Strangers in Crisis: Communication Skills for the Emergency Department Clinician and Hospitalist

Vaughn F. Keller, EdD, Michael G. Goldstein, MD, and Cecilia Runkle, PhD

Changes in the U.S. health care delivery system have brought about significant changes in the functioning of the nation's hospitals. Patients admitted for treatment today are sicker than patients admitted for treatment 20 years ago. The emergency department (ED) finds itself responding to a wider variety of patient health care needs, including the primary care needs of the poor and disenfranchised. At the same time, competition among hospitals has increased, with multiple stakeholders (physicians, patients, managed care organizations) increasingly able to choose among hospitals. Hospitals are concerned about how they are perceived, and many have established ongoing patient satisfaction survey programs.

Historically, clinicians in the ED have received lower patient satisfaction scores than have physicians in other services in the hospital [1]. More recently, patient satisfaction scores for hospitalists have been reported to be lower as well. The first author of the present article was invited to work with a large staff-model managed care organization that had recently initiated a hospitalist program. Consistent with other reports, the patient satisfaction scores for the hospitalists were lower than those for clinicians in other departments. Interestingly, many of the new hospitalists had received higher patient satisfaction scores when they were working as primary care providers. Hypothesizing that the new role called for a different set of communication skills, we undertook a needs assessment, which evolved into a communication workshop entitled "Strangers in Crisis." In this article, we describe the approach that is presented in the workshop.

Origins of the Workshop

Within the managed care organization, we interviewed and surveyed hospitalist chiefs to understand the nature of the complaints made by patients. We also surveyed hospitalists and ED clinicians about what bothers them the most and causes them difficulty. For both ED clinicians and hospitalists, 3 items emerged as primary concerns: working with the family members of a patient, the challenge of quickly establishing a relationship with a person who is in distress and a complete stranger, and communicating with other clinicians and staff in order to prevent things from"falling through the cracks."

To understand more specifically what bothered the clinicians, we conducted a series of "behavioral event" interviews with the hospitalists. In telephone interviews, hospitalists were asked to describe specific situations that had been bothersome and to go into detail about what took place, including what they did in response to the situation. This gave us an insight into the current behavioral repertoire of the hospitalists we would be training and allowed us to identify gaps between current and desired behavior.

Strangers in Crisis Workshop

The workshop is designed to address the 3 areas of communication that were identified as important staff needs in the ED and inpatient units: clinician-patient communication; communication with patients' families; and the clinical "handoff"—a particular type of team communication.

Clinician-Patient Communication: The 4 Es

To address the area of clinician-patient communication, the Bayer Institute's 4-E model [2] was adapted to the ED and hospital inpatient settings. The 4 Es (Engage, Empathize, Educate, and Enlist) are clinician communication tasks that are associated with positive outcomes, including improved clinician and patient satisfaction, reduced malpractice claims, increased patient adherence, and improvement in patient health outcomes [2,3]. When combined with the communication tasks of "opening" and "closing" the encounter and the clinical tasks of diagnostic reasoning and treatment planning, the 4 Es contribute to a complete model of clinical care [2] (**Figure**). The specific skills and strategies associated with the 4 Es have been described in detail elsewhere [2,4–6]. The version of the 4 Es that is used in the Strangers in Crisis workshop is shown in the **Table** and is discussed in more detail in the following text.

From the Bayer Institute for Health Care Communication, West Haven, CT (Drs. Keller and Goldstein) and the Permanente Medical Group, Oakland, CA (Dr. Runkle).

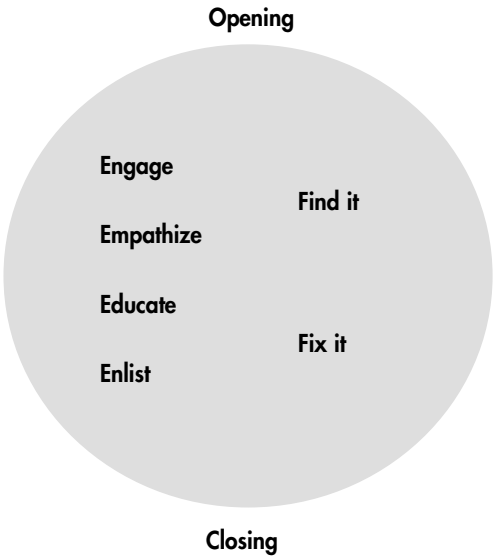

Figure. Model of complete clinical care.

The **Opening** segment is especially important in the ED and inpatient units, where patients and clinicians are often strangers to each other. This brief moment sets the stage for the initial interview and subsequent contact during a patient's stay. **Engagement** refers to establishing a sense of connection and the personal relationship that develops between a clinician and patient during an encounter. Challenges to engagement in the ED and inpatient wards include time pressures to see multiple patients who are in distress and the frequent need to elicit and process clinical information quickly because of the acuteness of the presenting medical problem. Engagement may be facilitated by using the techniques listed in the Table. *Joining* need not take long. A student of communication in the ED uses a very simple opening [7]: "How are you holding up?" This simple question simultaneously acknowledges that the patient is facing a trying situation and that the clinician is interested in the patient's current psychological state. It is particularly helpful and respectful in the ED and inpatient settings to *orient* the patient to the clinician's role (eg, "I will be your doctor for the next 8 hours"), as well as to what the care team will be doing and what will happen next.

Empathy is the second of the 4 Es and is achieved when the patient experiences being seen, heard, understood, and accepted [8]. When patients consider clinicians to be empathic, they are more satisfied with their care and more likely to adhere to treatment recommendations [9–13]. Strategies for conveying empathy are listed in the Table. *Eliminating physical barriers* (eg, sitting down and lowering the bedrail) and attending to privacy (eg, pulling the curtain between beds) are strategies that are particularly important in the ED and inpatient units.

Educate is the third E in the 4-E model. Even though care in the ED and inpatient wards is typically time-limited and usually represents just one episode in the patient's course of illness, the visit or stay may be viewed as a "teachable moment," a time when education about the condition or treatment has relevance and importance. If education is delivered in an effective manner, the patient is more likely to follow up with the treatment plan and adhere to treatments initiated or maintained while in the hospital setting [3,13,14]. Strategies for delivering effective education are listed in the Table.

The final E is **Enlist**. Enlistment is an invitation by the clinician to the patient to collaborate in decision making and actively participate in the development of the treatment and follow-up plan. Activated and empowered patients who are involved in decisions and given options or choices for treatment and follow-up are more likely to adhere to treatment recommendations and participate in self-management of their condition [15–19]. Strategies for promoting enlistment are provided in the Table. In the ED and inpatient setting, it is critically important to assess the patient's intentions for following recommendations for treatment and follow-up. Research, including studies conducted in ED settings, has found that adherence to recommendations is approximately 70% to 80% for curative regimens and only about 50% for long-term regimens [12,20,21]. One can assess intentions by simply asking the patient, "What do you intend (or plan) to do?" A more specific way to ask about intention is, "Are you willing to continue to take the medication 3 times a day for the next 2 weeks, until you see your regular doctor?"

To fully engage the patient in the process of decision making and treatment planning and to promote subsequent patient adherence, it is helpful to assess the patient's conviction and confidence [22,23]. Conviction is the belief that the recommended treatment, test, or behavior change is worthwhile and important to the patient's overall health and well-being. Confidence, or self-efficacy, is the belief that he or she can accomplish the specific behaviors related to carrying out the treatment plan, including overcoming anticipated barriers. The simplest way to assess conviction and confidence is to ask about them directly. For example, "How convinced are you that you need to use the inhalers daily to prevent asthma attacks? How confident are you that you can overcome the barriers to using the inhalers at least 3 times a day for the next several weeks?" The Table lists several other strategies that can enhance enlistment. Writing out the regimen or using pre-printed instructions is an important strategy, as most patients do not recall much of what they are told verbally, especially in the ED [20,21].

Finally, there is a need to anticipate and forecast discharge from the ED or hospital and provide some closure on the

Table. Clinician Strategies for the Clinical Encounter

1. **Open**
   - Introduce self: role, name
   - Greet the patient by name
   - Welcome the patient
   - Maintain eye contact
2. **Engage**
   - Join
   - Orient to role
   - Orient to process
   - Elicit the agenda
   - Elicit the patient's story of illness
   - Reflective listening
3. **Empathize**
   - Acknowledge facial and bodily expressions
   - Eliminate physical barriers
   - Reflect feelings, concerns, values
   - Normalize and express understandability
   - Self-disclose, when appropriate
   - Avoid judgmental statements or responses
4. **Educate**
   - Assess baseline knowledge, understanding and self-diagnosis
   - Tell—provide information that is matched to patients' needs
     - Address the following common areas of concern:
       - Mysteries of health
         - What has happened to me (diagnosis)?
         - Why has it happened to me (etiology)?
         - What is going to happen to me (prognosis)?
       - Mysteries of the medical world
         - What are you (they) doing for me (to me)?
         - Why are you (they) doing this rather than that?
         - Will it hurt me or harm me? How much? How long?
         - When and how will you know what this all means?
         - When and how will I know what this means?
   - Assure understanding
     - Ask about understanding
     - Clarify, correct, and reinforce
5. **Enlist**
   - Assume patient expectations and intentions about treatment
   - Ask about expectations and intentions about treatment
   - Develop a collaborative plan for treatment and follow-up
   - Assess patient conviction and confidence
   - Write out regimen/plan
   - Identify and remove obstacles
   - Plan for missed dosages/treatments
   - Prepare for side effects
6. **Close**
   - Anticipate and forecast discharge
   - Summarize diagnosis, treatment, prognosis
   - Review next steps:
     - Follow-up: who, when, where
     - Role of family and other caretakers
     - What to do if problems arise
   - Say goodbye and express hope

visit or stay. Three strategies for **Closing** are listed in the Table.

Communicating with Patients' Families

A patient who enters the ED or hospital often is accompanied by family members or persons who are part of the patient's "intimate system"—people the patient depends on for support, companionship, and belonging. Such individuals can help the clinician by providing information that may be important for diagnosis and treatment. However, the presence of family members complicates the communication process. Illness and trauma affect the family as well as the patient, and family members faced with trauma and loss often react emotionally. Moreover, the stress of a serious illness can strain family relationships and heighten conflicts [24,25]. In addition, there is tremendous diversity among families with regard to beliefs, expectations, rituals, and preferences, including preferences for communication and decision making. A clinician who enters the waiting room has no way of knowing how a specific family will react or what needs will emerge.

Initiating Communication with Families

What strategies might a clinician use to address the challenges of communicating with families in crisis in the ED and inpatient settings? Here are some suggestions for getting started:

- Provide privacy for conversations. This may not be easy in the hospital setting, especially in the ED. If possible, find a conference room or use the nurses' station. If a separate space is not available, pull curtains for at least a semblance of privacy.
- Sit down: introductions all around. Pull up a stool or chair if possible. Take time to find out who each family member is and the nature of each person's connection with the patient.
- Ask what they are most concerned about. This is an essential step that can save time and facilitate the family members' willingness to bring up their concerns.
- Ask how you can be most helpful. By its very nature, this is a compassionate response.

- Ask what works best for them in getting information to family members. This will help you to communicate most efficiently and will help the family to use and even strengthen its existing organizational structure.
- Clarify or discuss limits if necessary. The family needs to know that your first obligation is to your patient and that you may have limited time to communicate at the moment. Let family members know when you will be available.

Dealing with Strong Emotions

When family emotions run high and are expressed with intensity, it can be challenging for the clinician. Anger or outrage directed at the clinician may provoke a defensive response or the desire to flee or avoid contact. As an alternative, it is helpful to pause and take a step back and *assess*: did the system fail them; are there feelings of grief, loss, guilt, shame behind the anger and the blame? Other key strategies are to *listen deeply and reflectively* and *respond with empathy*. These skills are the same ones we reviewed when describing the 4-E model of clinician-patient communication. Reflect feelings, concerns, and values and express understanding and acceptance. Normalize when possible and self-disclose when appropriate. Then, *check to see if your reflections are accurate* and allow the family to correct or elaborate. When emotions run high, *provide space* for the family to react and *support silence*. This can be difficult for a clinician who is used to stepping in and solving clinical problems, yet silence may allow the family to process and express what is often a conundrum of confusing and conflicting emotions. Silence is also a signal that the clinician is willing to be patient and be present with them. *Asking family members what they need* and *offering to be helpful* are additional strategies that convey both empathy and compassion. One might ask, *"Is there anything else you need to know at this time?" "Let me know if there is anything else I can do"* is a useful way of offering support.

Here is an example of an interchange with a family member in the ED that demonstrates many of the skills listed above:

Dr. Z: (*walking into family waiting room*) Mrs. Martin? Hello, I'm Dr. Zorkas. I'll be taking care of your husband while he is in the hospital.

Mrs. M: (*stands*) He has been so uncomfortable, Doctor. I hate to see him like this. I didn't know what to do. Nothing I did seemed to help.

Dr. Z: (*gently*) I can see how upsetting this has been for you. (*gestures to nearby chairs. Mrs. M sits down, as does Dr. Z.*) It is hard to see him suffer, especially when nothing you do seems to help. It was good that you brought him in when you did.

Mrs. M: What else could I do?

Dr. Z: I don't think there is anything else you could have done. I am impressed that you and your family were able to care for him at home for so long.

Mrs. M: (*looks down, starts to sob, wringing hands*) I just feel so guilty for not being able to help ease his suffering.

Dr. Z: (*leans forward*) Many families feel guilty when they can't do anything to ease their family member's agitation and pain. It seems like your husband's condition deteriorated faster than anyone expected.

Mrs. M: (*looking up*) Yes, it has … Dr. Jackson, his oncologist, told us just last week that he still had several weeks or months left. He's slipping so fast.

Dr. Z: So both you and Dr. Jackson have been surprised by how fast the cancer has progressed. That must make it even more difficult for you.

Mrs. M: Yes, Doctor, it has (*sobs more intensely*).

Dr. Z: (*moves closer, takes Mrs. M's hand, and remains silent for about 1 minute*)

Mrs. M: (*stops sobbing, wipes her eyes*) Will you be able to control his pain?

Dr. Z: I am confident that we will be able to make him comfortable. I have already asked the nurses to start a morphine drip to control the pain and we will give him some sedatives to control his agitation.

Mrs. M: Thank you, Doctor.

Dr. Z: Is there anything else that I can do now that you think would be helpful?

Mrs. M: No, I don't think so, but my son is coming in from the coast. He may have some questions.

Dr. Z: It's good that your son is coming in. I will be available to talk with him or with both of you together if you prefer. Just have the nurses give me a page when he arrives.

Mrs. M: Nods slowly. Thank you, Doctor. I appreciate your kindness.

Dr. Z: You're welcome. I'll be back later.

Behaviors to Avoid When Communicating with Families

When communicating with families in these settings, several behaviors should be avoided:

- Arguing
- Defending oneself
- Raising one's voice
- Taking sides
- Reassuring prematurely
- Minimizing loss
- Walking out

Though it is natural to respond with defensiveness to strong emotions like anger or blame, it is helpful to avoid getting into arguments or defending one's behavior. When one feels the impulse to defend oneself, it is useful to reflect and legitimize instead (eg, *"You are obviously very upset about the delay in getting a surgeon in to see your son. I can understand your worry and concern."*) It is important not to take sides or get in the middle of family squabbles. Again, reflecting and summarizing can help (eg, *"I am impressed with the level of caring and support being provided by several members of the family. I am also hearing you have different perspectives on how to proceed. What can I do to help you make a decision?").* Premature reassurance can backfire when things don't go well. It is better to be honest than to raise false hope and expectations just to avoid strong reactions. Also, it is important not to minimize the impact of loss. Families generally want you to strive to understand the meaning and strength of their loss, especially if there was some element of oversight or system error. Finally, avoid walking out or away. Nothing makes families more upset than abandonment.

Accessing Other Resources

It is understandable that there are times when a clinician's emotions affect his or her ability to be patient, present, empathic, and compassionate. During these times, it is useful to take a time-out or reach out for help and resources that may be available within the hospital. Families will generally understand the need to take a time-out or get additional resources or help on board. In fact, they generally appreciate it. Humility and sensitivity are usually favored over arrogance and aloofness. Moreover, most clinicians benefit from having an opportunity to reflect and discuss difficult patients and family interactions with personal sources of support: a colleague, friend, or loved one. Support groups for clinicians working exclusively in these difficult settings are also helpful.

Team Communication: The Clinical Handoff

Because ED clinicians and hospitalists usually work as members of a team and work in shifts, repeated handoffs are necessary. These handoffs occur from shift to shift, from outpatient attending to inpatient attending, from ED to inpatient unit, and from service to service. To improve handoffs, we use the STARS model for enhancing team communication. Adapted from communication approaches used in the military and the airline industry, the model is based on the concept that communication is an exchange of meaning and is only complete when it is clear that an accurate exchange has taken place.

The STARS model has 5 elements: Situation; Timing; Action; Responsibility; and Summarize. Both the person initiating the handoff and the person receiving the handoff are responsible for ensuring that each of these elements is adequately covered. *Situation* refers to context—the background information that needs to be shared as well as the specific problem that must be addressed. *Timing* refers to the specific time when actions need to take place, as well as the frequency of actions if repetition is needed. *Actions* are behaviorally defined as specifically as possible. *Responsibility* for each action is specified, using the actual names of people, not pronouns. *Summarize* is the final element, a summary of all of the above, boiled down into one or 2 sentences. Once the originator relays the 5 elements of the STARS model to the receiver of the handoff, the receiver shares his or her understanding of the 5 elements. Misunderstandings are then corrected and obstacles addressed, after which the receiver again summarizes the 5 elements. The originator of the handoff concludes the handoff by confirming the plan.

Dr. X: Harris in Room 4 is a 19-year-old male asthmatic who came in a couple of hours ago with an O_2 sat in the high 80s and some CO_2 retention. We turned him around with some epi and a couple of bronchodilator treatments. I asked Joan, the new resident, to get another gas at 10 PM and to tell you the numbers. He had a low-grade fever, so I asked for a CBC. You need to check the CBC and listen to his lungs before letting him go. His primary doc is Rosen, who hates steroids, so you have to call her if you want to send him out with some. OK, so why don't you tell me your understanding of the plan.

Dr. Y: I will check with Joan about the 10 PM blood gas and then listen to Harris' chest before letting him go. I need to check with Rosen before writing for steroids.

Dr. X: Yes, that's right . . . and also check the CBC.

Dr. Y: Yeah, because he had a low-grade fever. OK, blood gas at 10, chest exam, CBC, and getting the OK with Rosen before steroids.

Dr. X: You got it!

Conclusion

Clinicians working in ED and inpatient hospital settings face daily challenges in the areas of clinician-patient communication, communication with patients' families, and team communication. We hope that the techniques addressed in the workshop and in this article will assist clinicians in transforming these challenges into opportunities to improve patient, family, and clinician satisfaction and ultimately health care outcomes.

Corresponding author: Michael Goldstein, MD, 400 Morgan Ln., West Haven, CT 06516, michael.goldstein.b@bayer.com.

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