15pm 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 a CO₂ 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 are responsible for the longest stage of the ED consultation, 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 Hmmmm 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 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's, 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 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.

Senior practice	Junior practice
D3 Could I get you to roll on to your side?	D1 Just gonna pop the bed down.
P Yeah, but what about the thing-ohs, are they OK? These.	P Now, what's gonna happen?
D3 The drip?	D1 (), So what I'll get you to do is to roll over on to your side.
P Yeah.	P Ooh, what about this? Is that OK?
D3 Yeah, the drip'll be alright.	D1 That's OK. Yep, just shuffle across and tilt towards me.
P OK.	That's right.
P I've got a ...	P (). [Background noise, Distant from mic]
D3 That's it.	D1 OK.
P Now, I've got this horrible old pad still on from this morning.	D1 Now can you bring your knees up? Bend your knees up for me. Do you think you could do that?
D3 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?	P Yes, how's that one. Oh excuse me, Doctor (). [Distant from mic]
P OK.	D1 It's alright.
D3 That's it. Roll over. Good-oh. Anyone in your family had bowel cancer at all Mrs [Patient's surname]?	[Background noise and Voices]
P No.	D1 I'll just pop your pants down.
D3 Have you lost any weight recently?	P [Patient groans.]
P No.	D1 Now first of all I'm just going to have a look at the outside of your bottom, OK?
D3 Oopsy-daisy. Just see if you can roll right on over. That's the way. Had any trouble with tummy pains recently?	D1 Right.
P No.	D1 I'm just going to pop one finger into your bottom, OK?
D3 Just relax, I'm going to have a little feel.	Patient groaning
P Right.	D1 That's it all over. (). [Distant from mic]
D3 All done."	P Pull up my pants ().

Senior practice	Junior 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'.	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 discomforted 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?'

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 below with Patient 71, Wilson (sore toe), and Patient 52, Dulcie (difficulty breathing), occur at slightly different points in their Admission stage. 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].</i> 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'? <i>[Family member laughing at the siren]</i> 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. <i>[Fire alarm is tested—this happens as N2 is talking]</i></p> <p>P OK.</p> <p>N2 Or the nurse will fill it out.</p> <p>P Alright.</p> <p>N2 So ask her what her name is.</p> <p>P OK.</p> <p>N2 And just so you know what's going on so you're not sitting here==</p> <p>P ==Yup==</p> <p>N2 ==Going 'I wonder what's happening'?</p> <p>P <i>[Chuckles].</i> Alright, then.</p> <p>N2 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.</p>	<p>N2 Hi I'm Sandy, I'm a nurse.</p> <p>P How are you?</p> <p>N2 Good thanks.</p> <p>N2 OK. So your full name please?</p> <p>P Dulcie <i>[surname]</i>.</p> <p>N2 Lovely. And your date of birth please?</p> <p>P <i>[DOB]</i>,==</p> <p>N2 ==Terrific. Alright. Just lie down on the bed for me please, Dulcie. <i>[Patient coughs]</i><i>[Nurse leaves to get armband]</i></p> <p>N2 OK. So I'll just ask you again, Dulcie, for your full name please.</p> <p>P Dulcie <i>[surname]</i>.</p> <p>N2 And your date of birth please?</p> <p>P <i>[DOB]</i></p> <p>N2 Thank you.</p> <p>P I'll get the six out yet. Twice I've had a shot at that.</p> <p>N2 Alright.</p> <p>N2 You in any pain at all Dulcie?</p> <p>P No. Me feet are frozen, I don't know why.</p> <p>N2 OK.</p> <p>P Oh, gawd.</p> <p>N2 I'll keep that in mind. <i>[Chuckles]</i></p> <p>P Need a bed warmer.</p> <p>N2 Be back soon. <i>[N2 leaves at 12.03pm]</i> returns at 12.35pm</p>

More effective	Less effective
<p>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.</p> <p>A little while later Nurse 5, who also looked after Wilson, was impressed to see the sheets were being of some, but limited use:</p> <p><i>N5 You know Wilson, you're one of the very few that have actually filled one of those out, I'm very impressed.</i></p>	<p>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>'I'm Sandy. I'm a nurse'</i>. 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>'I'll keep that in mind'</i>. 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 <i>'Ah, well I think he's coming back isn't == he?'</i></p>

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 CO₂ 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 patients' ability to be heard and may limit the explanations they give patients about their illness and about the ED system.

Our study found marked differences in the communication of doctors and nurses. Doctors' communication broadly centres on the process of enquiry and nurses' communication broadly centres on the process of providing information. However, both doctors and nurses tend to limit patient participation in their communication with patients. Both doctors and nurses tend to encourage patients to take a passive role and do not invite patients to be involved in their medical condition.

For example, we analysed the number and type of questions and the number and kind of statements made by the doctors, nurses and patients throughout patients' journeys. Figure 5.5 shows communication during stage 3 of Graydon's consultation.

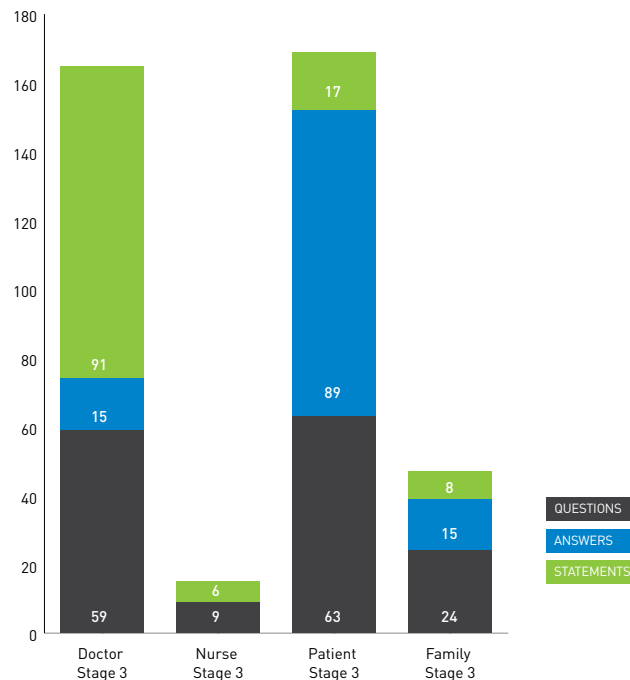
In Graydon's case, the junior doctor asked 91 questions (75 about illness and 16 about the system), while the nurse asked only 6 questions (six about illness and none about the system). The doctor also provided many explanations (59 statements: 20 about illness and 39 about the system), and the nurse contributed 9 (3 statements about illness and 6 about the system). The patient asked 17 questions (five about illness and 12 about the system) and his wife asked 8 (three about illness and five about the system).

Graydon's main contribution was through the information he provided about his medical history: his answers (89) to which his wife added 15, and his 63 statements (43 about his illness and 20 about the system). Graydon's wife added information to the shared knowledge by contributing 15 answers about Graydon's medical history and 24 statements (11 about his illness and 13 about the system). The majority of the questions asked by both the doctor (59 out of 91) and the nurse (6 out of 6), were closed questions, which limited the scope of Graydon's answers to a 'yes' or a 'no'.

The fact that different disciplinary clinicians use different communication options with patients is not in itself a problem. It is in fact consistent with the different roles and responsibilities of doctors and nurses. However, we do find problematic the finding that *both* doctors and nurses appear to discourage patients from taking an active, collaborative role in the exchange of information about their medical condition.

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.

Figure 5.5: Questions and statements in the consultation with Graydon (adapted from Manidis et al 2010b)



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 the 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 eating well obviously distressed because of that*.

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

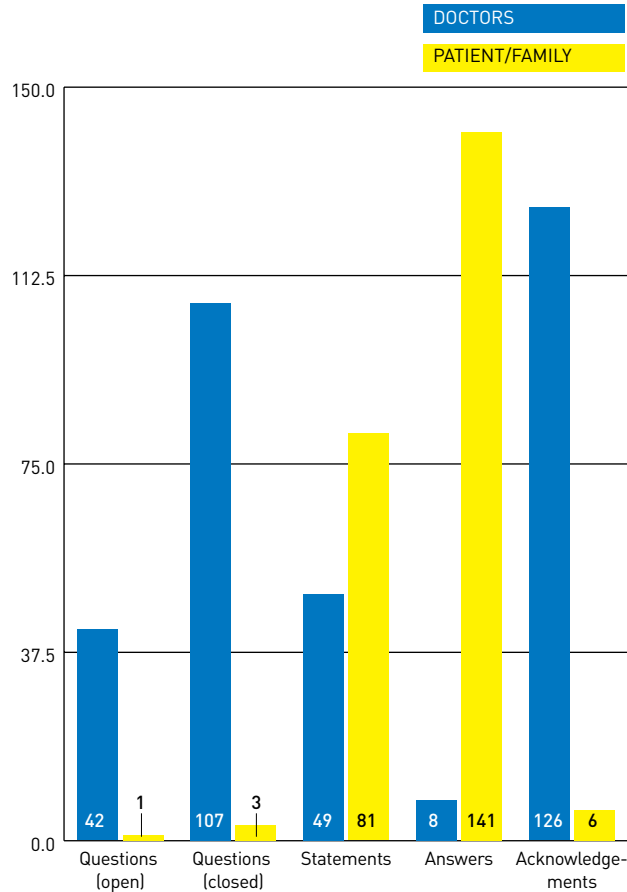
D2: *And is – what's wrong with your son?*

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.*

Figure 5.6: Analysis of questions and statements for Patient 1, Fahime



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 5.6 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 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 ...*
P: *Probably since early this evening, this afternoon.*
N: *So it's just today that it's come?*
F: *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?

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 healthcare. 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*

The focus of our research was to describe the kinds of communication strategies that clinicians used to manage individual patient journeys from Triage to Management and to examine the impact of these spoken interactions on the patients' care. Our study has taken account of the many challenges to communication that are inherent to ED sites, including the fact that EDs are dynamic and noisy workplaces and present a multitude of interruptions and distractions for clinicians, who must make multiple decisions about many patients over very short time frames.

Despite the fact that many patients who attend the ED are newcomers with sparse histories, with many presenting with atypical or vague symptoms or with multiple co-morbidities, clinicians are required to make decisions relating to diagnosis and treatment very quickly (due to both high demand and policy imperatives). Added to these difficulties, EDs in NSW and the ACT are used as training sites for junior doctors. This means that senior doctors are responsible for high-density and often vicarious decision-making (working on reported information only).

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 patient-friendly ways to communicate medical information and they must establish a more individual, 'human' connection with 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, presented in section 1. Below we discuss examples of each strategy. 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.

A senior registrar outlines his use of questions:

'So, I will often do—I call it a bit of a run around, especially when I'm by myself at night—I will go to the sick patients and maybe ask them five or ten questions, very rapidly, start the treatment plan, go to the next one, depending on how busy it is and then come back and then take more information as it comes.' (Senior registrar)

He continues to say that good questioning can go beyond the limitations of a protocol approach to particular conditions:

‘There’s one [protocol] for each [particular condition]; it’s a printed sheet. And the way it impacts, which I dislike, is it has a tick box. And if five people who aren’t very experienced in doing the job and using [it], they ask—their communication becomes a series of questions designed to tick the boxes off. And, in which case, you tend to ask very leading questions, because you’re asking yes or no questions to a prompt, which for a patient when they’re describing pain, is actually terrible. You plant that seed, “Oh, it’s tight, is it?”’ (Senior registrar)

The medical problems that are presented in the ED vary between those that are straightforward and those that are complex, often further complicated in the case of elderly patients by multiple co-morbidities. If patients are seriously ill, or elderly, they may not give the correct story or may have difficulty remembering, or they may not understand the questions correctly. In these cases questions may have to be asked repeatedly to ensure an accurate diagnosis, and to maintain patient safety.

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** (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?’*) 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 ...’*
- **Information command questions:** (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.

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

In all stages of the ED consultation, clinicians must find out about the patient’s medical condition and communicate medical information about the patient’s condition and management/treatment options. To do this effectively, clinicians need to be able to listen to the patient, impart medical information accurately and ensure the patient’s awareness of and agreement to the treatment plan.

Key to these strategies is the ability to listen to and validate the patient’s experience, rather than just be able to provide information. We identified the following component strategies for the effective achievement of these communicative goals:

-
1. Allow space for the patient to tell their story
 2. Seek and recognise patients' knowledge and opinions about their condition.
 3. Explain medical concepts clearly by moving between technical (medical) and commonsense (everyday) language.
 4. Spell out explicitly the rationale for management/treatment options and decisions.
 5. Provide clear instructions for medication and other follow-up treatment, appointments, etc.
 6. Explain the hospital processes the patient will need to go through.
 7. Negotiate shared decision making about treatment.
 8. Repeat key information, check comprehension and offer clarification throughout.

We now present and discuss examples from our data that demonstrate the use of these strategies. These strategies are summarised in Table 1.1 on page 11.

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 can sometimes deny the patient this valuable communicative opportunity.

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.

Indicators of whether the patient has been given sufficient space to tell their story are the use of particular types of questions, the type and number of acknowledgements made and the length of patient turns at talk.

Here is an example of a triage nurse starting her assessment by asking the patient an open question ('*Um, so what's happened today?*'). She then allows the patient the space to provide a detailed narrative, using minimal acknowledgements (such as *Yeah* and *Mm*) and asks more specific questions when she needs further clarification:

NI Yeah. Yeah. Um, so what's happened today?

P Um, I'm unwell sort of like as he said for days but this is different.

NI Why is he giving you penicillin, just for a upper respiratory tract infection or something is it?

P I don't know. I've been—had like a virus and tonsillitis and then pharyngitis.

NI Tonsillitis. OK.

P And then, um, had to go to my after hours 'cause I couldn't get into my doctor's. And after hours doctor gave me that one.

NI Yeah.

P So I started taking that by itself. I have had an allergic reaction to Keflex before.

NI Mm.

P But this isn't Keflex. So I—I had it and there was no allergic reaction to that. Was on it for a couple of days and wasn't getting better. Went to my doctor and he had one look at me and said "Shit, you don't look well". I was not well, I couldn't—have not moved for four days or ate or drink.

NI Mm.

P And he said bend over, and gave me a shot in my bum, gave me—said they're not strong enough, gave me a shot straight in the bum.

NI Mm.

P So last night I sweated all night, all night sweating. I thought oh, I'm finally going to break it, thank God. And this morning I went—I've had a temperature for five days, non stop—um, () this morning I felt a tiny bit better.

NI Mm.

P My face was going cold and numb

NI Mm.

P Felt like it was cold, um, like ice cold water running down from my neck, or down () it sounds very () but that's the only way I can explain it.

NI Yeah.

P It's the only way I can explain it, like cold, numb, just seeing little black dots and stuff.

N1 Mm.
P And was this white frothy stuff was coming out, bits of white froth.
N1 Yeah.
P And um, when I had a allergic reaction to Keflex, I had the white frothy thing too. So ...
N1 OK.
P I thought I'd just wear it out for a while. So I was laying in bed and thinking I'll get better, it'll go, it'll go...

In the next extract, the doctor gives the patient space to provide the information he needs, offering the patient space to provide an alternative in his first question and then using assumptive questions to show he's listening and to probe for further clarification:

D1 Um and at home do you need any oxygen? Or ...
P No, um, () Ventolin inhaler thing.
D1 OK.
P Ah, I was on Symbicort there, ah, Spiriva, is that another ()?
D1 It is.
P But the Ventolin he seems to have put me on and then uh, um the steroids.
D1 OK.
P And, ah, the Vibramycin is the one, I'd say that has released all this mucous==
D1 ==And so you are coughing up—you are coughing up gunk? [assumptive question]
P Oh, I have got yellow.
D1 Yellow.
P When it comes up. There seems to be a hell of a lot here that's not == coming.
D1 == So you feel like—you feel like it's there? [assumptive question]
P I feel like it's there.
D1 But you can't get all of it up? [assumptive question]
P I can't.
D1 OK.
P I've never been one to really be able to cough == up.

In contrast, in the excerpt below, the nurse begins with two open questions, but then does not allow space for the patient to tell his story as many of the questions she asks are closed (requiring a yes/no answer):

P == Some might say it would be easier.
N3 Yeah, so how far are you affected, in bowels and bladder or? [open question]
P Ah, well ...
N3 Not quite, or (). How long have you had [] for?
P Ah, since '91.
N3 (Was it) a kind of rapid onset for you? [closed question]
P Oh, no, gradual.
N3 Oh, () alright ().
N3 What specialist looks after you?
P Oh, B.
N3 OK, yeah. You're not on steroids at the moment? [closed question]
P No.
N3 Not allergic to anything? [closed question]
P Ah, yeah.
N3 Oh, OK.
P Pred—Prednisolone.
N3 Oh, are you? [closed question]
P And Keflex.
N3 () what they treat you all the time with? OK, now do I need to == ()? [closed question]
P == Yes, please.
N3 OK.
N3 I wish I could help you more (but).

In the following table we examine two examples from Triage for Patient 21, Jean (review suture for leg injury), and Patient 34, Graydon (cardiology admission), and discuss why we believe one is more effective than the other.

More effective	Less effective
<p>N1 <i>And you're here today for...? [Open question]</i> P <i>I um had some stitches put in on Sunday and it was sort of a tricky little uh cut, so they wanted me to come back today just to check on it.</i> N1 <i>OK. And how's the pain been in the leg?</i> P <i>It's OK. You know...you know it's there but it's not throbbing or anything.</i> N1 <i>Not too bad? OK. And you haven't noticed any redness or anything around the area?</i> P <i>Well I haven't taken it off.</i></p>	<p>N1 <i>Were you in here yesterday were you? [Closed question]</i> P <i>Yes, very early yesterday morning.</i> N1 <i>And what was the problem then? [Open question]</i> P <i>Um...oh well...</i> F <i>Same problem</i> P <i>Same problem, but um...</i> N1 <i>Yeah, it's just that I'm different so I'm asking the same sort of questions ==</i> P <i>Oh right.</i> N1 <i>So I can triage you, that's all.</i> P <i>That's alright. Um...so yeah, we went through um...blood tests, ECG, um...X-ray. They couldn't ah...the doctors at the time, they couldn't see anything acute... And he said er... there's a problem. Mmm...Basically what he's saying was that er... Is it the...is it the left ventricle?</i> F <i>It's ah...yeah...he's ah...he's in heart failure basically.</i> N1 <i>Mhmm. How old are you?</i> P <i>Fifty-one.</i> N1 <i>Allergic to anything?</i> P <i>No.</i> N1 <i>You on medication... at the moment?</i></p>

More effective	Less effective
<p>In this example, the triage nurse opened up the space for the patient to tell her what she knew about her injury by asking an open question. The focus of the questions narrowed as the nurse checked her understanding of Patient 21, Jean's (review suture for leg injury) level of pain ('Not too bad') and then she used an assumptive question ('And you haven't noticed any redness or anything around the area') to check for evidence of infection. The continued use of 'and' at the beginning of each question created a sense of continuity in the questioning process.</p>	<p>In this example, the triage nurse opened with a closed question followed by an open question. The triage nurse initially established that Patient 34, Graydon (cardiology admission), had presented at the ED the day before. When she asked what the problem had been then, (i.e. the day before) Graydon and his wife assumed that this information would be on record. Graydon and his wife were unaware that the same process is initiated for each patient who presents at the ED, even if they have attended the ED as recently as the day before. On each new occasion, the triage nurse must make an assessment of the presenting illness/injury on the basis of what she finds at the time. The interaction gives us an insight into the prominent role of the rules and protocols that apply in the triage process, sometimes over the seriousness of the illness.</p>

With Graydon, the nurse asked only five questions during Triage: four of these related to the patient's medical condition and one to the hospital system. Graydon asked only one question about his medical condition, and his main contribution to the interview was to respond to the questions he was asked. Although one of Graydon's responses as well as one of his wife's were more lengthy because they had been through the same process the day before and they were now more familiar with the system, they were constrained in terms of the space they were allowed. Having been told that Graydon was in heart failure, the triage nurse responded with 'Mhmm' and proceeded to ask another two questions about his age and allergies.

The triage nurse explained the reason she needed to reassess the presenting illness herself, and the patient and his wife responded by sharing what they knew. Once the presenting condition was established, the triage nurse returned to the triage protocol, even though this information would have been recorded on the patient's notes. This is a demonstration of the fact that all clinicians are accountable for their own practice and must stick to protocols—but it is frequently mystifying to patients who assume clinicians have access to prior information.

At the conclusion of the triage interview, the triage nurse told the patient that he was to be placed in the acute section of the ED, and then took him to the bed and began the Admission stage herself. She then double-checked the patient's personal details and reaffirmed her own responsibility for this when the patient appeared bemused:

N And you said you're not allergic to anything?
P No.
NI And your date of birth is [date of birth removed]?
P That's correct. [Sound of crashing] Should've left the... tag on from yesterday, shouldn't I?
F Yeah.
NI It wouldn't count.

Some doctors in our consultations opened space for patients to tell their stories very effectively in the Initial Assessment and Stabilisation stage. In the example below, the doctor gives space to Patient 21, Jean (review suture for leg injury), to outline her condition.

D1 So, what seems to be the problem now?
P Well nothing's the problem. I came in on Sunday.
D1 Mm hm.
P I had a very deep cut in my leg ==
D1 Mm hm.
P == and I came in the ambulance because it was bleeding a lot ==
D1 Mm hm.
P ==and ah, then [Name removed], or the doctor, ==
D1 Mm hm.
P ==She... It was har... difficult to sort of stitch because of the ==
D1 Mm hm.
P == because of the shape of it and everything ==
D1 Mm hm.
P == So, um, she just wanted me to come and have the dressing changed today and to check that everything was going OK.
D1 Mm, OK, good.

In this example, the doctor initially engaged the patient by asking an open, neutral question, and then limited her own contributions so that Jean could describe the sequence of events uninterrupted. The doctor's response at the end of the narrative was positive but non-committal, 'Mm, OK, good'.

In section 5 we quoted from the case of Patient 1, Fahime (dizziness, feeling stressed), the Middle Eastern patient who was examined by two junior doctors, neither of whom picked up on clues to her depression. In fact, in the three hours Fahime spent in the ED, she was asked 149 questions, the majority of which were closed (requiring only yes/no answers). By contrast, Fahime and her family asked a total of four questions, suggesting a striking lack of collaboration in the patient-clinician relationship.

Our data repeatedly indicates that allowing patients a greater opportunity to contribute to shared-knowledge building may be a way of making the patient journey more efficient. Patients may well be able to provide crucial medical information.

This is particularly the case in the Initial Assessment and Stabilisation stage: if clinicians allow patients room to tell their stories, by encouraging longer turns at talk, 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.

However, given the time and clinical pressures on senior doctors, they must find out efficiently what they need to know from patients. Some—mainly senior doctors—displayed considerable skill in allowing the patient room to talk while also narrowing in to clarify essential medical information.

For example, the two senior doctors involved in the Management stage for Patient 37, Nola (PR bleeding), and Patient 34, Graydon (cardiology admission), used the same strategy that other clinicians in our data have employed, and began the final history taking process by asking an open, neutral question, i.e. 'What were you doing at the time?' (Nola); 'Can you tell me what it was like?' (Graydon) This offers the patient communication space. They then made use of a range of question types, based on the information they needed to establish a plausible diagnosis/hypothesis.

The surgical registrar who took responsibility for care of Patient 37, Nola (PR bleeding), during the Management, Diagnosis and Disposition stage of her consultation invited Nola to tell her story:

D3 What were you doing at the time?
P Well nothing really. I—I'd just had lunch and I was, um, I'd had this green apple, oh well Granny Smith apple, and ah, I thought oh, that was giving me the pains in me tummy. Anyway, ah, so I thought oh, I better go to the loo.

He checked that some of the information Nola had given in the Initial Assessment and Stabilisation stage was still the case, by asking a series of assumptive questions (indicated in bold below). This less direct style of questioning appeared to place a positive value on Nola's earlier contribution. The re-questioning process gave Nola an opportunity to explain the reason why she did not have a scheduled colonoscopy and time to accept the inevitable need for another one in the future:

D3 **So you had some, ah, some tummy pains first?**

P *Just—just slight, you know, and I thought oh that's that green apple. When I got there, though, mm, it come away and then I felt faint and called to my husband.*

D3 **So you felt like you had to go in a hurry?**

P *No, not really. It was, um, just that I was just gonna go anyway...*

D3 **You mention that you felt faint as well?**

P *Oh, yes. Yes, I felt as if I was gonna faint. That's when I called out to my husband because if I fell I'd hit my head on the hand basin and all that 'cause it's all so close, you know.*

D3 *OK.*

P *So, anyway, anyway...*

D3 **You had some diarrhoea, some bloating and some pain?**

P *Mm. Is that what that says there is it? [Patient notes]*

D3 *Dr (). [Muttering while reading notes]*

P *No, but as soon as I () blood came I thought, this is it, I need another colonoscopy. But I hate that lead up to it, you know, that's why I sort of put it off from having another one.*

D3 **You were supposed to have another one and you never did. And it was nine years ago now?**

P *Nine years is it?*

D3 *Nine years.*

P *From whom?*

D3 **That was when you had the colonoscopy, was in 1999?**

When the surgical registrar required more specific information, he asked a series of closed questions (in bold below), often repeating what Nola said out loud, gradually building up a clearer picture of the problem for himself and for her:

D3 **And did you actually pass, ah ...**

P *Oh, yes. Yes. Clots, about that big, mm.*

D3 *Ah-hm.*

P *Dark.*

D3 **Can you—yeah, describe them to me? They were dark.**

P *Dark.*

D3 *Big clots.*

P *Clots of blood, mm.*

D3 *OK.*

P *How can you describe that?*

D3 *Oh well, just the colour, the size, I suppose.*

P *Yeah, clots. (Attempt to get more information from P)*

D3 **Did you do poo with it as well?**

P *Ah, no. That—that was all that came.*

D3 *It was just blood.*

P *Yes. A lot of it too.*

D3 *Oh, OK. Alright.*

With Patient 34, Graydon (cardiology admission), the senior staff specialist used a series of very specific, largely closed questions to focus on particular aspects of Graydon's history. Graydon's case was potentially very serious, so there was a sense of urgency in the interaction that precluded any negotiation around treatment. In the following examples, the doctor is focused on the patient's pain. Her questions (in bold) follow the classic three turn pattern described by Mishler (1984) in which the doctor asks a question, the patient responds, and the doctor briefly acknowledges the response before asking the next question and so on. In other words, the doctor has complete control of the interaction:

D2 **Can you tell me...what was it like? Can you describe it at all?**
P *I've tried this before ... um ... Not really sharp but ... acute.*
D2 **OK.**
P *Um ... and ... consistent?*
D2 **Did it go anywhere else other than across your back?**
P *No.*
D2 **OK. And was it absolutely non-stop? Or did it come in waves?**
P *No, it was non-stop.*
D2 **OK. And how did it get better? Did it gradually get better?**
P *Yeah. It um ... seemed to dissipate from the outside and took ... at one stage, ()...*
D2 **OK. And then did it go away ... completely?**
P *Yeah.*
D2 **How long did it last ... about?**
P *I'd say altogether somewhere between two and a half to three hours.*
D2 **Oh. And have you ever had a pain like that before?**
P *No.*

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. Here is one doctor doing this with another patient:

D1 **OK. Um, have you felt like you've had fevers?**
P *Ah, that day I had, and I've been taking Panadol and stuff for that ... I'm alright now.*
D1 **Do you think the Clindamycin has made a difference == to the rest of you but...?**
P *== Yeah. I think it's done... yeah, done well for my leg and it's just*
D1 **OK.**
P *Panadol and stuff, just kind've done alright.*

P *==Ah, sometimes I have headaches, um ...*
D1 **Associated with this ... this episode do you think?**
P *Yeah, I have in the—the last nine days.*
D1 **OK.**

When a clinician does allow the patient space to tell her story, the clinician can then intervene in the narrative at relevant points to clarify what the patient already knows about her condition. Failure to hear the story tends to lead to failure to find out useful information the patient could share, if encouraged to.

In the following examples, although both nurses use assumptive and closed questions, in the more effective example N2 alternatively allows space to Patient 37, Nola (PR bleeding), and occasionally hones in on a detail. On the other hand, N2 in the less effective example continues with closed and multiple questions and then follows these with questions, all of which restrict Patient 5, Chaitali (PV bleeding), in giving a proper account of her illness.

More effective	Less effective
<p>N2 So you've been leak—bleeding a lot have you? [Assumptive question]</p> <p>P Well I consider it's a lot.</p> <p>N2 Is it in the stool or around the stool when you open your bowels? [Closed question]</p> <p>P Um...I haven't had a bowel movement. It all started yesterday.</p> <p>N2 Yep. [Allows space to continue]</p> <p>P I had an apple, a Granny Smith apple, and I thought oh, the pains, I thought it's that sour Granny Smith.</p> <p>N2 [Laughs]</p> <p>P Anyway, I went to the loo...</p> <p>N2 Yep. [Allows space to continue]</p> <p>P And I could feel myself, coming out in a real sweat and I called to my husband 'causel thought I was going to faint and fall against the, you know, the basin and that.</p> <p>N2 Yes, yep. [Allows space to continue]</p> <p>P And—and then—and I'm perspiring, something terrible ==</p> <p>N2 == Mm mm [Allows space to continue]</p> <p>P == really big clots like that.</p> <p>N2 Yeah, so big clots. [Allows space to continue]</p> <p>P Yes, they were.</p> <p>N2 OK. Have you been constipated? [Closed question]</p> <p>P No not today.</p> <p>N2 Have you been constipated? Just lie yourself back.</p> <p>P Oh my bowels have never been really good I don't think.</p> <p>N2 Oh OK. [Allows space to continue]</p> <p>P Ever.</p> <p>N2 And have you had this before, in the past? [Closed question]</p> <p>P Not with the bleeding.</p> <p>N2 No? OK. Alright.</p>	<p>N2 So now you've come in with bleeding since this morning? [Assumptive question]</p> <p>P I—I was here actually last week. [Voice distant from mic]</p> <p>N2 Yeah, what time did you—did you just wake up and you were already bleeding? When you went to bed last night you were OK? [Assumptive question & multiple questions]</p> <p>P No, I also have the bleeding, but () never ().</p> <p>N2 Since your treatment, yeah? [Assumptive question].</p> <p>P Yeah, but this morning there were clots.</p> <p>N2 You're passing clots into a pad? [Assumptive question]. Have you got any pain at the moment? [Multiple questions]</p> <p>P Little bit.</p> <p>N2 What would you say it was out of 10 ()?</p> <p>P Pardon?</p> <p>N2 What would the pain be out of 10? Ten being hit by a truck, and zero, no pain. What would you say?</p> <p>P About eight.</p> <p>N2 Eight. Have you had anything before you came in for pain at all? [Closed question]</p> <p>.....</p> <p>N2 (). Are you allergic to anything at the moment? [Closed question]</p> <p>P Just codeine.</p> <p>N2 Codeine?</p> <p>P Yeah.</p> <p>N2 OK. And apart from your obviously, um, ovarian cancer, have you got any heart or lung problems? [Closed and double question]</p> <p>P No, I'm asthmatic,</p> <p>N2 Asthmatic</p> <p>P And osteoporosis, osteoporosis in my neck, pain in my neck [Chuckles].</p>

More effective	Less effective
<p>In this example, Nurse 2 briefly reviewed her understanding of why in Patient 37, Nola (PR bleeding), had presented at the ED. She firstly checked why Nola had come to the ED by asking her an assumptive question ('So you've been leak—bleeding a lot have you'), and then allowed her the space to provide a detailed narrative during longer turns of talk. The nurse responded to Nola's story with minimal acknowledgements (such as 'Yep' and 'Mm mm') as a way of encouraging her to tell all she knew, and asked more specific questions when she needed further clarification. Nurse 2 kept the patient's direct experience in focus, by using the personal pronoun 'you'. Nola in turn, responded by giving a very personal and detailed account of what had happened, from the perspective of 'I'.</p>	<p>In this example, an agency nurse settling Patient 5, Chaitali (PV bleeding), used several closed questions, assumptive questions and multiple questions all of which restricted space for Chaitali to respond. The question on the severity of pain is a standard one, but was initially misunderstood by Chaitali whose first language was not English. As Chaitali was in extreme pain, we would argue that the reference to the truck was also extremely inappropriate, as was the way in which N2 referred to her 'obviously, um, ovarian cancer'.</p>

Simply finding out what the patient knows is useful. However, it is even more effective for the clinician to actively demonstrate empathy and understanding, thereby validating the patient's collaborative contribution to the consultation.

In the extracts below we see the junior doctor involved in Patient 62, Donna (HX, anal fissure), seeking information about her condition and what she has experienced. The junior doctor valued Donna's input into the discussion by firstly allowing Donna to add further information about the time frame and development of the haemorrhoids and then she asked additional questions about her symptoms and experiences, listening attentively ('Yes, Yeah, OK, OK. Mm') and valuing her understanding of what the patient experienced. As the patient was in considerable pain, she also expressed her sympathy ('I'm feeling for you'):

D1 OK so tell me when this problem first started Donna.

P I'd say it's probably about a month, probably about—I had a haemorrhoid.

D1 *Yeah.*
P *And I had that lanced a couple of weeks ago.*
D1 *Yeah.*
P *==And, um—*
D1 *I'm feeling==for you.*
P *==but I thought that it was more than just a haemorrhoid.*
D1 *Yeah.*
P *And when that cleared up then==*
D1 *==Yeah.*
P *—yeah this fissure's just gradually got worse.*
D1 *Yeah, OK. So how long ago did the haemorrhoid sort of develop?*
P *I think only five weeks ago.*
D1 *OK, and had you had haemorrhoids in the past or was this a new thing for you?*
P *Yeah look I've had a haemorrhoid when I had my kids.*
D1 *Yeah, OK.*
P *So that's 19 years ago.*
D1 *Yeah.*
P *Yeah no, it's—but a fissure, I was in here, um, September 2007.*
D1 *Yeah.*
P *With a fissure for five days.*
D1 *OK. And the um—do you know whether it was an internal one or an external one?*
P *Oh it's just—just sort of in—it's just inside.*
D1 *OK. And was it==*
P *==So it's that spot.*

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.

In the following example, the senior registrar communicated his medical knowledge and his diagnosis to Patient 37, Nola (PR bleeding), by describing her condition in terms that she could understand. He also explained the medical consequences of her condition, and thus provided a clear rationale for his treatment plan:

D3 *There's a few things that can cause bleeding out the bum. I think in you the most likely is that it's coming from some diverticular disease. Now that means little pockets on the wall of the bowel that they've noticed before when they've done your colonoscopies.*
P *Have they?*
D3 *Yeah. It's not a serious problem, it's not like cancer. But these little pockets on the wall of the bowel can bleed from time to time and they can get infected.*
P *Oh.*
D3 *And I suspect that yours are bleeding. So we need to—there's no um specific surgery that we need to do, but we do need to bring you in to hospital to keep an eye on you until the bleeding settles down. And then once it's all settled down we, um, will do ... plan another colonoscopy.*

We see the same skill demonstrated by the senior doctor responsible for Patient 34, Graydon (cardiology admission):

D2 *Just because it's ... when it doesn't work well, it sort of backs up into your lungs. So you need to stay in hospital, OK? We're going to put you on some water pill, which is going to make you pee like a racehorse.*

In some cases, clinicians provide the correct medical terminology as well as using an everyday gloss of a patient's condition. For example:

P *I've worked out 15 operations since I was five, and that was tonsillitis the first.*
N2 *So you've had a tonsillectomy? The tonsils out?*

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.

In the following example, the doctor explains to the patient what he could see on her X-ray and why he was thinking of taking various options:

D1 *Well, ma'am, OK. Madam, I'm just going to explain to you. You can see the fracture clearly== here.*

P *== Yes, I totally can.*

D1 *It--it looks like in a good position from there. I'm going to talk to one of the senior doctors here just to get her opinion. But usually for such kind of fractures, what we do, we put a half cast.*

P *Yes, this is what my GP thought it would be.*

D1 *Ah, let me have a look at the other leg. Sorry, madam, just to compare. Yeah, this one is a bit swollen. I believe the swelling is related to the fracture.*

P *Yes.*

D1 *OK.*

P *Yes.*

D1 *So actually a full cast at the moment ...*

P *Yes.*

D1 *... within a few days this swelling is going to be subsided, == getting down.*

P *== Yes, it will, yes.*

D1 *And the full cast it going to be really loose.*

P *And that won't be == any use.*

D1 *==And it's going to be--it's going to be useless.*

P *Exactly.*

D1 *So what we do is a half cast, get this swelling subsided.*

P *Yes.*

D1 *And then give it seven days and then I'm going to give you a referral to the fracture clinic.*

P *Right.*

D1 *You will need to ring, get an appointment done and come [P Yes]--come the day of the appointment you will be seen by the specialist people, ortho wards, and they--they will get a full cast done and give you the good advice.*

As already mentioned, explaining medical knowledge clearly typically involves moving between technical and everyday terminology, as the nurse in the following example demonstrates. She also explains the medical consequences of the patient's condition and thus provides a clear rationale for his treatment plan:

P *Dr C did explain sort of briefly, um, the other day, like it's a sort of form of herpes. But sort of, no, not really?*

N2 *Yeah, well ...*

P *With a different sort of ...*

N2 *Yeah.*

P *... strain.*

N2 *Chicken pox.*

P *Chicken pox.*

N2 *It's called Varicella zoster.*

P *Oh, OK.*

N2 *Herpes Varicella zoster so we just call it HVZ, but it's not ...*

P *HVZ.*

N2 *It's chicken pox.*

P *It's chicken pox.*

N2 *And the--the silly name for it is that. But, we always go with the friendliest name, not the most unfriendliest name.*

P *[Chuckles]*

N2 *We go. So it's a virus.*

P *Mm-hm.*

N2 *It's part of the herpes virus family, called shingles.*

-
- P Oh, OK.
- N2 Ah, three trigeminal ganglions which is pretty much your arm, == and chest ...
- P == Oh, OK, arm and chest.
- N2 ... and your back.
- P Right.
- N2 So it follows that nerve route.
- P Oh, OK.
- N2 So it's a typical picture.
- P Yeah.
- N2 Ah, features. Has a rash. Painful, lasts 10 to 15 days. [P Mm mm] You have a kind of cold or a—feel as though you've got a cold for 48 to 72 hours before it ...

In the following example the triage nurse explains her reasoning very clearly to the patient about her high blood pressure:

- N1 Swap arms and we'll just measure this one. OK. Keep that nice and straight like so. So that one is 218, that reading. Um So it is up a little bit. Years ago we used to have a little capsule and it had a medication in it. We'd put a hole in it, squirt it under your tongue and it'd drop your blood pressure very, very quickly. Ah, that was about 15 years ago because we were very concerned == your blood pressure is up ...
- P == Ah, yeah.
- N1 ... would you pop a blood vessel in == your head and have a stroke?
- P == Yeah, yes. Yeah, that's why we don't ...
- N1 Or, would it cause lots of problems elsewhere in your body? We don't—the evidence now shows that blood pressure should be very, very carefully dropped. And that tends to be not over a 24-hour period even, it can be for longer. So we very rarely will, even with the blood pressure of 236, we'll have patients with blood pressures higher than that, and we will actually look at starting you on some kind of blood pressure tablets with your GP following it up because we only get to see you once usually. That's good for you.

Some clinicians explain their reasoning to the patient. This allows clinicians to provide patients with crucial knowledge, which gives them the opportunity to contribute to decision making.

In the next extract from the consultation with Patient 70, Jack (MS, feeling unwell, weak), the senior doctor explained his reasoning very clearly to Jack and why he was thinking and doing various options. Although he could not assist Jack further medically, he recognised that Jack required additional assistance:

- D2 Yeah. OK. Well, listen, I guess in terms of the results that we see, they look fine, OK. Your blood count is completely normal, inflammatory markers are not exciting. There's nothing that would suggest that you've got an underlying infection or anything, which is always a worry with the symptoms that you're describing.
- P It is for me, yeah.
- D2 Um, and you know, everything from that point of view looks alright. My bigger concern probably is that, you know, you've got a disease that is scary and all the things that you're describing are probably, you know, kind of mentally consistent with you being under quite a bit of stress with all of this. Um ...
- P Yeah.
- D2 Which I think may be part of this. Um ...
- P Yeah.
- D2 And you know, I guess in terms of following that up, perhaps CA and his bread and butter world, you know, you've got [], these are the symptoms of [], you carry on.
- P Yeah, yeah.
- D2 Um, but the question is whether there may be more help in terms of getting, you know, one of our psychologists or social workers,
- P Yeah.
- D2 Somebody to put you in contact with the network, you know, 'cause it sounds like you want answers and ...

In the following example, the senior doctor admits that she cannot explain the patient's pain at that moment but she shows herself willing to give her medical opinion, based on her extensive medical experience. At the same time, she provides a clear rationale for why the patient needed to stay in hospital:

- D2 I think though...I can't explain this pain that you had in your back, so my gut feeling is ... that it was muscular from the coughing thing. I ... I think that's probably what it was ... because usually when you

have a split in your big blood vessel in your chest ... very bad things happen ... and ... maybe it went away and you're the same as you always were. But I can't say for sure that's not the case.

P Mhm,

D2 The other thing is that your heart muscle is not working very well and that's why your breathing is bad.

P Yeah.

D2 Just because it's...when it doesn't work well, it sort of backs up into your lungs. So you need to stay in hospital, OK?

Explaining clearly is essential when a patient is being asked to consent to extensive tests. The following two extracts from the consultation with Patient 34, Graydon (cardiology admission), show the lengths to which the doctor needed to go in order to provide the patient with sufficient information before the patient could agree to have the tests. However, the 'payback' for the communicative effort was that Graydon indicated not only that he was willing to have the tests, but also that he understood that they were important:

D1 We may also want to do some more imaging ... studies here. Not right here ... back in the radiology department, but er—() cardiologist.

P OK.

D1 But I'll get () cardiologist one, and () make a plan between us as-to where this is going and when ... and what makes sense. Is that alright?

P Sounds great. Yeah.

D1 But um ... I'll go and go through all this and as soon as I know what's going to happen with the cardiology and with the next lot of tests, I'll come back and give you a shout.

P Alright.

D1 I'll speak to you soon Sir ...

D1 I just talked to my boss and she agrees with me that we need to do some rather more extensive imaging on top of your chest X-ray. What we'd like to do is a CT scan of your chest and abdomen because we'd like to look at particularly the condition of your aorta which is the big blood vessel coming in the top of the heart. Runs up to the heart, all the way down the side of your chest and you abdomen and down to your legs.

P OK.

D1 Now, we need to rule out a problem with the aorta as the cause of the pain down in your belly and your groin. And the only way to do that is to do a CT scan with and without the contrast injection. Now, contrast injections sometimes can cause a reaction. It's unusual. Have you ever had a CT scan before?

P Never.

D1 I think on the—in the balance of risk and benefit in the situation is overwhelming on the side of ...

P The CT scan's going to be, ah, important.

D1 Yes. I think it's an important thing to do. Um ...

P Alright.

6.2.5 Provide clear instructions for medication and other follow-up treatment, appointment, etc.

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.

In the following example, the doctor provides clear instructions for the management and follow-up treatment of the patient's wound:

D2 And hopefully tomorrow it shouldn't happen because you're off (the rest of the) stuff, going—morphine's are off your system, [medication] is off your system and it's Endone only, so it's not too much.

P OK, yeah. What's in that? Is that morphine?

D2 It's morphine-like.

P Yeah.

D2 But orally active.

P Yeah.

D2 It acts for four hours at a time, so it's pretty good. So your regimen will be Panadol four times a day.

P *Yeah.*
D2 *Your Voltaren, two to three times a day with food.*
P *Yes.*
D2 *There's Endone, I would think since you are in pain, four times.*
P *Right.*
D2 *But you wanna cut that back, you're fine, you're sleeping, so don't wake up for that, you can miss it.*
P *Yep.*
D2 *And Mon–Tues—Thursday, go to her, and then see how you are going then. She's otherwise also a good person to go to GP to start off with. I've told her your problem ...*
P *Yup, OK.*
D2 *... so you need to have some referrals to take to her.*
P *Yeah, OK.*
D2 *OK?*
P *Alright, thank you.*

When the patient's first language is not English, effective clinicians take extra care to ensure their instructions have been understood, as we see in this example with Patient 6, Luca (stiff neck), whose first language was not English:

N *So once that's done, you should probably use some pain relief or ...*
P *Um*
N *You've got some at home?*
P *I've got Nurofen Plus so.*
N *Oh, OK. Just make sure you um, have that with some food, yeah.*

The doctor then goes on to say:

D *I wouldn't be using anti-inflammatory tablets at the moment because they could make you bleed from thee ... prostate =*
P *= Yes, yes, yes. But I used Panamax. Four tablets = last week.*
D *= Yeah. You must ... No, yeah. But that's not enough.*
P *That's not enough!*
D *You need to take two ... every four hours.*
P *Ohhh!*
D *A maximum of eight per day.*
P *Oh.*
D *OK?*

A little later in the same exchange, Luca is still confused about the medication and the doctor clarifies the information again:

D *Have you got some Panadol at home?*
P *Yes I have. Yes, yes, yes.*
D *So keep taking them.*
P *OK. Every two hours?*
D *Every four hours.*
P *Every four hours.*
D *Two tablets every four hours.*

Towards the end of the exchange, the doctor checks a second time that Luca has understood:

D *Now, d'you understand everything I told you?*
P *Yeah, yeah. Panadol every four hours.*
D *Yeah. Until the pain gets better. Yeah.*

Getting patients to express their treatment instructions in their own words is one of the most effective strategies for building shared knowledge and ensuring patient understanding of their diagnosis and treatment.

6.2.6. Signpost the hospital process

While a large proportion of the activities in the ED are concerned with diagnosing and treating a patient's medical ailment (i.e. about the patient's illness), another significant focus is managing the patient through the hospital system and keeping them informed about what is happening. Doctors and nurses take responsibility for different aspects of this work through their communication with patients.

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.

While many patients in our study expressed anxiety about their medical conditions, only some were explicit about their concerns. One way to alleviate these concerns is to give patients a clear explanation about what is happening and what will happen next.

In this example, the triage nurse gives a detailed explanation of what the patient can expect to happen next:

NI *Alright, so like I said, Alwyn, 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 in one of the rooms and the house doctor will have a look at your knee, OK, if he needs to.*

This extract shows a detailed explanation from the doctor to the patient:

D1 *==No worries, OK. I'll have a quick listen, ah, but basically I think we'll—we'll need to take a chest X-ray, have a look at your chest and see if there's any obvious area uh that's infected. Um and depending on—and I'll take a little () blood see if there's any—any inflammatory response going on with white cells and things like that and make sure your kidneys are going OK.*

P *Mm mm [Papers rustling]*

D1 *Um and then once all that's back, we'll probably do—I'm sure you've done a spirometry before where we get you to puff into the ...*

P *Oh, please darl', no I'm not going to go any further than—I'll never do it.*

D1 *OK, well I'll—I'll ask you to [Patient coughs]—I'll ask you to do your best, that's all I can ask for. [Patient coughs] And once we've got all those things I'll, [Patient coughs] um, I'll see where we're at and, um, and basically make a decision then. Who do you live with, Dulcie? [Patient coughs].*

It's easy for clinicians to lose sight of just what the patients don't know about hospital procedures. In the following exchange, the consulting doctor gave his elderly female patient very clear information about her medical condition, and explained in detail what the treatment process would be but did not mention that she would need to be admitted to hospital:

D: *I would say that you've got a blockage in your oesophagus.*

P: *Yes?*

D: *In your gullet.*

P: *Yup.*

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

P: *Yes.*

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

P: *Yeah.*

D: *So I'll speak to one of the stomach doctors and get him to come and talk to you.*

P: *Yes*

D: *In the meantime, we'll put um a drip in and give you some fluid into the vein.*

P: *Thank you. Do you want me to stay here all day do you?*

Much patient anxiety and disorientation can be attributed to lack of understanding of the ED process: what the next stage is and when it might happen. The interaction below is an example of both poor information sharing by the clinician about Patient 2, Victor (can't lift legs—? stroke), and a missed opportunity by Victor and his family to rectify this gap:

D2 *It's something we do recommend to a lot of our patients who don't walk around because if a clot has formed in your leg then we need to get you Warfarin, a very powerful drug.*

F *Yeah, yeah no, OK.*

D2 *So we do recommend it once a day let's say. And um. Alright. Any questions, anything you want ==to ask me?*
 PP *==No.*
 D2 *Good. He's certainly ()*
 F *Like we're still just going to stay here?*
 D2 *No. He needs to come into the hospital.*
 F *Oh you are going to admit him?*
 D2 *Yep, yeah for pain control and circulatory vasculatory control as well.*
 F *OK.*
 D2 *Get the bowel working and get him up and about.*
 F *OK.*
 D2 *You happy with it? Are you happy now?*
 F *Yeah I am.*
 D2 *Are you happy with that?*

The doctor's opening '*Any questions, anything you want ==to ask me?*' is not taken up by Victor. The daughter's (F) question '*Like we're still just going to stay here?*' illustrates the lack of understanding about where Victor would go from that point onwards. It is not clear whether her use of the word 'here' meant the ED, or the hospital. The registrar assumed she meant the ED, hence responded with a 'No' saying Victor would need to come into the hospital. Victor's daughter then used the more formal wording '*admit*', which was the first time she had fully understood the next steps. The registrar then provided some additional information as to why '*Get the bowel working and get him up and about*'. The daughter then relinquishes the opportunity to seek further clarification from the doctor after his speedy questions '*You happy with it? Are you happy now?*' However she was initially surprised by the doctor's statement that they would bring Victor into the hospital.

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.

In the following example, we see Patient 37, Nola (PR bleeding), make a tentative protest about the doctor's recommendation that she have a colonoscopy, but she does not challenge his plan:

D3 *And then once it's all settled down we, um, will do ... plan another colonoscopy. [Patient is silent. Dr shuffling papers.] How does that sound?*
 P *I'd rather have anything else but a colonoscopy.*
 D3 *Well, I'm afraid you've just bought yourself another one.*
 P *[Chuckles]*

Despite the momentum of medical efficiency in the ED, some patients do succeed in being active in their conversations with clinicians. These are the patients who are able to assert their own agency, usually in interactions with a cooperative clinician.

In the more effective example below an experienced registrar allowed room for Patient 5, Chaitali (PV bleeding), to make an informed health choice. The registrar's question to Chaitali about her options immediately built on their previous shared knowledge, and gave Chaitali the space to make a choice. This was made possible through their already established relationship—which is rare between clinicians and patients in the ED and, arguably, occurred because of the patient's palliative care situation. Although there was little room for negotiation because of the critical nature of the patient's condition, the registrar was able to be firm about her limited choice

and went on to explain why other options would not be as good. This contrasts with the junior doctor's disposition in the less effective example, where no explanation of treatment was given to Patient 4, Clement, an 84 year-old male who presented with left-sided chest pains:

More effective	Less effective
<p>D2 Yeah. So I'll see you again tomorrow. If the bleeding settles down with the tranexamic acid, we'll leave it as it is, OK, and we'll let you go. But if the bleeding continues to increase, then we'll consider doing something else. OK. Really, what are the options? Well you really have to the definitive option. The definitive option is the radiotherapy.</p> <p>P Oh my God.</p> <p>D2 OK? So the other thing that we can do is with packing. You had radiotherapy, if I start putting things up, you'll be really, really sore. You understand what I mean?</p> <p>P Uh huh</p> <p>D2 So what they do is normally put a lot of packs, you know, cotton packs in the vagina so as to slow down the bleeding, OK. But if I start doing it now, particularly when you've just had radiotherapy, you're going to be really sore in the bottom.</p> <p>P OK.</p> <p>D2 So do you understand what I mean?</p> <p>P Yes.</p> <p>D2 I'd rather leave you alone, start with the tablets and see whether the things settle down.</p> <p>P Yes.</p> <p>D2 And then, um, just watch you overnight. We've already matched your blood should you suddenly have a big bleed, we can give you some blood. OK. But apart from that, we're not going to do anything extra. OK, just watch you overnight here.</p> <p>P Yeah. Is it OK to take this tranexamic acid like this? Is it OK?</p> <p>D2 You're bleeding, of course ().</p> <p>P I know, I know, I'm ... yeah, yeah.</p> <p>D2 Yeah. You know, anything to stop the bleeding. Because you are coming in a hospital, all relating to bleeding.</p> <p>P I know.</p> <p>D2 Tranexamic acid has this problem, OK, it can form clots. OK.</p> <p>P Yeah.</p> <p>D2 And you start clotting in an unusual spot of course, you know,</p> <p>P ==Yes==</p>	<p>Dr I give you good news or bad news?</p> <p>P Alright.</p> <p>Dr Which one?</p> <p>P Bad one first.</p> <p>Dr Bad one first. OK you did a scan and we found some clots. Multiple. Several clots in the chest. Right that's the bad news. The good news, we found out why you have clots It's not from the heart. The heart's not going to fail.</p> <p>P OK.</p>

More effective	Less effective
<p>In this example, the oncology registrar calls on his and Patient 5, Chaitali's (PV bleeding) shared knowledge and accepts Chaitali's choice – 'That's fine' and allows the patient to make the final decision about her treatment 'OK, that's not a problem. So you () are the boss I say. == I have no problem with that'.</p> <p>D2 ==we don't want it. But from home when you're bleeding, I mean of course we don't want you to bleed to death. Whereas the potential side effects hasn't happened yet. You know, we've got to treat what's obvious and the obvious thing is bleeding. OK. Now, remember how the last time we [] you just wanted oral chemotherapy. Is that right? You know, you didn't want to have the injection, the carboplatin?</p> <p>P Yeah.</p> <p>D2 Have you had a thought, and have you ...</p> <p>P Yes, I thought I'm going to with the tablet.</p> <p>D2 You want to go to with the tablets, OK. That's fine.</p> <p>P I don't think I can stand this chemo.</p> <p>D2 OK, that's not a problem. So you () are the boss I say. == I have no problem with that.</p>	<p>In this example above, the junior doctor delivered the 'good news, bad news' item after Patient 4, Clement (chest pain) had been in the acute section of an ED for 7 hours. The junior doctor wanted to give the feedback to the patient before he left for the day at the end of his shift. It is clear that the time pressure of the shift ending, the late delivery of the diagnostic information to the doctor and the difficulties with English have resulted in a diagnosis with little finesse, given the gravity of the situation. The junior doctor's 'good news, bad news' was preceded by Clement asking the doctor to give him 'the bad news' earlier in the consultation. Thus the junior doctor did take his cue from Clement. Cross-cultural differences and novice practice impacted on the quality and comprehensibility of the delivery of diagnosis.</p>

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

In the following example a junior doctor, who also did not have English as her first language, carefully repeats information a couple of times about what has happened and how long the injury will take to heal to Patient 12, Ghadir (back pain), who also had English as her second language:

D When you fell down onto that bone, it's called a coccyx point, the coccyx ... bone. It's a very thin area ... and when you fell down on to there ... it's going to be sore ... but most likely you don't need to do anything done for it.

That needs to take time ... to get better.

The bruising is going to be ... the ... the pain itself ... probably at least for one ... one week.

When you fell directly into that area, the bruising of the bone is probably one of the worst you can get. Very, very sore.

It's going to be a bit longer than normal bruising on your arm or anywhere else.

So it's going to be a pro ... a painful part of that area for at least a week.

In the following example, the nurse reinforces the doctor's instructions and offers reassurance:

N2: So when are you—are you coming back again? Or going to the GP?

P: Yeah, no, the other—that doctor said that—just to go to the GP in about three days==

N2: ==OK. That's good. If you're at all worried you can come back soon, you can come back here or anything like that.

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.

In the follow-up interviews we conducted with patients, we found that when satisfied with their ED experience, patients always referred to interpersonal aspects of their treatment—such as caring and attentive staff and clinicians who listened to them.

The clinicians we interviewed were also conscious of the communicative importance of establishing an effective relationship with their patients:

'(Successful communication with patients)—it's very, very important. Yes. I think communication plays a very vital role especially with our kind of work because you want to make sure that you're not misunderstood. If they have any questions, they always ask me. If they have any questions before they leave that they're happy with my plan.' (Registrar)

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).

One of the junior registrars at one ED was very explicit about the importance of developing good rapport with patients. In response to our question of what his main priority was as he responded to patients, he replied:

'Um, I think, the way that I was taught is really the history and developing a rapport is going to get an answer a whole lot more than just kind of taking a quick triage history and getting rid of them. So, my main priority is actually to try and get some connection with the patient ...' (Junior registrar)

He went on to say:

'But certainly in your average person who comes in here who actually has a problem that they just want an answer to that, having some empathy and listening at the beginning, as opposed to just kind of questioning yes and no, um, you know, is key. So, you know, and then you let them talk and they'll tell you and guide them, you know, and I guess that's the difference between kind of the old style of the two minute consult. "Does your chest hurt"? "Yes". "Where does it hurt"? You certainly need to ask those questions. I think that everybody reverts back to that when there's a time constraint, right. It's not touchy feely. It's just being a human being, getting the answer. Right. So, our goal is to actually get an answer [to] we're saying. So, you know, there's—if your mind is already set on a pathway then that's what the answer you're going to get...' (Junior registrar)

However, the layers of complexity in the ED mean that different clinicians develop different relationships with patients. Below, a very experienced staff specialist describes the pyramid of care with its consequential interpersonal flow (or lack thereof) on to the patient:

'Yeah, that's part of that is how to talk to patients, how to relate to patients um excepting I's'pose, we make assumptions to a certain extent on a minimum communication standard set. Emergency medicine is a little unique in that the doctor patient relationship is different in emergency to I think any other part of medicine in that the individual, especially as you get more senior, the individual patient becomes less important. So when I'm on a

clinical shift I'm sort of looking after 60 patients at once. The registrars are looking after 20 to 30 patients at once. If you look at both their own patients and the ones they're directly supervising—so what it means is that the type of communication stuff that you're teaching isn't necessarily focused on how to be the best one-on-one communicator. So how we teach our registrars is very different for example for someone in oncology would teach where you're very much a one-on-one, there's a personal relationship between you and that patient.' (Staff specialist)

The strategies we identified for the effective creation of rapport and empathy between clinician and patient include:

1. Introduce yourself and describe your role.
2. Use inclusive language.
3. Use colloquial language and softening expressions.
4. Give positive and supportive feedback.
5. Recognise the patient's perspective.
6. Intersperse medical talk with interpersonal chat.
7. Share laughter and jokes.
8. Demonstrate intercultural sensitivity.

These communication strategies are summarised in Table 1.2, presented in section 1. We now present examples of each strategy from our data.

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.

Patient 37, Nola (PR bleeding) had 172 different encounters during the time that she was in the ED, which meant either that she engaged with someone or the consultation was interrupted every 29 seconds. Add to this the fact that Nola was an elderly patient who was in pain, and the potential for confusion is increased.

In the Initial Assessment and Stabilisation stage of Nola's consultation, the junior doctor did not introduce herself to the patient. The nurse (N2), who was doing her 'obs', announced the doctor's arrival (N2 *'The doctor'll ask you questions now'*) but Nola did not register the information and thought the junior doctor was *'just'* a nurse. This assumption may well have affected the kind of information that Nola provided. After responding to many questions about her medical history Nola finally expressed her confusion by asking the doctor:

P So what's it ... what are you taking all the info for? There was another little girl that's gonna take a lot of info.

D1 There are lots of people you'll be talking to. I'm the doctor ... I'm one of the doctors who'll be looking after you.

P Oh ... you're a doctor. I'm really sorry I thought you were ... just a nurse, I couldn't () ...

Right at the end of the Initial Assessment and Stabilisation stage, the junior doctor announced that she was waiting on the results of tests and would return in due course. Again Nola tried to connect with the identity of the junior doctor:

D1 It can take just a little while to get the results, but I'll come back and let you know.

P Right. Thank you doctor. Doctor who?

D1 (laughs)

P Yes. What's ... what's your name?

D1 [Name]

P [Name]. Nice name.

By contrast, in another ED, Patient 70, Jack (MS, feeling unwell, weak), was in a wheelchair and in the advanced stages of Multiple Sclerosis. He had arrived at 9.00am and was first seen by the doctor at 13.05pm. The junior doctor, who must have known that Jack had had a long wait, was particularly welcoming to the patient:

D1 *So you're Jack, that's right?*
P *I'm Jack, yeah.*
D1 *Ah, hi Jack. Nice to meet you. [D1 shakes patient's hand]*
P *How are you?*

Below are examples of how other doctors and nurses introduce themselves:

D1 *My name's Afendi, the intern, OK?*
P *OK.*

N1 *I'm Frieda. I'm one of the nurses, OK? So just do your blood pressure. Now you've been having dizziness and that? Is that right?*

D1 *I'm Dr Lincoln, Mara. What's happened to you?*

D2 *Hello, hi. Hi. How do I pronounce—there's no hope of me pronouncing == that name.*
Pt: *== You can call me whatever you—(laughs).*

D 3 *Jamal. My name's Helen I'm one of the doctors here.*

D4 *Mrs A, my name's Farrah. I'm one of the doctors.*

D5 *My name's Alexander I'm one of the doctors here.*
P *Alright.*

N2 *I'm Amanda I'm one of the nurses here.*

D6 *My name's Daniel I'm one of the doctors here.*

N3 *I'm... I... I'm one of the nurses.*

D7 *I'm Dr Senisa. How d'you do?*

One of the doctors in the Fast Track section of one ED was particularly welcoming to this young patient who had severely lacerated his thumb and who was in great pain. The senior doctor was mentoring a young student doctor throughout the consultation and greeted the patient:

D1 *Hi, g'day. G'day I'm [D1], I'm one of the emergency doctors. How are you feeling right now?*

In one ED, Patient 12, Ghadir (back pain), who was born in a Middle Eastern country, was anxious to know the level of the doctor who had attended to her. She had just been told that the medication she would be on would not interfere with her breast milk and felt uncertain about this and about her diagnosis. Ghadir's husband (F) also commented on the couple's ignorance about the junior doctor's experience and status and how this would affect their trust of the diagnosis and treatment:

F []. (Don't know if) she [referring to the doctor] is provisional one or ... ?
R2 *Yeah.*
F *Or a new one or ... ?*
R2 *That's interesting isn't it?*
F *How can I trust ... ?*
R2 *Yeah, you don't—you don't feel comfortable because you don't know ...*
F *Yeah, I don't know who I am talking to.*
R2 *... her level.*
F *Yes.*
R2 *Yeah. That's interesting, isn't it? They don't wear badges or ...*
F *They should, absolutely. It's not that patient () ...*

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. In the following example, one clinician addresses Patient 8, Mara (blockage of oesophagus), by her first name:

N1 So, Mara, your blood pressure is a bit high so you've probably not kept your tablets down.

We found no examples in our data where patients were encouraged to address doctors or nurses by their first names—one indicator of the interpersonal distance between patient and clinicians, characteristic of many ED consultations.

With Patient 71, Wilson (sore toe), the nurse focused very specifically on the patient's statements about how long he had waited to get into the ED and encouraged him by saying it had not in fact been all that long given the current deteriorating situation. She used his name and positive feedback to try to soften the blow of his long waiting time:

N5 Oh, that's pretty good. If you'd been half an hour later you should see the patients in the corridor now. Now Wilson, are you allergic to anything?

P No.

N5 OK. And what medications == are you on?

The use of first names has the effect of putting the patient at ease in the interaction and helps create an environment where the patient feels more included in the process. 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 nurse with Patient 37, Nola (PR bleeding), tried to encourage her to co-operate in this way:

N2 Yeah, I'll put all those in too for you. That's a girl.

P Um I probably, I don't know, but it's on the cards that I could ...

N2 OK, I'll just == put a thing on.

P == bleed again...

N2 Don't worry. I'll put a thing on. There you go, gorgeous. Just pop up on there for me.

Other examples we came across included:

N1 OK, darling. I'm just going to leave that on your arm.

AC I need to check your details, darling. Um, are you a [Street]? And is that [Suburb]? [Admissions Clerk]

N2 Here, pop this over, darling, hold it down a bit.

N1 Do you have oxygen at home, darlin? Do you have puffers?

N3 Have you got an armband on, darling?

N5 Do you want a mask or are you happy holding a pipe, darl?

N2 OK. How about that pain at the moment, honey?

The inclusive pronoun 'we' can be used to co-opt the patient into the healthcare team. With Patient 34, Graydon (cardiology admission), the nurses emphasised the team nature of their work, by alternating their turns in the talk, by using 'we', and by explaining what the other person was about to do. In this way, the nursing staff succeeded in recruiting Graydon as a team participant, while emphasising the patient's role as an active agent in the consultation:

N2 We're going to count to six. No chest pain at all?

P No, not at the moment. No.

N3: Good.

N2 Right. So [N3] is going to put a cannula in and take some bloods now.

N3: How do they usually go taking blood from you?

N2 We're pretty much done here.

N3: OK. Yeah.

N2 Do you have any allergies? Oh, you've got an armband. Right. There's some stickers for you [N3]. I'll go and get this ECG on.

N3: OK. Just give your hand a bit of a pump for me. And hold it. Have a little poke round there OK? Just give a nice, cold swab. Stay nice and still for me...

Clinicians also used ‘we’ when referring to the medical procedures that would take place in the ED. This reinforced the fact that the medical care that Patient 62, Donna (HX, anal fissure), was receiving was a team effort. Nurses admitting patients frequently work in pairs and in the example below, Nurse 2 and Nurse 3 were settling Donna and changing her into her gown. Nurse 2 goes back and forth between offering her assistance both personally and institutionally (collectively):

- N2 *Just lie on—maybe lie on your side rather than== [Two nurses working together N2 and N3]*
N3 *Yeah.*
N2 *==sitting on it. Do you find lying down on your side might be a bit more comfortable for you?*
P *Yeah, yeah I just==, yeah.*
N2 *==What we’ll do is we’ll get you into a um, an actual gown, here’s one, here we are—*
P *Yeah.*
N2 *—there’s one here, opens up at the back, and I’ll get you to lie down and, um yeah, we’ll come back, I’ll come back to you in a minute OK? Alright just try and==*

The use of ‘we’ draws in the patient as an active agent in the consultation, juxtaposed with the use of ‘I’ when the doctor’s professional expertise is foregrounded. We see this with Patient 6, Luca (stiff neck):

- N1 *We’ll get you through as soon as we can, Luca.*

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 registrar with Patient 10, David (sore testes), uses the same technique:

- D2 *What we do have there is what we call epididymo-orchitis. That’s just our fancy way of saying infection.*

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. There are a number of examples in the interaction between Patient 37, Nola (PR bleeding), and the nurse in charge of her Admission. Notice how the nurse also uses a colloquial term of endearment (*love*) and everyday vocabulary (*pop up*) to make her request (‘Get up on the bed now’) sound friendly and polite:

- N2 *And just put one arm in, love, only because I’ll need to take the other one out anyway, and I’ll just get you to pop up on the bed now. Just put that in there. And leave that one out and just pop yourself up there.*

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.*

The doctor in charge of Patient 21, Jean (review of suture after leg injury), tempered her explanations with both *just* and the modality *probably*:

D1 *OK. So what we need, just to put a new dressing on.*
P *Yeah.*
D1 *OK, probably not that thick.*

The nurse in the following example also made a technically unnecessary—but respect-building—request for the patient's permission:

N2 *Now I might just move this so that I don't dribble saline on that leg... OK. I'll just wash my hands, if that's OK?*

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.

In the examples below, the most obvious way that the triage nurse established rapport with the patient was by making it clear that their contributions were an important part of the assessment process. In the more effective example, with Patient 8, Mara (blockage of oesophagus), we see evidence of reassuring feedback:

P *... Years ago I was knocked over by a car and I was here for six weeks.*
N *Oh my goodness, you've been very lucky.*
N *I'll just pop you in the waiting room just now and I'll go and get a bed and we'll pop you through.*
P *Thank you, darling.*
N *My pleasure.*
P *You've been very kind.*

In this example, the triage nurse gave reassuring feedback and showed empathy by commenting on the good luck of Patient 8, Mara (blockage of oesophagus). Even patients like Mara, who arrived at the ED with a medical condition that was not necessarily life threatening, responded well to these overtures.

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.

The nurse with Patient 21, Jean (review of suture after leg injury), interacted with the patient in this way. Jean responded positively to the nurse's more personal engagement and re-told the story of her accident in more vivid detail than she had used with the doctor. She also added a commentary about the way it had affected her, which she did not share with the doctor. It was the nurse's enthusiastic responses to Jean's tale that encouraged her to speculate about what had happened, and gave her the opportunity to share her experience:

N2 *How did it happen?*
P *[Laughs]*
N2 *You've probably told that many times.*
P *But it's such a freak thing. I... like I was walking the dog in the park, it's just ridiculous, and I stood on a stick, I must have, I stood on a stick with this foot and it's come up in the air and gone into this leg.*
N2 *Whoa!*
P *But I had long pants on and I cannot understand. So I didn't think ... it didn't tear my pants ...*
N2 *Wow!*
P *and whether it came up the leg of it ... I ... I don't know that cause ==*
N2 *== But that's from a stick?*
F *Mmm!*
P *Stick!*
N2 *Wow!*
P *So ... and all I ... because all the blood just came rushing out 'cause it was quite deep, and I felt quite sick, I didn't sort of think about that at the time or look for the stick [giggles] ... but I don't remember the stick going up the pants. But my pants aren't torn ... so it must have been a really, really, really sharp stick.*
N2 *It's very strange isn't it?*

Although less frequent, doctors did also provide patients with supportive, empathetic and reassuring feedback. Below, with Patient 62, Donna (HX, anal fissure), the junior doctor gave an empathetic response to Donna's less than delicate description of her pain:

D1 *Yeah. What's your pain like now out of ten?*

P *Probably about five.*

D1 *OK. Ah ...*

P *I feel like I've got a screwdriver up my backside most of the time.*

D1 *Yeah, ah look it's ghastly. It's one of those things where you know, you ha—there's not much to show for it, but they're dread—you know people have such discomfort it's awful.*

In the example below, the doctor reassures Patient 71, Wilson (sore toe), that he had been giving himself the correct treatment:

P *And I soak it with the Dettol and like a warm ==thing.*

D1 *==Good.*

P *Just warm == and Dettol.*

D1 *== It's exactly what you should be doing. OK. Alright.*

P *Yeah.*

In general, however, although doctors did provide patients with supportive, empathetic and reassuring feedback, their responses tended to be more measured, as the following extracts show. In the first example, the doctor gave Patient 21, Jean (review of suture after leg injury), supportive feedback and warned her what to expect when she unwrapped the wound:

D: *And it's no new swelling or pain just below here?*

P *Sorry?*

D: *No new pain or swelling just down below?*

P *No.*

D: *OK. That's good ...*

D: *Well, it won't look excellent.*

The doctor then gave Jean a positive review of her wound, which was cautious but reassuring for Jean to hear:

P *But everything's going OK?*

D *Absolutely, yes, looks fine. So ==*

P *== She did a good job didn't she?*

D *Oh, yes. It's—it's () you know, == (). [Overtalking]*

P *== She was very—very good.*

F *She was only ==*

P *== She was very good.*

F *We're just worried about this little, you know, the flap. See that bit of skin there.*

D *== No, no, no. Everything seems to ==be reliable.*

In the extract below Patient, 3 Federica, (dizziness, sore ear), presented to the ED with her medication list. Prior to her arrival, she had understood the importance of bringing her medication list to the ED so she had cut off the labels from each box of medication and placed them together in a pile. She had done this possibly because English was not her first language and by bringing the bundle of labels in, it was going to be easier for her to communicate these to the doctor. We see below how the junior doctor, who also didn't have English as her first language, gave Federica positive feedback about this strategy.

D1 *And are you taking any medications, usually?*

P *Yes.*

D1 *Did you bring them? OK.*

F *[Background coughing]. They're in her bag.*

P *Yes. Operation cataract.*

D1 *Cataract. Both eyes?*

P *Just—and before I have ()—out.*

D1 *Ah-hm. So they fixed == it so ...*

P *== only for (), only for ().*

D1 *Ah-hm.*
P *== ()].*
F *== ().*
P *In here. [Patient hands over bundle of medication labels]*
D1 *Oh, that's a smart way of ...*
P *(), the ()?*
D1 *Uh huh.*
P *I take one, and two in the morning and one and two in the night. And that one for the depression.*

The examples below demonstrate senior doctors providing supportive feedback in the final Management, Diagnosis and Disposition stage. In the first example, the senior doctor creates empathy by acknowledging the dread of the bowel preparation necessary for a colonoscopy felt by Patient 37, Nola (PR bleeding):

P *I would have gone back to Dr—ah, thingo only to-to have another colonoscopy, but it's the lead up to it that ...*
D3 *The bowel prep's terrible isn't it?*
P *The—no, the—you know the fluids and that, the ...*
D3 *Yeah, the stuff you drink, yeah.*
P *Oh God!*

When patients are suffering from a serious medical condition, as was the case for Patient 34, Graydon (cardiology admission), the need for reassurance is often heightened, and a few reassuring words can make a big difference:

P *Do you want me on my back ... or?*
D2 *No, you're just perfect.*

A basic way of showing support for what the patient is saying is to mirror the patient's experience. We saw earlier that clinicians often repeat back what patients say as a way of checking the information, but this strategy can also demonstrate the clinician's validation of the patient's interpersonal experience. The following extracts demonstrate how this was done with various patients:

P *A week—a week ago.*
N *One week ago. In this hospital?*
—
N *Did this just start yesterday?*
P *Two days ago.*
N *Two days.*
—
N *Have you had a fever or the shakes or anything?*
P *Evening time.*
N *In the evening time. OK ...*

Although many clinicians express empathy for patients' pain, most of the time clinicians do not give feedback that expresses personal attitudes or experiences about the patient's illness or test results. However, occasionally, clinicians do express thoughts to patients about their illness and this appears to be well received by patients. This female junior doctor was particularly sympathetic to Patient 62, Donna (HX, anal fissure), because her mother had experienced a similar condition. She was thus able to express personal attitudes and values about Donna's illness and predicament:

D1 *Right, alright. I need to have a look at you. I'm going to go and wash my hands and then I will come back and then I will have a chat to someone and we'll try and work out==*
P *Yeah.*
D1 *==what we're going to do next. Poor thing.*
P *Alright.*
D1 *I feel—I feel bad for you 'cause it's awful.*
P *It's just—'cause it's==*
D1 *Yeah.*

Here a more senior doctor expresses his positive opinion on the blood pressure results (previously high) of Patient 71, Wilson (sore toe):

D1 *Is your blood pressure under control now?*
P *Yes.*
D1 *What was it?*
P *Today was 128.*
D1 *OK, brilliant. Well done. OK*
P *Um, I was ... I saw him about three weeks ago or four weeks ago, it was 115. So the blood pressure's down,*
D1 *Mm mm*
D1 *Are you diabetic?*
P *No.*
D1 *Good. Anything else going on? What ... what == respiratory []?*

6.3.5. Recognise the patient's perspective

Yet another empathetic strategy is to reassure the patient that they are justified in feeling worried about their condition. Patient 37, Nola (PR bleeding), was embarrassed by her symptoms and anxious about what was happening to her. Both the nurse and the doctor who had responsibility for the Initial Assessment and Stabilisation stage made an effort to make her feel that her responses were quite normal:

P *Um I probably, I don't know, but it's on the cards that I could ...*
N2 *OK, I'll just == put a thing on.*
P *== bleed again.*
N2 *Don't worry. I'll put a thing on.*

D1 *Do you have any allergies?*
P *Mm? [Patient groans with pain].*
D1 *[Patient's Name]? Do you have any allergies?*
P *[Patient breathing heavily]. No.*
D1 *You're doing really well.*
P *I don't think so. I'm a real cocktail when it comes to needles.*
N2 *You're doing well, darl, just stay very still for me.*

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. In other words, the clinician would chat to the patient about aspects of either of their lives unrelated to the illness, but usually introduced into the conversation in some way by the patient. Used with care, this strategy can contribute positively to building interpersonal rapport, provided the patient perceives the 'chat' as somehow relevant to them and the clinician must correctly interpret the signals from the patient, as the following examples show.

More effective	Less effective
<p>P <i>I don't actually have any pain in the knee and it's a total mess. Did all the ligaments, bit more cartilage out in 1960.</i></p> <p>D: <i>Playing football?</i></p> <p>P <i>Yes.</i></p> <p>D: <i>What kind of football?</i></p> <p>P <i>Rugby Union.</i></p> <p>D: <i>Rugby Union?</i></p> <p>P <i>Yeah.</i></p> <p>D: <i>So what do you reckon is going to happen in the World Cup?</i></p>	<p>N4 <i>So where do you live? Are you a Sydney person?</i></p> <p>P <i>Yes, Arncliffe it just down this way.</i></p> <p>N4 <i>Oh, OK, yes. I had friends who used to live in, ah, Blake Street in Bexley.</i></p> <p>P <i>Oh, OK.</i></p> <p>N4 <i>Yeah, which is just up from the shops on the right. You know ...</i></p> <p>P <i>Not too sure.</i></p> <p>N4 <i>You know where the Arncliffe shops are?</i></p> <p>P <i>Yeah. Yeah.</i></p> <p>N4 <i>Just go literally...</i></p> <p>P <i>Opposite?</i></p> <p>N4 <i>Keep going straight up there ...</i></p> <p>P <i>By the school?</i></p> <p>N4 <i>Yeah, opposite. And the street on the right and that's Bexley ... that's Blake Street.</i></p> <p>P <i>Oh, OK.</i></p> <p>N4 <i>They used to live there on the corner but they sold their house and bought a house out at Dural so they're now running a small business.</i></p> <p>P <i>Aaaah. All way, way out Dural way. Oh, OK.</i></p> <p>N4 <i>Yeah. And, um, love it. They've got machinery and equipment and ...</i></p> <p>P <i>Yeah.</i></p> <p>N4 <i>Just love it. I'm just starting some fluids. So this is at a- um, two hourly rate but because I haven't been able to locate a pump literally I'm just gonna put it through (.). "</i></p>

More effective	Less effective
<p>In this example, the doctor followed Patient 10, David's (swollen testes) cue during the history taking, and then pursued a lengthy discussion (not included here) with David about a shared interest, rugby.</p>	<p>In this example, N4 returned to care for Patient 71, Wilson (sore toe) after an extended break. It is Nurse 4's first opportunity to engage with Wilson and the only example in our data of a clinician pursuing a line of informal chat not initiated by the patient. The level of detail in the conversation was unusual. A number of Wilson's responses indicate minimal interest.</p>

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

This triage nurse asks the patient who has just returned from Victoria, about the recent bushfires.

N1 *Um, have you—were you actually involved in the bushfires?*

P *No, no.*

N1 *OK.*

P *My son had a friend, he and his wife, you know, died in a car, but I mean um*

N1 *Yeah.*

P *That was sad but that—that wasn't the reason.*

N1 *It's tough isn't it?*

P *Oh it was awful.*

N1 *Particularly when we [City] went through that.*

Relevant and constrained personal disclosure can also help to express empathy. In the next example, the very empathetic junior doctor went as far as telling the patient that her mother had suffered a similar condition and therefore she understood her predicament more fully:

P *==no joke, just can't put up with the==*

D1 *Yeah, yeah, yeah.*

P *==pain anymore.*

D1 *Yeah, look I know, that's all==my mum actually had this problem, my mum has [digestive] disease and it was desperate, like it was so awful, so I really==*
P *Well you just==*
D1 *==feel for you, 'cause I==*
P *==you know just when it's really bad==*
D1 *Yeah.*

6.3.7. Share laughter and jokes

Several patients commented on the inappropriate use of humour in the ED. Here is one particularly insensitive example: This patient had Multiple Sclerosis and in finding out how incapacitated he might be the nurse asked:

N3 *Now what level down are you?*
P *Ah, what ...*
N3 *Incapacitated.*
P *Well I...*
N3 *I don't know your story, why you're in a wheelchair?*
P *Oh, MS.*
N3 *MS is it? Oh, OK, right. Fair enough. Didn't get (). I thought you must have dived off the pool. Bang, OK? MS!! ==*

However, we observed that the judicious use of humour during clinician–patient consultations seemed to help ease the patient's anxiety. The doctor responsible for the Initial Assessment and Stabilisation stage for Patient 21, Jean (review of suture after leg injury), shared a laugh with Jean over the size of the antibiotic capsules which had been prescribed earlier and this helped to develop the rapport between them:

D: *No, no. You just continue with your antibiotics ...*
P *Oh, they're huge ones, you know, like horse tablets [Laughs] ==two a day.*
D: *== [Laughs] Are they the () dissolvable ones?*
P *No.*

In the following extract, Patient 37, Nola (PR bleeding), made a joke at the expense of the senior nurse. Nola was concerned that her comments might have seemed a little rude but the nurse showed her good humour and everyone joined in the laughter. Nola even contributed with humour directed at her own condition:

P *==And it was Dr [Specialist's Surname], you wouldn't know him.*
Dr *No, I don't.*
P *He's before your time. This lady might, I doubt it.*
Dr *[Chuckles]*
P *Up on the corner.*
N2 *Yeah, I'm the old one. [Laughs]*
P *Dr [says Specialist's Name] up there on the corner.*
N2 *No, I wouldn't. I have been here that long, but anyway.*
P *No, I'm not being rude.*
N2 *I know you're not, sweetheart. I'm pulling your leg.*
P *Oh, no, don't pull it today. [Laughs]*
N2 *[Laughs].*

6.3.8. Demonstrate intercultural sensitivity

Cross-cultural awareness is a basic requirement for clinicians who are dealing with our multi-cultural population. In the less effective example below, an agency nurse inadvertently revealed her cultural assumptions. Patient 5, Chaitali (PV bleeding), was from a South East Asian country, and although she had a strong accent in English, her English was very good. The nurse and the patient were discussing the patient's son.

More effective	Less effective
<p>N1 <i>How long have you been in [City]?</i> P <i>About seven, eight years?</i> ----- N1 <i>So country of birth, where were you born?</i> F <i>[European country].</i></p>	<p>N <i>Yeah. OK, that's OK. Is someone here with you, or are you alone?</i> P <i>Yeah, I'm on my—yeah—yeah—() my son is here actually. He's a lecturer in the university.</i> N <i>Who just—who's the next of kin?</i> P <i>My son.</i> N <i>And what's his first name?</i> P <i>[name].</i> N <i>How do you spell that? [Chuckles]</i> P <i>[patient spells out the name, [name]].</i> N <i>Where are you from, originally? Malaysia somewhere? Indonesia?</i> P <i>[Says name of country].</i> N <i>[Repeats name of country]. Oh () on that, OK. What's your son's telephone or is it the same number as yours?</i> P <i>His [number].</i> N <i>(), OK. And he obviously speaks English, I hope?</i></p>

More effective	Less effective
<p>In this example, the nurse doing triage chats informally to Patient 56, Marchello (suspected DVT), about where he was born. The triage nurse could tell from his accent that Marchello was not Australian born, and as he was presenting with a sore leg after a long flight, she showed awareness of the fact that he might be new to the city. She did not need to ask his place of birth but in doing so, showed sensitivity and recognition of Marchello's cultural background.</p>	<p>In this example, the agency nurse laughed when she heard the Patient 5, Chaitali's (PV bleeding) son's name. She bundled a number of South East Asian countries together to determine Chaitali's country of origin. She misunderstood Chaitali's comment that her son was a lecturer at an Australian university and then questioned Chaitali's son's English proficiency. In the more effective example alongside, N1's question "Where were you born?" would be far more culturally appropriate than the agency nurse's question.</p>

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>

References

- Australian Institute of Health and Welfare and Australian Commission on Safety and Quality in Health Care. 2007 *Sentinel events in Australian public hospitals 2004–05*. Canberra: Australian Institute of Health and Welfare and Australian Commission on Safety and Quality in Health Care, p. 1-35.
- ACSQHC. 2010. *Clinical handover*. Sydney: Australian Commission for Safety and Quality in Health Care (ACSQHC). Available from www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-05#
- Booz Allen Hamilton. 2007. *Key Drivers of Demand in the Emergency Department*. Sydney: NSW Department of Health.
- Brock C, Salinsky J. 1993 Empathy: An Essential Skill for Understanding the Physician-Patient relationship. *Family Medicine*. 25:245-8.
- Coiera EW, Jayasuriya RA, Hardy J, Bannan A, Thorpe MEC. 2002 Communication loads on clinical staff in the emergency department. *Medical Journal of Australia*. 2002;176(9):415-8.
- Cordella M. 2004 *The dynamic consultation. A discourse analytical study of doctor-patient communication*. Amsterdam: John Benjamins Publishing Company.
- Eisenberg EM, Murphy AG, Sutcliffe K, Wears R, Schenkel S, Perry S, et al. 2005 *Communication in Emergency Medicine: Implications for Patient Safety*. Communication Monographs. 72(4):390-413.
- Elwyn G, Edwards A, Wensing M, Hood K, Atwell C, Grol R. 2003 Shared decision making: developing the OPTION scale for measuring patient involvement. *Quality & Safety in Health Care*. April;12(2):93-9.
- Garling P. 2008 *Final Report of the Special Commission of Inquiry: Acute Care in NSW Public Hospitals*. Sydney: Special Commission of Inquiry: Acute Care Services in New South Wales Public Hospitals.
- Haynes R, McKibbin KA, Kanani C. 1996 Systematic review of randomized trials of interventions to assist patients to follow prescriptions for medications. *Lancet*. August 10;10(348):383-6.
- Hobbs P. 2007 The Communicative Functions of the Hospital Medical Chart. In: Iedema R, editor. *The Discourse of Hospital Communication: Tracing Complexities in Contemporary Health Care Organizations*. Houndmills: Palgrave Macmillan.
- Kohn LT, Corrigan JM, Donaldson MS. 1999 *To err is human: Building a safer health system*. Washington D.C: National Academy Press.
- Manidis M, Slade D, McGregor J, Chandler E, Dunston R, Scheeres H, Stein-Parbury J, Iedema R, & Stanton N. 2009 *Emergency communication: report for Prince of Wales Hospital*. University of Technology, Sydney.
- Manidis M, McGregor J, Slade D, Scheeres H, Stein-Parbury J, Dunston R, Stanton N, Chandler E. 2010a. *Communicating in hospital emergency departments: report for the Canberra Hospital*. University of Technology, Sydney.
- Manidis M, McGregor J, Slade D, Scheeres H, Stein-Parbury J., Dunston R, Stanton N, Chandler E. 2010b. *Communicating in hospital emergency departments: report for Gosford Hospital*. University of Technology, Sydney.
- McGregor J, Manidis M, Slade D, Scheeres H, Stein-Parbury J, Dunston R., Stanton N, Chandler E. 2010. *Communicating in hospital emergency departments: report for the Hornsby-Ku-ring-gai Hospital*. University of Technology, Sydney.
- Mishler EG. 1984 *The Discourse of Medicine: Dialectics of Medical Interviews*. New Jersey: Ablex Publishing Corporation.
- NSW Department of Health. 2005 *Clinical Services Redesign Program: Redesigning a better patient journey*. Sydney: Sydney: NSW Department of Health.
- NSW Health Care Complaints Commission. 2009 *Annual Report 2008–09*. Sydney: NSW Health Care Complaints Commission.
- Nugus P. 2007 *The organisational world of emergency clinicians*. Sydney: PhD Thesis, University of New South Wales.
- NSW Department of Health. 2008 *N S W Health Patient Survey 2008 Statewide Report*. Sydney: N S W Department of Health.
- O’Keefe M. 2001 Should parents assess the interpersonal skills of doctors who treat their children: a literature review. *Journal of Pediatrics & Child Health*. 37(6):531-8.
- Slade D, Scheeres H, Manidis M, Matthiessen CMIM, Iedema R, Herke M. 2008 Emergency Communication: The discursive challenges facing emergency clinicians and patients in hospital emergency departments. *Discourse & Communication*. 2(3):289-316.
- WHO. 2008 *Action on Patient Safety – High 5s*. World Health Organisation. Available from: http://www.who.int/patientsafety/solutions/high5s/project_plan/en/.

Appendix 1

Comparative data for the five EDs studied					
	Prince of Wales	Hornsby Ku-ring-gai	Gosford	Canberra	St George
Number of presentations annually	44,791 (16)	29,908 (16)	49,916 (16)	56,198 (Hospital data)	59,017 (Hospital data)
Care options	Cubes (less acute); Acute; resuscitation x 3; integrated mental health (PECC); EMU	Fast track; Acute; resuscitation x 2; separated mental health seen as 'separate' to the ED (PECC); not trauma hospital	Fast track; House Doctor; Acute; resuscitation x 3; trauma hospital; good relationship with PECC	Fast track; advance practice nurses; acute; sub acute; EMU; Mental health; resuscitation x 3	Consult rooms; acute (Fast track); sub acute; EMU; resuscitation x 3; PECC; trauma hospital; ASET
Patients seen per day in time we were at the hospital	120 per day on average	81 per day on average	137.6 per day on average	151 per day on average	134 per day on average in 2006 160 per day on average in 2009 (19% increase)
Triage Category as % of presentations (in 2008/9)	Cat 1 1.2% Cat 2 6.9% Cat 3 40.2% Cat 4 42.0% Cat 5 9.6%	Cat 1 0.3% Cat 2 7.7% Cat 3 23.1% Cat 4 47.9% Cat 5 20.9%	Cat 1 0.4% Cat 2 8.9% Cat 3 30.6% Cat 4 50.3% Cat 5 9.8%	Cat 1 0.6% Cat 2 13.4% Cat 3 34.8% Cat 4 42.4% Cat 5 8.8%	Cat 1 1.5% Cat 2 11.8% Cat 3 37.9% Cat 4 43.8% Cat 5 5.0%
Bed block (the delay in transfer from the ED to a hospital ward) and off stretcher times	Severe; off stretcher ambulance off stretcher KPIs sometimes not met	Minor; occasionally problematic; escalate between clinicians rather than to GM as at one other ED; ambulance off stretcher KPIs met	Severe; has back flow beds in ambulance bay; off stretcher ambulance KPIs are not met	Can be extreme on some occasions; 90% of off stretcher KPIs met	Can be extreme on occasions; off stretcher KPIs have made good progress
ED Admission performance in terms of access	75% (16)	76% (16)	76% (16)	No stats available	71% (16)
Patient Demographic	Mixed ethnicity; high drug and alcohol presentations; inner city; no trauma	Mixed ethnicity; suburban; many patients ESB and elderly	Elderly; ESB; trauma; suburban	Mixed demographic; younger population than other EDs	Culturally diverse family population plus elderly ESB patients
Communication systems including handovers	ED has a communication diary; white boards with patient data in sub acute; medical and nursing handovers for acute done by walking through acute in the ED; in 'cubes' medical and nursing handovers for sub acute done in the corridor of the consult rooms	ED has a communication diary; whiteboard handovers; structured interprofessional care teams	ED has a communication diary; CC on 'flight desk' is highly involved; keeps white board up to date; in the process of improving communications; have white board handovers a couple of times a day; nurses do a bedside handover nurse - nurse	Have a communication book, a ground rounds medical (which nurses can attend) handover every day away from direct patient care area, other medical handovers take place on the 'flight deck' and nursing handovers are done on the 'flight deck'	"Handovers are done on the bedside with real time documentation in electronic medical records (EMR) – new checklists for handovers are due to be introduced

Appendix 2: Hospital data sets

Hospital A data sets									
No	Name	Patient demographics	Presenting illness/ injury	Time: triage consultation	Time: triage to seen by doctor	Length of stay	Triage cat	Clinician info	Recorded time
P01	Jacinta	Female, 29 years, ESB (Australia)	Left ankle injury	Triage not recorded	1 hr 13 mins	1 hr 40 mins	4	1x nurse; 1x doctor; 1x researcher; 1 x radiography staff; 2 x other staff	23.5 mins
PO2	Kathryn	Female, 83 years, ESB (Australia)	Dizziness	9 mins 46 sec	2 hrs 33 mins	6 hrs 47 mins	3	6xnurses; 2xdoctors; 1xresearchers; 14xother staff; 2xfamily; 1xaged care assessor	40.5 mins
P03	Federica	Female, 78 years, NESB (Spain)	Dizziness/ funny vision	12 mins 16 sec	4 hrs 51 mins	9 hrs 2 mins	4	7xnurses; 3xdoctors; 1xresearcher; 1xtea lady; 14xother staff; 1xfriend	1.2 hrs
P04	Naama	Female, 50 years, NESB (Lebanon)	Sore toe	3 mins 22 sec	1 hr 24 mins	1hr 39mins	4	1xnurse; 1xdoctor; 1xresearcher; 1xfamily; 1xradiography staff	22.3 mins
P05	Chaitali	Female, 67 years, NESB (Sri Lanka)	PV bleeding	5 mins	40 mins	6hrs 9 mins	3	4xnurses; 2xdoctors; 1xfamily; 4xother staff	57.5 mins
P06	Luca	Male, 69 years, NESB (Croatia)	Stiff neck	6 mins 10 sec	8 mins	30 mins	4	3xnurses; 1xdoctor; 1xresearcher; 2xother staff	9.44 mins
P07	Carlina	Female, 51 years, ESB (Australia)	Cut finger	4 mins 49 sec	58 mins	3hrs 6 mins	4	3 x nurse; 2 x doctor; 2xradiography staff; 5xother staff	29.3 mins
P08	Mara	Female, 84 years, ESB (Australia)	Blockage of oesophagus	6 mins 34 sec	21 mins	2hrs 58 mins	3	3xnurses; 2xdoctors; 2xresearchers	47 mins
P09	Olander	Male, 92 years, ESB (Australia)	Fall/head injury	5 mins 15 sec	50 mins	2hrs 20mins	3	4xnurses; 1xdoctor; 3xresearchers; 1xother staff	1.5 hrs
P10	David	Male, 69 years, ESB (Australia)	Swollen testes	Triage not recorded	13 mins	5hrs 11mins	3	5xnurses; 3xdoctors; 2xresearchers; 2xsonography staff; 5xother staff	44.9 mins
P11	Andre	Male, 23 years, ESB (Ireland)	Sore foot	3 mins 56 sec	18 mins	1hr 59mins	4	2xnurses; 1xdoctor; 1xresearcher; 1xradiography staff	13 mins
P12	Ghadeen	Female, 26 years, NESB (Lebanon/ Jordan)	Back pain	Triage not recorded	18 mins	2hrs 34mins	3	4xnurses; 1xdoctor; 2xresearchers; 1xfamily	47.6 mins
P13	Wanda	Female, 47 years, ESB (Australia)	Ear piece from hearing aid stuck in ear	Triage not recorded	22 mins	1hr 7 mins	4	2xnurses; 2xdoctors; 2xresearchers; 1xother staff	14.22 mins
P14	Wena	Female, 35 years, ESB (Australia)	PVB and abdominal cramps	7 mins 38 sec	20 mins	1hr 25 mins	3	2xnurses; 2xresearchers; 1xdoctor; 1xfamily; 2xother staff	24.6 mins

Hospital A data sets (cont)

No	Name	Patient demographics	Presenting illness/injury	Time: triage consultation	Time: triage to seen by doctor	Length of stay	Triage cat	Clinician info	Recorded time
P15	Natasha	Female, 36 years, ESB (Southern Africa)	Post op infection	6 mins 3 sec	3 hrs 52 mins	4hrs 39mins	4	2xnurses; 1xdoctor; 1xresearcher; 1xfamily	29.2 mins
P16	Jamal	Male, 46 years, NESB (Iran)	Low	11 mins 38 sec	19 mins	3hrs 5mins	3	4xnurses; 3xdoctors; 2xresearchers; 1xfamily; 1xradiography staff; 2xother staff	1.4 hrs
P17	Denae	Female, 43 years, ESB (Australia)	Left foot injury	6 mins 51 sec	34 mins	1hr 37mins	4	1xnurse; 1xdoctor; 2xresearchers; 1xother staff	32.32 mins
P18	Janice	Female, 38 years, ESB (Australia)	Bad back	Triage not recorded	1 hr 44 mins	2hrs 56 mins	4	2xambos; 3xnurses; 1xdoctor; 2xresearchers; 2xfamily; 1xother staff	1 hr 5 mins
P19	Ina	Female, 43 years, ESB (Australia)	Pain post procedure	9 mins 9 sec	28 mins	5hrs 30 mins	3	3xnurses; 2xdoctors; 2xresearchers; 1xorderly; 1xother staff	1 hr 15 mins
			Average times	7mins 30sec	68 mins	3hrs 23mins			

Total word count = 387 256

Hospital B data sets

No	Name	Patient demographics	Presenting illness/injury	Time: triage consultation	Time: triage to seen by doctor	Length of stay	Triage cat	Clinician Info	Recorded time
P20	NA	Female, elderly	NA	NA	NA	NA	NA	NA	NA
P21	Jean	Female, 64, ESB (Australia)	Review suture for leg injury	1min 4sec	10mins	55mins	5	2xnurses; 1xdoctor; 1xfamily; 1xresearcher	30min 42sec
P22	Evan	Male, 32, ESB (Australia)	Fell down stairs; bruising to sacrum with haematoma	3min 2 sec	3mins	1hr 1min	5	1xnurse; 1xdoctor; 1xresearcher	12min
P23	Bertha	Female, 89, ESB (Australia)	Knee gave way when shopping	2min 59sec	1hr 9mins	2hrs 55mins	5	3xambos; 6xnurses; 1xdoctor; 1xresearcher; 2xother staff; 1xwardsman; 5xradiography staff (including students); 1xphysio; 1xaged care student	1hr 16min

Hospital B data sets (cont)

No	Name	Patient demographics	Presenting illness/injury	Time: triage consultation	Time: triage to seen by doctor	Length of stay	Triage cat	Clinician Info	Recorded time
P24	Janelle	Female, 40, ESB (Australia)	Fell over in twisting motion; very tender ribs	5min 42sec	1hr 3mins (3hrs 43mins	4	4xnurses; 2xdoctor; 1xfamily; 2xother staff; 1xresearcher; 1xradiography staff	1hr 13min
P25	Edna	Female, 95, ESB (Australia)	Chest pain; lower epigastric pain	4min 45sec	5mins	11hrs 15mins	3	2xambos; 7xnurses; 3xdoctors; 2xresearchers; 2xorderlies; 1xASET; 5xother staff; 1xradiography staff	3hr 9min
P26	Kenneth	Male, 27, ESB (Australia)	Spider bite	2min 45sec	28mins	4hrs 10 mins	4	3xnurses; 1xdoctor; 1xresearcher; 1xclerical; 1xother staff	52min 28sec
P27	Ewan	Male, 77, ESB (Australia)	Ache in LT arm; chest discomfort/pain with exercise	7min 43 sec	1hr 32mins	4hrs 4mins	3	5xnurses; 2xdoctors; 2xresearcher; 1xadmin; 1xorderly	1hr 13min
P28	Rordan	Male, 50, ESB (Australia)	Burn dressing	Not recorded	8mins	23mins	5	2xnurses; 1xresearcher	10min 45sec
P29	Davin	Male, 40, ESB (Australia)	Neck pain, numbness, tingling in fingers, heaviness in arms	11min 48 sec	12mins	5hrs 34mins	3	5xnurses; 1xdoctor; 1xambo; 1xclerk; 4xother staff; 1xfamily 2xfriends; 1xresearcher	1hr 16min
P30	Janet	Female, 54, ESB (Australia)	Abdo pain	4min 26sec	39mins	7hrs 39mins	4	4xnurses; 1xdoctor; 1xfamily; 1xresearcher; 3xother staff; 1xwardsman; 2xradiography staff	1hr 26min
P31	Riana	Female, 21, ESB (Australia)	Laceration with dirty scalpel	4min 24sec	33mins	3hrs 8mins	5	3xnurses; 1xdoctor; 1xresearcher	18min 18sec
P32	Brendan	Male, 69, ESB (Australia)	Foot injury	4min 49sec	38mins	3hrs	5	3xnurses; 1xdoctor; 1xresearcher; 2xradiography staff; 3xphysios; 3xstudent physios; 1xother staff; 2xfamily	1hr 5mins
P33	Bethany	Female, 55, ESB (Australia)	Dizziness and nausea	Not recorded	15mins	3hrs 23mins	4	4xnurses; 2xdoctors; 1xresearcher; 1xadmin; 1xother staff	1hr 18sec

Hospital B data sets (cont)

No	Name	Patient demographics	Presenting illness/ injury	Time: triage consultation	Time: triage to seen by doctor	Length of stay	Triage cat	Clinician Info	Recorded time
P34		Male, 51, ESB (Zimbabwe)	Sent in by cardiologist for Admission and telemetry	3min 48sec	31mins	6hrs 45mins	4	3xnurses; 2xdoctors; 1xresearcher; 2xfamily; 4xother staff; 9xradiography staff (including students)	2hr
P35	Joanne	Female, 91, ESB (Australia)	Fell out of bed	Not recorded	11mins	2hrs 27mins	4	3xnurses; 1xdoctor; 1xresearcher; 6xother staff;	1hr 3mins
P36	Lisa	Female, 47, ESB (Australia)	Fell on knees, hurt back	Not recorded	30mins	3hrs	4	2xambos; 3xnurses; 1xdoctor; 1xresearcher; 3xradiography staff; 1xorderly	49min 40sec
P37	Nola	Female, 70, ESB (Australia)	PR bleeding	Not recorded	6mins	5hrs 59mins	3	3xnurses; 3xdoctors; 1xresearcher; 1xother staff	1hr 25min
			Average times	4min 46sec	29mins	4hrs 4mins			

Total word count = 318 436

Hospital C data sets

No	Name	Patient demographics	Presenting illness/ injury	Time: triage consultation	Time: triage to seen by doctor	Length of stay	Triage cat	Clinician info	Recorded Time
P38	Denton	Male, 79, ESB (Australia)	Temperature, and COPD	Not recorded	1hr	5hrs 30mins	3	2xambos; 8xnurses; 2xdoctors; 1xresearcher; 1xradiography; staff 1xorderly; 4xother staff	2hrs 5mins
P39	Powell	Male, 43, ESB (Australia)	Severe shingles	Not recorded	2hrs 30mins	8hrs	4	3xnurses; 1xdoctor; 1xresearcher; 1xfamily; 1xadmin; 3xother staff	1hr 35 mins
P40	Jillian	Female, 88, ESB (Australia)	Asthma – breathing difficulty	29mins	1hr 15mins	6hrs 30mins	3	2xambos; 6xnurses; 2xdoctor; 1xresearcher; 2xradiography staff; 1xadmin; 1xorderly; 2xother staff	2hrs 42mins
P41	Alywn	Male, 76, ESB (Australia)	Swollen/painful knee	2mins (partial recording)	10mins	3hrs 5mins	4	3xnurses; 2xdoctor; 1xresearcher; 1xother staff	1hr 24mins
P42	Joel	Male, 65, ESB (Australia)	Severe pain in left leg, difficulty mobilising	3mins	20mins	7hrs 2mins	4	2xambos; 6xnurses; 1xdoctor; 1xfamily; 1xresearcher; 1xtea lady; 1xorderly; 1xradiography staff; 1xother staff	2hrs 12mins
P43	Sharnelle	Female, 40, ESB (Australia)	Reaction to a number of medications	6mins	40mins	1hr 30mins	4	1xambo; 1xnurse; 1xdoctor; 1xresearcher	57mins

Hospital C data sets (cont)

No	Name	Patient demographics	Presenting illness/ injury	Time: triage consultation	Time: triage to seen by doctor	Length of stay	Triage cat	Clinician info	Recorded Time
P44	Clark	Male, 44, ESB (Australia)	Back pain	9mins	3hrs 45mins	6hrs 32mins	5	2xambos; 6xnurses; 2xdoctors; 1xresearcher; 2xother staff	1hr 8mins
P45	Blair	Male, 19, ESB (Australia)	Sore jaw, slurred speech, headaches, nausea as a result of sporting accident	Not recorded	9mins	1hr 20mins	4	2xdoctors; 1xresearcher	59mins
P46	Garth	Male, 44, ESB (Australia)	Ripped finger	3mins	1hr 6mins	6hrs 23mins	3	5xnurses; 2xdoctors	1hr 18mins
P47	Tracey	Female, 20, ESB (Australia)	Fall, lower back pain	Not recorded	1hr	3hrs 15mins	4	1xnurse; 1xdoctor	49 mins
P48	Wilburn	Male, 82, ESB (Australia)	Fainted	Not recorded	1hr 55mins	6hrs 23mins	4	1xnurse; 1xdoctor	-
P49	Forbes	Male, 73, ESB (Australia)	PR bleeding	Not recorded	1hr 33mins	7hrs 29mins	4	3xnurses; 3xdoctors	2hrs
P50	Nora	Female, 63, ESB (Australia)	Chest pains	Not recorded	35mins	6hrs 14mins	3	1xnurse; 2xdoctors	1hr 10mins
P51	Estella	Female, 78, ESB (Australia)	Spiral leg fracture	Not recorded	45mins	1hr 30mins	4	2xnurses; 1xdoctor	24mins
P52	Dulcie	Female, 63, ESB (Australia)	Difficulty breathing	8mins	26mins	9hrs 4mins	4	5xnurses; 2xdoctors	2hrs 16mins
P53	NA	Female (Australia)	Abdominal pain, fever, vomiting	Incomplete recording	3hrs 17mins	NA	4	NA	NA
			Average times	9 mins	1hr 16mins	5hrs 19mins			

Total word count = 182 522

Hospital D data sets

No	Name	Patient demographics	Presenting illness/ injury	Time: triage consultation	Time: triage to seen by doctor	Length of stay	Triage cat	Clinician info	Recorded Time
P54	Sean	Male, 41, ESB (Australia)	Injured middle toe	Not recorded	33mins	1hr 50mins	5	2xnurses; 1xdoctor 1xresearcher; 1xfamily; 1xother staff	22 mins
P55	Doreen	Female, 67, ESB (Australia)	Sore eyes; denies any injury	Not recorded	11mins	1hr 47mins	5	2xdoctors; 1xresearcher	45mins
P56	Marchello	Male, 61, NESB (Holland)	Suspected DVT; pain in calf after long flight	9mins	29mins	1hr 12mins	4	2xnurses; 1xdoctor; 1xresearcher; 2xother staff; 1x admin; 1xfamily	36mins
P56.5	Davis	Male, 43, ESB (Australia)	Pain in left side	Incomplete recording	6hrs	6hrs	4	1xnurse; 1xresearcher; 3xother staff	4 mins
P57	Vincenzo	Male, 71, NESB (Italy)	Wound review	Not recorded	59mins	1hr 50mins	4	1xnurse; 1xresearcher	45mins

Hospital D data sets (cont)

No	Name	Patient demographics	Presenting illness/ injury	Time: triage consultation	Time: triage to seen by doctor	Length of stay	Triage cat	Clinician info	Recorded Time
P58	Jim	Male, 35, ESB (Australia)	Urinary stricture, can't void	Not recorded	50mins	6hrs 25mins	3	4xnurses; 2xdoctors; 1xresearcher; 2xfamily	1hr 25mins
P59	Doris	Female, 85, ESB (Australia)	Tired with intermittent headache; BP up	17mins		21 hrs 19mins	4	2xnurses; 1xresearcher; 1xfriend; 1xadmin	21mins
P60	Casey	Female, 27, ESB (Australia)	Disoriented; developed acute parathesia to right arm	8mins	1hr 56 mins	7hrs 40mins	3	5xnurses; 4xdoctors; 1xresearcher; 3xfamily	1hr 9mins
P61	Helios	Male, 70, NESB (Greece)	U/S on arm; presents for results	Not recorded	1hr 24 mins	2hrs 25mins	4	1xdoctor; 1xresearcher; 1xother staff	19mins
P62	Donna	Female, 49, ESB (Australia)	HX anal fissure; pain increasing	Incomplete recording of Triage	10mins	3hrs 30mins	3	6xnurses; 2xdoctors; 1xresearcher; 1xfamily; 1xother staff	2hrs 7mins
P63	Adrian	Male, 20, ESB (Australia)	MVA; C/O back pain and shoulder pain	Not recorded	32mins	58mins	4	2xnurses; 1xphysio; 1xresearcher	21mins
P64	Brenda	Female, 21, ESB (Australia)	States she has migraine	Not recorded	4hrs 40 mins	5hrs 44mins	4	5xnurses; 1xdoctor; 1xresearcher; 1xfamily	36mins
P65	Erica	Female, 39, ESB (Australia)	Burns to face	Not recorded	2hrs 24mins	2hrs 46mins	4	1xambo; 1xnurse; 2xdoctors; 1xresearcher; 1xfriend	14mins
P66	Miriam	Female, 56, ESB (Australia)	PT JBIBA post experiencing sensation of throat and tongue tingling sensation	Not recorded	2hrs 42 mins	2hrs 38mins	4	3xnurses; 2xresearchers	6mins
P67	Jacob	Male, 26, ESB (Australia)	Deep laceration to thumb and finger	Not recorded	57mins	2hrs 30mins	4	2xnurses; 3xdoctors; 1xresearcher; 3xother staff; 1xradiography staff	1hr 20mins
P68	Gemma	Female, 56, ESB (Australia)	Pain in back & chest, slight rash	Not recorded	2hrs 19 mins	2hrs 40mins	4	1xdoctor; 1xresearcher	19mins
P69	Dickson	Male, 30, ESB (Australia)	Right side abdo pain	Not recorded	23mins	4hrs 10mins	3	3xnurses; 2xdoctors; 1xresearcher; 2xother staff	42mins
P70	Jack	Male, 41, ESB (Australia)	Feeling unwell; weak, lethargy, pain; C/O underarm pain	Not recorded	3hrs 37 mins	9hrs 40mins	4	7xnurses; 2xdoctors; 1xresearcher; 2xfamily; 1xother staff	1hr 6mins
P71	Wilson	Male, 40, ESB (Australia)	Increased pain in right greater to; unable to weight bear on foot due to pain	Not recorded	3hrs 53 mins	11hrs 47mins	4	6xnurses; 2xdoctors; 1xresearcher; 1xcleaner; 3xother staff	1hr 34mins
			Average times	11mins	2hrs 33mins	5hrs 2mins			

Total word count = 135,768

Hospital E data sets

No	Name	Patient demographics	Presenting illness/ injury	Time: triage consultation	Time: triage to seen by doctor	Length of stay	Triage cat	Clinician Info	Recorded Time
P72	Kirsty	Female, 42 ESB (Australia)	Extreme pain in lower abdomen	4mins	2hrs 54mins	10hr 37mins	?xx	1 x nurse xx; 1 x doctor; 1 x radiologist	42mins
P73	Jayden	Male, 33, ESB (Australia)	Noise in ear and sore ear	Not recorded	15mins	3hr 3 mins	5	2 x nurses; 1 x advanced practice nurse; 1 x doctor; xx	28mins
P74 (01)	Fahime	Female, 47, NESB (Lebanon)	Dizziness, feeling stressed	Not recorded	31mins	1hr 30mins	4	2 x nurses; 3 x doctors (2 x student doctors)	51mins
P75 (02)	Vince	Male, 84, ESB (Australia)	Can't lift legs. Stroke?	Not recorded	35mins	6hrs 8mis	3	2 x nurses; 2 x doctors	1hr 10mins
P76 (03)	Zahara	Female, 40, ESB (Yugoslavia)	Abdominal Pain	Not recorded	1hr 30mins	4hrs	3	2 x nurses; 2 x doctors	44mins
P77 (04)	Clement	Male, 84, ESB (Australia)	Left sided chest pain	Not recorded	12mins	15 hrs 52mins	3	2 x nurses; 3 x doctors; 1 x	2hrs 26mins
P78 (05)	Robert	Male, 81, ESB (Australia)	Urinary blockage	Not recorded	5mins	3 hrs 20mins	3	2 x nurses; 1 x doctor	1hr 21mins
P79 (06)	Zhu	Male, 26, NESB (China)	Vertigo	Not recorded	2hrs	2 hrs 17 mins	4	1 x nurse; 2 x doctors	11mins
P80 (08)	Nellie	Female, 87, ESB (Australia)	Cellulitis, pain left elbow	Not recorded	12mins	6 hrs 40 mins	3	2 x nurses; doctors	2hrs 25mins
PX (09)	1/6/06	Female, ESB (Australia)	Migraine	Not recorded	1hr 17mins	DNW	4		Left ED before consultation
P81 (10)	Judy	Female, 34, ESB (Australia)	Right eye infection	Not recorded	15mins	49 minutes	4	1 x nurse; 2 x doctors	19mins
P82 (11)	Anne	Female, 81 ESB (United Kingdom)	Swollen finger	Not recorded	47mins	1 hour 43 mins	4	1 x nurse; 2 x doctors	35mins
				Average time	53 mins	5hrs 5mins			

Total word count: 387,256

Appendix 3: Activity Stages

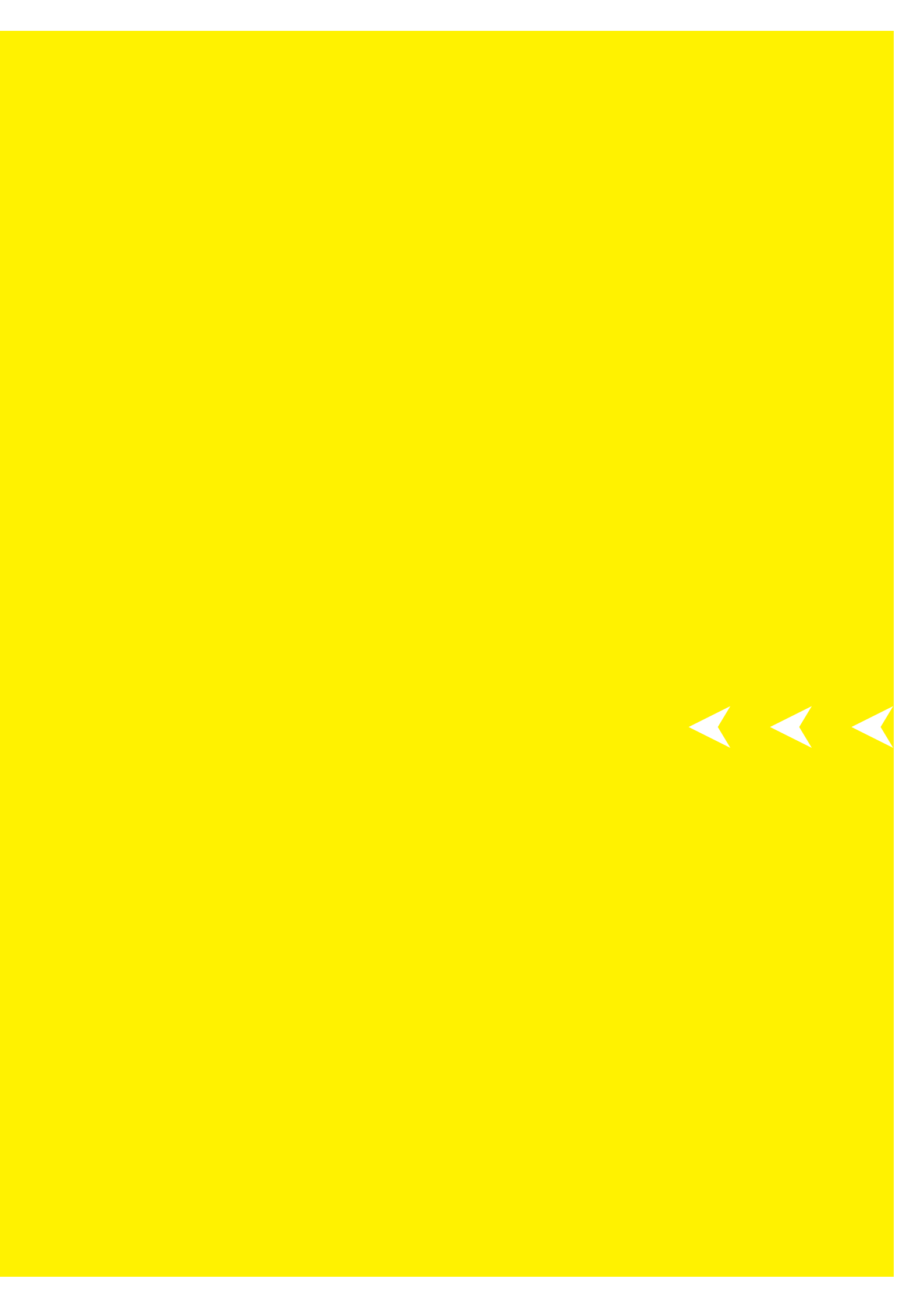
Table A3: Analysis of Activity Stages				
Language/organisational features of each stage	Triage	Nursing admission	Initial assessment and stabilisation	Management, diagnosis and disposition
Clinician roles change: primary responsibility	Nurse – senior nurse (RN, CNS) 4 mins 46 secs	Staff nurse	Doctor – junior, sometimes nurses at bedside with doctors work as a team (team activity generally parallel activity although at HKH ED this stage sees more of teams connecting horizontally across discipline boundaries)	Doctor – senior or registrar
Varying levels of responsibility (after Triage, hierarchy of staff and level of accountability increase with each stage)	Triage nurse has primary responsibility. Huge implications if they get it wrong	Staff nurse teams	Mentored/supervised/overseen by senior doctor – also often assisted by nurses – sometimes senior nurse with advanced training (ANP)	Primary responsibility for patient – but also for many patients and for training of junior doctors.
Competing priorities of nurses, doctors and patients	<ul style="list-style-type: none"> – Allocate triage category – medical and organize – Attend to waiting patients; send patient to most appropriate assessment/treatment area – Ensure patient care; allocate correct category and manage pain; assess presenting illness – Time constraints 	<ul style="list-style-type: none"> – Manage patient – Efficiently manage patient load (back and forth); undertake organizational tasks – change patient into hospital gown (patient unfamiliar, needs explanation, move between patients) 	<ul style="list-style-type: none"> – Comprehensive history, medical diagnosis – Efficient (20) management of the case – Learning the ‘practice’ order tests (CT, X-rays), establish initial diagnosis (hypothesis), treatment may be initiated 	<ul style="list-style-type: none"> – Correct history/ diagnosis/also responsible for the efficient running of department and of staff – Medical expertise limited – few senior doctors available, responsible for many patients
The purpose of the spoken interaction changes	Allocate triage category; manage pain	Admit patient into hospital system and comfort/ settle patient	Take history; make provisional diagnosis; find out as much as possible; focus on diagnosis; investigate hypothesis from evidence, symptoms (forming) age, gender	Focus on solution to the medical problem; confirm hypothesis; devise treatment/ management plan; negotiate with patient
Patients are placed in different roles by the clinicians	Brief encounter – patients provide limited information to very specific questions, more like customer service – they cooperate, respond	Patients cooperate; they have minimal engagement; and depending on their background, e.g. socio-economic, age, gender, they are more or less intimidated by the authority of the doctor/nurse/institution (power)	Doctors need patients to engage (POWER relations) more in the questioning process; patients must think carefully; remember; focus; explain. There is collaborative information building; patients respond in depth; stay alert; communicative burden on patients is considerable	This stage also needs patient engagement. Doctors’ focus is to explain – articulate/ describe. There is in-depth collaborative information building. Patients have had practice earlier with junior doctors. We must also consider communication burden on patients

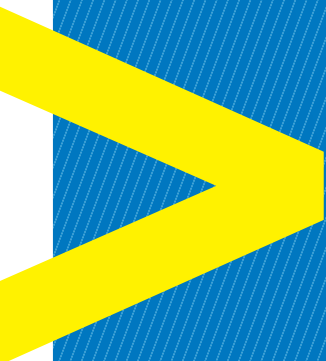
Table A3: Analysis of Activity Stages (cont)

Language/organisational features of each stage	Triage	Nursing admission	Initial assessment and stabilisation	Management, diagnosis and disposition
Particular patterns of communication/language	<ul style="list-style-type: none"> - Language is constrained by uniform set of criteria and a clear process - A limited number of prescribed questions are designed to achieve correct triage allocation - Patients are not encouraged to ask questions of their own - Patients rarely ask questions about what is going to happen to them - The information patients receive is generally limited to what they can expect to happen up until the end of this particular Activity Stage - The information triage nurses provide relates to approximate waiting times or to the staff members who will follow - There is limited opportunity to establish an interpersonal relationship 	<ul style="list-style-type: none"> - Patients rarely ask questions about what is going to happen to them - The information patients receive is generally limited to what they can expect to happen up until the end of this particular Activity Stage - There is limited opportunity to establish an interpersonal relationship (as the stage is very short) but often this is the first opportunity the nurses have to reassure the patients and calm their anxiety about being in the ED - The stage is dominated by nurses introducing the patient to the institutional life of the hospital. They focus on protocols about the patient's allergies, personal identification, belongings, changing them into the hospital gowns, their comfort etc. - Sometimes a quick check of the patient's story takes place (they check their understanding of why the patient is there) - The nurses usually explain what they are doing when they take observations or why they must change patients into gowns etc. - Most often they announce the (pending) arrival of the doctor 	<ul style="list-style-type: none"> - Doctors' questions dominate this stage, focusing mainly on the patient's illness/injury - Nurses ask questions to establish that patients are stable and pain-free - Patients mostly respond to doctors' questions and in most cases (but not all) they ask few questions themselves - Patients rarely ask questions about what is going to happen to them while they are in the ED - Doctors' statements are more focused on providing information about the hospital system - Nurses provide information to patients about the hospital system and explain what is happening to them, and what their medical condition means in terms of consequences or treatment - The information patients receive is generally limited to what they can expect to happen up until the end of this particular Activity Stage - 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 have carriage of this stage and they struggle under both the disciplinary and communicative weight of the initial history taking 	<ul style="list-style-type: none"> - Intense personal encounter - This stage is short, very focused and emotionally-charged - Senior doctors once again focus on questions about the patient's illness/injury - Senior doctors' statements are about diagnosis, the outcome for the patient and next steps - There is often repetition, checking the patient's comprehension of what has been said - Nurses focus on the system - Patients do ask questions in this stage if they are unclear about their diagnosis/treatment

Table A3: Analysis of Activity Stages (cont)

Language/organisational features of each stage	Triage	Nursing admission	Initial assessment and stabilisation	Management, diagnosis and disposition
Interviews	Triage nurse – can patient talk – breathe – circulation – why they've come in – if in pain	Package people – get observations done, make sure settled, pain under control, notes written – hypothesis – I know all I can now – all sorted	Nurse – we get to discuss patient with doctor – more on same level. NUM – every patient has some form of stress. RN – ED can be very daunting – scary – foreign environment – newcomers. D1 history and order appointment, investigations, must check this with D2. Wait for tests – decide diagnosis with D2	D2 introduce myself – start taking history/examination/initiate tests – blood request forms for tests – review patient notes (after history) systematic. Registrar: I explain to patient what I'm thinking, what I'm going to do, takes a while for tests to come back etc. (also tell relatives)
<p>ED is characterised by: complex bio-medical and socio-cultural presentations and investigations requiring differential diagnoses by specialised medical experts; rapid, changing and often fragmented or disrupted consultations; complex knowledge networks about each patient linked (to doctors/nurses and allied health practitioners) via notes, X-rays, computers, test results etc.; differentiated disciplinary priorities and practices – nurses, doctors, social workers – different knowledge domains; complicated organisational care structures– team arrangements; shift cycles; lunches; breaks; skill mixes; complicated physical layouts including mobile equipment, mobile patients and mobile clinicians; differentiated and competing priorities – moving patients through quickly while still providing 'best care'; and those of supervising junior doctors yet still allowing them some autonomy</p>				





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