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Characterizing Emergency Department Discussions about Depression

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Abstract

Background: The reality of emergency health care in the United States today requires new approaches to mental health in the emergency department (ED). Major depression is a disabling condition that disproportionately affects women.

Objectives: To characterize ED provider–patient discussions about depression.

Methods: This was a secondary analysis of a database of audiotaped ED visits with women patients collected during a clinical trial of computer screening for domestic violence and other psychosocial risks. Nonemergent female patients, ages 18–65 years, were enrolled from two socioeconomically diverse academic EDs. All audio files with two or more relevant comments were identified as "significant depression discussions" and independently coded using a structured coding form.

Results: Of 871 audiorecorded ED visits, 70 (8%) included discussions containing any reference to depression and 20 (2%) constituted significant depression discussions. Qualitative analysis of the 20 significant discussions found that 16 (80%) required less than 90 seconds to complete. Ten included less than optimal provider communication characteristics. Despite the brevity or quality of the communication, 15 of the 20 yielded high patient satisfaction with their ED treatment.

Conclusions: ED providers rarely addressed depression. Qualitative analysis of significant patient– provider interactions regarding depression found that screening for depression in the ED can be accomplished with minimal expenditure of provider time and effort. Attention to psychosocial risk factors has the potential to improve the quality of ED care and patient satisfaction.

Keywords

depression, emergency medicine, mental health, health care communication

Comments

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According to the World Health Organization, the number of years of productive life lost to disability and mortality stemming from major depression ranks fourth among all global diseases.[1] Nearly 17% of all Americans will experience major depression at some point in their lives, with women experiencing major depressive episodes at twice the rate as men.[2,3] It is now widely understood that individuals with mental health concerns and no source of primary health care often present to emergency departments (EDs).[4] Appropriately, emergency medical training includes a focus on screening patients with self-injurious behavior, assessment for immediate suicide risk, and referral of nonsuicidal patients for outpatient care,[5] although access to mental health services following an ED visit is frequently lacking. Another understandable source of both provider and patient frustration, patients with chronic pain and somatic complaints frequently experience depression and are high utilizers of emergency care.[6] Research in primary care finds improved biological outcomes when providers identify and address the psychiatric conditions that contribute to patients' somatic complaints.[7] Surprisingly, given the high prevalence rates, we could find no research on ED provider–patient interactions regarding depression. The goal of this study was to qualitatively characterize the nature of ED provider–patient discussions of depression.

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METHODS

Study Design

We conducted a secondary analysis of audio data collected between June 2001 and December 2002. The goal

of the parent study was to examine the impact of a computer-based health risk survey on provider–patient communication about domestic violence.[8] Because of the higher incidence of domestic violence victimization among women, the parent study was limited to female patients. Patients and providers signed written consent, and both hospital institutional review boards approved the protocol.

Study Setting and Population

The study was conducted at two socioeconomically diverse sites: an urban academic medical center and a suburban community hospital. The urban academic ED served a predominately publicly insured, inner-city, African American population. The suburban community hospital ED served a privately insured, suburban, white population. Both EDs are part of the same emergency medicine residency training program. Women aged 18–65 years, triaged as nonemergent, were sequentially recruited from the ED waiting rooms for a study of physician–patient communication. This study is a secondary analysis of the audio (N = 871) recordings from the parent study and computerized health risk survey (n = 486),[8] focusing on the subset of patients who had any discussions with their emergency provider (40 attending physicians, 46 residents, and four nurse practitioners) pertaining to depression.

Study Protocol

Consenting patients were assigned an intravenous pole with an attached box containing a digital audio recorder. The audio recorder remained in the room with the patient for the duration of the visit. The audio files were subsequently edited by using WaveLab 3.0 (Steinberg Media Technologies GmbH, Frankford, Germany) digital editing technology to remove all names, dead space, and non—provider–patient conversations. All 871 audiotapes were initially coded (coding sheet available in Appendix A as an online Data Supplement at http://www.aemj.org/cgi/content/full/j.aem.2007.06.042/DC1) for any remark, by physician or patient, referring to depression. Discussions about depression that contained two or more relevant depression comments were identified as "significant depression discussions" and targeted for detailed qualitative analysis.

The structured coding sheet for the analysis of all significant depression discussions was iteratively developed through a combination of group listening, discussion, and comparative coding until 100% agreement was reached on all variables, a well-accepted qualitative research technique.[9] Notably, all three coders (KVR, HMK, EP) had extensive experience in clinical psychology.

Coding focused on the length and context of the depression discussion, noting what questions, comments, and open-ended opportunities to talk were offered by the provider. We characterized the physician's communication style by coding positive characteristics (i.e., pauses for the patient to answer, conveys empathy or concern, uses well-worded and sensitive questions, discusses treatment modalities) and less than optimal communication characteristics (i.e., frames questions in the negative, minimizes patient's concerns, conveys judgmental attitude, asks multiple questions in a single utterance, interrupts the patient). We coded the patient's response to the physician's questions and noted whether and how she responded to the provider's probing. Patient satisfaction was assessed with an exit questionnaire.

Data Analysis

The results of the qualitative coding were entered into a database and analyzed descriptively to characterize overall interactions and the relationship between any psychosocial discussions with patient satisfaction using Stata SE version 9.0 (Stata Corp., College Station, TX). Because the number of significant depression discussions was low, no attempt was made to perform multivariable analysis or other statistical tests. Instead, we focused on characterizing the overall interactions.

RESULTS

Of the 486 patients who took the computer health risk survey (mean age, 32 years; 60% were African American, 60% had greater than a high school education, 51% were privately insured), 48% screened positive to feeling sad or depressed for more than two weeks in the past year. A total of 135 patients (28%) answered "yes" to "In the last two weeks, have you been sad or depressed most of the time?" and "yes" to at least one out of five of the following questions: change in appetite, feeling tired or without energy, feeling worthless or guilty, having trouble concentrating, or having thoughts of self-harm or suicide. Thirty-one (6%) said they had recent thoughts of hurting themselves or committing suicide.

Of the 871 audio-recorded ED visits, 70 (8%) included discussions containing any reference to depression and 20 (2%) constituted significant depression discussions. Table 1 shows the frequencies of coded depression discussion characteristics. Most (n = 16 [80%]) of the significant depression conversations were less than 90 seconds in duration. Notably, there was a wide range of discussion duration (<30 seconds to 25 minutes) due to a few extensive discussions. The content ranged from a couple of brief questions to extensive conversations that addressed psychosocial correlates to physical complaints.

Provider interpersonal skills varied widely. In half of the significant depression discussions (10/20 [50%]), a provider used at least one suboptimal communication characteristic, including dismissing the patient's concerns, conveying a judgmental attitude, asking multiple questions in a single utterance, interrupting the patient, or failing to communicate due to a language barrier. Furthermore, in a significant number of discussions (5/20 [25%]), questions were framed in the negative.

Positive communication characteristics were evident as well. In most discussions (17/20 [85%]), providers conveyed at least some empathy (defined generously, including any slight indication that the provider wanted to help the patient). In all discussions, providers offered open-ended questions and paused for the patient to answer, and in most (18/20 [90%]) providers used well-worded and sensitive questions when inquiring about depression. Despite the brevity or quality of the communication, 15 of the 20 yielded high patient satisfaction with their ED treatment. Representative examples of ED provider–patient

Table 1
Provider and Patient Characteristics of the Significant Depression Discussions

Characteristic	Significant Discussion, *n* (%)
Complaint (*n* = 20)	
Medical	13 (65)
Gynecological/urinary	4 (20)
Injury	2 (10)
Psychological	1 (5)
Duration of first discussion	
<30 seconds	8 (40)
30 90 seconds	8 (40)
>90 seconds	4 (20)
If more than one discussion, total time spent (min), mean (SD)	4.5 (7)
Context of discussion during HPI or social history vs. other	15 (75)
Indication that provider connects ED visit to psychosocial concerns	10 (50)
Provider (*n* = 20)	
Offers open ended opportunities to talk (average or better)	20 (100)
Responsive to direct or indirect patient cues (average or better)	19 (95)
Conveys empathy, concern (average or better)	17 (85)
Well worded and sensitive questions (average or better)	18 (90)
Discusses psychiatric symptoms other than of depression	10 (50)
Symptoms of depression used to discuss depression	7 (35)
Effort to determine origin of psychosocial distress	10 (50)
Pauses for patient to answer	20 (100)
Uses therapeutic reflections	7 (35)
Collaborative relationship	16 (80)
Counseling discussed	10 (50)
Psychotropic medication discussed	10 (50)
Other positive characteristics*	6 (30)
Frames questions in the negative	5 (25)
Other negative characteristics†	10 (50)
Missed opportunity: patient positive for depression, no follow up	8 (40)
Patient (*n* = 20)	
Patient's mental health concern	
Depression or sad mood	14 (70)
Anxiety, stress, panic	10 (50)
Other	5 (25)
Discloses mental health concern before provider asks	6 (30)
Discloses psychotropic drug use before provider asks	7 (35)
Responds comprehensively to provider's prompts	16 (80)
Connects mental health concerns to current medical complaint	9 (45)
Uses humor	5 (25)
Mental health concerns are in the past or not currently salient	5 (25)
Dissatisfaction with treatment, provider, hospital	5 (25)
Other patient characteristics‡	13 (65)
Suicide discussion, *n* = 11 (55%)	
Provider probes for suicidality	11 (100)
Suicide brought up dismissively or in the negative ("You're not suicidal, are you?")	4 (36)
Patient's response	
No	6 (55)
Only in the past	4 (36)
Yes, currently	1 (9)

HPI = history of present illness.
* Includes using humor and discussing treatment modalities in addition to medical and psychological (i.e., yoga, exercise, diet).
† Includes minimizing or dismissing psychosocial concerns, having a shaming or judgmental attitude, asking multiple questions in a single utterance, interrupting the patient, or not being able to communicate due to a language barrier. Each of these occurred in less than 25% of significant discussions.
‡ Includes the patient using recreational substances (self medicating), having an awkward or embarrassed affect during discussion, minimizing one's own symptoms, disclosing a concern about insurance, or attempting to change the topic. Each of these occurred in less than 25% of significant discussions.

interactions are presented in Appendix B as an online Data Supplement (available at http://www.aemj.org/cgi/content/full/j.aem.2007.06.042/DC2). Patients with any discussion of psychosocial issues were more likely to rate their satisfaction with the visit as very high (59% vs. 48% for those without psychosocial discussions).

DISCUSSION

This qualitative analysis of physician–patient interactions provides insight into mental health care delivery in the ED setting. ED providers rarely addressed depression, even when prompted by the computer to do so. When

they occurred, most depression discussions between emergency physicians (EPs) and patients were brief and focused on immediate risks. If a patient was experiencing depression and the EP identified this, those who explored the symptoms did so in less than 90 seconds. In fact, most EPs ruled out severe depression or suicide risk in less than 30 seconds.

While the ED may not be an ideal place to deliver acute mental health care, this study supports the feasibility that EPs can identify, and at least superficially address, some underlying psychiatric issues. For those presenting with clearly somatic complaints, it may be worthwhile to help patients make the connection between their mental and physical health. In our limited sample, this technique seemed to be well received by patients.

Of interest, "successful" interactions pertaining to mental health (i.e., those in which the patient is given space to elaborate upon her mental distress if she chooses, or in which substantive information is communicated about possible links between psychiatric and somatic complaints) did not necessarily require much time or particular finesse on the part of EPs. Based on patient response, EPs did not need to express more than minimal empathy to engage patients in positive psychosocial interactions. Felitti et al. demonstrated that looking beyond physical problems can provide an opportunity to direct patient care inward and also yields rich data sources for future research.[10] In retrospect, it would have been beneficial to have explored whether the patients who had mental health concerns addressed even briefly during their visit were more likely to leave the ED feeling that their concerns were addressed and, if so, whether this increased adherence to treatment recommendations. Likewise, future studies should determine whether a brief, straightforward EP–patient discussion that connects psychiatric and somatic conditions might effectively decrease the likelihood that the patient returns to the ED.

LIMITATIONS

Audiotaping of provider–patient visits has the potential for a Hawthorne effect; however, we believe the data presented provide some useful insight into the actual content and quality of provider–patient discussions of depression. We lacked "respondent validation," which would have bolstered the qualitative aspect of our research. Likewise, follow-up data on whether brief ED discussions about mental health issues decreased future ED use for somatic complaints, or resulted in linkage to appropriate resources, would have added value to the current study. Although we collected data at two socioeconomically diverse EDs, we only studied female patients, and both EDs are part of one residency program. Therefore, our assertion that addressing depression during emergency care may improve patient outcomes remains speculative and a source for future studies.

CONCLUSIONS

The topic of depression is rarely addressed during ED visits. Qualitative analysis of patient–provider interactions regarding depression showed that even minimal attention to psychosocial risk factors has the potential to improve the quality of ED care and patient satisfaction. More work is needed to determine the best methods for addressing both depression and somatic complaints with strong psychosocial components in the acute care setting.

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