Matters of Concern: A Qualitative Study of Emergency Care From the Perspective of Patients

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Study objective: A key to improving the quality of emergency care is improvement of the contact between patient and emergency department (ED) staff. We investigate what patients actually experience during their ED visit to better understand the patterns of relationships among patients and health care professionals.

Methods: This was an ethnographic study. We conducted observations at the ED of a large general teaching hospital. Patients were enrolled in the study on the basis of convenience sampling. We thoroughly analyzed 16 cases in a grounded theory approach, using the constant comparative methods (ie, starting the analysis with the collection of data). This approach enabled us to conceptualize the experiences of patients step by step, using the ethnographic data to refine and test the theoretical categories that emerged.

Results: Our data show that patients at the ED continuously and actively labor to deal with their disorder, its consequences, and the situation they are in. Characteristics of these “patient concerns” indicate a certain trouble, have a personal character, impose themselves with a certain urgency, and require patient effort. We have established a qualitative taxonomy of 5 categories of patient concerns: anxiety, expectations, care provision, endurance, and recognition.

Conclusion: Diligence for patient concerns enables ED staff to have a fruitful insight into patients’ actual experience. It offers significant clues to improving relationship building in emergency care practice between patients and health care professionals. [Ann Emerg Med. 2014;63:311-319.]

Please see page 312 for the Editor’s Capsule Summary of this article.

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INTRODUCTION

Background and Importance

The quality of care at an emergency department (ED) is primarily measured by clinical, logistic, and financial parameters. However, the experiences and satisfaction of patients who visit EDs largely seem to depend on the quality of their interaction with ED staff, their perceived waiting times, the provision of information, and ED environment and organization.1-8 Most recent studies of patient experiences at EDs entail quantitative, survey-based, or interview-based research and concentrate on judgments and stories of patients after their ED visit. Qualitative research complements these quantitative studies. Semistructured interviews with 37 respondents yielded 23 negative experiences, 16 positive ones, and 3 neutral ones. Waiting times, perceived quality of care, and staff-patient interaction shaped patient experiences.3 In another study, 9 ED patients were interviewed to better understand their perceptions of participation in ED care.6 These interviews demonstrated 3 significant conceptions of patient participation: (1) being noticed and having some minimal contact with ED staff, (2) becoming involved in the care process, and (3) having the opportunity to tell their story and enter into a dialogue with ED staff who are sensitive to their particular situation.

Although these studies have shown that patient satisfaction is strongly correlated to the physician’s interpersonal skills,1,7 much less is known about what patients actually experience during their ED visit.2 This led us to conduct an ethnographic study of participant observation, including informal conversation, to investigate actual patient experiences.

We are interested in the quality of patient care at EDs. However, we do not discuss “patient satisfaction” (which is a retrospective evaluation of care) but emphatically present an analysis of experiences of patients as they happen in emergency care. Our interest emerges from a growing awareness that good quality of care is not only a matter of “doing” things according to evidence-based standards but also of “relating” in a good manner to fellow human beings.9-16 Various studies have pointed out that good health care is also relationship-based care, in which health professionals and patients collaborate to create and direct
Editor's Capsule Summary

What is already known on this topic
Patient perceptions of emergency care have generally focused on global, macrolevel, retrospective judgments of quality or satisfaction.

What question this study addressed
The article used ethnographic methods of data gathering and analysis to understand patients' experience of emergency care as it unfolds, at a microlevel.

What this study adds to our knowledge
Patients' concerns centered around 5 issues: anxiety, expectations, the care itself, endurance, and recognition. Each patient concern has 4 common attributes: specificity (there is a particular issue of concern), individuality (it relates specifically to that patient's circumstance), urgency (the patient feels pressure to have the concern resolved), and activity (the patient must act to make the concern known to providers).

How this is relevant to clinical practice
A better understanding of the types and attributes of patient concerns should help support the development of more patient-centered emergency care.

Goals of This Investigation
The goal of this article is to determine the actual experiences of patients who received care at one ED. A better understanding of how patients experience care provision in real time may help to improve the quality of emergency care by identifying clues to better detect patients' needs and experiences. The long-term goal of our study is to better understand the relationships between patients and health care professionals and to contribute to the interpersonal skills of emergency care staff.

MATERIALS AND METHODS
Study Design and Setting
A qualitative, ethnographic study of patient observation and open interviewing seems to be the most proper research design for our purpose of investigating the experiences of patients. An ethnographic study provides "thick descriptions" of actual experiences and is particularly useful to uncover what really happens in health practices. We used grounded theory as an analytic tool, which means that we derived a conceptualization of the patients' experiences step by step from the ethnographic data. Analyzing in accordance with a grounded theory approach entails several rounds of coding and application of a constant comparative method, starting the analysis with the collection of data. The initially intuitive and thus hypothetical formulation of sensitizing concepts (Figure 1) is further refined and tested on the basis of newly collected data, and categories gradually originate from the data while being tested, rearranged, and relabeled until a satisfactory fit is found. So the conceptual framework is developed in a cyclic movement between the collected data and theory evolution, in which observation and analysis alternate with and reciprocally influence each other (Figure 2).
The setting was the ED of a large general teaching hospital in the south of the Netherlands. The hospital has 673 beds, and more than 28,000 patients visit the ED annually. Approximately one third of the patients are admitted to the hospital. Figure 3 offers a brief explanation of Dutch ED care. In 2009, the hospital in which the study was conducted started a strategic program called Professional Loving Care that promotes professional learning through communities of practice: "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly." The program also involves qualitative research into patient experiences. The current study was executed within the framework of this 5-year program.

Selection of Participants and Data Collection and Processing
Two researchers (C.P. and M.-J.S.) were present to make observations at the ED between October 7, 2010, and December 1, 2010. The ED staff and medical staff were informed about the study and the presence of the researchers. Both researchers independently observed patient visits during all ED shifts. The researchers did not wear a white hospital uniform but had a hospital badge saying "Researcher Tilburg University" displayed on their clothes. Patients were enrolled on the basis of convenience sampling. The researchers verbally requested consent and offered an information form to the ED visitors. The study was approved by the institutional review board of the St. Elisabeth Hospital.

Before the observation period, a scheme with a variety of categories of sensitizing concepts had been developed. This scheme contained concepts, questions, and notions to increase the researchers' sensibility and indicated possible directions of observation. The scheme was used as a checklist and guideline during the observations, interviews (purposeful questioning of participants for clarification), and communications (casual conversation during observation) and also functioned as a basis for further analysis (Figure 1).
The first encounter between patient and researcher took place in the waiting room, at the reception desk, during triage, or when patients arrived by ambulance. After obtaining consent, the researchers followed and observed the patients from the start of their ED visit until the moment it ended, at which time the patients were admitted to a hospital ward, referred to an...
This list of sensitizing concepts is developed to guide the first rounds of broad observations in which the sensitizing concepts under the heading “ED staff, patients, and their interaction” form the broad context of our focus: the relationships between ED staff and patients. The list is a developing scheme for further analysis focusing on the experiences of patients in their interaction with ED staff (see Figure 4).

THE ED

The extent of the ED: what belongs to the ED and what does not belong to it?

Description of the ED: furniture, decoration, rooms, smells, sounds.

ORGANIZATION OF THE ED

Features of ED work: duration of work, who is present, who gives orders, tasks of staff, triage, priorities, planning of work, work processes.

ED STAFF, PATIENTS, AND THEIR INTERACTION

Features of ED staff: appearances, contact, greetings, consultations, exchange of information.

Features of patients and attendants: which kinds of patients, which kinds of attendants, appearances, where are they seated (nonverbal), behavior, mutual discussions.

Normative statements of ED staff: eg, “that’s how we work here,” “no exceptions,” “this is what our work is about.”

Features of contact between ED staff and patients and attendants: greetings, questions and topics, are feelings mentioned, what kind of language is used, medical-professional or more common language, touch, initiatives, length of contact, consolation.

Figure 1. Observation scheme with sensitizing concepts.

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Primary Data Analysis

These Word files were imported into Atlas Ti version 6.2, a software package that is designed to assist with the organization and retrieval of qualitative data.20 Such a package enables researchers both to localize and code data and to develop a theory. All notes were read carefully, and relevant words and case fragments were identified and labeled with a code.25 The process of coding offers the possibility of comparing fragments of data that seem to accord with one another or relate to the same situation or object. Also, the software provides the opportunity to attach reflective annotations (“memoing”) about what a specific fragment reveals about the data, about methodological decisions, or about the meaning of codes. More specifically, the analysis of our data comprised 3 steps (Figure 2).

After observation of the first 3 patient visits, an initial round of coding took place. Both observers independently analyzed their collected cases. In accordance with this analysis, each investigator independently created a set of open codes that closely matched the raw observation data.26 Peer validation took place by thorough discussion of the individual interpretations of verbal and nonverbal expressions and interactions in the research group to establish interrater reliability.27,28 Subsequently, a second, more formal coding protocol of 6 codes was developed.20 The next cycle of analysis was based on these 6 codes (Figure 4).

Next, 8 other cases from the database were selected by way of purposive sampling.29,30 It was a priori agreed that the selected cases had to involve exemplary but average situations within the context of the total of 55 collected cases, be rich in detail, and differ from all the others. We comprehensively discussed the analysis and coding of each case on the basis of the 6 formulated codes and concluded that “self-talk,” “ED culture,” “cliff-hanger,” and “attendants” seemed less useful in our attempt to conceptualize what patients and their attendants actually experience at the ED. Self-talk, ED culture, and cliff-hangers can be considered as sources of patient concerns and the concerns of their attendants. Hence, we decided to narrow the framework and concentrate further analysis on concerns of patients and attendants, responses of hospital staff, and matches and mismatches between concerns and responses (Figure 4). In this article, reporting is restricted to the findings on patient concerns and does not discuss the observed mismatches between patient concerns and staff responses.

The 8 cases were again analyzed in detail on the basis of 2 central notions: concerns and responses. The analysis of each case was extensively reported in separate interpretation documents that were thoroughly discussed in the research group to establish interrater consensus. This led to a typology of concerns of patients and attendants under 5 categories, each showing a different type of concern (Table).

To examine the tenability of the developed typology of concerns, we selected 8 new cases: 4 cases of each observer. Because our initial typology was developed from average cases, it seems instrumental that these new cases were extreme cases that had to be clearly different from the initially analyzed cases. This procedure of theoretical sampling is intended to gain...
RESEARCH DESIGN

Qualitative (ethnographic) research design, with alternating phases of observation and analysis
Observations during 22 ED shifts in 2 mo
2 field researchers, 2 supervising researchers
Freely observing on the basis of formal, sensitizing observational categories (Figure 1)
55 patients (28 by researcher M.-J.S.; 27 by researcher C.P.)
By shadowing patients during the whole stay at the ED
Combined with informal interviewing/conversation

Phase I: Finding and Narrowing Observation Focus
Open coding of 3 separate cases during observation
Critical discussion of open codes, reformulation of open codes
Methodological memoing
Categorizing and narrowing down reformulated open codes into 6 central concepts (Figure 4)
Categorizing subcodes within those central concepts

Phase II: Detailed Analysis and Integration
Purposive sampling: selection of 8 cases (4 of each field researcher)
Criteria of inclusion: rich details, exemplary but average situation

RESULTS

Characteristics of Study Subjects
The researchers observed 55 ED visits, which involved 33 male and 22 female patients. Most of the observed patients arrived at the ED with an attendant, 10 were alone, and 17 were aged 18 years or younger.

Main Results
Our data show that patients are far from passive during their ED visit; they actively labor to deal with their disorder, its consequences, and the situation they find themselves in. Patients are troubled not only by their illness or injury but also continuously by all kinds of matters. Examples of these patient concerns are their efforts to admit that something is wrong with them, to put their trust in health care professionals, to patiently endure waiting periods, to give blood samples, to undress, to

Figure 2. An overview of research design and data analysis.

Coding and making analytic memos on possible meanings and causes
Reflection and analysis
Further definition of 6 central concepts (Figure 4)
Development of 2 key concepts: concerns and responses (with elaborated subcategories and criteria for individual concerns)
Selective coding of individual cases and detailed analysis, cfr. 2 key concepts
Pattern-seeking and cross-site (over case boundaries) analysis: 8 cases intensively compared (Appendix E1)
First sketch of typology of concerns and responses

Phase III: Testing and Validation*
Theoretical sampling: 8 new deviant cases (4 of each researcher); criteria of inclusion: extreme situations, rich details, challenging to the typology of concerns and responses
Making memos on methodology and analysis
Testing interjudge reliability (scoring mismatches)
Testing key concepts, testing the integrity of the typology “concerns and responses”
Making adaptations in the theoretical model

*In our original study, we investigated the character and frequency of patients’ concerns and carefully explored the responses of hospital staff to these concerns and whether they could be classified as adequate (match or mismatch). The current article is restricted to reporting patient concerns.
The Netherlands has about 16.5 million inhabitants, who all have health insurance. Hospitals are not allowed to refuse patients. General practitioners (some 9,000) are the single entry point in health care. In after-office hours, general practitioners are organized in 190 local cooperative acute care clinics, which cover populations as large as 300,000 patients. Health insurance can decide not to cover the bill of self-referrals to the ED. In 2009, emergency medicine was recognized as an independent profession without the status of a specialty. There are 105 EDs with various organization, staffing, and populations. Two thirds of all EDs have at least 1 emergency physician. The annual number of ED visits varies between 8,000 and 50,000, of which a highly variable portion (between 0% and 80%) are self-referrals. The remaining ED visitors are referred by their general practitioner or brought by ambulances. Waiting times in the ED rarely exceed 4 hours, mean process time is between 60 and 90 minutes, and mean treatment time is between 30 and 69 minutes.27,38

The St. Elisabeth Hospital is on the forefront of emergency medicine in the Netherlands. It is a teaching hospital for emergency medicine and one of the 6 departments in the country with a 24-hour presence of emergency physicians. There is collaboration between the ED and the local cooperative acute care clinic, which is in another part of the city. The annual number of patients in the ED is 28,000. The average time patients stay at the ED is 2 hours; mean treatment time is approximately 90 minutes.

Figure 3. Setting in general terms and ED care in the Netherlands.

return home, to persuade caregivers of the truth of their stories, to get something to drink or eat, or to reassure their partners. Several clues helped to identify the concerns: patients might explicitly voice their concerns, reveal them when talking to themselves, or show concerns through behavior (eg, posture, moaning, agitation), or a patient’s attendant may raise a concern. In general, the concerns of patients and their attendants have 4 aspects in common: they indicate a certain trouble, have a personal character, impose themselves with urgency, and require an effort from the patients (Figure 5).

In our analysis of 16 cases, we identified a total of 144 concerns. This led to establishing a typology of 5 categories of concerns that patients struggle with when they are at the ED. The Table presents this qualitative taxonomy, its subcategories, and the distribution of concerns. In the remainder of this section, we briefly introduce these categories. The order of the categories follows the course of an ED visit in which patients enter the ED with worries and with expectations, receive diagnoses and treatment, endure waiting times and pain, and finally hope to be taken seriously. Patient concerns focus on ED care from a care receiver’s perspective, which may seem illogical from a clinician’s perspective. All identified concerns meet the 4 aspects as presented in Figure 5 and are presented in italics (see Appendix E1, available online at http://www.annemergmed.com, for case summaries).

The anxiety of ED patients can be related to their experiences, to the present events, and to future developments. Feeling anxious is rather expressive and not neutral and requires of patients that they come to terms with what concerns them when they are at the ED. Our data show that most of the patient concerns related to anxiety arise during the actual stay in the ED (present) and in anticipation of events (Table). In case 4, for example, a mother and her toddler son arrive at the ED after a visit the previous day. The mother seemed to be worried and was engaged in a concern: Today, I have to make sure they do find out why my son is in such pain.

Generally, the “anxiety concerns” of patients that relate to future events focus either on the prospect of their being admitted

LIST OF CODES AFTER FIRST ROUND OF ANALYSIS

The concerns of a patient: Patients seem to actively struggle with all kinds of issues that cause feelings of worry and are not directly or clearly related to the disorder that brought them to the ED in the first place.

Self-talk: Patients talk about, reflect on, and comment on what takes place in their own mind (such as feelings and thoughts) and around them (for example, by the ED staff or during treatment). Mostly, these remarks are not directed to a specific audience; sometimes they are made in interaction with their attendants.

Culture: The habits and modus operandi of ED staff.

Cliff-hangers: Whether already initiated acts of care are completed by ED staff, indicating that they are finished, or inquiring whether there are any questions, or returning to report results of an examination.

Responsiveness: The responses of ED staff to patients.

Attendants: The tasks, functions, responsibilities, and concerns of those who accompany patients during their stay in the ED.

FINAL ANALYTICAL FRAMEWORK

1. What are the concerns of patients?
2. What is the response of health care professionals to those concerns?
3. Do these responses fit with the concerns?

Figure 4. Analytic framework that emerged from the data: coding protocol after 8 cases and final analytic framework.
After the 16 cases were analyzed on the basis of the 2 central concepts (concerns dependent. It is not in my character, and I do not want to bother the patient raised a signi

Figure 5. Four criteria that a single patient concern should meet.

Table. Types, frequency, and distribution of concerns of patients.*

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategories</th>
<th>Frequency</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Past</td>
<td>7</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Present</td>
<td>18</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Future</td>
<td>17</td>
<td>42</td>
</tr>
<tr>
<td>Expectations</td>
<td>On arrival</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>During stay</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>On departure</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Care provision</td>
<td>To tell story over and again</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>To undergo examination (again)</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>To undergo treatment (again)</td>
<td>8</td>
<td>26</td>
</tr>
<tr>
<td>Endurance</td>
<td>Pain (physical/nonphysical)</td>
<td>12</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Occupied time (waiting)</td>
<td>12</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Social relationships</td>
<td>6</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Worries (inside and outside ED)</td>
<td>9</td>
<td>39</td>
</tr>
<tr>
<td>Recognition</td>
<td>Wish to receive recognition</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Wish to express recognition</td>
<td>1</td>
<td>14</td>
</tr>
</tbody>
</table>

*After the 16 cases were analyzed on the basis of the 2 central concepts (concerns and responses), 5 categories of patient concerns were established (left column), which were divided into subcategories (middle column). The table also presents the frequencies of the categories and subcategories.

1. Concerns indicate a certain trouble or effort and point to a difficulty. Concerns reveal what is not going smoothly and cause feelings of worry.
2. Concerns have a personal character; they occupy a patient at a particular moment and force him or her to personally resolve the problem. Concerns are not about what patients in general have to overcome but are more precise, personal, contextual, and situational and are shaped by previous health care experiences of individual patients.
3. Concerns impose themselves with a certain urgency. It is hard for patients not to be caught up in the efforts to deal with a concern. Patients cannot ignore, omit, or neglect concerns.
4. Concerns inevitably require patient effort. For patients, dealing with concerns is not self-evident; it often takes courage, determination, patience, improvisation, talent, etc, to manage them and to get a grip on the situation.

At the ED, patients have to relate their story of what happened and undergo examination and treatment. For most patients, an ED visit means immersion in a culture that is not self-evident. The modes of working, the multitude of ED staff and their mutual relations, and the uncommon questions and environment may easily lead to patient concerns. Usually, the visit starts with patients telling time and again what happened to them. This seems to require both a certain expertise and keenness on the part of patients and their attendants. In case 7, for example, an intern inquires about the patient’s pain, to which the patient answered, “It’s as if I have too much nitrogen in my lungs, as they told me in another hospital.” From a medical point of view, this may be nonsense, but previous experiences seem to impel this patient to demonstrate a certain experiential authority: I have to show them that I am a knowledgeable person. His partner continuously monitored his answers and seemed to have the overwhelmed father was instructed to take his son onto his lap: The doctor asks me to take my son onto my lap. I have to do this.

Being an ED patient implies enduring a multitude of things: pain, waiting, dealing with attendants, or worries about the future. Not surprisingly, we have observed the endurance of pain and waiting most frequently (Table). Bearing pain does not always mean bearing one’s own physical pain. The parents in case...

316 Annals of Emergency Medicine

Volume 63, No. 3 : March 2014
3, for example, witnessed their son’s pain when a drip was being placed, which itself is painful: *I have to carry the burden of powerless watching my son in pain.* In 6 of the 8 cases, waiting times led to patient concerns. The ED visit in case 5 lasted about 7 hours (which is unusual in Dutch EDs; Figure 3), and the patient frequently referred implicitly and explicitly to the difficulty of undergoing the extensive waiting: *I have to endure the waiting.* Furthermore, we have observed that an ED visit can put pressure on social relationships that may cause concerns; for example, when the accompanying girlfriend (case 8) warned the patient not to be optimistic about the prognosis. In reaction, he gave her an affectionate look and said something sweet. And after a yawn, he suggested that she sleep on their way home. He appeared to be dealing with a concern: *I have to carry my girlfriend through this ED visit.* Finally, enduring an ED visit sometimes means the activation of worries from everyday, private life. When a nurse who was taking an ECG persisted in talking about how to raise offspring (case 7), he ignored the patient’s signs of having different experiences with children. After the nurse left, the patient and his partner told the researcher they have not seen their children in years. The nurse addressed a specific concern of the patient and his wife: *We have to deal with the fact that our relationship with our children is not good.*

Being recognized and being taken seriously was significant and led to concerns. Our data clearly show that, when patients are treated at an ED, they struggle with being recognized by staff as a sensible person with relevant experiences, and they desire to be addressed with at least some respect and dignity. In case 1, for example, the physician ignored the girl’s own story—based on ample experience of illness—which clearly annoyed her: *I have to deal with the fact that my story does not count; I am not being heard.* Another example is found in case 8, in which a male patient with a swelling on his skull was not being taken seriously while a nurse examined him just after arrival: *I have to see to it that she takes me seriously.* An interesting aspect is that patients sometimes seem rather reticent to compel some kind of recognition by overacting or to make an effort to behave in a manner that brings less risk of being ignored.

**LIMITATIONS**

Although qualitative, ethnographic methods score high on internal validity and in general document accurately the phenomenon studied, there are some limitations. First, the analytic process depends on individual research skills and the extent to which a group of researchers succeeds in reaching a consensus on the interpretation of the data by means of peer validation. But although the discussions in the research group were open and critical, it is unclear to what extent the most experienced researchers affected the analysis.

Second, data collection was limited to 1 urban ED that is located in a teaching hospital in the Netherlands. We suggest that the typology of concerns that emerged from the data is tenable in other EDs (eg, academic, rural, nonteaching) in other countries. This, however, is an issue for further study.

Third, collecting data in a single medical center complicates the reliability of the study. Although it is unlikely that it can be replicated in the exact way that we conducted it, we believe our results give an adequate and substantiated impression of what patients actually experience at the ED. By giving an extensive account of our methodological steps, we have attempted to confer on our analysis as much transparency as possible.

Fourth, discussion of the mismatches between patient concerns and staff responses and a detailed analysis of the course of their encounter can be instructive but are not included in this article. Although we acknowledge the importance of interpersonal interaction and “the other side of the equation,” because of limitations of space our article focuses on the perspective of patients and is restricted to reporting our findings on patient concerns.

**DISCUSSION**

Our study offers a practice-based conceptual framework that enables workers in the ED to examine the quality of emergency care from the perspective of experiences of patients. Looking at ED care through a lens, comprehending patient concerns, provides an opportunity to identify patients’ experiences during the course of their ED visit (Figure 5). It shows that ED encounters entail much more than well-structured diagnostics and therapy complemented with a transfer of information to patients. The results also show that patients’ impressions of ED care may often seem illogical from a clinician’s point of view. Our typology of patient concerns perceives patients’ experiences from their initial anxiety and expectations to undergoing treatment, to enduring waiting times, pain, and discomfort, to a more evaluative experience of recognition as a person.

Several studies suggest that improving the quality of emergency care and patient satisfaction requires investing in interpersonal skills on the part of ED staff. Whether it involves dealing with frequent ED visitors, improving patient comprehension of ED care, or providing information, studies repeatedly emphasize the importance of building rapport and tailoring interventions and interactions to individual patients. Our data show that most patient concerns emerge at the beginning of an ED visit, when patients are anxious about their disorder (Table; 42 patient concerns) and have to endure the visit and the time, pain, and worries it entails (Table; 39 patient concerns). This suggests that better connecting and attuning of ED staff to these aspects of patient experiences—notably, at the occasion of first contact—may reduce patient concerns and result in quality improvement from the perspective of patients.

We think the results of our ethnographic study may help ED staff to express empathy and to build rapport within the tight time constraints of the ED. Two arguments underpin this claim.

First of all, the 4 criteria for individual patient concerns and the typology of concerns we have developed enable ED staff to better understand patient behavior and (non)verbal remarks, enabling staff to perceive more clearly what patients experience
in real time during their ED visit. This gives ED staff the opportunity to pay attention to what occupies patients, enabling them to provide a tailored response that fits with patient experience. More specifically, the framework provides insight into the fact that patient-physician interaction is much more than a (non)verbal transfer of information. Our conceptual tool acknowledges the stakes for individual ED patients and that emergency care is a collaborative enterprise involving both patients and staff. It also confirms that the interaction at EDs is contextual and situational, and it acknowledges the inherent asymmetry of ED encounters.17

Furthermore, the conceptual framework and typology of 5 different categories of patient concerns offer a practice-based approach to learning patient-centered emergency care. The framework not only offers clues that may help ED staff to better perceive what occupies their patients but also may serve as a starting point for making staff more sensitive to patients’ verbal and nonverbal cues. Because patient concerns do not involve general patient characteristics but are practice related and emerge from the actual experiences of individual patients, it seems a suitable concept to help improve the quality of interpersonal skills of ED staff, resulting in professional responses that match with the experiences of individual patients.

First, it can function as an easy-to-recall lens through which individual staff members can observe their own daily functioning and rapport building.17

Second, it can be used for case-based learning in multidisciplinary communities of practice.25

Third, our framework may serve as an analytic tool for reviewing past emergency care situations that failed the requirements of good, patient-centered care.34,35

Fourth, it can help staff to better understand patients’ complaints about the care they received and help reduce the risk of liability.36 These, however, are hypotheses that need to be further tested in ED practice and supported by future research.

In conclusion, we argue that despite the hectic daily schedules of and time constraints on EDs, being sensitive to patient concerns will enable ED professionals to improve their interpersonal skills. The observations and reports of patient concerns offer both a rich outlook on real-time patient experiences and an opportunity to learn about and practice patient-centered emergency care. This article presented 4 practice-based criteria to identify individual patient concerns (a certain trouble, a personal character, urgency, and patient effort) (Figure 5) and a typology of 5 categories of concerns (anxiety, expectations, care provision, endurance, and recognition) (Table). These findings may contribute to quality improvement in emergency care.

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REFERENCES
APPENDIX E1.

Summary of 8 analyzed average ED visits

This appendix presents 8 case reports of how patients actually experienced their ED visit as it was happening. Patients’ impressions may often seem illogical from a clinician’s point of view. However, the goal of this article was to determine the actual experiences of patients who received care at the ED and not to discuss patient care from a clinician’s perspective.

CASE 1

A teenage girl reports to the ED desk, together with her mother. The girl has a long history of illness and pain. From the day she was born, her bowels have caused her trouble, and she has had a stoma for almost 10 years. Her mother urged her to visit the ED because she is in more pain than usual. After triage, a resident and a pediatrician examine the girl. The first ignores the girl’s own diagnosis, whereas the second does not take seriously the experiential knowledge of mother and daughter. The mother clearly expresses her concern, and the pediatrician requests an abdominal echography. The situation deteriorates when at the radiology department the girl is treated as an object, with no attention at all for her pain. She is alarmed when the radiology assistant seems to consult a physician and not inform her about that. The patient and her mother are informed about the results of the echography by the pediatrician. The girl is sent home with a prescription for a drug that she has taken before. Unfortunately, it did not seem to work that time.

CASE 2

Around noon on a weekday, a teenage girl and her mother arrive at the ED. The girl is sent in by a general practitioner who suspects a case of appendicitis. This is not the first time. The triage includes collecting a blood sample, which the girl experiences as an unpleasant event. After triage an intern examines her. When he leaves, the girl and her mother have to wait for more than an hour. They are hungry. The triage nurse checks in once in a while. Then an emergency physician enters the room with an opinion. Appendicitis is not under discussion, and the girl and her mother are allowed to go home but are recommended to make an appointment at the pediatric outpatient clinic.

CASE 3

Around 3 PM, 2 parents and their toddler son report to the ED. The father found the boy in bed with his body having turned blue. The parents were very frightened. The mother contacted their general practitioner, who saw no reason for referring them to the ED. The parents took the initiative to go anyway. The toddler is treated by a triage nurse, a pediatrics resident, and a pediatrician. The latter diagnoses a sepsis, which the parents want to treat intravenously. She also announces that the patient probably has to stay in the hospital for 72 hours. The boy is rapidly brought to the pediatric trauma room, where 2 nurses will assist. The pediatrician attempts to place a drip 3 times but fails. A staff member who did not introduce herself makes another 3 futile attempts. The toddler patient and his parents are experiencing stress. The unidentified health care professional admits that the drip is not succeeding, and she and the pediatrician withdraw from the trauma room to discuss further procedure. They never return. A seventh puncture to collect some blood for examination is made in the boy’s finger, and subsequently a radiograph is taken of his lungs. He receives a cuddly toy animal, which he likes a lot. Unannounced, 2 pediatric nurses call in for the boy to be admitted to the ward. Once in the pediatric ward, the parents talk to another pediatrician. He does not recall what happened earlier at the ED but reports that the radiograph looks fine and the boy’s blood seems normal. Admitting the boy to the hospital because of an infection is not necessary. Because the boy had turned blue, which may result from a high fever, the pediatrician wants him to stay for the night in case it happens again. The mother asks whether the boy can go home the next day, and the pediatrician answers, “If nothing happens, that seems likely.”

CASE 4

On a Thursday morning, a mother and her toddler son report to the ED. They were there the previous day. The boy has a painful leg. Radiographs were taken, but no cause was found. However, the boy did not sleep at night and constantly cries from the pain. The mother is concerned and believes something has to be wrong; why else would her son cry and refuse to stand on his leg? An emergency resident, an emergency physician, and another resident (orthopedics) consecutively examine the boy. He is given an analgesic. Again, radiographs are taken of the boy’s leg. Meanwhile, the boy’s grandmother arrives at the ED. The mother expects her son’s leg to be in a cast. The orthopedic resident disappoints her. He inquires about the painful leg (which was hurt at a playground, but the mother did not observe exactly what happened) and physically examines the boy. He is unable to discover what is wrong and suggests it might have been worse. However, the mother believes he trivializes the possible cause and places her son on his legs. Moaning loudly, the boy lifts his painful leg. The resident does not respond to the moaning or to the mother’s appeal and leaves the room to discuss his findings. When he returns he holds his ground; however, he arranges an appointment at the orthopedic outpatient clinic. The grandmother asks for a bandage, but the resident refuses. When grandmother, mother, and toddler are about to leave, the emergency resident says, “Well, it is nothing…” Later, the grandmother reacts: “It comes down to the fact that they do not take good care of you. They do not tell you what they do.” They return home empty-handed.

CASE 5

A woman aged approximately 40 years is admitted to the ED. She has a swollen stomach that strongly moves up and down. She
looks as if she is pregnant and a fetus is kicking inside her. When she arrives at the ED, she cries out with pain and constantly sobs and moans. During her stay in the ED, the patient is very afraid she will be admitted to the hospital. She is frightened of going insane if she should need to stay. It appears she previously has been admitted to a psychiatric ward and is anxious to avoid another admittance. Her concern “I have to avoid being admitted to the hospital” becomes her dominant worry and seems to be more important to her than discovering the cause of her stomach pain. Various examinations are conducted, followed by long periods of waiting. Finally, she is sent home with medication that should stimulate defecation. However, she already takes the drug without any success. She does not succeed in interrupting the physician to make her experiences known to him. He reports his findings and does not listen to her. He says, “I am very satisfied. I saw you and wondered what could be wrong. Fortunately, it is nothing.” The patient’s ED visit took 6 hours, and she returns home with stomach pain and a laxative she already uses.

CASE 6

In the afternoon, a male patient arrives at the ED by ambulance. He is aged approximately 70 years and experiences severe shortness of breath. While he is examined by a resident, a nurse relieves his dyspnea with medication. The man is a lung patient and was discharged from the hospital the previous day. Because he lives alone and had no food in stock, he had to go out for some groceries. He was not able to walk home with a full shopping bag. A passerby stopped and helped him carry the groceries home. The physician suspects an infection and advises the man to find help and not do his shopping on his own. Later, the patient confides in the researcher that he finds it very difficult to depend on others and also relates his fear of suffocation and death. He does not mention any of these concerns to ED staff. Finally, the physician informs him of the diagnosis: the patient has an infection and is admitted to the hospital. The physician leaves immediately. The patient considers this very bad news and says, “I am a class-4 lung patient; this could be fatal to me.” After an ED visit of 7 hours, he is admitted to a ward.

CASE 7

Early in the morning, a 50-year-old male patient arrives at the ED in an ambulance. He has cardiac complaints and is accompanied by his partner. Recently, he has had chemotherapy to treat cancer. Later that day, he has an appointment to receive the results of a computed tomography scan that monitored the growth of the tumor. His partner is a cardiac patient as well. They emphasize their past negative experiences in health care and believe the size of the tumor has increased because of incorrect treatment. During his stay at the ED, the patient is examined and medicine is administered to control his cardiac complaints, which seems to provide relief. After 3 hours, he is sent to the cardiac care unit, where his heart will be further monitored.

CASE 8

On a Friday around midnight, a young man and his girlfriend report to the ED desk. Because there are no other patients waiting, the receptionist sends them to a treatment room after a couple of standard questions. He tells the nurse that more than a week ago he had an operation on his skull to remove a (benign) lump. Since the operation, a swelling on his skull has been giving him trouble. The swelling comes and goes and causes pain. A nurse advised him the previous day to contact the ED if the swelling reappears and told him a puncture will be made to determine whether it is caused by brain liquid or septum. The patient is not well informed about the details of the operation, and he explicitly mentions this. On Monday, he has a telephone consultation with the surgeon. The ED nurse seems to be skeptical and believes he went to visit the ED for no good reason. A physician takes his concerns more seriously. He consults with a colleague, explains to the patient what may be the problem, and reassures him.