Emergency Medicine and Patient Expectations

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“Healthcare workers at all levels of the medical system often quickly forget that the system exists to serve the individual patient. During years of professional indoctrination, doctors and nurses can easily acquire a cloistered and overly clinical attitude toward the practice of medicine. Medicine, in its purest form, is a service industry; like all service industries, its success or failure is measured by the satisfaction level of the people it serves.”

We proceed by serving 'one patient at a time'. It would be good to borrow a phrase from industry, "we service what we sell!" The practice of medicine may be scientifically correct, yet morally bankrupt!

“As a group, patients come to the healthcare system with basically realistic expectations. They expect that the healing professionals will treat patients with dignity and will regard patients' welfare as their principle concern.”

This expectation that a sense of true kindness and caring will be shown by healthcare workers is held by all strata of society. “The healthcare system in the United States is essentially measured against higher ethical and moral standards than is any other business. Patients, society and the legal system expect that care will be given through the emergency services without regard to ability to pay. It is also their expectation that care will be rendered to the maximum ability of an institution's resources and that transfer to another facility will occur only in the patient's best interest and not for the fiscal strength of the hospital. The belief is so deeply ingrained in the American populace that it has been codified into federal law.”

In healthcare, patient satisfaction is the only product. “Classic examples of the failed expectations leading to dissatisfaction can be found in multiple Emergency Department situations; return visits to an emergency department are an example as are the patients’ expectations regarding pain relief and waiting times. Patients return with the expectation that people will be more concerned about their problems because they have been seen once and the problem was not solved. In contrast, the Emergency Department personnel often view such patients as annoyances.” Similarly, patients often come to the Emergency Department with a painful condition, expecting, rightfully so, that they will obtain relief. Studies indicate that the doctor's perception of the patient's pain is invariably lower than the patient's perception of such pain. Irrational fears about the use of pain medication and myths about the long-term effects of drugs have created an attitude in healthcare workers in which patients with legitimate pain may be denied effective relief from their symptoms. Another area where patient expectation and system performance conflict, is with regard to waiting time. No one likes to wait a long time for services. It is demeaning and gives the impression that his/her time is not important and the patient's pain and suffering are not worthy of the physician’s attention. We often hear hostile phrases like, "I'm glad I don't have a real emergency; I'd be dead by now!" Emergency Physicians will frequently suffer the wrath of patients because of time delays. Studies show that patient perceptions of the time waited are significantly different than actual times waited, with patients overestimating the waiting time from 50-100% and doctors underestimating by the same amount. Nevertheless, patients often do wait inordinate times for care, and that time may be increasing with the continued trend toward overcrowding in U.S. Emergency Departments. As waiting times increase, so do patients' anger and frustrations with the physician and the Emergency Department. Not infrequently, after the patient suffers a long delay, is isolated from friends or relatives, has submitted to painful procedures, has been denied food and drink and suffers criticism at the hand of doctors and nurses, they are given discharge instructions that they can neither read nor understand. This is considered by many to be the ultimate professional arrogance.

What then can we as physicians do to both increase patient satisfaction and improve our image? A sign conspicuously placed near a hallway where I once worked declared, "The best way to care for the patient, is to care for the patient". Research has shown that the strongest predictor of patient satisfaction is the patient's perception of the physician's behavior. “It is important for physicians to realize that the patient is not only unable to judge the technical quality of care given, but does not use technical quality of examinations, tests, and medications as the primary measure of satisfaction. Instead, patient's satisfaction is related to nontechnical interventions, such as patient education, stress counseling and negotiation.”

How do patients judge the competence of the Emergency Physician? Patients are entrusting their entire medical well being to a stranger. They have little data on which to judge that stranger's abilities, and they use whatever data are at hand. Emergency Physicians do not hand out their C.V.'s, testimonials from previous satisfied patients or other professional credentials. So patients are left with other means to decide a doctor's competence. The most obvious evidence available to them is the dress of the physician and the cleanliness of the Emergency Department.

Several studies on patients' attitudes toward physician dress all state that appropriate dress enhances the professional image of a physician. It has been said that within 15 seconds of the initial interaction, the patient has made a judgment as to whether the physician is competent. "Whether physicians personally agree that patients can judge their professional abilities based on their dress is not the issue; the fact is that patients do assess the Emergency Physician frequently on the basis of dress. Healthcare professionals who dislike "official" dress should regard it as "professional camouflage", necessary to their profession. For men, appropriate dress (according to patients) includes a clean white coat, a dress shirt and tie, dress slacks and dress shoes- not running shoes or sneakers. For women, dress should include a clean white coat, blouse and skirt or slacks. They are expected to look clean and well-groomed but not flashy.

Another negative image that the Emergency Physician needs to overcome is the common complaint among patients that the physician does not take enough time with them. Time spent with the physician is an important determinant of patient satisfaction. While it is recognized that the emergency interaction by its very nature must be brief, several things can be done to increase the patient's perception that adequate time was taken. "Studies have shown that if the physician sits in the presence of the patient, the perception of time spent with the patient is doubled. The act of sitting down not only signals that time is being taken with the patient, but that the physician's full attention is now focused."

Patients coming to Emergency Departments in academic institutions often leave feeling as though they have only seen a "student doctor" and not a "real doctor" when in fact they have seen several doctors, including the attending or several attendings. Why then this misconception? It is true that often the student or intern is the one who spends the most time with the patient, but it is likewise true that oftentimes we do not introduce ourselves and state our position in the Emergency Department. The patient is left to make his/her own mind up exactly who he/she saw and what their position was. It is always appropriate to introduce yourself to your patient and family and to state honestly what your position is. If you are an intern, tell them that you are an intern! It is also good to tell the patient that Dr. (X) is the attending (faculty physician), and that I will be reporting to him/her and that the faculty physician will be directing your care. He/she will see you shortly, or after X-rays or lab, whatever is the case. I remember a specific complaint a patient sent to MCG hospital administration. The patient alleged that he had only been seen by a “student” doctor and therefore was given substandard care and would not pay his bill. In actuality, when the chart was reviewed, he had been seen by a resident, myself as a faculty member, an orthopedic resident and the chief of orthopedics. It is likewise important to remember that a faculty member must see each patient if that patient is to be billed. Under present health care legislation, not to do so would be defrauding the US government under Medicare and Medicaid laws.

Lastly, often patients are under the impression they belong to this or that private attending physician. Indeed, the private attending may believe that the patient is "theirs". If this is the case, the private attending should be called to care for "their" patient, regardless of the time or day of the encounter as long as the patient is stable. Nothing you can or will do will satisfy either the patient or the private attending. In this case, the Emergency Physician is being used as a private house physician, which is demeaning to both the Emergency Physician and the patient. “In reality, this is a definitional problem. Physicians do not own patients. Patients are the responsibility of whatever physician they are seeing at the moment for care. An Emergency Physician presented with a patient takes on both responsibility and liability. Not to combine this with the proper authority to manage such patients is to invite disaster.” From the time that patients enter the Emergency Department, until they have been properly discharged or admitted into the healthcare system, the Emergency Physicians
duties are clear: to provide scientifically based, appropriate timely healthcare in a caring and compassionate manner.
