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Training interaction in primary care emergency teams: the role of the patient

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Abstract

Objective: "The needs of the patient" inform interactions in medical settings. Information regarding the role of the patient is, however, absent from emergency medicine guidelines and team training manuals. We sought to identify how we could introduce a greater focus on the needs of the patient in order to increase the person-centeredness of clinical services.

Method: During the course of one year (May 2010-11), we applied a framework of action research to an exploration of the simulated patient's role and participation in the context of interaction training in primary care emergency teams in Alta, a rural municipality in the county of Finnmark, Norway. All of the 10 rounds of team trainings we employed included 2 simulated scenarios. Each was followed by a de-briefing designed to elicit the participants' reflections upon the simulations and moderated as a focus group. Our study material included: field notes; the transcribed audio-recordings from 18 de-briefings and the transcript of a follow-up focus group held with local stakeholders.

Results: The analyses, bridging perspectives from ethnomethodology, conversation analysis and discourse analysis, revealed that participant reflections were dominated by language that objectified both the simulated patients and the participating professionals. When confronted with these findings, the local stakeholders expressed ambivalence about increasing the focus on the patient as a person when it was not of clear benefit to the patient and when it might impact negatively on "assessments and management" during the most critical phases.

Discussion: Despite these results, the dominant objectifying language may well suppress insights that patient participation could provide and which could potentially prove beneficial both to patients and professionals as persons, those who share the crisis in emergencies.

Conclusion: For future improvement, current emergency team trainings, characterised by increasing medical sophistication and professional competence, ought also to be enriched by increased focus on the role of the patient.

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Introduction

Situations defined as medical emergencies are given high priority in every healthcare system, taking precedence over other tasks. According to Norwegian Law, *patient needs* must be the deciding factor determining whether a collaboration of professionals in teams is required [1]. The law guarantees a patient's right to be kept informed and to participate in the implementation of healthcare services [2]. Usually, the patient's needs are not defined by the patient alone; relatives, healthcare personnel and/or treatment guidelines also play a role. Medical teams functioning outside hospitals are constituted *ad hoc* and, when interacting in inter-professional teams, physicians have responsibility for diagnostic and therapeutic decisions. What the patient's role is, or should be, in relation to such teams, has not yet been clearly defined.

In order to develop and maintain necessary interactional skills, pre-hospital professionals in Norway are required to participate in training sessions [3]. Team trainings have evolved in a variety of directions [4-6]. In contrast to individual training, team training offers the participants an opportunity to learn with, from and about one another's areas of competence, professional roles and

experience [7]. De-briefing sessions following simulations are deemed vital to learning [8] and the presence of a live simulated patient has been found to heighten the sense of realism [9,10].

Since 2003, a team training model focused on hospital trauma teams' interactional skills [11], BEST (BEtter and Systematic Team Training), has been adapted to and implemented within community primary care emergency medicine services (C-BEST). To suit the local context and create a sense of content ownership, the model's structure includes a preparatory lecture followed by 2 simulations designed specifically for that local setting. Subsequent de-briefings are semi-structured inquiries into participants' "reflections-on-actions" [12]. Initially, these trainings were facilitated by local general practitioners (GPs) [13]; later, nurses and paramedics were included and live simulated patients were introduced.

The inclusion of a live simulated patient in training sessions and debriefings is in accordance with the aims of "Patient Centred Medicine" [14], "Person Focused Healthcare" [15], as well as a model called "Person Centered Medicine" (PCM), which has been articulated fairly recently [16,17]. Proponents of PCM emphasise that the status of "personhood" must of necessity be accorded to medical professionals as well as patients, underlining that both the distress linked to crisis and the process toward healing are shared, inter-subjectively. A growing body of evidence documents the destructive impact that personal experience of serious distress has, at all physiological levels [18]. At the same time, caring therapeutic relationships [19-21] are seen to have a strong positive impact on the process of healing. Hippocratic medicine has expressed this phenomenon over the ages in its paramount ideal of, "giving the healing powers of nature a helping hand" [22,23].

The issue of autonomy is also crucial to an exploration of the appropriate involvement of patients in their encounters with medical services [24]. In the context of emergency medicine, that has been the focus primarily in such rare, albeit demanding, situations as when a patient refuses lifesaving treatment [25,26]. Patient autonomy and involvement may, however, be decisive in less extreme situations as well, as was found in a study of women who had undergone an emergency Caesarean section (C-section). When inquiries were made 3 months after the intervention, the women who felt they were *not* sufficiently involved in the decision to undergo a C-section were more likely to present with symptoms of post-traumatic stress (PTSS) as compared to those who felt that they *had been* sufficiently involved [27]. The possibilities for involving patients in decision-making may be no fewer in pre-hospital settings. Two Norwegian studies indicated that 70 - 84% of those patients in need of acute emergency care were not experiencing life-threatening conditions [28,29]. Most patients experiencing "red-response" emergencies are thus neither totally debilitated nor unconscious and would be capable of participation. Even someone in a deteriorating condition might be awake initially, when taken care of by the primary care team. A severely injured or debilitated person might feel encouraged by, and respond to, a caring, sensitive touch or hearing an empathic, "Keep breathing - we're here to help you!"

Nonetheless, advice regarding how to facilitate patient participation is still strikingly absent from such documents as local emergency plans [30], procedures [31-33] and regulations [3]. Similarly, no guidelines regarding the patient's role are provided to primary care emergency teams as part of their required training sessions.

Within a framework of action research, we set out to explore interaction training utilizing the C-BEST model in Alta, a rural municipality in the county of Finnmark, Norway, in order to identify possible ways to improve it. In the present study, we investigated the simulated patient's role and participation in the training sessions during the course of one year.

Methodological and theoretical framework

Both the team training model and this study are grounded in the democratic principle that all participants are on an equal level despite their differing roles and competencies.

This principle of equality ensures a diversity of opinions and safeguards their expression; it is a prerequisite for interaction as it prevents the suppression of differences that often characterizes hierarchies. This principle is in accordance with the action research framework of the study, which allows for a close connection between theory and practice in the pursuit of change as facilitated by a democratic process [34]. It is reflected *in the model* through all participants being asked to share their responses during the debriefing sessions. It is reflected *in the study* through the inclusion of a discussion, held later, with a group of 7 local stakeholders, centrally placed healthcare professionals, all of whom had participated in at least 1 of the trainings. In both discussion formats, all participants were accorded an equal opportunity to influence the process while also being held equally accountable for their own contributions.

We deemed the approach proposed by Miller & Fox [35], which bridges the 3 methodologies of ethnomethodology, conversation analysis and discourse analysis, to be appropriate for the analysis of our material. These were: field notes taken during an initial lecture and 2 simulations, transcriptions of the de-briefings and transcripts of the follow-up focus group discussion which was held 6 months after the researcher's participation in the training sessions.

We applied *ethnomethodology* to explore the everyday interpretive practices through which a local view of reality is constructed [35,36]. According to the developer Harold Garfinkel [37], all reflection is necessarily constrained by the discourses and social settings in which one is socialised. Thus, reflections *describe* and, simultaneously, *constitute* realities.

We used *conversation analysis* of the transcribed de-briefings to investigate how the professionals constituted social realities using speech as a complex form of interaction. Since language is the main means for defining

a prevailing discourse, language is also a central means for changing it.

Finally, we analyzed the transcripts using *discourse analysis* in order to explore the relationships between language and power revealed therein. This approach to the materials enables the identification of dominant speakers as well as dominant trends in how language is used. It concurrently facilitates the identification of those speakers and language usages which are overpowered and thereby blocked from accessing the discourse.

Our approach has also been inspired by philosopher Hans Skjervheim [38], who coined the term "instrumental mistake." He emphasised that research regarding social phenomena is insufficient if based solely on pragmatic-technical methods and strict calculations. Human interaction is ambiguous, since one can relate to one's fellow human beings as both subjects and objects. One can engage another person as *somebody*, a subject, on an equal level or regard that person as *something*, an object, which we judge and treat, in accordance with our prejudices. To avoid the risk of objectifying the patient, patient-professional encounters ought to be explored by a researcher who is not just an observer, but also a participant.

Participating researchers

The first author served as a part-time instructor and co-developer of the C-BEST model for 5 years (2003-8), as well as being a GP in Deatnu/Tana, another rural municipality in Finnmark. There, she observed how frequently the reflections of simulated patients seemed to take team training participants by surprise. This motivated her to examine more closely the role of the patient in emergency care. She brought a valuable dual perspective to that inquiry: her prior experience with the model afforded her an insider's view that deepened her insight into current practices; her residing at another location allowed her an outsider's view of the specific local context, making it easier to pin-point opportunities for improvement.

All the authors of this paper are participants in an inter-professional research group, the "Uni-Group," bringing a diversity of perspectives to the entire research process. Due to their contribution to the analysis of the material, the local stakeholders must also be considered as co-researchers.

Material

The first author attended monthly trainings in Alta, one of the few places in Norway where these were offered regularly. For 1 year (May 2010 to May 2011), she acted as an *observing participant*, taking field notes during all of the initial lectures and the 2 simulations that followed each of them.

The initial lectures' primary topic was practical trauma care, including a short introduction to such teamwork skills as communication and leadership. These sessions were detailed regarding *what to do* with the patients but not *how to interact or communicate* with them. In the scenario trainings, one of the instructors took the role of the simulated patient (patient-instructor). The second instructor observed the simulation while keeping his interventions to a minimum (observer-instructor). Almost all scenarios were time-critical, 1-patient accidents, though sometimes a "relative" was included. In 3 scenarios, the patient was an infant (mannequin) with a parent (live simulator). All were enacted as realistically as possible. For example, in 1 scenario, the teams actually drove to where a person was lying, in an awkward position, outside in the cold, near a road and wearing a helmet. The team's job was to suction the patient's mouth, provide breathing assistance, give reports, place the patient in the ambulance, insert IV-lines and then drive to the nearby primary care clinic for further intervention.

During the subsequent de-briefings, the first author adopted the role of a *participating observer* in a focus group-like approach [39]. The de-briefings aimed at elucidating the team members' reflections on their actions and interactions by requiring each of them to take a turn speaking and to talk to each other. The patient-instructor was present as a participant in a threefold role: as a colleague, as 1 of the instructors and as a simulated patient. During the first round, the participants expressed their personal responses to the question, "How did you experience the simulation?" The second round focused on the question, "What went well?" The question for the third round was, "What could have been done differently and how?" A total of 54 professionals - 6 medical students, 13 nurses, 18 ambulance personnel and 17 GPs, representing the majority of the GPs in Alta - constituted 10 different teams, performed 19 team training sessions. These generated 19 simulations and de-briefings, 1 of which could not be transcribed due to technical problems. The sessions were tape-recorded and then transcribed, *verbatim*, by the first author. The resulting transcripts were analysed in sequence in order to gain an overview of developments in how the de-briefings were conducted.

The final reflections emerged from the discussion among the 7 local stakeholders, based on preliminary findings from the analysis. Conducted by the first author 6 months after her participation in the training sessions, this discussion was also tape recorded, transcribed and included as part of the material for analysis.

The Regional Ethical Committee stated that their official approval was not required as the study neither involved patients nor sensitive information. All participants contributed on a voluntary basis and all signed informed consent forms.

Analysis of the transcripts

Seeking consensus at each step, the Uni-Group explored the participation of simulated patients. According to the rules agreed upon for a linguistic analysis of the de-briefing transcripts, the 1st-person voice, the voice of the "patient," was used as a starting point. Simulated relatives were also regarded as "patients." We marked 5 successive categories for patient representation: as a subject (termed "I"); addressed as a subject (termed "You"); as a bodily object (termed "He/She/It"); as a body part or function

(termed "This") and, as the locus of actions performed *on* the body (termed "That").

The texts were read closely for patient utterances as an "I," formulated, for example, in*:*

> "I felt safe as a patient" or, "It felt as if I slid down from the bed during the trip."

Frequently, statements made by the instructor-patient reflected a blend of roles:

> "I think you managed my neck very well, although that's always difficult to judge. But I tried all the time to be aware of how my neck was (handled). Anyway, I believe you did a good job. It was stable, which was good. You did well when turning me in several situations. I was lying in a rather twisted position, but you did this well."

This, and similar utterances, were categorised as 1st-person statements because, while they were mixed with objectifying 3rd-person forms of speech (it was stable), they explicitly represented the subjective perspective of the patient-instructor (turning me; I was lying…). As such, they expressed their personal experience of being handled in a way that both felt (subjective) and was (objective) appropriate.

The second category "You-statements" were the trainees' direct responses to the "patient" such as:

> "You might have received an injection of morphine"

or questions to the "patient" such as:

> "Did you feel safe?"

Statements such as:

> "I didn't understand that she'd been involved in an accident until I asked if she had an injury"

were also interpreted as regarding the patient as a reflecting person and were defined as "You-statements."

All other statements concerning the "patient" were *about* her or him and were quite diverse. In the third category of "He/She/It," the "patient" was spoken about as a bodily object:

> "The question was whether he ought to be transported seated or lying down."

Another example came during a short evaluation:

> This was because of the way he was lying. It was difficult to perform a proper check-up. And there was talk… " (P12) "Since he was talking, he could breathe." (A6) "Yes." (P12) "He was even awake." (A6)

The fourth category (the second objectifying category), "This," referred to bodily parts or functions:

> "But the pulse? What about the pulse rate?" Or, "I was primarily concerned with the head. And the neck should have been stabilized immediately."

The fifth category, "That," referred to interventions or actions targeting the body as a kind of medium, an abstracted locus of the application of devices or standardised procedures:

> "… but I delegated the blood pressure to you since it hadn't been taken and then I started to insert the infusion and picked up the pre-warmed "Ringer" and I got the needle inserted – when suddenly…." Or: "..Is what you're saying that you mainly had communication problems and that you were aware you faced an A and B problem on the ABC-checklist?"

Table 1 shows the total of the different types of statements: Table 2, details 2 types of proportions on 2 different levels: a) the percentage of the total number of reflections that were patient-related speech and b) the frequency of object-oriented language as compared to subject-oriented language. This overview formed the foundation of the Uni-Group's further analyses.

The transcripts from the final reflections, those of the stakeholder discussion group, were analysed differently. Each member of the Uni-Group identified relevant topics and from these, the first author extrapolated the core themes, which were then analysed through a collaborative discussion process.

Results

The C-BEST-model needed to be modified slightly. First, the simulated patient was asked directly to share her or his opinions in each of the de-briefing rounds. Also, the questions guiding the de-briefings were simplified into the 3 listed above. Next, the first author, acting as a moderator, refrained as much as possible from interrupting or leading the discussions, which made the sessions more close resemble a focus group process. Finally, the local instructors introduced new scenarios involving a change both of location (indoor swimming pool) and medical field (cardiology).

Between 17% - 41% (average 28 %) of the transcribed statements referred to the patient (Table 2). In all 18 transcripts, the proportion of statements referring to the patient as an object exceeded those referring to the patient as a subject (Table 2).

Although the people who had simulated patients or relatives were present during the de-briefings, they were generally talked *about* instead of *to* and predominantly referred to as a body, a body part/function or a locus of actions, instead of as persons with emotions, opinions and own resources. These findings did not correlate to the *degree of consciousness* displayed by the patients: the adult patients simulated complete unconsciousness in only 3 of the scenarios (Table 2).

Table 1 Amount of different statements

Category of statements	I-statements	You-statements	He/She/It-statements	This-statements	That-statements
Total number (n=1896)	271	223	655	353	394

Table 2 De-briefed scenarios with percentage of *patient-related* speech and factor of *object-oriented* speech compared to *subject-oriented* speech

De-briefing number	Scenario	Degree of consciousness during simulation	Simulated patient present during de-briefing	Percentage of total speech was *patent-related*	Factor of *object-oriented* speech compared to *subject-oriented* speech
1-1	A	Mostly conscious	Yes	23	2,3
1-2	B	Mostly conscious	Yes	25	12,6
2-1	B	Mostly conscious	Yes	26	2,7
3-1	B	Mostly conscious	Yes	32	3,0
3-2	F (Ch/M)	(mannequin infant)	No	37	13,5
4-1	B	Mostly unconscious	Yes	26	1,9
4-2	A	Mostly unconscious	Yes	18	2,2
5-1	B	Mostly unconscious	Yes	26	3,8
6-1	A	Mostly unconscious	Yes	17	2,0
6-2	B	Mostly conscious	Yes	20	3,9
7-1	C	Mostly conscious	Yes	29	2,1
7-2	G (Ch/M)	(mannequin infant)	Mother	40	1,7
8-1	A	Fully unconscious	Yes	30	6,2
8-2	H (Ch/F)	(mannequin infant)	Father	31	3,8
9-1	D	Mostly conscious	Yes	29	5,6
9-2	A	Fully unconscious	Yes	33	3,5
10-1	C	Mostly conscious	Yes	41	1,9
10-2	E	Fully conscious	Yes	17	2,8

A: Person with post-accident, abdominal pain, in the waiting room with a relative. B: Person lying by the road, face down, wearing a helmet. C: Person with neck pain, lying on a staircase after a fall. D: Person found face down in a swimming pool. E: Person outside the clinic with intense chest pains. F: Immigrant mother arrives in a panic, with unconscious infant (Child/Mother). G: Mother arrives in a panic, carrying a seriously burnt infant (Child/Mother). H: Father arrives worried, carrying a seriously burnt infant. (Child/Father)

The shifts between the categories of speech were often gliding and could occur within the same sentence: a focus on the person or body narrowed to a focus on bodily parts/functions and, eventually, widened when a new speaker entered the discussion.

Furthermore, some interactive patterns were consistent. A particular kind of attention seemed to be paid to the "voice" of the *patient*-instructor during de-briefings. The group members became more engaged in discussion whenever comments on particular actions were made by patient-instructor as compared to when comments *on the same issue* were made by the instructor in the role of *observer*. A comment from the "patient" was rarely offered spontaneously but rather came in response to a direct question. This would seem to indicate that the patient-instructor was not highly identified with the role of "patient" during the de-briefings. In addition, team members rarely directed questions to the "patient."

A variety of topics were identified in the transcript of the stakeholders' discussion. Ambivalence was expressed about addressing the simulated patient as a *person*, both in the opening lectures and the de-briefings, formulated as *a need for professional distance*. The group also emphasised that taking the right measures to preserve life and limb had *priority over* and needed to be attended to *before*, interacting and communicating with the patient. Such interactions were spoken of primarily as synonymous with *comforting* the patient, the function which one paramedic proposed might be served by speaking-while-doing. One physician reported assuming that his previous trainings using mannequins had been so influential in shaping his habitual professional behaviour that they might also have impacted his responses during this more recent training on live persons. The group voiced their need for reflecting on the role they played during the simulations in statements such as, "*We're still digesting the simulations*" and, "*We're examining ourselves.*" They acknowledged the patient-instructor's threefold role as colleague, instructor and representative of the patient's perspective. The discussion ended with the group's most experienced

instructor proposing to revise the preparatory lecture to focus more on team members' roles and interactions. No attention was given to questions regarding patient participation.

Discussion

The primary concern among the local stakeholders was that increased focus on the patient as a subject during critical phases of emergencies might negatively impact the objectifying tasks, the "assessments and management." This is a common concern. An interview study in a US emergency department showed that "personalising the patient" through allowing family members to be present during resuscitation was deemed by professionals to influence their work in an ambiguous manner [39]. A recent review, however, concludes that family presence does not adversely affect the efficiency of trauma resuscitation and should, therefore, be encouraged [40]. The significance of relating to the patient as a *person* during critical phases of medical emergencies has not yet been explored, either within "Patient Centred" or "Person Centered" medicine. Recent studies of distress-induced responses suggest, however, that it may be wise to include this perspective [27,41-43].

The stakeholders stressed the necessity of acting first with a "cool mind" and responding only afterwards with a "warm heart," with regarding the patient as a *person*. The transcripts from the trainings, however, reveal that the participants' "cool minds" and "warm hearts" were often expressed within the same sequence. Such rapid shifts were also observed during the simulations, indicating that the challenge is to achieve a proper balance between detached and engaged behaviour. This corresponds with Skjervheim's [37] claim that any social action involves people acting *both* as participating subjects *and* as objectifying observers. We believe this phenomenon to be underestimated in emergency medicine. This raises questions about how such insights might be integrated into training.

Documentation of the benefits of patients' engagement in their own healing is increasing, for example, in studies of patients' will to live [44], of involvement in decision-making during obstetric emergencies [27] and of appraisal of information in the acute phase of myocardial infarction [42]. Patient participation has also been associated with improvement of biomarkers of chronic diseases [45,46]. Such empirical evidence, as well as legal and ethical considerations, justifies considering whether and how, team training might involve the patient in an appropriate way. The preparatory lecture and de-briefing sessions could, for example, explicitly acknowledge the patient as a *person*, as endowed with unique values and competencies. The special attention paid to the *patient*-instructor's voice would suggest that patient competence is already acknowledged, though not yet named or thematised.

The stakeholders tended to voice their own needs to evaluate and take care of themselves. However, when these professionals were asked about their emotions during the de-briefings, only a few were able to be specific. They spoke almost exclusively of "stress," although such well-known bodily reactions to stress as increased heart rate and trembling hands [47] were never mentioned. Might the participants' consistently objectifying professional stance extend to include their relationship to their own emotional responses, perhaps as a coping strategy? If so, one might ask how well that functions for them. Team training settings could provide time and space to include *both* patients *and* interacting professionals as persons so that more flexible, robust and appropriate coping strategies could evolve.

Systematic, organised group reflections on interaction are not common within primary care; our team training sessions were thus somewhat unusual settings for the participants. Unique discourses and patterns of behaving, thinking and speaking may well emerge from these sessions, most obviously during simulations, where time is *not* a critical factor. The challenge inherent in one situation was how to handle a person with an injured spine *gently*. The professionals had difficulty, however, shifting their perspective from needing to keep up a fast pace to allowing a slower and more gentle approach, despite reminders coming from a simulated dispatch centre. Just as in the case mentioned above, where enduring habits were formed during trainings using mannequins, the expectations and experiences engendered during these team trainings might also have a long-term impact. Learning acquired during challenging experiences, such as team trainings or real emergencies, can carry over into less dramatic or demanding settings.

The Norwegian regulations regarding training of interaction in primary care [3] are worded in a problematic way; they apply only to professionals. Similarly, the emphasis observed in a Norwegian focus group studying how physicians interpret the term "interaction" [48] was on structural issues and professional competence, rather than on exploring relational aspects in general or relationships to patients in particular. This is consistent with what was found in the previously mentioned plans, procedures and regulation documents [30-32] as well as in our transcripts. Our analysis showed the dominant discourse to be biomedical; whenever the patient was the topic, the majority of statements rendered her or him a *biological object*. We assume that the participating professionals, the first author included, regarded this particular type of reasoning and language as being most appropriate, precise and efficient. Even the patient-instructors contributed to maintaining this tendency by speaking primarily in their role as instructor; they spoke from the position of the patient, to whom they were lending their body and receptivity, only when they were explicitly invited to do so. The dominant medical discourse placed the patient in a less central position than we reckon to be beneficial for mobilising her or his resources. In short: the voice of medicine [49,50] overpowered the voice of the patient, even when her or his presence was explicitly acknowledged.

The strengths of the study's design were: a framework facilitating inter-professional praxis-near explorations and the opportunity to participate in and facilitate change, as

well as the "thick descriptions" [51], made possible by inclusion of most of the local professionals throughout a 1-year training program. As an action research project, the limitations were the limited time available to observe any improvements and the less than ideal degree of local participation since the first author herself had formulated the research question. The study participants had been informed about our intentions to investigate their interactions during simulations by means of their own reflections. Presenting our preliminary findings concerning the *participating patient* to the stakeholders represented, in a sense, a "breaching experiment" [36]. Such "trouble making" in everyday settings can, however, make clear where the blind spots are in what otherwise seems well known - a first step toward change.

Conclusions

Our analysis indicates that reflections on simulation training in primary care emergency teams are framed predominantly in a language that objectifies both the patient and the professionals. Even those professionals who lend their bodies to represent the patient during simulations contribute more to language *about* the patient than they do to providing the patient a voice. The local stakeholders were ambivalent about increasing the focus on the patient as a person when it was not of clear benefit to the patient and when it might impact negatively on "assessments and management" during the most critical phases. However, the prevailing objectifying language may well suppress insights that patient participation could potentially prove beneficial for both patients and professionals as persons, those who share the crisis in emergencies. The powerful structures underlying the demonstrated dominance of the voice of medicine over the voice of the patient's lifeworld can not be altered simply by the revision of team training practices alone. This power is being challenged by medical science itself as a growing body of evidence emerges regarding the beneficial impact of patient involvement. For future improvement, current emergency team trainings, characterised by increasing medical sophistication and professional competence, ought also to be enriched by increased focus on the role of the patient.

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