Packaging Patients and Handing Them Over: Communication Context and Persuasion in the Emergency Department

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Study objective: Communication is commonly understood by health professional researchers to consist of relatively isolated exchanges of information. The social and organizational context is given limited credit. This article examines the significance of the environmental complexity of the emergency department (ED) in influencing communication strategies and makes the case for adopting a richer understanding of organizational communication.

Methods: This study draws on approximately 12 months (1,600 hours) of ethnographic observations, yielding approximately 4,500 interactions across 260 clinicians and staff in the EDs of 2 metropolitan public teaching hospitals in Sydney, Australia.

Results: The study identifies 5 communication competencies of increasing complexity that emergency clinicians need to accomplish. Furthermore, it identifies several factors—hierarchy, formally imposed organizational boundaries and roles, power, and education—that contribute to the collective function of ensuring smooth patient transfer through and out of the ED. These factors are expressed by and shape external communication with clinicians from other hospital departments.

Conclusion: This study shows that handoff of patients from the ED to other hospital departments is a complex communication process that involves more than a series of "checklistable" information exchanges. Clinicians must learn to use both negotiation and persuasion to achieve objectives. [Ann Emerg Med. 2017;69:210-217.]

Please see page 211 for the Editor's Capsule Summary of this article.

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INTRODUCTION

Background

Sociology teaches us that communication reflects and exposes the identities and cultures of those who communicate. That is, communication happens not in a vacuum, but within a particular cultural and organizational context. Within any given organization, specific behaviors, mediated through communication, will tend to generate specific outcomes.[1] Any organizational unit, including a hospital ED, will build up its own (relatively unique) culture over time.[2] This includes shared interwoven beliefs, norms, and behaviors governing roles, work processes, and objectives achieved among a particular group of people with a specialized role in the organization.[3-6] Culture and shared identity emerge through interaction,[7] and these interactions, in turn, are reflected in the way any specific group relates and intermeshes with other groups.[8-11] For example, when emergency clinicians seek admission for a patient, they might emphasize emergency clinicians' need for speed to reduce the number of ambulances waiting.

With limited exceptions,[9-12] most research treats communication within the health profession as a series of isolated exchanges of information. Such an approach, however, risks ignoring many important contextual aspects of communication that strongly influence its success or failure[13]; ignoring these factors, in turn, can diminish the usefulness of tools such as handoff checklists and handoff memory aids, which have proliferated in recent years.[9]

To take these contextual factors into account, Charaudeau[8] proposed 4 linguistic competencies required for communicative discourse (words that convey a particular ideology). These competencies are elaborated

Editor's Capsule Summary

What is already known on this topic

Emergency physicians must often share key facts, assessments, and plans with other providers to continue care, but the communication approaches in this environment are not well studied.

What question this study addressed

How do emergency physicians communicate when handing off a patient to another provider?

What this study adds to our knowledge

Using an ethnographic, structured assessment in 2 Australian emergency departments, the authors described 5 competencies and 4 contributing factors that shape successful communication.

How this is relevant to clinical practice

Knowing key steps and approaches might allow better or faster communication in emergency physician handoffs to others.

in Table E1 (available online at http://www.annemergmed.com) and will provide the conceptual framework for the present article. Briefly, they are as follows, in ascending order of sophistication: communicative competence (understanding roles), discursive competence (understanding situational identities), semantic competence (expectation matching), and semiolinguistic competence (tone evoking).

Importance

Conceiving of communication as a series of linear and isolated information exchanges overlooks the hard-to-explain nuances of particular communication contexts. This oversight occurs in medical education, for example, in which the contextual complexity of communication is reduced to several hours of skills training focusing on one-to-one interaction.[14] However, the need to assess, treat, and transfer a continual stream of patients makes an external focus unavoidably important in ED work.[15-19] Furthermore, threats to the safety of ED patients—including increased mortality and morbidity[20,21]—stem from resource and technological constraints (often exacerbated by the undersupply of beds) and difficulties transferring patients to inpatient departments.[22,23] External communication therefore looms as an important area of study.[24-26]

Goal of This Investigation

This article focuses on external (ED-to-other-department) communication. Its aim is to develop a rich, nuanced, and situated description of how ED-to-admission communication works and what competencies support it.

MATERIALS AND METHODS

Study Design and Setting

Ethnographic methods were chosen to explore the localized context of ED communication. Ethnography involves studying participants in real time, on location in their "natural" environments as they are carrying out their normal activities.[27,28] Ethnography allows researchers to observe what people *really* do, rather than what they say they do in interviews. The fieldwork involved approximately 12 months' worth of observation by P.N. in the EDs of 2 public, tertiary referral hospitals in Sydney, Australia. Both EDs are large (50,000 patients per year) public teaching hospitals with major trauma centers. Human research ethics approval was secured from the sponsoring university and the 2 host hospitals. Consent was obtained from individual participants.

Selection of Participants and Data Collection and Processing

Two large metropolitan teaching hospitals were purposively (as opposed to randomly) sampled to provide maximum interspecialty complexity and enhance the prospect of delivering findings that would resonate with other similar hospitals. Both informal observations (general observations, including 56 spontaneous "field interviews") and a program of formal observations (specifically shadowing individuals) were conducted (comprising approximately 1,600 hours in total) to gain a broad understanding of the patterns of ED work life.

For the formal observations, a purposive sample of clinicians was selected for close observation. A consistent procedure was established and followed across ranks: P.N. accompanied 2 junior, 2 midranked, and 2 senior emergency nurses and physicians from each ED for 2 full shifts each (totaling 24 shifts; approximately 220 hours). This helped ensure that multiple perspectives on the same organization were observed and recorded. The remaining observation time was spent in informal observations. The observer sought the maximum variety of informal observational opportunities, dividing attention between roles, events, and areas in the ED. P.N. and J.B. met weekly to discuss the observations and emerging findings.

By the early 1990s, both hospitals had been staffed solely by physicians certified by the Australasian College of