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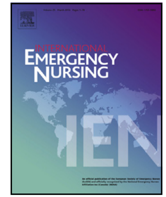

Powerlessness: Dissatisfied patients' and relatives' experience of their emergency department visit

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ABSTRACT

Aim: The aim of this study was to disclose the meaning of patients and relatives lived experience of dissatisfaction when visiting an emergency department.
Introduction: Even though most patients are pleased with the emergency department care, there are areas that dissatisfy them, for example lack of communication and unoccupied wait time. However, there are few studies that describe both patients and relatives experience of dissatisfaction.
Methods: This explorative study uses a phenomenological hermeneutic approach where patients and relatives were interviewed.
Results: Patients and relatives meaning of dissatisfaction mainly contain powerlessness, struggling for control over the situation, lacking knowledge and information, receiving and providing support.
Conclusions: The results showed that the experiences of dissatisfaction were similar among patients and relatives. They suffer in the same way when being treated like objects during their visits. Nursing rounds are one way to decrease dissatisfaction by making patients and relatives participating in the care continually updated with information.

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1. Introduction

Even though patients who seek care at emergency departments (ED) are pleased with their care (Ekwall et al., 2008; Fitzpatrick et al., 2014), both national and international studies reveal areas in ED care in which patients and relatives are dissatisfied with, for example lack of communication and information (Byczkowski et al., 2013; Elmqvist et al., 2011; Fitzpatrick et al., 2014), and unoccupied wait time (Bongale and Young, 2013). Patients who come to an ED expect to wait but not without being updated on how long the wait will be, which could make them feel abandoned and insecure (Elmqvist et al., 2011). Furthermore, patients sometimes experience nurses responding to them with nonchalance and irritation (Bongale and Young, 2013). These patients may perceive their visit to the ED as a struggle and as being at a disadvantage (Frank et al., 2009).

Patients consider it important to have a relative with them during ED visits (Paavilainen et al., 2009). Relatives hold an important role in supporting and caring for the patient. During the wait time it is common that relatives worry about the patient's health and they experience the environment at the ED as stressful (Ekwall et al., 2008). The most important factors needed for relatives to feel satisfied with the care at an ED are knowing the approximate length of wait time, receiving pain relief for the patient, and experiencing good communication with the nurses and physicians (Byczkowski et al., 2013).

Dissatisfaction is a subjective, complicated and negative emotion that transforms into a negative experience. However, dissatisfaction is not the opposite of satisfaction. Patients can be both satisfied and dissatisfied within a situation (Coyle and Williams, 1999). Dissatisfaction often occurs when positive expectations are not fulfilled (Thompson et al., 1996). Patient dissatisfaction can manifest itself as frustration and/or aggressive behavior (Frank et al., 2009). Frustration usually occurs when goals are not being met, and this can be the basis for aggression (Ferns, 2007). Aggression can also arise from the feeling of being treated as less significant or less worthy than desired (Lazarus, 1991). Frustration and aggression are common occurrences among dissatisfied patients and relatives in EDs (Talas et al., 2011). According to Coyle (1999) it is important to study dissatisfaction in order to define specific areas in need of improvement within health care. By listening to the experiences of patients and relatives, health care personnel could hopefully find the meaning of dissatisfaction and then be able to work to prevent feelings of dissatisfaction.

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Table 1
Examples of results of the structural analysis from the interview text.

Meaning unit	Condensation	Sub-theme	Theme
. . .It felt like I had been shown to a place where I was expected to sit quiet and wait	The patient was abandoned during the waiting	Being abandoned	Powerlessness
You come there (ED) and are in pain and no one takes your pain seriously. I explained how much pain I had but still I had to sit there on those hard wooden chairs and wait	The patient's symptoms were not taken seriously	Being disrespected	Powerlessness

Thus the aim of this study was to disclose the meaning of patients and relatives lived experience of dissatisfaction when visiting an emergency department.

2. Methods

This explorative study used a phenomenological hermeneutic method (Lindseth and Norberg, 2004) to investigate the meaning of dissatisfaction.

2.1. Setting and sample

The study took place at the ED of a central hospital in southern Sweden. About 126,000 habitants live in the county and the ED receives about 30,000 visitors each year. During the year 2010 the median wait time for the physician at the ED was one hour and the median total time was approximately three hours. The ED has four main clinics: General Surgery, Infection, Internal Medicine and Orthopedic Surgery. When a patient arrives at the ED he or she meets a Registered Nurse (RN) who triages the patient through anamnesis, vital parameters and clinical conditions. The triage method helps the RN to optimize safety and efficiency in the ED by prioritizing patients who are in greatest need of treatment without regard to means of arrival (Manchester Triage Group, 1997). While patients wait to meet a physician, the RN routine is to reevaluate each patient at regular intervals in order to be able to observe changes in health status. How often patients are reevaluated depends on which priority they received in the previous triage.

Inclusion criteria for participating in the study were patients and relatives who expressed dissatisfaction through questioning the ED process. An informative letter about the study was given to patients and relatives that at any time felt dissatisfied during their ED visit. In order to be eligible they were required to be 18 years of age or older. Exclusion criteria were difficulties in communication due to language barriers. Those who wished to participate in the study left a reply form in a locked box at the ED. Eight patients or relatives were interested in participating in the study. Two patients were excluded from participating due to language barriers. The first author contacted each responder to arrange a time and place for an interview. Finally, two male patients age between 30 and 50 years and two male and two female relatives aged between 40 and 65 years were eligible to be interviewed. Three were interviewed in their home and three were interviewed through a speaker phone.

2.2. Ethics

In the information letter and again before the interview started, patients and relatives were informed that they were guaranteed confidentiality, that their participation was voluntary and that they could withdraw at any time according to the Helsinki Declaration's Guidelines (2013). Patients and relatives gave written informed consent. An ethical approval for this study was obtained from the regional ethics committee.

2.3. Interviews

Interviews were performed one week after the patient or relative visited the ED, and the data collection period lasted 24/7 for six months. The interview was designed as a dialogue with open-ended questions in order to let patients and relatives talk about what they felt was important in relation to dissatisfaction (Lindseth and Norberg, 2004). The interview had two main questions: Would you like to describe your visit on the ED? What did you think and feel when you had left the ED? In order to attain a deeper description of the phenomenon dissatisfaction, the author followed up the answers with questions such as: What did you think then? How did you feel? The audio-taped interviews lasted around 40 minutes except for one that lasted for approximately 15 minutes; all interviews were transcribed verbatim.

2.4. Interpretation

A phenomenological hermeneutical method was chosen to reveal the meaning of the phenomenon dissatisfaction through interpretation of patients and relatives descriptions regarded as a text. This method was inspired by Paul Ricoeur (1976), developed and described by Lindseth and Norberg (2004) for interpreting narrative texts and it involves three phases: naive reading, structural analysis and the interpreted whole.

In the *naive reading*, the whole text was read several times. It was important to be open-minded and be affected by the text during the reading. The goal was to understand the text as a whole to get a naive understanding of the phenomenon dissatisfaction (Lindseth and Norberg, 2004).

In the *structural analysis* phase, the naive understanding was tested. As described by Lindseth and Norberg (2004) the text was divided into meaning units, i.e. a sentence or several sentences with the same content. There was a constant movement between reading the meaning units and the text as a whole in order to verify the meaning of the textual parts. The meaning units were then condensed and abstracted and these condensed descriptions served to reveal the meaning of the text. The meaning units with similar meanings were sorted into sub-themes, and similar sub-themes were later combined into themes (Table 1). The themes and sub-themes that were constructed from the interview text are shown in Table 2.

Table 2
An overview of the themes and sub-themes formulated in the structural analysis.

Sub-theme	Theme
Being abandoned	Powerlessness
Being disrespected	
Questioning	Struggling for control
Being reflective	
Being creative	
False expectations	Lacking knowledge and information
Concerns	
Being confirmed	Receiving and providing support
Being supportive	

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