

Short Report: Using complaints about communication in the emergency department in communication- skills teaching

R. Woodward-Kron¹, A. FitzDowse², I. Shahbal² & E. Pryor¹

Abstract

Introduction: Communication is an ongoing cause of complaints in emergency departments (EDs). These complaints can be used to inform communication skills teaching. Junior doctors are an important part of the ED team, and targeting junior doctors' communication skills, including raising awareness about why patients complain, can contribute to an improvement in quality and safety.

Context: Two interns, a patient liaison officer and a communication researcher, developed an evidence-informed teaching module for junior doctors. The module aimed to raise awareness of why people complain about communication in the ED and to engage junior doctors in identifying strategies at the individual and system level to reduce patient complaints about communication. Complaints about doctors' communication in the ED of a regional hospital over an 18-month period were collated and analysed thematically and the findings incorporated into the teaching module.

Innovation: De-identified complaints were used as triggers for discussion about quality and safety, with junior doctors being asked to consider the case studies from the dual perspectives of the doctor and the patient involved, using a series of question prompts.

Implications: Patient-complaint case studies from the hospital in which the teaching is implemented are a powerful way to engage junior doctors in communication quality and safety issues. Staff from quality and safety units can work collaboratively with educators to tailor this low-cost approach to different practice settings and health professional groups. The two-part module has been implemented in intern training and transition to practice for medical students.

1 Department of Medical Education, University of Melbourne, Parkville, Australia

2 Goulburn Valley Health, Shepparton, Australia

Correspondence

Robyn Woodward-Kron
Department of Medical Education
University of Melbourne
Parkville, VIC 3010
Australia
Tel: +61 3 8344 3072
Email: robynwk@unimelb.edu.au

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Introduction

Communication remains a major cause of complaint about healthcare internationally (Reader, Gillespie, & Roberts, 2014; Schaad et al., 2015). Emergency departments (EDs), in particular, are sites of patient dissatisfaction with healthcare (Källberg, Göransson, Östergren, Florin, & Ehrenberg, 2013; Taylor, Wolfe, & Cameron, 2002), as they are time-pressured, stressful environments with acute patient presentations, typically long waiting times and a perceived lack of information and continuity for patients—all of which are challenging factors for both staff and patients (Gallagher & Mazor, 2015; Slade et al., 2011). Junior doctors are an important part of the ED team; however, in Australia and internationally, there is very little specific teaching for junior doctors and transition to practice medical students about communication in the ED (Woodward-Kron, Flynn, Macqueen, Enright, & McColl, 2013).

Complaints to hospitals from patients, their families, carers and from primary care professionals provide a valuable perspective on the problems of healthcare systems and have implications for quality care and patient safety. Complaints can assist to identify patterns and problems in healthcare delivery (Gallagher & Mazor, 2015; Reader et al., 2014). They also have the potential to inform educational initiatives in health professional education in order to raise awareness among health professionals of patient concerns (Wofford et al., 2004) and to help identify patient-centred clinical skills (Jangland, Gunningberg, & Carlsson, 2009). Patient stories have been incorporated in innovative and powerful ways to teach about adverse events and open disclosure (Gilbee, Kiegaldie, Everard, Pryor, & Craig, 2014); however, patient complaints do not routinely inform teaching about safety and quality. This paper describes the development, implementation and evaluation of a teaching intervention “Addressing Complaints About Communication in the Emergency Department: A Communication Skills Training Intervention for Junior Doctors”, which aimed to raise awareness of why patients complain about communication in the ED and engage junior doctors in identifying strategies at the personal and system level to reduce patient complaints about communication.

Context

In response to concerns about complaints about communication in the ED, the consumer liaison officer and medical education officer at a regional Australian teaching hospital approached a healthcare communication researcher to co-design an education intervention to be incorporated into junior-doctor training. With support of the quality unit, we designed a research and development project utilising existing patient complaints to inform the teaching intervention. Two junior doctors wanting to gain research and teaching experience joined the project.

Ethics approval was given by the Goulburn Valley Health Ethics and Research Committee, Victoria, Australia.

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Research and development phase

This phase was conducted between May and August 2013. Complaints about doctors' communication in the ED, which had been logged by the consumer liaison officer in the Victorian Health Incidence Management System database from January 2012 to May 2013, were retrieved. In addition, the hard copy complaints were hand searched using the same keywords of "doctor", "communication" and "ED". The retrieved complaints were de-identified then analysed thematically using the seven categories that we adopted from Wofford et al.'s study of patient complaints about doctors' behaviours (Wofford et al., 2004), that is, *perceived unavailability*, *disrespect*, *inadequate information*, *disagreement about expectations of care*, *distrust*, *interdisciplinary miscommunication* and *misinformation*. All authors conducted the initial analysis independently then discussed until agreement was reached. We identified complaints to illustrate each theme. We then selected a cross section of complaint narratives and aggregated these in accordance with ethics approval to develop complaint case studies for the teaching module. Our criteria for selection were: complaints that were likely to resonate with junior doctors working in the hospital (e.g., were about junior doctors, described situations that could involve junior doctors) and complaints that were common themes.

Table 1
Complaint Categories After Wofford et al. (2004) and Data Excerpts

Complaint categories	Excerpts from complaints' data
Perceived unavailability (n = 7)	<i>He was told by nursing staff, without reviewing him further, that there was no chance he was going to be seen that night (#9, general practitioner)</i> <i>The doctor was busy racing round looking after other patients and did not seem to have any focus on B and her needs (#14, mother)</i>
Disrespect (n = 10)	<i>K felt dismissed and ignored . . . Dr came and asked about specific allergies and was very rude and had a very bad attitude—arrogant (#20, patient)</i> <i>It was humiliating for him (#12, patient)</i>
Inadequate information (n = 12)	<i>Lack of information provided to J (#11, friend)</i> <i>Patient fasted for 17 hours yesterday and did not find out he was not going (to theatre) until 10.30pm last night (#15, patient)</i>
Disagreement about expectations of care (n = 18)	<i>C was told by one of the doctors that since she had regained consciousness and they needed the bed that she should go home. Fortunately, she able to convince him this was not a good idea (#5, patient)</i>
Interdisciplinary miscommunication (n = 12)	<i>Discharged back to the facility with medication and poor documentation (#2, aged-care facility resident)</i> <i>Dr said he would arrange a bed but nurse came back 30 minutes later and discharged him (#23, patient)</i>
Distrust (n = 4)	<i>Asked for another opinion and got a very silly response from the next doctor (#26, mother)</i> <i>He was using such force that K felt alarmed and scared; he also had poor aseptic technique (#20, patient)</i>
Misinformation (n = 5)	<i>Was sent home saying we would send her an appt . . . she hasn't heard from us (#6, patient)</i>

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Findings of the research into complaints about communication

There were 33 complaints about doctors' communication in the emergency department during the period from 1 January 2012 to 31 May 2013. Of these, three were excluded from the analysis due to insufficient detail. Just under half the complaints were made by the patient ($n = 14$); 11 complaints were lodged by a family member, and five complaints came from a range of sources, including general practitioners, aged-care facility staff or a teacher. The complaint themes, with examples, are shown in Table 1.

Disagreement about expectations of care was the most frequently coded category, covering misalignments in expectations between health professionals and patients about diagnostic and management issues. Concerns about the quality of information exchanges either between health professionals (*interdisciplinary miscommunication*) or between health professionals and patients (*inadequate information*) also featured strongly in the complaints data. The majority of the complaints ($n = 23$) were multi-faceted with several communication themes.

Innovation

The teaching approach took into account the time paucity of junior doctors and roster constraints. For this reason, we designed a program that could be delivered in two parts: an online background module, which provided information about the scope and cause of patient complaints about communication in Australian hospitals and at the teaching hospital, and a face-to-face module. An overview of the three stages of the intervention incorporating the audit steps is provided in Table 2.

Table 2

Overview of the Three Phases of an Education Intervention Using Patient Complaints

Audit phase:

- Identification of complaints about communication in ED with support of Safety and Quality Unit
- Analysis of complaints themes
- Selection of complaint narratives
- Development of aggregated complaints as case studies

Teaching phase: Part 1—online training (20–30 minutes)

Covering:

- Information about communication challenges in ED
- Findings of audit phase about the nature of complaints to the hospital
- Videos of effective and less effective clinicians
- Strategies to improve communication in ED

Teaching phase: Part 2—face-to-face workshops (50 minutes)

- Presentation of aggregated complaints as case studies
- Small-group discussion using question prompts
- Whole group reflection
- Identification of key learning points to implement in the workplace

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The background online teaching module provided in PowerPoint format was made available via the hospital's learning management portal and involved a time commitment of 20–30 minutes. It utilised existing multimedia resources for communication skills teaching in EDs (University of Melbourne & University of Technology, 2011) and included findings from the complaints audit. The decision to provide an online module was made in consultation with the education officer and ED director in order to minimise staffing pressures on the ED, since some of the content was suitable for an online format. For the second teaching component, the participating junior-doctor researchers and the consumer liaison officer conducted a face-to-face workshop with interns, other junior doctors and any medical students on an ED rotation. The aim of the 50-minute workshop was to raise awareness of why patients complain about communication in the ED and engage junior doctors in identifying strategies at the personal and system level to reduce patient complaints about communication. The face-to-face workshop commenced with a brief recap of the online module in order to set the context about the cause and scope of complaints about communication as well as clarify how complaints are managed in the teaching hospital. The discussion was facilitated by one of the junior-doctor researchers (if available) or the lead researcher together with the hospital's patient liaison officer. Two to three aggregated complaints from the audit findings were presented for discussion (for examples, see Figures 1 and 2). Participants were made aware that the case study complaints originated from the teaching hospital. To facilitate discussion, participants were asked to put themselves in the shoes of both the patient and the doctor concerned and discuss the following three questions in relation to the case study/complaint:

Case Study: Communication Complaint A

Patient stories of unacceptable care:
Themes—Disrespect, inadequate information

Mr "A"—I came to hospital because I was bleeding from the back passage. The doctor who examined me in the emergency department said it was the first time she had done a rectal examination. The doctor walked out of the cubicle with faeces on the glove to talk to a colleague. This was humiliating. It's also not hygienic to wander around the ward like that. She came back and said you're good to go, but she didn't tell me what was going on. I should have been admitted to the hospital.

Figure 1. Case study "Mr A".

Case Study: Communication Complaint B

Patient stories of unacceptable care:
Themes—Disrespect, distrust

"Rachel"—We came to the emergency because I was bleeding. I was terrified I was losing my baby. The experience was made worse by the doctor who was rude and unprofessional. When examining me, he spoke to the nurse in his first language. This made me feel they were keeping information from me and added to my distress.

Figure 2. Case study "Rachel".

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- Why did that happen?
- How could it be avoided?
- What needs to change at a system level?

First, a complaint was discussed by the whole group with discussion facilitated by one of the junior-doctor researchers. To promote meaningful and insightful discussion, the facilitator asked participants to consider the clinical context as well as the interpersonal dimensions, such as patient as well as doctor stress, patient anxiety and patients' level of understanding of clinical information, when responding to the questions (above). Participants were then asked to discuss another complaint in small groups of two or three and respond to the three questions. A scribe who reported the group discussion back to the whole group was appointed in each group. The session concluded with workshop participants identifying key learning points for themselves and suggestions for quality improvement.

Evaluation of the online module and workshops

Four face-to-face workshops were delivered between September and December 2013. In total, 28 junior doctors (18 interns, 2 HMO2s), including eight medical students on their ED rotation, participated in the training during the evaluation phase. Thirteen participants completed the survey evaluation. The respondents either agreed or strongly agreed that they found the workshop useful for raising awareness about patient complaints about communication and that it was important to ask junior doctors for input about reducing complaints about communication. The respondents also either agreed or strongly agreed that they believed they could play a role in reducing complaints about communication in the hospital and that the training was relevant to their clinical practice. Few reported accessing the online module. Participant suggestions for quality improvement and improving the workshops included making a list of de-identified complaints available to ED staff on a regular basis for a "feedback" discussion and having more case-based discussion based on "real" complaints.

Even if the full skills workshop were not done on a regular basis, a discussion of the most common problems at the emergency department could be helpful. (workshop participant)

Implications

Patient-complaint case studies from the hospital in which a teaching innovation is implemented can be a powerful way to engage junior doctors in quality and safety issues related to communication. The often-multi-faceted nature of complaints means that teaching about communication skills can be integrated with awareness raising of other safety or administrative issues, reflecting the complexities and challenges of healthcare practice. Feedback from junior medical staff who participated in the training workshop indicated that the use of authentic complaint data from their own practice setting was valued and relevant. However, there was limited uptake of the online module, and our findings suggest future training could focus on the face-to-face delivery component of the program alone, thus reducing the time commitment needed. While the online module can be offered, facilitators should incorporate background information on the cause, prevalence and nature of complaints in the workshop, as well as processes for addressing complaints in their own workplaces.

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Conclusions

We have outlined an evidence-informed intervention that readily lends itself to different clinical settings. Educators can work with quality and safety staff from their own healthcare setting to develop workshops tailored to the needs and issues of the specific context. Since 2013, the training has been incorporated into the Transition to Practice curriculum for University of Melbourne medical students. Further benefits of using patient-complaint data are that it is low cost to implement and draws on data already available as part of quality reporting measures. Such an approach can support other more resource-intensive measures, such as experiential communication skills teaching involving simulated patients. Future longitudinal studies targeting all hospital staff working in the ED could examine whether the intervention has an impact on reducing complaints about communication.

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