Strategies for Improving Patient Satisfaction with the Emergency Department Experience

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I. Introduction

Yes, the emergency department (ED) is a special context that presents many challenges in any attempt to improve the overall experience of care. No, it’s not impossible to make this experience more positive and generate high patient satisfaction.

The suggestions that follow are likely nothing new to ED staff. They simply have to be discussed and implemented in a determined, inclusive manner. If taken seriously, high patient satisfaction will become the rule. Some of the suggestions are specific, while others are more general. All are open to modification depending on the idiosyncrasies of the department and hospital. The issues could be divided among teams to discuss and identify behavioral or organizational changes that would be necessary and then report specific suggestions to the full staff.

This report focuses on managing patient perceptions, not modifying the physical plant or hiring more staff. Of course the physical setting and budget have an impact on patients’ satisfaction with their ED experience. Of course new, cheerful, roomy emergency facilities are more welcoming. Increased staffing during busier hours is helpful. Bedside registration is more convenient. And having a lab and a radiology unit attached to the ED speeds up diagnosis. But not all hospitals can afford or accommodate these improvements. However, all institutions can implement behavioral and organizational changes that enhance the experience of care without significant hits to the budget.
Regardless of the newness of your facilities or the number and technical competence of your nurses and physicians, patients will not be significantly satisfied with your ED if they don’t perceive that your staff cares about the discomfort, anxiety, embarrassment, confusion, and delays they experience. And most important, your staff includes physicians. If they are not fully involved in and accountable for your patient satisfaction efforts, you can forget about improving.

II. Your Challenges

In any healthcare setting, patients want care, not just treatment. Care is the total experience of both technical elements (e.g., diagnosis, tests, treatment, prescriptions) and personal elements (attitudes, interaction, explanation, and empathy). The emergency setting presents many challenges for staff managing the care experience:

1. Stressful environment. Regardless of how new or glitzy your facility is, the ED is a highly stressful environment for patients. They are unfamiliar with ED machinery and rituals, privacy is significantly lacking, and other patients compete for the attention of nurses and physicians.

2. Mismatched views. Patients’ and staff’s perceptions of the ED’s function may differ substantially. For staff, the ED’s function is to stabilize; full healing is often impossible during the short ED visit. Patients, on the other hand, commonly assume that the ED’s function is to heal and may feel shortchanged if they are discharged with lingering symptoms, an incomplete diagnosis, a referral to a specialist, or a suggestion to “see your doctor.”

3. Disconnect in perceived acuity. Staff and patients may have different views about the severity of the presenting complaint. Busy staff sometimes feel abused by patients
presenting with complaints of dubious urgency, while patients, perceiving that staff are not
taking them seriously, may feel rejected or disdained.

4. **Conflicting therapy opinions.** Staff and patients may have different views about the best
method for treating the health problem. Patients bring their own medical systems, beliefs,
and treatment habits to the ED. These beliefs and behaviors sometimes clash with scientific
medical knowledge and practices, leading to breakdown of communication and trust
between patients and staff.

5. **Too little time.** The ED visit is short, leaving insufficient time for patients and staff to
establish rapport.

But does patient satisfaction matter? Aren’t patients receiving great medical care regardless
of whether they are happy with it? Is patient satisfaction worth the effort?

### III. Why It’s Worth the Effort

You can’t manage patients’ satisfaction with the experience of emergency care if staff aren’t
committed to it. **Staff won’t commit to this effort unless they all have the same
understanding of why patients’ personal experience of care is important to individual,
departmental, and institutional goals.** All ED staff must become familiar with the advantages
of high patient satisfaction.

Your entire staff must recognize that patient satisfaction is not only a measurable **outcome** of
care but also a **component** of care. As noted earlier, treatment is only a part of care. Blood
pressure and draws are not taken by themselves. Someone has to confront the patient, identify
himself, explain what’s going to happen, manage the patient’s discomfort and emotional level,
and close the encounter. Wrapping the cuff around the patient’s arm or making the stick for a
blood draw is treatment. The manner in which these procedures are performed and the interaction between the patient and healthcare professional flesh out the care aspect of the visit—the context in which treatment occurs. When emergency patients are satisfied during and after their care experience, both patients and staff benefit (see Press 2005, chapters 1 and 2).

Specifically:

- **Patients’ stress is reduced.** Patients are calmer, complications are less likely to develop, demand on staff decreases, and ED visits are shorter and easier to manage.

- **Patients’ trust increases.** Patients who trust staff are likely to be more cooperative and more tolerant of uncomfortable or scary procedures. They also are more likely to comply with discharge instructions at home. Greater compliance means fewer returns to the ED and better outcomes.

- **The placebo effect is working for you.** Placebo is Latin for “I shall please.” In the ED (and everywhere else in the hospital), higher patient satisfaction is a placebo, contributing to patients’ positive attitude and trust and enhancing the effectiveness of treatment.

- **Patient and staff satisfaction are closely correlated.** When patients are satisfied, staff are more satisfied with their workplace and careers, and turnover is lower. Reduced turnover means stronger, more collaborative relationships among you and your colleagues and lower recruiting and training costs for your department.

- **The ED experience sets the tone for subsequent care.** Between a third and three-quarters of your inpatients are admitted through the ED. Their experience in the ED predisposes them to positive or negative perceptions of subsequent inpatient care. Patients will experience and evaluate inpatient care more positively if they are admitted directly from the ED as highly satisfied customers (Pines et al. 2008).
• A positive ED experience protects the hospital’s brand. Patients are also customers (Mayer and Cates 2004). Satisfied ED patients are more willing to use the hospital again for other purposes. The ED is one of numerous interconnected services offered by a medical center under a single name and identity. In many ways, the medical center is a brand. The ED represents that brand and is typically a person’s initial encounter with it. If patients are turned off by their emergency experience, they’re less likely to use another department in the institution in the future for a profitable procedure such as a hip replacement or stent. They also are less likely to seek care for a family member at the organization. This avoidance affects the center’s bottom line and could have negative consequences for your budget, your salary, and ultimately, your job.

• Patient satisfaction is a form of risk management. Satisfied patients are less likely to perceive a treatment issue negatively (Press 1984) and are therefore less likely to bring suit for malpractice (Fullam et al. 2009). Studies suggest that close to half of all claims are not clearly based on a treatment error (Studdert et al. 2006).

• You become a better value in value-based purchasing programs. An increasing number of insurers want to see proof of your hospital’s quality—and quality includes patient satisfaction. The Centers for Medicare & Medicaid Services (CMS) already requires hospitals to measure the inpatient experience (using the Hospital Consumer Assessment of Healthcare Providers and Systems survey) and by 2013 will be tying reimbursement to satisfaction scores. Other insurers are contemplating similar value-based purchasing. Within a few years, CMS likely will require EDs to measure and publicly report satisfaction scores as well. It’s not too early to begin establishing behavioral habits that will ensure high performance.
Your reputation is enhanced. Your patient satisfaction scores eventually will be published and compared with those of your peers. Release of this information will affect your image, bragging rights, and local/national rankings.

Staff should be made aware of how patients’ care experience can affect their income, job satisfaction, and job security.

It’s clear that patient satisfaction is important. But what underlies it?

IV. Issues Underlying Patient Satisfaction with ED Care

Patients come to the ED with many, if not all, of the following worries:

1. Do I need to go to the emergency room?
2. Will they appreciate how stressful and inconvenient this visit is for me?
3. How do I get there?
4. Where do I go once I get there? Who do I see? What will happen next?
5. I’m embarrassed and don’t want my visit and condition broadcast. Will staff respect my privacy?
6. Will I feel confident and at ease with the staff member who asks about my symptoms?
7. Will I be seen by a doctor immediately?
8. I arrived before other patients. Why are they being seen before me?
9. Why is this whole thing taking so long?
10. Do they realize how scared and stressed I am?
11. Will they respect me if I’m (African American, Hispanic, Asian, Muslim, old, poor, on Medicaid, etc.)?
12. Will they sympathize if my problem is self-caused or a result of obvious negligence?
13. Will they treat me decently if my problem is “disreputable” (e.g., overdose, STD, street fight)?
14. I think my problem warrants a visit to ER, but will the doctors and nurses take me seriously?
15. Will they respect my ideas and practices regarding sickness and healing? What if I’m from a different culture?
16. What if I don’t speak much English? Will they understand my problem? Will I understand their advice?
17. Will they care about my comfort?
18. Will they treat my family and friends with respect?
19. Will they cure me?
20. When I’m discharged, will I be OK? Will I be able to take care of myself at home?

How well you deal with these issues is reflected in your patient satisfaction scores. Note that these statements are questions, not expectations. For many patients, the ED is a new and mysterious experience. Their expectations may be vague, unsettling, or downright unrealistic. Their unfamiliarity with the ED environment is an opportunity to shape and manage their expectations and their perception and evaluation of the experience (Toma, Triner, and McNutt 2009).

V. Addressing the Issues

1. **Do I need to go to the emergency room?**

2. **Will they appreciate how stressful and inconvenient this visit is for me?**

*Why It’s Important*

The ED visit usually begins at home. Hopes (as opposed to expectations) of what the ED can do motivate patients to go to the hospital. The more you know about the reasons behind their visit,
the better you will manage patients’ experience. Second-guessing the validity, appropriateness, or timeliness of a patient’s visit can lead to attitudes and behaviors that create frustration for you and a negative experience (as well as suboptimal care) for the patient.

The decision to go to the ED is not simple. Emergency staff know that patients show up for a variety of reasons. Serious injury or frightening, intense symptoms demand immediate attention. The visit isn’t a decision; it’s a necessity. However, many patients—ED staff estimate at least half—do not have a “real” emergency.

For all but the most serious conditions, patients go through a process of conscious decisions. Even the recognition of symptoms involves a decision. The statement “This is an emergency and I need to go to the emergency room” suggests that the patient has made a spur-of-the-moment decision—but she has not. First, the individual (or family) decides that something is wrong. Pain or discomfort may not be a symptom that requires professional medical attention. For example, a young woman develops a pain in her side. She dismisses it as stiffness from the rigorous work she does as a hotel housekeeper. It hurts, but it is understandable and signifies nothing serious. Over several days, the pain intensifies rather than diminishes. It becomes so severe that she cannot go to work or even do her own housework. If she calls her primary care physician (if she even has one), it might be days before she can get an appointment, so she opts to go to the ED. The same decision-making process occurs for the man who falls on the stairs. His ankle swells and hurts. He can walk on it, so he figures it isn’t broken. It’s a sprain, so it’s not an “ED-worthy” condition. Ice, ibuprofen, and rest for a day will do. But two days later, he can no longer walk on it. He cancels all of his social and sports activities and is off to the ED.

In both of these examples, the patient first self-diagnoses and tries one or more home remedies (e.g., over-the-counter or leftover prescription painkiller, rest, ice, a heating pad).
Indeed, for most people, self-treatment is the rule while they wait to see if their condition improves (most do). If time passes and the self-treatment brings no relief, people become frustrated. Their ability to fulfill social, economic, and family obligations is impaired, also threatening their self-esteem. Frustration, as much as the physical issue itself, can ultimately define the problem as an emergency.

In addition to symptom recognition, severity, and inconvenience, a number of other factors, illustrated by the following questions, motivate people to visit—or avoid—the ED:

- Will I look like a fool if I come to the emergency room with these symptoms?
- Is God punishing me? Should I pray longer or go to the ER?
- I have an embarrassing issue. Will emergency staff treat me with respect?
- It’s after office hours, and my doctor isn’t available. Should I wait until tomorrow to call him? Even if I do, I doubt he will see me the same day. His nurse will ask whether I have an emergency, and if I say yes, she’ll tell me to go to the ER. What should I do?
- Will the treatment I receive in the ER cost money?
- Will my insurance cover it?
- Will they respect me if I’m on Medicaid?
- Can I afford to take off work? Should I wait until evening or the weekend to go to the ER?
- I don’t have a car. Can I get to the ER easily and cheaply?
- Who will care for my kids (or my elderly mother, my dog, my cat) if I go?

These questions are but a few of those underlying a person’s decision to visit the ED. When a patient walks through your door it’s usually the last step in a series of acts and decisions involving a person’s medical beliefs, world view, self-perceived health status, and economic, domestic, and social situations. All of this “baggage” accompanies the patient to the ED. The
better ED staff accommodate (at the least, recognize) this baggage, the lower the patient’s stress and the greater the cooperation will be. These issues underlie patients’ response to an important satisfaction survey question: “How well did staff treat you as a person?”

**Strategies for Improving the Patient's Experience of Care**

- All staff must participate in discussions about the “legitimacy” of patients’ visits to the ED. What proportion of patients presents with issues that are clearly nonemergent or trivial? What are those issues? Do staff behave differently toward them in any way?
- The emergency experience begins with the person at the intake desk. This staff member should express empathy in addition to asking why the patient is presenting. This statement can be scripted (e.g., “That must hurt,” “I can imagine that’s a problem,” “I’m sorry that happened”).
- All staff should offer encouragement (e.g., “You’ve come to the right place,” “Don’t worry; we’ll find out what’s going on,” “We’ll take good care of you”). Emotional support and reassurance are important, especially to trauma patients, who arrive feeling vulnerable and frightened by the damage their body has sustained (Wiman, Wikblad, and Idvall 2007).
- All staff should help patients feel that they have made the right decision at the right time to come to the ED and that you take them seriously. Patients should not feel guilty or foolish. There is no “wrong” reason for coming to the ED. Harried staff may have difficulty sympathizing with people who bring problems that are clearly nonemergent and did not see their doctor or go to a neighborhood pharmacy walk-in clinic. Nonetheless, to patients, it’s an emergency, and they hope you agree with their definition. Staff must ensure that their behavior, words, and body language communicate empathy, not frustration or resentment. Staff also can exhibit empathy and concern by checking in with patients while they are
waiting in treatment rooms for the doctor to arrive, tests to be performed, and so forth.

Someone should visit each patient at least every ten minutes or so. Patients should never wait for “extended” periods (a relative concept, as minutes can feel like hours) with no reassuring attention.

- All staff should recognize the social and economic inconvenience of an emergency visit. In addition, patients’ roles and self-image as parent, child, worker, provider, spouse, caregiver, boss, leader, or lover may be threatened by the problem. Injury or illness can affect one’s looks, vitality, or independence, suggesting personal weakness or vulnerability.

- Staff should express empathy by enquiring about the patient’s children or other obligations the ED visit may affect. A consultation with social services may be needed. One study found that 20 percent of ED patients felt that nurses did not care about the impact of the medical issue on their personal lives (Muntlin, Gunningberg, and Carlsson 2006). This is probably an underestimation.

- It is useless to ask a patient “Why didn’t you come in sooner?” Patients don’t base their medical decisions on the same paradigms and priorities as do healthcare professionals. On the other hand, a question such as “Why are you coming in now?” might elicit a clue about the patient’s expectations of care and the likelihood he will comply with his discharge instructions once back home.

3. **How do I get to the ED?**

4. **Where do I go once I get there? Who do I see? What will happen next?**

*Why It’s Important*

The ED is alienating enough without being hard to find. Patients may have a rough idea of where the hospital or medical complex is, but where’s the ED entrance and where does one go once
inside? Frustration can begin long before the patient arrives. The ED may be a new experience for many patients. They are ignorant of ED culture: the layout, care protocols, staffing, and timing of events.

**Strategies for Improving the Patient’s Experience**

- Can patients easily find directions to the ED on your hospital’s website? Does it feature a large-scale map indicating bus and train routes to the hospital?
- Does the website include a zoom-in map indicating the entrance to the ED and the patient/visitor parking area?
- Highly visible signs for the ED should be posted on all major streets within several blocks of the hospital (and especially at the closest bus and train stops).
- If the ED registration desk is not immediately visible from the entrance door, a conspicuous sign indicating the direction to the desk should be placed there. A large sign that says “REGISTER HERE” (with an arrow) should be hung directly above the desk.
- The more information patients are given about what will happen during their stay, the more at ease and satisfied they will be with their care (Taylor and Benger 2004; Björvell and Stieg 1991). This information should be communicated verbally. Informational handouts provided at triage have little impact on patients’ satisfaction (Sun et al. 2004). If staff don’t have time for meaningful, personal orientation, a video (e.g., introducing ED staff, procedures, and common reasons for delay) may effectively inform patients and temporarily distract them from their problems and delays (Corbett, White, and Wittlake 2000).

5. *I’m embarrassed and don’t want my visit and condition broadcast. Will staff respect my privacy?*

**Why It’s Important**
Patients have a right to privacy, particularly when they are emotionally vulnerable and embarrassed by their problem. There’s always a chance that an acquaintance may be present in the ED. Concern for their privacy indicates that staff are sensitive to patients’ “personhood” and the stress of the visit.

**Strategies for Improving the Patient’s Experience**

- The physical setup of the intake interview must provide privacy for the patient.
- Another person should not be standing next to or behind the patient and overhearing the patient’s intake interview. A “please wait here” sign posted at least five feet away from the intake desk is one way to encourage privacy during the discussion.
- If patients must wait in a public area before proceeding to treatment, use a wireless paging system (typically a small, blinking, vibrating module) rather than call out a first or last name for others to hear.
- Privacy in the treatment area is also important to patients. While they are in the treatment room, it temporarily becomes their “turf.” A knock or a brief hello from nurses and physicians prior to entering the room may help the patient feel secure. One study found that patients felt their privacy in the treatment room was more protected by a solid wall and door rather than by a hanging curtain (Barlas et al. 2001).

6. **Will I feel confident and at ease with the staff member who asks about my symptoms?**

*Why It’s Important*

This is the first person the patient sees (perhaps apart from a security guard). This is the person to whom the patient tells his or her story (perhaps an embarrassing one—results of a foolish accident, error or judgment call, or symptoms of a sexually transmitted disease). This person determines the seriousness of the problem and how quickly the patient receives medical
attention. If the patient is embarrassed, the appearance, words, and demeanor of this person can mitigate—or exacerbate—the embarrassment. The intake experience sets patients’ expectations about the staff’s level of concern and empathy and about the quality of the treatment ahead.

**Strategies for Improving the Patient’s Experience**

- Patients want to be seen initially by someone who can effectively and nonjudgmentally deal with their problem—and the quicker this person does so, the better. Ideally, this person is a physician or a nurse. Likewise, the sooner the patient proceeds to the treatment area, the better. All of these elements say “We take your problem seriously.”

- If the person who elicits the patient’s symptoms is not a physician or a nurse, he or she must appear and act mature, empathetic, nonjudgmental, and educated (i.e., capable of recognizing the urgency of the situation as defined by the patient). To the patient, this person is more than a clerk or a secretary. Fluency in English and clear pronunciation are necessary. Bilingualism is desirable, depending on the demographics of your patients.

7. **Will I be seen by a doctor immediately?**

8. **I arrived before other patients. Why are they being seen before me?**

9. **Why is this whole thing taking so long?**

**Why It’s Important**

The patient has defined the visit as an emergency. Moreover, patients’ problems are their priority; the ED’s priorities, space limits, caseload, staffing, and the acuity of other patients are irrelevant to them. They want to be treated **now**.

Patients aren’t familiar with triage principles. Whether sitting in the waiting area or in a treatment room, patients feel slighted when others who arrived after them are seen by a doctor first. Few ED experiences build resentment and stress as much as long delays in the waiting
room or treatment area while nothing happens. During a typical ED visit, patients may be left alone for as many as a half dozen instances, waiting for the next (unknown) step to happen. Patients may wait between triage and admission, between admission and the nurse’s visit to take vitals, between the nurse’s visit and the doctor’s visit, between the doctor’s visit and lab testing / radiology, between lab testing / radiology and the doctor’s revisit, and between treatment and the nurse’s revisit to provide discharge instructions. Depending on the case, additional downtime may occur. In all these instances, the patient waits for an unknown someone to do an unknown something. Waiting in isolation for long periods, patients may interpret that they—and their problems—are viewed as insignificant.

Strategies for Improving the Patient’s Experience

• Ideally, the patient should be seen by a physician immediately. One ED study found that pairing a senior physician with the triage nurse significantly reduced time to treatment and to discharge and increased patients’ satisfaction with the ED experience in general (Travers and Lee 2006).

• Patients know little about triage principles. If patients must wait to see the physician, the triage or treatment nurse must provide an explanation, including the reason(s) the doctor is not available at that moment and how long the patient will likely have to wait until the doctor arrives. This time estimate is important because it helps patients tolerate the delay.

• The explanation also must inform the patient why treatment of her problem can safely be delayed. “It’s not that serious” won’t do. This same sentiment can be expressed without belittling the patient’s self-assessment of the seriousness of the condition. For example, one might say, “The doctor is working with some very sick patients. He’ll be with you as soon as he can—in about ten minutes. We know you’re worried [or hurting], but we’re on top of the
situation and we’ll take very good care of you and make you as comfortable as possible. What can we do for you in the meanwhile?” The explanation may also stress the necessity of preliminary tests or other actions that will help the doctor better diagnose and treat the patient when at last he does arrive.

- The distinction between actual and perceived waiting times is important. Studies clearly demonstrate that perceived waiting time has more impact on patient satisfaction than do actual minutes or hours (Thompson et al. 1996; Boudreaux et al. 2004; Cassidy-Smith, Baumann, and Boudreaux 2007). Even minimal delay can seem long to an anxious patient, while longer delays may be well tolerated by patients at ease with events and confident that they are taken seriously. Thus, waiting-time perception management is at least as important to patient satisfaction as actual reduction of throughput time (Hedges, Trout, and Magnusson 2002). Citing a Press Ganey study of 1.4 million patients’ evaluation of their emergency experience, Lloyd (2009) concludes that dissatisfaction with delays is less linked to actual time than to (1) lack of information about events and when they will occur, (2) perceived lack of personal attention, and (3) perceived lack of staff concern for patients’ comfort. Time drags for uncomfortable, scared, bored, or uninformed patients.

- Some delays are inevitable, but they become more tolerable and seem shorter when one knows how long they will last. National data clearly demonstrate that waiting times seem shorter and patients are more satisfied when staff explain the reason for the delay, apologize for it, and provide an expected wait time (Mowen, Licata, and McPhail 1993; Press 2005). Everyone who speaks with the patient—including nurses, physicians, lab technicians, and radiologists—must inform the patient about what will happen next and roughly how long it will be until it happens. This information resets the patient’s clock. “I’ve
been here an hour and a half already” becomes “ten minutes to go before the doctor arrives.” Updates must be given continuously; a onetime statement at admission about waiting times has little impact on patients’ tolerance of delays later in the ED visit (Mowen, Licata, and McPhail 1993).

- Delays are more tolerable and patients do not feel ignored when someone briefly drops in between treatment events to ask how they are doing. No one should remain alone for more than ten minutes. Some EDs employ patient liaison nurses for this purpose. Their function is to interact with patients and reassure them of staff’s attention. They orient patients to ED protocol; explain triage principles, tests, and procedures; monitor pain; provide blankets; and relay communication between patients and staff (Taylor et al. 2006). They also can keep family in the waiting area informed and make phone calls for patients. Yes, this role requires extra staffing, but liaisons need not be nurses or other paid clinical professionals if the visits are strictly nonmedical. Their function is interaction, explanation of ED protocols, and simple demonstration that “we know you’re here.” They can be college students or volunteers (see, e.g., Press and Smith 1986). Junior- or senior-year premed students at local universities will jump at the chance to spend a semester doing weekly shifts in an ED. You’ll have more volunteers than you need to cover every shift.

- The jury is still out on the question of whether patients find the ED “fast track” more satisfying than a standard ED experience. One study found no significant difference in satisfaction between the two, reinforcing the idea that actual time spent in the ED is less important to patients than other issues (Hampers et al. 1999). If you do have a fast-track setup, do not describe it as such to fast-track patients; they may perceive that you’re not taking their emergency seriously.
Some hospitals are experimenting with online notification of estimated wait times to the treatment area. One innovative program enables patients to schedule an ED appointment online. If unexpected critical admissions cause delays, patients are notified by phone or e-mail. When patients arrive, they are seen ahead of others who are waiting, as long as no other patient requires more immediate care (Manning 2012). Appointments also could be offered to patients with nonurgent conditions who are willing to wait or return home for an hour or two. A full- or part-time physician could be dedicated to patients who have appointments. By offering appointments, the hospital may seem to be encouraging nonurgent use of the ED, but let’s face it—the reality is that a large number of your patients are nonurgent and they would appreciate more convenient admission.

10. Do they realize how scared and stressed I am?

Why It’s Important

To the patient, the ED is a place where painful, frightening things can happen. The sounds, machines, and people they encounter are unfamiliar. Here patients cannot control what’s done to their bodies or what assaults their senses. They anticipate and fear possible (and even impossible) procedures that may be uncomfortable and invasive. They fear a bad diagnosis. No matter how new the facility, the surroundings are sterile, busy, and absolutely not reassuring or restful. As their fear and stress subside, patients become more manageable and cooperative and are more likely to be satisfied with the ED process and their outcomes. By reducing patients’ stress, you also create a calmer, more effective, and more satisfying work context for staff.

Strategies for Improving the Patient’s Experience

- The intake person and the triage nurse (or whoever leads the patient to the treatment area) must express empathy and reassurance. As suggested earlier, these statements can be
partially scripted (e.g., “I know you’re worried,” “Don’t worry; we’ll take good care of you”).

- Information is key to reducing stress. The unknown is scary; the known is more manageable. Information fosters familiarity and moderates stress and fear by clarifying the treatment ahead and limiting patients’ expectations. Patients easily anticipate the worst if they have no information about the procedures ahead. The nurse who escorts the patient to the treatment room must give the patient a rough description of the course of treatment—for example, “We’re going to take your blood pressure. You may need to have some blood drawn, which is not a big deal, and maybe an ultrasound, which doesn’t hurt. The doctor will decide which is necessary. Can I do anything for you until the doctor arrives?”

- The physician’s interaction with the patient is a major part of the ED experience. As stated earlier in this report, the short, intense visit leaves little time to establish rapport. If the physician sits while chatting with the patient (rather than standing and looking down at him), she comes across as concerned about the patient both personally and medically rather than eager to make the interaction as short as possible. A reassuring arm or shoulder squeeze also may have a calming effect on scared patients and their families.

- All subsequent caregivers must describe what they are going to do and what it will feel like. If patients know that an IV will be inserted or that blood will be drawn and are told where the stick will be made and the amount of discomfort it is likely to cause, their fears of other anticipated (imagined) procedures dissipate. Even a stressful test or treatment is easier for patients to endure if caregivers clearly describe it in advance and assure that they will make it as easy and painless as possible.

- Again, frequent visits by some staff member demonstrate concern and help reduce stress.
11. Will they respect me if I’m (African American, Hispanic, Asian, Muslim, old, poor, on Medicaid, etc.)?

12. Will they sympathize if my problem is self-caused or a result of obvious negligence?

13. Will they treat me decently if my problem is “disreputable” (e.g., overdose, STD, street fight)?

Why It’s Important

Political correctness might tempt us to dismiss these concerns as nonissues. ED staff universally believe that they treat all patients equally, regardless of race, ethnicity, economic status, or the nature of their medical problem. Nonetheless, many patients harbor the questions above. Sensitivity to slights or prejudice (real or imagined) is heightened in stressful situations. Many patients are concerned that staff will not take their problem seriously, particularly if drugs, alcohol, violence, or carelessness is involved.

Healthcare professionals do not have to inwardly approve of patients who present with addiction issues, self-caused problems, or “trivial” complaints while other patients struggle with serious illness or injury. Outwardly, however, staff should make all patients feel at ease with their decision to come to the ED. If patients sense underlying respect, friendliness, and concern from staff, they will respond more calmly and cooperatively during treatment and will be more likely to comply with discharge instructions.

Strategies for Improving the Patient’s Experience

- Attitude control is essential. ED staff do not exhibit racial, ethnic, or economic prejudice toward any patient. To ensure proper behavior, staff should discuss the ways they respond to patients of different racial or ethnic groups and those who are on Medicaid or uninsured. If a 16-year-old girl presents with lower abdominal pain, is she more likely to be labeled a
“crotch case” or a PID (pelvic inflammatory disease) case if she is on Medicaid or belongs to one racial group rather than another? If she obviously is sexually active, can staff refrain from judgmental behaviors? Can they be judgmental but not display their thoughts to patients?

- The ED is a fairly public place. In any interaction with patients, keep in mind that other patients and their families are nearby and may be able to see your behavior and overhear your conversations. They may be as turned off as the patient is by staff behaviors that appear to be insensitive or discourteous.

- Harried professionals may have difficulty empathizing with some patients. They may feel abused by patients who reek of alcohol or are obviously on drugs, be frustrated by patients presenting with nonemergencies, or have little sympathy for patients (or family members) whose problems reflect an apparent lack of concern for their own well-being (e.g., “sui-cyclists”—bikers who wear no helmets and are injured as a result—or mothers whose kids have ingested household chemicals left out on the floor). Staff discussion groups should focus on these issues with the goal of minimizing behaviors (e.g., statements to patients, asides that can be overheard by other patients, body language, eye rolling, tone of voice, slow response to calls) that could communicate disapproval.

- Unambiguous gestures of courtesy and empathy can be made to all patients. A simple routine is to ask patients how they would prefer to be addressed (e.g., by first name, or as “Mrs. Smith”) and communicate their preference to other staff so all address the patient consistently. By offering patients blankets, water, magazines, and so forth, you also communicate that their problem, race, or income does not affect your personal concern for their comfort.
14. I think my problem warrants a visit to the ER, but will the doctors and nurses take me seriously?

Why It’s Important

As noted earlier in this report, many patients come to the ED for primary care or minor trauma issues. Some patients are well aware that staff may not view their problem as an emergency, yet nonetheless, they expect fully empathetic care (Koziol-McLain et al. 2000; Hostutler, Taft, and Snyder 1999). Patients may feel unsure about their decision to come to the ED and anticipate staff disapproval. If the visit also is socially, domestically, or economically inconvenient, patients may feel even more stressed.

To many—if not most—patients, their decision to visit the ED is unambiguous. The pain, strain, cough, or swelling is definitely an emergency. The new mother whose baby “has been crying a lot this morning” and the man who spilled hot tea on his knee (“It’s not red now, but it was very red when it happened!”) believe they have an emergency that needs immediate attention. To staff, such cases are not emergencies. They may feel frustration about patients who “waste their time”; this emotion is understandable. But if staff display this frustration, patients may feel foolish or become defensive or angry and less likely to cooperate. Furthermore, friends or relatives who accompany patients to the ED are not oblivious to staff’s reactions. One interesting study found that family or friends who accompanied patients with less urgent problems were less satisfied with the care they witnessed than were those who accompanied patients with urgent problems (Ekwall, Gerdtz, and Manias 2008). Staff attitude management is essential. Your ED is a key marketing tool for the medical center’s brand. Many of the patients presenting with trivial complaints are first-time visitors to your institution. Today’s nonurgent
first visit could turn into a long-term, profitable customer relationship, or it could result in dissatisfaction and negative recommendations to friends and family.

**Strategies for Improving the Patient’s Experience**

- Attitude control and acceptance of the changing ED climate are essential. Staff should discuss their feelings about patients who use the ED for primary care or “trivial” issues. Discussions also should consider the medical and economic advantages for staff, patients, and the institution as a whole that could result if these patients are highly satisfied with their ED experience.

- As discussed earlier in this report, if you implement a fast-track program for patients with nonurgent conditions (run by physicians, nurse practitioners, or physician assistants), try not to make it stand out from the rest of the ED. An obvious separation suggests to patients that you don’t take their problems seriously.

- Patients with nonemergencies usually wait the longest for treatment (because urgent cases take precedence), so frequent visits with these people (as described earlier in this report) are essential.

**15. Will they respect my ideas and practices regarding sickness and healing? What if I’m from a different culture?**

**Why It’s Important**

This question concerns **cultural competence**. To some extent it’s necessary with all patients, not just migrant populations and ethnic minority groups.

Most patients have some thoughts about what caused their injury or illness and what should be done about it. Some of these ideas are widespread in popular medicine and not limited to certain ethnic groups or economically or educationally marginal populations (e.g., “Feed a cold,
starve a fever”; “If you can walk on it, it ain’t broken”). People of all backgrounds, ethnicities, and education levels may believe that stress (“tension”) causes hypertension. As a result, patients may cease taking their medications when they “feel calmer and more relaxed.” Many of these beliefs are logical deviations from official medical explanations (e.g., diabetes is “sweet blood” and can be treated with sour substances, such as lemon juice and vinegar). However mundane or erroneous, these concepts create expectations about care that patients bring to the ED. If patients feel that their beliefs about what’s wrong and how it should be treated are not respected, the result can be distrust and increased stress.

When cultural diversity is added to the mix, staff sensitivity is even more imperative. Patients may present with expectations of treatment that conflict with standard medical protocols and complicate diagnosis and patient management. These ideas may include not only how the illness was caused and how it should be treated but also who should participate in the process, where treatment should occur, and how caregivers and patients should behave.

All patients’ beliefs and practices related to health and healing, whether popular, ethnic-specific, mundane, or exotic, are typically the product of a lifetime of experience with illness and are reinforced by family and significant others through many bouts of sickness. Illness is always a threat to one’s lifestyle (if not to life itself), and a family’s response to these threats becomes a core part of the individual’s culture and values. Most bouts of illness are self-limiting (i.e., most of us get well regardless of how we treat our illnesses), so recovery reinforces the family’s ideas and practices. This means that patients and their families don’t automatically accept your medical explanations as gospel. Patients come with their own beliefs, and even if left unaddressed or denigrated, these don’t go away. Staff’s response to patients’ ideas is important
to establishing rapport, confidence, and trust and increasing the likelihood of compliance with treatment.

Cultural differences can further complicate medical management when issues of gender, age, and status differentials between caregiver and patient arise. Lifestyle variances, such as religious beliefs, eating habits, and family dynamics, also can affect patients’ compliance with medical regimens after discharge.

To complicate matters further, patients come to the ED not only with beliefs about their condition and how it should be treated but also their “sick roles.” A sick role defines the behaviors a patient and significant others feel are proper and expected when one is sick. People observe and assume these roles as they grow up, and those who exhibit them when they fall ill are rewarded with sympathy and eased economic and social obligations. Some patients may believe that overdependence, emotional display, or complaining is appropriate, while others exhibit stoicism or denial. Sick roles may include passivity or fatalism (perhaps reflecting the belief that the problem is divine punishment for some misdeed), which may lead to lack of cooperation during treatment. Undoubtedly some “patienthood” styles may irritate staff and impede efficient diagnosis and treatment, but patients invariably believe they are behaving appropriately “given the circumstances.” They will be more satisfied with care (and more compliant) if they (and those who accompany them) sense no impatience, disdain, or frustration with their behavior.

**Strategies for Improving the Patient’s Experience**

- You are not obligated to accommodate beliefs or treatment requests that would be harmful to the patient or waste valuable time, but by acknowledging them without disparagement, you exhibit respect. By listening to their ideas, you may pick up cues that will help you explain
how your medical management plan doesn’t conflict with—or even complements—their
beliefs (and thus encourage compliance). If you can accommodate some of your patients’
treatment expectations without compromising safety or effectiveness, you will build rapport.
If patients’ views and wishes conflict with proper medical protocols, explain why they cannot
be incorporated. A statement such as “Under the present circumstances, the approach I
suggest will work better because . . .” implies that you are not challenging the legitimacy of
the patient’s beliefs or treatment preferences but that they simply won’t work well for the
patient’s current problem. This “negotiation” tells patients that you take them seriously and
respect their beliefs.

• Of course, asking all (non-trauma) patients their view of what’s wrong and how best to treat
it is not practical. Most would respond with “I don’t know” or “Hey, you’re the doctor!” and
some may be taken aback by such a question. Those who do have their own ideas of causality
and proper treatment may be reluctant to offer them, fearing disdain or embarrassment.
However, if you suspect the patient may harbor alternative beliefs or practices, there are a
few questions that may trigger information without putting the patient in an awkward spot or
compromising caregiver authority and expertise (e.g., “Have you had this problem before?”
“What did you do for it?”). These questions (which are likely to be asked anyway) may elicit
patients’ ideas about sickness and their expectations for the kinds of treatments they view as
“proper.” At the very least, the answers can provide insight to planning medical management
strategies that may be more likely to encourage cooperation and post-discharge compliance.
An additional question, “Why do you think you have this problem now?” could offer insight
to the patient’s illness beliefs and suggest a clinical approach that may be more successful.
Staff should become familiar with the medical beliefs and practices of the ethnic and other cultural groups that are part of your patient constituency. Some cultural sensitivity training is essential (e.g., Rust et al. 2006). Many patients were raised in countries (or in families) where folk or other alternative medical concepts dominated everyday health practices. The more staff know about these beliefs and practices, the easier they will negotiate with patients and build trust and cooperation (good sources include Gropper 1996; Galanti 1997; and Spector 2012). Bring in representatives (religious, business, political, social service, or other leaders) of local constituencies to discuss their health beliefs and family practices. Questions to cover in these focus groups include the following:

— What do folks in your community view as the causes of sickness?

— What remedies/treatments are typical?

— How widespread are these beliefs and practices, and how do you suggest they be addressed by ED staff?

— What do people in your group expect of an ED visit?

— How should we interact with patients? Should we be aware of any particular courtesy issues? Should someone other than the patient be the spokesperson regarding the patient’s care? How might the patient’s age, gender, and social status affect their interaction with staff? Is assigning a patient to a caregiver of the same sex important? How do folks in your community respond to touch by a male or female caregiver?

— What is the role of accompanying family members? How much participation (or even control) should be expected of them during consultation and treatment?

— What is a typical “sick role” in your community? What’s viewed as appropriate behavior for a sick person?
— What’s the best way of convincing patients to accept ED modes of treatment?
— What negative comments (if any) have you heard about the care your community members receive in our ED?

- Many members of an ethnic group are fully integrated into the wider US culture and may be insulted if asked about variant medical beliefs. Just because patients have a Hispanic name doesn’t mean they have poor English skills or believe in folk illnesses such as “susto” or “empacho.” The issue should be raised in your focus group. How should one probe for these beliefs?
- Given that sick roles provide patients with guidelines for coping with disease or injury, they should be respected—but disruptive “acting out” behaviors should not be tolerated. Staff should discuss their definitions of acceptable and unacceptable behaviors (“good” versus “bad” patients) and the impact sick roles might have on patient management.

16. What if I don’t speak much English? Will they understand my problem? Will I understand their advice?

Why It’s Important

In general, non-English-speaking patients tend to be less satisfied with ED care and less likely to recommend the ED or hospital (Carrasquillo et al. 1999). Without clear communication, quality of care declines and the potential for error increases. If no caregivers on staff speak the patient’s language, the patient and accompanying kin may feel marginalized and vulnerable.

Strategies for Improving the Patient’s Experience

- Ask all patients for their language preference up front. You cannot always tell by name or looks whether a patient is fluent in English. To ensure patients do not feel stigmatized by their name, race, accent, or appearance, everyone should be addressed with a statement such
as: “We ask all patients which language they are most comfortable with for discussing their medical problems.”

- Professionally trained medical interpreters are better than using patients’ family or other “ad hoc” interpreters. Forcing kin who have some facility with English into the role of interpreter may create awkwardness between the sexes or generations. Family members may be medically naïve or poor English speakers themselves, resulting in faulty interpretation and longer ED stays. Family may also harbor personal agendas regarding the patient and his problem. Moreover, patients may be reluctant and embarrassed to describe their symptoms to certain family members. The use of professional medical interpreters is associated with higher satisfaction and more effective utilization of the ED (Ramirez, Engel, and Tang 2008; Tschurtz et al. 2011; Bernstein et al. 2002).

- If interpreters must be used for patients who speak little or no English, ask whether they prefer a male or a female for this role. For some religious and ethnic groups, communication of intimate details to a person of the opposite sex is awkward. Patients also may be more comfortable confiding in older and more experienced interpreters.

- “Remote simultaneous medical interpreting” over the phone may be useful. Some patients find it offers more privacy and feel less embarrassed speaking on the phone than to someone at their bedside (Gany et al. 2007).

17. Will they care about my comfort?

Why It’s Important

In addition to ameliorating patients’ pain, by ensuring their general comfort you meet their expectations of care (as distinct from treatment). These expectations include an idea of how a host should accommodate a guest. Comfort means more than just physical surroundings (e.g.,
walls, seating, fixtures, upholstery, cheerfulness, cleanliness). Other than physically distressed by their problem, patients may be cold, hungry, thirsty, tired, or mentally stressed. The personal concern displayed by staff for the patient’s general comfort communicates empathy, fosters trust, and helps patients tolerate inevitable delays, inconveniences, and unpleasant procedures.

**Strategies for Improving the Patient’s Experience**

- Patients expect you to cure their pain—quickly (Fosnocht, Swanson, and Bossart 2001). If you cannot give them pain medication immediately, you must explain why you cannot and why it is better for them to wait. If the patient’s pain cannot be fully controlled, the limitations of the analgesics you administer must be discussed. The more the patient knows about expected discomfort, the more discomfort she can tolerate—and with less stress.

- Many painful, unpleasant procedures cannot be avoided. However, when patients are adequately informed about the procedure and what it will feel like, the situation becomes known and tolerable. IVs, blood draws, stitches, and so forth should be described in advance, including the degree of discomfort the procedures may cause and the steps you will take to minimize it. Staff typically take some uncomfortable procedures for granted. For example, patients may have to lie on a hard X-ray table in the radiology lab. Staff can tell patients what to expect in advance, explain why the table isn’t well padded, and apologize for the anticipated discomfort.

- Staff also exhibit concern for patients’ comfort by offering blankets, snacks, water, and so forth (if appropriate) and asking, “Is there anything I can do for you?”

- Frequent drop-ins to check on or just converse with patients also demonstrate concern for their comfort and make the wait more tolerable. As indicated earlier, these visits need not be made by a nurse.
18. Will they treat my family and friends with respect?

Why It’s Important

One reason is obvious—they’re important to patients. Moreover, accompanying family and friends may transfer their anxiety, frustration, impatience, or distrust to patients, thereby causing them additional stress and possibly creating resentment. Accompanying family or friends may be more worried than the patient about the problem. Most patients don’t fill out satisfaction surveys without discussing the experience with their family. The experience of accompanying family members (and boyfriends, girlfriends, and pals) can affect your patient satisfaction scores and reputation.

Strategies for Improving the Patient’s (and Family’s) Experience

- Empathy and courtesy should be extended to those who accompany the patient. Their emotional demonstrations (if brief and nondisruptive) should be tolerated. Moreover, relatives or friends may suggest (or insist) that certain provisions be made for the patient. Rather than blow them off by ignoring them or asserting authority over the situation, explain your treatment plan to help family feel more included in the experience.

- Do not establish arbitrary rules for who is or is not eligible to accompany the patient to the treatment room. The patient decides who his significant others are and will likely be much more calm and cooperative with a desired companion in the room.

- Frequent explanations and updates about what will occur or is being done for the patient may calm anxious visitors in the waiting room. The individual who drops in on patients can fulfill this role.

- If refreshments or water is offered to patients, their visitors should receive the same service.
19. Will they cure me?

Why It’s Important

Staff’s and patients’ views of the function of an ED may be significantly different. Many patients expect the ED to fully diagnose, treat, and cure them. Dissatisfaction can result if they feel that they have “merely” been stabilized or referred to another doctor (specialist) for treatment.

Strategies for Improving the Patient’s Experience

- You must explain to patients why you are doing what you are doing and why you cannot do more. If referral to a specialist is necessary, a brief apology and explanation for not being able to deal fully with the situation on-site help patients understand the functions and limitations of ED treatment and feel more at ease with the level of care they received.

20. When I’m discharged, will I be OK? Will I be able to take care of myself at home?

Why It’s Important

Few patients leave the ED fully healed and feeling fine. After the intense and often high-tech activity, scrutiny, and interventions, patients commonly worry about what will happen when they are home with no medical experts in the next room. Thus, the discharge discussion is of considerable importance to the overall effectiveness and personal impact of the ED experience. Patients who return home with poor discharge information are not only less satisfied; they also are more likely to disregard discharge instructions (Thomas et al. 1996). This means potentially poorer outcomes and potentially more returns to the ED for additional care.

Studies estimate that up to a third of ED patients do not fully understand their discharge instructions (Engel et al. 2009; Waisman et al. 2003). At the same time, the more satisfactory the experience during treatment, the more likely the patient will recall or adhere to advice given for home care (Thomas et al. 1996).
Strategies for Improving the Patient’s Experience

- When you are discharging patients, reassure them. Patients must be told that if they follow your instructions, they will either (1) be OK and not require additional treatment or (2) not get significantly worse if they must delay further treatment until seen by another doctor.

- Clear discharge information must be given. Time spent on this step can increase the likelihood of compliance and prevent a repeat visit. Understandable, lifestyle-sensitive **verbal** discharge instructions—as opposed to written handouts—have more impact on patients’ recall and satisfaction (Isaacman et al. 1992).

- Ask a few questions about the patient’s ability to comply. Does she have any lifestyle or financial issues that might affect compliance? If the patient’s medications need to be refrigerated, does the patient have a refrigerator? Could the patient’s religious beliefs affect compliance with nutritional or medication instructions or physical therapy recommendations? Coordination of discharge instructions with a social worker may be helpful.

- You can enhance patients’ satisfaction by having a physician or nurse make a follow-up phone call in the evening after discharge to ask about their well-being and answer any questions they may have.

- Establish an ED “help line” that discharged patients can call if they have questions or concerns. A physician, physician’s assistant, or nurse practitioner who can answer questions and give medical advice would need to provide this service. Staffing this service likely will be less costly than return visits to the ED.
VI. Implementing Change

The following elements are the two most essential factors for improving patient satisfaction in the ED:

1. *Staff buy-in to the importance of higher patient satisfaction.* Rewards and sanctions are useful but won’t work well if staff aren’t committed to the value of higher satisfaction for themselves, their patients, and the entire organization. Make sure staff know all the advantages of making patients’ experience of care more positive.

2. *Staff training in satisfaction improvement.* You can’t improve what you don’t understand.

   This report suggests that patient satisfaction is complex and not an easy fix. Staff discussion of the issues is essential, and new employees must become familiar with the insights and solutions generated. Likewise, you can’t improve patient satisfaction if you aren’t measuring it. If you do periodic surveys to monitor your performance, you undoubtedly have noted that many of the issues discussed in this report are not directly represented by an item on the survey. Patients come to the ED with a variety of backgrounds, personalities, family healthcare traditions, and expectations of care. No survey can capture the full extent of a patient’s experiences in the ED; it would have to be a thousand questions long. The issues discussed in this report underlie your survey questions. Prior to implementing a patient satisfaction improvement program, have staff review the ED survey and brainstorm about possible issues that could underlie a low score for each of the survey items. What experiences might cause a patient to rate each issue as less than “top box”? You cannot hold staff responsible for improvement if they aren’t given problem-solving tools before implementation of the program.
VII. Conclusions

Most patients are unaware of the technical bases of treatment: the proper tests or antibiotics, the correct gauge of sutures, and the beta blockers given within a half hour of presenting with a heart attack. But they recognize care, which includes treatment and the manner and social/emotional context in which treatment is given. **Lower patient satisfaction means lower-quality care, regardless of the technical appropriateness of treatment and regardless of how well you do on the core measures.**

At base, patient satisfaction involves perception management. What patients perceive is reality to them. The fact that patient satisfaction is subjective doesn’t make its impact less concrete and objective. From the moment patients arrive in the ED, events, sights, sounds, and interactions build their experience. While in treatment, patients’ response to this experience (i.e., their degree of satisfaction) affects their levels of stress, trust, cooperation, patience, and tolerance of discomfort. Their satisfaction directly influences the ease and effectiveness with which you manage patients. As said earlier, patient satisfaction is thus a **component** of care—not just an outcome.

Patients’ experience in the ED can affect their satisfaction with subsequent care if they are admitted to the hospital. Post-discharge, their overall experience and satisfaction can affect their compliance and the likelihood of a return visit to the ED. Moreover, patients’ evaluations and recommendations have an impact on the financial strength and reputation of both the ED and its associated medical center.

In short, high patient satisfaction in your ED is not optional. It facilitates your mission. It secures your job. It’s good medicine and good business.
References


**About the Author**

Irwin Press is professor emeritus of the University of Notre Dame and cofounder of Press Ganey Associates. He was one of the earliest advocates for the importance of patient satisfaction as both a component and an outcome of care. He is the author of numerous articles and of *Patient Satisfaction: Understanding and Managing the Experience of Care*, second edition, published by Health Administration Press.