

THE MEANING OF WORK IN A HOSPITAL  
EMERGENCY DEPARTMENT

**CENTRE FOR NEWFOUNDLAND STUDIES**

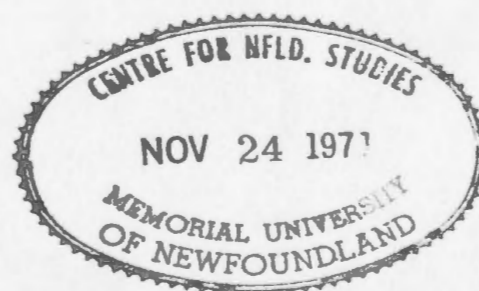
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THE MEANING OF WORK IN A HOSPITAL  
EMERGENCY DEPARTMENT

A THESIS

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of Memorial University of Newfoundland

by

Ronald Michael Joudrey

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## ABSTRACT

This exploratory case study is set in a hospital emergency department. The broad research problem is to acquire a picture of life in an emergency department as seen by workers there. To this end, participant observation was carried out by the author. Because of the relatively unstructured nature of the research, generalizations were developed in a grounded theory fashion.

The analysis is focused on staff attitudes and responses toward five types of patients: accident victims, medical patients, drunks, overdoses and drug cases, and nonemergencies. Four stages of the emergency career of each of these five patient types are discussed: initial contact, diagnosis and treatment, release, and post mortem. The treatment of each of these types of patients poses certain problems significant for "Emergency" staff.

The most significant finding is that most patients violate the staff's concept of an emergency department as a quick repair, quick release treatment center for serious cases of recent onset. As a



result of this discrepancy between staff expectations and reality, various strategies are used by workers to gain control over their work. Also, certain findings from previous studies of emergency departments are discrepant with the results of the present investigation.

An attempt is made to explain why staff remain working in Emergency despite their dissatisfaction which stems from treating a majority of nonemergencies, working in an inadequate spacial layout and facing staffing shortages. The theory of commitment is offered as an explanation.

Finally, practical and research implications are presented. The value of the present study in identifying typical situations in emergency departments is stressed.



In many occupations, the workers or practitioners (to use both a lower and higher status term) deal routinely with what are emergencies to the people who receive their services. This is a source of chronic tension between the two. For the person with the crisis feels that the other is trying to belittle his trouble; he does not take it seriously enough. His very competence comes from having dealt with a thousand cases of what the client likes to consider his unique trouble (Hughes, 1958:54).

There may indeed be in the minds of the receivers of emergency services a resentment that something so crucial to them can be a matter of a cooler and more objective attitude, even though they know perfectly well that such an attitude is necessary to competence, and though they could not stand it if the expert to whom they take their troubles were to show any signs of excitement. (Hughes, 1958:55).

## CHAPTER I

### THE RESEARCH PROBLEM

An ambulance speeding through the city streets means different things to different people. To the motorist, the flashing red light and siren is interpreted as a signal for him to pull to the side of the road to allow the ambulance to reach its destination as fast as possible. Aside from this immediate meaning and action, the motorist also may exhibit curiosity about the events preceding the ambulance journey. This curiosity may be satisfied later by newspapers and radio or television reports. Unless the "passenger" in back of the ambulance is a relative or friend, motorists and people in the street have minimal involvement in the event.

If we assume that our passenger in back has been the victim of an unintended accident and is not there through self-inflicted injuries his confused thoughts will most likely revolve around his own immediate condition; that is, if he is alive and conscious. It is difficult to empathize with someone in his

shoes, but we are probably right in assuming he feels a great deal of anxiety and perhaps wishes that he will never have to make a similar journey. For the accident victim, an ambulance trip is anything but a joy ride. Response based on his meaning of the trip is minimal; most likely he will continue to assume a rather passive patient role as long as he is in treatment.

For those driving the emergency vehicle the event is similar to many they have taken part in in the past and they expect many more. An ambulance trip is a routine part of their occupation. And once they reach their destination the passenger is delivered to others and their involvement ended.

There is yet another group of people who interpret this event differently. Chances are their responses have already begun before the ambulance pulls into the Emergency Department entrance. These people are the ones who start the passenger on his hospital career. If and when he leaves the hospital depends on what they do in a very short period of time. It is this latter occupational group that I am concerned with in the following pages. What does the above event and other less dramatic ones mean to these people and how



do they act on the basis of that meaning? In short, what does it mean to work in an emergency department? I shall be offering some answers to this question in this study.

Sociological research in an emergency department must be seen within the context of previous studies of hospitals. It is hardly surprising that one of our most important formal organizations has been studied often. The task of putting the present study in context is thus not an easy one. In the present chapter I shall discuss briefly what I feel are the most pertinent works and shall tie these and other studies in more specifically at appropriate places in later chapters. Comprehensive reviews of the hospital literature can be found elsewhere (e.g. Simmons, 1963: 493-581; Perrow, 1965:910-971; Rosengren and Lefton, 1969:45-116).

There is an increasing trend toward studying hospitals on a comparative and even cross-national basis (e.g. Glaser and Strauss, 1965, 1968; Rosengren and Lefton, 1969; Glaser, 1970). Goss (1963), in stating the need for comparative work, stressed that most hospital studies in the past involved only



one institution. Perrow (1965) went so far as to call the research efforts up to the time of his work "trivial". Nevertheless, there seems to be no good reason why the lone researcher with only limited funds should not confine his attention to one hospital and even to one department of one hospital. If the necessity for comparative work is granted, later studies of different institutions may be undertaken and results compared. Moreover, the trend toward comparative work may be in part, a product of both large research grants and what Kaplan (1964) calls "fad and fashion in science."

We can still profit from case studies of one hospital. Freidson (1970) states that the study of the general hospital as a whole is problematic. In his words:

While we may discuss the lying-in hospital, the mental hospital and others that specialize in particular conditions or problems of treatment as relatively homogeneous organizations, we cannot discuss the general hospital in the same way because of the varied illnesses, patients and procedures to be found in its special wards. Instead we must break down discussion of the general hospital into the various special services and wards, each of which has its own characteristics. (Freidson, 1970:128).

Freidson cites works by Burling, Lentz, and Wilson (1956) and Coser (1962) on the differences between medical and surgical wards as support for his statement on interdepartmental differences.

If we want to study only one department, which one do we choose? Personal interest guided my selection of an emergency department as the unit of analysis. Also, there have been many studies of hospital wards but few of emergency departments. These considerations along with evidence that the emergency department (in a practical sense) is one of the general hospital's most important departments led me to focus my research interests on this department. Rosengren and Lefton (1969:21-22) point up the importance of an emergency department as a "visible barometer of the changing medical scene" -- one that shows the obsolescence of certain procedures and highlights the need for change.

Closer to home, the administrator of the hospital I studied stressed in a personal interview the public relations importance of an emergency department. In his words:

We have 6,000 inpatients in a  
year here whereas the Emergency  
and Outpatients Departments



receive 50,000 visits a year.  
That means there are 50,000  
opportunities to develop good  
or bad relations as opposed  
to 6,000 inpatient opportunities.

Awareness of possible legal implications is also an especially important consideration in "Emergency". This results both from the types of cases that arrive there (car accidents and incidents of assault, for example) and the medical care that must often be given quickly. In short, I believe there is enough unique about an emergency department to merit investigation of it as a social world.

Although, to my knowledge, sociological literature on emergency departments is not voluminous, that department as an area of research interest has not been neglected. Studies carried out in 1966 by the Yale University Medical School asked the question: "What factors affect emergency room utilization?" It was found that the largest proportion of people who utilize this service are from the lower economic strata, and that increasing use is made of the service for nonemergencies by all economic strata. These findings seem to be common knowledge now among hospital administrators as evidenced by journal articles. The use of the department for nonemergencies is considered later on in the present study. The focus of the Yale study then was on client utilization.

Roth (1969) has an article in a book entitled Poverty and Health (Kosa, Antonovsky and Zola). The general theme of the book is that the lower income segments of the population receive worse health care than do the middle and upper classes. Roth maintains that this holds for emergency clinics and for private physician and inpatient care. He, too, points out that these clinics are the main source of medical care for America's poor and are likely to treat a large amount of nonemergencies.

Roth admits that quality of care as a whole is difficult to evaluate and that his data are somewhat impressionistic. Nevertheless, in the short section on emergency clinics, he shows why the poor receive worse medical care in some aspects. He found that there is an impersonal atmosphere in the clinics (as opposed to the personal bond between doctor and patient) and that there is resulting lack of communication between poverty stricken people and medical staff. Clinic doctors hold negative stereotypes owing to the patient's inability to pay. Other accompanying features of poverty, such as dirt and inability to follow directions as well as the nature of many of the complaints (e.g., drunkenness



and venereal disease) influence treatment. Roth also argues that the care of welfare patients is often superficial.

In general, Roth's account is polemical and owing to the short length of the article little evidence is presented in support of his assertions. In Canada, where all Canadians receive many medical services free under a shared national and provincial Medicare scheme, the ability to pay issue seems to be less problematic.

Rosengren and Lefton's (1969) work exemplifies the comparative trend in hospital studies. This study has the ambitious aim of presenting a comparative model for the study of hospitals that takes account of and supercedes previous theoretical traditions towards hospital studies. In essence, the model contrasts organizations on the basis of how much they intervene in the client's longitudinal and lateral life space. An emergency department is presented as an example of an organization that has little longitudinal intervention ("quick repair, quick release") and little lateral intervention (the ailment is usually specific and doesn't involve the "whole person") in a client's biography. As a result

of differential intervention certain implications are supposed to follow. In the case of organizations, such as the more focused emergency room, some things we should expect are a minimum of patient compliance problems; few problems in staff consensus at the formal level of task accomplishment owing to the well-articulated nature of what has to be done; well-developed lines of authority and an isolated rather than comprehensive interest in the patient.

I believe the above could best be looked at as ideal types of the formal characteristics of an emergency department. Moreover, they are issues that must be taken account of in each individual case by the staff and clients as they attempt to "fit their lines of action together" (Blumer, 1969). Organizational definitions are set by members of the bureaucracy rather than the patients. In actual cases, though, the patient must be taken into account. Where his definition of the situation varies from the organizational definition, the characteristics of interaction in an emergency department become more complicated than those in a setting where organizations do not have to adjust to various types of patients. In this regard, Rosengren and Lefton's model is discussed further in the concluding chapter.



Rosengren and Lefton single out one of the above implications for discussion with regard to an emergency department. They criticize the isolated rather than comprehensive interest in clients and suggest that nonemergencies be handled elsewhere. Organizations, they urge, should reach into the community; they should take account of more than the immediate ailment that an emergency client presents. Also resulting from this fragmented type of care is a susceptibility to innovation at the technological level but not at the ideological level. In other words, medical procedures may change but philosophies toward clients remain the same.

Generally, Rosengren and Lefton, as Roth, address themselves to the current problems in American medical care. Their work thus has a practical social problems orientation. As such it is part of the recent trend in medical sociology urging a reorganization of medical care on a more comprehensive basis.

Another recent interest in medical sociology has been the sociology of death. Glaser and Strauss (1965, 1968) address themselves to the handling of death in hospitals. To do this, wards are compared in terms of how death is handled. The emergency ward is discussed at points throughout their work where



the handling of death is compared with the treatment of this event on other wards.

Glaser and Strauss' main points with regard to emergency departments are that it is one place where quick definitions of whether or not death will occur are possible; it is a place characterized by "heroics" and speed; the patient is there for a short time and there is an emphasis on moving the dying patient to other wards so as to minimize nurses' sentimental involvement. Glaser and Strauss say the ward is characterized by speed both in reaching a definition of how much time remains and in terms of work done there. Another characteristic of an emergency department is that spacial arrangements are often such that they give away the fact of imminent death to relatives.

As a comparative study, the research of Glaser and Strauss is a contribution but the main topic is death. Emergency departments are discussed only as they relate to that interest.

Another work in the same vein is that of Sudnow (1967). He is interested in the handling of death in two hospitals and discusses the emergency ward in relation to the social definition of death. Social factors such as age and social class, we are told, often

determine how much effort goes into saving a patient. In cases where the patient has low social value (old, drunk, and self-inflicted injury are examples), Sudnow tells us the definition of death is often hasty; staff nonchalance characterizes the whole procedure. The picture Sudnow paints is anything but flattering to the medical profession.

Sudnow's unflattering picture, however, is not without difficulties. In his preface he states (1967:v):

this study ... seeks to depict the heretofore undescribed social organization of "death work" and to do so from the perspective of members of a hospital staff (*italics mine*).

We know from the outset whose side Sudnow is on<sup>1</sup>. He says the study is an ethnography. But that is precisely the problem -- it is too much of an ethnography for his purposes. As an ethnography it is well done. He describes in great detail how hospital staff care for the dead and how they make social definitions of death, but fails to tell us why. Emphasis is entirely on the dependent variable of

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<sup>1</sup> Howard S. Becker has called attention to the importance of stating explicitly our value preferences when it comes to our studying social issues. Medical care, as many other social issues, often involves two or more viewpoints. In the case of medical care, the clash of perspectives has most often been between the patient and medical staff.



death work. Had Sudnow given us reasons why hospital staff behave the way they do we could accept the claim that we are receiving "the perspective of ... members of a hospital staff." The work, however, ends as a critique of medical staff based on description rather than on naturalistic study.

David Matza (1969:5) defines naturalism as "a philosophical view that strives to remain true to the nature of the phenomenon under study". The naturalist, he goes on to say, tries to discover the subject's definition of the situation and to understand why he behaves as he does given his world view. Presumably, if the reader, at least partially, sees the world as it looks to the subject, the subject's actions will seem less alien and more understandable. Naturalism cannot help promoting tolerance. In summary, Sudnow did not go far enough to give a good naturalistic account -- though he promised he would. Readers who confront his work, I suspect, end up with anything but understanding for the medical staff of his two hospitals. Does not sociology seek as one of its goals to promote understanding in a dual sense: "ability to comprehend" and "to have a sympathetic attitude towards" (Merriam-Webster, 1964:539)?



The reason I have discussed Sudnow's work in this regard is that I, too, seek to adopt a naturalistic attitude and to tell as accurately as possible the medical staff's side of the story. Neither Roth nor Sudnow do this, although Roth does not set out to.

Thus, the literature on emergency departments includes: studies showing that more lower-class people utilize the service for nonemergencies and that quality of care is generally poor in these cases; a model for comparative study of hospitals that uses the emergency room to exemplify part of the model; studies on dying in emergency departments. None of these works gives us much insight into the social world of an emergency department -- the aim of my research. Moreover, most of the research is on American hospitals. Freidson (1970) says most studies in medical sociology are American and therefore that more are needed from other countries. Without the resources to carry out a truly comparative study, it is hoped that this case study of a Canadian emergency department will be used comparatively by linking it to the existing literature.

As there is little literature to rely on, I felt the problem could be handled best in an exploratory

fashion. As characteristic of exploratory research, there was no clearly defined problem at first other than my desire to present the viewpoints of certain hospital staff. Above all I wanted to gain a picture of life in the Emergency Department as those who work there see it and to organize this into a coherent statement.



## CHAPTER II

### STUDYING THE EMERGENCY WARD

With a broad research problem such as the discovery and presentation of the standpoints of emergency department personnel, how does one proceed? We may start by selecting the appropriate study design. Selltiz et. al. (1964) separate types of research according to purpose. There are exploratory, descriptive and experimental designs. When the purpose of investigation is to accurately describe social phenomenon or to determine how often something occurs, Selltiz et. al. maintain a descriptive study design is most appropriate. An experimental design usually sets out to test causal relationships among variables. Both descriptive and experimental designs usually require that the researcher knows enough about the phenomena under study to set out the design in advance. An exploratory study, on the other hand, has as its purpose:

to gain familiarity with a phenomenon or to achieve new insights into it, often in order to formulate a more precise problem or to develop hypotheses (Selltiz et. al. 1964: 50).



This type of study is usually used when little is known about the area of life one wants to study. In an extensive long range investigation of a phenomenon an exploratory study would be the first step. The preliminary work is ideally followed later by the original researcher or others in the form of the more precise descriptive or experimental studies.

As my review of the literature showed, there is little research to rely on concerning emergency departments -- at least insofar as it concerns the work meaning of staff there. Hence, it was difficult to develop precise hypotheses beforehand. There was no guarantee they would have any relevance to what actually goes on in the social world of an emergency department. I thus decided an exploratory study would be most appropriate. Rather than beginning the study with any theory or hypotheses, an exploratory study emphasizes discovery of the theoretical generalities from the data rather than their verification. To this end this type of study is not precisely set out in advance but commonly characterized by flexibility. In Blumer's (1969) terms the methods become subservient to the area under study. This means that such a study can change its focus

according to what is discovered. In contrast, specific hypotheses are best utilized when one has a great deal of information on the phenomenon under study. My only prior picture of emergency departments came from the small amount of literature and from layman's notions of what goes on there. If anything, it was characterized by a belief that what went on in such a setting is usually dramatic. In that way it approximated the image student nurses often have before they work there -- "a Ben Casey image of glamour and excitement". Like student nurses, my images were subsequently challenged.

#### DATA GATHERING

Given my aim of wanting to gain familiarity with how the staff of emergency departments give meaning to their work, the next question I had to face was how to gather data. Since questionnaires and interviews would presuppose a knowledge of the types of questions to ask, it seemed that participant observation would be the most appropriate means of data gathering. This is the means commonly used when one wants to study an organization (or part of one) when little knowledge exists (Becker, 1958). Exploratory



research on organizations commonly takes the form of participant observation. Blalock (1970) goes so far as to make participant observation and exploratory research synonymous.

What do we mean by participant observation?

McCall and Simmons (1969) say participant observation is a style of research. Rather than one specific technique, it involves a range of techniques: direct observation, informal and formal interviewing and analysis of documents and records.

As for direct observation, Becker (1958) and Blumer (1969) state that it involves watching people under study as they interpret and handle the situations that confront them and listening to their conversations. Schutz (1963), however, suggests that much is missed by relying solely on observation. The behavior may have a different meaning to the observer than it does to the participants and one's inferences may not truly reflect the meanings of the participants (Kaplan, 1964).

Hence, some form of questioning becomes important. This seemed especially so to me since my research was concerned with meanings. Interviewing also has the function of getting at historical factors. The history

of an organization obviously has an influence on its present structure. However, before beginning the field work, I did not know what form the questioning would take since I wanted to adapt the techniques as much as possible to the social world being studied (Blumer, 1969). This is where the flexibility of exploratory research comes in. In participant observation one may know the general techniques he wants to use in such a study but as for knowing the proportion of each technique to use and the circumstances under which they are best carried out, it seems best to wait until one is "in the field". Before the data gathering I thought I would observe in the setting for a period of time then formally interview the participants at the end of the study. As will be seen later, this strategy was changed. Blalock (1970) sums up the nature of participant observation by stating that the observer gathers a wide range of data reflecting different viewpoints.

#### HISTORY OF THE PRESENT INQUIRY

After I decided I would like to carry out such a study in the fall of 1970, limited time and resources dictated that the study could concern only one institution. Once I decided which hospital emergency



department I wanted to study<sup>1</sup>, I faced the problem of access. Of course, every researcher who wishes to study an organization has this to contend with. A letter was written to the Hospital Administrator concerned stating my purposes and requesting an interview. The interview was arranged and I assured the Administrator at that time that my findings would be confidential and that he would be granted access to my data. This promise caused me much concern later because I had developed what I considered a close relationship to the people in the Emergency Department. At the time of the interview, I was naively unaware of the role that I would come to play there. The Administrator was, of course, interested in the practical benefits of the study. Once he had discussed the project with the people concerned, I was granted permission to do the research. My letter was also posted in the Emergency Department to inform them of the purpose of the study.

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To protect anonymity, I cannot identify the particular hospital involved.

I began my observations on the first of October on the evening shift. The Administrator introduced me to the staff of Emergency, so I thus entered under administrative auspices. This is congruent with the advice given by Dean, Eichorn, and Dean (1967) who stress the advisability of gaining acceptance in an organization by moving from the top down through the hierarchy.

Blalock (1970) says the basic prerequisite of participant observation is to gain confidence so as not to change the behavior observed. My next task was to gain this confidence. I assured the informants I was not an administrative spy and that I was not evaluating work efficiency. The head doctor had inadvertently stated that I had the latter purpose. There was considerable questioning the first few days as to what I was doing there and I explained my purposes were to get a picture of life in the Emergency Department as they saw it. This rather vague statement seemed to satisfy them and when they introduced me to people from other departments they'd usually say that I was doing a "survey" for the university. It seems that despite my answering of questions and the posted letter, some people working there still



thought I was studying patients and was only peripherally interested in their behavior and actions. I let the matter stand throughout the research because I was satisfied with the rapport and kind of data I was getting.

Information was not forthcoming immediately however. A white jacket had been issued to me so as to make it appear to patients that I was one of the staff. This, of course, was meant to grant me access to treatment situations. A few nurses must have interpreted the white jacket as a "significant symbol" of work (or as an obligation to work) because it was not long before one nurse said, "It must be great standing around and doing nothing". I took the hint and believe that it was an important decision from the standpoint of the type of information I subsequently had access to. Had I remained "standing around doing nothing" it might have appeared to the staff that their activities were under constant scrutiny and some of their behavior might have been concealed from my view. This strategy of taking part in the staff's daily round (resulting from a remark resenting my passivity) may be viewed from a methodological perspective as an aspect of flexibility that characterizes

studies -- adoption of a research role to fit the requirements of the area under study.

So throughout the research I volunteered my services to help out whenever I could. Often staff would ask me to do things but usually only when they were busy. The types of jobs I was delegated and volunteered for were tasks usually performed by orderlies: taking blood upstairs to the "lab", transporting patients back and forth from "X-ray", checking patients in, holding a troublesome patient down for treatment, helping the intern with suturing, and occasionally helping to transport bodies to the morgue.

My role in the field situation comes closest to what Junker (1952) and Gold (1958) call "participant-as observer". Gold lists it as one of four theoretically possible field roles. The participant-as-observer role is characterized by a mutual awareness on the part of both informant and observer that they are in a field relationship through the observer participating in the daily round of his informants. The role has drawbacks from the standpoint of getting data: two prominent ones being spending too much time participating and achieving over-rapport, which unduly biases research findings.



At times the first drawback came to the fore. For example, I wanted to watch the handling of an accident case but the nurses asked me to take blood to the lab at that time. To maintain the rapport I felt was developing I complied with the request and hurried back to watch the situation. Since this was not an uncommon occurrence, however, a fair amount of behavior was missed due to the role I took. This undoubtedly affected the representativeness of the observations. I see no easy way around this problem.

Participating by doing these travelling jobs had the advantage of allowing note taking. I soon found it was not feasible to write down things in front of the informants having to contend a few times with curiosity as to what I was writing and occasional sarcasm. Thus the practice was developed of note taking in the washroom and corridors down by the morgue. I would often volunteer to do tasks so as to be able to write down quickly what I had just heard or observed. The notes were taken at the earliest opportunity following an event. In most cases the conversations noted were close to being word for word. Field work seems to have the added advantage of affording short term memory training.

As for the second drawback of participant-as-observer, that of going native or over-identifying with the informants, I don't feel it was a real problem because part of my main interest was to get a picture of life in Emergency from staff's point of view. A certain amount of empathy was thus necessary. The realization was there on my part that my main purpose was to gather material for a research project and the constant note taking reminded me of this. Moreover, I spent short periods of time away from the field work over the four months of data gathering. During these respites I discussed my findings with others.

The participant-as-observer role had advantages that I feel far outweighed the risks. By participating in the work of the staff, access was granted to the "back regions" of the ward. Two areas of the Emergency Department are primarily back regions -- the Nursing Stations and the office of the head doctor. These areas are discussed more in the next chapter. After I began helping out (early in the inquiry) I am very confident few conversations and actions were subsequently hidden from me. At times I was looked upon as a coworker, as evidenced by one nurse's comments "It was a busy night, it's a good thing there were



three of us on." (She and the orderly were the only two officially working.) Despite this, every observer in an organization by virtue of being an outsider somehow influences the behavior he is observing. I doubt whether the staff in Emergency had a real clear conception of my study aims despite the posted letter and my explanations. If they had known that their behavior, verbal and otherwise, was being noted, things might have been more hidden.

One limitation of data gathering came, however, from the nature of the phenomena under study. It would seem that medical sociologists in general are prone to this issue. The technical medical jargon was often difficult for me to interpret meaningfully. For this reason important data were missed. The problem here was mostly confined to doctors' conversations. Whenever possible, I tried to ascertain the meaning of the terms. Frequently I questioned staff about what was meant by a certain word.

Becker and associates (1961) apparently had similar problems in studying medical students, but pointed out that participant observation affords good opportunities for solving this problem. One hears

phrases used over and over and by careful observation, questioning and a good medical dictionary, the problem diminishes.

Another problem in gathering data was experienced mostly on the day shift. There were often so many people around the small area that I became bewildered. Here I had to select intentionally events to focus on. In settings where there are many people interacting, the solution is perhaps -- whenever possible -- to have a team of observers. Many sociologists studying hospitals do employ such a strategy. In the present case the problem was solved partially by following one or more staff as they concentrated on one task.

In all, about four hundred hours were spent in the setting -- a total of about fifty shifts. In most cases, shift changes were witnessed because they allowed valuable information on inter-shift communication. When observing on evening shift, I would usually come an hour or so early and try to remain until night shift began. Occasionally double or even triple shifts were witnessed but boredom and fatigue were most likely to occur here. Campbell (1957) calls this "instrument decay."



More night shifts were observed mainly because this generally quieter shift allowed more opportunity to talk with and to interview informally the informants. Also, access to records was much easier "on nights". Nevertheless, all three shifts were observed enough so that I saw the same kinds of situations recurring again and again.

The observations were carried out between October 1970 and January 1971. Had the research been carried out in the summer, somewhat different findings might have emerged. One reason is that patient volume is heavier in the summer.

One access problem I had involved observing treatment situations. For example, someone might ask to see the doctor alone. And occasionally an intern would indicate he'd rather examine a female patient alone. Ordinarily, however, even these situations were open to my view since usually I could be of minor assistance. Patients did not usually comment on my presence; most apparently assumed that I was an orderly or intern.

On a few other occasions two or three nurses who were good friends went in the Casualty Officer's Office and shut the door. I thought it best not to intrude in these situations and would remain in the Nursing Station talking to other staff. Even here, however, most often I would be invited to join them in their back region exchanges and coffee breaks.

## BEHAVIOR OBSERVED

Just what types of behavior were observed over the four month period and specifically how was the range of techniques called participant observation carried out?

Most observation time was spent in the Nursing Station. Here is where the conversations regarding feelings about work and attitudes toward patients were expressed most frequently. Between and during patient care situations, the staff would return here and discuss their work. It was also the center from which treatment situations were coordinated. As is to be expected, the conversations witnessed here were not meant for patient ears; the area is a back region. Any comments concerning patients, other staff, other departments and emergency work in general I tried to note.

A fair amount of time also was spent observing the treatment process: going freely in and out of the treatment rooms, noting what was done with various types of patients and witnessing the comments expressed around these treatment situations.

Coffee and lunch times in the cafeteria also allowed me to listen to staff conversations and I would sometimes question them about situations I had



witnessed or about their general work in Emergency. As for my questioning, it can best be called informal interviewing -- whenever possible I questioned staff in all the above places about matters that I and they deemed significant. If Emergency was very busy, immediate questioning about specific incidents was impossible and thus delayed.

As the study progressed, more specific questions were posed as new interests came to light. At first questions focused on the nature and meaning of the daily round. In line with exploratory research, the informal interviewing assumed a flexibility. Moreover, I knew better what to ask as I became more familiar with the setting (and the behavior therein). Nothing approaching formal interviews was undertaken because of the role I had developed. It was felt that the use of formal interviews would threaten rapport. It also would unduly impose upon people who had given me much information over a four-month period. Unstructured interviews were held with five people: the Hospital Administrator, an administrative assistant, a nurse from Nursing Office (also part of Administration), the Supervising Nurse in Emergency, and the Student-Nurse Supervisor. These were felt to be necessary to fill in gaps. Some time was also

spent riding in the Emergency Ambulance. In retrospect, my most fruitful source of data came, I feel, from just listening passively to conversations and watching staff behavior.

Document analysis constitutes another technique of participant observation. I was permitted access to the daily record book, a valuable source of comments on patients. Such access also enabled me to count the number of patients. Some idea of average patient volume by shift is given in the next chapter. Whenever I thought it advantageous, patient charts would be looked at also. The record book and patient charts were valuable as sources of medical definitions of patients.

The fieldwork was ended as soon as I felt that the same types of situations were being observed repeatedly. When the researcher feels that his observations are bringing no new data, when he feels there are no new categories or generalizations emerging, then the inquiry has reached what Glaser and Strauss (1967) call "theoretical saturation". It is one reason for ending an exploratory inquiry. It is usually an arbitrary matter when to end fieldwork, and it is common to feel that you are never finished. After participating in fifty shifts I felt I had observed enough to allow valid generalizations.



## ANALYSIS OF DATA

In testing theories, the analysis is done in line with preconceived research design and statistical techniques. However, in exploratory research there is little or no prior theory to test and hence anything resembling theory should ideally arise out of the research process. This has been discussed at length by Glaser and Strauss (1967). They refer to theory arising out of the systematic analysis of data as "grounded theory". The strength of grounded theory is that it is true to the area under study -- that is, facts are not forced to fit theories. Rather it is the other way around: theories must fit the facts since they arise from them.

The grounded theory that Glaser and Strauss speak of does not naively imply that the researcher has no preconceived assumptions. Critics of grounded theory often assail the approach for not making theoretical assumptions explicit. Since prior assumptions always precede even exploratory research, the critics maintain that grounded theory advocates do not tell the whole story when they say the findings emerged wholly from the fieldwork. The researcher, to give a more complete picture, should be aware of his assumptions

and attempt to make them as explicit as possible. Sjoberg and Nett (1968) discuss some common assumptions that most research must take cognizance of. These include: assumptions about social reality (for example, whether it is fluid or stable, whether characterized by harmony or conflict); assumptions as to whether man is constrained by society or whether he can change his environment; and whether the researcher sees himself as being apart from his data or an integral part of his research situation.

As the stress on meaning in the broad statement of the problem may imply, some of my main theoretical assumptions derived from a symbolic interactionism orientation. Some of the premises and implications of that school of thought are well discussed by Blumer (1969:1-60). I shall here make explicit what I feel were my main theoretical assumptions that influenced the research process. Regarding the above assumptions discussed by Sjoberg and Nett, symbolic interaction typically assumes: a fluidity as characterizing social reality (it is constantly changing); social reality is many faceted and that harmony or conflict models are too simplistic; the researcher is an integral part of his research setting -- he is influenced by it and in turn has an effect upon the setting.



A symbolic interaction orientation has led me away from factors such as technology and social class to the interpretations actors place on these variables. Furthermore, as Blumer points out, people act toward objects (including social objects) on the basis of meaning derived from interaction. In this study it was assumed that people in the Emergency Department defined recurrent situations in their occupations similarly. This led me to expect, in turn, that there would be group perspectives on various types of patients: meanings derived from interpretations of similar situations experienced in the past.<sup>2</sup>

A further assumption of symbolic interactionism is the importance of the process of constructing one's action as it relates to the rules of the organization. This assumption has led to a consistent focus on the informal aspect of formal organizations rather than formally defined rules. In actual situations the rules are taken account of, but so are many other things. In Sjoberg and Nett's (1968:63) "man is not merely a

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<sup>2</sup> These memories of past events are activated in specific situations and influence on-going behavior. Campbell (1963:97-112) calls them "acquired behavioral dispositions" whereas Stebbins in a later work uses the term predispositions to refer to the influence of cognitions acquired in the past on behavior in the present.

billiard ball who responds to external social forces", he can change his environment.

Thus, we see that there have been many theoretical assumptions influencing this inquiry. The above listing undoubtedly does not exhaust them. Despite all the assumptions, within the specific area of inquiry theory is generated from the data as much as possible. The assumptions provide a broad framework within which specific generalizations are developed.

The present study had a broad focus. This means a great deal of information was collected. As Blumer (1969), Glaser and Strauss (1967), and Blalock (1970) point out: in exploratory research, one does not know what the relevant theoretical issues are until the inquiry is well under way. Blalock (1970:42) states that the researcher "should not begin sifting these facts and interpreting them until he has become very familiar with the general life pattern of the people being studied." Preconceived theories and hypotheses in an area where there is little knowledge risk being inapplicable to that area. In contrast, the unstructured nature of exploratory research is more conducive to a spontaneous discovery of theoretical propositions.



When does the analysis take place? Glaser and Strauss maintain that analysis should take place during the fieldwork process and that such analysis should guide further data gathering. This appears to be sound advice, especially when a project covers a long period of time and uses many researchers. The present research was short enough to make analysis during the fieldwork less necessary. While I deliberated on ideas, revised preconceptions, discussed findings, and wrote memos on my observations no systematic analysis was undertaken until the fieldwork was finished.

The following chapter deals rather extensively with the setting. Data relating to general staff views of work in Emergency are considered along with objective features of the setting. The majority of the data dealing with patient-staff contacts are dealt with subsequently.

Data on patient-staff contacts are most profitably analyzed by focusing on types of patients, what was said about them and done to them by staff members at various stages of their career in the Emergency Department. In this way staff relationships with other hospital departments and "outsiders" could also be handled since most cases involve some extradepartmental

contact. The work done in connection with certain types of patients involves more than just staff members in Emergency. The intervention of these outsiders in the patient's emergency career raises certain issues that have consequences for staff work meaning. While the main interest is in the meaning of work of the staff, the meanings of other medical employees at the same hospital or even other hospitals affected by and affecting staff work were recorded whenever possible so as to provide a more rounded picture.

In short, work situations selected for analysis centered on types of patient. Different classes of patients present different problems for staff and must be handled in different ways. Classification by type of patient is routinely carried out by staff in the Emergency Department (although often implicitly) as part of their commonsense world; it is not a mere analytic classification. Rather, the analytic classification builds on the commonsense classifications used by the staff of Emergency.

Four stages of a patient's career in Emergency were delineated. The first stage is initial contact. This includes staff actions and verbalizations from



the time the staff are aware of the patient's presence or expected presence until the diagnosis and treatment processes being. Stage two is diagnosis and treatment and includes the events from the beginning of diagnosis until the patient leaves the treatment section. Stage three is the release stage and consists of the events around the patient's release from active treatment and his subsequent admittance to the hospital, discharge, or overnight stay in Emergency's Observation Room. Finally events were classified as the patient post-mortem stage which includes statements and conversations about patients after they have left the departments or other consequences resulting from their visit.

The types of patients considered are: accident cases, medical patients (ailments of an internal nature; for example, abdominal and chest pains), drunks, overdoses and drug cases, and nonserious emergencies. All data concerning each type of patient were coded under one of the four stages. Next, generalizations were made about the meaning of the patient for each staff member involved and

the meaning of the staff member's part in the situation. Such generalizations were made for each stage by comparing actual incidents of patient career.

In the following chapters the data are presented in a discussional form rather than in a statement of formal propositions. This format facilitates presentation of the many contingencies involved and especially the subtleties of the medical decision-making process. Unless supporting data from other studies are cited, all generalizations made here are elements of an emerging grounded theory, which require more rigorous subsequent verification. To encourage such verification the categories and generalizations discovered are presented in the present tense often as if they have universal application; this is the form that is most readily testable.



## CHAPTER III

### THE SETTING

This chapter focuses on the research setting and general staff views of work meaning in that setting. The emphasis on work meaning is in keeping with the largely subjective emphasis of the study. The following are discussed: features of the hospital where Emergency is located; physical plant of the Emergency Department; rules affecting work there; people in Emergency (the tasks they perform and their role relations to each other); daily round of the Department with an emphasis on shift differences, general staff feelings about working in Emergency; and staff conceptions of their "patients."

### THE HOSPITAL

Capital is a 354 bed general hospital in Eastern Canada; one of several hospitals in the city where it is located.<sup>1</sup> Its clientele is composed only of

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<sup>1</sup> Capital is the fictitious name of the hospital studied.

those over sixteen years of age. Until a few years ago children were treated there also, but a recently opened children's hospital has changed this. Capital has the only facilities in the community for treating orthopedic cases. It also runs the only ambulance service there. In addition, Capital is a teaching hospital drawing its intern and resident staff from a wide geographical area. At present medical students from a nearby university also utilize the hospital for learning purposes.

Capital is owned by the Provincial Government but administered by a corporation. The majority of the financing comes from the Provincial Government. (This government in turn gets a large grant for provincial medical services from the Federal Government.) Outside support by hospital auxiliaries is minimal and largely includes money needed for new equipment. The individual departments submit their estimated budgets for the coming year to the government appointed corporation. Following this the corporation submits their total estimated budget to the Provincial Government. After government-corporation negotiations so much is allotted to the corporation to run the day-to-day affairs of the institution.



Usually, however, the amount allotted proves insufficient and further financial needs must be submitted to the government for approval as they arise.

Until a few years ago Capital was run by civil servants. The changeover to corporation management is seen by many staff as a crucial historical factor. (The consequences of the changeover are worthy of study, but can only be touched on here.) Staff at Capital see the changeover in terms of how it has affected their work. Tighter financial control and increased supervision are the most noticed changes. Under civil service administration there is a feeling that finances were abused and wastage was rampant. A present administrative official mentioned the lack of interdepartmental communication as a holdover from the government administration. The present Administration is making plans to correct this. Many staff see these plans as making for increased supervision of their work. Further consequences of the administrative changeover are discussed later.

## THE PHYSICAL PLANT OF EMERGENCY

The Emergency Department of Capital is the only sizeable one serving adults in Capital City. Other hospitals run smaller emergency departments but these do not operate on a twenty-four hour basis. Since it has the only well-developed emergency service in an area of approximately two hundred thousand people, Capital experiences excessive demands on this function.

Diagram I shows the physical layout of Emergency. Three main types of behavioral settings are discussed here: treatment rooms, back regions, and the waiting area. First, the treatment rooms. Critical cases receive treatment in the Resuscitation Room, a room reserved for real emergencies. Its location near the Department entrance reflects the importance of the room. Cases defined as serious are rushed into the "Resus Room" immediately after entering the Department, for the types of cases treated here time may be crucial. The equipment found here likewise reflects the importance of the area. There are a variety of life-saving devices and regular checks ensure that the room is always adequately equipped.



A genuine emergency allows no time to look for necessary equipment elsewhere.

Most suturing, another common occurrence in any emergency department, is done in either the "O. R." (Operating Room) or the suturing room. The majority of patients (those with nonserious ailments) are treated in the rooms 1, 2, 3, in Diagram I. The "cubicles" are fairly small and only sliding partitions close them off from the outside. Cases of a serious but noncritical nature are commonly treated in the "P. V. Room" I shall call these cases second priority emergencies. This area is larger, and cases that require restraint and have to be watched (for example, overdoses and hysterical patients) are most often treated here. If there is more than one case of a critical nature at the same time, one is put in the P. V. Room. Minor cases also are treated here if the three cubicles are filled as is often the case. The P. V. Room seems to function, then, as a miscellaneous treatment area.

Emergency's Observation Room can be considered another part of the treatment area. Patients awaiting admission to the hospital or patients kept in Emergency

for any prolonged period for observation are typically placed in this room. There are usually two beds and a stretcher in this room, whereas the other treatment rooms are set up to handle only one patient at a time. The Observation Room is located adjacent to the Nurses' Station to permit easy surveillance of patients by staff.

Back regions comprise another class of behavioral settings in Emergency. Common to any organization where workers and clients meet, a back region is "the place where the performer can reliably expect that no member of the audience will intrude" (Goffman, 1959:113). I have labelled two rooms in Emergency back regions: the Nursing Station and the Office of the Casualty Officer. Staff are most commonly found in the Nursing Station. It functions as a center from which patient care is co-ordinated. Patients are discussed here, patients' career plans are made, charts are written up and phone business is transacted. In addition, staff take some of their leisure in the "Station". All staff from doctors to orderlies commonly congregate here. The rather small area is often crowded with many staff



engaged in divergent activities. Patients and relatives are discouraged from entering this area in order to control medical information and give staff an area to themselves.

A large window in the Station serves the crucial function of allowing staff to survey the entrance and waiting area. Medical definitions of serious or nonserious can be made by staff about incoming patients. Also, the general state of affairs in the Department can be assessed from this vantage point (for example, the number of patients waiting to be seen). A problem with the glass enclosed Station is that patients and relatives also can observe staff activities and misinterpretation may result. Staff feel that this is a disadvantage; if a member of the "audience" sees staff talking in the Station the activity may be interpreted as mere standing around. In reality a patient-care situation may be under discussion at the time. As one nurse put it: "You feel you're on stage at a concert hall". As Goffman notes insufficient control of back regions (audience intrusion) is a recurrent problem in most organizations.



Since there is no official coffee room in Emergency, the Nursing Station and Casualty Officer's Office also must serve as leisure areas. The small Casualty Officer's Office is used by the doctor during weekdays so that its leisure usage is limited. Emergency's present cramped condition has the disadvantage, as seen by a head nurse, of bringing all status levels together. She felt that "nonprofessionals" (nursing assistants and orderlies) should not be able to hear patients being discussed, but realized that "there's no place for them to go".

The third behavioral setting in Emergency is the waiting area. This is a small area with two small benches placed amid signs urging accident prevention and located near the treatment areas. The adjacent Outpatient waiting area can be used by Emergency on nights and weekends when the clinic is not operating. Most of the time, however, the small waiting area must serve the purpose. Relatives and patients waiting for treatment are often dissatisfied with the inadequate waiting space; they wander freely throughout the treatment areas ignoring "No admittance" signs. Often there are many relatives and friends



accompanying patients, which compounds the problem. Because of the closeness of the waiting and treatment areas, conversations between staff and patients can be heard by all.

The spacial layout of Emergency is seen by staff as one of their biggest problems. Neither staff nor relatives have much privacy with the present layout of the crowded Department. A city newspaper reporter also highlights this as the main weakness of the system. One nurse who has visited and worked in other emergency departments said it was the worst spacial arrangement she has ever seen. Administrators at Capital have as one of their first priorities the correction of this inadequacy.

Nurses feel that relatives should not be in such close proximity to treatment areas because it is distressing to hear patients in pain. Patients also find it embarrassing to have others overhear their conversations with doctors. Since "Outpatients" is so close, patients from that department often rush down to Emergency when they sense excitement. Having staff activities visible to outsiders also has its disadvantages from a public image standpoint. One



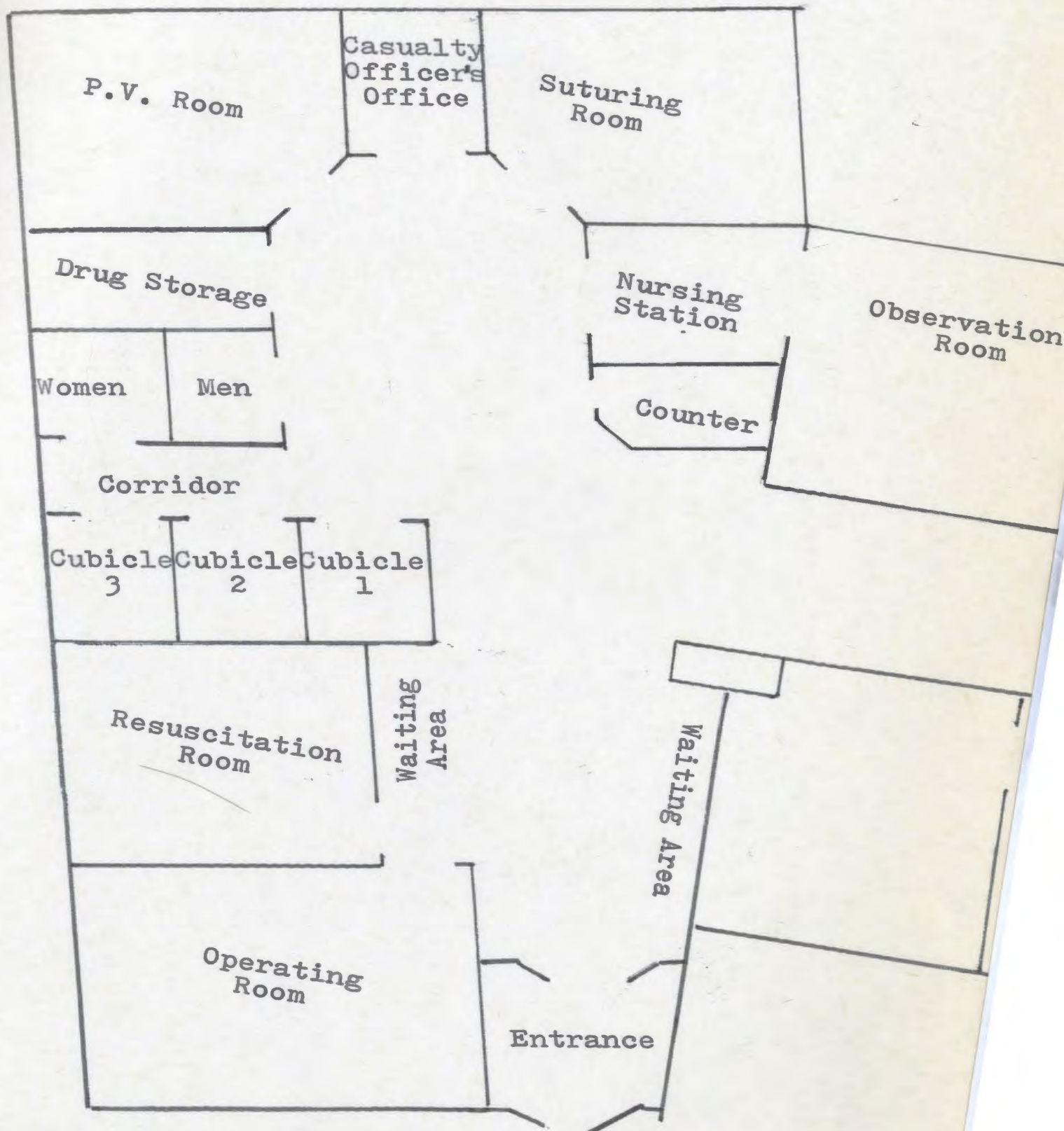
nurse commented that people see what they want to see; a five dollar reward for best newstip of the day is conducive to misinterpretation of staff activities. Waiting for relatives or friends in treatment is a boring activity. There is a danger that any ongoing event will be attended to and misinterpreted by laymen.

Staff, however, do not passively accept the space problem. They have devised strategies to partially control it, such as putting up screens to block off the treatment area and telling the relatives to wait outside. Doors to treatment rooms can be shut, though this has the disadvantage of cutting off staff views of patients. Many patients in Emergency have to be watched closely. Some workers in Emergency have an attitude that I call anti-relative. They find many relatives nuisances, nosy, and of little help other than giving initial information about patients they accompany. This anti-relative attitude is partially explained by problems arising from an inadequate spacial set up.

One can sum up the physical plant as being too small. There are often not enough treatment areas,



DIAGRAM I  
PHYSICAL SETTING OF EMERGENCY



no adequate staff rooms and no suitable waiting area. The spacial problem can be seen, on a broader level, as resulting from a failure to keep abreast of the emergency demands of the growing population.

## RULES

Every organization is characterized by formal rules which members must take into account before acting in different situations. Consideration of rules and how they are made gives us valuable information on the formal structure of an organization.

Relying on the classification used by the supervising nurse of Emergency, there are two types of rules affecting staff there. Internal Rules, or those affecting just the Emergency Department, are made within the Department by the Casualty Officer or the Supervising Nurse, or both. In the Supervising Nurse's words: "We have unique problems that don't happen anywhere else in the hospital. Some of these come because we run on a twenty-four hour basis". An example of an internal rule is that the Emergency Intern must not leave the Department without the head nurse's knowledge.



External rules are those rules affecting the Emergency Department as well as other areas of the hospital. These rules come down from "Administration." The general policy, however, is that these rules usually result from requests put in to Administration by the Casualty Officer or Supervising Nurse. Staff nurses and orderlies in the Department take work problems to the Supervising Nurse who then decides whether or not to refer the problem to the Nursing Director (part of Administration). External problems dealing with patient care are referred from the Casualty Officer to the Hospital Administrator. In addition to the handling of specific problems as they arise, there is a regular monthly meeting of the supervisors of Emergency and Outpatients. Any recommendations discussed in these meetings are referred to Administration for consideration. All external rules involving medical staff (doctors) must be approved by a committee of doctors as well as Administration.

External rules, then, usually result from requests by workers in the Department. Rules imposed from above without initially being put in as requests are often resented and fought against. During my fieldwork a



rule came down from Administration without Emergency staff being consulted beforehand. This rule stated that the Emergency orderly had to go on the ambulance five nights a week to assist should the need arise. This practice would have left the night shift without an orderly. Consequently, the night nurse expressed her objection to the Nursing Supervisor. The Casualty Officer concurred with the objection, referred it back to Administration, whereupon the rule was rescinded. As this incident illustrates, staff in Emergency do not passively accept rules they feel are imposed without consideration of the Department.

Both new external and internal rules are posted during the day shift in the Nursing Station. Those on evening and night shifts often do not understand the rationale behind the new rules and therefore often resent them. As one nurse expressed it: "They couldn't have been too busy on days; all they could find to do was to put up stupid rules." A new rule often contravenes an existing rule. It also becomes something new for staff to take into consideration in various situations. In short, new rules mean added responsibility.



Most new rules characteristically result from one incident that highlights a problem area. The problem may crop up occasionally, but one incident dramatizes it. Only after the dramatizing incident is action taken. Staff seem to learn from adverse experiences. There are many rules in Emergency both formal and informal that have come about this way. The manner in which one informal rule came about was related by a nurse: "I'll never forget the time one old lady fell off a stretcher and fractured her hip. Ever since that we always put up the side rails."

There is evidence that this practice of dramatization of outdated existing rules is common throughout all departments at Capital. A resident related a further example of the practice:

I'll never forget that young guy who died in I.C.U. because we thought he was a crock. We didn't carry out all the tests we should have. From now on, anyone who swallows anything automatically gets a barium swallow.

Rosengren and Lefton (1969) point out the importance of an Emergency Department as a barometer of the changing medical scene, one that highlights the



obsolescence of existing rules and procedures. The present study shows one way change comes about.

#### PEOPLE IN EMERGENCY: ROLE RELATIONSHIPS AND JOB ANALYSIS

At the time of the study, the staff of Emergency consisted of: a Casualty Officer, three head nurses, a Student Nurse Supervisor, eight staff nurses, three nursing assistants, five orderlies, and two interns per month (a total of eight over the four month period). In addition to this Emergency based staff of twenty-eight people, many medical residents, other more senior medical staff, administrative officials, admitting clerks and laboratory technicians are present at various times. At busy periods other nurses and orderlies are called in from other floors to help out. Second year student nurses training at Capital take turns spending two-week periods at Emergency.

The chief medical officer in Emergency is the Casualty Officer. He supervises the medical care of patients (when on duty) and can be called in at other times if major problems arise. The chief Casualty Officer at the beginning of the study had been recently appointed; his working hours were "nine to five" on



weekdays. This left the department without a senior medical officer during evenings, nights, and weekends. Since completion of the study, the situation has been somewhat remedied by appointing a second Casualty Officer to work evenings. While it is generally agreed that this second senior man is badly needed, the hospital's budget did not allow for his appointment until recently. Basically, the job of the Casualty Officer is to supervise patient care. As part of this job the Casualty Officer treats some patients and supervises the interns' work. He also is the one who usually brings about internal rule changes and recommends to Administration that certain external rules be changed.

Until the appointment of a second Casualty Officer, the prime medical man on hand most of the time was an intern. Interns spend a month working in Emergency; two are sent here each month as part of their hospital rotation.<sup>2</sup> These two interns work alternate days on a twenty-four hour basis. Some of Emergency's main problems, as seen by Administration, have come from putting little experienced doctors in such a responsible position. While serious cases are

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<sup>2</sup> It should be added that the monthly intern change is one organizational change that occurs regularly.



referred to the appropriate medical resident or senior staff man, the intern has to make the decision (often with the aid of a nurse) as to which cases should be referred. Because of consequences of a few incidents where an intern took too much responsibility, a second Casualty Officer was appointed. Even now, in most cases, the intern is the first (and sometimes the only) doctor to see a patient.

In actuality, then, the intern is in charge much of the time. As usual, however, the formal structure of authority fails to tell the whole story. The interns, since they are only in Emergency for one month, can be viewed as transient staff members. In fact the nurses (usually head nurses) as more permanent staff members occasionally step in to co-opt this formal authority should they deem it advisable. Every organization has role incumbents who by virtue of their experience know more about the workings of the organization than do new higher ranked members.

Mechanic (1968:423) states the matter well:

Employees with long tenure have considerable information about the organization, its traditions and procedures and persons in other parts of the organization. This gives lower-ranking persons



substantial power over the new administrator, doctor, or professor who, if faced with a complex and unfamiliar organization is dependent on lower-ranking personnel for information, guidance and action.

While the relationship between long tenured nurses and new interns at Capital is for the most part symbiotic, there is little doubt who has to make the most concessions. The issue was stated frankly by one nurse: "We usually get the interns to see things our way".

For orientation to the policies and rules of Emergency as well as advice on medical care, the transient interns rely mainly on the nurses who have been there longest. Hughes (1958) refers to the "old faithfuls who give an institution its character" as the "home guard". At Capital there are four nurses in Emergency who comprise the home guard: The main Supervising Nurse in Emergency (also the head nurse on day shift), a head nurse on evening shift, a head nurse on night shift and the Supervisor of Student Nurses. All four have been there over ten years. I have often heard it said by staff at Capital that these nurses can diagnose a patient when he comes

through the door, and I often saw them do just that. When speaking of any of the three shifts at Emergency, people often speak of the head nurse on the shift. There is some rivalry between the three head nurses, manifested mostly in comparisons of number and seriousness of patients on their shift with number and seriousness of patients on other shifts. In addition to identifying with Capital and Emergency, there is considerable identification by the home guard with their respective shifts. We can expect shift identification of all organizational members assigned permanently to one shift.

Beside the home guard, there are other staff nurses in Emergency. At the time of the study there were seven of these, all registered nurses, who rotated through the three shifts. These younger women have worked in Emergency less than two years. Like all staff in Emergency, training for work there is gained on the job.

It is rather difficult to describe the many jobs of nurses in Emergency; they seem to do everything. One writer (Mauksch, 1965:251-265) calls the nurse the "co-ordinator of patient care."



Generally, besides orienting interns to Emergency, nurses there assist doctors in patient care; keep track of the number of patients and their stages of treatment; send and receive telephone messages; write up charts, reports, and laboratory requisitions; dispatch the ambulance; and supervise the work of nursing assistants and orderlies. The head nurse on each shift does most of the remaining supervisory work.

It is the nurse who decides initially which patient is in most serious condition and should be seen next by the doctor. If the intern orders a drug that the nurse knows from experience may cause an adverse reaction, she checks to see if the patient has had such reactions from the drug in the past. There is usually little hesitancy in informing the intern should he forget an aspect of diagnosis or treatment. At Emergency, this advice is usually given good-naturedly; the intern relies on the nurse's longer experience and the expertise derived therefrom. During my research I witnessed only a few incidents where the interns resented nurses' advice on medical matters. Head nurses even teach foreign interns various medical skills; for example, how to set up



intravenous fluids or how to suture. This is seen as necessary since many foreign interns come from communities that have little modern equipment. Such unofficial actions are most likely to occur at the beginning of the interns' monthly rotation.

Also the nurses perform a valuable service for the interns by informing them of senior doctors' likes and dislikes. From experience, the nurses (particularly the head nurses) have accumulated what Cooley calls "social knowledge"<sup>3</sup> of many of the doctors at Capital. This information can aid in preventing the intern from making mistakes that may result in reprimands. A common expression heard in Emergency by a nurse is: "Dr. \_\_\_\_\_ will want all the bloodwork done before he is called."

In general, there is little strain in the intern-nurse relationship. One person stated that the nurses "adopt" the young interns. There is much joking between the two classes of workers. The nurses sympathize with the doctors' long hours. If there is conflict it is short lived and usually comes during the intern's first days in Emergency. At this time

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<sup>3</sup> According to Cooley (1926:69), social knowledge "is developed from contact with the minds of other men, through communication, which sets going a process of thought and sentiment similar to theirs and enables us to understand them by sharing their status of mind."



he has been used to doing things a certain way; he may resent the nurse's telling him to do those things differently. The pleasant manner in which the advice is usually given no doubt prevents much conflict from arising in what would seem to be a potentially stressful relationship. The nurse by virtue of her longer tenure is expected by Administration to see that things run smoothly. She, thus, has an interest in seeing that interns follow hospital rules. If not, she may be held responsible. Advising interns also provides her with opportunities to demonstrate her expertise. For these reasons, I have called the intern-nurse relationship at Emergency, symbiotic.

The third occupational group in Emergency is composed of the nursing assistants and orderlies. With the exception of two nursing assistants, these staff also rotate. Nursing assistants and orderlies are responsible to the head nurse of their shift; however, orders can come from the doctors or any staff nurse. These workers have as their tasks: checking patients in (getting information from incoming patients), assisting the intern or nurse in patient care situations, tidying up the physical plant and doing most of the travelling jobs. By travelling

jobs I mean those which take personnel out of Emergency for short periods of time. Included here are the transporting of patients back and forth from "X-ray," taking blood up to the lab for testing, and getting supplies from other parts of the hospital. Orderlies are valued by the nurses because they can control troublesome patients, do much of the heavy lifting and know the physical layout of Emergency. In a real emergency, they can be relied upon to fetch necessary equipment. If the place is overly busy, nursing assistants and orderlies help out by doing medical tasks ordinarily performed by the better trained staff nurses. Again, there is little outward conflict in the nurse-nursing assistant and nurse-orderly relationships. Orders are usually given in a pleasant manner.

Student nurses are in Emergency for one week on day shift and one week on evening shift. They mostly perform tasks done by orderlies and nursing assistants. Since they are not fully trained they are not expected to perform the tasks of more experienced staff nurses. In addition they often check to see if equipment is on hand and spend time talking with patients. Student nurses are the only group in Emergency who spend much



time casually interacting with patients. When I asked a few why this was so, they replied that it is a carryover from their first year of training, which stresses the importance of communication with patients. They have not developed the hurried manner of more experienced Emergency nurses.

#### DAILY ROUND

Much of what transpires in a setting like an Emergency Department depends on the number and types of cases that enter it. At any given time it is difficult to predict what will be happening. This is unlike more regularized work settings like factories where the same participants occupy them the whole time. Staff in Emergency are aware of the uncertainty factor; a common staff statement is: "You never know what's coming through the doors next". Nevertheless, certain regularities do exist.

#### DAY SHIFT

The day shift was from 8 o'clock in the morning to 4 o'clock in the afternoon. As Table I shows, the largest number of patients come to Emergency during

the day and evening shifts. The table is oversimplified since it does not include "leftovers" or patients that enter during one shift and are not fully treated when the next shift comes on. The table also does not show the many patients who come during the day for things that are not charted. There is typically more activity in Emergency during weekdays because the hospital is in full swing. Many patients come to Capital for surgery. Those requiring surgery of a minor nature (for example, dental extractions) are prepared in Emergency. In addition, many sutures are removed and dressings changed during days. Since more laboratory technicians are on duty from 8 o'clock to 4 o'clock on weekdays, more tests are ordered. Staff in Emergency engage in more "make work" during day shifts also; the place is usually cleaned out, equipment rearranged, the department tidied up, and supplies ordered. For these reasons staffing is highest on days.

Workers from other departments are often in Emergency to do tasks during days: laboratory technicians come down to do tests and orderlies from X-ray transport patients back and forth. Add to this a constant flow of patients between Emergency and the adjacent Outpatients Department and the small area



often becomes characterized by a sense of confusion. Although Emergency staff often comment on the confusion of days, they seem able to perform their tasks as well as on other shifts.

I, for one, was surprised at how they are able to carry on amid this confusion. When discussing shift preferences, staff mention that "there are too many bosses around on days". Staff feel the presence of more authority figures makes for a less "carefree atmosphere" on this shift than on evening and night shifts. Staff relationships are more apt to be characterized by formality. The recent change in Casualty Officers has brought the presence of a more authoritarian "boss" to Emergency. Lentz (1950) speaks of the effect a change in bosses in a hospital business office had on staff morale. Workers in Emergency perceive the Casualty Officer on days as having an adverse effect on staff morale. One intern who had worked there earlier stated: "It's too bad because one of the nice things about Emergency was its congenial atmosphere." The boss's personality has an important influence on staff morale in any work setting. Despite a feeling on the part of regular staff in Emergency that morale on weekdays has recently declined, the more

transient interns and student nurses often comment on the generally higher morale of all shifts in Emergency compared with that in Capital's wards.

### EVENING SHIFT

The evening shift was from 4 o'clock in the afternoon to 12 o'clock midnight. In Table I, it can be seen that evening shift in Emergency is also quite busy in terms of patient volume. The extra tasks that characterize day shift are not performed here, so staffing is lower than on days. The entire hospital slows down after supper; laboratory technicians are not as plentiful nor are Administration officials. Since Outpatients has closed down, the flow of people from there ceases. All these factors reduce confusion, except, of course, when Emergency patient volume is extremely heavy. Weekend evenings are usually busier because of the increased number of drunks served.

Morale on evenings is seen by staff as high. One finds all evening staff taking equal part in conversation and there is less formality in staff relationships than on weekdays. Joking and teasing among staff are noticeably higher on evenings. Workers from other



departments often drop in to chat if the place is not busy. Much of the high morale of evenings is attributed to the presence of fewer bosses.<sup>4</sup>

### NIGHT SHIFT

The night shift was from 12 o'clock midnight to 8 o'clock in the morning. Table I shows that patient volume is lowest on night shift, although leftovers are omitted as before. Staffing on night shift is also lowest: there is one intern, a head nurse, and an orderly. At busy periods this staff is too small; personnel from other floors are brought in to help at these times. During the study some of the most serious cases came in on night shift. One nurse relieving on nights said, "At nights you're too much alone". Staff attribute this to the tighter financial policies of the new corporation.

An Administrative nurse at Capital contrasted nights to the other two shifts: "At night it's entirely different. For one thing the doctors are harder to get out of bed." Interns and residents working on a twenty-four hour basis will try to get a few hours sleep at

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<sup>4</sup> The presence of a new Casualty Officer on evenings has no doubt affected morale. This extra boss has been appointed since the study was completed, and consequently his influence has not been examined. I suspect his presence has attenuated some of the high morale of evenings.

nights. Getting them up causes delay in patient care, one that patients often complain of. Further, the doctors are more apt to be irritable when called out of bed. This negatively affects the morale of night shift.

Further delay on nights results from calling in laboratory technicians should they be needed. Staff feel Emergency's X-rays are done faster on nights, however. During the day the technicians have the whole hospital to serve. Also a number of drunks are apt to show up after the bars close. The Head Nurse on nights is seen by many as being very competent to handle "the type of stuff that comes in on nights". As an Administrative official said of this Head Nurse "You need someone like her on nights. She's not afraid and she's been there so long she hardly needs to refer any problem to the Nursing Office."

Most patients come early in the shift. There is a tapering off of patient volume in the early hours of the morning. Then, just before "changeover" to the day shift, those to be prepared for the Operating Room begin arriving. This typically causes the night staff to rush just before they leave the shift. Because there are few staff and long periods between patients



in the middle of the night, the atmosphere is conducive to conversation. Members of the local police force often drop in for coffee and to exchange stories.

### CHANGEOVER

Shift changes deserve attention in a discussion of the daily round. Since staff from two shifts meet at changeover, it is the time when most Emergency staff are together. Nurses and orderlies of the two shifts exchange stories. Those going off duty relate significant happenings to the oncoming shift; they also give justifications for actions they may have taken during their eight hours of work. The oncoming shift usually accepts the justifications given by the other shift. The time of changeover appears to foster staff identification with the Emergency Department, a kind of we-they feeling. Knowledge of how their colleagues handle situations becomes available to staff at these times. Thus, changeover aids the development of common patterns of behavior and thought.

However, there is usually a sour note about shift changes. Oncoming staff have to confront the presence of patients left over from the previous shift, which are not appreciated by them. These personnel prefer

to come on duty with no patients left over. Leftovers are confusing. In the words of one nurse, "You don't know where their clothes are, which cubicle they're in, what has to be done to them, or anything else." Intershift communication is important here; the previous shift staff must relate to the new staff the stages of treatment of and future plans for these leftovers.

Oncoming staff are likely to complain among themselves about leftovers, but like much of the complaining in Emergency it is short lived. There is such a variety of cases that attention is unlikely to focus on any one case for any extended period. Pressure of further patients to be treated forces frequent mood switches. Moreover, complaints seem to be a recurrent feature of every work setting.<sup>5</sup>

The number and nature of work complaints influence morale. Morale is important to workers and undoubtedly affects their task performance. It is also both antecedent and consequent in the worker-client relationship. In a setting like Emergency where team work is essential

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<sup>5</sup> The phenomena of work complaints is one worthy of investigation. Why is it that workers everywhere complain and yet go on working? Work rewards, occupational commitment and the in-group feeling fostered by group complaining would seem to be tentative answers on a general level.



TABLE I

AVERAGE NUMBER OF PATIENTS PER SHIFT  
BY MONTH FOR A FOUR MONTH PERIOD\*

Month	Shifts		
	8 - 4	4 - 12	12 - 8
September	14	17	7
October	15	15	6
November	17	15	6
December	15	15	6

\* Although the observation period was from October through January, due to the unavailability of the January record books, these figures show patient volume for September through December.

the importance of morale is evident. Because the nature of emergency service is part of the hospital's reputation, low staff morale when manifested in bad staff-patient relationships is undesirable. For example, there is a possibility that the dislike of leftovers by Emergency staff may be taken out subtly on these leftovers. Morale, then, appears to be a significant aspect of the informal structure of any work setting like Emergency.

#### GENERAL WORK MEANING

General work meaning refers to the attitudes of personnel toward their work (or aspects thereof) in the Emergency Department. Many of the attitudes expressed were in response to my questions. Three classes of workers are considered: interns, nurses (including nursing assistants), and orderlies.

#### Interns

Although the interns at Capital are on call twenty-four hours on all wards, there is some evidence that Emergency is the most difficult service to work. One intern expressed it like this:



If you're on the wards, at night the nurse can call you and you can tell her what to do over the phone because you've already seen the patient a few times. In Emergency, you have to get out of bed and come see the patient because chances are you haven't seen him before. You don't grab much sleep in the 24 hours.

As is to be expected, interns evaluate their one month stay in Emergency mostly from the standpoint of how adequate the learning experience is. Most are disappointed at the vast number of nonemergencies that provide for new experiences. Interns feel the interesting cases are far outweighed by the trivial. If the intern wishes to be a general practitioner, however, (as few seem to) the Emergency experience is seen as valuable because of the variety of cases treated.

Interns compare their internship at Capital with previous training received at their medical schools (and affiliated hospital). At the time of the study, some of them were from England. All interns, whether from North America or England, feel that interns have more responsibility in England and hence learn more. For example, at Capital the intern cannot admit patients to the hospital; this must be done by a resident. The lack of medical responsibility given

interns (in North America generally) is attributed to the greater risk of litigation in North America. Administration here are less likely to let interns "get in over their heads" because of the possibility of legal action against the hospital. Again, this is particularly crucial in Emergency. Although Administration officials and doctors at Capital agree there has been little litigation in their province they feel it will increase following the North American trend.

Interns feel that rules resulting from this threat of legal action, give them too little responsibility. For example, certain types of cases are supposed to be referred to residents rather than being treated by interns. Nurses typically act as guardians of hospital rules and are reluctant to assume responsibility when these rules are broken. This exemplifies one ever-present problem of hospital nurses. They are often caught between two lines of authority: administrative and medical. As elsewhere, this dilemma is felt by nurses at Capital. [See, for example, Corwin (1965) and Smith (1958)]

Concerning the learning experience in Emergency specifically, there are mixed feelings. Some interns feel that teaching is practically nonexistent. These



interns hold that most diagnoses of medical cases made in Emergency are wrong since they are made so quickly. Consequently following up patients after they leave Emergency is the only way to see if their diagnosis is correct. However, feedback from doctors on Capital's wards is defined as poor; the onus is on the intern to follow-up cases. He must make the effort to telephone the wards or ask interns there about cases of interest. On other wards a resident is present to teach the intern.

In contrast, other interns feel that working in Emergency Departments is a better learning experience than working on regular wards. This argument is exemplified by one intern's remarks:

In Emergency, you get the patient fresh off the street with no label attached. When you see a patient in the ward he's been worked up by others and labelled. I think most interns prefer to have patients fresh off the street.

These conflicting viewpoints converge somewhat in the belief that while interns do not get much responsibility in Capital, they get more in Emergency than on the wards.

During weekdays there is an added advantage to learn in Emergency, owing to the presence of a Casualty Officer who is an orthopedics specialist. One can often find him questioning the Emergency intern on aspects of orthopedics. Since Emergency gets many orthopedic cases, the interns see the Casualty Officer's presence as a benefit. Also, when he is on duty he treats some of the routine cases giving the intern a chance to focus on the more interesting cases.

### Nurses

The most prevalent attitude among nurses in Emergency is exemplified in a comment by one of the head nurses who had been there over ten years. When I asked if she still finds the work interesting she replied: "Yes, the cases are all new and exciting, every one different." In speaking of work in Emergency, nurses often compare it with nursing in the wards:

It's too routine in the wards.  
You know what you have to do  
every day: baths, temps, meals.  
Here it's exciting, you never  
know what's coming through the  
doors next.

Most nurses mention their dislike of bedside nursing. This dislike was manifested clearly during my research. Owing to staff shortage in the hospital



there is a rule that requires nurses from any area of the hospital to "float" or to move to other wards for a day should these wards be short staffed. On a few occasions Emergency nurses were asked to go to other wards to do bedside nursing. This is always vigourously resented; nurses on occasion have threatened to quit should this rule be enforced. Besides disliking the tasks of bedside nursing, mention was made of the steady routine of the wards. In contrast, nurses feel that in Emergency "when you're busy you're really busy, but when you're not you can relax".

In contrasting the two types of nursing, the nurses speak of always seeing new faces in Emergency. Because contacts are quick and superficial, there is no time to get involved with people and most nurses like it this way. In the wards the same patients are often seen for long periods of time. Whether these attitudes exist before coming to Emergency or are acquired while there is a question unanswered in the present work.

Nurses see working in Emergency as a good learning experience. They have much more responsibility here than on the wards. They do many tasks that are supposed to be performed by doctors only (taking blood,

starting intravenous flows, and doing electrocardiograms are examples). Often there is only one intern on, one who may be very inexperienced as well as busy. General hospital rules as to which tasks are to be performed by which workers are seen as unrealistic in a setting where fast action is often important. Nursing assistants find they too have much more responsibility in Emergency. Nurses see their experiences (gained from performing these tasks many times) and the staffing shortage as adequate justification for co-opting doctor's duties. Moreover, interns come to expect that nurses will do this. Hence, there is little of what Carol Taylor calls "boundary fighting".<sup>6</sup>

There is a great deal of paper work in Emergency. The importance of clear records can be traced, in part, to the possibility of legal action. Good nurses' notes and well-prepared forms are crucial for resolving any legal problems that should arise. Paperwork is accepted, and nurses feel there is no more of it in Emergency than on the wards. Much attention is being paid currently

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<sup>6</sup> Taylor refers to boundary fighting in a discussion of the relationships between different occupational groups in hospitals. Each group resents efforts by other groups to co-opt certain tasks. The conflict thus revolves around who is to do what task and is similar to the age old problem of jurisdiction.



by nursing educators to the increasing amount of administration that takes the nurse away from patient care.

There are also complaints made by nurses in Emergency. We have considered some of these already and others are discussed in following chapters. Emergency nurses seem willing to tolerate these disadvantages because they prefer this type of nursing to other possibilities.

### Orderlies

The five orderlies observed have all been in Emergency under two years. They mention the unavailability of other jobs as one reason for remaining there. While the job was seen as confusing at first because of a lack of preparation, the orderlies are now confident in their ability to serve as valuable assistants in times of necessity. They find this and other aspects of the work rewarding. The main disadvantage for this occupational group stems from their lack of authority. Whereas all other staff can give orders the orderlies must always take them -- often from conflicting sources. As is common in such situations, the orderlies have ways of "making out". Travelling jobs grant opportunities to

get away from what may be perceived as too much pressure. Compared with the other staff, orderlies are the most mobile group in the Department. When subjected to what they feel is undue pressure they "let it go in one ear and out the other". If nurses or doctors are giving conflicting orders they often remain in other parts of the hospital until they feel the confusion has subsided.

Nurses see the orderlies as valuable partners capable of undertaking much of the nurses' work should the need arise -- and it often does. In a setting like an Emergency Department, orderlies realize they may be called upon to perform tasks that strictly speaking are not their responsibility.

#### STAFF CONCEPTION OF PATIENTS

I shall close this chapter with a discussion of general staff attitudes towards the patients that frequent the Emergency Department. Since the remaining chapters are concerned with staff conception of specific types of patients, this more general discussion will introduce the remainder of the work. It must be remembered that conceptions of patients varies by types of patient as well as by how each individual presents him-



self for treatment. Aside from the nature of the ailment, factors such as appearance and behavior while in the setting are important in determining how staff respond to the patient.

The history of Capital has had an important influence on how staff view patients. Being a government hospital, it was until recently frequented largely by Welfare patients. Other private hospitals in the city catered to the more well-to-do segments of the population. With Medicare and the separation of Emergency and Outpatient Departments, all classes of people now use Emergency. Administration feel that the tradition of Capital as a Welfare hospital is reflected most clearly in the staff philosophy. They see the staff in Emergency as blase and often giving patients improper respect. In short, all patients are treated as indigents. As I hope the following pages show the issue is not as simple as Administration thinks.

Staff do see the Department as frequented by many illiterate people. But regular staff in Emergency know that while there are many illiterate patients the patient population is not comprised totally of what one doctor called these "idiots". Staff identify

patients in more than one way. The Supervisor of Student Nurses in Emergency stresses that her students observe patients closely and strive for more information than the patient gives. Also nurses often question further a patient who tells them he has never been in Emergency before. As one nurse put it: "You can't always go by their word. Some don't know whether they've been here before or not."

This skepticism about relying solely on the patient's word has its positive functions. Because they have learned from experience that many clients' words are unreliable, nurses find it helpful to remember that a patient has been there once. This memory is important where back records are required in order to adequately treat a patient. I have witnessed incidents of nurses disbelieving a patient when he said he had not been there before. The nurse then obtained the history of the patient from a shelf. In these situations record retrieval is done subtly. There is little danger that a patient who cannot remember whether he has been in Emergency before will perceive what Administration calls the "negative stereotypes". Paradoxically those negative stereotypes can function to give the patient more adequate treatment. Few people doubt the importance of a medical history as an aid to good treatment.



Transient doctors develop conceptions of patients also. These result partially from comparing patients at Capital with patients they have seen elsewhere. In this regard some interesting differences have been observed. One American doctor saw Emergency's patients (and those of the whole province) as "stoical". Consequently, they provide interesting learning experiences because more advanced cases also are treated. By contrast a few doctors from England classified the typical patient as "spineless" and panicky, bringing the most trivial ailments for treatment. Because this comparison is based on only a few incidents it is somewhat impressionistic. However, it suggests the importance of further study into how professionals develop client conceptions and the consequences of these conceptions. In the example given, explicit comparison of Emergency patients with those of the doctor's previous work place was done by both doctors. The conceptions differ greatly. In contrast, most Emergency nurses and orderlies develop their conception of clients from one work setting. The majority of the regular staff have worked in one Emergency Department. What evidence I have, suggests that the regular staff's

conceptions of clients are much more similar to each with each other (and hence more unitary) than those of the transient medical staff who have worked in various settings.



## CHAPTER IV

### TREATMENT OF ACCIDENT CASES

Victims of car accidents, industrial accidents, fires, acts of violence, or other disasters are referred to as accident cases.<sup>1</sup> They are one type of first priority emergency at Capital's Emergency Department. The treatment of less serious cases is delayed while most staff effort is immediately concentrated on the accident victim (or victims). Staff in Emergency regard these "real emergencies" as the true *raison d'etre* of the Department; most staff show a preference toward handling accidents and other real emergencies. Many workers feel it would be more satisfying to work there if more real emergencies occurred. Besides giving staff with a predilection toward emergency medical care a chance to demonstrate their experience based expertise, the accident case provides both interest and excitement. Administration and other

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<sup>1</sup> Car accidents and industrial accidents are the most common occurrences of this category at Capital. During my research I witnessed only a few victims of acts of violence and 2 fire victims.

employees at Capital feel that staff efficiency is most visible in their care of this type of case. We can expect that all hospital emergency departments will be characterized by a more intense staff effort in treating what the staff feel are real emergencies.

Below I shall discuss the career of the accident victim in Capital's Emergency Department and attempt to make certain generalizations that should be found elsewhere. The discussion of accidents and other patient types is organized around the four stages delineated in Chapter Two.

#### Stage I: INITIAL CONTACT

Staff in Emergency first become aware of the expected arrival of an accident case by a call from the main switchboard requesting that an ambulance be dispatched to the accident scene. This is commonly recognized as an "ambulance call" by the switchboard operator's strategy of alerting staff by two or three short rings of the telephone. From the time of the telephone call, then, staff begin anticipating a serious case. This is seen in such staff utterances as "Uh, oh, here we go!" as they pick up the phone.



After the operator's call the ambulance is dispatched by the nurses in Emergency. While in some types of cases, as we shall see later, nurses use their own discretion as to whether or not to dispatch an ambulance, the Emergency Ambulance is dispatched in all cases for accidents.<sup>2</sup> The time of the call and the person requesting the ambulance are noted, this being the first notation on the record kept for each accident case. In the Department precise directions are given to the ambulance driver; new employees particularly are advised on the importance of such calls.

There is presently a controversy at Capital as to whether it is necessary to send the intern in the Emergency Ambulance. There is little he can actually do in the ambulance because of lack of facilities. Moreover, at times when the Casualty Officer is away the Department is left without adequate doctor coverage while the intern goes on an ambulance trip that may last an hour or more. Coverage by residents

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<sup>2</sup> At Capital there are two types of ambulances: a routine ambulance (for less serious cases) where the drivers go alone, and the Emergency Ambulance for serious cases. The intern from Emergency accompanies the drivers in this ambulance.

and other staff doctors has in the past been unsystematic. Nurses feel that these other doctors will not cover Emergency adequately unless there are real emergencies to be treated. Needless to say, this often causes a delay in patient care and a piling up of cases. The Head Nurse in Emergency, however, feels that it is necessary to have an intern in the ambulance going to an accident scene. She expressed the view that:

There may be one time in a hundred when a life may be saved because of his presence. Also, people in accidents like to know there is a doctor present. It gives them a psychological lift.

The ambulance controversy illustrates how a hospital staffing difficulty in one department creates problems throughout the hospital.

Emergency staff are not idle while the ambulance is picking up the patient; they are preparing themselves for action. Nurses want to know in advance about serious cases. They do not want to be caught off guard. Inadequate preparation is costly to the patient also. There is little time to search for necessary equipment after his arrival.



The preparation is quite extensive. As one nurse put it "For accident cases you have to have an anticipatory mind and expect the worst". Space is allocated for the expected patient. This means that less serious cases are moved out of key treatment rooms, especially the Resus Room. There also are checks to see that these rooms are adequately equipped. After receiving information from the ambulance over the two-way radio as to nature of injuries, the appropriate residents are called in. Nurses often seek this information if the driver fails to volunteer it.<sup>2</sup> The minor cases that may be present in the Department are told about the expected accident case in an attempt to get them to come back later. Also other departments are notified of the accident: The Intensive Care Unit (because the seriously injured go there after their short stay in Emergency); the X-ray department (because many x-rays are required of accident cases); and the laboratories (so that blood is on hand in case of transfusion needs). For multiple casualties extra staff from other floors are called in, though this is

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<sup>2</sup> If the patient has been pronounced dead, the driver will use the code word "5". The term "red blanket" means a serious case. In addition to facilitating staff preparation, these code words serve the function of denying information to nonemployees who may be present in Emergency at the time.

more apt to happen at night when Emergency staffing is lowest. In addition to this external preparation staff prepare mentally for the event by anticipating their role in the treatment process.

A contingency that often arises in the ambulance trip is that the patient may be moved from the scene when the ambulance arrives. Relatives or others present may panic at the ambulance delay and bring the patient in by car. Emergency staff resent such initiative; to them it is interference by laymen in matters that only trained medical personnel are able to handle. In addition they see medical facilities as being misused by the public in these instances. While staff seek a justification for these inappropriate actions in the individual case, the long term solution would seem to be public education in such matters. This ambulance-without-a-patient contingency is likely to be especially resented at Capital because of the loss of the intern's services while he is on a "bum steer."

Assuming the above contingency does not occur, the patient arrives at the Emergency Department in the ambulance. Where he is dead on arrival (D.O.A.) the intern has already pronounced him such in the ambulance. The body is not brought into Emergency



because of a few past dramatic instances where patients and relatives panicked at the sight of it. The rule at Capital is that the body is transported directly to the morgue. This also saves the staff in Emergency the work of having to process the body. If there is doubt as to whether the patient is dead or if death has occurred just prior to the ambulance's arrival at the hospital, resuscitation measures are carried out (discussed in the next chapter). In case of D.O.A.s the only staff involvement is answering requests for information from relatives or curious witnesses of the accident. In all cases efforts are taken by staff to keep the event of a D.O.A. secret from those other than staff.

With the arrival of an accident victim (or victims) the shortage of space in Emergency becomes critical. Relatives usually arrive at the same time as the ambulance carrying the victim or shortly thereafter. To the public an accident involving a relative is a significant event. As many as ten relatives may crowd into the small area seeking information the whole time their relation is in Emergency. Police too are usually on hand to gather information about the event. Added to this, the siren often attracts curiosity seekers who may be in the nearby outpatient clinic. All these people crowd the Department and create a sense of confusion.

Besides getting in the way of staff, those present constantly interrupt the work of staff to ask for information about the victim. Staff shortages intensified by the immediate pressure of caring for the victim allow little time for answering these questions. In addition to requests for information by those present, the Department usually receives a number of phone calls for information. The policy here is to deny information to nonrelatives. There is a fear that premature news releases will unnecessarily startle relatives and friends of the victim who are still unaware of his plight. Despite the hurry of caring for patients, staff in Emergency do show some ability to role-take with relatives. This is further evidenced by the reassurances given these relatives when time allows. The Director of Nursing at Capital told me that after an accident people are upset and like to talk about the event. In line with this she expressed the need for extra staff to perform this function. Besides the actual care of the patient, then, the controlling of nonpatients is seen as a major problem by staff in accident cases.



Because the victim often cannot give necessary information, relatives and police are called upon to provide this. Relatives are also needed to sign admittance forms. Their presence in the Department is necessary but staff seem to prefer them to be "out of the way." Generally, however, the presence of relatives seems to be tolerated in serious cases. Two items of information of immediate concern to staff are the patient's age and religion. If under sixteen years of age the patient is quickly examined by a doctor to see if there are major injuries. Then the child is rerouted to a children's hospital elsewhere in the city. Determining religion allows the appropriate clergyman to be called if it is expected the patient is in danger of dying.

## Stage II: DIAGNOSIS AND TREATMENT

The time span between patient's entry and diagnosis and treatment is shorter for accidents than for any other type of patient. The following hospital rule is taken seriously by staff in Emergency:

Don't keep accidents waiting;  
it is poor public relations  
plus it is is potentially costly  
to the patient, the doctor, or  
the hospital.

Almost upon arrival accident cases are rushed into treatment. The work tempo throughout the patient's career is speedy. Much has to be done in a short period of time.

Upon entry the accident victim is rushed into the Resus Room. If there is more than one victim a quick decision is made by staff as to the most serious. Most staff effort subsequently is concentrated on the most serious case. Doctors and nurses feel they can identify immediately major injuries. One nurse mentioned the easy diagnosis of accident compared with medical cases: "At least you know whether it's a cut or a fracture with an accident case." Immediate definitions are necessary in accident cases because they determine whether or not the patient can be moved. Certain signs are important: a patient with his foot at right angles denotes a broken hip; a patient with tingling in the spine may have a fractured cervical spine. In the case of "cervical spines", the least movement can cause immediate death. These immediate definitions of the medical situation must, of course, be communicated to other personnel. One of the major points stressed to student nurses in their short stay in Emergency is the ability to make these quick definitions although senior personnel are more accomplished at this.



For serious cases residents are on hand and medical care is under their direction. For less serious cases or on nights when no senior doctor is present the experienced nurses help guide the work of the inexperienced intern. An outsider coming into Emergency could judge a serious case by the number of personnel working on it. Usually the majority of staff on hand are working on a serious accident case. Needless to say, teamwork and calmness by staff are major aids to efficient care of accident victims.

Orderlies have the initial job of cutting the victim's clothes off so that examination can be made. Nurses assist the doctors with these examinations. It is interesting to note that patients have been known to come back a few weeks later and complain of their clothes being damaged. Lacking here is the realization by these laymen that had clothes been taken off in the traditional way, the effort might have been disastrous.

Among the routine practices in most accident cases are stoppage of bleeding, application of temporary splints applied to fractures, setting up of intravenous solutions, taking of blood samples to determine blood type for transfusions (if needed) and taking of vital

signs such as pulse, respiration, and blood pressure. Extent and nature of injuries are determined in a preliminary fashion; suspected fractures are confirmed by x-rays. The extent of injuries in each case determines what else is done medically in the Department.

For serious cases it is imperative that necessary equipment be close at hand. One nurse mentioned how a certain item "costs only two cents but if you need it it's never there." Delays that result from looking elsewhere in the hospital for equipment could be costly. It is accident cases that dramatize the importance of a well-equipped emergency department.

Not only is it important to have equipment on hand but also it is important for staff to know the layout of the Department and hospital as a whole in order to work effectively. Orderlies, particularly, are asked to get equipment; they must do so hurriedly in accident cases. "Knowing where everything is" is viewed by them as a major part of their occupation. In this regard, the on the job training given orderlies is seen by them as inadequate should an accident case come in during their early days on the job. At this time they do not know the layout as do more experienced workers. A serious case at these times creates confusion.



This unfamiliarity with the layout is also viewed as a disadvantage by Emergency nurses should extra staff be called in:

It's no good bringing nurses in from other floors in accident cases. You have to tell them where everything is and they might as well go back up. What's more, they're used to bedside nursing and it's different here.

There also is a feeling by workers in Emergency that the present spacial setup and staffing are inadequate should mass casualties occur. Some nurses feel extra Emergency staff should be on call as in other departments at Capital. This would obviate the present practice of bringing untrained staff from other floors. Rosengren and Lefton (1969) speak of the emergency department as a barometer of the changing medical scene -- one which dramatizes outdated procedures and inadequacies. From the above we can see that equipment shortages, staffing, spacial layout, and job training are inadequacies dramatized at Capital's Emergency. We can qualify Rosengren and Lefton's proposition by saying that certain types of cases are more apt to point up deficiencies than other types. Accidents are one such type of case.

Some writers have observed that certain types of patients are accorded differential treatment in emergency units. For example, Sudnow (1967) discusses differential handling of D.O.A. cases on the basis of social definition. Some serious cases he notes are given inferior care because of certain stigmatizing traits or behaviors, such as drunkenness, old age or attempted suicide. Sudnow's discussion is relevant to the handling of accident cases. In the present research no such differential treatment was found. All serious cases were, as far as I could determine, given the same quality care. Staff might express annoyance, for instance, at a patient whose drunkenness caused an accident. But when questioned about it they frequently echoed the words of one nurse "It doesn't really matter what you personally think, you've got a job to do."

These seemingly contradictory findings may simply reflect social and cultural differences in the communities in which the hospitals are located. Sudnow studied hospitals in American cities. American doctors at Capital told me there is more idealism among medical staff in that hospital than they experienced in hospitals in their home country. Also patient volume is not as heavy in emergency departments here as in American cities. Thus, there is more time to spend on every patient.



There is yet another reason for uniform handling of accident cases irrespective of social attributes. There is increasing recognition that the number of nonemergencies seeking treatment in emergency departments is increasing relative to the number of serious emergencies. (See Shortliffe, 1962; Rosengren and Lefton, 1969). These nonemergencies receive the brunt of staff dissatisfaction. Moreover, because of Medicare in Canada many general practitioners are overloaded. Therefore, people must take their ills to emergency departments. If this trend continues, nonemergencies will soon outnumber serious cases. The increasingly smaller proportion of serious cases is a compensation for the more boring work of caring for routine nonemergencies. Consequently, staff in emergency departments should be eager to perform well in those cases that constitute what they believe is their real work. In sum, I wish to hypothesize that differential care of serious cases based on social definition by staff plays a less prominent role in emergency departments as the proportion of nonemergencies seeking treatment increases. Rather, uniformity of treatment for serious cases prevails.

## Stage III: RELEASE

Glaser and Strauss (1968:38) call the emergency department a way station. For the accident victim only a short period of his hospital career is spent in Emergency before he is sent to other wards. The work done there is more in the nature of "patching up" the patient rather than any major lengthy procedures.

A hospital rule at Capital cautions against embarking upon lengthy procedures in Emergency. It is not known when other serious cases may arrive. More important, facilities do not exist in Emergency for major medical procedures to be undertaken. There is, thus, an effort by staff to rush the accident victim to other wards where these major procedures can be more efficiently carried out. When talking about accident cases, staff in Emergency make efficiency synonymous with moving the victim through the Department quickly. The above discussion on diagnosis and treatment indicates, however, that more than just patch-up work is done in Emergency. The blood tests, determination of injuries, and vital signs are important aspects of treatment. While no major procedures are carried out in Emergency, the tests and preliminary diagnosis that are done there are crucial to the future hospital career of the patient.



After patch-up work and preliminary diagnostic tests are done in Emergency, the accident case is ready for movement to other parts of the hospital. Fire victims are usually sent directly to the Intensive Care Unit ("ICU") whereas accident victims go first to the X-ray Department and then to either the Operating Room or the Intensive Care Unit. In cases of less serious injuries, the patient may be brought back to Emergency after going to X-ray. Here the x-rays are read and minor fractures set in a nearby plaster room. The treating doctor in Emergency determines the number and kind of x-rays necessary.

It is during the release stage of the patient career that Emergency comes into its most intense contact with other departments in the Hospital. X-ray and Intensive Care can be considered two of the key departments that Emergency is in contact with. A consideration of the interdepartmental relationships shows us much about situations where more than one department must cooperate in the care of patients.

At Capital the location of X-ray is problematic for Emergency staff. Emergency is located on the ground floor and X-ray is located two floors above. For serious accident cases, a nurse must leave Emergency and stay

with the patient until he is ready to be moved to the ICU or O.R. This takes a nurse out of Emergency for as much as two or three hours. Moreover, orderlies complain about the number of trips they must make to and from X-ray. Staff feel the time it takes for the trip could be dangerous to the patient. They recall situations where patients died in the elevator on the way to or from X-ray. Some see the solution to be an X-ray department located in Emergency. An administrative official dislikes the idea of having an X-ray department in Emergency, however. He points out that an Emergency X-ray would be unable to handle mass casualties; also equipment is becoming so specialized that it would be necessary to build nearly a whole new X-ray department -- something out of reach financially. Advancing technology and economics seem to dictate that the present system will remain despite staff dissatisfaction. This situation again illustrates how an emergency department can dramatize hospital inadequacies.

There is often a clash of perspectives between staff of the X-ray Department and the staff in Emergency. Because accidents can do more damage than may be readily apparent, doctors order many x-rays on accident victims.



Doctors x-ray excessively partly because of the greater risk of litigation in North America. Some feel that fear of court action in North America generally is clearly shown in the need for x-rays. Scheff (1966:110) mentions cautiousness as characterizing physician diagnosis in general. He mentions how doctors' training stresses the rule: "When in doubt, diagnose". This, he calls the medical decision rule. Overdiagnosis or overexamination also is likely to occur because physicians' norms caution against prematurely releasing patients who may be ill.

X-ray workers, however, see this caution as added work demands. X-rays on accident victims are difficult and time consuming. Because the victim may be in pain, there is considerable moving around on the x-ray table. The patient cannot be sedated for pain because sedating accident victims could mean death. Hence, many x-rays must be retaken. Workers in X-ray resent doing numerous x-rays particularly when reading them reveals no fractures or dislocations. From the standpoint of X-ray staff, "unnecessary" x-rays are requested by incompetent doctors. As one person in X-ray told me:

It's quite easy to dislike a new intern or resident before you even meet him. Dr. \_\_\_\_\_ sent a patient up (to X-ray) tonight

and the whole requisition sheet was filled. What's more, there was nothing definite. The place was boiling. A stupid intern can make our job difficult.

Nurses in Emergency, however, are more apt to sympathize with the doctors. This comes from working closely with them and seeing the demands they face. They often support doctors' actions. After the above incident one nurse told the X-ray technician involved:

Yes, but you have to see the intern's point of view. Someone is on their back if they don't do the x-rays. Every once in a while they find something the intern forgot to x-ray and then he's in trouble. The patient can come back and complain, too, and then the hospital's in trouble.

This clash of perspectives can be viewed in terms of role-taking. It has been stated by sociologists that adequate role-taking presupposes social knowledge of others. As part of this social knowledge, adequate role-taking in work situations requires knowledge of work demands faced by others. The difficulty in X-ray staff taking the role of interns seems to be that the two do not work in close proximity; hence knowledge of work pressures faced by others is absent. Nurses working in close proximity with the doctors facilitates better role-taking.



The other side of the coin in this frequent clash of perspectives is that staff in Emergency often complain that X-ray does its work slowly. This complaining is apt to occur in those minor cases where the patient returns to the Department. X-ray staff reply to this criticism with: "They (Emergency staff) don't know how long it takes and how many shots (x-rays) it takes." Here Emergency staff have inadequate knowledge of the work conditions of X-ray staff. Role-taking again is hindered.

The priority of accident cases at Capital is shown by the ease with which beds can be obtained for accident cases. Where other types of patients may have to wait in Emergency for longer periods, serious accident cases have a much better chance of getting beds on short notice. Rearrangement of other patients may be necessary, but questioning is rare as to whether or not it is necessary to admit accident cases. Nurses in Emergency realize this and expect accident cases to have a shorter Emergency stay than other patient types. As noted before part of this desire to "move accidents through fast" may result from the realization that more adequate facilities for major treatment exist elsewhere in the hospital.

Somewhat similar role-taking problems frequently occur between the Emergency Department and the Intensive Care Unit -- the place where most serious cases are taken that do not have to be x-rayed. The zealously of Emergency nurses to get patients quickly up to ICU results occasionally in conflict between staff of these two departments. On nights in Emergency staffing is shortest. Demands of patient care may prevent notification of ICU nurses by those in Emergency that a patient is "on the way up." Just as those in Emergency like to have advance notice of serious cases so as to prepare, so do the staff in ICU. If a patient arrives unexpectedly from Emergency, the head nurse in ICU is likely to blame the head nurse in Emergency; complaints may even be made to Administration. Even with notification, ICU nurses may feel that the patient is sent up too fast and there is no time to prepare the Unit. The following passage illustrates subsequent justifications by Emergency nurses in these instances.

What did she (nurse in ICU) expect me to do, leave the patient and phone her? I told Nursing Office that she (the fire victim) was on the way up.



As in the case of relationships with X-ray and ICU, role-taking between other departments is often poor. In focusing on problems of their own department, staff may be unaware of work problems faced by those in other departments. Administration at Capital speak of the tradition of poor interdepartmental communication. One solution to the interdepartmental role-taking problems may be for departments who often care for the same patients to exchange personnel for short periods of time. That is, X-ray staff could spend a few weeks working in Emergency and vice-versa. Presumably the knowledge gained would allow staff to be more understanding of problems of other departments in future incidents. Rather than wondering why procedures "are taking so long" they would have this insight gained through their time spent in the other department.

Any tensions between staff of different departments or different health agencies who must co-operate to provide comprehensive care to the same patients are potentially dangerous, both to staff morale and the patient. The problem of interdepartmental co-operation is, however, many faceted. For in developing the we-they attitude, staff in one department develop identification with their work setting and those in it

vis-a-vis outsiders. This group solidarity would seem to contribute to intradepartmental morale. Much research is needed in interdepartmental relations in hospitals.

#### Stage IV: POST MORTEM

Because the care of accident victims requires an intensive work effort in a short period of time, there is typically little time to discuss the case informally until after the patient leaves the department. The work of staff is not finished even then for careful records must be kept of accidents. Information must also be prepared for the police and the press.

Staff are interested in details of the accident itself -- that is, the circumstances surrounding it. This often takes the form of layman's curiosity. Police will usually supply these details to staff. The accident will then be compared with other accidents in the past. In such discussions nurses and orderlies often will recall the most serious accidents they have witnessed. If there have been deaths in the accident, ascertaining the age of the victim is likely to be the main interest. Death of younger people, those with



high social value, may be regretted. The future prospects of living accident cases are also discussed. Further post-mortem accident talk by staff will revolve around their handling of the particular case. Nurses and orderlies may discuss the performance of certain doctors and also give justification for actions they themselves have taken during the case. It is a time conducive to high staff morale; they have worked hard at what they believe is their real purpose in Emergency. Now they collectively discuss the events.

As Glaser and Strauss (1968) point out, the short nature of staff-patient contact in emergency departments is not conducive to high staff involvement. Interest must soon be switched to other patients.

#### SUMMARY

The unquestioned dispatch of the ambulance, the elaborate preparations for fast work, and the number of personnel working around accident victims are evidence that accidents are one type of first priority in emergency departments. Staff regard this work as their real work -- as the reason for the Emergency

Department's existence. Staff complaints thus concern not the client but the relationships with other departments involved in handling the case. Accident cases dramatize inadequacies of the Emergency Department and its running. Interdepartmental grievances also are more likely to develop under the pressure of caring for these serious cases.



## CHAPTER V

### TREATMENT OF MEDICAL PATIENTS

"Medical Patient" is the name given by staff in Emergency to a large group of patients characterized by ailments affecting internal body organs. Patients with chest pains, asthma, diabetes, epilepsy, ulcers, gastrointestinal bleeding and various abdominal ailments are referred to by this label. Work problems encountered by staff dealing with medical patients and general aspects of treatment of this patient type are discussed below.

#### Stage I: INITIAL CONTACT

The arrival of members of this patient type at an emergency department must be viewed within the context of medical care in the community. Many of these ailments are not of recent onset; they have been bothering the patient for some time. Factors leading the patient to seek treatment are varied.<sup>1</sup> Generally,

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<sup>1</sup> Mechanic (1968:130-131) discusses ten factors that may influence a patient's decision to seek treatment. Social factors in addition to immediate symptoms are among the factors discussed.

however, the ailments of this group are those a community general practitioner ordinarily treats. The decision to bring these ailments to an emergency department reflects in part the difficulty of obtaining a general practitioner since the introduction of Medicare. Staff at Capital mention how "G.P.'s" can now make more money in their offices and will not make house calls, particularly those involving travel out of the city. They also partially blame the patients for bringing to the Department ailments that are really the responsibility of G.P.'s. In one nurses words:

Many of the patients who said they tried to get a G.P. before coming here have only tried one doctor. After he refuses to make a house call they panic and come here.

Whatever the reason for the patient's arrival, there is a general staff feeling that many medical patients represent a misuse of service. Emergency departments are set up to treat emergencies -- serious cases of recent onset -- not ailments that have been bothering the patient for some time. This belief in misuse of services engenders resentment of medical patients. Other factors further intensify this resentment.



Staff learn of the arrival of a medical patient by his unannounced presence in the Department or by a call for an ambulance. Unlike accident cases, the ambulance request is sometimes turned down for these cases if the request comes from nonmedical personnel. The head shift nurse in Emergency often, after a discussion with the treating doctor, uses her discretion as to whether or not the case seems to warrant sending an ambulance. Certain factors are considered; for example, if the patient is up and walking the ambulance request is often refused. In the case of refusals the nurses advise the patient to try to seek other means of transportation to the hospital; frequently she gives the patient names of G.P.'s that make house calls. From the telephone call indications of the seriousness of the expected case are obtained. Further clues as to what to expect come when outside general practitioners request the ambulance. From past encounters nurses have built up a stock of knowledge about these "outside doctors". They know that Dr. so-and-so often "Palms off all the rubbish on us" where if Dr. \_\_\_\_\_ is sending a patient in there is a good chance the patient warrants admission to the hospital.<sup>2</sup>

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<sup>2</sup> As one administrative official told me, there are two ways doctors can get patients in the hospital; by



Outside doctors are classified by Emergency staff on the basis of whether they send real emergencies or "rubbish". This knowledge is activated in recurring situations and affects staff expectations as to how serious a case is. The problem of outside doctors cluttering up Emergency with rubbish is seen as a real one at Capital. During the research there was an attempt by Administration to label the doctors who regularly send in nonemergencies. Reporting the offenders to the local medical society is seen as one way to cut down the number of nonemergencies coming to the Department.

Workers in Emergency are often asked by staff of other Capital City hospitals to send an ambulance to these other hospitals to pick up patients. These situations manifest the identification with Capital vis-a-vis the other hospitals. The typical feeling is that the other hospitals "palm everything off" on Capital. This desire to palm off patients is more

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having privileges at the hospital or by sending the patients through Emergency. In the case of elective admission only doctors with privileges can admit whereas any doctor who believes his patient should be admitted can refer them to the Emergency Department. After the referral the doctors in Emergency make the decision whether or not to admit the patient. Sending patients to Emergency then, is often a strategy used by doctors to get patients admitted quickly. Needless to say, the perspectives of doctors and Emergency staff are at odds. There is little actual contact between G.P.'s and Emergency staff and neither group realizes the work demands of the other.



likely to be imputed if the expected patient is old. In the case of relatives bringing an aged relative to Emergency there is a feeling that the relatives are trying to get rid of the old person. If the old patient is dirty, ill cared for or senile and illness is not of recent onset this motive will almost certainly be imputed by staff to relatives.

Because of the frequent occurrence of such events, many staff at Capital (including those in Emergency) believe that staff at other hospitals, outside doctors and the public have an image of Capital as a place where "anything goes." Hence, workers there feel Capital's services are misused. The nature of cases sent to a hospital emergency department will have an influence on how staff view their hospital and themselves in the "looking glass."

As with accident cases, staff like to have advance notice of the more serious medical cases. The preparation is somewhat the same as for accident cases, although it frequently is aided by charts with past histories of the patients. There is a good chance with ailments of long duration that the patient has been at Capital before. Reading the old chart informs staff what to expect. Acquiring the charts is a problem at

Capital. Many of them are located a floor above Emergency; this means that time and effort is spent getting them. Both Emergency staff and Administration feel this is a top priority issue. The feeling is that the charts should be closer so that they can be retrieved on short notice. Again we have an example of how an inadequate spacial layout can impose recurrent problems on hospital staff.

In the case of ambulance calls, staff usually have some knowledge of what to expect before the patient arrives. The nature of the referral, the symptoms given over the telephone, and the chart provide this knowledge. This preliminary diagnosis continues with the patient's arrival. Where the patient's arrival is unexpected, the preliminary diagnosis begins when the medical patient comes through the door. At this point, it is established whether the patient's condition is serious or nonserious. Here experience of Emergency nurses comes to the fore. The nurses rely on certain cues in establishing this preliminary diagnosis. The patient's first words tell much and so does his face. Nurses emphasize the importance of establishing a preliminary diagnosis of serious/nonserious by looking at the patient's face. In the words of one nurse: "It /The



face/ is the only part that's uncovered in winter." This preliminary diagnosis, of course, determines how fast the patient goes into the stage of more specific diagnosis and treatment.

## Stage II: DIAGNOSIS AND TREATMENT

When the preliminary diagnosis dictates the patient's ailment is of an emergency nature the work tempo is similar to that of serious accident cases. The prototype of medical patient emergencies is the cardiac arrest. The medical activities associated with an arrest are discussed at the end of this section. A real emergency is seen by staff as being fairly clear cut in terms of diagnosis. Most medical patients, however, are hard to diagnose. Diagnosis difficulties are the main reason for staff dissatisfaction in treating medical patients.

Nurses in Emergency must recognize the medical patient in general as one for whom certain routine things must be done. Before the doctor sees a medical patient his "vital signs" are taken by the nurses. This is a further part of the diagnosis process. Should these vital signs (temperature, respiration, pulse, blood pressure, and for chest pains an electrocardiogram)

indicate the patient is seriously ill then the work tempo increases. Taking vital signs is a time consuming process -- each test involves considerable work. In the end the process gives only a general medical definition of serious or nonserious. Further specific diagnosis must be carried out by the doctor. One nurse's comments sum up rather the well the reaction of permanent staff in Emergency to the medical patient:

Those bloody old medical patients.  
I hate them. You never know what's  
wrong with them and have to go  
through all the rigamarole. What's  
more Medicine and Surgery can't  
make up their mind who should treat  
them...One trying to palm it (the  
case) off on the other.

Medical cases are seen as the hardest to diagnose. They are often compared with accidents (which are more easily diagnosed). For nurses, medical patients are time consuming. Doctors too admit these cases usually present diagnosis difficulties. One doctor said the hardest part of internal medicine is making a diagnosis while an intern in Emergency went so far as to say: "Nine out of ten of the diagnoses made in Emergency are wrong. They're made so quickly."

While these more transient doctors feel the diagnosis of medical patients is made quickly the permanent staff certainly do not. Often it is hard to



tell immediately what is wrong with medical patients and a few hours of "wait and see" tells more. This few hours or wait and see, however, violates the permanent staff's conception of how long a patient should stay in Emergency. Staff like patients to move through as quickly as possible. In the preceding chapter I discussed reasons for this. It should also be noted that medical patient diagnosis is likely to be prolonged on day shift. More tests are ordered because the laboratory staff is in full operation.

Added to diagnostic difficulties stemming from the nature of the case itself, other problems often complicate matters. A large number of patients are seen by staff as inarticulate; this makes history taking difficult. On the other hand, patients who are especially articulate are seen by doctors as a nuisance; they ask too many questions. These observations are harmonious with Freidson's belief (1970) that doctors prefer not to treat intelligent patients. The ideal patient seems to be one that gives a good account of his symptoms without asking a lot of questions. At Capital, many interns are from nonEnglish speaking countries and this further hinders patient-doctor communication. Still, medical patients have ailments

which require (more than other types of cases) a good history. And in the absence of immediately clear cut objective signs the patient's account is important. Hence good communication is especially important. Obviously communication difficulties such as these slow the diagnostic process.

If the objective tests indicate nothing definite there is a likelihood that the patient will be labelled a "crock". Becker, et. al. (1961) documents medical staff displeasure at crocks. They are time consuming; staff prefer to treat patients who are really sick rather than those who are faking. Certain cues used by staff make the definition of crock more likely. One cue is the absence of objective findings from the tests (vital signs, etc.); another is exaggerated symptoms. Patients may present symptoms that staff believe impossible to have. For example, nurses refused to believe one patient who said he had been vomiting for three days. Doctors tend to watch a patient's face while doing a physical examination. If the facial grimaces fail to match the verbal complaints the definition of crock is likely to be made. In the words of one doctor: "A sick patient doesn't tell you it hurts and then laugh."



Nurses in Emergency compare patients with previous patients they remember. If a patient is doing more or less complaining than others who had similar ailments, suspicions are likely to arise. Again, a nurse's comments illustrate this point:

I don't believe there's anything wrong with that fellow who is doing all the hollering. Remember that lady we had in here before. She had the same thing and she was moving around on the stretcher a lot more than he is. He's too still.

At Capital's Emergency the motive usually imputed to crocks is that they want attention -- more specifically they want to get in the hospital. Nurses at Emergency usually refer to crocks as "psychiatric patients." One intern sees this as unfortunate and mentioned how the label is kind of "rubbish bin." The new Casualty Officer at Emergency has an intense dislike for this labelling. In essence, he is challenging the extant diagnostic stereotypes used by staff who have worked there longer. He feels the label of psychiatric functions to stop the search for a truly organic ailment. His worry partly seems to be that the stereotypes used by more permanent staff will be adopted by the less experienced interns and lead to under diagnosis.

This objection can be viewed as another application of the medical decision rule used by doctors. Doctors, because of their occupational code and training, are more apt to search for organic ailments even when other medical staff use labels of psychiatric. The latent function of the label is that if successfully applied the patient is referred to a psychiatrist and his time in Emergency reduced. Thus its successful application performs a positive function for staff and a potentially negative one for the patient.

Another issue highlighted by the crock phenomenon is the quality of medical care. Roth (1969) has pointed out the difficulty laymen (including sociologists) face in judging whether or not medical care is efficient. The problem in many cases is that medical diagnosis and treatment are too subtle to allow outsiders to judge quality. Relying on verbal statements of medical staff, however, ensures that these judgements by outsiders as to quality of care are well based. The following words by a doctor at Capital illustrate an instance where sociologists would be justified in speaking of good or bad treatment:

If a patient bugs you, there is a tendency to stay away from him. As a result, you don't go over him as thoroughly, you don't take as good a history nor do you watch him as closely.



Perhaps those laymen interested in quality of medical care would do well to confine their interest to worker's verbalizations. This will tell us the medical staffs' side of the story and makes the phenomenon more understandable from their point of view. In the present work I have tried to eschew judging quality of care where staff verbalizations did not support the judgement. Staff prefer not to treat certain types of cases (most medical patients, for example) but whether or not they treat them less effectively is open. Much of the staff dislike of patient types may go no further than complaining.

#### CARDIAC ARRESTS

There is one type of medical patient that staff consider a true emergency: the patient who has a cardiac arrest. When an arrest happens an acute medical emergency exists. Usually in contrast to other medical patients, an arrest is of recent onset. More personnel are involved in trying to "bring a patient back" than in caring for serious accident cases. A fast and intensive work tempo characterizes the procedure. The significance of arrests is seen in student nurses' evaluation of their short Emergency stay by how many they have witnessed.

As Glaser and Strauss (1968:40) point out, few patients die (or arrest) in emergency departments. There is a desire by staff there to move the patient to another ward before he arrests.<sup>3</sup> Part of this desire results from overcrowding in the rather small Resuscitation Room. They feel the ICU is better equipped to handle this. Also, there is a lot of cleaning up to do after an arrest as well as processing the body.

After an arrest, staff spend time discussing it. The discussion revolves around whether or not they have fulfilled their responsibility. Age is discussed; there is typically regret when younger persons arrest. Because of the short stay there has been little time to get involved. An arrest that results in death noticeably affects the mood, however. Arrests also are judged as interesting or noninteresting. Interest is high when there is a chance to revive the patient. One nurse spoke of an arrest: "It wasn't a good one. He was dead when he came in."

Generally staff are ambivalent about arrests. They put an intensive work effort into such a case, regard it as exciting and often interesting, but prefer it not to happen in Emergency. They prefer this excitement,

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<sup>3</sup> Staff in other wards at Capital are aware of how Emergency staff dislike a patient to arrest in Emergency.



however, over demands from other types of medical patients. Diagnosis and treatment is more clear-cut here.

### Stage III: RELEASE

Because the diagnosis of medical patients is a long process, actual treatment rarely begins in Emergency. Moreover, many of the ailments require long term treatment. Thus, medical patients present further difficulty as to release from Emergency. Many are borderline cases -- whether or not they should be admitted to the hospital is uncertain. The problem of inpatient bed space at Capital appears in these situations. There is difficulty in obtaining beds for many nonacute medical patients. Staff from one health agency in Capital City mentioned how it is practically impossible to get old people admitted. Since there is bed shortage at Capital, only the more experienced doctors (including residents) can admit. Each resident is allotted so many beds and the decision on his part whether or not to admit must be based on many factors. Whatever his decision it has work consequences for the staff of Emergency.

Even when a patient is to be admitted, the procedure takes time. A bed must be found and this requires a joint effort by Administration, Admitting Office, and the ward concerned. To Emergency staff it means the patient lingers in Emergency. Once word comes of the patient's admittance they feel their work is finished. Complaints are often heard concerning how slow Admitting is. Personnel in Admitting are rated by their speed in getting patients from Emergency to the wards. The different time perspectives of staff from different departments is similar to that between X-ray and Emergency discussed in the previous chapter. Wards like Emergency with a time conception of quick repair, quick release impose this time conception on other departments. Difficulties of role-taking again result. In the rush to get patients out as quickly as possible, Emergency staff refuse to do certain tasks. This is shown by the following examples: "If that has to be done, why not admit him" and "They can do that in the ward after he's admitted."

An interesting exception to this general rule occurs on night shift at Capital. The Admitting Clerk often visits Emergency for a casual chat with the night nurse. Here work problems faced by the individuals



are discussed and more social knowledge of the other's work demands results. The consequence is that there is good rapport between the two departments on this shift. Rarely does the night nurse complain about the slowness of Admitting. Informal interaction between departments results in better role-taking.

Many medical patients are not admitted or discharged but kept in Emergency's Observation Room for a period of observation. The few hours of wait and see that occurs in these borderline cases places further work demands on staff. They must observe the patient often, take vital signs occasionally<sup>4</sup>, and answer patient requests. Routine requests for meals, bedpans and the like are viewed as an unnecessary part of Emergency nursing. Nursing of patients kept for long periods of time approaches routine bedside nursing. The dislike by most permanent Emergency nurses for this type of nursing was mentioned earlier. Also, nurses feel patients kept for long periods of time get poorer nursing care. They admit that when something more serious occurs it is easy to forget to observe the

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<sup>4</sup> There is often conflict between doctors and nurses over how often vital signs should be taken. To do vital signs every half hour, for example, puts heavy demands on nurses, particularly if they are short staffed. Nurses, thus, push for vital sign readings spaced further apart.

patients kept over. There is a dilemma between caring for these long stay patients and the more immediate emergencies. A number of such patients kept over on the same shift led one orderly to express his dissatisfaction thus: "This place is getting to be a fucking boarding house. I'm going to put a sign up outside 'Rooms to let.' "

The establishment of a small ward distinct from Emergency and staffed by full time personnel may be a viable alternative to the present handling of borderline medical cases. Understaffing, lack of facilities and pressures of immediate Emergency cases lead to staff dissatisfaction with the present long stay patient policy.

#### Stage IV: POST LORTEL

Because of the problems associated with most medical patients, nursing and orderly staff are glad to be relieved of these patients. Their involvement ends. Interns however find these types of cases interesting and make efforts to follow them up to find out whether or not their diagnosis was correct. While medical patients are interesting cases for doctors (because they allow a chance to practice diagnostic



skills), nurses and orderlies regard most of them as time-consuming, unexciting work.

### SUMMARY

Medical patients are viewed by permanent staff with mixed emotions. The more serious ones provide opportunities for true Emergency care. Like accidents, these are given first priority. The majority, however, involve much time consuming work. Staff see many of these patients as coming to treatment for other than medical reasons. Diagnostic difficulties of medical patients violate permanent staff's conception of Emergency as a quick repair, quick release treatment center. This time conception is often at variance with that of other departments. The hospital bed shortage problem also is illustrated in the treatment of medical patients. Because of this shortage, patients must often remain in Emergency for longer periods of time than staff feel is desirable. With these types of patients nursing care comes closest to bedside nursing -- something which most nursing staff there are predisposed against. Interns and other doctors in contrast regard medical patients as interesting; a chance to learn. The treatment of medical patients also illustrates the inadequacy of existing community facilities.

## CHAPTER VI

### TREATMENT OF DRUNKS

"Drunks" present a variety of complaints for treatment at Emergency. Lacerations or suspected head injuries resulting from fights or falls are the most common reasons drunks come or are brought to Emergency. "Regulars" are another common category of drunks. They present a variety of complaints such as headaches or stomach upsets; some only wish a place to sleep it off. Still others in the drunk category seek relief from hangovers or other ailments caused by drinking. The main sign for staff in Emergency that a patient is a drunk is that he shows up for treatment in a state of intoxication believed to result from alcohol consumption. Other patients, such as the above mentioned regulars, may not be intoxicated at time of treatment but staff know from experience that drinking is correlated with their visit.

In the scant literature on emergency departments, drunks receive some discussion. The statements about them are consistent. The drunk receives lower quality



care relative to other more "deserving" patient types. Staff, we are told, put less effort into helping this class of patient even when he is on the verge of death (Glaser and Strauss, 1965:83-84; Sudnow, 1967:104-105). Because the drunk has caused his own condition, staff regard him with disgust. Perhaps the most trenchant statement about drunks in emergency departments is that of Roth (1969:231):

On the other hand, certain categories receive the brunt of staff hostility and these tend to come from the impoverished and disreputable segments of our society. There is an almost universal hatred of drunks. If they have to be transported, they will be treated like baggage. Their stories are not believed and they are frequently insulted or treated with a deriding jocularly. They are kept for a long time without examination and then given only cursory attention even when they have sustained an obvious injury. Serious disorders producing neurological malfunctions (epilepsy, diabetic coma) are sometimes missed because of the assumption that a dirty, ragged man smelling of alcohol is "just a drunk."

The present research lends support to some of the previous work on drunks. Drunks are often one of the least preferred patient types although as we shall see below this is not always the case. Their treatment often is not immediate, but there are reasons other

than moral for this. Moreover, the treatment of all drunks is not delayed. The category of drunk must be broken down into finer subcategories. Previous writers (Glaser and Strauss, 1965; Sudnow, 1967; and Roth, 1969) have tended to treat drunks as a uniform category. This has tended to make the discussion about emergency department drunks too simplistic. Also, viewing the matter from the staff's perspective takes us further in showing why drunks are often disliked. Low social value of drunks and resulting negative staff conceptions may tell part of the story. Previous writers, however, have advanced low social value as a total explanation of why drunks may receive low priority in Emergency. There are other factors, independent of a patient's social value, that help account for what may appear to laymen as staff non-chalance in treating drunks. In the present discussion I shall show how the treatment of drunks creates special problems for workers in Emergency. Doing so will lend support to an earlier assertion that judging quality of medical care is a complicated matter.



## Stage I: INITIAL CONTACT

Unlike most other patient types, there is a temporal aspect to the arrival of drunks. Although the late evening shifts and night shifts of payday weekends are the time when expectations are highest, evenings and nights of any weekend are key times for the arrival of this type of patient. Expectations are at their highest on Friday night of payday weekend, "after the bars close." These expectations are, of course, based on past working experience of staff. At these peak periods staff show their anticipations in their conversations with each other. Surprise is likely if no drunks show up.

It might be hypothesized that a patient appearing for treatment at these times smelling of liquor has a better chance of being identified as a drunk than at other times. The head nurse in Emergency sees this as a problem with possible repercussions. There is a chance of false labelling: "respectable people" might be labelled as drunks. They might resent staff attitudes and complain of this to the press or the hospital administration. To prevent repercussions that could arise as the result of false labelling, Emergency nurses do not write "drunk" in the record book even though they

use the term in their conversation. Rather, they usually note that a patient is "smelling strongly of alcohol." Formally noting such a characteristic serves to protect staff. This practice is discussed in connection with Stage IV.

There are four ways drunks arrive in the Department for treatment: driven by ambulance; accompanied by police; or escorted by relatives and friends. Others come alone. If the ambulance is requested by the drunk or by others who are intoxicated, nurses' discretion determines whether or not the ambulance is sent. In the case of regulars who have "cried wolf" before, chances are the ambulance will be refused. There is a general feeling by staff that if people can afford liquor, they can afford a taxi to get to Emergency. Moreover, experience has shown staff that drunks are more apt to misuse the ambulance service; their drunkenness leads them to exaggerate the seriousness of minor injuries.

When others, such as police, request an ambulance and say it is for a drunk, the ambulance is sent grudgingly. Faith is put in the police's ability to determine whether or not an ambulance is necessary. Drunks found lying beside the road with undetermined



injuries are the ones for whom police most frequently request an ambulance. Because the seriousness is undetermined, caution dictates that the intern go in the Emergency Ambulance. This call takes the doctor away from other patients in the Department who may be sick through no fault of their own. Remarks by interns on these occasions speak for themselves:

It's awfully easy to be callous in this job. There's that woman who's sick back in the Department. She has to wait for half an hour while we go pick this drunk up.

and

It's bad enough treating this stuff in the Department without going out and bringing it in.

Police are more likely to bring in victims of brawls who have been arrested for assault or creating a disturbance. The presence of a patient with a police "escort" is an early cue used by staff in labelling someone a drunk. In these instances, police relate to Emergency staff the circumstances surrounding the case. Staff see this information as valuable, for knowing how an incident of this sort occurred gives valuable clues as to diagnosis.

Other drunks come for treatment on their own or with friends or relatives. Those heavily intoxicated probably cannot make it on their own and so are usually accompanied. Often these relatives or friends have been drinking too. Their presence creates control problems for staff. The relatives may wander freely around the area ignoring "No Admittance" signs and being a general nuisance. For these reasons drunken friends and relatives are particularly annoying to staff.

Staff label a patient drunk on the basis of certain signs. Police escort was mentioned as one such sign. Others include: a staggering walk, slurred speech, red face, dilated pupils and the heavy smell of alcohol. Usually these signs occur in combination. Even well-dressed people who are intoxicated may be labelled drunk since the same treatment problems may arise as in the case of dirty ragged drunks.

Drunks are not responded to uniformly. One dimension along which responses are differentiated is interaction style. Interaction style of drunks usually falls into two categories: the humorous good natured drunk and the abusive drunk. Many drunks, because of their funny speech and actions are viewed by staff as



comic relief characters. They provide workers with humour which has the function of relieving work tensions and boosting group morale. This is more apt to happen when there are no serious cases around. There is more time to "get a kick out of" the good natured drunk. If there are more serious cases present, however, even the good natured drunk may be viewed as a nuisance presenting control problems that other patient types do not.

Other drunks are abusive. They frequently use insulting and profane language with staff while demanding immediate attention. This is more apt to happen when no police are present to calm them. Nurses are apt to resent the abusive drunk for this reason alone. They also feel professionals should not have to take this abuse. Abusive drunks are treated with less than the usual respect given other patients, but not because of drunkenness alone. The lack of respect accorded him also seems to be a function of his behavior while in the setting. Abusive drunks are also apt to lie about how they sustained their injury. For example, if they have been in a brawl, they commonly say they fell.

The head nurse on nights is more likely to encounter drunks than those on other shifts. As a result of frequent encounters with abusive drunks she has devised a rather unique approach to their behavior. Other staff in Emergency and at Capital frequently mention her interactive style when discussing drunks. The night nurse's style is "giving the drunks as good as they send." She is noted for standing up to them and "sassing them back." She has been physically assaulted on a few occasions. Also, she often scolds them for their state. Chances are she has seen them in the same state before. Rather than viewing drunks with the distaste that many other nurses do, the night nurse finds them the most interesting type of patient. She views her approach as a form of expertise. The fact that she can handle drunks better than other nurses is a source of pride.

Staff in emergency departments who have most contact with certain types of patients can be expected to devise coping techniques. Drunks afford an opportunity to demonstrate expertise peculiar to this type. It can be viewed as a work skill.



The good natured drunk and the night nurse's style of interaction with abusive drunks makes Roth's assertion about a universal hatred of drunks in emergency departments less tenable. Interaction styles and the chance for certain staff to demonstrate their expertise clearly show that staff attitudes towards drunks are not uniformly negative.

## Stage II: DIAGNOSIS AND TREATMENT

How fast stage I leads to stage II varies with defined seriousness and other emergency business at the time. If the ailment appears relatively minor and there are more serious cases in the Department, the drunk patient has to wait. Sometimes abusive drunks with clear cut injuries who are demanding immediate attention are sent to treatment quickly in order to get them out. Lacerations resulting from brawls are usually the only problems in these cases.

Regulars are often made to wait long periods of time. Experience has shown nurses there is ordinarily nothing seriously wrong with them. The following nurses' comments illustrate the prevalent attitude toward these regulars who have "cried wolf" in the past:

He comes in all the time, always drunk and complaining of something different each time. Sometimes we don't even bother with him.

and

I was hoping if I ignored John Smith long enough he'd go away. He's drunk out of his mind again.

There is a curious ambivalence toward these regulars, however. Nurses also are aware of the dangers in defining them as nonemergencies, on the basis of past experience. There is always a chance that they could be mistaken. The issue of regulars is discussed more fully in Chapter VIII.

The abusive drunk in particular tends to create control problems throughout his stay in Emergency. Getting him to co-operate with treatment is one such problem. If there is a laceration to be treated he may not lie still while the doctor sutures it. Frequently the abusive drunk refuses the tetanus toxoid needle routinely given in cases of laceration. He may continue to abuse the staff verbally during treatment. The tactic for getting abusive drunks to co-operate is most often verbal persuasion. This unco-operativeness is a further reason why drunks are not the most preferred patients in Emergency.



Interestingly enough, drunks accompanied by police are forced to undergo treatment. The police hold abusive and unco-operative drunks down while they are treated. Police are regarded highly by Emergency staff because of their help in controlling recalcitrant patients. This service is particularly valuable where there are staff shortages. The irony of the matter is that some drunks may get better medical treatment than other patients. It is virtually forced upon them. Others requiring treatment who get impatient at waiting have the option of leaving without being treated if police are not there. This observation further qualifies the findings of other sociologists that drunks get worse treatment in emergency departments: certain drunks may get better treatment than other types of patients.

Undetermined Injury drunks present Emergency staff with special problems. Usually these patients have been picked up lying on the road. Others may have been involved in car accidents. It is not readily apparent whether they are unconscious or just drunk. Intoxication by alcohol makes diagnosis difficult because it masks valuable symptoms. Blood pressure goes down, reflexes are unnatural and pupils are dilated.

Head injuries are often suspected with this class of drunk. Furthermore, intoxication (whether the patient is conscious or not) makes history taking especially difficult. One doctor expressed the general problem with undetermined injury drunks:

They make everyone anxious because you never know what's wrong with them; whether it's just booze or there's something really wrong.

Staff in Emergency feel that one drunk out of ten of this type has something really wrong.

If head injuries are strongly suspected, the patient is x-rayed. Yet, drunks are especially difficult to x-ray. They move around on the x-ray table and many repeats have to be done. There is a reluctance by Emergency staff to send drunks to X-ray for this reason. This is one situation where there is good role-taking by Emergency staff; they are aware of the problems faced by X-ray staff in the case of drunks. X-ray difficulties, then, are a further reason why diagnosis of undetermined injury drunks is delayed.



### Stage III: RELEASE

How the drunk is released from active treatment varies with the ailment. Those with minor ailments such as lacerations are treated and released. Regulars who suffer from chronic drunkenness or hangovers are often referred to a psychiatrist or social work agency. Staff feel these patients are not emergencies. The type of short term treatment offered in Emergency does not cure them.

Because it is difficult to diagnose the undetermined injury drunk while he is intoxicated, one strategy is to keep him overnight in the observation room. He is then diagnosed more fully when he sobers up. Doctors find it difficult to decide whether or not to release this type of drunk since there is a chance of error. One doctor feels that to avoid this error all undetermined injury drunks should be kept overnight. Crowded facilities may dictate, however, that only a few can be kept overnight.

Everett Hughes (1958) says mistakes are a common feature of work in all settings. In emergency departments, drunks especially expose workers to the risk of work mistakes. For this reason, it is to be expected that they are not a favoured category of

patient. Workers in Emergency have been penalized for prematurely releasing drunks. Yet they continue to do so, justifying their actions by saying it is a risk people must take if they're going to get intoxicated and make diagnosis difficult. The drunk is one who causes his condition by his own foolishness. The staff image of drunks as undeserving patients (Glaser and Strauss, 1965) is supported.

Certain problems arise for Emergency staff when undetermined injury drunks are kept overnight in the observation room. While the staff realize that the decision to keep drunks over may be justified on medical grounds, this does not make their work easier. The abusive drunk is likely to continue being abusive when he wakes up. Often he attempts to leave and has to be restrained. A shortage of personnel exacerbates the problem. In the case of regulars, the permanent staff are aided by their social knowledge of the regular drunk and his moods. In the words of one orderly: "You get to know their moods and when you can calm them down."

If physical restraint is necessary, it is the male orderly who must apply it. Staff, however, do not see these control tactics as an integral part of their work. Analytically, such work is "dirty work" Hughes



(1958). As such, the lower status personnel usually perform it. If abusive drunks are occasionally handled roughly, both physically and verbally, this too can be viewed as a technique for coping with such dirty work in the face of staff shortages. Rough treatment, if it occurs, is usually invited by the drunk attempting a physical assault on the staff.

If overnight drunks are awake they often are viewed by staff as nuisances. They request a variety of things from water to urinals. Borrowing cigarettes is seen by orderlies as particularly annoying. As one orderly stated: "I ain't giving them drunks no cigarettes. If they can afford booze, they can afford cigs."

Still other work problems occur when drunks are kept over. They are more apt to be incontinent creating extra work for orderlies. Vital signs must be taken at regular intervals by the nurses. Until the drunk sobers up taking vital signs (part of the diagnostic process) is likely to remain difficult. Also, the nurse who takes the vital signs runs the risk of waking up the abusive drunk. Even if awake, drunks are not viewed as the most co-operative patient. When the undetermined injury drunk sobers up the diagnosis and treatment process carries on without hinderance.

There is a special effort to "get rid of the drunks" as soon as possible after day shift begins. Leftovers are always viewed by the oncoming shift as annoying; leftover drunks being especially annoying.

#### Stage IV: POST MORTEM

Drunks are a category of patient that may have unwanted consequences for workers after release from treatment. As a result, staff have devised certain coping strategies. The behavior of abusive drunks is noted in the daily record book as protection from repercussions. Noting that a patient was "loud and abusive" gives more credibility to the staff's story should the drunk complain later of improper treatment. In the words of one nurse:

It lets everyone see it a little more from your point of view if the patient comes back complaining.

When drunks return with major injuries, blame may be placed on the intern or the more experienced nurse for allowing the intern to release the patient prematurely. Because of this possibility, post mortem discussions involve justifications by staff for actions



they have taken during the drunk's stay in Emergency. Nurses and interns are particularly concerned that they have done their work responsibly.

Also postmortemed in staff conversations is the unusual behavior of some drunks while there for treatment. There is a good possibility that this class of patient has showed some unusual behavior because of intoxication. Whether humorous or annoying it is discussed and communicated to those on other shifts. In the case of regulars who will return, this inter-shift communication allows staff to develop a common knowledge of those regulars. Orderlies most typically relate to other orderlies control problems of drunks and how they were handled. Like other post mortem discussions of patients, these conversations enable staff to build up what Stebbins (1969) calls cultural definitions of the situation involving patient types.

#### SUMMARY

Drunks present a variety of ailments to the Emergency Department. The most common characteristic is intoxication upon entering the Department. Drunks are, in most cases, disliked by staff. There are a few exceptions to this. The reasons for disliking

drunks are the difficulty in getting them to co-operate; they use abusive language which offends staff; they have caused the ailment themselves; they are difficult to diagnose; and they make staff prone to mistakes at work. If quality of care is lower for this class of patient it is often because of difficulties in diagnosing them immediately. It is simplistic to say, as others have, that moral judgement of drunks alone leads to low quality care. The present research qualifies some of the previous findings on drunks in emergency departments.



## CHAPTER VII

### TREATMENT OF OVERDOSES AND DRUG CASES

"Overdoses" are patients who accidentally or wilfully have taken enough of a drug so as to cause someone to feel that the drug poses a threat to the patient's well-being. Taking overdoses is the most common form of attempted suicide at Emergency.

"Drug cases," on the other hand, are usually young people who "are having a bad trip" from drugs, such as marijuana and LSD. Staff at Capital feel the number of drug cases coming to treatment reflects the increasing drug usage among students. Accordingly, they expect the prevalence of drug cases coming to Emergency to increase.

#### Stage I: INITIAL CONTACT

A telephone call from a relative or friend usually warns staff of the possible appearance of an overdose. Emergency nurses attempt to find out by telephone the kind and amount of the drug taken.

Familiarity with the drugs taken helps them decide whether the amount is enough to cause concern. If not, advice is given over the telephone. If the kind and amount taken is uncertain and if the patient appears unconscious to relatives the nurse dispatches the Emergency Ambulance.

Following the telephone call and ambulance dispatch, staff expressions of annoyance are universal. Glaser and Strauss (1965:83) discuss how staff in emergency departments express disgust for attempted suicides and other patients who have caused their own condition. In general, medical personnel seem to prefer to treat patients who have ailments that are not self-inflicted. If staff find out the overdose has been accidental, they are likely to be less annoyed. However, it is not enough to say that staff attitudes towards undeserving patients mirrors the negative feelings of citizens in general towards suicides. When discussing medical staff attitudes towards patients we must go further and show how the attitudes arise in the context of work problems created by these patients.



At Capital the ambulance trip for the overdose means that the intern is away from the Department resulting in a pile up of other cases. As we have seen before, there are times when the intern's absence is likely to be crucial. Overdoses are particularly troublesome because often the patient must be treated before he is brought to Emergency. If the dosage is heavy it is imperative that the drugs be expelled from the body as quickly as possible. For these types of cases, then, the doctor is likely to be gone for some time.

For overdoses, there is little that can be done in the way of Department preparation. While waiting, staff frequently express hope that the patient will arrive conscious since he is usually easier to treat. There is a kind of preparation for patients who have been in with an overdose before. Staff consult the old charts, and in some cases their memory, to see if the patient has presented control problems in the past. Information on past behavior in the cases of overdoses fosters a mental readiness in workers. If troublesome before, it is anticipated that the patient will be hard to control again. Accordingly, preparations are made as to how he is to be restrained.

This expectation about the patient's behavior is confirmed or disconfirmed as he enters the Department. If drugged heavily, the patient is apt to present few control problems. The type of drug taken, of course, also has an influence on how the patient behaves. A stimulant is likely to cause control problems, whereas a sedative drugs the patient making him more manageable.

Drug cases are apt to arrive escorted by friends or relatives. Early identification of a patient as someone who is "on drugs" is made by staff on the basis of his behavior. Screaming or funny sayings are characteristic of this type of patient. While in the station out of public earshot, staff often express annoyance to each other when they see someone on drugs. Expressions such as "it makes me sick" or "it's his own fault" are common. Attitudes towards people on drugs seem to mirror those of conventional society.

Drug cases further illustrate how an emergency department reflects community health problems. The types of medical problems extant in a community are often manifested dramatically in patient treatment at Emergency. The state of community facilities to deal with such problems is also highlighted by the



patient's arrival for treatment at an emergency department. In Capital City few other facilities exist for medical treatment of drug problems although a drug center is presently being planned. Staff at Emergency feel it should be the job of other agencies to deal with drug problems.<sup>1</sup>

## Stage II: DIAGNOSIS AND TREATMENT

As with other cases, the speed at which diagnosis and treatment of overdoses occurs varies with defined seriousness. Whether the patient is conscious or unconscious is important for subsequent treatment. A really serious case is taken immediately to the Resus Room, while a less serious case is put in the P. V. Room. The P. V. Room, being the largest treatment room in Emergency, has more space for controlling troublesome patients.

The diagnosis of overdoses frequently presents major problems. It is important that kind and amount of drug taken be determined. This tells how serious

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<sup>1</sup> In Capital City such a drug center now exists. This should relieve Emergency of some of the burden of treating drug cases.

the case is. Unconscious overdoses are particularly troublesome because they cannot give this information. Sometimes some of the pills and the container are brought in with the patient. If not, the person accompanying the unconscious overdose is questioned. Even here the task is not easy. Most people apparently take overdoses when alone so that no one else knows what they have taken. Furthermore, Emergency staff do not often find the information given by the overdoses' relatives reliable. Persons taking overdoses are informally labelled 'psychiatric' by Emergency staff. This label also seems to be applied to relatives or friends as illustrated by the following: "His friend seems a bit odd, too. I don't think we can rely on what he says." All members of a family may be stigmatized by having a family member labelled mentally ill (Scheff, 1966; Mechanic, 1968). However, it is conceivable that these friends or relatives are merely upset by the event causing them to act in what staff perceive as a bizarre fashion.

Even when pills accompany the patient it may take a great deal of time to identify them. Many pills have subtle differences in colour. What may look like one kind of drug may actually be another. The pre-



scribing doctor and the drugstore where the prescription was filled are frequently contacted. The absence of a drug chart in Emergency is seen by staff as a factor that hinders easy identification of drugs. Without a drug chart identification rests on the nurse's and doctor's ability. When Emergency staff cannot identify the drug the hospital pharmacy and those on other floors may be contacted. Identification may take a couple of hours during which time the patient's body is absorbing the drug. A blood test for barbiturate level helps here in that seriousness can be determined even in the absence of precise drug identification.

Assuming diagnosis of kind of overdose is made, the next step is treatment. A conscious overdose is typically given an emetic, which induces vomiting. If this fails or if the patient is too drugged to swallow, a tube is passed through the nose and down the throat. This too makes the patient regurgitate. While these treatment processes are fairly simple they require a co-operative patient. Frequently overdoses are unco-operative. If they took the overdose as a suicide attempt their motivation to recover is usually low. The words of one nurse in Emergency

express the general staff sentiment toward overdoses: "I hate overdoses. Usually they won't cooperate or anything."

Given the ideal of co-operative patients, a patient that does not want to get better violates expectations of the "sick role" (Parsons, 1951). In these cases, persuasion is usually used to get co-operation. Not surprisingly, the more experienced home guard nurses are more skillful at talking recalcitrant patients into taking treatment. Conscious patients who have taken some form of stimulant may have to be restrained and treatment forced upon them.

The unconscious overdose is difficult to treat. Many cannot be fully treated in Emergency but must be moved to the Intensive Care Unit. There is frequently a clash of staff perspectives in how to treat an unconscious overdose. Some favour passing a stomach tube to induce vomiting while others are vehemently against this procedure. The permanent nurses are apt to uphold the tradition of not doing this procedure while some of the transient interns are used to doing it their way. To prevent this clash, nurses rush to get the unconscious overdose out of Emergency. The two main procedures done in Emergency are setting up an IV to



help flush out the drug and keeping the patient's breathing passage open to prevent him choking on his vomit.

Drug cases are usually treated fairly easy. Some form of tranquilizer is given to let them sleep off the bad trip. Since they are often hysterical, a further advantage of a fast acting tranquilizer is that it restores the mood of Emergency to one of peace and quiet.

### Stage III: RELEASE

Both drug cases and overdoses violate Emergency staff's ideal of the place as a quick repair, quick release treatment center. Drug cases are allowed to remain to sleep it off and usually there is no further problem. They are released when they wake up.

The unconscious overdose is frequently moved to Intensive Care Unit. Emergency staff express reservations about this in the case of repeaters -- those who have been in for overdoses on other occasions. They speak of the waste of time and money on these repeaters and how it would be better to let them kill themselves. Expression of this enmity, however, is

strictly verbal; there is little indication it influences treatment. After one such incident a nurse asked a doctor if the patient was to be sent to the Unit. He replied "Do you think he deserves it?" Another nurse said how she had little time for such patients. The complaining may be sufficient to release tension and anger.

Moderately serious overdoses are apt to be kept over for a while for observation. The problems for staff are similar as those for other overnights. Also the patient is apt to be dehydrated after vomiting and his frequent requests for water tend to annoy staff. Some present control problems when they awake.

Staff are aware that treating an overdose in Emergency does not solve the problem. They feel the underlying problem is psychiatric. Because of the chance of return, these cases are frequently referred to outside agencies, such as psychiatrists and social workers. Overdoses are one type of case for which short term treatment is insufficient. Rosengren and Lefton (1969) call attention to the need for various health agencies to co-operate in treating certain patients. Nurses in Emergency mention that, by working there, they learn how inadequate resources for



comprehensive care are in Capital City. The follow-up care of overdoses and other psychiatric patients seems to dramatize these inadequacies. A valid index of the adequacy of community health services could be gained by studying the views of Emergency staff. Their work is greatly affected by existing inadequacies.

#### Stage IV: POST MORTEM

The shift that has numerous overdoses is generally reviewed by staff as "depressing." Part of this depression results from sympathy for people who accidentally take overdoses. This is especially likely if the patient is young. Attempts to find causes for the phenomenon are frequent in post mortem discussions of both overdoses and drug cases. Broken homes and "just for the experience" are frequent motives staff impute to young drug users. The motive of attention getting is most commonly imputed to overdoses, particularly if the case is a repeater. Regulars of the Emergency Department become part of the common topics of staff conversation. An extensive knowledge of the regulars is accumulated as staff relate to each other their characteristics and latest escapades.

Nevertheless, workers find that frequent contact with these regulars detracts from the variety in the Emergency Department. After treating some patients, staff can feel a sense of satisfaction which they can collectively share, but with regular overdoses:

You get fed up after a while. It's a waste of time. There comes a point when they've got to help themselves.

There is little satisfaction in treating overdoses only to have them return again. Repeaters get "monotonous" for staff.

#### SUMMARY

Overdoses and drug cases are two other patient types which lead staff in Emergency to express dissatisfaction. Part of this dissatisfaction results from the intentional nature of the ailment; but it also results from the work problems, particularly in the case of overdoses. These cases may take the doctor away for long periods of time and also present diagnosis difficulties. Staff find little work satisfaction in treating conditions which are merely symptomatic of underlying problems. Regulars who take overdoses are particularly resented. Again it



is argued that although staff annoyance is freely verbalized, this annoyance fails to affect the quality of treatment. Overdoses and drug cases also dramatize the inferiority of existing community health facilities.

## CHAPTER VIII

### TREATMENT OF NONEMERGENCIES

It is increasingly recognized by hospital administrators that emergency departments are receiving a greater proportion of nonemergencies than true emergencies. Partly, this results from the unavailability of other sources of medical care in the community. As noted before, in Canada Medicare seems to have made it more difficult to obtain the services of general practitioners, the ones who would ordinarily treat these nonemergencies.

Seeking treatment at emergency departments for nonemergencies can also be viewed from the layman's standpoint. An ailment is sensed by its bearer with more immediacy than by medical staff who treat the ailment. Any ailment that disrupts a person's normal routine may be interpreted as an emergency. Hence, to the patient, going to what may be the only place he can receive treatment appears reasonable.

Those who must treat a nonemergency in a place set up for emergencies are bound to view the matter differently than the patient. For one thing, non-



emergencies violate the staff's beliefs of what their true purpose is. There is a widely held belief that the purpose of the Department is for treating serious cases. Any other usage is a misuse of services.

This belief is reasonable. Medical tradition has fostered it. At Capital inadequate physical facilities and staff shortages make this belief even more reasonable. Here, Emergency staff's views on treating nonemergencies are clearly illustrated by terms such as "rubbish", "shit", and "junk" used to describe these types of cases. Medical patients are also an undesirable patient type, but the right of a sick medical patient to come to Emergency is unquestioned. The complaints stem from the time-involving work that must be performed on medical patients.

While staff in Emergency question the legitimacy of nonemergencies to seek treatment there, they are well aware that this type of patient is the most numerous. This is shown clearly in staff expectations as to when patient volume will be heavy or light. Factors like weather should be unrelated to the arrival of real emergencies for treatment. If a patient is really sick he will come at any time. Bad weather could lead the nonemergency patient to post-

pone his visit, however. In speaking of expectations, staff stress the importance of factors like weather. Hopes are expressed that patient volume will be low because of rain or snow, whereas on a sunny day staff expect many patients. One such sunny day one nurse expressed: "I never saw so much shit today. The sun's bringing them out like flies." Another nurse feels that it never gets busy on nights when there is a hockey game until the game is over.

There is a variety of nonemergencies: "quick repair, quick release patients," "regulars," "pre-ops" and those to whom staff impute a motivation other than seeking treatment. Each of these sub-types of non-emergencies is discussed below. Because there is such a variety, discussion is in general terms rather than stages of treatment used for previous patient types.

#### Quick Repair, Quick Release Patients

This is the most common sub-type of nonemergency. It includes a wide variety of what staff define as minor ailments. Minor work injuries, lacerations, sore limbs, influenza and mild stomach upsets are examples. The patient is usually treated in Emergency



or advised and discharged. Rarely is the ailment serious enough to warrant admittance to the hospital.

There is a temporal dimension to this type of nonemergency in terms of acceptability. Sometimes staff treat these patients without complaining, at other times annoyance is expressed. At busy periods, in the middle of the night, during snowstorms, or on holidays staff find nonemergencies hard to accept. They treat them grudgingly or use various strategies of delay. Occasionally these nonemergencies are actually treated as soon as they enter so as to move them through fast. This is most apt to happen if the ailment can be treated quickly.

There is a rule at Capital that all patients coming to Emergency for treatment must be seen by a doctor regardless of seriousness. Only the Casualty Officer has authority to turn patients away and this is done in only a few types of cases (dental problems or those wishing a check up, for example). Informally, however, staff have developed ways of getting around this rule. These strategies of "making out" insure two things: that priority is given to serious cases and that staff have some control over working conditions.

For example, if a patient phones Emergency for advice on whether or not he should come in, the nurse uses her discretion. If she defines the case as minor and it is one of the nonacceptable times discussed above, she is likely to advise the patient that he should wait and see if it gets worse. Or, the nurse may stress how busy it is at present and tell the person he will have a long wait if he comes now. This long wait is likely to discourage him from coming, particularly if the nurse has reassured him "it is nothing to worry about."

If an accident case is expected, nonemergencies present but not yet in treatment ~~are~~ likely to be discouraged from staying. The nurse explains to these patients that the Department is expecting a serious accident case and that it will be a few hours before the less serious cases can be seen. Staff shortages are apt to be played up in these instances. The aim is, of course, to get the nonemergencies to go home. In the words of one nurse:

Usually you can get rid of them by telling them they'll have to wait a long time but we can't do it when \_\_\_\_\_ (Casualty Officer) is around.



If these types of nonemergencies show up in the middle of the night the nurse often intentionally delays treatment if the doctor is in bed. Again she defines seriousness. If the case is defined as non-serious her sympathies are apt to lie with the intern who has worked all day and should not be awakened to "treat the like of that." The patient is apt to be told he will have to wait because the doctor is busy elsewhere.

There is another delay in treatment of nonemergencies resulting from Emergency nurses' desire to ensure convenience for doctors. X-rays at Capital's Emergency Department are usually examined by residents before the patient is released. If two or three patients come at the same time to have nonserious ailments x-rayed, nurses or interns usually wait until all the patients are back from X-ray before they call the resident. This saves the residents the bother of making two or three trips to Emergency for minor duties. For the patients, it means a longer waiting time though they are likely to be unaware of the reasons for the delay.

While doctors are apt to be more cautious than nurses in releasing nonemergencies, they, too, give nonemergencies second priority. If, for example,



residents are covering Emergency while the intern is on the ambulance they will usually delay coming down to treat nonemergencies. Adequate coverage is assured only for serious ailments.

Strategies like the above can be expected to be informally used whenever workers are subject to a rule they do not believe in. In Capital's Emergency, staff think it unreasonable they should have to treat "everything that comes." They see patients as taking advantage of this rule. In the words of one staff member: "They know we have to see every patient here so in they come." Using strategies to get around the open-door policy allows staff some control over their working conditions. The fact that everyone must be treated does not mean that every case gets equal priority.

Certain quick repair-quick release nonemergencies are particularly annoying to staff; for example, self-inflicted ailments, poor prevention, broken appointments at Outpatients, and delayed treatment seeking. For these cases, they have few qualms about delaying treatment. These patients are apt to be greeted with less than usual courtesy by staff. They may even be scolded. Staff expect that only patients whose ail-



ments are of recent onset should seek treatment in Emergency. The patient who sustained an injury two or three weeks ago and shows up for treatment in the middle of the night is resented. In fact, one sure criterion of a nonemergency is that the ailment occurred in the past.

Nonemergencies that staff experience as humorous fail to provoke the annoyance that many of these patients ordinarily do. In contrast, funny, nonemergencies are seen as interesting and morale building for staff. While certain cases are viewed as amusing by staff there is the realization that patients often find these cases embarrassing. Signs of the patient's embarrassment is an early clue that staff use to define a case as humorous. For example, the classic case at Emergency is the guy who comes in blushing because his penis is caught in his zipper. Ailments affecting the genital areas are generally experienced by staff as amusing, but by patients as embarrassing. The patient who asks to see the doctor alone is suspected to have venereal disease. Uneducated patients with "bizarre" views of medical cause and effect are also experienced as funny. One such patient associated swallowing a french fry with a

subsequent pain in his chest. Besides laughter and staff conversation, notes in the record book indicate that staff view a case as funny.

Owing to the inadequate spacial set up at Emergency, there is a chance that the patient may hear the laughter of the staff. Laughing at patients is meant to be a form of back stage behavior. When it is witnessed by a patient who takes his ailment seriously, the interaction is likely to be somewhat embarrassing for both staff and patient.

### Pre-Ops

Patients having minor surgery are often prepared for the surgery in Emergency. This occurs on weekday mornings. This task is resented by Emergency staff since it is in no way seen by them as a part of Emergency medical care. It is a procedure that could be done anywhere in the hospital, but has somehow been delegated to Emergency staff. They do it grudgingly. The pre-op procedure is a standard one, and if extra tasks are demanded staff may refuse to do them. If serious cases come, the treatment of pre-ops is delayed even though they may be scheduled for the Operating Room at a certain time. Pre-ops are listed



in advance, however, so that staff know how many to expect on a certain shift and when they will come. This seems to compensate partially for such superfluous work.

### Regulars

While the number of regulars coming to Emergency is fairly small the frequency with which they come forces staff to take special account of them. Regulars are patients who have been coming often for some time. Their complaints are viewed as nonserious, because emergencies don't happen to the same person every week. On the basis of past experience, staff define every succeeding visit of a regular as a non-emergency. Regulars are seen as wanting attention and faking symptoms to get this attention. "Psychiatric" is the label commonly applied.

While regulars are a nuisance, particularly if they come at busy time, staff frequently discuss them. They expect them to come to Emergency. If they fail to appear staff wonder why. As one nurse said of one regular:

He comes in about once a week complaining of something different each time. If a week goes by without seeing him we think there's something wrong.

Because regulars are defined as nonemergencies staff, especially when busy, may delay treatment of them. The common strategies are to ignore them hoping they will leave or to tell them to wait. Staff are uneasy about their behavior towards regulars, however. There is the belief that the regulars "will cry 'wolf' once too often." Staff are aware that they may give them short shrift the one time there may be something genuinely wrong. Because of the medical decision rule, doctors may examine some of these regulars more than regular staff think is warranted. In these cases nurses try to get the doctors to accept their point of view. For the most part, staff take the chance there is nothing seriously wrong with the regular despite their uneasiness about this assumption.

#### Patients Whose Goals are Other Than Treatment

Some patients come to Emergency for what staff feel are nonmedical reasons. Annoyance is greatest towards them. Patients who have previously been



treated in Emergency often show up some time later with accident insurance forms to be filled out. Chances are the treating doctor has long since left Emergency. Staff refuse to handle finances or similar matters in any way. After one such incident a nurse told the person "my sole purpose here is patient care." These people are directed elsewhere.

The public may also use Emergency as a lost and found bureau for missing persons. Frequent calls and visits to Emergency are made by relatives or friends looking for a missing person. This is the only form of this sub-type that staff accept. They are sympathetic with people who have lost a relative. Moreover, it is possible that the missing person could show up at Emergency later.

In the above two examples, people present themselves at Emergency for other than medical reasons. Still others present ailments that staff define as nonexistent. They feel the person has come for other reasons. Such motives are imputed as the patient: wanted a bed for the night, wanted attention, wanted time off work, or wanted drugs. The criteria that staff use to impute these motives are subtle and hence difficult to determine. Two common criteria seem to be the patient's unconvincing presentation



of self and the lack of objective evidence that anything is medically wrong. While the staff informally label these persons fakes, medically they are usually given the benefit of the doubt and examined. Later information may support their original diagnosis as correct as in the following:

There is absolutely nothing wrong with him. I knew it. He's in from \_\_\_\_\_ City and just wanted a place to stay overnight. Look at him in there sleeping.

Staff resent the utilization of the Emergency Room for nonemergencies. The public, however, has a different image of the purpose of these facilities. Michael Crichton speaks of the need for the hospital to change as public expectations for medical care change. At Capital, staff are reluctant to adjust to public expectations. Administration see the Emergency staff philosophy with regard to nonemergencies as in need of change. The feeling by Administration is that workers there are going to have to get used to the idea that the number of nonserious cases is going to increase. The aim of Administration is to make these staff accept nonemergencies as an integral part of their patient population rather than viewing them as a misuse of service.



The direction of change in staff philosophy is hard to predict. As we have seen, the strategies and philosophy toward nonemergencies have positive functions for the treatment of serious cases. This alone may be reason to proceed cautiously in trying to force staff to accept patients they feel shouldn't be there. Perhaps the crowded facilities and staff shortages should not be overtaxed by other than emergencies. Part of the answer may lie in public education in the use of the Emergency Department rather than in a change in staff philosophy. Also the present community health complex of Capital City should be reassessed by those interested in comprehensive medicine. Other existing facilities also may be in need of change. For example, at present it is nearly impossible to get an appointment with a dentist on short notice. This leaves little choice for those in pain except to bring the ailment in to Emergency.

#### SUMMARY

Nonemergencies are the most numerous patient type. There is evidence that this is true in emergency departments elsewhere in North America. Staff are

unwilling to accept this class of patient. In the face of a rule demanding they do, informal strategies have been devised to get around it. The view was taken here that staff complaints have some legitimacy when seen in the light of work pressures.



## CHAPTER IX

### CONCLUSIONS AND IMPLICATIONS

The major findings of this study of one hospital emergency department have now been presented. Since chapters four through eight included summaries, no further attempt is made to give a detailed summary. Rather, the task of the present chapter is to suggest conclusions and implications. The implications are of two types. Those of a practical nature addressed to people who, occupationally, concern themselves with the day-to-day running of an emergency department. These should be of particular interest to the Board of Directors, Administration, Emergency staff and all other employees at Capital whose work brings them in contact with Emergency. Research implications, on the other hand, are intended primarily for sociologists interested in studying hospitals.

## Conclusions

Because the present study is exploratory, no systematic testing of hypotheses or prior theories was attempted. However, in keeping with the cumulative aim of science, specific findings were related to other research at appropriate places throughout.

Rosengren and Lefton (1969) have presented a set of more general characteristics concerning a short term treatment center like an emergency department as part of their comparative model for a study of hospitals. Although these characteristics were presented in Chapter One, I shall now relate them to the findings of the present research. According to the authors, a quick repair-quick release treatment center should be characterized by: minimum patient compliance problems; few problems in staff consensus at the formal level of task accomplishment owing to well-articulated duties; well-developed lines of authority; and isolated rather than comprehensive interest in patients.



For the most part, my research does not support these hypotheses. With certain types of patients (for example, drunks, overdoses, and regulars) much staff effort is devoted to controlling recalcitrant patients. The indecision involving medical patients and undetermined injury drunks is evidence that treatment consensus does not hold for all types of patients. For some patients what has to be done is anything but clear cut. Nor are the lines of authority well developed as shown particularly in nurse-intern relationships. We have seen that the formal authority of transient interns is often informally challenged by the more permanent Emergency nurses.

Why do the findings of the present research fail to support Rosengren and Lefton's hypotheses? I should like to suggest that the comparative model of these authors is too narrow. They are concerned only with the ideal type of emergency department patient -- the quick repair, quick release type. We have seen, however, that there are a variety of types of patients coming to Emergency. Moreover, there are noticeable differences in treatment of

and attitudes toward these different types. While an emergency department may officially be set up to deal only with the type of patient discussed by Rosengren and Lefton, in reality many other types of patients are treated there. Hence, the model presents an oversimplified conception of patients. As a result, the implications of the model are likewise oversimplified.

Rosengren and Lefton's hypothesis that an emergency department is characterized by an isolated rather than a comprehensive interest in patients is supported by the present study. Because of the number of patients treated and the generally short nature of patient-staff contact, there is little time to learn much about an individual patient other than the nature of his ailment. Michael Crichton (1970) has stated that emergency department illustrate impersonality in its most exaggerated form. It seems that the current emphasis on dealing with the "whole patient" rather than just his ailment becomes a reality only in medical settings where there is adequate time for staff to get to know a patient. It could be hypothesized that long term



treatment wards best exemplify comprehensive interest in patients.

One of the main questions the present research set out to answer was: What does it mean to work in an emergency department? Although some answers were given to this question by considering the staff meaning toward various types of patients, a more general answer is offered here. Work in an emergency department means that one is compelled to deal with many patients whom one feels should not be treated there at all. In short, much of staff routine work is distasteful. The preference to treat only real emergencies seems to lead them to seek work there originally. In fact, the very name Emergency Department seems to be significant in influencing worker expectations. Much of the discrepancy between what workers in Emergency desire and what actually occurs is explainable by the difference between medical staff (in the broad sense) and public conceptions of the use of the Emergency Department.<sup>1</sup> Given that workers' ideals are not

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<sup>1</sup> Rosengren and Lefton (1969) have called attention to the way symbolic interactionists studying hospitals have theoretically stressed this difference between medical worker and patient perspectives.

realized, the question arises: why do they continue to work where they are dissatisfied with much of what goes on?

A partial answer to this question is provided by the theory of commitment discussed by Becker (1960), Kanter (1968) and recently by Stebbins (1971). I shall rely here on Stebbins' discussion because it is the most extensive. Stebbins (1971:35) defines "continuance commitment" as:

the awareness of the impossibility of choosing a different social identity or rejecting a particular expectation because of the imminence of penalties involved in making the switch.

It is continuance commitment to the identity of Emergency worker that is of concern to us here. Stebbins (1971:36-46) points out that there are pre-conditions, which must be met before people can be said to be committed. (1) There must be "identity committing arrangements" -- certain arrangements in social life must function to retain people in certain social identities. (2) Subjective penalties or costs must be perceived as resulting from these arrangements. They are of three types: social, psychological, and physiological. Each type is



either a "renunciation penalty," those that occur when one abandons an identity, or a "continuation penalty," those that occur when people remain in an identity. (3) The penalties must be perceived as imminent. (4) The person must be more or less aware of his commitment. (5) There must be objectively possible alternatives to the committed identity. The theory holds that social actors weigh the costs of continuing in a line of behavior (continuation penalties) against the renunciation penalties. When the continuation penalties are perceived as far less costly than the renunciation penalties, the actors are likely to remain in the identity. Furthermore, commitment can be divided into two additional types based on whether actors see their commitment as contributing positively to their self-image ("self-enhancing commitment") or negatively ("self-degrading commitment").

Stebbins' theory helps explain why regular emergency staff stay in their jobs.<sup>2</sup> The precondition of identity committing arrangements is met.

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<sup>2</sup> Nurses and orderlies are regular emergency staff. Transient interns who only remain in Emergency for a month are not.

The majority of workers enjoy living in Capital City and their occupations help sustain family life. They have a stake in pension plans and the system of promotion by seniority. Also, they have invested considerable time and effort in training. This applies particularly to the Registered Nurses. Further effort has been invested by all workers in learning the specific skills required of Emergency personnel.

The main continuation penalty is that they are required to treat large numbers of patients who violate their conception of Emergency's purpose. Further continuation penalties for workers in Emergency are the inadequate spacial setup and staff shortages. One major renunciation penalty is the likelihood of returning to bedside nursing should they renounce Emergency nursing entirely. Other renunciation penalties result from the penalty-producing arrangements just discussed. The relative absence of excitement would also be penalizing. The continuation and renunciation penalties are both social and psychological.



The workers are aware of the imminence of the renunciation penalties as judged by their conversations. They are also aware of possible alternatives, although the alternatives are all undesirable. There is only one other Emergency Department in Capital City, one which serves children. However, employment opportunities there are limited. So other than the alternative of leaving Capital City, the only real alternative for medical work is on regular hospital wards. There is, of course, the alternative of leaving this type of work altogether.<sup>3</sup>

The majority of workers wish to remain in Emergency, which is evidence that they perceive the continuation penalties as less costly than the renunciation penalties. The unanimous and vehement dislike expressed by staff for working on regular hospital wards indicates the alternatives are less attractive than working in Emergency. Moreover,

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<sup>3</sup> Since the study was completed a few nurses have left Emergency for "family reasons"; that is, pregnancy and transfer of husbands elsewhere. In these cases commitment to the identity of housewife overshadowed the commitment to Emergency nursing. It can be hypothesized however, that should these nurses return to nursing they will seek out Emergency nursing. The phenomenon of dual commitment is a

the commitment seems to be of the self-enhancing variety. Stebbins (1971:57-58) points out that there is less motivation to escape this type of commitment than self-degrading commitment. Staff do enjoy the serious cases that arrive for treatment; the ability to handle them skillfully is a source of pride. Also contributing to self-enhancement is the freedom to do a variety of tasks that would be restricted on the regular wards. Further, the numerous cases add an attraction to the job. Finally, the informal strategies used to control nonemergencies seem to attenuate considerably the costliness of continuation penalties.

### Practical Implications

Administration at Capital express a desire to change the philosophy of Emergency workers. They see the present philosophy as comprised of negative attitudes toward all patients other than real emergencies. Hopefully, the present work should enable these officials to see the workers attitudes

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complicated matter. Because it involves the notion of role-conflict and several related ideas, consideration of this interesting and important matter must await separate treatment as the main focus of analysis.



more sympathetically. Moreover, there is little indication that attitudes of staff actually affect negatively quality of care. As Rosengren and Lefton (1969) point out, a short term treatment center, such as an emergency department, is susceptible to change at the technological level but not at the ideological level. The attitudes of workers at Capital, as in other emergency departments, seem to be resistant to change. Accordingly, the implication is that caution should be exercised in any efforts by Administration to enact change lest they alienate the workers.

There are areas where spacial change may be beneficial. As Hall (1966) and Sommer (1968) have pointed out, account must be taken of man's spacial needs. Clearly the present spacial setup of Emergency is inadequate. I understand efforts are now underway to expand Emergency. This should positively affect worker morale.

Also problematic is the staff shortage due to budget cutbacks. As a result, Emergency staff are over-worked. Obviously this has a deleterious affect on worker morale, especially when accompanied

by increasing patient load. If the Emergency Department is crucial for the hospital's reputation, it is important to guarantee worker satisfaction. Dissatisfaction is apt to be reflected in undesirable staff-patient contacts. A reevaluation of staffing priorities is called for. It seems strange that such a high priority department as Emergency should suffer staff shortages.

Interdepartmental relationships are in need of scrutiny as evidenced by inadequate role-taking between personnel of different departments involved in caring for the same patients. One solution is to arrange for closely related departments (for example, Emergency, X-Ray, and Intensive Care) to exchange personnel for short periods of time so that members of each department gain an awareness of the demands faced by workers in other parts of the hospital as those workers see them. In short, there is need for more communication between departments. This would help guarantee comprehensive personalized care rather than fragmented impersonal care. One obvious difficulty is the variation in time perspectives. Presently each



department imposes its time concept on other departments. Awareness of differential departmental time perspectives should prevent workers from one department accusing others of "taking too long" or "sending patients up too fast".

A further long term implication is the need for public education in the proper use of an emergency department. This public education could take the same form as that used by organizations, such as the Canadian Cancer Society or the Victorian Order of Nurses. Health agencies in the same community could pool resources to create a public understanding of the proper use of medical facilities. Circulars, newspapers, television and radio advertisements are obvious resources in this connection. The suggestion by Rosengren and Lefton that the hospital must play a more active role by reaching out into the community may well be one of the most important suggestions made for improved medical care.

Finally, the community health resources of Capital City are in need of scrutiny. Are the present resources adequate to meet the needs of a

growing population? The difficulty obtaining dentists and general practitioners is one reason why the Emergency Department is functioning as a "residual treatment area". Many of those seeking treatment there might well go elsewhere. The possibility of Capital City's other hospitals taking some of its emergencies should be investigated. The influence of such widespread government programs such as Medicare has been profound and multifaceted. Careful extended study of such programs in terms of their functions and dysfunctions is called for.

#### Research Implications

The preceding discussion of the oversimplicity of Rosengren and Leftons' comparative model lends support to Freidson's assertion that we have much to gain from studying one department of a hospital at a time. When comparing several different types of treatment centers, one risks concentrating only on comparable surface characteristics. Unless the comparative model is built from careful studies of these individual departments, issues important in these units may be missed. The suggestion is that



comparative study of hospitals should not neglect the more detailed case studies. There is need for both types of investigations.

The present research has been exploratory. There is now need for more structured studies. This work has identified recurring situations and their meanings in an emergency department. Such knowledge should help future researchers ask the right kinds of questions, without violating the commonsense world of the respondent. An exploratory study like the present should guide the construction of more formal interviews and questionnaires for these future studies.

Also, the present work has focused only on an emergency department for adults in a rather small city. Studies of children's emergency departments are necessary as are studies of emergency wards in larger cities. Replication in other settings would tell us how the findings presented here vary. Consideration of similarities and differences will help develop a theory of the emergency department.

Following more intensive studies of the emergency department, its relation to the rest of the hospital is in need of investigation. Knowing

how it influences and is influenced by other hospital departments will take us far toward a sociological theory of the hospital. It is also necessary to carry out more intensive study of other individual departments. Surgical wards, medical wards, the morgue, terminal illness wards, operating rooms, and obstetric wards have been studied. I know of no intensive studies of x-ray or laboratory departments.

The present study has looked at Emergency from the inside. It is also necessary to get the patient's side of the story. What leads patients to seek treatment in Emergency rather than elsewhere? A questionnaire distributed to random samples of people from different communities would tell us much about the public's conception of the emergency department. Also, how do they view treatment there? Many of the present attitudes and practices of Emergency staff are based partly on patient definitions of an emergency department function. We have seen that staff-patient definitions are often at odds. Getting both sides of the story is necessary for an objective view of any medical facility.



Finally, the present research has implications for the sociology of work. We have identified several factors that influence worker satisfaction and dissatisfaction. Also discussed were strategies used by workers to bring existing states of affairs in line with their expectations. These issues should be examined in other work settings, particularly those involving practitioner-client relationships.

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