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E.R. Patients Often Left Confused After Visits

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A vast majority of emergency room patients are discharged without understanding the treatment they received or how to care for themselves once they get home, researchers say. And that can lead to medication errors and serious complications that can send them right back to the hospital.

In a new study, researchers followed 140 English-speaking patients discharged from emergency departments in two Michigan hospitals and measured their understanding in four areas — their diagnosis, their E.R. treatment, instructions for their at-home care and warning signs of when to return to the hospital.

The study, published online in July by the Annals of Emergency Medicine, found that 78 percent of patients did not understand at least one area and about half did not understand two or more areas. The greatest confusion surrounded home care — instructions about things like medications, rest, wound care and when to have a follow-up visit with a doctor.

“We’re finding that people are just not prepared for self-care, and that’s what is bringing them back,” said Dr. Eric Coleman, director of the Care Transitions Program at the University of Colorado, who was not involved in the study.

The researchers described a woman in her 20s who went to the emergency room with abdominal pain. After extensive testing, doctors there diagnosed pelvic inflammatory disease, a sexually transmitted infection.

But when interviewed by a researcher, the woman said that she was not aware of any diagnosis, that she did not realize she had been sent home with an antibiotic (she took only the pain medication she was given), and that she did not know she should abstain from sex, tell her partner or have follow-up care.

“The risk is that she could become more seriously ill,” said one of the authors, Dr. Kirsten G. Engel, a clinical instructor at Northwestern University. “It’s a significant risk to her fertility, and she could pass it to her partner.”

Dr. Paul M. Schyve, senior vice president of the Joint Commission, the main organization that accredits hospitals, said: “This study showed that this is much more common than you think. It’s not the rare patient.”

Similar results have been found for patients leaving hospitals, not just emergency rooms. And experts say they help explain why about 18 percent of Medicare patients discharged from a hospital are readmitted within 30 days.

Doctors and patients say that with hospitals pressed to see more patients faster, patients get less attention. “When I start my shift, I know what I’d like to accomplish, but by the end of the shift, my main concern is that nobody dies, and the other things become less important,” said Dr.

Michael S. Radeos, research director in the department of emergency medicine at New York Hospital Medical Center of Queens.

Jaleh Teymourian Brahms of Millburn, N.J., ended up in the emergency room after falling face down on a street in Manhattan. “I had pavement embedded in my face and two chipped front teeth,” she said.

After being examined for broken bones (there were none), she waited four hours before she was discharged, with bits of pavement still embedded in her face. Ms. Teymourian Brahms said she received no instructions about how to care for her face. Her dentist had to pick the tar and gravel out with a dental tool, then instructed her on how to clean her face and to keep it moist with an antibacterial ointment.

“I risked a nasty infection had I not seen him,” she said.

Everything is exaggerated in the emergency department. Doctors are harried, they have little time to go over complicated information and they do not know the patients. Most patients are anxious, upset and not likely to be thinking clearly.

“These factors do not make for the best environment for someone to absorb information,” Dr. Engel said.

The problem is particularly acute when it comes to drugs. A patient-education program used in 130 health delivery systems across the country found that about 40 percent of patients 65 or

older have a medication error after they leave the hospital. A 2006 report by the Institute of Medicine found that doctors and nurses were contributing to these errors by not providing information in an effective way.

“The physician’s ability to predict whether a patient understands isn’t as good as can be,” said Dr. Rade B. Vukmir, an emergency physician at the University of Pittsburgh and spokesman for the American College of Emergency Physicians.

In the past, patients who did not follow discharge instructions were often labeled noncompliant. “Now, it’s being called health illiteracy,” Dr. Coleman said, adding that as many as half of all patients are considered to lack the ability to process and understand basic health information that they need to make decisions.

But the patient is only part of the equation, he continued; doctors are notoriously inept at communicating to patients.

The new study found that people were not aware of what they did not understand, suggesting that simply asking a patient if he understands is not enough.

“We’re good at saying, ‘Here’s the information, any questions?,’ ” Dr. Coleman said, “and the person nods his head, but they don’t get it.”

Older patients are particularly vulnerable. “They have the kinds of communication barriers we might expect, with vision and hearing problems,” said Dr. Susan N. Hastings, an instructor in geriatrics at Duke. The hectic environment of the emergency department can be particularly

stressful for them.

Until recently, poor communication was largely ignored by hospitals. “Just a few years ago, there were subtle incentives for hospitals to not get involved in this area, because of financial gains when people come back,” Dr. Coleman said.

But hospitals are now being forced to face their communication inadequacies. “We’ve raised the bar of what’s expected of hospitals,” said Dr. Schyve, of the Joint Commission. At the same time, the Medicare Payment Advisory Commission, a government agency that advises Congress on Medicare issues, has recommended a policy change that would reduce payments to hospital with excessive readmission rates. It has also asked Medicare to allow hospitals to reward physicians who help lower readmission rates.

Experts in doctor-patient communication recommend a “teach back” approach, in which the patient, preferably accompanied by a relative, friend or caregiver, has to repeat the instructions back to the doctor.

“No matter what you put in writing, what diagrams you have, you really can’t be confident that patients understand what they should be doing unless you have them repeat it back to you,” Dr. Schyve said.

Dr. Vukmir, of the emergency physicians’ group, recommends a “dual discharge” approach: the physician talks to the patient about the results, treatment plan and follow-up care. Then a nurse follows up with computerized discharge instructions.

But Dr. Coleman believes this is not enough. “A third of people over 55 have impaired executive cognitive function,” he said, adding that such patients might understand their medications and know when to take them, but fail to follow through.

He recommends that hospitals coach patients on self-management skills before discharge. Patients need to ask questions, he said. Hospitals should make follow-up calls and visits to patients, a costly endeavor but potentially less expensive than getting reduced Medicare payments if readmission rates are high.

“Hospitals need to have some accountability for the no-care zone, the period between when you leave the emergency department or hospital and when you get into your primary care setting,” Dr. Coleman said. “They should be available for 72 hours.”