

Journal Club Synopsis

Block 4 Journal Club 2012

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Special thanks to Drs. Bricking, Freyhof and Pook for their participation

“How does physician-patient communication in the emergency department affect patient care and patient satisfaction?”

Clinical Scenario:

One year out as an attending, you are at your first annual performance review. Your boss says “Your Press-Ganey scores suck. When we meet again in 6 months, there had better be improvement!” What do you do?

Introduction: Everyone has their own communication style. Unfortunately, it may not always mesh well with the patient’s communication style. This can lead to poor Press-Ganey scores and more importantly, poor patient care. Additionally, the topic of physician-patient communication and performance has been incorporated by ABEM as one of the requirements for maintenance of certification (MOC).

An initial list of over 15 articles was produced by our medical research librarian from a thorough literature search for articles pertaining to this subject. The literature was searched for articles studying physician patient communication; whether deficits or suggestions for improvement. The limits placed on that search besides those which are inherent in our clinical question included being selective for articles that were clinical in nature and as recent as possible. I also asked that all relevant articles from the emergency medicine literature be included. From there, a review of the abstracts narrowed the list to less than ten to choose from, and then I chose those that I thought best reflected our clinical setting and patient population

There are a fair amount of articles out there on this topic; however, there are a limited number of articles on this topic specific to the physicians in the emergency department setting. All three articles are relevant to the emergency department setting; the first looks at the physicians’ feeling on the communication; the second is from the patients point of view, and the third objectively comments on physician patient interaction.

Article 1:

The impact of communication barriers on diagnostic confidence and ancillary testing in the emergency department. Garra G, Albino H, et al. *Journal of Emergency Medicine*, 2010, 38(5):681-5.

This article had emergency physicians comment on communication barriers (CBs) with patients to assess how CBs affected patient care and ancillary testing. This was a prospective survey. Language was the most common CB identified. Diagnostic confidence was lower in patients with perceived CBs versus those without CBs. Since diagnostic confidence was lower, more ancillary tests were ordered to narrow the diagnosis.

Group Discussion: The group first commented that “you didn’t even need patients to do this study.” Basically, this was a questionnaire for physicians to fill out based on their interaction with a patient to relate if there a perceived communication barrier. The physician was then asked about reliance on diagnostic testing. The study did not assess the patients’ perception of the interaction. Additionally,

there was no measure of ancillary tests used; this would have been a more scientific way to correlate if more tests were actually ordered in the event of a perceived CB. Language was cited as the main CB and most people thought this was true in their own practice. Some people thought it was interesting that a translating service did not help lessen the CB. Also interesting was that senior physicians perceived less CBs than novice physicians. Overall, this article was probably the least helpful in contributing toward the clinical question.

Article 2

Complaints from emergency department patients largely result from treatment and communication problems. Taylor D, Wolfe R, Cameron, P. *Emergency Medicine (Fremantle)*, 2002, 14(1):43-9.

This study out of Australia retrospectively analyzed emergency department complaints over a set period of time. They noted that complaints often involved the very young and the very old. Complaints were most often made by someone other than the patient. 33% related to treatment issues and 31% related to communication, including poor staff attitude, discourtesy, and rudeness.

Group Discussion: The group first noted that almost 75% of the issues were resolved satisfactorily; usually with explanation or apology. We noted that if the explanation or apology was given while in the ED/at the time of the incident, then time addressing the incident later could have been saved.

This led to commentaries on customer service. The book "If Disney ran your hospital" was cited. At Disney, the three core values, in order of importance, are safety, courtesy, and efficiency. In medicine, the values are safety, efficiency, and then courtesy. We discussed how this applies to the ED. For example, how getting your patient a cup of water or a warm blanket improves their experience in the ED. Press-Ganey scores are more related to patient experience than medical care.

Our guest speakers all commented on through-put. Timeliness is a major factor in patient satisfaction. Overall, what the literature teaches us to create a satisfied customer: Door to doc time < 30 minutes and Door to decision time < 120 minutes. Driving throughput processes is an essential element.

For each letter written, there are 8 unhappy people (on average). Isolated incidents, especially when care is adequate, are not an issue. Trends often require intervention.

Article 3

Resuscitating the physician-patient relationship: emergency department communication in an academic medical center. Rhodes K, Veith T, He T, et al. *Annals of Emergency Medicine*, 2004, 44(3):262-7.

This study audiotaped and coded 93 ED encounters. When reviewing the encounters, they specifically evaluated indication of training status, use of open-ended questions, average time to interruption, thoroughness of discharge instructions and prompting of the patient for questions. Overall, the study noted that the physician-patient encounter was brief and lacking in important health information. This was a small pilot study. One limitation is that audiotaping does not capture non-verbal elements of communication.

Group discussion: During this discussion we talked about the benefits of "scripting." People gave examples of their personal scripts. One attending noted that scripting works – e.g. "I am closing this curtain/door for your privacy."

Other things to remember:

Noise control helps – hearing demented grandma screaming in the next room increases anxiety. Sit, be attentive, listen to concerns. The "wow" comments are often attached to the things that medically don't matter. For example – Recently, a patient commented that the doctor remembered them from 2 months ago. This is probably not true, but the doc had quickly looked at visit history before going into the room.

Summary:

What we do as residents matters. Yes, residents are named in complaints. Often communication – poor or lack thereof – is at the root. At Kettering, the issues regarding education are typically vetted through one of the attendings.

Yes, residents are given kudos by patients. They can be named specifically in a Press-Ganey write up or in a letter. These are also forwarded and are much appreciated.

Additionally, how we practice now entrenches that habits for how we practice as attendings when we have even more pulls on our time and attention. We should strive to develop and maintain good patient communication skills now.

Good communication helps improve patient satisfaction, but more importantly helps improve patient care.