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## **Obstacles to Communication in Health Care Settings: Participant Observation in an Emergency Department and Retail Pharmacy**

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Obstacles to Communication in Health Care Settings: Participant Observation  
In an Emergency Department and Retail Pharmacy

Senior Project

by

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## INTRODUCTION

Over three years ago I applied for the College Scholars program because I saw a need to be prepared to excel both during and after medical school. To this end, I wanted to maximize my undergraduate academic experience with a combination of biological sciences and speech communication curricula. The sciences are obviously important for success as a physician, and, unquestionably, medical schools do more than an acceptable job of training in this area. Great communication skills are necessary as well, and, unfortunately, many physicians are much less prepared for competence in communication.

I also wanted to supplement my academics with first-hand exposure to medicine. Through jobs in the clinical settings, I have experience that has helped me in many ways. For example, seeing physicians communicate poorly during rotations on a summer internship convinced me to pursue the individualized College Scholars program to incorporate communication courses into a typical science pre-med curriculum. Recent literature suggests that a health care provider “should be broadly educated in the humanities and sciences before embarking upon professional studies,” and classes that integrate the social, behavioral, and natural sciences with the humanities can broaden the pre-health major (Thornton, Marinelli, & Hayes, 1993, p. 3). The jobs in family practice medicine, retail pharmacy, and in an emergency room have provided insight into the career I have chosen and have excited me about it, charging me to excel in preparing for it. My exposures have revealed to me, repeatedly, the lack of adequate communication by providers and patients in many aspects of health care.

How can we learn about communication in health care? Because the communication is so context oriented, direct observation reveals much about the communication occurring. Direct questions to participants also shed some light, although one-sided, onto the problems in health

communication. Through narratives from a mini-ethnography I hope to reveal some obstacles and flaws in communication in health care today. Also, I draw some conclusions and make some suggestions to improve the stressed but imperative communicative part of health care.

Before enjoying the communication sagas of this mini-ethnography, it is important to know my background of experience in health care. During high school, I worked for 2 years in a retail pharmacy. Then, I joined a family practice group of physicians to work as a medical assistant. During college I have worked as a pharmacy technician as well. I continued my exposure to medicine by completing a voluntary summer internship rotating through departments at a regional hospital and by working as an Emergency Department Technician for St. Mary's Medical Center in Knoxville, Tennessee. Currently I work on an "as needed" basis for St. Mary's and in the pharmacy at a local Walgreens.

In the emergency department, I am responsible for phlebotomy or drawing blood as well as performing electrocardiograms and assisting with procedures. Techs assist with all aspects of running the emergency department. The job requires us to do many things at once, including being "gophers" for the licensed staff. There are usually two techs working with five nurses and two physicians. In the pharmacy, I assist the pharmacist with filling prescriptions. Depending on the number of staff on a shift, techs in the pharmacy input prescriptions in the computer, fill them, and check out patients at the cash registers. These duties are basic requirements. Customer service skills are practiced in both jobs as well.

Because of my experience in these settings, I am able to observe the communication interactions clearly. Since I am accustomed to these jobs and have long been a part of their culture, I overlook things that might be distractions to other communication scholars. The culture

is normal to me, and, because of my inside knowledge, I can write about the communication both as a participant and as an observer.

## LITERATURE REVIEW

Before immersing into the descriptions of culture in the emergency department and retail pharmacy, we must, first, review some current extant literature. What is communication? Human communication is a dynamic process; it does not start and stop. It is unavoidable, because we are continually involved in creating, responding to, and assigning meaning to messages. These messages produce meanings that are in people and not in the words, objects, or things involved (Kreps, 1992, p. 20). Human communication is irreversible and is bound to a context. Communication is a two-way process that often includes much nonverbal communication, as well. The goal of human communication, particularly in health communication, is communication competence. Communication competence involves using empathy, behavioral flexibility, affiliation and support, social relaxation, and interaction management as communication skills (Thompson, 1986, p. 8).

Health communication is narrower in scope than human communication. Health communication is concerned with the application of communication concepts and theories to transactions that occur among individuals on health related issues. The transactions can be verbal or nonverbal, oral or written, personal or impersonal, and issue oriented or relationship oriented (Northouse, 1992, p. 4). Health communication provides several contexts for communication. Examples of different contexts and situations will be the focus of this project. It is important to first understand that health communication occurs within a system. The health care system for the patient or "client" involves the individual, the health care practitioners, the health care setting, and the outside environment (Kreps & Thornton, 1992, p. 43). The goal for

both patient and provider should be to establish a therapeutic relationship. The skills of communication competence repeat themselves in therapeutic communication. By using the aforementioned communication competence skills along with trust, validation or confirmation, honesty, and caring, therapeutic communication helps patients make better health care decisions, which lead to better health outcomes (Kreps & Thornton, 1992, pp. 46-51).

Two other important aspects of therapeutic communication are the use of humor and listening. Health professionals should use humor to help relieve strain. While crude jokes are inappropriate, gentle humor is useful because it neutralizes stress and alters situations to make them less stressful. Likewise, listening is an integral aspect of therapeutic communication. Patients want to be heard and cared for. Nonverbal cues such as nodding, eye contact, and body posture can confirm that a message is heard. Good listeners will provide reflective feedback by asking questions in addition to the nonverbal confirmations. An obstacle to listening is distractions, and they should be minimized when a one-on-one interaction is necessary to develop a therapeutic relationship (Kreps & Thornton, 1992, pp. 52-3).

Physicians are not the only players in the game of developing therapeutic communication. Today's health care is delivered by using a team approach, and this approach requires health care teams to work together and ignore real or imagined differences and egos. Relief from job stresses can even come from support from coworkers. There must be coordination at an interpersonal level and at an organizational level (Kreps & Thornton, 1992, pp. 104-111).

Because the relational aspect of physician-patient communication is understudied, there is only fragmented research available instead of complete models or all-inclusive communication theories (Pendleton, 1983, p. 5). Although researchers have focused more on the content level of

the doctor-patient relationship, patient satisfaction has been positively related to patients' perceptions of physicians' interpersonal involvement and expressiveness, which are relational aspects of the communication. On the other hand, patient satisfaction was negatively related with patient perceptions of the physicians demonstrating dominance (Street & Wiemann, 1988, p. 436).

The communication styles used by physicians have been associated with patient satisfaction and compliance. Ben-Sira (1980) suggests that a patient's satisfaction with the professional activities of his physician is determined to a great extent by the physician's mode of presentation. Buller and Buller (1987) and Buller and Street (1991) present two main types of communication styles used by physicians—affiliation and dominance/control. Physicians who are more affiliative (friendly, relaxed, open, attentive) were viewed as creating a positive relationship with their patients. The physicians who exercised a more dominant communication style were viewed as creating relationships with patients that focused on control and authority. In a summary of literature reviews, Pendleton (1983) claims

...that satisfaction of the patient is more likely when the doctor discovers and deals with the patient's concerns and expectations; when the doctors' manner communicates warmth, interest and concern about the patient; when the doctor volunteers a lot of information and explains things to the patient in terms that are understood (p. 39).

In addition, body posture can communicate interest or concern. The way the physician seats himself in regard to the patient may directly influence both the communication between the two and the patient's level of relaxation (Pendleton, 1983, p. 23).

The communication styles used by physicians may be enhanced further by their use of nonverbal communication with patients. According to Burgoon (1991), relational nonverbal behaviors convey meanings that “define and clarify the status of interpersonal relationships” (p. 234). Some of these relational messages include immediacy, receptivity and trust, similarity/depth/equality, dominance, composure, and formality. One of the most prominent nonverbal behaviors involves the use of touch. Clearly, touch may have symbolic value in healing, but it also may affect the interpersonal nature of the doctor-patient interaction.

Through many studies on the nonverbal communication of touch, Burgoon (1991) showed that face and arm touch conveyed the most dominance. The handshake was distinctive in that it expressed less dominance but the most formality (Burgoon, 1991, p. 247). In another study of family practice physicians by Street and Buller (1987), physicians were found to nonverbally exercise greater dominance by using social touch—social and task touch, specifically. The authors suggest that these findings indicate that physicians communicate their social power by controlling communicative exchanges. In addition, the use of social touch by the physician was somewhat correlated to the patients’ satisfaction with their physician. Indeed, physicians’ use of touch is often perceived to indicate dominance, but patients may also be more satisfied with their use of touch than with its absence (Street & Buller, 1987, p. 244).

Barnlund (1976) reveals some of the obstacles to effective health communication. Ego involvement, differences in knowledge, social status, communicative purposes, emotional distance, one-way communication, verbal manipulation, ambiguity of language, role of jargon, and pressures of time can inhibit a therapeutic relationship between patients and providers. The lack of teaching important communicative tactics to medical students and residents also hinders



the development of effective communication relationships with patients (Thornton & Kreps, 1993, pp. 33-38).

When asked the most frequent cause of malpractice lawsuits, attorneys have responded, “80% of their cases were attributable to ‘communication issues,’ such as ‘physician attitudes’ and ‘failure in communication’” (Hirschmann, 1999, p. 39). Although there are many shortcomings involving communication and its lack of perfected use in health care, patients are still treated daily and still need a therapeutic relationship. To provide better overall care, tomorrow’s physicians simply have the challenge of utilizing therapeutic communication more than their predecessors have. As a future physician, I hope to avoid some of the weaknesses in health communication suggested in the literature and present in this “mini-ethnography.”

## METHOD

To explore the obstacles in communication in health care, I have recorded detailed notes from situations while working. These field notes were recorded during my shift in the Emergency room or in the pharmacy or immediately following my shift. The notes of encounters with patients or with other staff members were then transcribed from their shortened version to a complete narrative. These narratives appear in the following episodes sections. Following the episodes and to accompany the field notes, I compiled questionnaires for staff members (physician, nurse, and technician) at the hospital. The questionnaire asked them to identify and list the biggest obstacle(s) to effective communication in the emergency department.

The field notes represent the use of an anthropological means of research called ethnography. Ethnology is the study of contemporary cultures and applies to this study of health communication because the various settings of health care are, themselves, cultures.

Ethnography or an ethnographic account is a detailed written description of a particular culture

(Barnouw, 1978, p. 8). Ethnographic methods can be distinguished from other approaches such as survey or experimental research. There is, clearly, a difference in scale. Whereas a survey researcher might give a standardized questionnaire to participants, a researcher using participant observation might “hang out” with a few individuals. Researchers using participant observation are not interested in how frequent a behavior occurs; rather they wonder about the meaning of a behavior. They seek, generally, to understand the character of the day-to-day life of the people in the study.

Ethnography is a written report about a particular culture. It is descriptive, cultural, focused, comparative, and theoretical. Although these characteristics of ethnography were originally intended for anthropological descriptions of a people, the same characteristics can be applied to research for communication revelations. According to Gilbert Ryle, the intellectual effort of ethnography is an “elaborate venture in ‘thick description’” (Geertz, 1973, p. 6). Without claiming to be a native, ethnographers realize that culture is not a power but rather a context, which can be intelligibly or thickly described (Geertz, 1973, p. 15). Ethnographers “inscribe social discourse” of a culture. A fleeting event can then be transformed into an account that exists richly in its description and can be revisited (Geertz, 1973, p. 19).

Ethnography as a research method was more recently popularized by Goffman (1989), who once said that to do ethnography, participant observation in particular,

You must [subject] yourself, your own body, and your own personality, and your own social situation, to the set of contingencies that play upon a set of individuals, so that you can physically and ecologically penetrate their circle of response to their social situation, or their work situation, or their ethnic situation...so that you are close to them while they are responding to what life does to them (p.125).

Although ethnography can be a terrific means of gathering vivid descriptions, the translations of field notes into narrative accounts reflect emotions of the writer as well as the participants. Narrative writing brings the researcher into the account in a way that is both meaningful and self-reflexive. Thus, ethnography includes both the participants and one's self to construct an account of how understandings emerge during interaction (Kleinman & Copp, 1993, p. 16-17). The descriptions of my encounters are included in the following episodes of this "mini-ethnography."

## EPISODES

### **The Sunday Psycho**

Only after a couple of hours into a busy shift did the highlight of the day come. She was a fifty-year-old white female who presented to the triage nurse with complaints of leg pain. She had a handicap of her left leg and was mobile only via a wheelchair. Little did we know that this means of moving around would be a blessing in disguise. Her daughter wheeled her back into the department.

Since it was a typical Sunday afternoon, every room was full. She had to go into room 10, although it is typically our room used for ENT (ear, nose and throat) problems. As I was hurrying by room 10 on an errand, I heard someone yell, "Hand me my popcorn. I'm hungry." This caught my attention, as we don't usually have patients yelling, especially at their family members. I started to shut the door per our policy, and the patient yelled at me. "I'm claustrophobic; don't you shut that. Where's the doctor?" I said that he would be in to see her soon and that we couldn't have her disturbing other patients with outbreaks of yelling. It was not a normal encounter at all. I warned the doctor before he entered.

At this point, I questioned if the lady was in the ER for only leg pain. I later noticed the doctor discussing the lady's history with her daughter in the hallway. They stepped around the corner and were speaking very quietly. Usually, physicians confer mostly with the patient directly or with the family but in the presence of the patient. This was different and rightly so.

We soon moved her up the hallway to room 14, which is a typical observation room. She inherited this room because it was closer to the security guards who were watching another psych patient next door in room 15. Room 15 is the normal room for psychiatric presentation and evaluation. After an initial visit with the physician, the normal procedure for psych patients began. "Call 'Mobile Crisis'," the doctor said. Mobile Crisis is a service that provides counselors who travel to local ERs to see psych consults. They are looking for a need to commit the patients either to our hospital or to another institution for withdrawal symptoms, detox, and drug abuse, etc. We knew we were in for a long night.

We removed belongings such as cigarettes and medicines from the patient per our policy, which is to prevent self-induced harm. Her things were safe on the corner of the nurses' station. The lady challenged us all night. She demanded to be taken outside to smoke at least every thirty minutes. She brawled with the security guard who was monitoring her. For a couple of minutes she acted as if they had been life-long friends; then, she snapped, telling him to "Get away!" The lady was a textbook case of bi-polar disorder. She asked for something, screamed at me, and then cried, while sliding her fingers down the glass door that we finally closed. Sometimes, she blocked the door with her wheelchair just so we could not get in. She thought she was in control.

After one episode of rolling herself out into the middle of the hallway and yelling, another tech walked up the hallway and handled her for the moment. This tech, Helen, is one of

my favorite people at work. She is a tall lady who commands respect often without saying a word. She worked her magic on this uncooperative patient. Helen walked up the hall toward the commotion, looked down sternly at the lady in the wheelchair, raised her hand and pointed toward room 14, instructing her to return herself to her room. Neither of them said a word. The lady ducked her head, backed her chair back into room 14, and didn't make a sound for 30 minutes. A half hour later, we heard her again because her smoke urges were uncontrollable. By using gestures and body posture, Helen's use of nonverbal communication had a brief, positive impact on controlling this patient. Furthermore, I contributed to communication competence by informing the physician of this case before he entered the room. Because he was familiar with the situation, he was still able to have a therapeutic relationship, although he may have exercised the therapeutic communication with the patient's daughter.

After the Mobile Crisis counselor came and admitted her to a local mental hospital, we had to wait and wait and wait. We were waiting for her transportation to arrive. The patient and the staff were growing tired. She was getting even moodier as the night went on. By 10:00 p.m., the cab driver arrived. We were eager to get this lady discharged for many reasons, including the fact that this room had been occupied all evening and there were many other people who needed to be seen. Although it may be crude to say, turnover is an important part of running an ER. Needless to say, the staff and the other patients, undoubtedly, were glad to see this lady go. The Sunday night storm was now calmer.

### **Can I Watch The Game?**

Sitting in the two green chairs along the wall in room 5 were the man's wife and daughter. I spoke to them briefly and told them I would return soon. It was the beginning of a

typically busy Sunday afternoon shift. The rooms of the ER were full, and the waiting room was crowded with families and patients waiting to be seen. The transition between shifts is extremely hectic because the department is crowded not only with patients and families but double staff coverage. For at least 30 minutes, the day shift staff (7:00 a.m. to 3:30 p.m.) and the evening (3:00 p.m. to 11:00 p.m.) staff overlap for the transition. During this time, nurses and techs are passing on information about the patients they have been taking care of. The new staff assumes the care of the day shift's patients, and they want to know the basics of what is wrong, what has been done, and the prognosis. The day staff is eager to pass on this information and thus the care of their patients. Especially on weekends, some nurses work twelve-hour shifts. Only about half of the positions are filled in this way. Many would agree that eight hours of weekend work are plenty for one day.

At the beginning of this Sunday afternoon shift, I was visiting patients that I would take care of. The patient in Room 5, which is one of the most frequently used rooms for cardiac care, caught my attention. He was going to be admitted to a unit in the hospital for at least an overnight stay. He had presented to the ER with low blood pressure. A ritual at the beginning of each shift is to discharge or admit the patients who are ready to leave. Turnover is a major concern in the emergency room, especially on busy days. Patients also become restless and want to go to their more comfortable hospital bed or to their much more comfortable home. They are often impatient with our rendering of care. This was not the case for the hypotensive man in room 5. He was definitely in the minority, as he was extremely pleasant even after a five-hour stay in the emergency department.

I went into his room to prepare him and his family for the transport we would be making to his room. They already had his clothes together. He was ready. There was one thing. As I

was taking his vital signs for the last time, he looked at me and asked, “Do you get cable TV?” “Do you have Comcast in my room?” I clinched his right forearm, looked up at him, and said, “Yes, we have Comcast. You can watch the game, and I wish I could join you.” We began to discuss the big Lady Vols basketball game that was airing in a few hours. He wanted to make sure that he could still watch them play Florida. It was a big game, and he was very concerned. Being a fan myself, I chatted with him about basketball for a short while. We decided that the Lady Vols would have no trouble.

Since my conversation was mainly with the man about his room, the television, and basketball, I paid little attention to his wife and daughter waiting at his bedside. As I was leaving the room, they grabbed my attention. I heard the daughter say to her mom and dad “What a great doctor he’ll make!” She mentioned something about personality and mannerisms. She did not know that I heard her, but she and that incident turned what was destined to be a horribly busy day into a terrific one for me. I was excited about my job and my career choice. I felt that there could still be some meaning in interacting with patients, even if we are too busy. I realized that stopping and paying attention to the patient and to both his medical and, more importantly, emotional needs meant more to them (and to me) than transporting him to his room quickly. They appreciated my time and undivided attention. In return, I earned their respect without even meaning to do so. I know we both enjoyed the therapeutic communication interaction, for it occurs rarely during the hustling of staff in the ER. They had made my day.

### **Who’s The New Guy?**

Amidst the busy shift change, there was one odd element. We always have two of the same seven physicians working in the ER. Today’s afternoon shift physician was brand new to

St. Mary's Emergency Department, and it was obvious. While the other physicians wore their traditional kelly green scrubs and white lab coats, the new physician had on navy slacks and a polo shirt with his long white lab jacket. From the beginning, he looked out of place. I remember one nurse asking me, "Who's the new guy?"

The new guy stood out not only because he looked different but also because he was obviously unfamiliar with our culture. Physicians communicate their orders to the staff on certain parts of the patients' charts. Today's doctor wrote his orders in a seemingly correct place, although it was a different place from where the staff was looking. Lab orders were delayed. The unit clerk was totally confused. Discharge instructions for patients are usually written on a sheet that is given to the patient to take home with them. He did not use those sheets or communicate instructions to the nurse or tech. The issue was not that the new doctor provided inadequate care; he just did not do it our way. A few nurses quickly whipped him into shape. Now that he knew the way that he must go, the night had to get better.

The effects of the breakdown in written communication for that first hour were severe. Because it was a busy afternoon, rooms needed to be filled and emptied quickly. After one patient complained that his blood work was taking too long, we checked on its status. It was not ordered. This delay could have been avoided if someone had oriented the doctor on our procedures. The other physician and charge nurse were too busy to do so. Instead, we had minor chaos for a short while. The lack of interpersonal communication between colleagues caused the communication problems, but maybe learning the hard way was beneficial to the "new guy." Now, he is one of the staff's favorite physicians.



### **I Think I'm Having A Heart Attack**

Although the 31 year-old male presented to the triage nurse with chest pain, he did not receive the expedient care that the 53 year-old man in room 6 did. The young man “smelled like onions,” the nurse said, and she put him in room 4. Since we ask our patients to rate their chest pain on a scale of one to ten, with ten being the worst pain ever felt, this patient said his pain was “a seven,” with an onset of one hour. I stepped in the room to do his non-impressive electrocardiogram. He still had pain of seven, supposedly, and still smelled like onions. We drew his labs and began his care. His first treatment was the ever-popular “GI cocktail.” This grossly thick pink liquid contains Mylanta, Xylocaine, and Levsin, an upper gastrointestinal relaxer. The combination tastes awful. He downed it, and we waited.

Meanwhile, in the hall way was a scramble. The 53 year-old man in room 6 was actively having a myocardial infarction, “MI,” as we say, or a heart attack. He was incorrectly dropped off at the admitting office of the hospital, while the Emergency department is on the other side of the hospital. He was quickly wheeled to the ER. Although he went into the only empty room 6 at first, three nurses and myself quickly moved him up the hallway to room 2, where we could take better care of him. Room 2 is set up to be a cardiac treatment room, and it is complete with a “crash cart,” in case he coded and needed many medicines instantly. Nurses were busy trying to establish more intravenous lines. He needed several clot dissolving drugs quickly. The ER physician called in a cardiologist. He was actually in the hospital and came down quickly.

During the scramble of providing quick care, nurses were stepping out of the room yelling to the clerk “We need a portable chest and ABG’s.” They wanted to get his chest x-ray and blood gases finished immediately. There was a problem with the verbal orders being yelled

in so many directions. A nurse walked out and yelled for the clerk to page the cardiologist on call. The clerk was on the phone and typing orders into the computer. She did not hear the nurse, at first. The clerk was busy but still managed to make room 2 a priority. I did at least four EKGs on him in less than 30 minutes. We all recognized the severity of his chest pain. It was clearly a ten! The man was pale and sweated profusely. He was obviously in severe pain. His facial expressions twisted and turned, signifying to me the sharp shooting pains coming and going. The cardiologist arrived and directed his care for the duration, which was extremely short. He was quickly transported to the Cath lab for the heart catheterization procedure.

It took a team effort to give him the immediate care he needed. Unfortunately, the team effort was somewhat impeded by some uncontrollable things like the patient's lack of good veins and inability to talk to us much. Breakdowns in therapeutic communication occurred because of a lack of listening, increased stress, and one-way communication.

After the thirty minutes of non-stop attention to the 53 year-old man, I stepped into room 4 to see our young man. "How do you feel now?" I asked. He said, "Much, much better." "What's your chest pain now?" "A three," he said and smiled. The room still smelled like onions. I should have asked him what he had eaten. I am certain the doctor and nurse did, though.

### **No, Really, I Am Listening**

On another semi-busy afternoon in the ER, we were seeing patients with all sorts of problems—chest pain, nausea and vomiting, diarrhea, headache, abdominal pain, etc.

I managed to avoid some of my duties for a few minutes and enter room 9 with one of my favorite physicians to see the 57 year-old male with "N/V/D" (nausea, vomiting, and diarrhea) as

the board read. By the way, “the board” is our key to communication in the ER. It is a huge white marker board where we can quickly view the room number, patient’s last name, age, sex, chief complaint, and x-ray, lab, and admission status. I never knew so much information was only a glance away. We could not survive without it. Anyway, after glancing at the next chart to be seen by the doctor and then at the board, I knew this case might be interesting.

Dr. Seifert is one of my (and one of everyone’s) favorite physicians. He is polite, relaxed, fun, and confident. Patients usually love him, as well. He and I entered room 9 in the back of the ER to find a pale middle-aged man resting uncomfortably on one of our oldest stretchers. Dr. Seifert began with the usual “Hi, I’m Dr. Seifert, and this is Ryan. What brings you to the ER today?” Dr. Seifert was seated beside the stretcher with his legs crossed and the chart on his lap. He was writing furiously. His history and physical sheet has several boxes that require checkmarks when those parts of the physical exam have been completed. With one question after another, the sheet soon becomes almost complete. Dr. Seifert listened to the man’s lungs bilaterally and checked his ears and throat. These things probably had little to do with his chief complaint, but the HEENT (head, eyes, ears, nose and throat) are a part of the physical exam and form that needed completing. After a few palpations of the abdomen, Dr. Seifert explained that we would “get some IV fluids going, draw some blood, and make some x-rays to see if we can figure out what’s going on with you.” Dr. Seifert patted the patient’s right lower leg, and we left the room. His care was about to begin.

While we were in the room, I noticed that Dr. Seifert sat on the stool beside the stretcher. His body was turned toward the middle of the stretcher. He could see the patient’s mid-section and the man’s wife sitting in the chair across from us. I stood behind him near the counter.

I noticed that while Dr. Seifert was writing on the chart, he seldom looked up at the patient or at his wife. Although the man was talking slowly and quietly, Dr. Seifert just nodded his head occasionally as if to agree. The physical exam required his attention be given to the patient, but the questioning must not have warranted it. The patient and his wife said very little about how he felt, physically. He only said what he had recently eaten. After that interview, we left the room, but somehow I left also with the impression that the couple was confused and somewhat displeased with their care. They had puzzled looks on their face, yet they asked few questions. Although Dr. Seifert used the nonverbal behavior of touch, his body posture did not communicate sincere interest in the patient.

The man ended up, after about three hours, feeling and looking much better. His nausea had diminished, and his color was healthy again. They left with prescriptions for anti-nausea medicine and a diagnosis of gastritis, but I am unsure if they had a positive impression of the emergency department and/or Dr. Seifert.

### **It Takes A Small Army**

What was I to expect? I had heard so many terrible rumors about the zoo. The Walgreens pharmacy on Broadway fills over 1,000 prescriptions per day, and they are the second busiest store in the nation wide chain. Many would agree that this location is not in the most esteemed part of town and lacks a well-trained staff. The staff was supposedly mean and hateful. Needless to say, I was intimidated by all these facts.

On a bright and clear Monday afternoon, I arrived at 1:30 p.m. for what was certain to be a challenging pharmacy experience. I met the store manager in the office and got established in their computer in order to be paid. That was very important. I walked back to the pharmacy and

dared myself to enter. Everyone was right. There was a small army running the place. I hoped to blend in. The lighting in the store was poor. The walls were a deep tan to yellow color. I felt trapped inside.

The Senior Pharmacy Technician, Sabra, who had yelled at me on the telephone on Friday because I could not work on Saturday, told me to work in the fill zone. The fill zone is the area between the drop off window where prescriptions are entered in the computer and where the pharmacists check the prescriptions. The counter was full of labels and prescriptions waiting to be processed, checked and sold. The flow is designed to be an assembly line. This store used it, and it worked well. She told me to jump right in, and I did.

Because I was new to the employees there, they kept a watchful eye on me at first. They had me processing the prescriptions—counting medicines and labeling bottles and prescriptions. This was not the hardest job in the pharmacy. Some techs were busy pulling drugs off the pharmacy shelves and lining them up with their appropriate labels on the counter.

Two techs were busy pulling medicines while myself and another lady, who was extremely soft spoken, processed the labels with the medicines they pulled for us. Two people doing each task created less confusion than all four of us searching through the pharmacy for the correct medicines. The two of us working to fill the scripts were even getting in each other's way. There was no room for 4 people. I heard "Can you please scoot down?" at least five times in one hour. "Oh, I'm sorry honey," wasn't uncommon either. We were killing each other. The small army was not vicious just focused.

While thirty prescriptions are on the counter to be processed and passed on, there is one extremely annoying noise in the background—the telephone. It rang and rang and rang. The phones played their own tune. The phone rang so much that we simply could not answer all the

calls. It was difficult to think about each prescription I was working on while trying to either catch the phone or tune out its annoying rings. As they played their own song, the telephones almost got the best of me.

The afternoon progressed quickly. It was 4:45 p.m. before I had even glanced at my watch. That indicates a very busy shift. The senior tech that had once yelled at me on the phone was not yelling at me today. She was begging me to transfer to her store, although I would never do such a crazy thing.

After her lunch break, another technician took over the “in window” and entered the scripts into the computer. She wasn’t as efficient as Sabra or Saber, as I called her to her face. She looked at me and quickly said, “Honey, I’ve been called much worse.” The new inputting tech was much slower than the Saber “machine.” She caused us to get really behind. She tried hard but was overwhelmed with customers continually coming in to drop off prescriptions. New prescriptions were lined up from her computer terminal down the counter for about 4 feet. Several prescriptions can fit into an area four feet long. She was buried, and the wait time for patients was at one hour. Thankfully, Sabra returned from lunch and saved the day. The whole time we were getting slammed with business the telephones continued to sing their own song.

The madness continued, but we kept working hard. Sabra had to go home, for she had endured her 8 hours of hell. Little did I know that it was my turn next? She switched me to the “In-window,” and, actually, I was glad. That’s the station in the pharmacy that I like best. I was ready to tackle this challenge.

I typed as quickly as I could. I was slinging out those scripts like a mad man. The army was getting much more than basic training, now. The girls were impressed. They asked me so many questions about how I did certain things on the computer. I could hardly keep up a steady

pace. I was constantly interrupted by “Show me that trick,” and “How’d you do that?” There was an even greater annoyance--the telephone. I have never heard a phone ring in a pharmacy more than it did that day. The telephones almost defeated that small army. By the end of the night, my fingers and wrists were cramping. Filling that many prescriptions was indeed a workout of the upper extremities. The obstacles to communication here were the distractions. It was difficult to exclude external stresses and listen effectively. The team effort did, however, make a difficult war a victory.

Time flew. An eight-hour shift usually drags on, and you feel tired near the end of it. This day was different. We were so busy that there was no time to feel anything but overwhelmed. I learned to avoid questions by somewhat inexperienced staff, tune out the songs of the telephones, and keep typing. I left that day feeling like a tired but strong soldier.

### **Drive-Thru Convenience**

On a typical busy Tuesday morning shift in the pharmacy, the pharmacist, Joe, and I were the only ones working. The pharmacy opens at 9:00 a.m., and the first fifteen minutes are usually slow. Then, it happens. We begin running in circles.

Supposedly, Walgreens has “the best” computer system in retail pharmacies today. I agree the software is advanced. The problem, at least on this (and most) mornings, lies in the lack of staff. It takes human bodies to actually fill the prescriptions. Amidst the telephone ringing constantly, people asking for advice for over the counter medicines, wanting to pick up their prescriptions at the cash register, and the dreadful buzzer of the drive-thru, prescriptions still have to be filled for those people who are waiting or have phoned in an order. There is little

time to take care of this important matter. We still do our best and offer customer service with a distraught but honest smile.

That is the summary of a typical morning. The morning of Tuesday, April 4, 2000, was no different. The telephones played their own tune at times. For a moment, I felt I was back with the small army. Joe and I were hustling with each of us doing at least three things at once. We perfect performing multi-task skills or we would simply drown. While trying to answer a patient's question about automatic refills on the telephone, I was ringing out a customer's prescriptions, Easter candy, and sodas at the first cash register. Meanwhile, a car rolls into the drive-thru. The normal bell sounds, signifying the presence of a car in the lane. The bell dings again and again until we talk to the customer over the intercom system. Some patients have discovered the black button above the pick-up drawer. This buttons generates a loud and annoying buzzing sound inside. They buzz us when we do not answer promptly, in their opinion. Unsurprisingly, the bell had already rung twice. I saw the lady waiting in her Toyota Camry. Then, she did it. She buzzed us!

Finally, I was able to get to the window. "Can I help you?" I asked. She replied hastily, "Yes, I need to pick up my Premarin. The name's Wooten." I put the intercom on hold and went to the bins where ready prescriptions are filed. Her prescription was not there. I checked our invincible computer, and her name flashed, "ENTERED." This means her refill was phoned in, has not been printed, filled or checked by the pharmacist. This is bad news when patients buzz us from the drive-thru.

I went back to the window and explained that her medicine was not quite ready. I remember sugar coating the situation in hopes of preventing a brawl. "Why is not ready? I phoned it in three hours ago?" she screamed. I replied, "Ma'm, we are really busy this morning.



I apologize, and it'll be just a minute." She was reluctant to wait, but she did. I hurried to fill her medicine, got Joe to check it, and sold it to her quickly. She thanked me for hurrying. Ms. Wooten expressed concern about my frantic hustling inside. She asked why we did not have more help and if it was always this way. I thanked her for acknowledging our fast pace. I also told her "Yes, there's usually just the two of us." She said, "It's not right that you have to ring up candy and groceries. You all need more help. It's always this way when I come here. Is there anybody that I can call to tell them you need more help? What is the phone number to the supervisor?"

I was shocked. First, I was glad I had prevented a complaint on Joe or me. Instead, this may work in our favor, I thought. I expressed my sincerest apologies and gratitude to her. Most people do not recognize how busy we are. Ms. Wooten indirectly recognized our team effort despite the stresses of distractions. She demanded the supervisor's phone number, and I gave it to her--quickly. As I was trying to finish with Ms. Wooten and jump to help other customers, Mr. Berry butted in. He is an assistant manager who is well on his way to becoming a store manager. Needless to say, he plays by the rules. He asked Ms. Wooten and me what was wrong. I had to waste more of my time and hers to explain. Mr. Berry told me to give her the phone number. I quickly replied, "Thanks for your help; I already have and she's fine." What a waste of time his interfering was! Finally, I was back to the hustle and bustle. There were more problems to prevent.

### **No, You Don't Like What I'm Telling You**

The phones were ringing uncontrollably, and there were 5 people lined up at the cash register. Then, the drive thru buzzed. Ellen, my pharmacy manager, and I were the only ones

working. As usual, according to Walgreens, it seems that only two people are necessary to provide excellent customer service and the correct medicine. We did it one person at a time.

The obstacle of handling so many things at once is not difficult if everything goes smoothly with each person. This Monday morning was one from hell. As we were hurrying to clear out the customers waiting, the third person in the line halted our progress. In order to protect the patient's privacy and uphold confidentiality, I will call her Ms. Michel. Ms. Michel was the kind of patient who recognized that we were extremely busy but did not care. She wanted customer service at its finest.

"What's the name"? I asked. "Michel," she said. "Just one for Michel." I was startled that she only had one prescription ready this morning because she usually purchased a bag full. I scanned the receipt and told her the cost was \$147.99. Her pupils dilated and she stepped backwards quickly. "What?" she exclaimed. "I always pay twenty dollars for brand name." I failed to tell her, at first, that her medicine was not covered by her prescription insurance. The company had not approved her Celebrex, a new anti-inflammatory drug for severe arthritis. I explained to her this simple fact. "Your insurance does not cover this drug. Shall we ask the doctor to try to get it approved for you?" I asked. With people still lined up behind her and the drive thru buzzing, Ms. Michel repeated "but I always pay \$20." Ellen recognized my frustration. After three attempts of saying the same thing to her, Ms. Michel was still confused.

Ellen stepped over to help. She said, "Ms. Michel, this medicine is not covered on your plan. Do you still want it today?" Ms. Michel told Ellen the same \$20 line she used with me. Ellen firmly explained it all again. Ms. Michel was getting angry. I could see it in her facial expressions. While she was scrambling through her purse looking for her insurance card, she told Ellen "You're just plain rude." Ellen snapped. She said, "No, Ms. Michel. I'm not being

rude. You just don't like what I'm telling you." Ms. Michel stopped digging in her huge pocketbook and looked up. She said, "Oh, they don't pay for this one?" We both nodded and said, "Yes." Finally, she had heard us. She calmed down and asked us to check with the doctor for a prior authorization for coverage. We agreed to do that at our earliest opportunity. One-way communication and a lack of listening were our biggest problems on this morning.

Ms. Michel scooted out of the way, and I helped the next person. The others who had witnessed this scene asked no questions. They happily took their medicines, paying attention to what we said the entire time. Rudeness was not the intention, but being direct with a stubborn customer made her stop, think, and listen. Listening—that was the key to us providing customer service on this busy morning.

### QUESTIONNAIRE RESULTS

I knew another way to measure the problems with communication in the emergency department was to simply ask my colleagues. I presented the staff of doctors, nurses, and techs the opportunity to answer my short questionnaire. This questionnaire is only a convenience survey and does not represent a control or random sample. It does, however, reveal what forty true members of the ER culture think about communication at work. I asked the staff "What is/are the biggest obstacle(s) to effective communication in the ER?"

Many staff members listed obstacles that are related to stress. Noise in the emergency department such as beepers, doorbells, phones, IV's/other machines beeping, and radios was a common problem listed. Others described the interruptions and "constant commotion." The heavy patient loads and busy shifts with tight staffing increased stress and created fatigue of staff members, which also increased the stress level. An increased stress level caused staff members showing a lack of respect for others as well. The distractions in the emergency department (and

in the pharmacy) greatly increased the stress level of workers, thus inhibiting effective communication.

Listening was another issue represented by a majority of staff members. Poor listening skills were related to the increased stress levels and fast pace of work. Another common obstacle to communication was a lack of time. This also detracted from effective listening and, thus, effective communication. Although this is only a convenience sample, it is interesting to note that I observed many of the obstacles that staff members described most often in their questionnaire.

## CONCLUSIONS

Through the qualitative research methods of this “mini-ethnography” and the answers presented from one important direct question, much is revealed and learned about communication in health care. First, communication is influenced by many external factors that are often beyond the control of participants. Some of these outside factors include lack of adequate staff, time, volume, and poor communication skills, in general. Hopefully, the latter can be improved through recognizing weaknesses and learning better communication skills.

It is true that in the emergency department and in the pharmacy (or in any health care arena) staffing may never be sufficient for the patient/work load. Good care must still be provided. Therefore, obstacles to communication must be overcome. It was my experience that small communication tactics made big differences. For example, the short chat with a tired patient about a basketball game seemed to relieve anxiety for patient, his family, and myself. The conversation occurred while performing job tasks, and the use of touch took less than three seconds. This simple example of caring shown through communication triggered an extremely

encouraging response from the family. They thought I would be a good doctor. Indeed, I do believe that the small things can make all the difference.

One of the most overlooked aspects of communication is listening. So many mistakes and misunderstandings occurred because of a lack of participants listening effectively. The participants—both workers and patients—often heard what they wanted to hear, rather than hearing the actual intended message. Health care workers and patients often assume they know and jump to conclusions. Health care worker must also exclude external stresses and distractions and focus on the important messages at hand. Effective listening can prevent many misunderstandings and breakdowns in communication.

Because health communication involves so many participants, it is important to realize and respect the difference in personalities and communication competencies. New staff members may need extra attention just as new patients or distressed patients may. Paying special attention to psychologically challenged patients may make everyone's job easier. Using nonverbal communication may also improve patient satisfaction by communicating interest in the care being provided. Furthermore, quality health care is successfully provided through a team effort. My staffs have proven to be effective working in teams. Indeed, recognizing weaknesses in and polishing communication skills will only enhance the team effort.

It is clear that there are many problems with communication in the fast-paced style of care given in the emergency room and retail pharmacy. Both settings often require too few people to give great care and customer service to too many patients. Regardless of the mismatch, competent communication must prevail. My hospital system has recently recognized the importance of communication in the emergency department. All of Catholic Healthcare Partners emergency rooms are undergoing a "Rapid Redesign" during the year 2000. St. Mary's is one of

four “alpha” sites to undergo redesign. In order to decrease wait time and increase patient turnover, Rapid Redesign takes a look at the entire communication process involved in the emergency department’s care provided. It is believed that the ER is the “front door to the hospital,” and patients who are pleased with their hospital experience must first be satisfied with their experience in the emergency department. The way of thinking is new and exciting. The first hospital in the system to analyze its communication problems between departments and with patients decreased their wait time from six to eight hours down to less than two hours. They also improved patient satisfaction by simply using the word “care” as often as imaginable. They introduce themselves to the patients and then follow with “and I care about you.” The word “care” is emphasized continuously. As revealed in surveys, their patient satisfaction ratings went from 4% to 75% in the first month.

It will be interesting to see how the redesign improves the communication and patient (and staff) satisfaction at St. Mary’s. The redesign is only in the beginning stages, but the “rapid” part means many things will be implemented at once, reviewed later, and perfected. It is great to see the entire hospital committed to solving the communication problems between departments and the ER staff committed to enhancing customer service by improving communication skills.

Although this mini-ethnography is only a small sample of the huge problems of communication in healthcare, it does reveal some foundations necessary for any improvement. To solve the problems in horizontal communication, staff members must respect each other and work hard in teams. To comfort anxious patients, health care workers need to revert back to therapeutic basics: touching and talking to people. Human interaction can do wonders in the healing and comforting process. Finally, practicing better listening skills can prevent many of

the breakdowns in communication, which endanger patients' care and weaken customer service.

It is imperative that this revelation applies to patients as well as health care workers. As a medical student, I intend to remember these observations and revelations and practice therapeutic communication. Indeed, the obstacles and problems of communication in health care today are situational and vary in severity, but exercising therapeutic communication and communication competence will enhance the health care experience for all involved.

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