THE IMPACT OF NON-MEDICAL VARIABLES ON EMERGENCY WARD TRIAGE

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L A K E H E A D U N I V E R S I T Y

T H U N D E R B A Y

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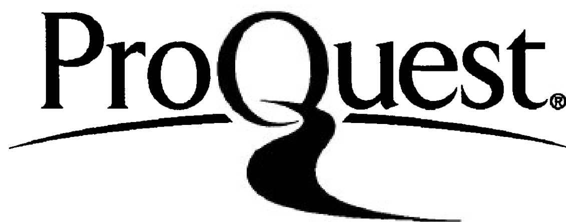

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ABSTRACT

This research, based on four periods of participant observation in the Emergency wards of the Royal Victoria Hospital of Barrie and the Port Arthur General Hospital of Thunder Bay, focuses on how patients are perceived and treated by the staff. The staff place patients into triage categories of 'nuisance', 'urgent', or 'emergency' and treat these patients as members of a category instead of as individuals. These categories cannot be adequately understood by examining the patient's ailments, since similar ailments are often categorized differently. Thus, a fuller understanding requires an examination of the way members of each category are perceived and treated by staff.

'Nuisance' patients are not believed to be ill and consequently are assigned a low priority in terms of the speed with which they are treated and the personnel and resources allocated to them. 'Urgent' cases are seen as being sick enough to justify being in the ward and are of middle priority. 'Emergency' patients are perceived to be dying, are treated in the operating room, and are given top priority.

Patient categorization is also based on a moral dimension. Patients who are friends of the staff or are

recognized as prominent citizens receive preferential treatment. On the other hand, patients who frequently visit the ward with minor problems receive slow treatment and are assumed to be suffering from the 'same old problem'. The majority of patients, who are not known by the staff are grouped into moral/medical categories of 'good', 'stupid', 'negligent' and 'self-abusive' according to the cause of their ailments and what they did about it once it occurred. Each category receives a particular type of treatment.

The staff take into consideration a number of conditions which, while not directly related to medicine, are felt to be important. Demand characteristics such as the types of patients who are treated, the volume of patients, the way doctors cover the ward and how doctors use the ward influence the way records are kept, where patients are placed in the ward, the workload of the staff and so on. While these demand characteristics do not 'determine' any of the ward routines, in certain situations the staff take them into consideration.

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CHAPTER I

INTRODUCTION

The hospital Emergency ward is used by a large segment of the population. Yet, despite its popularity and importance, there is very little literature which deals with how the department operates and almost no literature about Canadian Emergency wards. Before we can speak about Canadian Emergency wards, a fundamental understanding of particular Emergency wards must be gained. The goal of this paper is to make a start toward understanding Emergency wards by analysing two Ontario Emergency departments.

The setting for this thesis is the Royal Victoria Hospital emergency ward (Barrie) which was studied for two periods (48 Shifts) during 1977. The Emergency Ward of Port Arthur General Hospital of Thunder Bay was also studied for two periods (16 shifts) during 1977 and 1978 in order to gather additional data. While these two settings are different in many ways, they are similar in the fact that they are both public hospitals funded by the Ontario government, are both approximately the same

size (250-300), and are both staffed by community physicians instead of residents. By comparing and contrasting these wards, a sense of the uniqueness as well as similarities can be gained.

The general goal of this paper is to study the way the Emergency ward staff view their job, their patients, and how they process patients. In order to learn what the staff actually do and how they organize the ward, I entered the setting as a participant observer. Inherent in this type of research are numerous problems, many of which cannot be answered completely or to the satisfaction of a quantitatively oriented sociologist (Chapter 2). In the final analysis I use this research method, not because it is 'better' than others but because it provides the best way of getting at how the staff actually assess and treat patients.

The literature about Emergency wards is both helpful and frustrating (Chapter 3). One important fact gleaned from the literature is that nurses are trained to assess the severity of ailments. This process, called triage, is necessary since serious cases require immediate attention and minor ailments can safely wait for treatment. Patients are grouped into 'nuisance', 'urgent', and 'emergency' categories. Although numerous writers attempt to 'define' these categories, in the end they all fall back

on common-sense definitions.[1] In short, among the writers there is little agreement as to what emergency, urgent, or nuisance cases are.

In order to develop the meanings of triage categories, I draw heavily on the work of David Sudnow (1965; 1967). Sudnow's findings that juvenile officers categorize typical cases into 'normal' categories and then treat the individuals as members of a category, is similar to the way that patients are processed in the Emergency ward. The nurses, like the juvenile officers are accustomed to certain types of ailments and patients, and have standardized ways of handling each type of patient. These categories cannot be defined by merely examining the types of problems which compose them, but must be understood through an examination of how the staff perceive and treat the different categories of patients (Chapter 5). For example, patients who boldly violate the NO ADMITTANCE sign at the front of the Emergency ward are perceived as seriously ill irrespective of their ailment.

Each type of patient is perceived in a certain way, treated in a specific area, has a priority, and is treated in a particular manner. Each category also represents a potential source of trouble and the staff organize the ward and their routines in order to neutralize or minimize the impact of these problems.

There are an important group of conditions (demand characteristics - Chapter 4) which, while outside the control of the Emergency ward staff, have a significant impact on how the department operates. While demand characteristics do not cause any of the ward routines in a deterministic way, they are often considered by the staff to be important and consequently provide an explanation for some of the ward practices. The types of patients who use the ward and the volume of patients processed, influence not only the normal categories used by the staff but also the routines of the staff. Other demand characteristics such as the way doctors use the ward and how they provide medical coverage for the department are also important, for they affect the 'busyness' of the staff and how the medical personnel go about treating patients.

There has been a lot of research done which shows the importance of socio-economic status on the way one is treated in public institutions. While I observed some instances where dress, mannerism, race, nationality, language and so on seemed to influence treatment, these are less important than another set of variables which influence the moral evaluation of the patients by the staff (Chapter 6). Patients such as friends and recognized civic leaders, who are known to the staff, receive rapid and special treatment in the ward. On the other hand, 'repeaters' who frequently use the ward because of minor problems are assumed to be suffering from the same problem which always

brings them in and receive very slow treatment. Thus, being known can result in either very fast or very slow treatment.

Patients who come into the ward and are not known to the staff, are also assessed on moral grounds. This assessment is based in large part on how their ailment occurred and what they did about it after it happened. Patients are grouped into moral/medical categories of 'good', 'stupid', 'negligent', and 'self-abusive' and are treated as membersof that category rather then on an individual basis.

In the concluding section of the paper (Chapter 7), the findings of the research are summed up, possible shortcomings are noted, suggestions for further research are made, and problem areas in Emergency ward treatment are pointed out. Before a more comprehensive understanding of Emergency wards can be claimed to exist there are many issues which must be explored and understood. This thesis, while not covering all aspects of the ward, attemtps to provide a valuable starting point for further Emergency ward research.

In conclusion, I would be remiss if I did not acknowledge my tremendous debt to the staff of the wards which were studied. This thesis is about these people, how they perceive their patients and job, and how they process patients. The staff were willing to allow me into their workplace, providing all the help that could

possibly be expected while knowing all the time that I might write things about them that would not be complimentary. This paper exists as testimony to their willingness to risk criticism in the hopethat I might uncover things which would help them do a better job in treating patients.

CHAPTER II

RESEARCH DESIGN

Field research, while not the major technique of sociology is becoming more popular. This research technique is defined by Howard Becker as a situation in which the researcher,

> gathers data by participating in the daily life of the group or organization he studies. He watches the people he is studying to see what situations they ordinarily meet and how they behave in them. He enters into conversation with some or all of the participants in these situations and discovers their interpretations of the events he has observed.
>
> Becker 1958:652

Aaron Cicourel's definition of the process, combined with that of Becker provides an excellent picture of this data collection method.

> We define participant observation as a process in which the observer's presence in a social situation is maintained for the purpose of scientific investigation. The observer is in a face-to-face relationship with the observed and by participating with them in their natural life setting he gathers data.
>
> Cicourel 1964:41

Participant observation makes use of observational ability which is common to all members of the society. However, unlike the observation done by members, participant observation is, "not a casual or accidental method of accumulating data . . . but rather is a rigorous and demanding process" (Fish 1971:18-2). The participant observer is in the setting for one purpose: observation. While in the field, his major task is to record how members function while at their jobs.

The increasing popularity of participant observation is in many ways not surprising. It is generally agreed that, "participant observation gives us the most complete information about social events" (Cicourel 1964:76). While the depth of this data is excellent, the method has been largely ignored for it is considered too 'soft', subjective, unsystematic and difficult to replicate.

In recent years, participant observation has gained popularity due to criticisms that have been levelled against survey research. Garfinkel, Cicourel, Sudnow and other ethnomethodologists have shown that what sociologists have studied has often been taken for granted. The ontological fallacy which has plagued much of social research is well illustrated in Cicourel's book, The Social Organization of Juvenile Justice (1968). He shows that juvenile delinquency

rates are the product of the everyday activities of police officers. His research calls into question the value of studies of causes of juvenile delinquency or the frequency of crime. Statistics are not meaningful without an understanding of how they are created. He challenges the belief that crime rates reflect what actually goes on in the world and shows instead, that these rates indicate how the officers do their job, not how many juveniles commit crime.[2]

> The meaning of official statistics therefore, must be couched in the context of how men, resources, policies, and strategies of the police, for example, cover a given community, interpret incoming calls, assign men, screen incoming complaints, and routinize reports. It is necessary to seek an organizational context for understanding how law-enforcement justifies practices which may have little to do with the implied rationality of ideas of legality and justice abstractly discussed by legal theorists.
>
> Cicourel 1968:28.

Participant observation appeals to me for a number of reasons. Firstly, I acknowledge my ignorance of Emergency wards. Because of this ignorance I am, "interested in understanding a particular organization . . . rather than demonstrating relationships to make research theoretically meaningful" (Becker 1958:658). My goal is to gain an understanding of what-really-goes-on in the setting, for without this, any conclusions I reach will be largely meaningless. "I do not know enough about the

organization *a priori* to identify relevant problems . . . and they must be discovered in the course of research" (Becker 1958:652).

Participant observation provides the best way, "of discovering the rules employed by the actor for managing his everyday affairs" (Cicourel 1964:5). By observing people as they engage in everyday life, the researcher can observe this ordering. Since this is the focus of my research, participant observation provides the best way of observing,

> persons in everyday life as they order their environment, assign meaning or relevancies to objects, and base their social activities on commonsense rationalities.
>
> Cicourel 1964:61

"Sociology must ultimately be measured by its ability to say and analyse 'what goes on'" (Cicourel 1964:18). This simple statement provides the primary reason why I chose participant observation as my data collection method. In choosing this method, I should be able to say 'what-actually-went-on' in the ward.

Research based on surveys and interviews tells us what people say they do, what they think they do, what they are supposed to do, what they do, or any combination of these. Such research makes the crucial assumption that what people say they do or think is in fact what-really-

goes-on. Such data however is gathered in a setting that has a significant effect on what the members report. Variables such as the age and sex of the interviewer influence the responses that are gathered (Cicourel 1964:74-80). The problem is intensified by the fact that the difference between what people say they do and what they actually do is something that cannot be adequately measured or controlled for. The problem is similar to that of intelligence tests. Whereas the I. Q. test tells us only how well an individual scores on an I. Q. test, a survey or questionnaire tells only how a respondent answered a set of questions.

Participant observation requires that one "participate in the daily life of the group under study" (Becker 1958:652). My participation was conducted in four stages. The Barrie Hospital was studied for 29 shifts in July and August and for 19 shifts in December of 1977, and the hospital in Thunder Bay was observed for eight shifts in December and an additional eight shifts in the following February.[3] The research in Barrie was much more intensive than that in Thunder Bay. The reason for this is that Thunder Bay served largely as a check on my Barrie study. Because of greater exposure to the field, higher patient turnover, and better penetration of the field, Barrie became the major focus of my study. The relationship between the two studies is similar to that of Sudnow (1967)

who analysed County Hospital in detail and occasionally used Cohen Hospital as a secondary data source.

Researcher Role in the Field

Every researcher who enters the field acquires a role in the setting under study. "In part the field worker defines his own role; in part it is defined for him by the situation and the outlook of the natives" (Cicourel 1964:41). The role he is given or acquires will influence both his acceptance by the members and also the data to which he will have access.

In both hospitals, permission for the study was granted by the hospital administrator. In Barrie, the administrator was approached directly and granted permission after he had consulted with the nursing supervisor and the head nurse of the ward. The only condition attached to this entrance was that patients' names would not be reported.

The initial contact in Thunder Bay was with the head nurse of the ward. She was presented with a copy of the thesis proposal and then pleaded my case before the administrator. The vaguely stated conditions of this entrance were that I not bother the patients and not look at any medical records. These conditions had little effect on my actual research. No one in the ward cared if I looked at

the records; in fact, the staff occasionally offered them to me. Patient contact, although not pursued, was an inevitable consequence of my presence in the ward. Thus in actual fact, there were no limitations to my research except in involvement of myself in personal examinations by doctors.

My role in the ward is similar to that of an anthropologist who is studying a foreign society. I was,

> accepted by the society but seldom, if ever fully integrated into the society except in terms of the special status and role which the society might give to that observer.
>
> Fish 1971:18-2

If one uses Junker's four roles of field research (Junker 1952), then I was an observer-as-participant. The ward staff knew that I was in the ward to observe them and my presence was very obvious. Other legitimate members of the setting interpreted my presence in a number of ways. A couple of doctors addressed me as an ambulance attendant. Other doctors viewed me as an orderly and expected appropriate behaviour from me. My wearing of a white lab coat resulted in patients thinking I was a staff member and one to be asked about aspects of the ward or medicine. In short, the lab coat identified me as a legitimate member of the setting to the patients and as an ambivalant something to the doctors.

Stages of Field Research

In both wards, I went through an initial stage where I was questioned and artificially 'accepted'. The staff offered information that they thought would be 'helpful'. Interspersed with this help were questions about what I was really doing in the ward. They were constantly offering definitions of my research such as, "You're here to improve things" or, "Are you here to see how well we do our job?" During this stage there was little certainty of what I was 'really' doing in the ward and what I was researching.

The doctors were much more skeptical about my presence than were the nurses. The doctors that I saw on more than one occasion came to me, introduced themselves, and asked who I was and what I was doing in the Emergency ward. No matter my answer, whether it was specific or general, technical or loose, they criticized it and offered negative comments. They seemed to feel that they must criticize my research. It was as if they had to prove to themselves and those in the area that they were intellectually superior to the researcher. In subsequent encounters they were friendly and offered no further comment on my study or about my presence in the ward.

Over time, the attitude of the staff to my presence went through a gradual change. At first my presence

was questioned. The staff were happy to answer questions and often offered information. They behaved in the 'proper' way and offered 'good' answers to my questions. In the instances where I overheard or saw something that was not 'correct', a staff member explained this occurrence by telling me that such action was undesirable but necessary or that the action was improper and would be corrected.

After a short period of time (three shifts), I entered a second stage when the staff consciously rejected me. During this period I was ignored and talked around. This is not to say that the staff were not aware of my presence, for a great deal of data was offered to me but almost always in an indirect manner. Many of the conversations which I overheard were artificial and one nurse would explain to another some event in such a way that I could not help but overhear it. However, the staff were not particularly friendly, ignored me, and were very obvious in their attempts to show that I was 'in the way'.

Once past this second stage, I entered the final period where I was accepted as a part of the setting. I was expected to provide help when it was needed and to know enough about the ward to keep out of the way. This stage was best entered into in Barrie. It was during this period that the data collected were of the most value.

Because of a number of reasons discussed below, I did not enjoy the excellent penetration of the field in Thunder Bay that I experienced in Barrie. The PAGH staff never accepted me fully but always retained a certain amount of hesitation about me. However, while I did not gain as complete penetration in PAGH, I did enter the final stage to a limited extent.

Validity of the Observations

The goal of my research was to be accepted by the staff so as to not be viewed as a threat. If this goal could be reached, then the value of my data would be greately enhanced. While it is difficult to measure such an elusive concept, Erving Goffman presents a model which can be used to evaluate how well I got 'behind the scenes' to what really goes on. Goffman notes that there exist both a frontstage and a backstage. When an individual is engaging in frontstage activity,

> his activity will tend to incorporate and exemplify the officially accredited values of the society, more so, in fact, than does his behaviour as a whole.
>
> Goffman 1959:35

In the frontstage, activities and conversations are 'managed' to present the proper picture of the staff and the ward. Part of this impression is that of an Emer-

gency ward run by professionals who take their job seriously and are concerned about providing good patient care.

Backstage activity occurs when interaction between people is not designed to reinforce the official picture of the ward. In the backstage area the staff relax, interact informally and generally 'let down their hair'. Goffman defines this area as,

> a place, relative to a given performance where the impression fostered by the performance is contradicted as a matter of course. Here the performer can relax; he can drop his front, forego speaking his lines, and step out of character.
>
> Goffman 1959:112

Within the backstage, certain types of behaviour occur which, if seen by outsiders would destroy the impression of the setting that the staff is maintaining.

> The backstage language consists of reciprocal first-naming, co-operative decision-making, profanity, open sexual remarks, elaborate griping, smoking, rough informal dress, 'sloppy' sitting and standing posture, use of dialect or sub-standard speech, mumbling and shouting, playful aggressiveness and 'kidding', inconsiderateness and minor self-involvement such as humming, whistling, chewing, nibbling, belching, and flatulence.
>
> Goffman 1959:128

(1) <u>Backstage and My Research Presence</u>

In order for my research to be valid, it was

necessary to gain access to the backstage. Only when I was accepted by the staff to the degree where they would engage in this informal behaviour, could I begin to get behind the scenes. My admittance to the backstage of the Emergency ward was surprisingly rapid. It did not occur as a radical jump but rather, a gradual process. At first, although I was present in the usual backstage area, I was kept away from backstage activity. Staff members were very careful about what was said in my presence. In Thunder Bay, the nurses congregated in the staff room or the medicine room to engage in backstage activity but when I approached they quickly reverted to 'proper' activity.

The difference between backstage and frontstage activity is well illustrated by what happened when I approached an area where backstage activity was taking place. The first person to notice me approaching would glance at the speaker or whisper to the speaker and the conversation would die down, die out, or change. If I did not move away the group would disband. Some of the changes in conversation which I overheard were quite dramatic.

> (nurse-nurse) "Dr. Smith is a real butcher. You'd think that with the special instruments he has to have he'd do a good job." (second nurse glances out of the room and sees me standing there) "Well, I guess it's time to go for coffee." (and they left)

Gradually, my presence appeared to become less threatening to the staff and their attitude toward me changed. In Thunder Bay I often sat at a desk in the treatment area. From here I could overhear the conversations that were going on at the front desk. By the end of the fifth shift, the conversations did not appear to change appreciably when I approached.

While my presence appeared to have a less constraining influence over time, it would be näive to say that it had no impact. In Thunder Bay, the staff were always reluctant to engage in indepth conversation when I was present. A core of four people, all who appeared to be leaders in the ward, would initiate critical comments when I was present but the more junior members of the staff would not be critical in my presence.

In Barrie, my acceptance seemed to be much better. By the end of the eighth shift, the backstage had reverted to the main desk. This was due to a number of factors. Firstly, this was the most central area in the ward and the only place where the nurses could meet during a shift. This meeting at the desk area was part of their daily routine and my presence did not change this routine for more than a few shifts.

Secondly, the Barrie staff had a more demanding workload than their counterparts in Thunder Bay. The department

was often backed up with a number of patients who were waiting for treatment. Because of the heavy workload, the staff had to have a place to relax and 'let down their hair'. Consequently, the central meeting area at the main desk was the only place where nurses assigned to different areas could get together and talk.

Thirdly, the hospital staff in Barrie was dragged into conversation and interaction by the doctors. The doctors would sit at the desk and write reports, talk to other doctors or nurses, and wait for patients. The attitude and actions of the doctors did not seem to change with my presence. Even when I entered the nurses' station as the doctors were criticizing another doctor, they continued with their conversation and appeared to take little notice of me.

In Barrie, the Emergency ward was ripe for research. The hospital is affiliated with the nursing program at a community college and often has 'visitors' in the ward. Also, during my second visit they were in the midst of an in-service training period for ambulance attendants. Thus, the staff were accustomed to visitors.

Another reason that I was accepted by the Barrie staff was that I came to be seen as a 'serious' researcher and not just another student. Two staff members told me that I was much more serious about my research then J., a

student who had been in the ward for six hours. Initially they expressed surprise when I returned day after day. It became a point of contact with the nurses asking me how long I'd been there the night before or how long I was staying today. One day, when a doctor was complaining about working until 2300 hours the night before and then starting at 0800 hours the next morning, a nurse responded, "That's not too bad. Doug was here 'till three last night." When, by my continued presence in the ward I showed that I was serious about my research, the staff accepted me much more readily and dropped much of the facade since,"You know what's going on, anyhow" (nurse).

On my second visit to Barrie, I found that I had much better rapport with the staff than when I had first encountered them. On entering the ward, I was greeted warmly by the staff. Staff members introduced me to new members as, "Doug, who was here a couple of months ago". In the period between my two visits, I had become a legitimate part of the setting.

It is difficult to exaggerate how well I was accepted in Barrie. I had been in the ward only 10 minutes on my second visit when one of the nurses drafted me to hold a baby while she gave it an injection. I was asked to move stretchers to x-ray, help transfer patients from one stretcher to another, and file forms. I was also asked to supply

information on the whereabouts of patients when a new shift came on duty. Since my exposure to the ward went across shifts, the staff often turned to me for explanations of actions that were made in the previous shift.

Also of interest is the fact that a certain chair and desk area had become 'mine'. During my first visit I had been asked to move constantly. However, in the second study I was asked to move only once. This allocation of a physical area seems to indicate that my presence was accepted as legitimate.

The excellent penetration of the field that I enjoyed in Barrie can partially be explained by two factors. The first of these is the friendship that I struck up with a nurse, J. While she was not the head nurse, she was probably the most important person in the informal structure of the ward. Parties were usually held at her home. The doctors treated her with respect and she was a final authority on what was going on in the ward. During my first three shifts in the ward, she was on duty. During these night shifts, she explained different aspects of the ward, the history of the hospital, and other interesting stories from her experiences. Only during my second visit did I realize how important she was to my access to the ward. During my conversations with a number of the nurses, they indicated that she considered me to be a personal friend.

Since I was a friend of such an influential person I had better access to the ward than I would have otherwise enjoyed.[4]

The second reason that I gained such good rapport with the staff was because I became viewed as a 'good guy'. As Cicourel has noted:

> A person becomes accepted as a participant observer more because of the type of person he turns out to be in the eyes of the field contacts than because of what the research represents to them. Field contacts want to be reassured that the research worker is a 'good guy' and can be trusted not to 'do them dirt' with what he finds out. They do not usually want to understand the rationale behind a study.
>
> Cicourel 1964:42

After my first study in Barrie, I sent letters of appreciation to the hospital administrator and the staff of the ward. I offered to send them a copy of my paper if they so desired. The administrator replied almost immediately that he wanted one and a month later I received a similar letter from J. When I arrived in the ward for the second visit I was greeted with such comments as, "I liked your study", "We were talking about your paper last week", and "That was an interesting paper". With the exception of one nurse who read the paper while I was in the ward, all the other nurses, nurses' aides clerks and even one of the cleaning staff had read the paper. Their positive

reaction to the paper showed they were not afraid that I was going to betray any confidences. Thus, my friendship with J. and the fact that I sent a copy of the paper to the ward were factors that removed the fear of the staff that I would criticize and betray them.

(1) The Backstage and The Ascription of Motives

Researchers are often concerned with what motivates individuals to engage in certain types of action. We want to state why certain actions rather than others, are chosen. Cicourel believes that the decision as to why an individual committed an act is not usually related to the motive the individual had in mind when he committed the action.

> He (the sociologist) ascribes, thus, to this fictitious consciousness a set of typical in-order-to-motives corresponding to the goals of the observed course-of-action patterns and typical because-motives upon which the in-order-to-motives are formed.
>
> Cicourel 1964:62

Cicourel states that there is no necessary relationship between actions and ascribed motives. What is being given a motive is a 'fictitious consciousness', not a living person, and what sociology should be concerned with is how living people act.

Howard Becker presents a solution for the problem of ascribing motives in participant observation research. He states that the number of directed statements should be small in comparison to the volunteered statements.

"The proportion of items made to the observer alone should not be overwhelming and there should be a reasonable proportion of activities as well as statements by respondents" (Becker 1969:252). However, this technique does not solve the problem. He accepts as evidence the reasons that members offer for their actions and these data are not better than thosegleaned from interviews.

My research, in order to be meaningful, had to arrive at variables that were used by the staff in ordering their workload. At first I asked staff members why they treated a patient in a particular way and what was wrong with the patient. While this data collection method was necessary at first, it was soon abandoned because it provided answers to questions raised by a researcher. While these may have been the motives for the actions, this approach requires the assumption that what people say is the truth; an assumption which cannot be controlled for and calls the data gleaned in this type of situation into question.

The way that the staff perceive and feel about patients is best understood by observing the staff as they process patients. If any data will remain 'pure', these will, for they are given in the course of patient treatment and if modified will result in confusion in the ward. The ward clerk upon filling in the information sheet for a patient, reports that a person with problem x is in the waiting room.

Then, the desk nurse informs the area nurse to bring in patient Jones when a stretcher is free. The doctor then is contacted and told about the patient. Upon arrival in the ward, the doctor will be told how the nurse perceives the patient. After examining and treating the patient, the doctor will usually inform the nurse about what is 'really' wrong with the patient. It is during these exchanges that the normal traits of ailments emerge. This data should be the most valid for they are uncovered as the staff go about their everyday routine and not in response to questions from a researcher.

As a researcher, there is a tendency to use the categories that the staff use, without thinking. As I became familiar with the ward, I started to take for granted what was going on. While it is probable that I could characterize ailments in a manner similar to the staff, such a practice cannot be checked for accuracy and must be rejected. When I discovered that I was slipping into this problem, I found it helpful to leave the ward for a period of time in order to resensitize myself. When I returned, a great deal of material that I had not noticed prior to my leaving was recorded.

It was crucial to arrive at an understanding of why a patient was treated in a certain way. If Mr. X comes in and is treated in a certain way, unless I can say that

he was perceived as a member of a specific category (i.e., drunk, senile), I have not discovered anything valuable. If a male of fifty years of age comes into the ward smelling of alcohol and receives treatment y, then unless I can say that the staff perceived him as a drunk, I cannot draw a relationship between being drunk and how he was treated. Perhaps he received that treatment because he was fifty years old or perhaps because he was a male. Thus, what the staff say about the patient is my best means of discovering how he was perceived and in so doing I can discover how people who are perceived in a certain way are treated.

One could argue at greater length about how well I penetrated the field and the impact that my presence had on what I observed. I have attempted to show that I was well received by the staff, became a legitimate part of the setting and was not seen as a threat. However, I acknowledge that my presence had an impact on the actions of the staff, especially in Thunder Bay. It is my belief that this impact was minimal and did not disrupt the well established patterns of interaction and conduct in the ward. While my presence undoubtedly influenced some of the smaller aspects of interaction, I believe that the major patterns remained intact.

Besides J., two other people aided my research. The first of these was a fellow student who was conducting separate research in the Barrie Emergency ward. She had

worked as a candy-striper in the hospital and explained procedures and practices of the hospital. More important however, was the fact that I was able to check my field notes against her observations during the first phase of my study in order to ensure that I was observing accurately.

A second aid to the research was a professor who supervised my original research. During our discussions he suggested areas that needed to be looked at as well as methodological issues. His comments and criticisms helped me to diversify the study and to look at new types of data which I may have otherwise missed.

Data Recording

One of the biggest problems in participant observation is the recording of data. If one waits too long before recording what has transpired, a lot of data tend to be lost. What is left is impressionistic and ignores interaction and incidents that are contrary to the general impression of the ward that has been gained.

In the first study in Barrie, I observed for fifteen minute segments and then went to a self-service cafeteria and wrote down what had been observed. This meant that I was often out of the observation area and consequently did not always stay on top of what was going on.

Research by Fish (1971:11), and Powdermaker (1966) indicates that in settings where note taking is part of the everyday routine, the researcher can take notes and this will not be a suspicious action. This technique was tried during the last shift of the original Barrie study and appeared to be successful.

During the second Barrie study, almost all the notes were made on the spot. This activity did not seem to affect my interaction with or the interaction among staff members. However, I took great care not to appear to be recording what I was actually recording. If there was a lot of activity in the ward, I recorded conversation as it was being said. Because I was facing a desk and there was a lot of activity, the members of the conversation did not know that I was interested in what they were saying. If there was limited activity in the ward and my writing of notes would have indicated that I was recording a conversation, I waited until the conversation was completed and then wrote it down. In most cases, the conversation that was recorded in this manner was of less than five minutes duration and such a span can be remembered fairly accurately.[5]

While the Barrie staff did not seem to react to my note taking, a certain amount of discretion was felt to be necessary. One evening the husband of a nurse who worked in the hospital was brought in dead. The head nurse was

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upset by this event because the man's wife had been her maid-of-honour and was a close personal friend. In this instance and others of extreme emotion, I did not record on the spot but went to the small cafeteria area to record my notes. In this way, I maintained the proper sense of decorum and did not appear as an insensitive outsider.

The Thunder Bay setting limited my ability to take notes on the spot. Because there was no desk at the nursing station on which I could write, I was forced to leave the area to record my data. While this was not desirable, I discovered that if notes were recorded in the nursing station, I was indicating to the staff that something noteworthy was taking place at that moment, and that noteworthy 'something' stopped as I started to record it.

What I recorded, changed between the first and second studies. In the first period, because of my trips to the cafeteria, I could remember and retain only phrases and short conversations. By the time I entered the second period, I was recording entire conversations. In this way I was better able to capture the 'sense' of what was being said.

It is extremely difficult to record meanings of conversations. A simple phrase such as, "Another sick one" (doctor to doctor) can have a number of meanings. While a member who is present knows what is meant, it is difficult

to state why the statement was serious, or cynical. Variables such as a laugh, a smile, a smirk, a particular tone of voice or the context in which a statement is made influence what is meant. When I recorded conversation, I attempted to gather notes which indicated the meaning of the comments. My ability to analyse what is 'really-going-on' resides largely on my ability to decipher the 'intention' of comments that I overhear.

Conclusion

Writers on the topic of participant observation are unanimous in their claim that there is no adequate 'cookbook' method for field research and that researchers must feel things out for themselves. However, after stating this they go on to provide a cookbook method, stating the do's and don'ts of 'good' research. While these works fail to provide an adequate approach, they are valuable in raising issues that the field researcher must consider.

The major problem that field researchers must overcome is the effect of their presence on the people they are studying. Using Goffman's concept of frontstage and backstage I have demonstrated that the backstage was entered. Partially because of the way the staff viewed me, partially because of the 'busyness' of the ward, and partially because of my friendship with J., I was seen as a legitimate member

of the setting and the staff stopped 'playing' to me. While the staff had hesitations about me in Thunder Bay that were not present in Barrie, I entered the backstage in both settings.

In Barrie, field notes were taken as the events occurred. This type of recording is highly accurate and gets around the problems of selective retention of data which occurs when a researcher waits for a period of time before recording the data. In Thunder Bay, however, this accurate recording of data was not possible and notes were taken in a remote area at approximately fifteen minute intervals.

It is impossible to provide a defence of participant observation which neutralizes all possible criticisms. I have attempted to show that this study took into account problems inherent in this type of research. In the final analysis, all I can attempt to do is to minimize the impact of these problems. This method of data collection was chosen, not because it suffers from fewer problems than other methods, but because it provided the best way to get at the data which I needed.

CHAPTER III

EMERGENCY WARDS: AN OVERVIEW

Emergency wards are facing increased usage which is, "taxing the facilities to the breaking point" (Albin et al. 1975:1063). This development covers both Canada and the United States, resulting in increases in Emergency ward use of approximately 300% in the last twenty years (Goldman 1976:35). In Canada, the average yearly increase is approximately 13% (Statistics Canada 1972:178), but in some places such as Barrie, the increase between 1966 and 1976 has been over 300 percent. While Port Arthur General Hospital has not seen this type of dramatic increase, their facilities are also becoming more heavily used.

Variables in Emergency Ward Use

The Emergency ward is not used with equal regularity by all strata of society. Certain social strata and ethnic groups make more use of the ward than do other groups. Alpert, Solon and Weinerman have conducted research in an attempt to discover who uses the ward.

Alpert (1969) believes that the difference between patients who use the Emergency room as opposed to seeing

a private physician for medical care, is found in the relationship that the patient has with a physician. Patients who have family doctors will likely go to them for aid, and if they lack a faimly physician, the Emergency ward may become their primary source of medical care (Alpert 1969: 60).

Alpert also found a positive relationship between income and having a family doctor. In families that earned less than three thousand dollars annually (in 1967), only 16% had a physician who usually treated their medical problems. This percentage increased steadily until 85% of families earning more than ten thousand dollars a year had a family doctor (Alpert 1969:57).

Alpert also found a significantly different attitude toward the Emergency ward in high and low income families. The lower income group believed that the hospital was and should be their doctor whereas the upper income group usually saw a private physcian for their medical problems (Alpert 1969:57-9). Thus, the lower income group expected medical care from the institution (the hospital) and the upper income group looked for personal care from doctors in their offices (Alpert 1969:60).

The category of unstable-hospital relationship (ie. those who do not have a physician who cares for their children and do not use the clinic for regular care) has

a very different composition from the other categories. It is composed of 'disadvantaged families'; that is "those on welfare, of low income, Negro or with Spanish surnames" (Alpert 1969:58). Eighty-four percent of the welfare cases, 70% of those whose income is less than $4,500, 84% of the negroes, 76% of the Spanish and 74% of the uninsured use the hospital Emergency ward when they have any type of medical problem that they feel requires professional attention (Alpert 1969: 58). Thus, not only is it poor people who frequent the Emergency ward but also minority groups and disadvantaged people in general.

Research conducted by Solon (1969) shows a similar pattern. His research, conducted in an area where there was a high percentage of East European immigrant people, showed that the percentage of them who had a private physician was much lower than the rest of the population (Solon 1966:887-9). Also substantiating Alpert's study was the fact that 65% of this group viewed the hospital as the central source of their medical care and never visited a private physician (Solon 1966:890-1). Again, we see that a disadvantaged and unestablished group uses the Emergency ward more frequently than the more established population.

We have seen that people with high incomes and social advantage tend to use a private physician if they have a medical problem and those with low income use the Emergency

ward as their doctor (Weinerman 1966:1051). While both groups may frequent some medical facility, the minor complaints of the upper income group are treated in the doctor's office and do not show up very often in the Emergency ward. On the other hand, the lower income group show up at the Emergency ward more frequently with minor complaints since they have not been screened by a doctor. The large number of lower income patients who show up at the Emergency ward with minor complaints may have an influence on how this group is categorized. It is very conceivable that the nuisance cases may be seen as coming from the lower income group and the justifiable patients may be seen as coming from the upper income group.

Changing Medical Patterns

It should be noted that Americans (Canadian and U. S. residents) are becoming more health conscious (Zola 1972:492-500). This pattern is well illustrated in the case of the birth of a child. Once, a child was born in the home, usually without the help of a doctor. Now, the doctor gives the mother a pregnancy test, numerous checkups before the birth of the child, is present when the child is born, and provides checkups on the progress of the baby and the mother. This is but one example of the increasing influence

of medicine as it becomes a part of an ever increasing sphere of activities and gains more and more control over people's lives (Zola 1972).

There has been little research done which compares the popularity of different medical facilities. While we know that Emergency room usage is increasing faster than hospital admissions in general, we do not know whether the increase in hospital usage is larger than the increase in the use of medical clinics or private physicians. However, what is important is that more and more people are turning to the hospital for medical diagnosis and treatment.

The increased use of Emergency wards by the population has been partially the result of a change in medical practices. Despite the fact that the population is increasing, the number of general practitioners is decreasing (down 18% in 15 years) (Goldman 1976:4). This is not to say that the doctor/patient ratio is dropping but points instead to the increasing percentage of doctors who are specialists and see only referrals. Consequently, there are fewer doctors to do the referring and more doctors to whom you may be referred.

General practitioners have also modified their practice of medicine over the last twenty years. Very few doctors now make house calls (Goldman 1976:4). Many also have office hours that are rigid, and will not treat pa-

tients at night or during the weekend. This, coupled with shorter office hours has resulted in an increasing scarcity of doctors when they are needed (Goldman 1976:4).

The increasing usage of medical facilities indicates, among other things, that a significant portion of the population believe that only a medical specialist is qualified to evaluate and treat medical problems.[6] However, many people cannot get in touch with a doctor or feel that it is too difficult. Consequently, Emergency rooms which are always open and accessible, are filling the void that has been created in medical coverage.

While the changing role of the doctor may partially explain the increased usage of Emergency wards, the fact that 92% (Alpert 1969:56) of all Emergency patients visit the ward between 0990 and 1700 hours casts questions on how adequate this explanation is. During these times, doctors are in their offices and clinics are open. Consequently, if doctor unavailability was driving people to the Emergency ward, this usage should be much lower during the day than during the night when the doctor is not available.

The increasing use of the Emergency ward has been accounted for by examining the population at large and changes that have occurred over the last few years. As the population has become more mobile, more and more people are dis-

placed from their home town and most do not choose a family doctor in their new town (Goldman 1976:18). When an emergency arises or they feel in need of medical attention, they go where they know they will receive help -- the Emergency ward (Goldman 1976:20).

A significant part of the increase in Emergency ward usage has also been accounted for by examining the different use that the ward receives today. The use of the ward by patients with minor complaints is high, between 45 (Goldman 1976) and 50 (Alpert 1969:1063) percent. Instead of bothering to choose a family doctor, more and more people are using this ward as their primary source for ongoing care (Alpert 1969:55).

A final possible explanation of Emergency ward popularity is found in the attitude of doctors toward the facility. As medicine becomes increasingly more sophisticated, many doctors find it easier and more profitable to use the well-equipped Emergency room instead of buying the necessary equipment for their own offices (Alpert 1969: 60).

Newspapers have expressed concern about the consequences that the increased usage of Emergency wards has on the care that is provided. They point out that "Patients with minor ills jam the Emergency Room" (Goldman 1976:19)

and that these patients use up money that should be used to treat the truly sick.

The consequences of this increased usage have also been considered by medical experts. "Non-emergency cases may result in increased and unacceptable delays in rendering care to true emergencies (Albin 1975:1063). Pool (1976) claims that "the resulting influx of patients with non-emergent conditions has strained the capabilities of most emergency departments and interferes with the care of patients with true emergency problems" (p. 26). The essence of these papers and many like them is that medical care is being harmed because of the increasing number of non-emergency patients who use the ward.

Hospital administrators have responded to the unjustified use of their facilities by unsick patients in a number of ways. They have chastised these people and blamed them for overcrowding the ward (Pink 1977:35). Others have attempted to educate the community about the ward and its proper function but these attempts have proven unsuccessful (Pink 1977:35). A final response, and one that has proved valuable has been the establishment of a normal 'triage' system to rank patients as soon as they enter the ward. In some hospitals, patients are ordered to separate areas depending on their triage. In other hospitals where

such alternative facilities are not readily available, the non-urgent cases are forced to wait until all the serious cases are treated. In this way the serious receive the rapid treatment they require and those who can wait without danger are forced to do so.

Triage

"A basic problem in treating patients lies in assigning priorities" (Pink 1977:35). Whether it is acknowledged or not, the staff must assign priorities to cases in order to perform their job efficiently and provide adequate treatment for the patients who present themselves. The formal ordering or sorting of patients has come to be called 'triage'.

The term triage was first used to, "describe the sorting process used in military field hospitals where decisions had to be made quickly with mass battle casualties" (Pink 1977:35). Today, triage is used to, "indicate the order in which patients should be seen by medical officers in a medical centre" (Pink 1977:35).

A formal concept of triage in the Emergency ward is a relatively new development. Because of the increasing number of non-emergency cases, hospitals were faced with a backup of patients. It was felt that it was inappropriate

to treat patients in the order in which they presented themselves since serious patients need quicker treatment than non-urgent cases. While such sorting had always been done, medical schools and hospitals developed triage courses which taught the student how to "provide immediate, brief medical evaluation of all incoming patients, determine the general nature of the problem, the trend of service needed and the appropriate referral" (Albin 1975:1063). This instruction not withstanding, today only the larger hospitals engage a professional triage nurse and in most places, the original assessment of the patient is done by a clerk who usually has no special medical training.

The triage nurses or ward clerks collect data and then categorize the patient. First, they conduct a short interview which is designed to gather, "a history of the current medical problem" (Shields 1976:38). Then, they perform a "brief, pertinent physical evaluation" (Shields 1976:38). By considering these data the nurse, "interprets the physical symptoms" (Pool 1976:25) and then "categorize the patient in the proper category" (Shields 1976:38). Success and competence in a triage nurse is measured by the "ability to assess the situation with a high degree of accuracy" (Warner 1976:25). The process of interpretation of symptoms and what constitutes accuracy

in triage are areas which will be examined in a later part of this chapter. It is sufficient to notice at this point that the nurse is involved in making decisions and choices and can therefore make 'mistakes'.

As has been previously noted, in many hospitals a triage nurse is not employed. In these cases, the patient is evaluated at two levels. The ward clerk takes a short medical history and looks for 'obvious' medical problems. Then the patient will be given a short examination by a nurse. Thus, unlike the large hospital, the assessment of the patient is carried on at two levels (Pool 1976:26).

The term 'triage' properly belongs only to medical diagnosis made by medical personnel. However, ward clerks also make decisions about the severity of patients' ailments.

Because of this fact, I have broadened the concept to include the original assessment of the patient as made by the ward clerk, nurse, nurses'
the medical training of these people differs greatly, they all serve the same function if they are processing and assessing patients' complaints as soon as they enter the ward.

Much of the literature about 'triage' is designed to show how the process can be improved. One of the most important requirements is that it be done systematically and scientifically (Warner 1976:21). Experience also

plays a significant role in improving the ability of a nurse to perform triage (Pool 1976; Shields 1976; Albin et al. 1975). However, there is a large void in the literature about the process of making decisions and interpreting the data on which the triage is based. One value of this study is that it will examine the process of making decisions about the seriousness of patient illness and attempt to discover the variables that enter into this decision.

Triage Categories

The ability of the staff to order their workload and daily routines in order to do a good job is dependent on their knowledge of ailments and ailment categories. There exist three broad categories that all nursing staff are taught.

While the categories are accepted by almost all triagers, they come under various names and are often defined differently. The first category contains those cases which are "urgent" (Pink 1977), "emergent" (Pool 1976; Weinerman 1966) or "emergency" (Kirkpatrick 1967). In explaining this category, the writers use illustrative phrases such as "acutely ill (life or death)" (Shields), or "life threatening" (Warner; Pink; Weinerman). These

cases are seen as serious medical problems and the proper work of the Emergency department.

This category is very loosely defined. It, like the other two, appeals to a common-sense knowledge of medicine. It presupposes that any member of the medical setting would know that a certain set of symptoms constitutes an emergency. What these writers list are descriptive synonyms and little effort is made to explicate the meaning of the category.

The emergency category is also defined in terms of specific medical problems. "Active bleeding, severe pain" (Pink 1977:36), "chest pains, head injuries, unconsciousness" (Warner 1970:3), and "complicated external fractures and narcotic/barbiturate overdoses" (Shields 1976:38) are all medical problems that fit into the emergency class. The medical problems which are placed in a particular category differ from one author to another. This difference suggests that the categories have different compositions depending in which hospital they are used.

The category of emergency is also seen by those who use it as a time category. Some of the writers believe that any patient who should be treated immediately is an emergency (Warner; Pink; Shields). The exact meaning of

immediate is not spelled out by these writers but Albin (1975) defines it as within a two hour period (p. 1065) and Kirkpatrick (1967) say, "within six hours of the onset or injury" (p. 20). This difference shows that while all feel these patients should be treated immediately, what is immediate ranges from five minutes to six hours. While the category has a common meaning from place to place, the way that it is operationalized differs greatly.

The second category is called "non-urgent" (Warner; Kirkpatrick), "urgent" (Weinerman), "priority" (Pink) and "category 2" (Albin; Shields). What this category contains is never explicitly defined. It is a residual category between emergency cases and non-justifiable complaints. It is not as serious as an emergency but deserves treatment because "extended delay will cause further agony" (Warner 1970:4). "The cases are not as ill as category 1 but require emergency facilities" (Shields 1976:38). This category is composed of cases which are "fevers, sprains, bruises" (Warner), "fractures, suspected fractures, objects in the eye" (Pink) and "sore throats and minor ailments" (Kirkpatrick). In this author's judgment, these ailments differ from those in the other two categories only in matter of degree. Thus, the decision as to whether a case fits into this category or the one above or below it is very difficult and arbitrary.

The third and largest category is composed of cases designated as "non-emergent" (Warner), "non-urgent" (Pink), or "those not in need of the facility" (Kirkpatrick). This is the nuisance class, the group who interfere with the smooth running of the department by their unwarranted presence. People who want "physical examinations or prescriptions" (Warner), "immunizations" (Kirkpatrick), and those with "minor problems not urgent or caused by a recent accident" (Pink) constitute this group.

The non-urgent category exists in a peculiar relationship to the other categories. It is a category into which people with no justifiable complaints are placed. Justifiable however, is dependent on the perception of the person who performs the triage. It is a residual category where patients who are not serious enough for the other categories can be placed. However, we noted that category 2 is also a residual category. Consequently, the decision as to who belongs in which category is not as simple and straight-forward as it first appeared. Because of the vagueness of the dividing lines between categories, non-medical judgments enter into the placement of patients.

The ranking of patients takes place not only in terms of three categories, but also in relation to other patients. The ultimate goal of triage is to order patients

relative to other patients so that the most serious can be seen first (Shields 1976:38). Thus, the categories serve as a tool in the process and only by considering the ranking of one patient against another can we fully appreciate what is happening.

The non-urgent and non-emergency categories, as well as the emergency class, are defined by time. The non-emergent class lies between the time boundaries of the other two classes. Pink feels that any patient who can safely wait ninety minutes is a non-urgent case, Kirkpatrick sees the cutoff point at six hours and Albin believes that a case that is non-urgent can wait longer than five days to be treated. Again, we see different definitions of categories that go under the same name.

While there is no agreement on the exact number of patients who belong to the non-urgent class, the researchers agree that it is increasing. It is commonly agreed that between 45 and 66% of all patients using the ward are non-urgent cases (Lublin 1974:41; Shields 1976:41). While this figure seems high, it is much lower than the estimates of non-urgent cases that are often made by the staff. Weinerman found that the staff estimate that between 75 and 95% of all patients using the ward belong to this group (1969:1042).

The category of non-urgent case is a highly moralistic one. The critical attitude of the popular television series EMERGENCY is an accurate picture of how both popular and medical writers depict the non-urgent patient. Albin sums up these sentiments when she says,

> The overload of non-emergency cases results in increased and unacceptable delays in rendering prompt care in true emergencies. Patients with non-emergent conditions have strained the capabilities of most emergency departments and interfere with the care of patients with truly emergency problems.
>
> Albin 1975:1063

'Normal' Categories

The decision as to which category a patient should be placed in is by no means a simple and straightforward process. Duff and Hollingshead (1968) have shown that this decision depends to a large extent on the person who is doing the processing. Because the diagnosis of ailment severity is largely an inferential and interpretive task, a set of complaints and symptoms can indicate a number of illnesses.

Emergency ward staff operate with a concept of 'normal' ailments in a manner similar to that of the Public Defender's concept of 'normal' crimes (Sudnow 1965).

These are, "occurences whose typical features i.e., the way that they usually occur and the characteristics of persons who commit them . . . are known and attended to by the Public Defender [or triage nurse]" (Sudnow 1965:260). As we saw in their definitions, these categories vary radically from one location to another. Since a patient's course of treatment could depend upon the staff members' perception of the ailment, members of a particular ward must maintain a common conception of the patients' ailments.

Competence for a triage nurse is measured by the ability to perform accurate triages. This is equal to the ability to use the categories that are accepted in the ward in a manner that is accepted. Since 'correct' is dependent on the agreement of others in the ward, then a proper triage is one which is agreed to by all, or to put it more precisely, is not disagreed with by members of the staff who encounter the patient during treatment. While all members of the ward have a certain amount of medical knowledge and an approximate idea of how serious an ailment is, the exact way that ailments are perceived is dependent on the way that the staff of the ward conceptualize illness.

Normal categories are both descriptive and ascriptive. The person who is categorizing, attempts to

establish that "this person [or case] is a case just like any other in the category" (Sudnow 1965:267). Consequently, "first questions directed to the patient are of the character that answers to them either to confirm or throw into question the assumed typicality. The goal is to establish similarity with events of the sort that belong in a category" (Sudnow 1965:267).

Faced with a high volume of patients and a heavy workload, the categorizer gathersonly enough, "information to confirm his sense of the case's typicality and construct a typifying portrait" (Sudnow 1965:268) of the patient. Once this is established there is "attributed to them personal biographies, modes of usual activity, histories, psychological characteristics and social backgrounds" (Sudnow 1965:259). The typifying portrait shows that the individual demonstrates sufficient traits common to the category to place him/her squarely in that category.

Not all cases are slotted into categories. The special and unusual as well as organizationally problematic cases are usually treated as unique. However, normal cases ie. the type of cases that are seen frequently, are grouped. Thus, 'normal' ailments and ailment categories are most important in the perception and treatment of everyday-type ailments and of least importance in the treatment of un-

usual and spectacular ailments.

The case, once categorized, is no longer unique but is part of a category and is given the attributes of the category. The individual is given qualities and interpreted in light of the category or label which has been attached to him/her. Thus, the category has a life of its own and is able to influence the way cases which compose it are perceived. Roth shows the significance of this process in the case of 'drunks'. "The label of 'drunk' is accepted by hospital personnel because of the way the patient is treated, as it is to say that he is treated in a certain way becasue he is drunk" (Roth 1972:844). Thus, "the category into which the patient has been placed may have more effect on determining the decisions of medical personnel than does his immediate behaviour" (Roth 1972:845).

The decision as to which category an ailing individual should be assigned, is based on the processor's medical knowledge, knowledge of 'normal' ailments, knowledge of how the ward functions and, "the patient's demeanor, appearance and style of talking about the event [ailment]" (Sudnow 1965:269). A very important part of the processing of patients is the way that they are perceived by the original processor as they enter the ward.

Patient Evaluation

Research conducted by Sudnow, Cicourel, Garfinkel, Becker and others shows that people are constantly making decisions about the social and moral worth of other people. Becker et al. (1961:323-7) discovered that in the case of doctors, such decisions were constantly being made and could not be removed or neutralised, even if the doctors were made aware of the process. This decision as to the social and moral worth of people is important for it influences the way we respond to and interact with people (Sudnow 1967:95-108).

In the Emergency ward, patients are ranked by being placed in medical categories. This activity, performed by a triage nurse or ward clerk is extremely important for the assessment of the first person to encounter the patient often influences the assessment others will make.

> Those who are the first to process a patient play a crucial role in moral characterization, for members at later stages of the processing are inclined to accept earlier categories without question unless they detect clearcut evidence to the contrary.
>
> Roth 1972:841

The decision made by the original processor is crucial. Once the label is attached to the patient, only

an overwhelming mass of evidence to the contrary will change it. Thus, a decision by a person who has a brief encounter with the patient (usually 2-5 minutes) and often the least medical training of anyone in the ward (the ward clerk) will affect the way the patient is perceived by the entire staff.

The original label is extremely hard to change and usually defies 'correction' because of the hectic pace of the ward. Since many patients walk in off the street, little is known about their medical history. Because of the volume of work, doctors and nurses have little time to do in-depth questioning of patients. This, combined with the fact that the patient is in the ward for a very short period of time means that the way the patient is categorized at first will usually not change.

The original processor of patients has a significant amount of control over patients and the running of the ward in general. Besides the original evaluation influencing diagnosis, treatment and dispoistion of the case (Roth 1972:839-40), the original processor also decides, "how soon the patient is seen, what area he will be treated in and sometimes whether he will be treated at all" (Roth 1972:839-40). Thus, although the original processors may never treat the patient, they have a crucial role in de-

termining how the patient will be treated.

Non-medical criteria have a larger influence on the way that a patient is treated than is usually realized. Because, "a minimum of information is available about the character of the patient" (Roth 1972:842), the processors make snap decisions about the patient, often based on how they feel about the patient or on what they think is "really wrong" with them. Because of the short contact with the patient, these non-medical criteria have an important influence on how the processor interprets the severity of the ailment.

The Ascription of Social and Moral Character

Numerous studies have shown that people make decisions about how clientele will be treated on the basis of ascribed social and moral character. Cicourel illustrates the significance of class, language and deportment on the way that juvenile offenders are treated (Cicourel 1968: 243-92). Sudnow, in his research on dying patients notes that similar criteria are used to establish the social worth of patients and this has a bearing on the way that the patient is treated (Sudnow 1967:117).

Gill and Horobin (1972) sum up their research in a similar manner stating that, "the judgements which

the doctors make are based for the most part not upon medical criteria, but on their perception of the woman's social position and circumstances" (Gill and Horobin 1972: 517). Thus, the way that patients are perceived in relation to their social position and circumstances must be understood before any type of meaningful statement can be made about how Emergency rooms operate to treat patients.

The decisions that are made about moral and social worth are very closely related but not exactly the same thing. Social worth is decided prior to moral worth but is part of the same process. The individual is placed in a social category by the staff. Then, by using a concept of normality as it relates to classes, a decision is made as to moral worth. A person of the upper socio-economic class who is drunk retains some of his dignity and personhood while a lower class person with the same condition is a bum, drunk or alcoholic. While both people have the same medical condition, their moral worth is different because of membership in different classes.

It is important to note that what is acted on is the perception of the patient by the staff and not what the patient really is. Social worth is established for the patient by the staff. Moral worth is also an ascribed category, not necessarily related to the way that the patient lives. Thus, a person of the upper class can be

seen as being from the lower class and will be treated accordingly. In short, as patients are perceived, so are they treated!

The placing of a patient in social and moral classes is made by the staff who are concerned with what the patient 'really is'. What the patient really is,

> is an accomplishment of a chain of processors who need to do a competent-job-for-all-practical-purposes. That is, what the act, the person, (or event) 'really is' is as it is attended to through the members' practical work.
>
> Molotch and Lester 1974:103

The moral evaluation of the patient is based on readily available clues. Easily observable things such as age, race and mode of dress play an important part. Sudnow has shown that the young receive quicker and better treatment than the old (Sudnow 1967:100). He also noted that the well dressed receive better treatment than the poorly dressed. A final observation is that ethnic minorities receive poorer treatment than the rest of the population (Sudnow 1967:98-9).

Zola also noticed that minority groups were receiving slower treatment. He was not satisfied that this was based solely on blind prejudice that the staff had toward the group. In his study of Italians, he noted that

they showed, "more diffuse reactions to being sick, more symptoms and complain about the negative affect of the ailment more" than the rest of the population (Zola 1963a: 830). He believes that these patients are seen as putting on a show and overreacting. Research by Zborowski shows that, "uninhibited displays of reactions to pain" provoked distrust of the patient by the doctor treating him (Zborowski 1958:256-68). Consequently, the way that the patient complains and "how the patient presents himself is largely responsible for how he is perceived and ultimately diagnosed and treated" (Zola 1963a:829-30).

There are numerous other clues that have been shown to influence the way a patient is perceived and consequently treated. One's command of the language, accent and word usage provide indicators of background and social class (Cicourel 1968). Response to the staff is also important and the way one addresses the staff will influence how a patient is perceived as will his body odor, cleanliness and the presence of alcohol or drugs (Roth 1972: 842).

A second group of data is available to the processor as the necessary forms are filled out. The type of employment of the patient, type of insurance, whether the patient has a family doctor, marital status and previous use

of the ward are all variables which, while medically insignificant, are important in deciding the social and moral worth of the patient (Roth 1972:842).

A final group of data also helps to place the patient in the proper category. The way that the ailment occurred, the neighbourhood in which it occurred, the presence of "supportive others" and the mode of arrival at the ward all influence diagnosis (Roth 1972:842-3).

One can list different variables that influence treatment, but these are of limited value outside a particular setting. It is possible that the staff of an Emergency ward is largely Italian and an Italian who presents himself will receive better and more sympathetic treatment than an Anglo-Saxon. Thus, it is impossible to say that a variable is important or how important it is outside a particular setting. What the writers have done is to show how perception influences treatment of patients in specific hospitals. For the sake of illustration, I will list seven variables that Roth discovered to influence the treatment of patients.

1 Young patients are more valuable than old.

2 Welfare cases do not deserve the best care.

3 People of higher status are likely to be afforded more respectful care.

4 Dirty, smelly patients are objects of contempt to the staff.

5 Certain ethnic groups are discriminated against.

6 Those dressed with scanty clothes or as hippies are frowned upon.

7 Drunks are more consistently treated as undeserving than any other category.

Roth 1972:480-500

While these variables influence treatment, they are generalizable only within a particular setting. However, assumptions cannot be made about their applicability prior to the research being conducted.

Summary

Emergency wards are becoming more popular as medical treatment areas. More and more people are using the ward as their primary source of medical care. Much of the use of the ward is by people with non-urgent medical conditions. This usage is encouraged by the increasing unavailability of doctors, the increasing transience of the population and the declining number of general practitioners.

The non-urgent patient has been pointed to as the cause of increasing cost in medicine and poor treatment for Emergency ward patients. Some hospitals have attempted to educate the population as to the proper use of the ward but this has not proven successful. Instead, many hospitals have accepted this usage as inevitable and have set

up a system to order patients according to the severity of their illness.

Triage uses three broad categories. They come under various names and are differently defined. What is of interest to my research is the operationalization of these categories by the staff.

Emergency wards are not used with equal regularity by all segments of population. The poor and disadvantaged in general tend to use this ward for all their medical care. Thus, this group is often viewed negatively by the staff who encounter numerous lower class people with ailments that 'should have been seen at a doctor's office'.

The staff use a concept of 'normal' illnesses in order to organize their job. Patients are given membership in categories and then treated in a manner appropriate to the category. In placing patients, non-medical variables influence how the staff perceive them and consequently how they are treated. By 'interpreting' the actions of the patients, the staff give them a social and moral profile that is important in determining their treatment while in the ward.

The person who plays the most important part in categorizing the patient is the ward clerk or triage nurse. This person develops a profile of the patient that will influence the way that the patient is treated. The clerks

are also important since they decide when patients are seen, where they are treated and by whom they are seen.

Sociologists have conducted a number of studies on the importance of socio-economic variables on the way that people are treated and perceived. The variables which they found to influence perception are interesting but cannot be assumed to apply to all situations and therefore serve only as guideposts to sensitize the researcher. There is a definite lack of material on the importance of these variables in the treatment of patients in Emergency wards and this research analyses the importance of these variables in two Emergency wards.

CHAPTER IV

DEMAND CHARACTERISTICS

The hospital, like any other institution, exists in a specific time and place. It is not merely a building, but rather a number of people who come together in a specific location to do a job, namely treating patients. The institution is the way that the people who fill its roles go about doing their job. The institution is constantly changing, adapting to the demands of the larger society and forces outside its control. It is the importance of these external variables on the routines of the ward and ultimately the treatment of patients that is of interest to us in this chapter.

The temptation of this type of analysis is to try to develop causal links. Such an approach, while attractive, will not be used in this paper chiefly because it ends in the chicken and the egg dilemma. For example, does PAGH not have an ambulance service associated with it because it is not a busy hospital or is it not a busy hospital because there is no ambulance service associated with it?

The approach of this chapter is to show how the organization and routines of the Emergency ward staff make sense in light of external factors. These factors, called "demand characteristics" by Bittner (1965) and Turner (1969) are, "those situational and contextual features which persons engaged in everyday routines orient to as governing and organizing their activities" (Turner 1969:4).

What a public institution does cannot be adequately defined by looking at its legal mandate. On one hand the hospital has a job to do, namely curing illness. However, this does not describe how the staff view their job, how that job is done, or the priorities involved. Unlike Bittner, who maintains that some sort of distinction can be made between the official definition of the job and 'the craft' which develops "in response to a variety of demand conditions" (Bittner 1965:699), I see the two as being part of the same process. Since a legal mandate only very roughly draws the parameters of the rights and responsibilities of the institution, it becomes interpreted in light of the demand characteristics that the members of that institution face.

The way that members of a public institution view their job is not the same as the way it is viewed by the public they serve. While they acknowledge and orientate

to the expectations of the public in situations where they are being watched (Turner 1969:9), from the viewpoint of a nurse the world is full of sickness and it would be naive to suppose that any hospital activity could change this situation.[7] In short, the procedures employed by the institutions members are not equal to their legal mandate but are consistent with their[8] interpretation of the mandate in light of the demand characteristics they usually encounter.

In terms of the Emergency wards under study, there are a number of demand characteristics to which the staff respond. The type of patients who use the ward, the volume of patients processed, the organization of the doctor coverage of the ward, and the way that doctors use the ward are all demand characteristics influencing Emergency ward routines. By comparing the two wards, we can gain an understanding of how these demand characteristics differ from one setting to another and how this affects the operation of the ward.

There is not a cause and effect relationship between demand characteristics and the actions of the staff. Instead, there are structural determinants in typical situations which the staff perceive as demand conditions for their actions (Bittner 1967:701). Only in specific

situations, when certain conditions are present, do these demand characteristics become important. While this chapter focuses on situations where demand characteristics are important, it should be remembered that in many other instances these characteristics are not significant and the staff do not consider them in the course of making decisions.

Demand Characteristic # 1: The Patient Population

One significant difference between Port Arthur General Hospital and Royal Victoria Hospital is the types of patients processed. This is important, as it determines the assumptions made about patients and the normal categories the staff use in organizing cases. In Barrie, the RVH processes all emergency cases in the city while in Thunder Bay, PAGH receives a non-representative sample of patient. Since there are three Emergency wards in Thunder Bay, the location of the hospital, the organization of the ambulance service and the specialties associated with each hospital all influence the type of patients who use a specific Emergency ward. Finally, the effects of the types of patients who use the ward on the normal patient categories used by the staff will be reinforced by considering how these categories change when the common type of ailments begin to change.

In Thunder Bay, the patient has a choice as to which Emergency ward to use. This decision can be based on which facility is most convenient or on a preference for one hospital as opposed to another. I observed numerous cases where patients travelled past another hospital in order to go the PAGH, claiming they had received better treatment there in the past. Thus, each hospital develops a loyal following.

While some patients do not mind going across town to a particular hospital, the distance discourages many people from using this facility. PAGH is located on the outskirts of town, out of walking distance for most people in Thunder Bay. A bus goes past the PAGH but also goes by the downtown hospital, resulting in most patients getting off there rather than riding for an additional fifteen minutes in order to see a doctor. Thus, PAGH does not get walk-in patients (with the exception of those from the Salvation Army hostel) and those who arrive usually do so by car or taxi.

The proximity of the Salvation Army is also important in explaining the normal categories used by the PAGH staff. Most of the people who stay at the hostel are disadvantaged, wear shabby clothing, are old, have no permanent address besides the hostel and have no friends

with cars to take them to the hospital. These people use PAGH because it is close and they can walk (or sometimes stagger, if they are drunk) into the ward.

A patient who walks into the hospital ward in shabby clothes is categorized as, "Another one from the Sally Anne" (nurse). Along with the assumption that they are from the hostel, they are also assumed to be suffering from either alcohol intoxication or an alcohol related problem. One of the nurses explained that, "Over fifty percent of our patients (not including chemo-therapy or out-patient surgery) suffer from an alcohol related problem. Either they're drunk or they got drunk and hurt themselves when they were drunk". She went on to say that, "You've gotta suspect that every patient has been drinking because most of them have".[9]

The assumption made by the staff that poorly dressed patients suffer from alcohol-related problems is sometimes more powerful than the actual medical diagnosis of the patient. In the following example, when the medical diagnosis and the assumptions made by the staff member come into conflict, it is the assumption that wins out.

> A patient was brought in from a nearby fast-food place where he had 'gone into convulsions' as he was drinking his coffee. The doctor diagnosed the problem as resulting from the mixture of alcohol and medication

> that the man had taken. However, the alcohol itself had not caused the convulsions. The next day a RNA was looking up the causes of convulsions for a paper she was writing. One of the nurses asked her if she had included drinking, to which she replied that it was not a cause according to the books she had been using. The nurse replied, "Most of the cases of convulsions we get are because the guy's been drinking. Like that guy yesterday. His convulsions were caused by the bottle".

Although the doctor had defined the problem in terms of the mixture of alcohol and medication, the nurse 'knew' that the cause was really over-drinking.

The heterogeneity of the population which uses the PAGH Emergency ward is further destroyed by the structure of the ambulance services in Thunder Bay. Both St. Joseph's and McKellar hospitals have ambulance services associated with them. Thus, when an ambulance goes out to pick up a patient, it usually returns to its home base. Occasionally an ambulance uses PAGH but this is usually due to a request by the patient or a backup in the home hospital.

The fact that ambulances do not usually deliver patients to PAGH is important in understanding how the Emergency ward operates. While the staff use the category 'emergency', the possibility of this type of patient arriving during a shift is not great. Thus, although the

staff make a conscious effort to keep at least one operating room unoccupied they are often over-ruled by doctors who perform operations when it is most convenient for them.

In Barrie, the possibility of an emergency case arriving in the ward is much greater. Unlike Thunder Bay where most of the serious cases go to St. Joseph's and McKellar hospitals, in Barrie they all come to the RVH. Thus, the staff makes a point of ensuring that the main operating room is kept open. Elective surgery is never booked for this room and even stitching that will take time is placed in another operating room. Thus, the staff makes sure that this room is always available because there is a possibility that an emergency case will arrive in a few minutes.

The category of chemo-therapy is a common one in Thunder Bay but does not exist in Barrie. Most of the chemo-therapy patients in Thunder Bay receive their treatment in the PAGH Emergency ward. Statements like, "There's a chemo in 1" are common. However, during my stay in Barrie I never heard the designation chemo-therapy used to classify a patient. Since this type of treatment was not done in RVH, the category did not exist.

PAGH serves as the treatment centre for patients from the local psychiatric hospital (LPH). Patients from

that institution who require medical care are brought by ambulance to the Emergency ward. Because of the number of mental patients who are processed, the hospital staff have a well developed concept of what a 'psychotic' or 'neurotic' patient is and how to treat them. These people, unless noisy and troublesome, are not isolated in any special way and are placed in any convenient place where the staff can keep them under surveillance. This treatment is given to all patients who are classified as 'mental cases', whether from the LPH or from the community at large.

The impact that processing numerous patients from the LPH has on the routines of the staff is clarified through a comparison with the RVH Emergency ward. In Barrie, the presence of a psychotic or neurotic patient is a noteworthy event. This type of patient disrupts the operation of the ward, whether their behaviour is disruptive or not and is discussed by the staff at a future time. The staff takes special steps to isolate the patient from the staff as well as from other patients. They usually call the psychiatric ward and tell them to send a nurse to the ward immediately. This action is unusual as it is the only time that nurses are brought from other wards to handle patients on the Emergency floor. No matter how heavy the workload, the staff of the Emergency ward is not complimented by other staff. By calling in special staff, the

head nurse indicates that something unusual is taking place. Unlike PAGH, where only agitated and troublesome mental patients are isolated, any patient in Barrie classified as a 'mental case' is treated as troublesome.

> At 2100 hours a distraught woman (makeup smeared, tears on face, crying) came to the registration desk in Barrie and said that Dr. A. had told her to bring her husband in. The clerk asked what was wrong with him and she replied, "He's a out-patient at ________ and won't take his medication. He's gone wild. I can't take care of him anymore . . .". The man who appeared calm and was not causing any disturbance was put in examining room 4 (the room with walls and a door), the door was closed and the head nurse called the psychiatric floor and told them to send down a nurse. During the hour and a half that the man was in the ward, no ward nurses went into the room. There was also a lot of whispering among the nurses about the 'nut' in room 4. By the time he left the ward, every nurse on duty knew about him.

Since mental patients are not common in this ward, the staff did not know what to expect and consequently treated this patient as troublesome although he did not indicate this.

The types of patients the staff usually see determine the normal categories that are used. In Thunder Bay, because of the numerous chemo-therapy patients, 'nuts' and drunks that arrive at the ward, the staff have particular ways of processing these patients. In Barrie how-

ever, 'nut' cases are infrequent and do not form a normal category. The relationship between the types of patients who are processed and the normal categories is well illustrated by the change of normal category which occurred when the typical patients underwent a radical and rapid change.

During my first period of study in Barrie and at the beginning of the second, the staff assumed that unless they proved otherwise, patients were nuisance cases with a minor problem.[10] This was the assumption until a flu epidemic hit the community. Then, as more and more people arrived at the ward with 'colds', the normal categories began to change as the typical patient ailment changed.

Many types of minor problems came under the general category of nuisance cases. Bee stings, scraped and bruised shins, bruised ribs and 'colds' were all part of the nuisance class. At the beginning of the flu epidemic the 'colds' were classed as nuisance cases. Then, the staff noticed an increasing number of colds patients and began to comment that, "A lot of people seem to be coming down with the flu". Within two days of this statement the assumption was that patients were suffering from a 'cold'. As the number of patient with this type of complaint increased (up to 70% of the total on some shifts), finer distinctions

began to be made by the staff.

Appendix IV is a graphic depiction of the development of normal categories during the flu epidemic. The category in CAPITAL LETTERS represents the problem that a patient who arrived at the Emergency ward was assumed to have. As time progressed, not only did the assumptions of the staff change, but the categories used divided into sub-categories which in turn became distinct in their own right. Thus, the original nuisance category had spawned five distinct groupings by the end of the epidemic.

The evidence for the existence of these categories (Appendix IV) is found in the attitude of the staff, the different places the classes were treated in the ward, the priority of each class, the type of examination given by the doctor and the medication that was prescribed for the patients. "Flu with complications" and "lingering flu" which formed one category were placed in the recovery area. This is important for flu and cold patients were treated in the examining room. Thus, placement in the recovery area indicates a distinct and more serious type of ailment.

Complicated flu cases were of higher priority than the other types of nuisance problems. In fact, the 'complicated flu' patient was given a status similar to that of the urgent patient. However, the group is dis-

tinct in that the cause of the problem is the flu, not some other problem.

The differentiation between the cold and the flu was based on the severity of the problem. If the patient was believed to be in little discomfort and having a non-serious problem, they were diagnosed as a cold. These people received very brief examinations and were usaully not given any medication. They were seen by the staff as having a problem which, if had by a staff member would not be sufficient to keep them from their job.[11] This differs from the flu which received a more thorough examination, was often given 282's® and penicillin, and was seen as being a problem of sufficient severity to keep a staff member home because of sickness.[12]

It is clear from this analysis that the type of patients who use the Emergency ward influences the normal categories used by the staff and the way that a patient of a particular type will be treated. As the number of cold and flu cases increased in Barrie, these became the expected and normal categories. It has also been noted that an unusual type of patient, such as a mental patient in the RVH Emergency ward, does not fit neatly into a category and causes disruption to the smooth running of the ward. Consequently, it is possible to say that the 'usual' types of patients who use the Emergency ward will determine the

normal categories that the staff use and ultimately whether a particular ailment is treated as 'usual' and receives the normal treatment associated with that category or as 'unusual' and receives 'special' treatment.

Demand Characteristic # 2: The Volume of Patients

The number of patients who are processed in the Emergency ward is a factor which, while largely outside the control of the staff, has a profound impact on the routines of the ward. While the concept of busyness is not easily defined, it would be safe to say that the Barrie Emergency ward was busier than PAGH. Although RVH processed significantly more patients than did PAGH (50 a day was heavy for PAGH, 200 for RVH), the difference in workload was not as great as one would expect. While the staff in Thunder Bay did not handle as many patients as in Barrie,[13] their job was organized in such a way that each patient used up considerably more staff time than was the case in RVH. A comparison of the two wards showed that in Thunder Bay the contacting of doctors and the placement, movement and directing of patients took up more time than in Barrie. Furthermore, the taking of inventory, restocking of supplies and the keeping of records was more time consuming in PAGH than in RVH. Finally, the patient load explained part of

the difference in when and where coffee breaks were taken in the two hospitals.

A major difference between the two settings is the way that patients are placed. In Barrie, once patients are placed they usually remain in that location until treated and released. Patients are moved from the recovery room to an operating room but once the procedure is completed they are returned to their original area. In Thunder Bay however, a considerable amount of time is spent moving patients around the ward. For example, a teenage boy was having out-patient surgery. Between the time he entered the ward and went to the operating theatre he was moved from recovery room 4 to recovery room 2, then into the hallway where he waited for an hour and finally to the operating room (see Appendix II). In PAGH, the staff had a light enough workload to be able to afford these moves but in Barrie, because of the heavy workload they did not have the time to relocate patients. Thus, the placement of a patient in Barrie was more important than in Thunder Bay for once placed, a patient was not moved.

Another interesting contrast between Barrie and Thunder Bay is the presence of a doctor's roster board in the RVH Emergency ward and its absence in PAGH. When nurses in RVH want to see if a doctor is in the hospital, they look across the desk to a board which lists the doctor's names. When

doctors enter the hospital, they are supposed to switch on the light which lights their name and indicates they are in the institution. In Thunder Bay no such board exists in the Emergency department. In order to discover who is in the hosptial, a call has to be made to the switchboard. Thus, in comparison to RVH, the PAGH staff have to make an extra phone call for every patient who comes into the ward.

In PAGH, when patients from the Emergency room are to be moved to a ward on one of the floors of the hospital it is the Emergency ward staff who move them. In Barrie, the receiving ward sends staff to pick up the patient.

Another difference between the two wards is that in Barrie, there are a series of arrows on the hallway floor that lead to the x-ray department. Ambulatory patients who need x-rays are told to follow the arrows. Other patients in wheelchairs who are accompanied by supportive others are wheeled to the x-ray department by the supportive others who are told by the staff to follow the arrows. The arrows simplify the directions that the staff have to provide. This contrasts with PAGH where the staff have to tell patiens how to get to x-ray and often find it easier to accompany the patient there than to tell them how to find it. Thus, we see again that Barrie is designed to minimize the workload of the staff where as in PAGH, similar tasks re-

quire more staff time.

The keeping of patient records also influences the workload of the staff. In Barrie, whoever takes the information from the patient fills out an outpatient/accident report (Appendix II). In PAGH, only the ward clerk fills out these forms. When she is not in the registration area, the nurse or nurse's aide who takes the information from the patient fills out a preliminary report form (Appendix VI). This is paperclipped to an emergency report (Appendix VII). After the patient is treated and released, the forms are given to the clerk who transfers the information from the preliminary report to the top part of the emergency report. While this results in neater, typed forms it also requires a duplication in the recording of information, something that would be a 'waste' of time in Barrie.

The taking of inventory and restocking of supplies also uses up staff time in PAGH that is not consumed in Barrie. In Thunder Bay, inventory is taken, and supplies restocked during the day shift. In Barrie, these tasks are done by the night shift who have more time. Thus, the workload of the day and evening shifts in Thunder Bay is increased by non-essential tasks that are not imposed on these shifts in Barrie.

Finally, the patient load influences where and when

coffee breaks and lunch breaks are taken. In Barrie there is a constant struggle to get off for coffee and dinner during the day shift. The head nurse usually tells the staff when to go for lunch. She asks if they have gone for lunch and if they have not, orders them to go. Often they are reluctant to leave because of the strain this places on the staff who have to cover for them. In Thunder Bay the staff usually go to the head nurse and tell her they are going for lunch or ask if there is any reason why they can not leave. Since the PAGH staff are not usually rushed, they can arrange to go, knowing their absence will not place a heavy burden onthe remaining staff. In Barrie however, the staff usually do not come to a place where there is a break in the action and their leaving means that those remaining in the ward have to work at a hectic pace.

It is also interesting to notice where the head nurses of the respective wards eat their dinner. In Thunder Bay, they usually go to the cafeteria for both coffee-break and lunch. If they do not go it is because, "We can get coffee for nothing down here" or "It's too much trouble to walk all the way to the cafeteria". In Barrie, the head nurse often eats dinner in a small room between the two fracture rooms. In this way she remains in the ward and can be called in case she is needed. This is

also used by the staff on the rare occasions that they have a coffee break. Thus, the staff in Barrie and particularly the head nurse, tend to remain near the ward in case of a sudden influx of patients. This however is not the case in PAGH as there is little chance of such an influx.

While patient volume does not have a direct impact on the way that patients are treated, it is important in explaining many of the routines of the ward. This is an important demand characteristic and one to which the staff often orientate their routines.

Demand Characteristic # 3: Organization of Doctor Coverage of the Emergency Ward

The way that the Emergency wards are covered by the local doctors is an important demand characteristic of the staff. This coverage influences the routines of the staff, how rapidly a patient will be treated and also how much telephoning the staff must do.

Neither PAGH or RVH have resident physicians and consequently the local doctors are organized to treat patients who use the Emergency ward. In Thunder Bay the doctors treat their own patients in the Emergency ward. When a patient arrives at the PAGH Emergency ward the staff contact the patient's doctor who is then informed of the

presence of a patient in need of treatment. Those patients not having a doctor are seen by the physician designated as on 'city call'. This system is very difficult to operate efficiently. The head nurse commented that, "I spend half my day trying to get hold of doctors and the other half filling out reports". Often, the staff will spend fifteen or twenty minutes in tracking down a doctor. This process must be repeated for every patient who comes to the ward. Often three phone calls are required before the doctor is contacted.

In Barrie, doctors are organized into three groups according to the geographical area in which they practice. Each day is divided into three shifts with one doctor on call for each group during each shift. A patient who comes in and has a doctor who is part of a group will be treated by the doctor who is covering for that group. During each shift one doctor is also on 'city call' and also treats these patients.

In Barrie, the staff spend considerably less time in contacting doctors than is the case in Thunder Bay. Since the staff have to keep track of only three doctors, they usually know where the on duty doctors are. The doctors on call make a point of letting the staff know where they can be reached. While I observed two cases where a

doctor was temporarily 'lost', the staff found him after only two phone calls. In short, the staff in Barrie spend considerably less time trying to locate doctors than is the case in PAGH.

The impact of the way that doctor coverage is organized on the routines of the staff is easy to see. In Barrie, the staff do not have to make as many calls as their counterparts in Thunder Bay and consequently can spend more time treating patients. If the system that is used in PAGH was transferred to RVH, the staff would get behind in their work and the ward would rapidly fill up.[14] The great amount of phoning that the organization of doctors necessitates creates a type of busyness in Thunder Bay that is not present in Barrie.

Demand Characteristics # 4: Finances, Doctors, and Their Use of the Emergency Ward

At first it appears strange to view doctors as a demand characteristic influencing the organization and routines of the Emergency ward. However, the doctors are not fully a part of the ward. Their job is largely outside the confines of the hospital, in private practice. Since they are part-time and marginal members of the Emergency ward staff, the way they use the ward is important

in understanding how the ward operates.

There exists a complex relationship between doctors and nurses in the Emergency ward. The nurses run the ward, make decisions about patients and decide when a doctor will be called. If the patient is an emergency case the nurses will already be treating the patient before the doctor is called. This ward is unique in that its patients arrive unexpectedly, usually without known medical history or doctors' orders to aid the nurses. Thus, the nurses take a very active role in the diagnosis and treatment of patients. They use their own judgement more than most nurses who are supposed to 'carry out orders' and 'do routine work well' (Riley and Nelson 1974:59-60).

It is the doctor who is the final medical authority in the ward. While nurses can administer medication in order to save a patient's life, they must, in all other cases follow the orders of the doctor. It is however, the doctor who admits patients and officially prescribes medication.

While the doctor is the final authority in the ward, the nurses often challenge their treatment practices. In numerous instances I observed doctors order medications and the nurse challenge the order. In one instance a doctor ordered a drug given intravenously and the nurse

pointed out that it had to be given intramuscularly. In another case I observed a doctor suggest a quantity of a drug and a nurse suggest that the dosage be higher than the doctor had first ordered. Thus, while nurses do not have the power or authority to officially diagnose patients' problems, they often have an important unofficial role in patients' treatment.

Often, although it is the doctor who officially orders the medication, it is the nurse who has decided on what medication is needed and how much should be given. This process was especially evident in Barrie during the night shift. The staff would often phone the doctor to discuss a patient's symptoms, give their opinion about what was wrong with the patient and suggest a treatment. Occasionally the doctor would disagree but in many cases the assessment by the nurse was accepted and given official approval.

The relationship between doctors and nurses is as varied as the personalities of the people involved. These range from animosity and contempt to true friendship. Most doctors however, make a conscious effort to be kind to the nurses and the nurses are equally disposed toward the doctors. In the case where there is a degree of friendship between the nurses and doctors, both sides

benefit. The nurse will not call the doctor during the night unless the patient has to have treatment and often offer diagnosis and treatment over the telephone so the doctor does not have to come to the ward for a minor problem. The doctors reciprocate by coming to the ward as quickly as possible when called by a nurse without challenging the definition that the problem is serious enough to require a visit.

In Barrie, because of the extended periods the doctors spend in the ward, the staff are much closer to the doctors than is the case in Thunder Bay. The interaction is often informal and on a first name basis. Staff parties include the doctors. In general, the attitude is one of a team working together for a common goal.

There are however, doctors who present a problem to the nurses, constantly criticizing them and complaining. These doctors, while having the official mandate to tell the nurses what to do, do not receive any more help from the staff than is absolutely necessary. The nurses let them do their job, offering very few suggestions and little help unless asked. However, even these doctors present a demand characteristic for the nurses. The nurses are reluctant to call an unliked doctor during the night because of the disdain with which this action will be met. Thus,

while the staff do not like these doctors, they are reluctuant to call them into the ward during the night just as they are reluctuant to call in well-liked doctors.

Much of the attitude of doctors toward Emergency ward duty can be explained by the way they are reimbursed for their services. Their use of the ward affects how busy the ward is, the types of patients who use it and the demand that are placed on the nursing staff. The existence of shifts can also be shown to influence the type of patients who are in the ward.

In Ontario, doctors are paid for their services by the Ontario Health Insurance Plan (OHIP) according to the number of patients treated. Of course, certain types of treatment result in greater reimbursement for the doctor, but in the context of the Emergency ward a general practitioner who treats fifty patients will make more money than a doctor who sees only thirty.

Money alone is not an adequate explanation of why medicine is practiced as it is. I observed doctors who travelled thirty miles in the middle of the night to treat one patient with a minor problem. Most doctors feel a certain responsibility to their patients and will treat them first, even if this costs them money. For example, one doctor in Barrie had ten patients waiting to see him in the Emergency ward. However, he called in the backup

doctor to treat these patients because he wanted to see three patients of his own who were waiting in his office.

While ideals are important in some instances, many doctors are disillusioned by what they have experienced in their practice of medicine. This is well illustrated by a conversation I overheard between two doctors.

> "You came out of training pretty idealistic, didn't you?" 'Yea, but after seeing all the junk that I have, I don't have the idealism any more'. "I know what you mean. Half the patients who come into the office don't have anything wrong with them, and the other half don't take care of themselves." 'I wouldn't do this job for $60,000.' "I guess you're making more than that." 'You're damn right and if I wasn't I wouldn't be in this business.'

This conversation and others like it which I overheard indicate that money is a consideration for at least some doctors.

Doctors in Thunder Bay view their trips to the Emergency ward as a necessary evil. They are reluctant to go and often ask if there isn't another doctor in the hospital who can look at the patient. Their attitude is similar to that of many of the Barrie doctors who are contacted in the middle of the night concerning one patient with a minor ailment. They are reluctant to come to the ward, partially because the $10.00 renumeration does not make a trip across town in the middle of the night worth-

while.

In Barrie, the attitude of the doctors is significantly different toward duty in the Emergency ward. Since there is a larger population coming into the ward, the doctors on call make a substantial amount of money. This aspect is further enhanced because only three doctors are on call at one time and treat all the patients who come into the ward.

Many of the doctors in Barrie engage in the 'stockpiling' of non-urgent patients. The goal of this process is to ensure a constant supply of patients when the doctor is in the hospital. This is desirable for a number of reasons, one of the chief being the maximization of financial benefit for the physician.

A number of specialists engage in stockpiling. The orthopedic surgeons hold a fracture clinic every Tuesday morning. They come into the ward to set broken bones and apply casts when this is required but their regular work such as changing and removing casts is scheduled for one morning a week.

On Tuesday morning the ward takes on a different appearance. Janitors bring in extra chairs and place them from one end of the hall to the other. A sign is placed on the NO ADMITTANCE door that tells patients of the orthopedic surgeons to come through the door and take a seat in

the hallway. The two surgeons set up in the fracture rooms and one nurse from the ward is assigned to work with them.

At 0800 hours approximately 15 people file through the door and take seats in the hallway. As each surgeon finishes with a patient, the nurse brings in the next patient along with their chart. At 1000 hours another group of patients comes through the door and takes seats in the hallway. Usually by 1300 hours the patients have all been seen by the doctors and the specialists have left the ward.

It is interesting to note that all the patients are told to arrive at the ward at one of two times. When a patient complains about the wait the nurse explains that, "We're running behind today. Be patient and we'll look after you as soon as possible." In actual fact, the patients had been told to come to the ward at the same time and a wait is inevitable. By having a number of patients in the ward at all times, the surgeons ensure a constant supply of patients. In this way the doctors make every minute count and do not have periods when no patients are present because a patient is late or forgets to come in.

The surgeons engage in a similar process. On the booking sheet for minor surgery, they will have a number of operations listed for the same time and the same room. In this way if the procedures go faster than anticipated, there are patients ready for their operations. The approach

is similar to that used in mass production where the assemblers (doctors) remain in one place and the work is brought to them. By ensuring a constant material (patient) supply the doctor can maximize productivity and consequently waste as little time as possible in the ward.

Mass production medicine in the Emergency ward extends to the walk-in patient as well as the pre-booked patient. This process was well illustrated during the flu epidemic in Barrie. At the height of the outbreak, a local physician was interviewed on the local radio station about what to do when one caught the flu. He said they should rest, take aspirins, drink plenty of fluids and not go to the hospital unless the problem did not go away in two weeks. One could assume that the people of the area either did not hear this advice or did not heed it for up to 125 people per day showed up at the ward with 'colds'. However, another possible explanation can be found in the actions of the doctors.

Doctors stockpiled cold and flu patients. Dr. Smith was covering for both B group and city call one evening. During the shift he had at least five patients waiting to be treated. As people contacted his answering service the answering service phoned him and he then contacted the person who had placed the original call. During

the next evening shift the doctor on city call engaged in similar behaviour. Again, almost every patient who called into the ward was told to come in.

The actions of the doctors cannot be explained by claiming something was seriously wrong with these patients. During the first part of the shift everyone who phoned the Emergency ward was told to come in. However, by the end of the shift everyone who phoned was told to rest in bed, drink plenty of fluids and take aspirins to reduce the fever. This development is interesting, as patients with identical illnesses received different advice depending on when they phoned the doctor. Since Dr. Smith repeated what was being said to him on the telephone, I could compare patients to see if the time of the shift influenced what a patient was told to do. A parent who phoned at the beginning of the shift about their child who had a temperature of 38 degrees C. was told to bring him in. However, at the end of the shift another parent whose child had the same problem was told to stay in bed. Because of the similarity of these instances, it is clear that the doctor was orientated to the time of shift more than the ailment which the patient had.[15] Thus, the time the patient contacts the doctor will often determine what they are told to do about their ailment.

Since doctors are paid according to the number of

patients treated, they may attempt to maximize their profit. Often, the presence of patients in the Emergency ward who do not have serious problems is not indicative of the patients' misusing the ward but shows rather that the doctors are thinking about the financial return that such patients represent.

Economics also influences who gets admitted to the hospital from the Emergency ward. An admission is worth more to a doctor than a patient who is treated and released. One evening a doctor coming onto shift remarked to another doctor that she must have made a lot of money during the previous evening shift. "Yeh",she replied. "I treated sixty patients" (worth around $500). The doctor coming on shift responded, "Well, I doubt if I'll have a busy night. I guess I'll have to admit everyone who comes in tonight". I thought no more about this comment until I returned the next morning. Of the five patients who had shown up during the night shift, four of them had been admitted to the hospital for observation. To my untrained eye, their symptoms were no worse than those of the hundreds of patients who had arrived at the ward during day shifts and had been treated and released. While it is possible that some serious medical problem was not reported on the information sheet, it is more likely that the doctor made his stay at the hospital worth-

while by admitting as many patients as possible.

Admission practices are a constant source of debate and comment among the doctors. One night I overheard the following conversation between three doctors.

> "How many admission did you have last night. It looks like you filled up the whole hospital". 'Yea, I admitted everyone who came through the door. The newspaper man came in and I admitted him. Somebody came in to see their mother and I put them in a bed'.

While such comments were said in jest and probably not true, they show that doctors are sensitive about the way they admit patients. The fact that this issue comes up in everyday conversation indicates that doctors are sensitive about the subject and may be admitting patients who are not, in their eyes, strictly admission material.

The way that doctors use the ward influences the routines of other staff members. The staff must operate the ward, even when it is crammed with patients who are being stockpiled. This means that there is a constant struggle to keep beds free in case a serious ailment comes in. Often the ward is full because of the stockpiling that goes on. Patients who have been prepared for minor surgery must be watched closely by staff. Thus, the stockpiling practice of the doctors influences the working conditions in which the staff do their job.

The ambiguity of what constitutes a 'sick patient' and 'a patient sick enough to be admitted' becomes more important in chapter VI. The illustrations that have been presented, show that these decisions are not based solely on medical criteria but are also influenced by financial considerations and the time of the shift. Thus, the severity of an ailment is often decided on non-medical basis.

Conclusions

The divisions that have been made in this chapter, while helping to clarify the demand characteristics which exist, are artificial. The busyness of the ward is partially determined by the way doctors use the ward. As we observed in the discussion of admission practices, the type of patients using the ward is also influenced in this way. One could also argue that the way doctors organize themselves is a result of the type of patients that they see in a ward. Since PAGH does not process serious cases, the doctors do not feel that 'good' coverage is needed for this hospital. In short, these demand characteristics and other more subtle ones are influencing the routines and organization of the Emergency ward.

This chapter has pointed to the significance of

demand characterisitcs on the routines and organization of the Emergency ward. The way doctors cover the ward, the activity of the ward and the type of patients who avail themselves of it influence the 'normal' categories of patients, the way that patients are treated, and the routines of the ward in general.

At the risk of being overly simplistic, it can be claimed that the ward is organized more in consideration of the doctor than the patient. This is not to say that the patient who needs immediate treatment is ignored, but points instead to the fact that in cases where the patient's problem is perceived as non-urgent (most cases) the nurses orientate themselves to the demands of the doctor. The nursing staff are involved in a complicated job of balancing patient demands with those of the doctors. Thus, the ward is not organized primarily for the patient but is designed to accommodate the doctor and to a lesser degree the nursing staff.

CHAPTER V

AILMENT CATEGORIES

Chapter 4, while clearly pointing to the importance of certain demand characteristics, does not present a complete picture of the Emergency ward. It fails to consider the physical structure of the ward and how the staff use this in organizing patients. This chapter is an examination of the physical setting of the Emergency wards; how patients, through response to the the setting indicate the severity of their ailment, how placement in a specific treatment area indicates a patient's degree of illness and how different treatment areas help control specific types of trouble which different categories of patients represent.

Barrie: Treatment Areas

The Emergency department of the Royal Victoria Hospital is located on the main floor (Appendix I). It contains a waiting room, five examining rooms, five recovery rooms, two fracture rooms, five operating rooms, storage areas and washrooms. Each area contains special

equipment designed to help a particular type of patient.

Operating rooms I and II, the major surgery facilities of the ward, are equipped to handle the most serious cases and contain the most sophisticated equipment. Operating room I is designed to handle 'emergencies' and minor suturing that will not tie up the room for more than ten minutes. Operating room II is used for suturing that will take a prolonged period of time and most other operations performed in the ward.

Operating rooms I and II contain the usual operating room equipment. Both are equipped with nitrous oxide and oxygen lines for induction of light anaesthesia. They also contain operating tables and numerous types of surgical trays stored on shelves around the room. Since these rooms are not sterile, serious surgical cases are moved upstairs to the sterile operating theatres.

Operating rooms III and IV are specialty rooms not containing anaesthetic equipment. Operating room III is largely used for gynecological examinations and contains the appropriate equipment. Operating room IV is used for eye, nose and throat (ENT) examinations. It is also used by the dentist when he comes into the hospital and a portable dentist's cart is kept for his use. This room contains machines for examining vision, tuning forks for

testing hearing and other equipment for this type of examination.

In terms of decreasing complexity of equipment, the recovery rooms come after the operating rooms. Each of these five rooms which are separated by curtains contain an oxygen outlet and a stretcher.[16] By looking through a window at the back of the nurses' station, the staff can see into all of these rooms if the curtains are slightly open. This area is officially designated as the place for patients recovering from day surgery and is also used for patients with heart problems.

The two fracture rooms are used largely to apply, remove and change casts. These rooms are equipped with saws, cutters and special cast making materials. They are connected by a small room which contains forms for casts as well as chairs and a coffee perculator that the staff use when they take a break.

The examining rooms are the final treatment area. With the exception of room four, the others are separated only by curtains. Each room contains a wall-mounted auroscope, an otoscope, a blood pressure cuff, a sink and a moveable stretcher. This is the area in which patients who require minor examinations are seen.

Examining room four has a special status in the

ward. This room is constructed of block walls and has a wooden door. It is the only treatment room that is soundproof and private. It is often used to inform next-of-kin of a death and occasionally used to store a corpse, although the staff do not see this as a desired practice. This is the only area outside the operating rooms that is closed in and affords total privacy to a doctor and patient.

Apart from the treatment rooms, there are two waiting areas. The first of these is the main waiting area which can accommodate 10 persons. The second is composed of 10 chairs which line the main hallway (see Appendix I).[17]

Port Arthur General Hospital: Treatment Areas

The Port Arthur General Hospital Emergency ward is quite a bit smaller than its counterpart in Barrie. It contains a waiting room, four recovery rooms, two closed-in examining rooms, an operating room, a fracture room, a room used for 'scope' examinations as well as storage and washrooms (Appendix V).

In Thunder Bay, there is not the clearcut difference between the fracture room and the operating room that is found in Barrie. The fracture room is really just the

second operating room which is used for applying and removing casts. Both these rooms are equipped in a similar fashion to Operating rooms I and II in Barrie.

Both the closed-in examining rooms and the recovery areas are used for the diagnosis and treatment of minor problems. However, most patients end up in the recovery areas unless these stretchers are already full. The examining rooms are used for informing the next-of-kin of death and for examinations where privacy is required. For example, a patient who had a 'personal' problem (Pediculosis) was taken into this room and examined by the doctor.

The examining rooms also function as holding areas for patients who are waiting for beds in the hospital. Most patients who are admitted to the hospital through the Emergency ward must wait between twelve and forty-eight hours before they can get a bed 'upstairs'. Also, the Emergency ward is officially designated as the 'hallway' for every ward in the hospital. If there is any overflow in a ward, the patients are to be placed here instead of in the hallways associated with the ward. Thus, if patients will be in the ward for a number of hours until a bed comes free, they are put in one of these rooms.

A final area of treatment is the special operating room where 'scope' examinations are performed. Although

the staff can walk to this room without leaving the ward, patients on stretchers must be taken on a long journey through the hospital because there is not enough room to move a stretcher directly.

In Thunder Bay, much more use is made of the hall-ways as an area to store patients than is the case in Barrie. The staff often place patients in the hallways, a practice neither viewed as bad nor undesirable. Thus, the bed limit of the ward is increased because the staff can place five or six patients on stretchers in the hallway.

Most of the patients who come into the ward end up in one of the recovery rooms. Examinations and treat-ment done in the ward generally takes place in this area. Chemotherapy patients who require lengthy treatments (4 to 10 hours) are placed here. Each cubicle is separated from the others by a sliding curtain and contains a stret-cher, oxygen outlet and a wall mounted blood pressure cuff.

The waiting room is fairly small, containing two groups of four chairs clustered around two small tables. This area looks into the nursing station through a glass window which has an opening through which patients register. The nursing station is small, approximately six feet wide and fourteen feet long. This extremely small room is crowded when three people are in it and consequently the staff

members congregate in either the medicine room attached to it or the nurses' room at the back of the ward.

Categories of Ailments and Their Meaning

As noted in the review of the literature, the meanings of medical categories are far from clear-cut or obvious and differ radically from one writer to another. This problem shows that similar medical symptoms can indicate different things in different settings. While some medical signs such as the lack of a heartbeat have a generally accepted meaning, what is done about this condition and how rapidly it is done varies, depending on the setting (Sudnow 1967). The meaning of symptoms is dependent on the normal categories which the staff use, the treatment areas in the ward, the severity of other patients' ailments and other considerations such as the smooth operation of the ward. Thus, the severity of an illness cannot be decided merely by looking at the medical symptoms of the patient.

Each area in the ward, besides being specially equipped to handle a certain type of patient, carries with it a particular meaning. Not only are emergency cases handled in the operating room but patients in this room are considered to be emergencies. Consequently, once patients are placed, their ailment becomes that which is treated in that

area. The patient becomes part of a category, defined by a specific area in the ward.

Another major consideration of the staff is the desire to have a smooth running ward. True, they are concerned with treating patients but they are also concerned with doing this in such a way as to ensure minimal disruption in the ward. Because of this consideration, the setting is used and routines are organized in such a way as to minimize the impact of potentially disruptive forces.

Emergency Cases

'Emergency' is a temporary and transitory state which occurs when a patient is believed to be dying. Emergency cases are relatively rare in the Emergency ward. Most patients with emergency conditions are either dead-on-arrival (DOA) or have passed through the crisis and are in serious but stable condition. However, emergencies occur occasionally. While emergencies can occur anywhere in the ward, the staff prefer to place these patients in the operating room.

Emergency patients do not enter the ward under their own power. Usually they are defined by the ambulance drivers who bring them in. Although the ambulance attendants are called 'truck drivers' and 'meat-wagon-men' by the medical

staff, they can label a patient as an emergency case, even before the staff see the patient.

> The ambulance dispatcher phoned in a case that was arriving in ten minutes. The patient was said to be a 35 year old male with a possible heart attack. The dispatcher informed the nurse that the operating room should be ready for the patient. By the time the patient arrived an I.V. was set up, the monitors were plugged in and ready to be attached and the operating table had been moved to make room for the stretcher.

While the staff have numerous stories about attendants who have called in emergencies which were not that serious, the request by the attendants to set up the operating room for an emergency is obeyed.

The emergency cases which do not arrive by ambulance are usually detected at the registration area as they enter the ward. The staff, by interpreting the complaints of the patients discover what is 'really wrong' and decide how serious the problem is. They do not accept statements at face value, but interpret what patients say. For example, when a butcher came in and said that he had cut a major blood vein in his wrist, the nurse asked to see it while he was still at the registration window and did not take him to the operating room. While he had defined it as an emergency, in the nurses' opinion the condition was not that serious.

Usually emergency cases are detected immediately

upon entering the ward. These are patients who are perceived to be in the process of dying. Occasionally however, the staff fail to detect an emergency case. While patients are not usually moved from a treatment area to the main operating room, the staff may discover that they have not detected the emergecy case at the front desk and move the patient to the operating room.

Most emergency cases are transferred almost immediately to other wards in the hospital. If the problem is surgical, the patient is sent to the surgical ward or operating room after only a brief stay in the Emergency ward. In the case of most emergencies, the ward serves as a referral service, sending emergency cases upstairs.

A case is an emergency when the normal activities of the staff are seriously disrupted on account of that patient. A nurse informed me that the staff face numerous 'emergencies' each day. "For example", she said. "That boy in three is an emergency. If we don't get his nose-bleed stopped he'll bleed to death". While what she said was true, the case did not cause a disruption in the routines of the ward since 'all' nose bleeds are perceived as being easily correctable. The only staff members who looked at the boy were the doctor and the nurse assigned to the recovery area. This patient was not perceived as threatening to die, did not cause a disruption in the routines of the ward and con-

sequently was an urgent and not an emergency case. Thus, the severity of a case is ultimately described in terms of action rather than through ambiguous labeling technique.

The Royal Victoria Hospital has a formal policy to handle the most common emergency, the cardiac arrest. When a patient goes into arrest a nurse dials 5 on the telephone and repeats EMERGENCY RED, or PEDIATRICS RED, or ___________ RED depending in which ward the arrest occurs. By dialing 5 on the telephone, the call automatically goes over the hospital public address system and is heard in all wards. Upon hearing this message, the person at the front desk turns a key which sends all the elevators in the hospital to the floor containing the coronary care unit (CCU). Staff from this ward take a crash cart along with them to the elevator and go to the appropriate floor and assist in treating the cardiac patient. However, the call for help does not go out in very many instances. Only when a ward needs additional help for a cardiac arrest do they call a RED. Thus, a RED is not called for most patients who arrest.

Cardiac and respiratory arrests are the most common emergency situations in the ward. The following example clearly illustrates a typical emergency and shows how the regular routines of the ward are disrupted.

> One evening the ambulance dispatcher phoned in a possible coronary. As the

> patient was wheeled into the ward the attendants announced that the patient had just arrested. The attendants ran down the hall with the stretcher and placed the patient in operating room I without asking the staff where he should be placed. Four nurses and two doctors were right behind the stretcher as it was moved into the operating room. During the period that the patient was in the operating room the regular routines of the ward were shut down. The other patients were left alone as the staff concentrated their efforts on bringing one patient to stable condition.

There are a number of reasons why emergency patients are disruptive to the smooth operation of the ward. One already mentioned is the huge amount of time and resources which they tie up. A second reason is the undesirability of having a patient die in the ward; and emergency patients often do die.

Death, while a part of nursing, is not liked or taken for granted. The staff do not like to handle corpses or even to have them around the ward. The following two examples show that the staff have a dislike for corpses which is similar to that of members of the society in general.

> A nurse came to the head nurse one evening and asked her to phone the orderlies again and tell them to take the corpse out of the ward. "It makes me feel funny having a stiff here" she said.

> One nurse, on observing a marking on the blackboard that indicated a corpse was in the fracture room said to the head nurse, "Call the orderlies again and get it out of here. It gives me the creeps".

Although death is a part of the life of the staff members, they do not take it for granted and attempt to prevent deaths on the ward if at all possible.

While the staff do not like to have patients die in the ward and prevent it if at all possible, occasionally it is more expedient to have patients die than to keep them alive. The staff can afford to have the ward shut down for only a very short period of time. When an Emergency patient is in the ward, the rest of the ward is neglected, other patients must wait for treatment, and the staff get behind in their regular work as they treat the emergency patient. The following comment by a nurse shows that patients can reach a point where it is more convenient to have them die than to keep them alive.

> A nurse described why no concerted attempt had been made to revive a patient who went into cardiac arrest for a second time. "It didn't make any difference", she said. "We might have brought him back again but the same thing would have happened so what's the use?"

Another problem that death causes is that corpses must be stored until they are removed to the morgue. In Barrie, the preferred place for this is Fracture room II

but if this room is unavailable Operating room II is used. Fracture room II is popular because it is not frequently used to treat patients and thus an active treatment area is not tied up. When the body is in either Fracture room II or the operating room, the door to the room is kept closed. On the back of the door to the second fracture room is a sign that says, DO NOT ENTER. When this sign is visible (when the door is closed) the staff know there is a corpse in the room. Patients also stay out of the room because of the sign.

The ward is organized in such a way as to minimize the chance of staff member inadvertantly entering a room containing a corpse. One way that the staff know of a corpse's whereabouts is through word of mouth. Another way is by looking at the patient placement board on the wall opposite the nurses' station. The patient's name, along with the name of the attending doctor, is written beside the room designation. If however, the room contains a corpse or some type of unusual patient (drunk, mental patient) a stroke is put next to the room designation. Upon seeing this a nurse knows that something unusual is going on in that room and usually asks about it.

Since most emergency patients are treated in Operating room I, those who die must be moved to the fracture room in the presence of patients. The staff do not cover the face since this indicates a corpse, but rather move it with the face uncovered. Sometimes the staff will act as if the patient is alive, making comments such as,

"Let's put Mr. Jones in here for a while and let him rest". A nurse explained to an R.N.A. that, "If you cover the face they [the patients] know he's dead and get upset". However, the orderlies who move the corpse to the morgue do not observe such niceties since they do not work in the Emergency ward and are not concerned with the reaction of the patients to a corpse.

Another disruptive effect of having a patient die in the ward is that the next-of-kin must be called in and informed of the death. The nurses have to phone and tell them to come into the ward without admitting that the patient has died. When the next-of-kin arrive, they are put in Examining room IV (the enclosed room) and the doctor informs them of the death. Besides having crying next-of-kin in the ward, the staff also have to be careful not to talk about the death while the next-of-kin are in the vicinity. Consequently, the presence of these people in the ward forces the staff to modify their usual and natural way of interacting.

While the operating rooms are the best equipped rooms in a medical sense, they are also ideal rooms for emergency patients in another way. If an emergency patient dies in one of the recovery or examining rooms the people on the next stretchers hear the staff talking about the

patient and become upset. However, a patient who dies in the operating room is isolated from the rest of the patients and therefore does not upset them.

In the case of an emergency patient, the primary goal of the staff is that the patient not die, at least in their ward. However, since this is a possibility, they order their routines in such a way as to minimize the disruption in the ward. While the emergency case represents one type of potential trouble, the nuisance case presents another more common and very different set of problems.

B. Nuisance Cases

The staff of the Emergency ward are faced with a constant problem. "The less serious the case, the more they complain about the speed that they're looked at" (a nurse). The minor cases frequently must wait for a couple of hours before they are treated. These people often become extremely upset about the 'slow' service they receive. The staff are constantly being told that, "If I came in here and was really sick, I'd be dead before I got treated" (patient to nurse). The staff point out that such criticism is unfair and if they were really sick they would receive immediate attention.

Patients treated in the examining area are by

definition minor problems or nuisance cases. Once placed in this area, all the staff know that these cases suffer from no serious problem.

Not only are nuisance cases treated in the examining area but during crowded periods they may not receive the minimal privacy an examining room affords. Many of these patients are treated in open and public areas. A bee sting was looked at by a doctor in the hall waiting area in the midst of other patients. A sore wrist was wrapped behind the nurses' desk. A minor cut on a hand was dressed in the open area in front of the examining rooms. Some problems in this category require privacy but most do not, and so are treated in the most convenient place.

Nuisance cases can also be differentiated from the others in terms of the way their registration forms are processed. If the case is not serious it is placed at the bottom of the pile and the doctor treats patients from the top down. However, if the case is urgent the nurse will place it on top of the pile so that the doctor treats it first. Consequently, nuisance cases are those which must wait their turn for treatment.

Nuisance cases represent trouble to the staff because their definition of their ailment differs from that of the staff. Most of these patients believe that

their problem is serious and should be treated immediately. However, the staff see these problems as minor, of low priority and able to wait for treatment. The way these patients are processed and where they are placed encourages them to redefine their ailment as non-urgent. If by chance they do not redefine, there exists a mechanism through which anger can be expressed without harming the hospital's public image.

Patients entering the Emergency ward are confronted by stretchers and wheelchairs. If they walk past these, they have already shown that the ailment is not as serious as those requiring these aids. In the case of some sensitive individuals, the insignificance of their ailment in relationship to the problems of 'other' patients is already established.

When patients enter the registration booth in the waiting room, they are confronted with a sign which says in part, "If your case is not a true emergency you may have to wait some time before a doctor is free from his other duties to attend you". This warns nuisance patients to expect to wait before being treated and helps to 'normalize' the wait that may be experienced.

During the registration process, nuisance patients are further shown their insignificance in the eyes of the

staff. The ward clerk who is at the registration wicket will not stop talking with another staff member when a patient comes to the window. Many of the patients clear their throat a number of times to get the attention of the staff or say, "Excuse me". Thus, even before they are registered, patients are shown that they are not seriously ill.

Only when staff members are finished their conversations will they register potential patients. However, if during the registration the telephone rings, the registration is interrupted and the phone answered. If the phone call requires action away from the wicket, then away goes the clerk. Again, patients are shown that in the busy ward they must wait for treatment.

During the busy periods, when the ward is backed up, the nuisance cases are stored in either the hallway or the waiting room. The area where they must wait reminds them of the serious business that goes on in the department and the insignificance of their ailment. Patients in the outer waiting area see the top third of the torso of nursing staff members as they move behind the registration desk. They do not observe where they are going or where they are coming from but see only constant movement. Thus, it appears that the staff are extremely busy.

Other movement is visible from the outer waiting room. Patients who are being transferred into the R.V.H. from other hospitals arrive by ambulance and are moved through the second door and down the hallway to the main registration desk (Appendix I). Women going to the labour rooms take the same route. Many of the hospital staff enter through the emergency doors. Thus, the patient observes: 1) the activity of the hospital, 2) the bustle of the staff, and 3) the seriousness of the cases that are being treated in the hospital (the number of stretcher cases that go past).

The hall waiting area is also designed to control potentially troublesome patients for extended periods of time. As patients look toward the front of the department they observe the staff moving across the hallway between the examining rooms and the nurses' station. This positioning gives the impression that the staff are hard at work. Out of sight is the nursing station where the doctors may be sitting and telling jokes as the nurses drink coffee. Again, the patient sees only the busyness of the ward.

The hall waiting area is on the major traffic route in the ward. Cases are wheeled from the treatment areas to the x-ray department and back again. Furthermore, when sitting in this area, the patients cannot help but see occupied stretchers being moved across the back hall from one

x-ray area to another (Appendix I). Again, the busyness of the hospital is reinforced.

It is important to notice that the hall waiting area is directly across from Fracture room II. Patients sitting in the hall look directly into this room and are further reminded of the serious ailments of 'other patients'. Occasionally they see a cast being put on or removed in Fracture room II but more commonly they see a dimly lit room where there are a number of occupied stretchers. This room is used as a recovery room for minor surgery patients, especially sterilizations who are placed here to recover after their surgery. Patients cannot help but compare their ailment with that of the gowned, still patients in the fracture room and many redefine the severity of their problem because of this.

Signs also play an important part in the control of patients. Down the hall, about ten feet from the last chair in the hallway is a sign hanging from the ceiling which says, QUIET, SURGERY IN PROGRESS. This sign is a permanent fixture and not a statement of fact. It shows patients that this department is processing serious cases and that one will have to wait one's turn for treatment.

The hallway is preferred by the staff over the waiting room for control of potentially troublesome nuisance

patients. Not only is the setting stronger in its reinforcement of the seriousness of the work of the ward, but once patients are into the actual ward they tend to wait quietly for a longer period of time than they would in the waiting room. Numerous patients who were told to wait in the waiting room returned to the registration area and asked if they had been forgotten, if the doctor was coming in or when they would be seeing a doctor. While the waiting room could control a patient for approximately one half hour, the hallway would usually control the patient for one and a quarter hours. If patients had to wait longer than this they started to get restless, often walking to the nurses' station to ask why treatment was taking so long and occasionally walking out of the ward in anger.

During the night, when beds are available in the ward and there is no backlog of patients, the staff use a different method to ensure patients will wait for extended periods of time before being treated by a doctor. The night staff attempt to persuade patients with minor problems to, "Rest here and we'll keep you under observation. When the doctor comes in in the morning he'll look at you" (nurse). While sensitive to the problems waiting patients cause, they are more concerned with having patients leave before being seen by a doctor. Patients who want to leave are urged to sign a form which releases the hospital from any responsi-

bility for the patient's well-being. If by chance the patient left without being treated and happened to die, the hospital could be held responsible for the patient's death if such a form was not signed.

Most patients who have minor problems and come in during the night are willing to wait until morning for a doctor. However, in some cases a patient will get upset. The common response of the staff is to separate these patients from their accompanying others. These people are told to, "Go home and we'll look after her 'til the morning" (nurse to a patient's husband). If the supportive others can be removed, the patients will usually remain quiet and accept the period of 'observation'.

Some patients however demand immediate treatment. While most of these people do not know it, they have a legal right to this type of service. The staff discourage the patient from seeing a doctor but if the patient persists they can see a physician before morning.

> One evening a patient was brought in by her husband. The nurse commented to the nurse's aide that, "There is nothing wrong with her. We'll keep her overnight and the doctor can look at her in the morning". However, the man would not leave. He demanded that a doctor look at his wife immediately. The nurse attempted to convince him that his wife needed a period of observation but he would not accept this and demanded

> to see a doctor. The nurse finally called in the supervisor who told the nurse to call the doctor even though he would be upset about coming in for a minor problem.

Thus, while it is unusual, a patient who insists on treatment can overrule the nurse's assessment of the situation and be seen by a doctor.

The techniques that are used to control nuisance patients are very effective. They usually remain quiet and are willing to sit for extended periods of time before being seen by a doctor. Occasionally however a patient gets upset and extremely angry. If this happens, this anger can be expressed in a harmless way.

Some patients who get angry stomp out of the ward before being treated by a doctor. However, most wait and if, after being seen by the doctor they are still upset, some follow the instructions of two signs. On the wall of the waiting room as well as on the wall across from the hallway waiting area are framed signs in bold, black letters which say,

> If you wish to comment on any aspect of this "Emergency" service you are invited to obtain a form from any member of the emergency service staff. Please return the completed form to the staff member.

This form provides a way that patients who feel they have received poor treatment can take out their frustrations.

If they fill out a form that is critical of the department, they are less likely to write the newspaper, the hospital administrator, or the director of nursing. They can vent their anger in this non-public way and the hospital can avoid adverse publicity; something about which they are very concerned.

The form exists, not as a way that the staff assess the performance and operation of the ward, but as a way to neutralize patient criticism. The positive comment forms are taped to the wall across from the nurse's station along with cards of thanks which are received. I never observed any negative comment forms on the wall and a nurse explained that, "We throw them away. We only put up the good ones". Thus, the good image of the ward is intensified by the positive comments of former patients.

C. Urgent Cases

In terms of ailment severity, the urgent case lies between the nuisance case and the emergency. This is the stabilized, serious case. While these patients are not presently in the process of dying, they may have just come through a serious medical crisis. These patients are placed in the recovery area and are perceived by the staff to be the proper work of the ward.

The urgent case does not represent trouble as do the other two categories of patients. They are not threatening to die but are ill enough not to wander around the ward or complain about slow service. These patients, like the others are best described not in terms of the ailment or medical problem that they have but in terms of how they are processed.

Urgent cases are non-nuisance cases and are treated as such. They are placed in the recovery rooms, are not forced to wait for treatment in the hallway or waiting room, have their charts placed on the top of the piles of out patient/accident report, do not have to 'wait their turn for treatment' and are perceived as being 'really sick'.

Patient Categorization

Thus far I have examined the categories which the staff use to organize patients. However, the placing of patients in these categories is something that has been overlooked. In the review of the literature section it is noted that medical criteria are not adequate in explaining how patients are processed. If medical criteria are not the sole basis of this decision, then what factors are important in deciding how serious a patient's illness is?

Triage takes place when patients first enter the

ward. The major distinction the staff make is between nuisance and non-nuisance cases. The assumption is that, unless they prove otherwise, all patients are nuisance cases. Certain medical symptoms such as unconsciousness, chest pains or large wounds are sufficient to result in a non-nuisance classification. However, in most cases these medical conditions are not present and the defeating of the assumed nuisance' classification is dependent upon responding to the physical setting in a particular manner.

Upon opening the outer doors of the emergency department, one enters a fire space of about ten feet, at the end of which is another set of double doors (Appendix I). Lining the sides of this hallway are wheelchairs and stretchers. Patients who are unable to continue can sit down on a wheelchair or lie on a stretcher and then be rolled through the second set of doors by supportive others. The appearance of a patient on a stretcher or wheelchair ensures immediate access to the back area and a non-nuisance classfication.

Through the second set of doors is a hallway perpendicular to the short hallway (Appendix I). Immediately in front is another set of double doors with frosted glass and NO ADMITTANCE in bold letters.

When one come through the second set of doors, a choice must be made. If the patient's ailment is not painful or pressing, the NO ADMITTANCE sign is significant.

Thus, most patients enter the registration area at the front of the waiting area. In so doing they indicate that their ailment is not a matter of 'treat me or I'll drop dead'. They have shown that the sign is important and that their problem is not serious enough to warrant a violation of the NO ADMITTANCE sign.

In some cases, patients or the person who has brought them in feel that the illness is critical or serious. That person tends to stride through the NO ADMITTANCE doors. If they walk through these doors in a positive manner, they will receive immediate attention.

> A man came through the doors with his wife in his arms. He was immediately told to take her to examining room I and lay her on a stretcher (all the recovery rooms were full).

His bold violation of the frontstage/backstage boundary indicated that this was not a nuisance case.

Occasionally, someone does not violate the NO ADMITTANCE sign even though they have a serious medical problem. The nurses talk about this type of case a lot, fearing that they will make a mistake and have someone wait who should be treated immediately. One case graphically illustrates this problem.

> A male (about 35 years of age, well dressed) arrived at the ward at 1000 hours. He was carrying a young girl (age 8 years). He waited for a lady who was registering to finish and then

> entered the registration room with the girl. The nurse asked him what was wrong and he said that the girl had been hurt. The nurse started filling out the registration form, discovering that the man was not the girl's father but the vice-principal of the school. When the form was completed, the nurse told him to bring the girl in and place her on the stretcher in recovery room 5. The nurse helped him place her on the stretcher. When she removed her hands they were covered with blood. On discovering this, three other nurses entered the room and a doctor was paged. Within ten minutes the child had been moved to the operating theatre. The problem was twenty wounds administered by a stick knife.

This case was discussed by the staff for a number of weeks. Part of its attractiveness was the violent nature of the injury but also mentioned was the way the vice-principal had registered the child. The staff had been fooled into thinking that this was just another nuisance case. This is the type of instance which the staff worried about, fearing that a patient might die because of improper categorization. It clearly indicates the importance of the patient's response to the setting on their assessment.

The way that patients respond to the setting indicates the severity of their problem. Patients who take the proper route into the ward are nuisance cases. However, a violation of the NO ADMITTANCE sign does not automatically indicate a non-nuisance case. If the violation is hesitant,

the individual is perceived as an intruder, nosey or uncouth. The presence of these patients is usually not acknowledged at first and sometimes they retreat to the other side of the door and enter the registration area. However, if they do not respond to the subtle cues which the staff direct their way, they are asked what they want. If it is a medical problem they are told to go out and register. If they are a relative of a patient they may be taken to the patient or told to wait in the waiting room. The following case is representative of what happens to hesitant intruders.

> A man of about 55 came hesitantly through the door. After he had stood inside the door for approximately five minutes a nurse asked him what he wanted. He said that he wanted to see Dr. X. He was informed that Dr. X was at his office and that he should go there and see him. The man was then ignored and eventually left.

The decision as to whether patients are nuisance cases or not is important. It determines how soon they are treated, where they are treated, and the assumptions which are made about them. Nuisance cases are assumed to have nothing wrong with them and receive brief, extremely superficial examinations by the doctor. Non-nuisance cases on the other hand are seen as being sick and the medical staff treat them much more seriously, giving them more extensive examinations and looking for illness. The common non-nuisance patient is one who has chest pains. Often, the nurses start

an I.V. without waiting for an order from the doctor. They will also order ECG's and get the doctor to rubber stamp the orders at a later date. This is radically different treatment from that afforded nuisance cases.

In Summary

The Emergency ward staff treat a wide variety of patients, varying from those with life-threatening conditions to others who have colds and light temperatures. These patients require radically different types of treatment and place different demands on the staff. The staff assess the severity of the cases and then assign them to different areas of the ward. Each treatment area is designed to handle a certain type of patient and also has a certain ascriptive meaning. Thus, placement in a particular area indicates the severity of a patient's ailment.

In Barrie, there are three major treatment areas which correspond to the three triage categories. Emergency cases are placed in O. R. I and are believed to be in the process of dying. The staff attempt to prevent death, but if it occurs they adjust their routines so that its disruptive impact is minimized. By treating a corpse as alive, by closing doors to rooms containing corpses, by putting a slash on the blackboard when a corpse is in a room and by

isolating dying patients in the operating room away from other patients, the staff reduce the disruptive impact of having someone die in their ward.

Urgent and nuisance cases can also be separated by considering how they are processed and where they are treated. Nuisance patients are treated in the examining rooms and occasionally in the hallway whereas urgent cases are seen in the recovery area. Nuisance cases also differ from urgent cases in that they often must wait for treatment while the urgent cases receives almost immediate medical attention. Urgent cases are not treated in the order they come to the ward but have higher priority than the nuisance cases who must wait until the urgent cases have been treated, and are then treated in chronological order.

In Thunder Bay, the distinction is made between nuisance and non-nuisance patients. Unlike Barrie which has three distinct treatment areas and three normal categories of sickness, in Thunder Bay the nuisance cases are treated in the recovery and examining rooms and urgent and emergency patients (non-nuisance cases) are placed in the operating room. Because of the lower volume of patients seen in Thunder Bay, nuisance cases do not have to wait and are usually placed on a stretcher once the registration form is completed.

The existence of long waiting periods for nuisance

patients in Barrie presents a problem for the staff. Many of these patients become upset and cause problems for the staff, occasionally storming out of the ward. The problem is that many nuisance cases believe their ailment to be serious and deserving of immediate medical attention while the staff see it as a minor problem. In the registration process and the waiting period, these patients are constantly reminded, both by the actions of the staff and by things which they oversee, that their ailments are not very serious in comparison to the 'sick' patients in the ward. In this manner, patients are encouraged to redefine their ailment as minor and accept the wait as appropriate.

The the staff of both wards are forced to decide how serious patients' ailments really are, in Barrie this decision is made more frequently because of the heavier workload. Unlike PAGH where almost all patients are immediately assigned to a stretcher, the staff in Barrie have to decide which patients can safely wait in the waiting room. The biggest help in deciding this is the way that patients respond to the setting. If they barged through the NO ADMITTANCE door and demanded treatment they are classified as urgent cases. If however, they do not ignore the sign but go to the registration window they are classified as nuisance patients.

Despite the differences between the two wards,

there is one important similarity. In both settings, patients are seen as suffering from a minor problem unless they prove otherwise. Certain medical symptoms such as loss of consciousness, large open wounds and chest pains are usually sufficient to result in an immediate urgent classification. Urgent classifications are also achieved by those patients who violate the NO ADMITTANCE door. While these two sets of conditions are sufficient to defeat the nuisance categorization, it would be interesting to see if there are other ways that this classification can be defeated.

CHAPTER VI

NON-MEDICAL VARIABLES AND PATIENT PROCESSING

Numerous studies (Becker et al. 1961; Glaser & Strauss 1964; Sudnow 1967; Roth 1972) have shown that hospital personnel differentiate between patients on the basis of socio-economic clues. It is this type of differentiation which most people expect to read about when they see a title such as, The Impact of Non-Medical Variables on Emergency Ward Triage. Yet, socio-economic class is a very difficult and slippery concept to deal with. It is problematic as to what a person's or an occupation's prestige really is. Is the ranking derived from a rating scale such as Blishen and McRoberts' (1967) important in explaining differential treatment in an Emergency ward and do members in their every-day activities rank people as they do on a formal ranking exercise? Such questions obviously defy simple and neat answers.

In the Emergency ward, the patient's socio-economic class is decided by the staff who interpret readily available clues. Dress, mannerisms, where the patient is employed, manner of speech and so on all help to locate the patient.

During my field research I became competent in predicting how patients would be processed. At first it appeared that I was interpreting socio-economic clues, but after more extensive study it was discovered that this was a faulty interpretation.

Indicators of socio-economic status cannot be thrown away and said to have no impact on patient processing. Their importance however, is not as significant as the variable which this chapter examines. Whether or not patients are known to the staff, what type of ailment they have, and how they respond to the ailment all help to explain different treatment patterns. It becomes clear, especially in the section dealing with whether or not a patient is known to the staff, that it is very easy to misinterpret the data and claim that socio-economic class is the crucial dimension. However, as this chapter proceeds it will become clearer that this is not the case.

Acquaintance with the Patient

Whether or not patients are known to the staff influences how they are processed. Patients who are known are not processed in the usual way. If a friend of a staff member comes into the ward, the primary consideration ceases to be the smooth and proper running of the ward and

becomes the treating of a friend in a manner appropriate to friendship. In the following example the nurse felt that her presence would be inappropriate since a friend was having a 'private' examination. While the nurse had been involved in hundreds of pelvic examinations, she did not feel that her involvement was appropriate when a friend was being examined.

> The nurse who was covering the gynecological room (OR III) observed a friend of hers come into the ward and she talked with her for a while. The nurse then went to the head nurse and said. "Mrs. Smith, Joanne is having a pelvic examination and I would like another nurse to go in with Dr. Jones. She's a good friend and I don't want to be there. It's a pretty private examination". The head nurse told her to ask Lee if she would trade places with her for a while. In talking to Lee she again stated that, "I don't want to be there for that. She's a good friend of mine".

That normal ward routines are modified when a friend enters the ward is further illustrated by what happened one evening when the husband of a nurse in the hospital was brought in dead-on-arrival (DOA). This man and his wife were good friends of the head nurse and another nurse in the ward. In fact, the nurse had been maid-of-honour at the head nurse's wedding. After the man was pronounced dead by the doctor, the head nurse phoned for two orderlies. When they arrived she asked them not to

strip the body before placing it in the morgue. When they agreed she responded, "Thanks a lot. I'm really glad you talked to me first. He's a good friend and I wouldn't want that done to him. It's so degrading and besides, the undertaker will be here in a little while". This processing of the corpse was unusual for most corpses were undressed and prepared in a specific manner. However, we see that a friend receives unusual and special treatment.

The crucial thing is not whether patients are friends of a staff member but whether the nurse in charge of their treatment area knows about this friendship. The nurse responsible for the area determines in what order patients are treated and how much effort is made to get a doctor into the ward to treat them. The importance of the area nurse recognizing a patient is well illustrated in the following instance.

> One evening an off-duty ward clerk from the department brought in her father with a possible broken arm. She accompanied him through the NO ADMITTANCE door, took a registration form and filled it out. She then asked the head nurse if she could take him to x-ray and was told to do so. After being x-rayed, the man and his daughter waited in the fracture room for 3/4 of an hour. Finally, the clerk went out and talked to the head nurse about the delay. The nurse for the area overheard the conversation. She said, "I'm sorry Joe. I saw that name on the board and thought it looked

> familiar but couldn't place it".
> Within ten minutes the doctor had
> looked at the man. The next day,
> on encountering the clerk the doctor
> asked about her father and apologized
> for the delay the previous evening.

Thus, the fact that a patient is known is important only if this information gets to the proper staff member.

Another type of known patient is the 'community leader' who, while usually not known to the staff personally, is recognized. Prominent lawyers, ministers, and civic leaders, when recognized receive special treatment. In the presence of these people the staff become more serious, and sharply curtail their backstage, informal behaviour. They consciously 'play' to this audience whereas they do not usually bother 'playing' to the other patients.

> A man brought his wife into the ward
> and she was placed in an examining
> room. After about fifteen minutes of
> waiting with her he came out into
> the hallway and stood against the wall
> opposite the nurses' station. A
> nurse who came to the station from
> another area a few minutes later
> whispered to the other nurses that
> he was Hartly, a prominent local
> lawyer. After hearing this a nurse
> went over to him and apologized that
> the doctor was not there yet (this
> was unusual considering the short
> time he and his wife had been waiting).
> During the 40 minutes they waited,
> she twice more went and apologized for the
> delay. During the time he stood there
> the staff did not engage in their
> usual informal activities. Their
> actions, demeanor and conversation

> were 'managed' in a manner similar to that which I observed upon first entering the ward as an observer. When the doctor arrived, the nurse took him to the lawyer's wife although she had not been in the ward as long as some other patients and her ailment was no more serious than theirs.

It is the impact of a known person and not the presence of a stranger that results in the changed actions of the staff. One evening I observed another man standing where the lawyer had stood. The staff conducted their business as usual, fooling around and telling jokes. This behaviour was slightly modified when the staff discovered that the man was in the ward to see his sick father and did not yet know that he had died. However, this modification of the staff's behaviour was minor in comparison to that which occurred when the lawyer was in the ward.

Well dressed, obviously affluent people who appear to be from the upper socio-economic strata do not receive any better treatment than persons who are wearing cheaper clothes, and have similar medical symptoms. For example, in the following two instances, the minister's mother although not as well dressed as the young man, who appeared to be of the upper socio-economic strata, received better treatment. These examples show that patients who are recognized receive preferential treatment and that patients from the upper socio-economic strata do not necessarily receive

special treatment. In fact, they may receive extremely slow treatment.

> A woman was brought in by her husband and son. After she had been on a stretcher for half an hour, one of the nurses asked her if her son was a minister. "I thought the name looked familiar", the nurse responded upon receiving an affirmative reply. When this information became known to the rest of the staff, a nurse immediately went into the waiting room and talked to the husband and son. She also brought them in so they could talk to her. Also unusual was the fact that the doctor went to the waiting room which was empty except for the two men and carried on a lengthy conversation with them.

> A man of about thirty years of age was brought into the ward by a friend. The man was dressed in an immaculate suit, spoke eloquently, and had the general demeanor of someone of the upper socio-economic brackets. He was placed in an examining room and had to wait for two hours before a doctor treated him.

The previous examples show that some variables which are usually thought to be indicators of socio-economic class are not very important in the staff's assessment and treatment of patients. Although the young man was very well dressed, spoke eloquently and appeared to be of the upper class, he did not receive special consideration and in fact his treatment was slower than usual. On the other hand, the mother of the minister received preferential treatment. From this example, and numerous others which I observed, traditional symbols which have been taken to indicate socio-

economic class are of little value in explaining differential treatment of patients.

Another group of patients known to the staff are the 'repeaters'. Most of these people suffer from alcohol related problems and are social outcasts. Upon seeing one of these patients, the staff usually tell them what their problem is. While questions are occasionally asked about the ailment, the assumption is that the person is suffering from the same problem that brought them to the ward all the other times. Upon seeing Alice at the registration window a nurse asked, "Where's you stick them this time?" (the patient stuck pins into herself). Another nurse asked a patient, "Been drinking again George?" before she had talked to him about his problem. Thus, the staff assume that patients who are habitual repeaters return with the same ailment that always brings them in.

The impact that being known has on the way patients are treated in the Emergency ward is fairly obvious. Most patients however, are not known by the staff. On what basis do the staff decide who needs and deserves fast treatment and for whom a prolonged wait is justifiable and appropriate? The staff want to be fair and do not want anyone to experience a prolonged wait for treatment. By performing a medical/ moral assessment of the patient the staff decide what type of

treatment is appropriate. Patients are placed in either the 'stupid', 'negligent', 'self-abusive' or 'good' categories. Each category has a distinctive meaning in terms of the way patients in it are viewed by the staff and the way they are processed.

Patients, Illness, and Response to Illness

Patients are assumed to be responsible for at least the way they respond to their ailments and usually for the ailment itself. The staff use normal categories of 'stupid', 'good', 'negligent', and 'self-abusive' which are related to the way patients responded to their illness. This patient assessment, while partially related to medical symptoms, is also a moral judgment which has a profound impact on their Emergency ward careers.

A. Stupid

The staff assume that every member of society should possess a certain, basic knowledge of medicine. How patients measure up to what-every-member-should-know determines how they are viewed. Every member should know what constitutes symptoms of sickness as well as what problems are just part of living. They should know what to do when they catch

a cold or the flu. If patients lack this knowledge, they are stupid.

In Barrie, the most common stupid patients are those who bring their children to the Emergency ward with mild fevers. Usually the staff decide that these are stupid patients without even talking to them. A typical example is the mother who brings in her child wrapped up in a 'bunny suit' which covers all but the child's face. The following example typifies how the nurses react.

> "Is your little boy running a fever?" (nurse to mother). "Yes", responded the mother. "Well, the first thing you can do is take that suit off him. You're just keeping his temperature up. You want him to cool off, not to stay hot". The registration form was then filled out and the mother and child were sent to wait in the waiting room.

Patients should also know when to use the Emergency ward. Patients who come in with minor problems which the staff feel could and should be treated at a doctor's office are both nuisance and stupid cases. Not only is the problem minor and consequently 'nuisance', but these patients are seen to be 'stupid' since they did not recognize a minor problem. While the moral condemnation of these patients is fairly great during the day, during the night their presence in the ward infuriates the staff, partially because they must get a doctor out of bed for a "piece of

crud" (nurse).

Many stupid patients overplay the sick role. While it is acceptable for a truly sick person to make demands on the staff's time, such behaviour is not justifiable for stupid patients. Their complaints about pain when the staff 'know' that they are not in pain are viewed as attention getting devices and they are told, "It's not that bad", "Be tough, you can handle it", or "You're acting like a two year old" (statements by nurses to patients).

It is impossible to develop a definition of a stupid patient or any other type of patient which states the conditions necessary for the classification. Stupid patients are those who are viewed as stupid by the staff. However, a patient does not necessarily have to do anything in order to be labelled stupid. Patients who were told to come into the ward by a doctor were often classified as stupid by the staff. Thus, what constitutes stupid behaviour can also be seen as intelligent behaviour; that is, following the advice of a doctor.

During a flu epidemic in Barrie, a type of stupid patient became extremely visible. When entire families came in complaining of 'the flu' they were all placed in one treatment room. Their presence was noted on the board in the hallway with, "X4 Smith/Dr. Jones". Staff members

who saw this knew that they were stupid cases because there was a whole family in the room (X4 meant four patients) and whole families don't get sick at the same time. These patients received extremely slow treatment and were bottom priority unless they wandered around the ward or allowed their children to wander. When, through their wandering they became disruptive to the smooth operation of the ward, the nurse would ask the doctor to look at them so, ". . . we can kick them out. They're running all over the place, the little brats" (nurse to doctor).

B. Negligent Patients

While stupid patients overreact and show up at the ward when they should stay home, negligent patients stay home when they should be in the ward. Many people who injure their arms or legs, or experience chest pains do not go to the ward, believing the pain will go away. However, when it doesn't they come to the Emergency ward complaining of prolonged pain. Thus, the negligent patient is one who waited for an unjustifiable period of time before going to the hospital.

The most common type of negligent patient is the one who breaks a bone and then waits a number of days before seeking medical aid. These patients are chastised and told

that they should have come in immediately upon hurting themselves. A common response was that, "I didn't think it was anything serious. I've hurt myself before and it always healed itself". To this, the nurse responded, "You should have come in and made sure. We're here to help you". Thus, negligent patients underestimate the significance of their symptoms.

There exist certain types of medical problems which the staff view as serious enough to bring a patient into the hospital. Suspected fracture, chest pains and a loss of consciousness are usually viewed as potentially serious problems. Even if there proves to be nothing more seriously wrong than a strained muscle, the staff do not condemn the patient. Consequently, these patients who injured themselves five days previously and yet have nothing seriously wrong, are chastised by the staff for not coming in immediately, even though it turns out that there was no serious problem. With possible broken bones and chest pains the rule is, "Better safe than sorry".

Negligent patients receive very low priority treatment. The rationale of the staff is that if the patient has survived for days since the injury, then an additional couple of hours will not make any difference. In the case of patients with suspected fractures who do not

come into the ward for a couple of days after the injury, they are x-rayed and then sent home. The doctors look at the x-rays when they are in the hospital but do not make a special trip to see the patient.

C. Self-Abusive Patients

The category which is most bizarre and unusual contains people whose problems are self inflicted. In the eyes of the staff the drunk, the overdose and the mental patient have problems by choice.

Self-abusive patients are treated as less than complete people. Their treatment is similar to that given to a person who is under a general anesthetic in the operating room. The staff talk over, around and about these patients with little consideration of what they feel and what they may think about what is being said. The person is a body, not deserving of interaction or communication. In many respects the staff treat these patients as things, occasionally softening this attitude to one of kindly superiority typified in the case of the parent who tells his child to stay in the house after supper,"BECAUSE". While there is logic and reason behind treatment, this is not communicated to these people because they are not capable[18]

of understanding.

In both hospitals, self-abusive patients are 'freaks'. The staff showed these patients to me, explaining their histories and peculiarities. Often I was encouraged to go and satisfy my curiosity about these strange cases.

The following conversation between a nurse and an 'alcoholic' illustrates how patients in the self-abusive group are processed. Of special interest in this interaction, which took place at the registration window, is the fact that the alcoholic is treated as a child.

> "Well, what's wrong with you?" (nurse). "I came in to get some medicine" (patient). "Oh, that's nice. You're an alcoholic aren't you" (nurse). "Yea, and I feel really shakey and sick" (pat.). "Where are you from?" (nurse) "Kitchener. I came up to help a friend of mine. He's in jail and is getting out tomorrow" (pat.). "How'ya going to help him? You can't even help yourself. How old are you?" (nurse). "26". "If you keep going at this rate you'll be dead by the time you're thirty" (nurse). "I know". "If you know, then why do you do it?" (nurse). He persisted and was finally placed on a chair in the examining area. He waited three hours before anyone treated him and during that period none of the staff talked to him.

A number of things are noteworthy about this example. Firstly, it is interesting to notice how the nurse tried to get him to leave without registering. She did not fill

out a registration form until he had been standing at the registration window for one half hour. During the time he was there the nurse asked him to go and sit in the waiting room a number of times so she could register the patients who were waiting in line behind him. Finally, after all her attempts to discourage him from registering failed, she was forced to process him.

Secondly, his being placed in the middle of the examining area meant that his name did not appear on the blackboard since this was not a treatment area. Since his name was not visible, he was easily overlooked. The doctor who came into the ward to treat the patients for city call did not see this name and consequently did not ask about him. In this way the man was forced to wait an unusually long time before a doctor examined him.

Thirdly, it is important to note the volume and tone of the nurse's voice when she was talking to this 'drunk'. She talked unusually loudly and every person in or near the nurses' station could not help but overhear. She scolded him and criticized his character instead of asking about the ailment he had.

There also exists an attitude that, 'If you did it to yourself, then you can wait for treatment'. This is best exemplified in the case of 'drunks' who come to the

ward during the night. The nurses refer to these patients as 'skum', 'crud', and 'crap'. Even the doctors do not like coming into the ward to treat them. As one doctor who was on call for the night shift left to go home, he said to a nurse. "Don't let in any drunks. I want to get my sleep and they sure can wait to be treated until morning". She replied, "Don't worry. We're locking the door and none of them are getting in". In actual fact the door is locked at midnight and although I never observed drunks being locked out, it is within the realm of possibility.

The staff have more sympathy for mental patients than for any of the other self-abusive patients. They acknowledge that these people do not have problem by choice. "She hears voices telling her to do it. She can't help herself. When the voices aren't talking to her she really hurts and comes in. She's really nice when the voices aren't telling her what to do" (nurse to nurse in PAGH). However, while the staff are slightly sympathetic, this sympathy is not manifested in the way mental patients are treated.

> When the doctor finally got there (a two hour delay) he asked the nurse where the patient had done it this time and was told that she had stuck them in her neck. "You know", he said. "Dr. X told her to leave the heads on and then she could pull them out and use them again. For a while she did but now she's breaking off

> the heads again . . . If none of you nurses come in with me when I look at her I'm going to say, Feel that pulse. Why don't you stick a big pin in it. Something about the size of a nail or a knife". "You're terrible" (nurse). "Yeh, I am, but it's a waste of the tax-payer's money to treat her. She just goes out and does it again".

This attitude towards the patient is consistent with the way she was treated. She had to wait a long time before the doctor would look at her. The doctor was in the ward once but left after telling the staff to get the next general practitioner who came in to look at her. However, he returned after a nurse phoned him again and told him to come back. When she was finally treated, the attitude of the staff was expressed in their actions.

> When the doctor finally got around to treating X he ordered soft tissue x-rays to find out how many pins she had used. The x-ray technician said, "You'll want us to mark them, won't you?" to which the doctor replied, "No, I'll just have to probe anyway". The doctor, after working for an hour finally called the surgeon to remove the second pin. The surgeon ordered another set of x-rays and had the pin's location marked.

While I am not a medical expert, the actions of the doctor who decided he did not want the pins marked seems to be unusual. For one thing, the technician assumed that the pins would be marked so they could be located faster. Secondly, the fact that the surgeon had them marked indi-

cates that this was the usual procedure. The doctor's attitude was one where the patient did not really matter. The fact that he had to probe for an hour and left a serious scar was not important. In my opinion, this type of practice would not be used on any member of society who was not part of the self-abusive category.

Since self-abusive patients are responsible for their ailments, the staff often attempt to reform them. This is noted in the numerous lectures which they give to patients. It is well illustrated in the following instance where a doctor set out to teach a patient who habitually took overdoses of drugs a lesson.

> "I decided to teach him a lesson. He doesn't look too smart but there's nothing wrong with his brain. I gave him two things of Ipecac® and got him to drink about a gallon of juice. Every time he brought up I gave him something more to drink. They had to carry him out in the morning, he was so weak. He looked at me and I just laughed. He knew what I'd done but it worked because he hasn't been in since." (doctor to doctor).

In the eyes of the staff, some people are more responsible for their self-abusive behaviour than are others. Medical personnel and former medical personnel are viewed as knowing what they're doing when they engage in self-abusive actions. They, more than the population in general should value life, including their own. Thus, it is

one thing for a member of society to take a drug overdose, but quite another for a nurse to do the same thing. Such action by a nurse is especially condemning.

The fact that a patient has been or is a nurse is noteworthy to the staff. This information is conveyed to the doctors when they are notified about the patient. It is also used by the staff as a way to condemn these patients for their actions.

> At 0300 hours a female patient was brought in who had taken sixty Mep 282's® and six 50 mg Demeral® tablets. The patient was placed on a stretcher and the nurse called the doctor who was in the hospital. Meanwhile the nurses' aide was filling in the registration form with information provided by the patient's parents. When the aide discovered that the patient was a nurse, she went and asked the barely conscious patient why she had taken the overdose. "You should know better than doing this", the aide told the patient.

Self-abuse patients are kept in the hospital for as short a period of time as possible. If they can be convinced by the staff not to register, then they are sent away untreated. While they must wait for extended periods of time before being treated, once they have been seen by a doctor they are usually released as quickly as possible. One nurse explained that, "We throw them out as soon as they can move".

D. Good Patients

In many ways, the good patients are the hardest of all groups to define. It is best to view this category as being composed of all the patient who do not fit into the other categories. They are the residue; those who, in the opinion of the staff have not done anything improper.

It is self evident, but good patients are those who are classified in this way by the staff. The staff believe that these patients reacted properly once the ailment occurred and were not responsible for the onset of the problem. This is not the same as saying that these patients were not responsible for their ailment, for most patients are, to some degree responsible for their ailment or can be shown to have somehow brought the problem on themselves. For example, a patient who is sixty-five years of age, overweight and is suffering from chest pains may or may not be seen as bringing on the heart attack because of overweight. The decision as to how responsible patients are for their own problem is dependent on the way the staff perceive them, and not on any clearcut evidence.

Good patients are those who know what constitutes sickness and what constitutes health. They are the ones who show they have, "done everything I would do if I was

sick" (nurse to nurse). As another nurse put it, "If you've done all that and the child is still sick and running a temperature you'd better bring her in. It's the people who don't do anything and then bring in their kids that bother us" (nurse to a parent on the telephone).

Good patients are not those who have a doctor or come to the ward on the advice of their doctor. Referred patients who come to the ward, erroneously expect to receive rapid and special treatment. They often walk through the NO ADMITTANCE doors and demand treatment immediately by Doctor X. What they do not realize is that doctors usually do not come to the ward until contacted by the staff and if they are already there, no special priority will be given to patients who phone in advance.

Conclusion

The moral assessments the staff make influence how patients are perceived and treated. One important factor in this assessment is whether the patient is known to the staff. Friends and community leaders receive preferential treatment in the Emergency ward. On the other hand, known repeaters who come in frequently with the same problem receive slow treatment and are assumed to be suffering from the same minor problem that always brings them in.

It is easy to see how one could conclude that socio-economic class is used by the staff to group patients. Since most of the staff are middle class, their friends, neighbours, and acquaintances are also from this class. Thus, the patients who receive special treatment are from the middle class. However, the special treatment is due to the fact that they are friends, and not the result of their socio-economic class.

The second group which receive special treatment is composed of people who are leaders in the community. These people are usually of the upper middle class. However, other patients from the same class do not receive special treatment. Once again, preferential treatment is not given on the basis of whether patients are of a good socio-economic class but rather because they are recognized as being community leaders.

The group which receives consistently slow treatment is composed of repeaters. The staff assume that these people are not seriously ill and that they suffer from the same problem that always brings them in. While they are usually from the lower socio-economic strata of society, their poor treatment is not so much a result of their class as a consequence of frequent use of the ward because of minor problems. Other patients from the same class receive

faster treatment if they are not repeaters.

The other part of the moral/medical assessment of patients is based on how their ailments occurred and what they did about them. Four categories called good, stupid, negligent and self-abusive are employed by the staff to group patients. However, what each category means is far from simple. For example, a person who has been drinking may be viewed as merely being intoxicated or as a self-abusive drunk. Thus, the way patients are viewed is more important than what they 'really' are.

The one fact which comes out of this chapter is that non-medical variables play an important role in determining how patients are treated. If the medical care provided by the Emergency ward staff is to be understood, factors such as whether patients are known to the staff and the moral assessment of their character must be considered.

CHAPTER VII

CONCLUSION

After a reading of this work I can agree with William Blake who said that to understand his works one had to read the entire work simultaneously. Unfortunately, this is not possible as one reads one word at a time. In this last and final section, my goal is to present the material covered in this paper in a slightly different and condensed fashion. Hopefully, when this section is read against the backdrop of the entire work, the reader will be able to see the ward as a unified and complete setting.

From its inception, this paper and its supporting research focused on how the Emergency ward staff viewed their job, the patients, and the way in which patients were processed. This interest is partially explained by the volume of ethnographic research I read during my first period of observation, and especially David Sudnow's Passing On (1967). These works aroused my interest in participant observation and convinced me of its value in discovering 'what really goes on'.

Considering the focus on member's rationality

participant observation was the only logical data collection method. This method, although discussed in numerous books and journal articles, is little understood by most sociologists. Part of this can be explained by the fact that studies must be tailored to the setting under study. There is an attempt to show that as a researcher I was able to penetrate the backstage thus validating the research observations made.

This paper can be divded into three areas. First, the impact of doctor usage and coverage of the ward on patient processing is examined. While there is no deterministic link between the coverage and the way patients are treated, the staff take these 'demand characteristics' into consideration.

The other major focuses of this paper are 'triage' and the moral assessment of patients. Triage is the process of deciding how serious an ailment 'really is' and how fast it should be treated. The moral evaluation is part of this process and refers to staff decisions as to what type of person the patient is. As part of one process, these two activities (triage and moral evaluation) are separated for analytical purposes only, in order to explain their influence on the treatment of each patient.

Triage

Triage is a medical concept which appeared during W. W. I. It is the classification of patients according to ailment severity for the purpose of ensuring that the serious are treated before those who can safely wait for treatment. While the actual terminology is not the same, the process has become standardized to the point where today, three categories called nuisance, urgent and emergency are found in all the triage literature. The meaning of these categories which are used in patient classification are far from clear. For example, the definition of an emergency varies from patients who must be treated within five minutes to those who need treatment within six hours of the onset of the problem or injury. Attempts to define the categories according to medical problems also fail since different writers classify ailments in different ways. Thus, while Emergency ward practitioners are constantly using triage categories, there exists no common definition of what these categories mean.

The literature on 'normal' categores helps in understanding triage categories. Sudnow (1967) noted that in a situation where a number of people work together, they develop a common conception of clients and use categories which may differ from officially defined views. The meaning

of the categories is found in the way that members process clients and not in official definitions of the member's job. Thus, the meaning of triage categories is found in the different ways that patients are perceived and processed by the staff.

Emergency cases are temporary and tranisitory. These patients are perceived to be dying and the ward is shut down as the staff attempt to stabilize their condition. Since emergency patients are threatening to die, the setting is organized to limit the number of deaths and to neutralize the disruption which these deaths cause.

Nuisance patients are those who are seen as undeserving of the attention and facilities of the Emergency ward. They receive superficial examinations, often have to wait for extended periods of time before being treated, and are treated in the examining rooms or any other place that is available. Because of the long waits they experience, many become upset and disrupt the ward by complaining and bothering the staff. This problem is partially overcome by the way they are registered and where they are located in the ward. By manipulating these two variables, the staff encourage them to redefine their ailments as minor and accept the long waits for treatment as justified. However, should this fail, nuisance patients are encouraged to com-

plete complaint forms and in this way vent their anger in a harmless manner -- that is, by not damaging the hospital's public image.

Urgent cases are the final triage category. These are patients who do not belong in either of the other two categories. They are not in the process of dying but have something wrong with them which warrants their being in the Emergency ward. They are assumed to be sick, do not wait in the waiting room, and are treated in the recovery rooms.

The decision as to which category a patient belongs is a complex one, and is only partially explored in this work. The actual triage is usually performed by a ward clerk who, like the nursing staff, assumes that there is nothing wrong with the patients (they are nuisance cases) unless they demonstrate otherwise. Certain medical clues such as large open wounds, loss of consciousness, or chest pains are usually sufficient to defeat the nuisance classification. The other way that a nuisance classification can be changed is if the patient boldly violates the NO ADMITTANCE sign and strides into the backstage area. The way a patient responds to the ward is important. If the patient claims a serious medical problem but responds to the ward in a non-urgent manner, the response to the ward usually over-rides the verbal self-diagnosis and the patient is classified as a nuisance case.

Moral/Medical Evaluation

The staff, as well as deciding on the severity of the patient's illness, assess the patient's moral character. The ascribed moral worth is important in understanding how patients are treated in the ward. Friends of the staff and recognized civic leaders receive rapid and courteous treatment. On the other hand, patients who are known because of their frequent trips to the ward due to drunkenness are perceived as suffering from the same problem which 'always brings them in' and receive slow treatment.

The moral/medical assessment of the patient is also influenced by the types of ailments which bring patients into the ward and what they have done about the problem. On this dimension, patients are categorized into stupid, negligent, self-abusive and good categories. Stupid patients are those who do not know how to use the ward properly and interpret minor problems as serious. Negligent patients are those who should have come into the ward at the time of the ailment, but waited for a period of time before doing so. Self-abusive patients are alcoholics, drug overdose cases, and mental patients who harm themselves. Finally, good patients are not responsible for their ailment, have res-

ponded to it in the proper manner, and use the ward in the correct fashion.

The Ward as a Whole

To be understood, the treatment a patient receives must be considered in the light of all the issues which have been raised in this paper. Each patient is affected by the way doctors cover the ward, the moral character which is ascribed to the patient and the way they are triaged. Each of these variables affects every patient in a unique way.

If this thesis has one downfall, it is that it fails to consider in great enough depth relationships between the different ways the staff assess patients and the 'demand' characteristics present. In order to be simple and concise, examples were used which clearly illustrated the point being made and the dimension being discussed. Perhaps a consideration of the problems facing a truck driver student will help to clarify the problem. In the driving manual the basic aspects of driving such as steering, braking, gear-shifting, using grades to an advantage, braking distances, driving in heavy traffic and acceleration are all considered in separate areas. However, in order to understand truck driving, the student must get into a truck and learn to

consider all these dimensions simultaneously. In the same way, this paper has broken the Emergency ward into a number of simple and clear areas. As the student must climb behind the wheel to learn how the different chapters of the book relate in different situations, so, in the final analysis, the sociologist must go into the Emergency ward to understand how the variables discussed in this paper interrelate .

Recommendations: For Further Research

This thesis, while making a start at understanding the Emergency ward, uncovered a few areas which warrant further study. Before I list these areas, it should be pointed out that if the Emergency ward is ever to be adequately explored, some sort of standardized approach must be introduced. It is imperative that a research design and approach be developed which can be replicated by subsequent researchers. If this is not done, the result will be studies which are difficult to compare because they have been done in different ways.

Although my thesis examines how the staff group patients into normal or typical categories, questions about how this process occurs are left unanswered. My study focuses on how categories are used in two hospitals of similar size, but does not consider the nature and use of ailment

categories in larger or smaller Emergency rooms. The staff usually have a common perception of patients, but what happens when doctors and nurses perceive patients differently? How is this possible disagreement resolved? While the thesis examines patient categories and stresses the importance of non-medical variables, it does not examine in detail how triage nurses or ward clerks 'decide' the severity of patients' ailments. Finally, the thesis does not explore how patients can themselves overturn the original categorization. The following recommendations are advanced as ways of adding to our knowledge about the Emergency ward.

1) That research be undertaken which studies how the ward clerk or triage nurse categorize patients when they first enter the ward.

2) That research be undertaken which studies how the original categorization of a patient can be called into question and then changed.

3) That various sized Emergency wards be studied in order to determine how patient categories differ from one setting to another.

4) That research be conducted which studies how the diagnosis and treatment of patients by doctors is affected (if in fact it is) by the way the patient has been categorized.

5) That the way doctors and nurses perceive patients be studied. Do doctors' and nurses' perceptions of patients differ? If there is a difference in perception, whose perspective has a dominant affect upon treatment?

<u>Recommendations: For Improving Medical Care</u>

Throughout this thesis I have attempted to avoid judging the efficiency and routine practices of the Emergency wards under study, feeling that my task was to explain and not to evaluate. However, in this final section I step outside this 'neutral' stance in order to show problem areas in these wards. While I am fully aware of the limitations of my knowledge, I nevertheless feel that my research experience has given me some insights which may be of value to those who work in and are served by the Emergency ward.

My observations revealed two groups who misuse the Emergency ward. Doctors misuse it by making appointments to treat patients there instead of in their offices, e.g., a doctor used the ward as an office until his was constructed and by stockpiling patients in order to make more money. Equally guilty of misusing the ward is the large number of patients who have no serious medical problem (nuisance patients) but come to the Emergency department instead of

seeing doctors at their offices. These two groups are responsible for most misuse of the Emergency ward.

A second major problem is the way that some patients are treated and processed by the staff. Self-abusive patients receive extremely slow and often poor medical care. Nuisance cases, while not receiving as poor treatment, often must wait for extended periods of time before they are treated. This long wait results in frustration for the patient and problems for the staff who must deal with aggravated patients.

My research, while making a start at understanding how the Emergency ward operates, is not of sufficient depth nor of the proper focus to provide a basis for the type of change which is required, if Emergency ward care is to be significantly improved. Thus, the major recommendation of my work is that evaluative and practical research be conducted. A comprehensive study of the purpose and function of the Emergency ward is needed. It is essential that the official mandate of the Emergency ward be reconsidered in light of the way the ward is used.

The function and utilization of the three Emergency wards in Thunder Bay should be assessed. This should be combined with a time and motion study of the staff of the different Emergency rooms. How much time is expended

on actual patient treatment? How much time is required to keep the bureaucratic/administrative machinery going? How much time is used in performing non-vital tasks such as telling patients how to get to the x-ray department, filling out two forms for one patient, making extra phone calls for doctors, and so on? Questions such as these need to be answered.

These studies represent only the first step in effecting intelligent change in Emergency ward care. Such research should then be presented to nurses as they are being educated and during in-job training sessions. This research should encourage the staff to critically consider how they treat self-abusive and nuisance patients and hopefully will result in better care for these people.

Discussions need to be held among hospital administrators, physicians and nurses concerning the goals and priorities of the Emergency ward. The structuring, goals, and priorities of Emergency wards must be decided in light of the concerns and considerations of each of these groups, and the way that patients use the facility.

Finally, the misuse of the Emergency ward by physicians needs to be checked. Possible solutions are to place doctors on salaries or to have doctors who work for the hospital in the Emergency ward. No matter how doctor abuse

is handled, it is clear that if the Emergency ward is to become an efficient medical facility, this fundamental problem must be overcome.

FOOTNOTES

1 Common-sense definitions refer to the way that members of a particular group view a situation. While what is 'common-sense' may differ from one group to another, within the specific group, the definitions are accepted as proper.

2 Douglas (1967) makes the same argument about the variety of legal, official, and practical definitions of suicide.

3 Each shift was observed for at least four hours. The mean contact per shift was approximately five and one-half hours.

4 The importance of the friendship of an important member of the setting is well illustrated by Doc's relationship with Whyte in W. F. Whyte's Street Corner Society (1943).

5 See Olson (1976), Chapters 1 to 3.

6 While there is a limited backlash against the medical profession, the increasing usage of doctors and medical facilities indicates that this negative attitude is not yet of great significance.

7 This is a reworking of Turner's (1969) analysis of the view of a police officer.

8 Bittner (1967:703) notes, as do I, the uniformity of the staff's perception of their job and clients.

9 The importance of this categorization is well illustrated in Chapter 5 where it is shown that patients who are put in the 'self-abusive' category receive different treatment.

10 A study of how a categorization can be defeated would make an interesting piece of work. Hart (1965) deals with how legal contracts can be defeated but no work exists on the possible ways of defeating the staff's definition of a patient.

11 This classification was one which was used by the staff in numerous cases where they were discussing the relative severity of a patient's problem in comparison to their own.

12 This is not the same as saying that the staff actually acted on this conception of illness severity in their own lives, but shows instead that they had a common conception of when they should stay home because of illness.

13 Although Barrie had a slightly larger staff and a larger ward in which to work, these differences were not enough to reduce the patient-load per staff member to that of PAGH.

14 The organization of doctors in a town is in response to demand characteristics which they encounter. The number of hospitals, and types of patients seen in a particular hospital are all factors which undoubtedly influence how doctors organize their routines.

15 The importance of the shift as a demand characteristic is well illustrated by Turner (1969:7) who shows that whether a 'drunk' is arrested or let go can be determined by the time in the shift the person is observed.

16 A 'crash cart' is kept in this area (see Appendix I). This portable cart contains a defibrillator, cardiac monitor and other equipment designed to treat patients who go into cardiac arrest.

17 These waiting areas are used by both friends and families of patients who are being processed and nuisance cases who are waiting to be seen by a physician.

18 In the rationale of the staff these patients are either incapable of or unwilling to understand their treatments.

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APPENDICES

The Royal Victoria Hospital of Barrie

I. Emergency Ward Floor Plan

X-RAY
AMBULANCE
STAIRS
O.R. #3
CLEAN UTILITY ROOM
A
H
DIRTY UTIL. ROOM
STERILE SUPPLY ROOM
O.R. #4 E.N.T.
MEDICINE ROOM
PT'S CHANGE ROOM
SCRUB SINKS
O.R. #2
#1
#2
#3
#4
#5
RECOVERY ROOM
O.R. #1
B.R.
B.R.
NURSES
POISON CONTROL
NURSES STATION
WAITING ROOM
EMERGENCY ENTRANCE
O.R. #5
FRACTURE ROOM #2
M.D. CHANGE ROOM
CAST ROOM
X-RAY WAITING ROOM
X-RAY
X-RAY RECEPTION
FRACTURE ROOM #1
EXAMINING ROOM
#1
#2
#3
#4
#5
B.R.
B.R.
TO MAIN DESK + LOBBY
NURSING OFFICE

The Royal Victoria Hospital of Barrie

II. Outpatient/Accident Report

REPORT

BARRIE, ONTARIO

E73396

DATE SEEN DAY / MONTH / YEAR	TIME:
FAMILY DOCTOR	TIME DOCTOR CALLED
CONSULTANT	EXAMINED BY
ANAESTHETIST	TIME EXAMINED

M F	DATE OF BIRTH DAY MO. YEAR	AGE	PLACE OF BIRTH	NEXT OF KIN	RELATIONSHIP
DATE OF ACCIDENT		M.V.A. ☐		ADDRESS	TELEPHONE

ADDRESS | BROUGHT IN BY: POLICE | AMBULANCE | SELF | OTHER

WCB | O.H.I.P. NO. | INITIALS | CHARGE | PAID | THIS DOES NOT INCLUDE DOCTOR'S FEE

ENT | WEIGHT

RESP | PULSE | TEMP | ALLERGIES | PREVIOUS ADMISSION YES ☑ NO ☐

COMPLAINT

OBSERVATIONS

X SIGNATURE

Y, SIS, TREATMENT

SIS

R'S ORDERS

X SIGNATURE

TION: HOME ☐ ADMITTED ☒ TRANSFERRED TO: TIME:

DISTRIBUTION: WHITE | BUFF | PINK | YELLOW | GREEN

The Royal Victoria Hospital of Barrie

III. Emergency Department Comment Form

ROYAL VICTORIA HOSPITAL
BARRIE ONTARIO

EMERGENCY DEPARTMENT COMMENT FORM

To assist us in improving our Emergency Department Service we invite you to submit any comments or constructive criticism you may have based on your experience in our Emergency Department.

ME of PATIENT ______________________________ AGE __________

TIENT'S ADDRESS ______________________________ PHONE NO. __________

ME of PERSON SUBMITTING THIS REPORT ______________________________

TURE of PATIENT'S PROBLEM ______________________________

EN DID THIS PROBLEM BEGIN? ______________________________

ES THIS PATIENT HAVE A FAMILY DOCTOR IN BARRIE? __________

If yes, who ______________________________

S THE DOCTOR CONTACTED BEFORE COMING TO EMERGENCY DEPARTMENT __________

If yes, what was his advice? ______________________________

____

AT TIME DID PATIENT ARRIVE IN EMERGENCY DEPARTMENT __________ LEAVE __________

W LONG HAS PATIENT LIVED IN BARRIE? ______________________________

MMENTS:

____

____

____

____

____

____

____

____

____

____

____

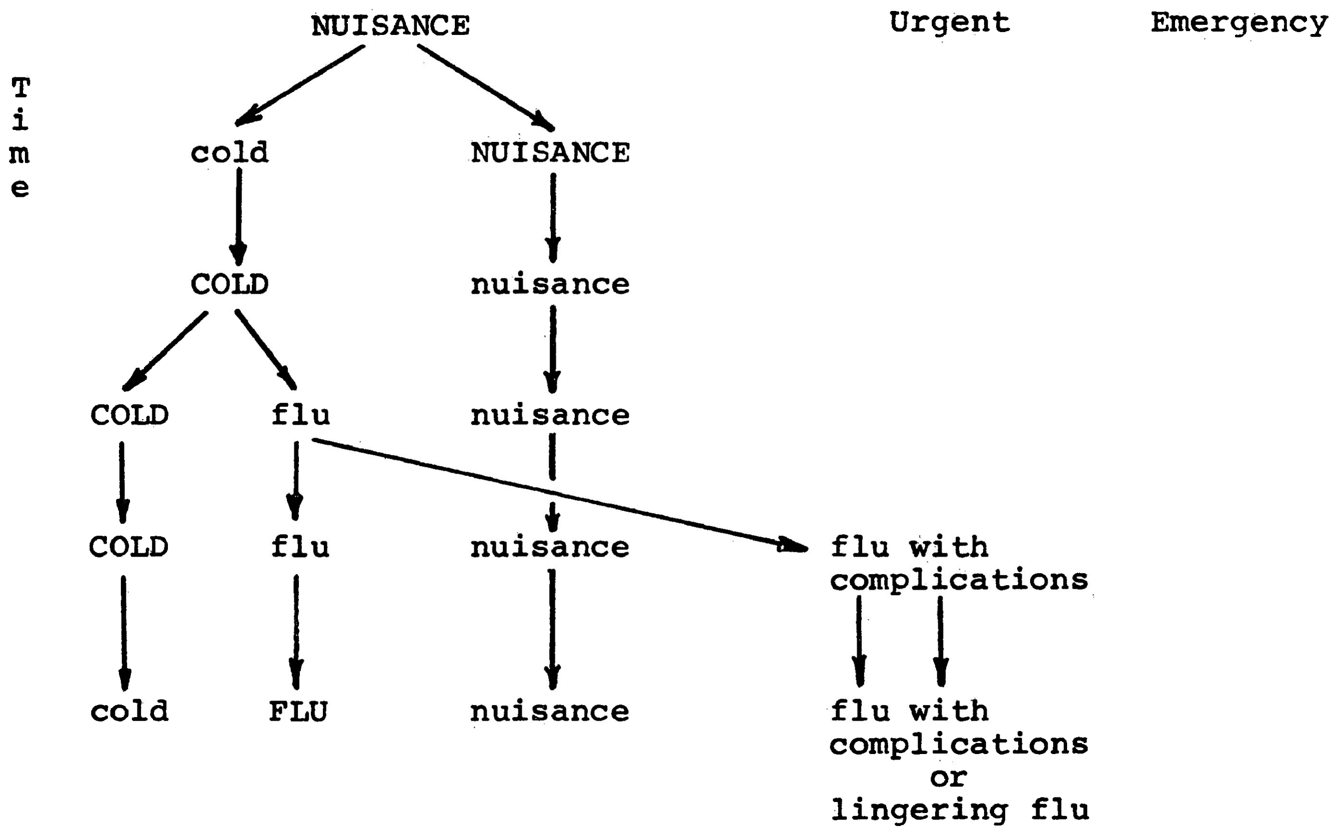
E ______________________________ ______________________________

Signature.

The Royal Victoria Hospital of Barrie

IV. Changes in Normal Categories During the December 1977 Flu Epidemic

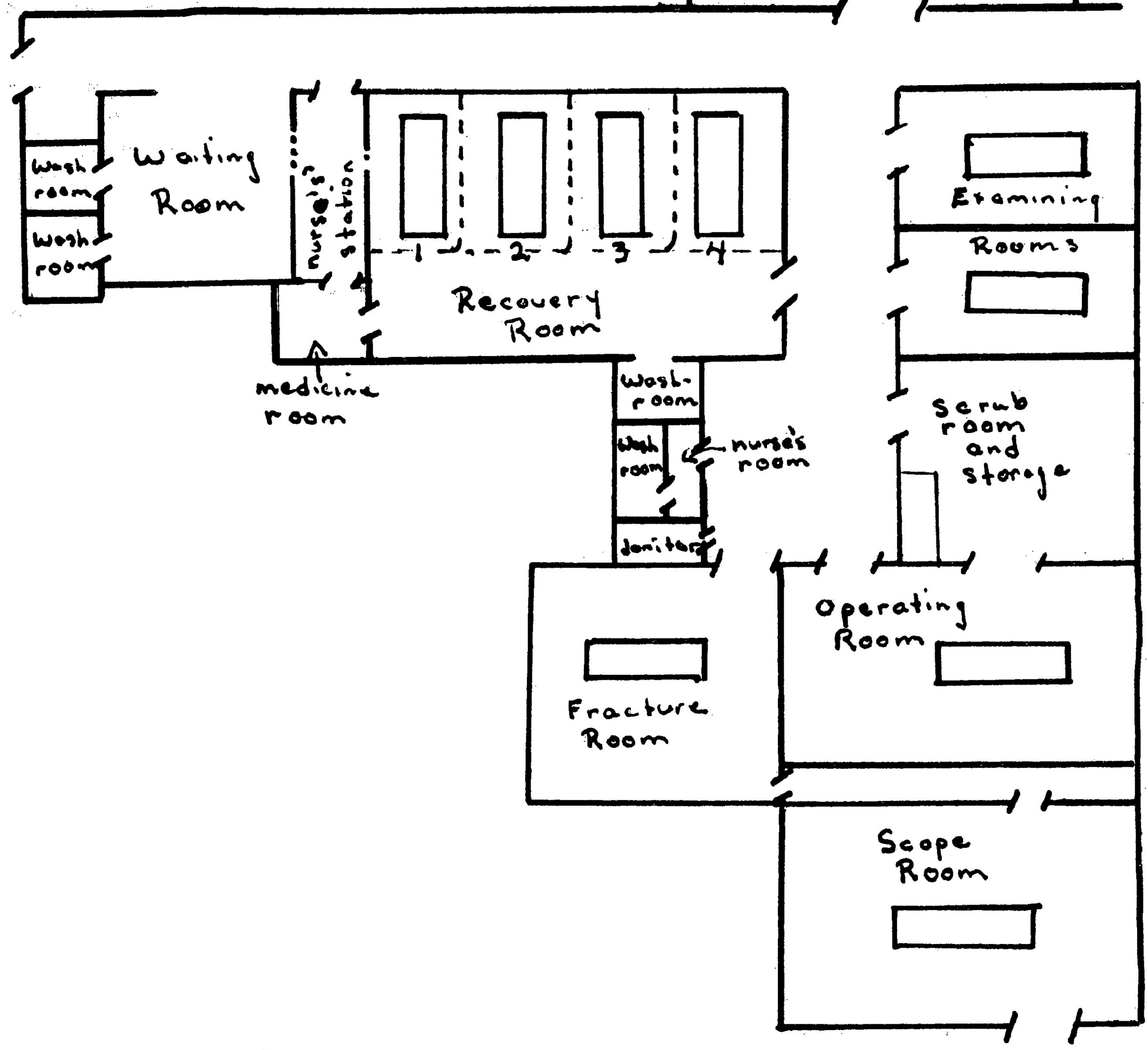
Increasing Seriousness of the Ailment



The CAPITALIZED illness is what all patients were assumed to be suffering from.

The Port Arthur General Hospital of Thunder Bay

V. Emergency Ward Floor Plan


X - Ray Department
Wash room
Wash room
Waiting Room
nurse's station
1
2
3
4
Recovery Room
medicine room
Wash-room
Wash room
nurse's room
Janitor
Examining Rooms
Scrub room and storage
Operating Room
Fracture Room
Scope Room

The Port Arthur General Hospital of Thunder Bay

VI. Preliminary Emergency Report

THE GENERAL HOSPITAL OF PORT ARTHUR

SURNAME	GIVEN OR CHRISTIAN NAMES	ADM. DATE AND TIME	NO.

DDRESS (OR R.R.)	CITY, TOWN OR VILLAGE	RELIGION	BIRTH PLACE

OF BIRTH			AGE	SEX	S.M.W.D.	PHONE NO.	OCCUPATION
	MONTH	YEAR					

'S NAME	ADDRESS

ENCY NOTIFY	RELATIONSHIP	ADDRESS	PHONE NO.

ARRIVED?	PREV. ADMITTED AND DATE

CIDENT AND HOW?	TIME DATE OF INJURY

G PHYSICIAN	ADM. TO ROOM	OHSC NO OR CLAIM NO

OF RES	PREV. ADDRESS	ANAES		24 HR EMERGENCY	YES	NO	RELATION TO CERT HOLDER
		GEN	LOCAL				

L	OHSC	WCB	PSI, OMSIP OR OTHER MEDICAL INSURANCE	INFORMATION TAKEN BY

ADDITIONAL INFORMATION

RELIMINARY EMERGENCY REPORT

The Port Arthur General Hospital of Thunder Bay

VII. Emergency Report

THUNDER BAY, ONTARIO

E.R. AA 14129

GIVEN OR CHRISTIAN NAME	DATE AND TIME	EMERGENCY NUMBER
	Dec. 10/77 @ 1020 hrs.	

	PHONE	BIRTHDATE DAY	MONTH	YEAR	AGE
Thunder Bay		4	8	62	15

RELATION	ADDRESS	PHONE	SEX	MAR. STATUS	RELIGION
& Marilyn/ parents/	s/a	s/a	M	S	United

ADDRESS — WCB YES [ ] NO. [ ] — PREVIOUS ADDRESS

ACCIDENT — WORK [ ] MVA [ ] — DATE, TIME AND CAUSE

CAR [ ] TAXI [ ] AC [ ] AMBULANCE [ ] — ACCOMPANIED BY: father — NOTIFIED RELATIVES — CORONER — POLICE

OHIP — RELATION TO CERT. HOLDER: MR son — SOCIAL INSURANCE NUMBER — OTHER

ELECTIVE SURGERY [ ] FOLLOW-UP [ ] — WITHIN 24 HRS. [ ] MEDICAL EMERGENCY [ ] OTHER [ ] — IP — OP X — ANAESTHETIC G [ ] B [ ] L [ ] — ALLERGIES NO [ ] YES [X] PENICILLIN

PHYSICIAN NOTIFIED [ ] — REFERRING PHYSICIAN DR. NOTIFIED [ ] SEEN [ ] — ADMITTING PHYSICIAN DR. NOTIFIED [ ] — INFORMATION TAKEN BY: oc/sam

SENT TO DIAGNOSTIC, MEDICAL, SURGICAL, X-RAY
DURES ADVISED AND EXPLAINED BY PHYSICIAN AND
ME RESPONSIBILITY FOR CHARGES NOT COVERED BY
DICAL COVERAGE.

WITNESS

DIAGNOSIS: Stye Right Eye/ conjunctititis Right

Stye (R) eye
Conjunctivitis (R) eye

ADMITTED — ROOM — TIME — NEXT APPOINTMENT DATE — RECENT IMMUNIZATION YES [ ] NO [ ]

NOTES

T P R

PHYSICIAN'S REPORT

Exam – Compress
R+
Eye pad

ION AND TREATMENT

	Hct [ ]	Diff [ ]	EKG [ ]
		Basos [ ]	X-rays [ ]
		Eos [ ]	Na [ ]
		Bands [ ]	CL [ ]
is [ ]		Segs [ ]	K [ ]
		Lymphs [ ]	BS [ ]
		Monos [ ]	BUN [ ]

OF NURSE — CONSULTANT DR. — ATTENDING PHYSICIAN DR.

EV 11 75

EMERGENCY REPORT