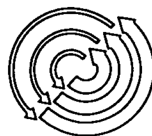

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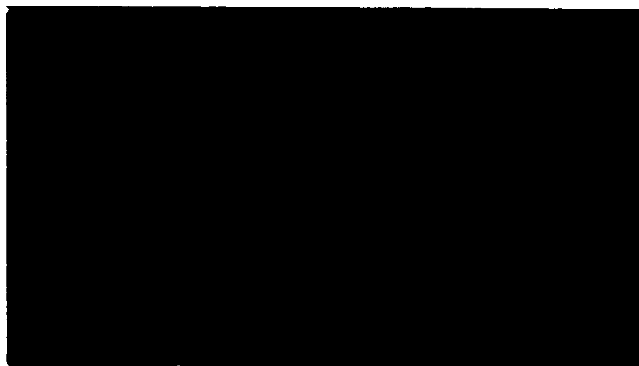

NO BEGINNING AND NO END:
A STUDY OF THE EMERGENCY ROOM AS A SOCIAL SYSTEM

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PREFACE

The goal of this study is to understand how the Emergency Room of a private general hospital functions, using some of the concepts and methods of sociological inquiry. This research was facilitated by the cooperation and assistance of the administration and staff at "Williams Hospital." We would especially like to thank the physician in charge of Emergency Services for his enthusiastic support and encouragement of our research from the onset of the study. The Research Committee of the Hospital expressed confidence and trust in us by allowing access to a sensitive area of the Hospital, and to them we owe our thanks. We would like to thank all of the staff of the Emergency Room and the numerous other people with whom we spoke for allowing us to share part of their lives.

The research described here was conducted in conjunction with a graduate seminar entitled "Research on Social Organizations" conducted by Professor Lawrence J. Redlinger at the University of Michigan. Through every stage of the research Professor Redlinger offered us his time, energy, expertise, and support. His advice and counsel helped us in dealing with the problems we encountered along the way, and without his continuing confidence in us this study would not have been completed.

We found that the staff of the Emergency Room were not only willing to tolerate our questions but many times actively assisted us in gathering data. Whatever errors or omissions exist are generally the result of demands made on us by our schedules and personal lives, and for these we accept full responsibility.

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Chapter I. INTRODUCTION

In the last few years, the emergency departments of local hospitals have been increasingly utilized as an alternative to traditional medical services. Along with "walk-in clinics" and "street clinics" they have assumed the role of providing medical care for patients who for a variety of reasons have no other direct access to the health care delivery system (Sudnow, 1967:29; Weinerman et al, 1966; Kaplan, 1970). Emergency Departments are particularly important to certain groups of people, especially inhabitants of rural areas, members of minority groups (especially nonwhites), and the aged (Kaplan, 1970).

As Walker and Miller (1973:321) have noted:

> The utilization of emergency department services has grown steadily, out of proportion to concomitant increases in hospital admissions, clinic visits, or population growth in a service area.

These authors also note that part of this growth is due to an increase in use by patients with "non-emergent" conditions, in other words, those without accidental injury or life-threatening conditions (1973:321). Other investigators have suggested that the use of emergency department services is higher for individuals with psychiatric histories (Miller, Browning, and Tyson, 1971).

There have been a number of studies dealing with the types of services and patient utilization in emergency departments (Walker and Miller, 1973; Weinerman, 1966; see also recent issues of the Journal of the American College of Emergency Physicians), with the general structure of hospitals and health

care delivery systems (Freidson, 1963; Fox, 1959; Hartog, 1964; Applé, 1960; Skipper and Leonard, 1965; Kaplan, 1970; National Advisory Commission on Health Manpower, 1967; Susser and Watson, 1971), and with the medical profession and medical training (Becker _et al_., 1961; Merton, Reader, and Kendall, 1957; Hall, 1946; Bloom 1965). However, these studies have few references to emergency department structure or procedures.

Sudnow (1967) has conducted an excellent study of how death is handled in hospital settings, including some references to its treatment in emergency departments. To our knowledge, however, there has been no attempt to systematically observe how an emergency department operates on a day-to-day basis in dealing with both emergency and non-emergency patients and to gain from this an understanding of the social structural characteristics of such a department.

Our mutual interest in emergency services, in the social structure of emergency departments, and in the relationships between emergency departments and other social systems such as hospitals and the communities in which they exist led us to work jointly on the research reported here. We agreed at the onset of the study that we would observe in the emergency department of a hospital with the hope of understanding the nature of the social relationships that were evident there, the general structure of the emergency department, and the relationships between this department and the outside world.

Our basic methodological approach was that of "fieldwork" (Junker, 1960; McCall and Simmons, 1969). It involves the observation of people where they are, in the present case in an emergency department. Junker (1960:36) describes a continuum of "theoretical social roles for field work" ranging from complete participant (characterized by comparative involvement with subjectivity and sympathy) to complete observer (characterized by comparative detachment with objectivity and empathy). In between are the roles of "participant as observer" and "observer as participant," and in the course of the study it became obvious that one of us had adopted the role of "participant as observer" while the other adopted the role of "observer as participant." (A more detailed discussion of the methodology used in this research can be found in Appendix I.)

Williams Hospital, where the study was conducted, is a 550-bed, private community general hospital. It is one of two major hospitals in a midwestern community of 100,000. The emergency department consists of a group of rooms on the ground floor, in a newer section of the hospital. The entrance is located on the south side of the hospital on a street that is one-way westbound. The entrance is near the corner, and the street is marked to allow emergency vehicles to enter the hospital from the west when necessary.

In spite of its actual size, the emergency department is called the "Emergency Room" by hospital staff, and we will refer to it in this report as the "ER". It contains a registration area, a staff room (the central work

area), lounges for the staff, and six treatment rooms. (More specific descriptions of the rooms will be presented in a later section).

The Emergency Room at Williams Hospital handles approximately 2500 cases per month. Table 1 below presents a summary of the cases handled by the ER from October, 1973 through April, 1974, the period of our observation.

Our first contact with Williams Hospital came at the end of September, 1973. After speaking with a hospital administrator we approached the physician in charge of the emergency department to ask permission to conduct the research. His enthusiastic reception to our request greatly facilitated the formal process of obtaining access. We submitted a proposal to the Research Committee of the Hospital, and it was approved on October 2, 1973. We began our observations the same night.

The emergency department operates on a 24-hour schedule 365 days a year, and the fact the ER is always open created a number of problems for us. Carey (1972:82) has noted the fatigue and the conflict with the researchers' "conventional commitments" that accompany research on groups that function round-the-clock, and these same problems had to be dealt with in the present study. We devised a rough schedule that would enable us to observe at every hour of the day and night at least twice during the course of the study and with the exception of the period from 11:15 A.M. to 1:00 P.M. (which was only observed once) we were able to meet this objective.

TABLE 1

Cases Handled by the Emergency Department, by Month, and Type,

From October 1, 1973 through April 30, 1974

Type of Case	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.
Allergy	46	45	38	13	18	27	35
Cardiology	35	42	53	57	65	60	40
Dentistry	20	8	16	9	9	9	11
Dermatology	36	38	24	19	19	28	20
Gynecology	118	95	100	98	80	95	95
Medicine	730	693	687	692	821	927	949
Neurology	28	23	21	16	22	35	34
Neuro-Surgery	24	26	29	27	17	13	25
Obstetrics	36	24	27	32	23	35	27
Opthamology	123	85	78	71	64	86	94
Orthopedics	269	211	198	273	249	214	250
Otorhinolaryngology	27	39	42	41	30	34	52
Plastic Surgery	49	30	31	39	29	29	38
Psychiatry	32	26	44	12	9	21	15
Surgery, General	1139	967	915	877	776	861	989
Surgery, Thoracic	7	-	5	3	2	3	7
Urology	58	56	63	63	45	65	59
Total Visits	2777	2408	2371	2342	2277	2541	2740

Conflict with our personal lives or "conventional commitments" was more difficult to resolve to our complete satisfaction. The ER functions on a three-shift schedule, and as indicated in Table 2 below, the day and evening shift handle the bulk of cases treated. Because of our academic and personal commitments during the day, however, most of our observation time was spent on the evening shift with the next largest amount of time on the night shift. Thus we had a larger percentage of observations over percentage of cases on the evening and night shifts. This discrepancy is less serious, however, when it is noted that the day shift was by no means totally ignored, and when it is realized that one of our major interests, namely how the ER functions in periods of both high and low activity, could be adequately observed on the evening and night shifts.

As noted in Table 2, we observed for a total of 150 hours 25 minutes during the seven months of the study. These observations occurred on 42 separate occasions. On eight of these occasions, involving some period of observation on each shift at least twice, we observed jointly. The other 34 observations were conducted independently.

Another characteristic of the emergency department with which we had to deal was the necessity of maintaining confidentiality in regard to information about individual patients, and we were always careful not to include any identifying information about patients in our notes. Data of a "personal" nature about individual staff members has not been reported.

Table 2

Case Load and Observations by Shifts, October, 1973 - April, 1974

	Cases Handled*	Percentage of total cases	Hours of Observation	Percentage of total Observations
Day Shift (7:30 A.M. to 4:00 P.M.)	7697	43.3%	21 hours, 15 minutes	14.1%
Evening Shift (4:00 P.M. to Midnight)	7728	43.5	89 hours, 35 minutes	59.6
Night Shift (Midnight to 7:30 A.M.)	2233	13.2	39 hours, 35 minutes	26.3
Totals	17758	100.0%	150 hours 25 minutes	100.0%

*Listed by time of registration in the Emergency Department

The most sensitive issue for us involved opinions received from staff members about other staff members. Because of the small size of the staff and the fact that almost any identifying information about the person or the situation could reveal the source of the statement to his/her colleagues we have had to present such statements in a much more general form, as examples of the varied opinions of each other held by the members of the staff. It is our hope that this will offend no one and protect everyone.

In addition, since we do not wish to be seen as either advocates for the ER or as infiltrators from the hospital administration, we have had to exercise care in reporting some incidents and stories. If a statement or incident was important in understanding the ER and yet was potentially damaging to anyone or "politically motivated" we have attempted to generalize the report so as not to lose the major content and yet to offer some protection.

Conduct of the Study

From the beginning of our observations we were very open about what we were doing since we both have strong reservations about covert observations (McCall and Simmons, 1969; Polsky, 1967). Whenever a new person was in the field we would inform them of who we were as soon as it became apparent that they wanted or needed to know that. Whenever we were asked what we were studying, our stock answer was that we were "studying the nature of the ER as a social system...how the different people interact with one another, staff with staff, staff with patients, things like that."

Although the study was presented openly, it became necessary to deal with the problems of "fronting behavior" (D. Douglas, 1972; Goffman 1959). A "front" is a "facade erected, on the one hand, by the individuals in an organization the researcher proposes to study or, on the other hand, by the researcher himself in order to accomplish his ends" (D. Douglas, 1972:93). As researchers, we found it necessary to compromise with total openness when one of the physicians asked us to wear some form of hospital attire instead of civilian clothes while observing. This request was made after about five weeks of observing, and the doctor said that he thought we would fit in better and be less conspicuous if we looked like another staff member. We followed his advice and began to change into the appropriate attire as soon as we entered the ER, and we discovered that not only did patients seem less concerned about who we were, but also that we felt more comfortable in being able to blend in. Thus, this "front" appears to have been useful.

On the other side, most of the staff members dropped their fronting behavior as they became more comfortable with our presence and came to trust us more. This process was most complete on the evening and night shifts. Because we did not observe as much as the day shift, the fronting behavior of some day-shift staff continued throughout the study. One of the things that facilitated the dropping of staff fronting behavior was their realization that we could handle the pressures and tensions in the ER. In addition, it was simply impossible for the staff to "front" when they were dealing with a crisis situation and we were there observing every movement.

Several other problems were encountered in the course of our observations. One was the "status problem" noted by Hall (quoted in Junker, 1960:95):

> Several peculiar difficulties are encountered in trying to study the medical profession. The status of its members is generally higher than that of the person making the studies. Since it is usually considered inappropriate to discuss one's important affairs with those of a lower status this limits the kinds of facts revealed.

As far as we could tell, the doctors in the ER were very open and honest in answering the questions raised and in allowing us to observe.

At the same time, we had to be aware of not-over-impressing the other members of the staff who were generally in a status equal to or lower than our own. This situation was quite different from that described by Hall. One product of the multiple status system in the ER was the fact that we sometimes became a vehicle for members of lower status position in the ER to express some of their negative opinions about the doctors.

Thus, the "status problem" seemed to work in two ways; while it may have inhibited the collection of certain types of data from the doctors (such as information about "failures" in the ER), it seems to have enhanced the gathering of other types of data from other staff members.

The issue of rebuffs deals with the way certain probes or attempts to collect data were blocked by staff members. Although in general we were able to maintain fairly good access to the data sought, occasionally

we would encounter difficulties. Some of these involved interpersonal relations with individual staff members. Occasionally there were times at which certain staff members did not want to be bothered by our questions, and the only thing we could do was either hold off and try again later or else ask someone else.

A third issue is that of "trade-offs", the process of doing or giving something in return for information. The basic trade-off in this and almost every field work situation was that of treating the respondent as a human being whose opinion and information you consider important. Thus, attentive listening must be considered more than just a methodology. It is a way of showing the respondent that you really care about what he/she has to say.

In this study, however, there were many other trade-offs. One of the most frequent ones, especially on the night shifts, was the providing of information in return for keeping the respondent company and giving them someone to talk to. This pattern also operated at times of low activity levels on other shifts as well. Another trade-off came on a number of occasions when we happened to be in the right spot at the right time and something needed to be done. In such hectic situations we were occasionally asked to perform certain elementary tasks such as delivering messages or forms, or bringing supplies to a doctor or nurse.

The notes from our observations began as brief comments written in a field diary or on small pieces of paper. These we expanded upon leaving the ER and then typed in complete form as soon as possible after leaving the field. On a few occasions we were unable to complete the typing of the notes and thus have utilized our field diaries.

Summary

In this chapter we have presented an overview of the research described in this report. We have covered such issues as why this topic is important, how the research began, how it was conducted, and some of the problems we encountered in the course of the study.

As we have noted above, our major interests revolved around the internal dynamics of the emergency department and the way the ER as a unit is related to the outside world. These interests all relate to the ideas of the Emergency Room as a "social system", and it is to this theoretical perspective that we now turn our attention.

Chapter II. THE CONCEPTUAL APPROACH

The basic conceptual framework used throughout the research was the notion of "social system." The importance of this concept for social theory was first demonstrated by Henderson (1935a), and the concept has been further developed by Parsons (1951) and Buckley (1967).

A "system" is a unified whole composed of interdependent parts whose unity depends on the functional quality of the relationships within it. Any change in one part of the system is seen as bringing about changes in the other parts. The "normal" state of the system exists when all of the parts are in balance, and when this balance is disturbed the system reacts toward reestablishing the "normal" state, a process called homeostasis. The "structure" of the system is seen in terms of the patterns of relationships. A "social system" consists of two or more individuals interacting according to stable social roles. Basically, then, a social system is a set of ordered roles, relationships, and activities specifying reciprocal relations of interacting human beings either as individuals or groups.

The social system approach has been applied to the general structure of medical systems (Parsons, 1951:428-479; Susser and Watson, 1971:237-279) and to the more specific relationship between doctor and patient (Henderson, 1935b; Bloom, 1965). However none of these studies focuses specifically upon the emergency department as a social system, and the latter is the subject of the present research.

It is our intention to describe the characteristics of the emergency department as we observed them, and they will be described in terms of the social system model. In doing so our emphasis will be on the internal structure of the ER, but we will also deal with how the ER responds to various external stimuli in the course of its normal operation. We will discuss briefly the position of the ER in the structure of Williams Hospital and its dependence upon the medical profession and the community, but it is not our purpose to present a social system analysis of the Hospital or the community. The reader is referred to the studies noted above for a broader treatment of these latter issues.

Before considering the systemic characteristics of the ER at Williams Hospital we will define a few more key terms to be used throughout this report. These include subsystem, culture, status, position, and role.

A "subsystem" refers to a smaller unit of interaction within a given system. Each subsystem is an interdependent part of the system. We will be discussing three major subsystems in the ER at Williams Hospital, each of which consists of a number of actors working on certain tasks and tied to a specific area within the emergency department. Specifically these subsystems are located in the registration area, located at the entrance of the ER; the staff room, or central work area; and the treatment area, consisting of the five treatment rooms, the supply room, and the main hallway.

Sociologists and anthropologists refer to culture as "the total way of life of a people, the social legacy the individual acquires from his group" (Kluckhohn, 1957:20-21). Culture is seen as providing us with a set of prescriptions for what must, should, may, and must not be done. These prescriptions are generally referred to as cultural norms.

The notions of status, position, and role are all interrelated. A "position" is a particular location within a social structure. A "status" is the relative social rank of any position regardless of the individual characteristics of the persons who occupy the position. A "role" is the dynamic aspect of a status and refers to both the normative patterns of rights and duties which accompany any position based on the cultural system within which it exists, and the actual behaviors of the individuals in this position. In the next chapter we will describe the positions and roles observed in the ER.

It should be noted that these last three concepts involve the notion of reciprocity of behavior between two or more individuals. In other words, they are activated within the context of social interactions or transactions (Spiegel, 1954) such as those which occur in the patterned relationships of social systems.

Social System Characteristics

When we began this study we had a set of initial assumptions about what the ER was like and how it functioned in relation to the major groups in its environment. We believe it is important to report our starting

point and the process of development from that start so that the reader can get a better feel for the entire research process which we are describing.

These assumptions are illustrated in Figure 1 below. This simple model shows the ER within the structure of the hospital, and within the ER itself we find the staff: the doctors, nurses, clerks, etc. The ER was seen as a basically open system, with input coming in the form of patients, police, ambulance crews, and relatives. Patients, the major inputs, were to be processed through the ER and then either released back to the external system or else admitted to the hospital.

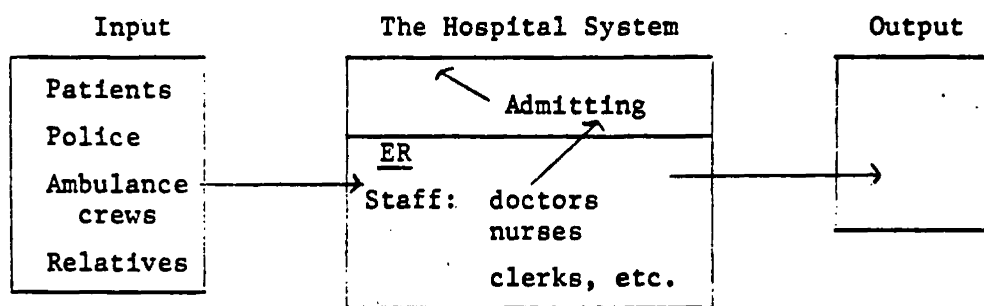

FIGURE 1

By the end of the study we had developed a more complete understanding of the systemic characteristics of the ER. These will be described in detail in later chapters, but the basic outline is presented here.

The first important characteristic of the ER is its openness. This quality refers to much more than its 24 hour a day operation. The

boundaries of the ER are totally fluid, and as noted above what happens there is to a large extent dependent upon the people who enter the system. This, in turn, depends upon the patterns of action in the community as well as upon the relationships between the ER and Williams Hospital and other medical systems.

A second major characteristic of the ER is the repetitive nature of what transpires there. In addition to general patterns of patient flow by time of day and day of week there are regular types of cases that are treated in the ER and some standard procedures that are followed. In the course of our observations we also noted some patterns of behavior which reflected recurring "moods" or "states". All of these will be described in detail in succeeding chapters.

The third major systemic characteristic of the ER is its dependence on other systems. For example, the Hospital provides many services utilized by the ER in treating patients; physicians practicing various medical specialties are frequently called in for consultation; and many administrative services are handled by the Hospital. In addition, interdependence exists within the ER itself with the various staff members dependent on each other for the competent and efficient operation of the department.

Some of this interdependence is a product of the administrative structure of the ER and the nature of its relationship with Williams Hospital. The physicians who staff the ER are members of the Emergency

Room Physicians, a private corporation formed seven years ago to staff the ER under a contractual agreement with the Hospital. As such they form a private corporation within the Hospital setting. The Hospital provides the facilities and other staff to operate the ER, and because of this the Hospital maintains a great deal of authority over the staff, most significantly in the area of hiring and firing. (An excellent discussion of authority relationships in medical systems is provided by Susser and Watson (1971:241-261).)

Summary

In this chapter we have presented the major elements of the conceptual framework that has guided our research and analysis. We have also briefly described some of the major characteristics of the ER. In the following chapters we will fill in the details of this analysis, and then return to the conceptual framework in order to summarize our findings.

Chapter III. POSITIONS, ROLES, AND INTERACTIONS IN THE EMERGENCY ROOM

In the last chapter we presented the basic definitions which will be expanded in this chapter. A position is a location in a social system. A role consists of both the normative definitions of a position (or the role expectations) and the manner in which the people who occupy a position actually behave in their interactions with other people (the role behavior) (deFleur, D'Antonio, and DeFleur, 1971:42).

The regular staff of the emergency department consists of physicians, nurses, technicians, registration clerks, and staff room desk clerks. In addition, interns rotate through the ER for a one or two month period, and volunteers are sometimes on duty. Each of these job categories designates a position within the system.

In the course of its normal operation, a number of other people can be seen in the ER. Among these are patients, physicians and residents who are called in for consultation, ambulance-crews, law enforcement personnel, clergy, and technicians or messengers from other units of the hospital. Each of these also designates a position.

The composition of the staff varies according to shift, and it reflects the flow of patient visits to the ER. Both the day and evening shifts usually are staffed by one doctor, two nurses, two technicians, two registration clerks, and one staff room desk clerk. Occasionally there are three nurses and one technician on duty. The interns usually work on these shifts. The night shift is usually staffed by one doctor, one nurse,

two technicians, and one desk clerk who covers both the registration area and the staff room.

The role expectations corresponding to most of these positions are enumerated in the Emergency Department's Policy and Procedure Manual, and these are presented in Appendix 2 below. There is no formal set of expectations for the registration clerks in the Manual, but they are given an ER Clerk Manual which outlines all procedures, and a Desk Manual which contains copy of all the major forms they might have to use, complete with instructions on their use.

Expectations for interns are also not included in the Manual, but each new intern is given a set of "Service Instructions" and a list of "Potential Goals for Interns Assigned to the Emergency Department". The formal statement of duties and responsibilities for the ER doctors is contained in the Manual in the form of a set of contractual rules between the Emergency Room Physicians (also known as the Corporation) and the hospital. These contractual arrangements can also be found in Appendix 2 below.

Roles and Interactions

We noted above that an important component of the concept of role is the actual behavior or performance of the individuals in a given role. This behavior can be observed both in the way the individuals perform the technical aspects of their jobs and in the way they interact with other members of the social system, either regular staff or others. In this section we present a summary of our observations of these aspects, focusing in turn upon each of the major roles.

A) The Doctors

Four of the five doctors whom we observed during the study are members of the Emergency Room Physicians. One of the most important things that the four doctors have in common is that they prefer having a job with definite hours instead of being on-call twenty-four hours a day. Each of them had been in private practice as general practitioners before working in the ER.

Although the doctors are in charge of the ER, they are very dependent upon the people who occupy the other roles in the system. The clerks, technicians, nurses and interns who work in the ER, and the residents and staff physicians who cover special cases -- all of these are important in carrying out the duties of the doctors. As noted above, the fact that the physicians form a private corporation under contract to the hospital and thus work with a staff that is technically hired and fired by another administrative unit of the hospital is an organizational characteristic that is crucial to the efficient functioning of the ER (See Appendix 2).

Relationships between the doctors and the nurses tend to be of two major types. First in importance are the aspects that deal directly with patient care. The nurses take their orders from the doctors, and a significant percentage of the interactions we have observed between these two groups involve matters related to patient care. Because all of the doctors are male and all of the nurses are female, it is not surprising to find that another important type of interactions between these two groups involves flirtatious joking behavior. This type of behavior both relieves the tensions created by the pressure of the work itself and gives a legitimate way of handling the feelings present in any heterosexual work

environment:

> Each of the new staff in turn teased (the doctor) about the incident, and at one point (he) and (one of the nurses) were flirtatiously touching and tickling each other with the nurse singing..."he touched me..." and everyone around was laughing. (Notes, p. 329)

Seven of the ten technicians we observed were males, and the doctors related to the males in approximately the same proportions of patient non-patient oriented interactions. With the male technicians however, the major topics of conversation were sports, news, and the past, depending upon the doctor. The female technicians were treated in much the same way as nurses.

The registration clerks had fewer interactions with the doctors than the staff room clerks, but even for the latter the number of interactions was below that of the nurses and technicians and a higher percentage were related to the patients. Most of the non-patient oriented interactions involved two of the more out-going staff room clerks, and they shared in the flirtatious joking behavior noted above. The female registration clerks were not as often involved in this behavior largely because of their spatial isolation in the registration area. This behavior occurred most frequently during periods of relative inactivity in the ER, and also after very tense and/or hectic situations. This will be described in more detail in the section on joking behavior in Chapter IV below.

Among the people who were part of the regular ER staff, the interns seemed to be the group toward which the doctors related most as equals. Even the two female interns were treated more as colleagues, though both

male and female interns were obviously "junior" colleagues. One interesting fact is that the only staff member who we ever heard being critically evaluated by the doctors in the presence of other non-doctor staff members was an intern, and this most probably was because the interns were still in some sense "students" and they were also only temporary members of the staff, whereas the rest of the staff was "permanent."

Relationships between the doctors and the residents and staff physicians who came to the ER to treat patients, were for the most part, cordial and professional, with variation due to the extent that the doctors knew each other as individuals. One of the keys to the level of acquaintance was the way one doctor would use the word "doctor" in talking with each other or in addressing other doctors. The residents seemed cognizant of their position as "intermediate" colleagues, and their manner of relating to the doctors reflected this. The residents occasionally used a little bit of flattery to gain points:

> "Doctor, while I'm here, I'd like to pick your brains about general medicine..." (Notes, p. 242)

Although the doctors rarely spoke about other staff members, and never in the presence of other staff members, the nurses, technicians, and clerks all had their opinions about the doctors and never seemed reluctant to discuss them. This is probably a reflection of the differential statuses involved here. One of the things that became apparent in the course of our observations is that the rest of the staff held a tremendous variation of opinions about each of the doctors. None of the doctors was equally liked or disliked by all of the staff, and none of them was ever seen as either perfect or totally incompetent. The variation seemed to be due to both

personality factors and to the types of criteria used in evaluating the doctors.

There have been a number of important works dealing with the doctor-patient relationship. (Parsons, 1951:428-479; Bloom, 1965), but this was not a major focus of our research. From our observations we can, nevertheless, draw a few conclusions. For example, each of the doctors had his own style of dealing with patients, ranging from the cheerful and happy to the straightforward and serious. One thing very noticeable, however, was the difference in the way the doctors related to male and female patients. Without actually seeing the interaction one could almost always tell from the tone of voice and the inflections whether or not the patient to whom the doctor was speaking was male or female. Other characteristics of the doctor-patient relationship will be explored in later chapters.

B) The Nurses

As a group the nurses maintained the closest ties within their own group members and with the technicians, the group to whom they were most closely related by work tasks and status. These relationships also extended to some of the staff room clerks, especially those who were full-time employees. One of the more frequently observed conversation patterns involved nurses, female techs, and desk clerks talking about clothes, hairstyles, diets, patients, men, etc.:

> In a few moments (one of the female registration clerks) came in and made a comment to (one of the female technicians) expressing her approval of the latter's new make-up, and the fact that no one else had noticed it. One of the nurses joined them and the three proceeded to discuss make-up for a few minutes. (Notes, p. 229)

As was true of the relationships between doctors and nurses, the nurses

and male technicians often engaged in flirtatious exchanges, and the same pattern extended to some of the male interns and the residents and staff doctors who appeared in the ER to treat a patient.

One area of variation among the nurses came in their opinions about men and where to find them:

> The three women (two nurses and a clerk) also discussed the patients who come through and whether or not they're married, good-looking, etc. One of the women said "...that's what (another nurse) does -- she checks out every male patient to find out if he's single, what he does, how old he is, and she thinks she may meet her man here..." To this the other nurse said "...I wouldn't waste my time. Most of the people who come in here are real losers, and if they're not they're here because they're really sick..." (Notes, p. 338)

In actually relating to the patients the nurses appeared to be very efficient but appropriately gentle, especially with male patients, but also with female patients. As a group, they seemed to be the most cautious in allowing contact between the fieldworkers and the patients, although they also teased the doctors and male technicians when the latter were treating a female patient, especially if she were young and attractive.

Another important aspect of the nurses' relationships with other staff members concerned their desire to learn more about patient care and medical practices, treatment, and equipment. On quite a number of occasions we observed the nurses asking a doctor or a technician to explain some of the intricacies of their work.

As with any other group there was a tremendous amount of diversity among the nurses, and it does not do justice to the various individuals to treat them as if they were the same, but the patterns mentioned above illustrate some of the major characteristics shared by the majority of them.

One final note that interests us is the fact that most of the nurses, when asked why they liked working in the ER, stated that they liked it because it offered "variety and excitement". What is curious about this is that there seem to be so many patterns and procedures that are regularly employed that the routines in the ER would be similar to other units. Perhaps the difference comes in the fact that in the ER it is difficult to tell what is going to happen the next moment whereas other units in the hospital may be more predictable, and also from the fact that patients are not routinized and sectioned off according to specific medical problems.

C) The Technicians

Along with the nurses, the technicians provide much of the labor that goes into patient care in the ER. The technicians can perform all of the tasks that the nurses perform except giving medications, drawing blood, and starting IV's.

The technicians seem to maintain their closest extra-group ties with the nurses, and the "nurses lounge" is the lounge for both technicians and nurses. Most of the male technicians are fairly young (in their twenties), a characteristic they share with most of the nurses.

The technicians seem to share the nurses desire to expand their knowledge of medical practice, and when working with one of the specialists who come in to treat patients, they seem to be trying to learn as much as they can about what is going on.

D) <u>Clerks</u>

There are really two different types of clerks working in the ER, and their roles in the system are quite different.

The registration clerks are usually the first people seen by a patient coming into the ER. They are responsible for obtaining all of the necessary information about the patient, and then escorting the patient to the boundary of the treatment area, where a nurse or technician will usually take over. If a patient comes in by ambulance, one of the clerks will go with the stretcher and continue to try to get the necessary information. Thus, the registration clerks have a large amount of contact with the patients. (See section on "Registration" in Chapter V).

Because of their location on the boundary of the ER and their isolation from the rest of the staff, the registration clerks spend a lot of their time together alone. They have relatively low rates of interaction with the rest of the staff, and in fact they constitute one of the major subsystems of the ER.

By contrast to the registration clerks, the staff room desk clerks have almost no contact with patients and a much higher level of interaction with the rest of the staff. They are in the staff room almost all of the time, and they usually join in the activities of the rest of the staff. Their major duties include managing the phones and processing requests for lab and x-ray work. The more outgoing clerks take an active part in interactions with the other people who come into the staff room, like police and residents and other doctors.

Both of these roles must be filled by one person on the night shift, and a number of the registration clerks are classified for this double position. On the night shift the one clerk often moves back and forth between the staff room and the registration area, thus moving from greater to lesser contact with the rest of the staff. During the times when they are at the registration desk they often do some of the paperwork that is necessary to keep the records in order.

E) <u>Interns</u>

The interns are the only major temporary full-time members of the staff. The interns can stay for either a one-month or two-month period, but both doctors and the interns seem to prefer the two-month rotation:

> "We prefer for the interns to stay at least 2 months because it takes two weeks to orient them to the ER, two weeks to teach them ER basic medical procedures, and then they have a month to learn..." (Notes, p. 259)
>
> the intern explained that they have a choice of a one-month or two-month rotation, and he was glad that he had taken the two month option because it really wasn't until the second month that he was really able to learn very much (Notes, p. 248)

When the interns arrive they are given a two-page list of 13 major "potential goals for interns assigned to emergency department", each of which is subdivided. The interns are given a few other sets of instructions, but one of the basic ideas is summarized in one sentence:

> If you will bring to us a basic knowledge of anatomy, pathophysiology, and an awareness of people as total human beings, we will expose to you a wide variety of medicine as you will see it in practice. (from "Service instructions", p. 3)

This is along the lines of a comment from one of the doctors who said that:

> "...(the ER) is the closest thing to general practice except for the area of follow-up care. That's what makes it a great experience for the interns too..." (notes, p. 329)

The social position of the interns within the ER system is at times unclear. Their status as almost-but-not-quite-full-fledged-physicians leaves them in-between in a system whose full time members routinely deal with residents and staff physicians. Thus, they share some of the patterns of the doctors and some of the patterns of the nurses and techs.

F) Residents and Staff Physicians

Because of the tremendous number of residents and staff physicians whom we have observed in the ER at one point or another during the year, it is particularly difficult to come to any general conclusions about them, except to say that without them it would be almost impossible for the ER to continue to exist. The residents and staff physicians provide a very wide range of medical specialties, ranging from pediatrics to neurology to orthopedics, etc. One of the reasons that we have observed so many different residents and staff physicians is because the people "on call" are rotated throughout the year.

Upon entering the ER the resident or staff physician quickly looks at the charts, x-rays, blood reports, etc., and then moves directly to treat the patient in question. As a general rule it is only after the treatment of the patient that these physicians have time to relax a little. At that time they may return to the staff room for a cup of coffee and a little conversation, but their relationships with most of the ER staff (except the doctors and occasionally the interns) seem to be friendly but somewhat reserved and official.

G) Police

The ER was often visited by members of the City Police Force and the County Sheriff's Office. Most of the time the visits occurred when the officers decided to take one of their coffee breaks in the ER. It was common knowledge that the coffee pot in the staff room was available.

Such visits by the police were most frequent on the night shift, and both the ER staff and the police seemed to enjoy the exchange, provided that the work load in the ER was not heavy at that time. The visit by the police seemed to provide a break in the boredom that was often found on the night shift, and on a few occasions it appeared as if one or two members of the night staff had developed fairly close friendships with the police. The conversations during these visits ranged from discussions of sports to exchange of personal information about family members.

Some of the ties between the night shift and the police had been strengthened a few years ago when the police had come in to help deal with some groups of people who were causing disturbances in the ER. At that time they came in on a number of different occasions. Now apparently they try to get to the ER as quickly as possible whenever they get a request for assistance from the ER. In February one of the authors observed such a call being placed and the police were on the scene in 3-1/2 minutes. (Notes, p. 325).

When the officers come in for a coffee break during the evening shift, it seems to be much harder for them to get into a conversation because most of the staff are usually busy with patients or each other. In situations

like this the police would just get into a conversation with whoever was near the coffee pot.

There were, of course, times when the police came in on business, for the purpose of completing reports on auto accidents, gunshot wounds, possible suicide attempts, etc., or when they had to bring in a prisoner for treatment. At such times they would often stay for a cup of coffee.

Another type of situation which brought out the police in larger numbers was when another police officer was injured:

> As I turned the corner to go across the hall...I saw about 10 or 12 city and county police standing around the staff room door and in the conference part of the room itself. "...It must have been something big..." I thought to myself... (later I was told that) two city police had been very seriously injured in an auto accident of as yet unknown cause, and they had just gone up to intensive care about 15 minutes before. (Notes, pp. 316-317)

H) Ambulance Crews

Ambulance crews will be discussed in great detail in a number of sections below, but in this section it will be helpful to give some overall impressions.

When the crew wheels a stretcher into the ER they stay with it while the patient is being examined, and the crew tries to inform the doctor, nurse, or technician of what they know about the situation. What is interesting is that there is rarely a two-way conversation between ambulance attendant and doctor or nurse. There are occasional questions asked for clarification, but it almost feels as if the attendants are seen as having a duty to perform, namely to report on their patient, but that once this has been completed the

attendant's additional comments are probably not of value in treating the patient.

After leaving the patient, the crew usually goes out to the registration area to complete the gathering of information which the clerk might have but they don't. While at the registration desk the attendants often have helped themselves to a cup of coffee and then stayed a few extra minutes to talk to the registration clerks. The latter appeared to be the group within the ER with whom the crews interacted the most, and with whom they shared the most personal information. Conversations with the doctors and nurses were limited to information about the patients, and even that information was sometimes difficult to get across.

A somewhat reversed or inverted situation took place one night when two attendants came into the ER to find out if they had any chance of contracting hepatitis after being in contact with a patient who had it. In that situation they were speaking with a doctor and asking for his advice, but if you hadn't seen their uniforms you would never have guessed that they were ambulance attendants. The way they addressed the doctor showed the same respect, distance, and uneasiness that any other patients would have shown.

Chapter IV. THE SOCIAL SYSTEM AT DIFFERENT STATES

We have previously discussed the idea of the ER as a social system and the various roles played by the members of the staff. One of the repetitive characteristics of the system is the occurrence of various moods or states which can be determined by observing the behavior that the members of the ER exhibit.

A state is a set of circumstances or attributes characterizing a person or thing at a given time; it is a way or form of being. These states, while somewhat subjective in nature, are accompanied by specific objective patterns of interaction, which can be readily observed.

Given this definition of state, we set about to define or at least to label, these states and to describe the patterns of behavior that occur along with them.

In the course of the study we became most interested in the following: work, action, waiting, rest, quiet, joking, tension and crisis.

Our next task was observing and recording the types of behavior exhibited by the staff when the system was at each of these states. We were also interested in knowing how each of these different states related to one another and when each was most likely to occur.

Because several of these states or concepts are so closely related we have decided to discuss them together.

Work and Action

One of the interesting characteristics of the ER is the fact that the staff members seem to equate working with action. A frequent comment that we heard went along the lines of "it was nice of you to show up after all of our work is finished", (notes, p. 228). It was difficult for us not to pick up the same point of reference.

The clearest indication that the system was in this sense "at work" was the fact that almost all of the staff members were moving:

> At the time I arrived, almost everyone was moving, and it was difficult to get a bearing...I found myself consistently being passed by one person or another... (notes, p. 232)

Each staff member had a job to perform, and when the system was in action they were all performing them. At times the contrast in the jobs was very evident:

> Perhaps the most beautiful example of how the ER can function as well as of the division of labor that exists there, occurred right after the young auto-accident victim was brought in. While (the nurse) was racing around the supply room preparing the equipment for drawing blood samples on the patient, (the registration clerk) was calmly cleaning the coffee pot in the same room, (the doctor) was examining the patient, and the two techs were taking care of the other patients down the hall. (notes, p. 329)

Because of the difference in the size of the staff, it takes a lot less action to make the night shift feel like it is "at work," as in the above quotation. A corollary to this is that the night shift can be overloaded much more easily. There are simply fewer staff to handle the patient load. On the other hand, there can be too many staff members on duty:

> While watching (the doctor) at work, I looked down the hallway and was surprised to see so many staff. In addition to (the first nurse) who was standing right alongside the stretcher, I also observed three other nurses and a technician in different doorways down the hall. I found out shortly thereafter that another technician was also there that evening, making a total of six nurses and technicians. Usually there are only 4, and sometimes there have only been three. In the course of the evening I asked a number of people why this was so, and most of them said they didn't know or "...it just happened that way..." or "...that's the way the schedule worked out..." In addition, though I got similar comments from a number of people about the effects of so many staff. One nurse said, "...it's been awful... all we do is stare at one another's eyeballs... another nurse said "...I've never seen so many people in white..." A third nurse said, "...it's been a fairly slow night, and we've almost gotten to examining each other..." and a technician said "...we've been falling all over each other all night..." (notes, pp. 355-366)

After about the first three months of observation we began to notice there was a certain flow to this activity: it moved from the registration area to the staff room to the treatment rooms, and at any given point in time the different sections could be at totally different levels of work. For example, if there are no patients in the treatment rooms at the time, all of the staff except for the two registration clerks can be sitting in the staff room joking and talking while the registration area is filled with people and the two clerks are typing away madly. A few minutes later, however, the registration area will be clear of people and the registration clerks calmly chatting, while in the treatment area the rest of the staff is running in and out of treatment rooms, with an occasional stop in the staff room to give the desk clerk and order for a lab test or x-ray. Ten or fifteen minutes after that you will find the registration

clerks still relaxed, most of the other staff members in the staff room talking and joking, and the treatment rooms in a state of activity with the "work" being carried on by residents or staff doctors who have been called in, with the help of one or two of the nurses or techs. Thus, it is impossible to judge what is "happening" in the ER just by standing in one part of it and noting what is going on there.

Waiting - Rest - Quiet

Though waiting, rest, and quiet are very closely related they do differ in terms of definition. (1) Waiting - to stay in a place or remain inactive or in anticipation until something expected takes place; (2) Rest - refreshing ease or inactivity after work or exertion; the act of ceasing from work, actively or motion; quiet; (3) Quiet - making no noise, silent, calm and unmoving, still.

The important difference between the state of wait and the state of rest is that the state of wait occurs in anticipation of something expected occurring and rest occurs "after work or exertion" has occurred. Quiet occurs along with both of these states.

An important point of consideration is what attitudes in addition to behavior the members of the ER staff exhibit in each of these states. In each of these states certain behavior is more common than in any of the other states mentioned at the beginning of the chapter. These behaviors include coffee-drinking, reading, working cross-word puzzles, idle talk, sleeping, joking behavior (to be considered in detail later) and occasionally sewing or knitting. Though we have no quantitative data to attest to it, our data would seem to indicate that the behavior chosen at a given moment has a great deal to do with how much time is perceived as being on hand at that time in addition to

what state the system happens to be in at that time. For instance, if it seems that there will only be a short period of quiet during a waiting state the behaviors exhibited most are those at coffee-drinking and idle talk. This is most probably attributable to the fact that they take less time and can be ended more easily than any of the other types of behavior. If however, a long lull is anticipated, the behaviors most often seen are those that take longer periods of time to get into, and do, and are not quite so easily dropped as drinking coffee e.g. reading, working cross-word puzzles, sewing, knitting and sleeping.

> On the way back I noted that N1 was in the lounge with her feet propped up in a chair with a book in her lap...
>
> FW: "What are you reading"?
>
> N1: "Oh, (holding the book so that I could see the front) it's a book about the plight of Stewart Alsop". (She went back to the book almost as soon as she had said this--as if that was all that I was allowed to get from her tonight). (Notes, p. 178)

The one type of behavior that occurs in all of these states but changes in frequency is that of coffee-drinking. The amount of coffee consumed during a quiet period of waiting seems to be more than the amount consumed during a quiet period of rest. The amount of coffee consumed also increases as the degree of quiet increases whether the system is at wait or at rest.

> "The coffee pot was being used more than usual. There was constant traffic back and forth from the coffee pot...This to me was an indication that the evening was unusually quiet." (notes, p. 179)

There also tends to be more physical activity during a period of waiting than during a period of rest. The fact that a period of rest usually comes immediately following a period of exertion (e.g. a heavy case load) when the staff members' energy has been expended is more than likely a contributing

factor. The other contributing factor is that during a waiting period more coffee is consumed thus more activity.

The last thing we wish to turn our attention to in the Wait-Rest-Quiet group is the idea that there are various attitudes displayed by different members of the staff toward the state of quiet. By most of the staff a quiet staff is regarded as something to be tolerated (time passes quickly when one is busy):

> Nurse: You keep coming here and staying even when it is quiet like this. I don't know how you can stand it. I think that I would have to go home and come back some other night if I didn't have to stay here." (Notes, p. 189)

However, there were several occasions on which one or another of the staff members expressed appreciation for a little peace and quiet.

> One of the technicians came into the lounge to find the doctor who was on duty that night so that he could fill out the chart on a patient:
>
> Doctor: "I knew it was too good to be true." (Referring to the peace and quiet that he had been having the last hour or so.) (Notes, p. 183)

In the final analysis the conclusions that we came to in regard to the states of wait-rest and quiet was that generally the staff members exhibit waiting behavior only if the time period between one heavy work period and another is at least an hour long. Otherwise, resting behavior tends to be exhibited and quiet occurs along with both states.

On the other end of the spectrum, we concluded that one can tell how busy the ER is by how many components of the system (staff members) are activated.

Joking

In the previous section we made mention of joking behavior as one of the behaviors often exhibited by members of the staff during periods of wait and/or rest. However, because this behavior is also exhibited in most of the other states we thought that it deserved special attention.

Because joking behavior is so closely related to the states of anxiety and tension and crisis we have decided to include these topics in this section.

To joke is defined; to jest, to speak in fun, be facetious, to tease. Given this definition and realizing that "...humor is an expression of the collective experience of the participants and receives response only from those who share common concerns". (Coser, 1965: 296) We examined joking and humor in the ER. In the case of the ER staff, the common concern is coping with whatever state the system happened to be in at a given moment; wait, rest, boredom, tension, crisis or anxiety.

When the system is at wait or rest, we have often noticed that along with the behaviors discussed earlier in this Chapter, joking behavior is exhibited, and it appears to be a function of boredom during these periods. Many times when the tempo of the ER slows down to the point of boredom, joke telling or teasing sessions ensue. Occasionally practical jokes are played. This account from our field notes:

> ...Before this conversation took place Paul and I had left to go upstairs and make some copies of records that we planned to use in our work. As we finished talking D3 came and found a tody roach on the counter by the telephone. This was a roach that T4 used to play jokes on the staff, especially on T5 who is a woman. (Notes, p. 47)

In addition to serving the purpose of passing time or relieving boredom associated with the states of rest or wait, we found that joking and teasing are used as a means of coping with the tensions and anxieties in the ER.

"One important social function of humor, involving as it does the very physical relief of laughter, is to manage tensions in situations involving strain." (Bredemeier, 1962, p. 158)

We have noticed that the most tense moments in the ER seem to occur either when the system is extremely quiet, when it is extremely busy or when there has been some disagreement among the staff members. Inevitably one of the ways that the staff deals with this tension is by the use of joking or teasing behavior, which occasionally takes the form of flirting between the staff members.

One instance where joking or teasing seems to relieve tension when the system is in a lull is shown in the following account: This particular technician was about to show the female member of our team where a copying machine could be found

> Technician: "What's everybody grinning about?"
>
> Receptionist: "We just don't want you to get stuck in the elevator T2."
>
> At this, the rest of the staff chuckled and T2 turned an even darker shade of red. (Notes, p. 77)

On the other end of the spectrum during highly tense periods that are the result of an extremely heavy caseload, a crisis (severe case e.g., severe injuries or critical illness) or a death or possible death, Freud once observed that humor serves as a means of allaying anxiety. It is

in relation to this notion that the use of joking behavior becomes most interesting. Often in situations when a patient comes in with injuries so severe that death is possible, references to the patient will be made in a joking manner. For instance, a woman who had a head injury from being hit with a brick might be referred to as "Miss-brick-in-the-head" during her stay in the ER. Or if someone dies in the ER from a myocardial infarction the staff might refer to the patient by calling him "infarc." We might add at this point that referring to a patient in this manner in no way shows disrespect for a patient or his condition on the part of the staff. Joking references of this type seem to make potentially difficult situations easier to cope with.

In summary, joking behavior is used by members of the ER as a means of making the tensions and anxieties that exist in the ER problems with which they can cope.

In the next chapter, we will turn our attention to some of the basic procedures used in the functioning of the Emergency Room.

Chapter V. PROCEDURES

In this Chapter we will turn our attention to some of the basic operating procedures that are necessary in the day to day functioning of the ER.

A procedure is defined as a set of established forms or methods for conducting the affairs of a business. However, rarely are the formally stated rules of procedure followed to the letter by any organization.

> "...The working organization is a product of the interaction of both formal and informal patterns of behavior..."
>
> The informal structure is best understood as composed of patterns that develop when the participants face persistent problems that are not provided for by the formal system. (Broom, 1968:196-201) (See also Blau)

The ER is no different in this respect. There are formal policies for most procedures but most of the procedural steps are amended from time to time to fit the particular problems of the immediate situation. What follows in this Chapter is a description of some of the most frequently used procedures as we saw them.

Registration

Unless a person arrives by ambulance, the registration desk is the first point of contact with the ER. The registration desk is staffed by two people on the day and evening shifts, and one person on the night shift. During lunch time a woman who works in the outpatient department fills in for the registration clerks in turn as they go to lunch so that there will always be two people at the desk.

Each registration clerk has a typewriter on his/her side, arranged so that if both clerks are operating their machines at the same time they will be facing one another. As soon as a person walks in the door one or the other clerk will turn on the typewriter, ask "may I help you?", and puts a medical chart into the typewriter, all in one continuous movement. If the patients is alone or is not able to convey the information, the clerk proceeds to get all the necessary details from the individual. These include name, address, phone number, place of work, nature of injury, whether or not the patient is allergic to any drugs, and the name of the family physician if known. The patient is also asked if he/she has a Hospital Outpatient Card and a medical insurance card. The outpatient card is a plastic credit-card-like object on which are stamped the patient's name and Hospital I.D. number:

> Every patient must have an outpatient card and if they didn't have it with them or if they were new patients (the clerk) would make it for them right there. The clerk showed me the machine used for punching the cards. (The clerk) would look up the patient's name in a massive computer print-out list and if they already had an outpatient number he/she would just use the same number. This card was used to identify all reports, requests for lab-work, etc, so that there wouldn't be any mixups. (Notes, p. 228)

If the patient is too sick to talk, but can safely wait, the clerk will get the information from whoever comes in with the patient. If the patient is in need of immediate attention, the clerk will take them back to the treatment area and either get the information from those accompanying the patient, or, if the patient is alone, will get the information from the patient as soon as possible in the treatment room.

When the clerk takes the patient to the treatment area she/he hands the chart to the nurse or technician most available. If the chart is not completed yet, the clerk will go with the patient to the treatment room.

Any relatives or friends who come with the patient are usually asked to wait in the waiting room and help themselves to a cup of coffee if they want to. When we first began the study, visitors were not allowed in the treatment area, but occasionally an exception was made. However, in January we learned that the outpatient department had changed the regulation:

> as part of their program to improve public relations (from text of Outpatient Department memo). The New Rule, which came complete with a sign on the wall, read "one relative or friend is allowed in the treatment room only with approval of attending physician." (notes, p. 86)

Although the old rule had been violated at times when the attending physician believed it to be justified, the doctors apparently did not like the new rule either because it made it more difficult for them to refuse to let a visitor in the treatment room and thus reduced some of their dicretionary powers. In the months following this change, though, we did not often observe any visitors in the treatment rooms, so apparently most patients themselves decided that they would rather not have visitors.

When the patient comes in by ambulance, the registration procedure is different (see section on ambulance cases below). One of the registration clerks will take a chart with them and go right to the ambulance stretcher. They ask the individual patient the necessary questions if they can speak, and also try to get information from the ambulance crews, who are most often standing there trying to get very similar information for their forms. If the doctor is already examining the patient, the doctor will often ask the questions to which the clerks need answers in addition to their own questions about the patient's chief complaint. Thus, the doctors really are able to help the clerks with their jobs. If the doctor orders that the stretcher be put into one of the treatment rooms immediately, the clerk follows and gets the information as the nurse or

technician with the patient asks the questions. If the patient is unconscious or unable to speak, the clerks try to get as much information as possible from the patient's wallet or purse.

The importance of this registration process to the ER and to the hospital in terms of economic and records factors, was reflected in the comments of one of the doctors after examining a patient who had arrived DOA:

> At that point (one of the techs) came in and asked the doctor if he was going to talk to the family. He said "yes, in a few minutes." Then he turned to me and said, "we usually wait a few minutes before telling the family that someone has died so that the girls out front can get the necessary information before the family might have a bad reaction to the word of the death." (notes, p. 298)

Admitting

The following outlines of the admitting procedures is outlined from the hospital procedure manual.

A patient is considered as being admitted as an inpatient when all of the following steps have been taken. The absence of any one of these steps shall eliminate the patient from being considered as an inpatient:

1. The assignment of a case number.
2. The assignment of a room -- the admitting department assigns adult rooms. The Head Nurse in pediatrics assigns in that department for the day shift. Pending deliveries are assigned an 8000 number and only receive a room number after delivery.
3. Implied or expressed consent of the patient -- if the case is an emergency condition (a condition in which loss of life or limb is immediately threatened) a verbal consent is sufficient. If the patient is unable to give verbal consent the fact that the patient is present at the hospital signifies that consent is implied. If the case is an elective admission, the patient must sign a consent form.

Care of Dead

In the event of a death in the ER or of a DOA (Dead on arrival) the ER personnel is responsible for draping the body and transporting it to the morgue. The following steps outline the steps that we have seen.

1. The technician prepares the body by undressing the body and putting the clothes and other belongings that were on the body in a plastic bag.
2. The body is then covered with a white, disposable cover.
3. The technician then gets the information that is needed for the toe tag. (Name, cause of death, etc.) He then puts this tag on the great right toe.
4. The physician responsible for signing the death certificate. (He has the authority of examiner.)
5. After the body has been prepared, it is then taken to the morgue until the family is able to make arrangements -- unless a postmortem is seen as necessary.

Codes

The word code when used in the hospital can refer to a number of different types of situations depending on the number that follows the word code. The one most often referred to in the ER is a code 33. Code 33 is used in the event of a life or death situation. In all of the months that we spent in the ER only one of us got to see a code, so our observational data is lacking in this area. Quite often the case was that we would arrive in the ER only to have the staff tell us that we had just missed a code.

Basically, according to reports, what occurs when someone in the ER shouts Code 33, other not so urgent business is dropped and the staff reports quickly to the patient's room. There they take whatever measures necessary to bring the

patient through the crisis.

Codes are used on the public address system instead of saying "Mr. X is dying" so that only the staff will know that the crisis situation exists, thereby eliminating the possibility of panic in the hospital.

The arrival of an ambulance is usually preceded by a call from the ambulance over the two-way radio located in the staff room. The call usually consists of the age and sex of the patient, a brief description of the injury or complaint and circumstances surrounding the incident, conscious or not, blood pressure and pulse, whether or not the vehicle is travelling on emergency status (lights and sirens), and approximate time of arrival. The call is usually taken by a nurse or technician, or by the staff room desk clerk.

If the case is not a serious one, the staff simply waits for the stretcher to be wheeled in through the double-door entrance. The doctor on duty will then come out to speak to the patient as soon as possible. If, on the other hand, it is a serious case, one or more of the nurses and techs will wait for the ambulance at the tunnel entrance to provide assistance to the ambulance crew or directly to the patient. When it is a serious case, the doctor on duty is alerted and he usually waits for the stretcher just inside the double door or in the doorway of the staff room. He can thus begin the process of examination and treatment immediately.

The ER staff have to rely upon the ambulance crew for some sense of the seriousness of the case, but we learned on the very first night of observation that the staff:

"usually take comments from ambulance drivers with a grain of salt since they're not trained diagnosticians. If you ever hear us laughing at the information coming in over the radio from a driver it's not because we don't care -- it's just that they really don't know. Like the woman tonight, the accident victim. The ambulance crew called in and said we should be ready to ger her heart going again if necessary, but we could tell from their description that she had massive brain damage and would probably come in DOA or, if not, then she'd be a vegetable. I wouldn't hesitate breaking my ass for a serious case, but I knew there would be nothing we could do for this one." (comment from nurse) (Notes, pp. 224-224)

In the months that followed, we observed the staff treating the cases seriously, but often getting quite a laugh over the information that came in over the radio.

Because the ambulance belongs to a private firm and is not connected with the hospital, one of the major concerns of the crew (in addition to information as noted above) is to retrieve all of the equipment that belongs in their vehicle. Thus, as soon as possible they try to collect their blankets, sandbags, stretcher, boards, and anything else that was used on the patient. This requires moving the patient from the ambulance stretcher to one of the ER's, and we often wondered if anyone was even injured in the process of being moved. The ER staff and hospital crews do their best to be careful, but it always looked like an awkward procedure.

The non-emergency cases that come into the ER often consist of minor injuries which did not require immediate attention. However, the ambulance company is required by contract it has with the county to respond to all calls, and since it is subsidized and covered by health insurance one of the doctors believes that people:

"call an ambulance instead of a taxi-cab because it's cheaper for them. Only you and I pay for it in the long run." (notes, p. 39)

Thus, the arrival of an ambulance does not by itself indicate that an "emergency" has arrived.

Change of Shift

One of the times at which it is sometimes difficult to get a bearing on what is happening in the ER is at the change of shift. There is an overlap of about 15 minutes when the shifts change, and during that time the staff members themselves try to get a bearing on what has been happening. If the treatment area has been relatively quiet up to the time of the shift change, the transition is usually quite orderly. However, if there are a number of patients being treated at the moment, the exchange of information must take place on the run. And if there are some serious cases being worked on, especially if there is a patient who was just put in Room 1 (see section on rooms below), the shift coming on will begin to work right away along with those going off duty, and the latter will stay until things have settled down a little. There were a number of times during our observations when the change of shift occurred at exactly the right moment to get some badly needed people in to help with the work.

The exchange of information takes place in the form of an informal "report", with each group of workers passing on the appropriate information to their fellow workers on the next shift.

> A nurse said that there was no "formal" process involved but that one of the nurses (and it varied from day to day) always told the night nurse about any patients who were being seen at the time the shifts were changing. She also told me that the slanted chart board provided an immediate picture of what was happening at any given time since it showed which patients were being seen and which ones remained to be seen. (Notes, pp. 29-30)

In addition to summarizing the current state of events in the ER, the informal report usually contains information about what kind of shift the previous one has been, highlighting the unusual or serious cases and in general giving a flavor of the previous eight hours.

A similar type of information exchange exists for the doctors, but theirs usually takes place a little later and often takes place inside the doctors room.

The language used in the doctors' informal report tends to be more technical than that utilized by the nurses.

The staff room desk clerks have a similar kind of reporting system, one which was made "formal" in February:

> I noticed a memo from the (chief clerk) stating that beginning February 21, 1974, all of the reception clerks are to give a formal report to the people working the next shift, indicating the types of patients in at the time, lab work that was in progress, things that might have to be done immediately, etc. I asked (the desk clerk) about the memo, say "...is this something new?..." and she said "...yes, the memo is new but what it talks about really isn't. We've been doing this all along. You know, you really have to so that people coming on duty know what is happening, what has to be followed up, what might have to be done right away, it's something that we just have to do. The memo just makes it official policy..." (notes, pp. 122-123)

Once people have been informed about what is happening and what has happened, and providing there is nothing going on which requires their remaining, the shift going off duty begins to leave, the doctors are usually the last to leave because their exchange doesn't take place until some time after the rest of the shift has changed.

Another practice that leads to some continuity is that when the interns are on a certain schedule, there is an overlap of about two hours during the late afternoons, when activity tends to be a little higher in the ER. On these occasions, having the two interns there can help take some of the pressure off the doctor in charge.

In this Chapter, we have given brief descriptions of a few of the procedures used most often in the ER. These procedures are essential to the smooth functioning of the system as it goes about the business of processing patients through the ER and either back into the outside world or into the hospital community.

In the next chapter, we will discuss patient categories.

Chapter VI. PATIENT CATEGORIES

In this Chapter we will discuss various concepts or categories which refer to certain types of people or cases seen in the ER. Some of these terms are employed by the staff members themselves in describing patients or cases. Others are terms we have used to name certain patterns that we have observed.

Accidents

The definition of accident is-- a happening that is not expected, foreseen, or intended. However, after being in the ER for a while we realized that this was not exactly the definition of accident that the ER staff uses. When the staff refers to an accident, unless they specify otherwise they are usually referring to an automobile accident or a "Big Crunch" as they call them. When the system is in a lull it is not uncommon to hear the remark "What we really need now is a big crunch," indicating that if they did get one things would pick up for a while at least. It is interesting to note that some of the staff would have rather had a big crunch in order to keep them busy than have to figure out how to kill the time while they are on duty--after all you can only clean a room so many times.

This area cuts across several of the other areas that have been covered in this paper, for instance tension. The handling of a "big crunch" is one of the times when tension is seen as being a negative state.

> As usual when I got settled, the staff told me that I should have been there the night before because the ER was packed to the walls with bodies. There had been several accident cases brought in that had kept the staff busy for quite a while. (Notes, p. 80)

Usually when the staff told us about a night like this, it was with a certain amount of excitement. They thought that we had always come at the wrong time, because to them these were the "real emergencies".

Real Patients and Real Emergencies

The use of these two categories by the staff members illustrates the fact that the ER staff deals with many cases which are not medical emergencies, and that some of the people who utilize the facilities and services of the ER do not really need them, or at least are seen by the staff as not needing them.

There are a number of different types of people who would not be classified as "real patients". Among these are people who come to the ER because they are drunk and need an excuse to get out of work or who need someone to help them deal with their hangovers. Another type are basically described as being hypochondriacs:

> "There's nothing medically wrong with them, they just have a little ache here or a little pain there and want some attention." (notes, p. 23)

Also included in this group of people who just want attention are some older people who live alone and have no one to talk to. A third group includes those people who for one reason or another do not have a private physician of their own and thus turn to the ER for treatment. These people are viewed in different ways by different staff members. To some, they are just "too lazy or too stupid to get their own doctor", whereas to others they are "the people whom the rest of the medical system misses. They simply do not have access to the kind of medical services that you and I expect". (notes, p. 276)

As for the category of "real emergency", we never really discovered any clear-cut rules for using the term, but there seemed to be two levels of use, both defined in terms of the specific behaviors involved. The first indicator seems to be whether or not the doctor on duty is the first person to conduct the

medical examination. Thus, ambulance cases arriving on "emergency status" usually are first examined by the doctor. In addition, certain "walk-in" cases are treated that way (for example if a person passes out in the registration area or is bleeding heavily).

The second level of the definition comes after the initial examination, and its operational characterization involves placing the patient in Room 1, where the most serious cases are treated (see section on rooms below). Almost every time we were told about a "real emergency" that had been treated earlier in the day, it was a patient who had been treated in Room 1.

Repeaters

There is a category of patients who are called repeaters -- because they repeat or are seen in the ER repeatedly. There are several reasons that a patient might be seen in the ER 'regularly': 1) chronic illness; 2) attempts to get drugs; 3) and sometimes just to have somewhere to go.

The first of these reasons is self-explanatory. The second reason concerns a small number of people who come to the ER and report various symptoms simply in an effort to obtain narcotics for which they need a prescription. These people will be described in the section on drugs in the next Chapter. The third reason relates to the fact that the ER becomes, for some people, a place to socialize. These people do not have any "emergency" symptons, and they are thus not what the staff would call "real patients." The staff knows most of them and usually humors them -- after all they have to pay for the treatment or examination. Many of these repeaters who seem to be seeking company are older people or people without family. There was also an alcoholic who at least once a week came into the ER to get some coffee, spent a couple of hours

hanging around in the waiting area and then left.

For the most part, the attitude of the staff toward these people is one of amusement--unless the person causes trouble. In fact, there are certain times when they actually expect to see certain of the repeaters and when they don't one of them would remark, "Gee, we haven't seen ______ in a while. I wonder what's happened to him? In essence, the staff deals with these people as just another part of their life in the ER and fits them comfortably into the rest of the pattern.

Other Definitions

There are a few other definitions used by the staff to refer to patients . These are discussed in this section.

One of these is the notion of the "good patient". It is generally used to refer to a patient who does not cause any trouble, does not complain, and accepts the reality of his/her situation. The term is most often applied to older people:

> "The old people are the easiest to deal with. They rarely give us a hard time. I guess they just sort of accept what has happened to them". (comments of a registration clerk, notes p. 291)

"Medicaid patient" is a general term used to refer to people whose treatment will be covered by the Medicaid program. Some of the staff see it as a license to get unnecessary treatment:

> "There's an old gent back there who was a Medicaid patient in Missouri and Florida and now in Michigan too. He injured his back six years ago and now wanders into an emergency room once in a while to have it checked". (comments of a doctor, notes, p. 262)

A third category which is not used overtly by the staff but which is nevertheless real is the notion of patient as object. (Bloom, 1965: 58-60) This occurs, for example, when a doctor is trying to explain some point of medical practice to another staff member, and a patient is used as a case in point. It is even clearer when a patient is unconscious or deceased:

> Once it was certain that the man was dead, almost everyone in the room relaxed a little, and the staff acted as if he was no longer human. (A nurse) asked (the doctor) to show her what to look for in the man's eyes to tell her how long the heart had not been functioning, and (the doctor) demonstrated on the man. (notes, p. 297).

Another example of this is the use of parts of the body rather than peoples' names in referring to them, like "take the hand down to the x-ray room". (notes, p. 329).

The final category of patients is that of "suicides". Drug-related suicides and suicide attempts will be discussed in the next Chapter, but here it is appropriate to describe some other aspects of the concept.

There are no specific procedures related to the treatment of suicides and suicide attempts, but there are a number of behavioral characteristics shown by the staff members when treating cases of this type.

The first class of these were verbal and non-verbal expressions of revulsion at the thought of someone trying to kill himself. Related to this is the pattern of assuming that such a person must be psychologically disturbed, together with the attempt to interpret other known facts about the patient in terms of emotional illness. For example, one time a female patient was brought in with a self-inflicted gunshot wound, and when it was discovered that she had burn scars on her body, it was assumed by the ER staff and the consulting physicians that these too, must have been the result of self-inflicted injuries.

These reactions are very similar to the typical reactions of members of our society to the idea of suicide, but they seemed to us to be a bit "out of place" in a medical setting, whose major concern is the well-being of the patient.

Chapter VII. ARTIFACTS AND SOCIAL SPACE

In this Chapter we will describe some of the physical characteristics of the Emergency Room and the implications these have both for the staff and for the patients who are treated there. It is important to note that in the perspective of the social scientist a room or location derives its meaning from the overall cultural context in which it is located and from the use made of it by people (E. Hall, 1966; Sommer, 1969).

We will also describe some of the "artifacts" found in the ER. An artifact is a tool or object which derives its meaning from the use made of it by the members of a cultural group.

The Rooms

The "emergency room" actually consists of six treatment rooms, in addition to other offices and work areas. Each of the treatment rooms has some special characteristics that go with it and which define in some way the patients who occupy these rooms. By knowing the criteria used in assigning patients to rooms, one can predict what room a given patient will be placed in and, working the opposite way, by knowing what room a patient is in one can usually conclude some things about the type of patient. An example of this took place one evening:

> At one point I had just walked into the staff room from the reception desk...and one of the techs asked "are they typing up anything interesting out there?"...When I told him that there was a nine year old girl with a possible wrist fracture he turned to (another tech) and said..."what do you think? Should we put her in 4 or 5 (referring to room numbers)...? after which they talked about it and figured out that she'd probably go to Room 5 (which is where she was eventually put). (notes, p. 277)

Directly across the hall from the staff room door is the "Eye Room", which is used for treating eye, ear, nose, and throat injuries which do not require surgery. It is the smallest of the treatment rooms, and it is especially equipped with lights and instruments for dealing with these kinds of cases. If there is a heavy influx of patients this room can be used for other types of cases, but it is not equipped for cases which might require surgery or other serious procedures.

Right next to the staff room is Room 1, which is used for the most serious cases which come into the ER. It is here that the true "emergency" cases are brought, for example, seriously injured auto accident victims, serious gunshot wounds, heart attacks, head injuries, etc. This room more than any other internal

characteristic defines an individual as an "emergency". The room is well equipped, it is close to the supply room and staff room, and there is plenty of floor space for specialized equipment that might have to be brought in (like the portable x-ray unit or an oxygen system). It is in this room that one is likely to find the largest concentration of staff people working on any one patient. One night, for example, a young boy was seriously injured in an auto accident and there were a total of ten medical personnel around his bed at one time, six of them working directly on him and four people watching.

Rooms 2 and 4, which are directly across the hall from one another, are usually used for male patients. There are three beds in each room, separated by curtain dividers. In both rooms the bed closest to the door is reserved for surgery, and all of the supplies necessary are kept on that side of the room. Rooms 3 and 5, which are next to rooms 2 and 4 respectively, are usually used for female patients, and again the bed closest to the door is reserved for surgery. It is supplied in much the same way as Rooms 2 and 4.

The basic descriptions of room usage presented above are the standard operating procedures, but if there is a heavy influx of people the usage patterns can be changed around. For example, if there are no surgery cases in the ER and beds are needed to deal with other types of patients, then the beds normally reserved for surgery cases will be used.

Another important room is the supply room, which is located directly across from Room 1. Most of the drugs and supplies needed in the ER are kept here, and the most heavily used items are replenished each day. Special items which are not kept in the ER (such as certain types of sutures) can usually be obtained from other areas of the hospital.

Although the staff seems to be utilizing the space available in an efficient way, two problems were noticeable. First, the hallway became very congested when a number of ambulance cases were coming in at the same time. There simply was not enough room to maneuver. Second, the fact that there is only one entrance to the treatment area sometimes hindered the flow of traffic.

Equipment

One of the aspects of the ER that surprised us was the number of non-medical items which play an important part in how the ER functions. Some of the medical supplies will be discussed below, but in this section we focus on the major pieces of equipment that are used.

In the registration area, the two most important items seem to be the electric typewriters and the machine used for punching the outpatient cards that are attached to the medical chart during the patient's stay in the ER. Also present in this area are wheelchairs for use if needed, and a large coffee pot, for use by patients and visitors.

Moving to the staff room there are a number of important pieces of equipment. Closest to the registration area is the desk at which the staff room desk clerk works, and there we find a machine used to imprint the patient's name and I.D.# on all laboratory request forms and x-ray forms. Along the top of this desk are a number of phones, one used for regular calls, and one used only for outgoing calls to physicians.

In front of this desk is the Consultation Room, and in this area we find the large coffee pot used by the staff, some lounge chairs, and a lighted panel used for reading x-rays. On the wall is a large blackboard upon which is placed the list of consulting residents and staff physicians, as well as a list of all

patients admitted to the hospital (and their room number when known) since the morning shift.

On the other side of the staff room are more phones, one of which is a direct line to the laboratory. Also on this side of the room is the slant board upon which all medical charts are placed while the patients are in ER. In the corner of the room nearest the hall is the main part of the heart monitor machine, which allows the staff to keep track of whoever is being monitored on the portable unit.

The rest of the items in the staff room consist of the charts and forms needed in carrying out the paperwork, pens and writing equipment, prescription forms, etc. At any given point there are also likely to be ashtrays full of half-smoked cigarettes, and half-empty cups of coffee. In addition one can often notice a newspaper or other reading material near the desk, used by the staff when things are "quiet".

Drugs

There are three major categories that can be placed under the heading of drug and/or drug related behavior. They are: (1) drugs used by the hospital (ER): (2) Drugs used by the patients: and (3) The concept of overdose.

1) Drugs used by the ER. This category can be broken down even further into two sub-categories: a) Medicines used by the staff for treatment of patients and b) coffee (caffeine) used by the staff as a stimulant. The second sub-category was a very interesting one because it became apparent after observing in the ER that there was a definite relationship between the amount of coffee consumed and the mood state that the ER happened to be in at the time. For instance, when the ER was at rest or in a state of waiting, the coffee

consumption increased noticeably. The description below is similar to others made many times in the course of our observations:

> The staff room was crowded. Everyone was standing around talking to one another and drinking coffee.

Sometimes it looked as if the staff was afraid that they would go to sleep if they didn't drink coffee.

2) Drugs used by patients. This category can be broken down into two sub-categories also: a) those used by patients in the treatment of an illness and b) those used in some type of illegal or unethical act e.g. selling, etc. In the second sub-category, one could place people who come to the ER feigning illness in order to obtain drugs for their own use:

> The young man was very thin and was using a cane when he came in. 15 talked with him for about fifteen minutes and then he got up and went to the staff room and then returned with a prescription pad. He took a seat next to the young man and wrote a prescription for him. ...The young man left. After the room was empty, I asked R2 and R3 why they had looked at each other the way that they had when he had first come in the front door. They said that the reason they had looked that was because the young man had already been in the ER twice that day. They said that he had been there for a prescription for Valium because he had been shot in the leg several months ago and suffered a lot of pain. ..."How true his story is I don't know." (notes, p. 94)

In all likelihood, the man's story was not true because he had made three trips that day for a prescription for Valium -- a prescription that ordinarily would last for two weeks. This sub-category could also include those "patients" who come into the ER feigning illness in order to obtain drugs to sell. One of the doctors told me of a husband and wife that had been working all of the Emergency Rooms in the area. The wife would pretend to be ill, get the drugs, and then give them to her husband who was a bartender. He in turn had quite a lucrative "under the counter" drug business at his bar.

3) Overdose -- This category can be divided into two sub-categories: a) real and b) fakers. The most important aspect of this category is the fact that in observing the doctors handle the overdose cases that came into the ER we noticed that they usually could tell in the first few minutes after seeing the patient whether or not he was faking. And, most of the time if the patient was faking and the doctor realized it the reaction of the patient would be one of indignance at having been discovered.

SUMMARY

In the last five chapters we have described in detail the roles, states, procedures, categories, and artifacts found or used in the Emergency Room. Each of these is a significant aspect of the social system of the ER, and each lends support to our basic conceptual framework.

It is time now to return to this basic framework and try to summarize our notions of the Emergency Room as a social system, and to describe its relationship to the other social systems in its environment. These are the goals of the next chapter.

Chapter VIII. THE EMERGENCY ROOM AS A SOCIAL SYSTEM

During the seven months of the research we came to develop a more formalized statement of what we meant by the notion of the Emergency Room as a social system, and we learned a great deal more about how the Emergency Room fits into the larger social system of the hospital and the community.

The working definition of a social system that we used was as follows: a social system is a set of ordered roles, relationships, and activities specifying reciprocal relations of interacting human beings either as individuals or groups.

In the preceding five chapters we have attempted to describe in detail the components of this social system. We have shown how the major characteristics of social systems --patterned interactions, formalized procedures, recurring states, etc. -- can all be observed in the Emergency Department. And we have demonstrated that the Emergency Room must be seen as an open-ended, repetitive, interdependent social system.

In addition to this analysis of the internal characteristics of the Emergency Room, the image of a social system is enhanced by observing the relationships between the Emergency Room and the larger social system of which it is a part, and it is to this task that we now turn.

Specification of the Model

The simple understanding of the Emergency Room with which we began this study, as shown in the model presented in Chapter II of this report (Figure 1), quickly had to be discarded as we learned more about the Emergency Room and

its relations with other social systems in the environment. The revised model which we developed from our field observations is presented and explained below (see figure 2).

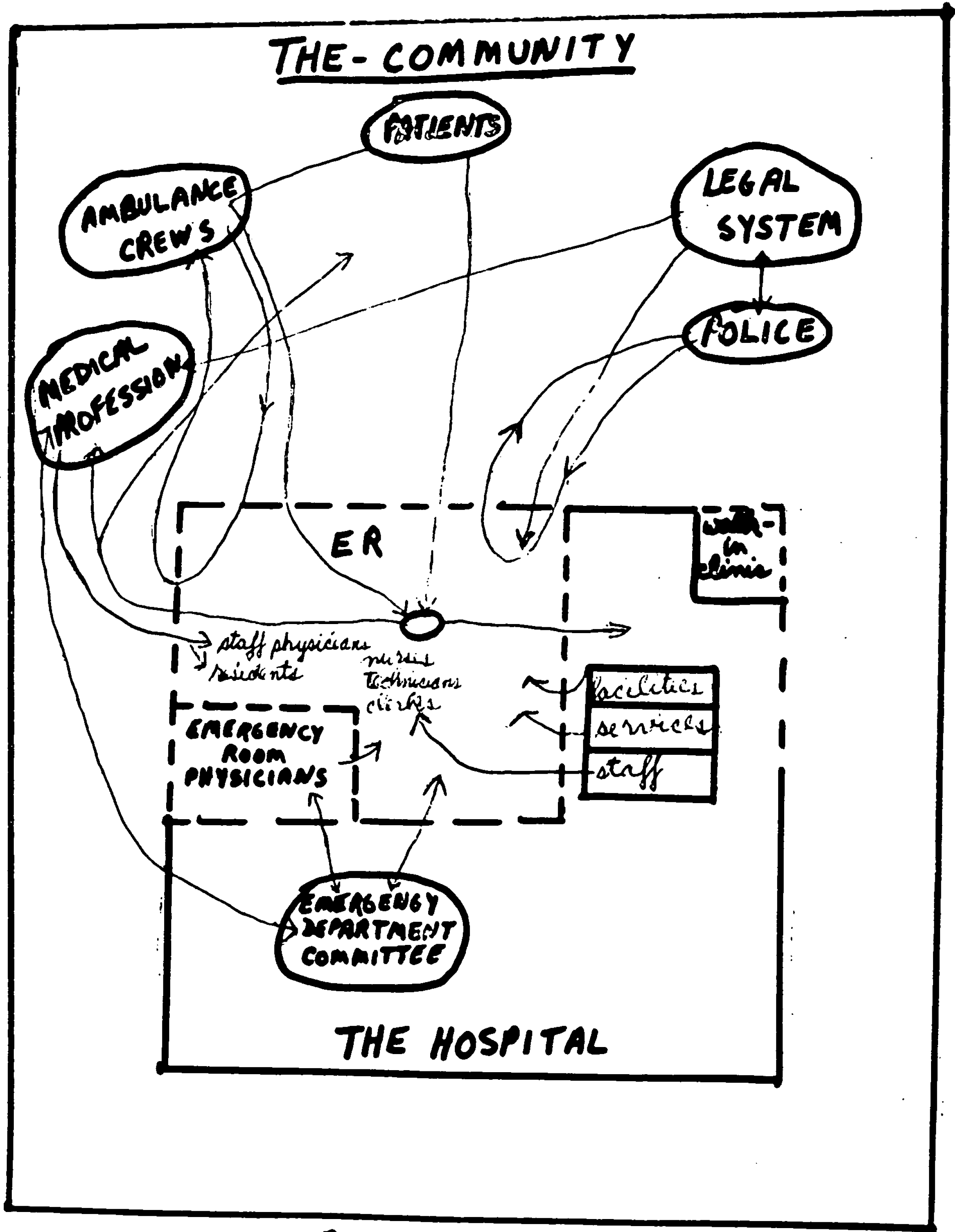

FIGURE 2

The Emergency Room in the Community

The Emergency Room does not exist in a vacuum. It is in a community and it interacts with that community in a number of important ways.

First of all, the community provides the major input to the system: patients. The flow of life within the community influences the flow of "work" into the system by affecting the types of patients who will come to the emergency room. For example,

> "Early spring tends to bring a large number of motorcycle accidents because a lot of people have been sitting out the winter and as soon as the weather gets nice they want to go out on their bikes, and they forget that they haven't riden for awhile--that they've lost their touch." (notes, p. 314)

The staff has its own understanding of the workings of the community, and how this affects their work. Various times of the day and week are labeled in terms of how they affect the ER:

> "Sunday mornings are usually pretty quiet until about 10 A.M., when we get a lot of older women who have hurt their backs on the way to church, or else people coming in just because they're out of the house and near the hospital" (notes, p. 330)

Another facet of the community which affects the types of patients is the economic sphere. Because the ER fees are not based on ability to pay, the patients that come in are either people who can afford the fees themselves or people on Medicaid. For those people in the community who do not fall into either group, the ER is not a very real alternative. Last fall the Hospital finally opened a walk-in clinic that is open in the evenings, and this has helped to provide some service for this middle group. However, there have been some published reports that the doctors in the ER opposed the walk-in clinic because of the effect it might have on patient loads in the ER (Michigan Free Press Weekly, March 20, 1974).

There are two occupational groups in the community who become regular actors in the ER on occasion, namely the police and the ambulance crews in the area. As was noted above, both of these groups play important roles in the daily life of the ER, and they provide a direct link between the ER and the community.

One of the responsibilities of the police provides a point of contact between the ER and another important system in the community, namely the legal system. In addition to treating police cases, prisoners, and accident victims who must be questioned by the police, the ER comes into contact with the legal system through a number of other types of situations. There are very specific laws and practices that relate to the treatment of minors, 'rape cases', certification of death, the "unconscious patient", and accident victims. Each of these situations has a body of written and unwritten rules connected with it, and the doctors in the ER are very much aware of them:

> "You know, about two-thirds of what we do in the medical profession is dictated by the legal system. We have to be careful about everything we do, to make sure that it is legal. Sometimes it seems as if the groundrules of medicine are made by lawyers." (notes p. 354)

Another part of the community which obviously has ties with the ER is the medical profession. Contacts must be maintained with the physicians who treat patients after their visit to the ER, and the relationship is even more important if the particular doctor is also on the specialty staff of the ER. More indirect but nevertheless real influence can be exerted by the County Medical Association and the Hospital Administration itself.

The Emergency Room and the Hospital

We have noted at various places in this paper that the physicians who run the ER have formed a private cooperative practice and have a contract with the

Hospital Administration by which they run the ER and the hospital provides the facilities, services, and other staff. What this means, in effect, is that the Emergency Room Physicians form a private corporation in semi-public space, the Hospital.

The ER is administratively placed in the Outpatient Department, and most administrative details are handled through that department. In addition, there is an Emergency Department Committee which operates as the liason body with the Hospital, conducts an evaluation of service in the ER, and maintains administrative control over the other ER staff.

Because of the contractual relationship between the Emergency Room physicians and the Hospital, some of the above matters can become critical at the time of contract renewal. This is especially true of the evaluation of services study conducted by the Committee. It is interesting to note that this evaluation is made by the physicians outside the ER to whom individual patients have been referred, not by the patients themselves.

The ER is dependent on the Hospital for the provision of services and supplies, as well as for maintaining the staff of the Emergency Department. This administrative structure creates one major source of possible strain in the system in regard to the ER staff. Although most of the nurses, technicians, and clerks have very strong loyalties to the Corporation and to the Emergency Department, largely a product of their working together in many tense, emotional situations that occur in the normal operation of the ER, there are certain issues on which the staff will use its association with the Hospital in opposition to the doctors of the Corporation. Such issues as pay, hours, division of labor, and responsibility of various tasks, can bring this conflict out in the open and disrupt the close personal ties among all of the staff that seem to maintain the smooth, efficient operation of the ER.

In addition to this structural characteristic of the ER itself, it is dependent upon the X-Ray Department and the Laboratory for the provision of critical services. When there is an overload in either of these key service departments, the flow of work in the ER can be drastically affected.

Another important point of contact between the ER and the hospital comes through the process of admitting described earlier in this paper. About 12% of the patients who come into the ER are admitted to the hospital, and when the hospital has no empty beds, the ER in effect becomes a "holding room". This fact is not appreciated by the doctors in the ER.

The relationships between the Emergency Room Physicians and the doctors who provide specialized treatment have been described above. This is a very important part of the delivery of services to the patients, and it underscores the dependence of the ER on groups and individuals outside the system. The dependence is not always one of necessity. It is often one of convention, but this does not make the dependence any less real.

Boundaries

It should be clear by now that the ER is a very open system. It cannot be understood simply by noting the physical limits and observing the people whose job is located in the ER.

There is very little control over the input and output of this system. Patterns of life in the community, as well as the economic and social structure of the community affect who comes into the system. The patients who enter are by no means all "emergencies" in the medical sense. Rather they come because it is convenient, or because they have no place else to go for medical service, or because their insurance makes it more feasible to come to a hospital. Thus the boundaries of the system are defined by forces totally external to the ER itself.

While patients are inside the physical limits of the system their treatment depends on other factors that enter through the boundaries of the system. Their lab work and X-Rays, for example, must pass through the boundaries. If they require specialized care, their physicians will pass through the boundaries. And if they are treated solely by Emergency Room Physicians, they will be referred to another physician outside the system for follow-up care. If they need extended or very specialized treatment, they will pass through the boundaries and into the Hospital itself.

Once they leave the physical location of the ER their only further contact will be a bill for services rendered, sent to them by an outside collection agency with which the Emergency Room Physicians have a contract. And if they return again, they will become another part of the flow of people who pass through the boundaries.

Thus, the amount of control exercised by the people who work within the ER itself is limited. Even the doctor on duty exercises control only if and until another doctor is called in for specialized consultation and treatment. In times of heavy activity, there will be more people working in the ER than people whose jobs are defined by that location. There were a number of occasions upon which we sat in the staff room with the ER physician, nurses, and technicians while people from outside the system were treating other people from outside the system.

Chapter IX. SUMMARY AND CONCLUSIONS

The Emergency Room as we came to know it through our fieldwork is a contradiction in terms. First of all, it is not a room but a series of rooms clustered in one part of a hospital building, and having important connections with rooms in other parts of the building. Second, it does not deal exclusively with emergencies in the medical sense. Indeed, the mind boggles at the thought of handling over 2,500 real medical emergencies per month.

People come into the "Emergency Room" at all hours of the day and night. Some come on foot, some by ambulance stretcher. There is no necessary correlation between the method of arrival and the seriousness of the medical problem. They come because they need a medical excuse to get out of work, or because they just happened to be passing by, etc. There is almost no limit to the types of reasons that people have for arriving at the Emergency Room.

The system responds as soon as the person walks through the door. From the registration process to the initial examination, treatment and discharge, the individual is treated efficiently and usually courteously, but with no overabundance of sympathy. The atmosphere reminds us of a quotation from the play, The Apartment: "If it's sympathy you want, go to a specialist".

One of the major reasons for the emphasis on efficiency was expressed by one of the doctors:

"A good Emergency Room is an empty one..."

and every attempt is made to expedite treatment. The staff seems to respond to the individual patients according to the kind of case involved, and their most negative comments are reserved for people who are obnoxious to them or

who seem to have no real need of being there, but most of these reactions are shared only with other staff members.

The actual treatment process often calls for the introduction of workers from outside the immediate ER social system. Lab Technicians, x-ray technicians, medical specialists, etc., play very important roles in carrying on the work of the ER, but they come and go through the system in much the same way as the patients do, except that they pass through more often. They also get a chance to interact with the "regular" members of the system in a different way. The same holds true for the police and ambulance crews who enter.

The individuals who enter this system as patients are people, but their medical problems are objects. The staff does not treat Mr. X or Ms. Y., they treat the broken hand, or the cut forehead, or the coronary. There is thus a level of detachment from the people, but it is a detachment necessary to continue working with people who have been hurt.

Another type of detachment is built into the system by the way it functions, and this is the fact that many times the staff will never find out what has happened to a serious case after the patients leave the ER. Sometimes they hear, but when they do it is by chance. This fact leads to the very strong emphasis on the here and now, because neither successes nor failures are often discovered. The staff can talk about the chances of success of a given patient, but they will often never know. And it is frightening to think of how hard it would be for them to continue if they cared too much. Occasionally someone will send a plant or a bouquet of flowers to the staff, thanking them for everything, and perhaps the unsigned notecard is most appropriate.

The staff who work in the ER are human--they too are real people. They have their differences of opinion, their likes and dislikes among the other staff members, their best and least liked types of patients. They all lead lives that occur for the most part outside the confines of the ER, and these lives travel with them wherever they go, the ER being no exception. For some the ER is a job, for others it is a business. There are no angels of mercy here, nor are there voyeurs or watchers of death. They are people doing a job, and seeing a slice of the world walk into and through their world of work.

In one of our first visits to the ER we asked a registration clerk why she like her job. Her reply was:

> "...because it's like working on a team. If you're around here sometime when a real emergency comes in you'll see what I mean. Everyone has a job to do, and everyone does it..." (notes, p. 227)

In the course of the observations we had many chances to observe what the staff calls a "real emergency," and we saw the "team" in action. In spite of their differences of opinion and their personality clashes, this is a group of people who know their job and perform it well, each helping the other to perform their part of the process.

During the seven months of observation we have seen our simple picture of the ER grow more and more complex as we learned more about what makes it work. It is a system constantly in motion, a system composed of many parts never seen by those outside.

What is most important is that it is a <u>social</u> system, one which is defined by the interaction of the people who work there and "visit" there. As unique

as these people are, there are certain patterns to the way they behave while in the Emergency Room, and it is these recurring patterns that make up the social reality of the system. The Emergency Room is open-ended, repetitive, and interdependent. It is a system in many ways without boundaries. It has no beginning and no end.

There is much more that we wanted to learn about, but we have appreciated the chance to learn what we have. We have come to know a little more about the ER, the people who make it work, and the way these people see the world. We can only hope that we have portrayed these realities accurately.

A Final Note

Our concluding remarks are directed to those who will come after us and continue the exploration of the social system of emergency departments. Together with Appendix I which describes our methodology, we hope that these comments will be useful for those fieldworkers with similar interests.

The first recommendation concerns the structural characteristics of the medical profession. It is important that a fieldworker go through the appropriate channels in arranging for access to a particular site, and to make note of the administrative systems with which he or she is dealing. Emergency departments are not independent entities. They exist within other social structures which are important in understanding what occurs within the emergency departments themselves.

The fieldworker must be prepared for a difficult assignment. Long hours of observation at unusual times of the day and night must be devoted to the study, and this can wreck havoc with one's "normal routine". We would recommend that the fieldworker schedule observations to cover every hour of every day at least once.

APPENDIX 1: METHODOLOGY

Because the particular activities you may want to observe (codes, for example) do not always happen when you want them to, it will be necessary to devote as much time as possible to the study. In addition, observing for longer periods of time (two hours or more) each time you go to the field has the advantage of establishing a real sense of rapport with the staff and makes it easier for each to view the other as real people. It will also be worth the effort to observe an entire shift whenever possible.

Observing in the emergency department is not the type of work for mild-mannered social scientists in formal attire. It requires a real sense of involvement, both physically and emotionally. The fieldworker must be aware of his or her own limitations in regard to tension and anxiety, for both will be encountered. This is not the work for those with weak stomachs either. It requires a tolerance for blood and gore, and for viewing fellow human beings in a state of agony and pain.

Finally, the work requires honesty, openness, and the willingness to really share in the lives of the people who make up this social system. It cannot be done from afar.

Methodology

In working out the methodological aspects of the project, we had several practical characteristics to take into consideration. First of all, we were going to be working in a stationary site which operated twenty-four hours a day. This fact proved to be a problem as our work in the field progressed. Because what we wanted was as complete a picture of the ER as possible, we found ourselves keeping all sorts of odd hours and erratic schedules.

Another fact that had to be taken into consideration when planning the type of methodology that we were to use in our study was the fact the staff was definitely divided--as usual, in a complex formal organization there existed a definite hierarchy of staff members. We realized that this characteristic alone might present major problems in establishing rapport. We realized that if there was a division in the staff that we were not aware of that coming into the ER with the approval of one of the levels might well close access to the other levels of the staff. Then, as the project progressed we found that one of the most important aspects of the project that we had to deal with on a day to day basis was TIME-- there never seemed to be enough of it.

The following section is a summary of our basic methodological approach.

The Nature of Field Work

In doing this study, we used methodologies that are classified under the general heading "Field Work". Field Work involves:

> "...the tasks of observing and recording and reporting the behavior of living people in contemporary situations with no intentions of changing them or their situations, in any direct way, and with, rather, every intention of avoiding disturbance to their natural activities." (Junker, 1960: 2)

The field work approach that we used most often in the course of our study was that of participant observation.

> "...participant observation is most sensibly regarded operationally as the blend of methods and techniques that is characteristically employed in studies of social situations or complex social organizations of all sorts." (McCall & Simmons, 1969: 3)

Participant observation is:

> "...A type of research enterprise, a style of combining several methods toward a particular end, analytic description.
>
> Analytic description (1) employs the concept, propositions, and empirical generalizations of a body of scientific theory as the basic guides in analysis in reporting, (2) employs thorough and systematic collection, classification and reporting of facts, and (3) generates new empirical generalizations..." (McCall & Simons, 1969: 3)

Junker describes four theoretical social roles for field work ranging from complete participant on one end of the continuum to complete observer on the other with two intermediate roles (participant as observer and observer as participant).

In the course of our research, it became apparent that one of us, (Toni) had taken the position of "participant as observer" and the other, (Paul), had assumed the role of "observer as participant." The "participant as observer" role is one in which the field worker takes a relatively more active part in the life of the

people than he does in the "observer as participant" role. Each of these roles has its advantages and disadvantages.

Selecting a Topic

Our major reasons for choosing the emergency room for the site of our study was that both of us had an interest in studying medical systems and each had spent time working either in the medical field or some related areas.

Before the actual project was under way, we investigated the possibilities of doing our study at several different places. The greatest difficulty that we encountered in gaining access to the medical field centered around the problem of confidentiality. In our case, access to the field was facilitated by the physician in charge of emergency services at Williams Hospital.

After we had gained access to the ER, the major problem was that of acceptance which of course was primarily a function of time spent there.

Doing Field Work as a Team

As we mentioned above, we had both at one time in our lives been involved in some way with the medical field. This was one of the factors that motivated us to do a joint research project. Doing field work as a team had its advantages, but it is not without its disadvantages.

The advantages of doing field work as a team are: (1) more territory can be covered, e.g. when we observed together, we would often cover different parts of the ER and brief each other on the activities going on. (2) in our case because one of us is a male and one female we were able to take advantage of the fact that some people are more comfortable with females. For example,

this statement was made by a male resident to Paul:

> "...And you know I don't care what they say about Women's Lib, I think the men in this place make it work -- they're the ones you can count on. The nurses just stand around and look important, but don't ever ask them to do any real work..." (Notes, p. 352)

(3) we each had the other to check our perceptions with.

The disadvantages of doing field work as a team are: (1) coordinating our schedules; (2) personality problems; (3) working out agreements on specific problems as they arose.

Presentations on Self

The most important aspects for us in presenting ourselves to the members of the ER was trying our best to put the staff members at ease by presenting ourselves and our project as honestly as we possibly could.

Fronts: We soon realized that we were dealing with problems of "fronts" in the field (the staff members and ours)

> "A front, in the context of sociological observation, is a facade erected on the one hand, by the individuals in an organization the researcher proposes to study, or on the other hand by the researcher himself to accomplish his ends." (Douglas, 1972: 93)

In the case of the staff members, we found that as time passed and we were around more, most "fronts" were dropped. In the case of ourselves, we quickly discovered that we were more likely to get information from a doctor if he knew that we were in the doctoral program than if he thought we were just one of the other staff members in the ER.

Another aspect of the notion of fronts is the fact that we often took on the role of learner in order that things might be more clearly explained. (McFall & Simmon, 1969: 70).

It was also important that the staff members know that we were interested in them, not just as subjects but as people we would like to know. The importance of this type of acceptance becomes apparent in this quote from our field notes. This conversation took place between Toni and a technician after he had overheard a conversation between her and another staff member.

> T: "You know when you first came here I resented that you were invading our world. I really resented the fact that you got a chance to ask a lot of questions and we didn't about you..."
>
> FW: "What changed that?"
>
> T: "Oh, I was sitting there listening to you talk about your life and your kids and for the first time (pause) I guess I just realized that there is another side to you besides what I see here at the hospital—you walking around the hall looking, asking questions and taking notes about what we do and say." (Notes, p. 87)
>
> "I guess that you can say that I kind of like you. I've found that you have feelings and are not here just to be nosey but because you are interested in learning. And that you are really a pretty nice person." (Notes, p. 88)

The other major factor which had to be dealt with that affected the way in which we presented ourselves was the anxiety factor. There were many times when the anxiety level was high which occasionally led to tension between the staff members and ourselves. Closely related to presentation of self is the area of personal involvement and ethics.

Personal Involvement and Ethics

While working on the project we spent many days and nights in the field simply "being with" the members of the staff. It was probably inevitable that some close relationships develop that extend beyond the scope of the project.

As one might expect the fact that we became close to some of the staff had both advantages and disadvantages.

The most obvious advantage of becoming close to someone in the field is that in addition to having someone that will give you information that you need it also gives you someone to talk to when needed. There were many times when things would become tense or when things had not gone well that day and the fact that we had someone to talk to about other things than the ER made the work go a lot more smoothly.

A close relationship with someone in the field work setting could be looked at as a sort of "trade off" at times because though the relationships were a help to us, we are aware of the fact that often they were a help to the people that we established these relationships with. This in no way means that we purposely set about to create a situation where the person felt that we were his friend when in actuality we were not. The friendships that were formed in the field were and are genuine and warm. This fact brings up the next question--that of ethics.

Ethics--The problem in the case of field work is stated by Robert Janes:

> "If the strategy of participant-observation calls for achieving access to and acceptance by "social circles" for the purpose of unwitting revelation of information by their members, does this practice constitute a violation of prevailing ethical principles of our society?" (Janes, 1969: 58)

Janes' answer to this question is one that guided us in handling relations in the field:

> "If a social group under observation has a newcomer's role which permits the practice of participant observation, and if the long-run functioning of the group is not disrupted by the ...observation made by the investigator and his subsequent departure from the group, then there would be no violation of prevailing ethical norms." (Janes, 1969: 58)

The disadvantages of forming close personal relationships in the field usually did involve questions that we would ask ourselves about ethics. As we became close to certain members of the staff, we would often find it difficult to write about them because even more than ever the last thing that we wanted to do was to reveal any information that might bring them harm. We were also aware of the fact that having close relationships in the field might distort our perceptions. Hopefully we were aware of this possibility so that we took precautions not to focus attention solely on these people.

Field Diary and Notes

In recording the data that we collected we used field diaries in which we recorded pertinent information that we did not want to forget. In most instances this amounted to the jotting down of something that was said or done in the field in a very brief statement--usually just enough to trigger the memory when we began to type the field notes for that particular observation.

Field notes containing descriptions of events and conversations were typed as soon as possible after each observation.

Use of tape recorders--at the beginning of the project we had considered the use of tape recorders in a formal interview type of situation but we quickly discarded this idea. However, there were many instances when because of time

pressure we had to resort to the use of a tape recorder in the recording of our field notes. The notes would be taped as soon as the observation had been done and then transcribed as soon as possible.

Conversational Interview & Informants

We at one time considered using the formal interview, thinking that it would be necessary in some instances when we wanted specific information. However, as time went on we discarded this idea. We soon realized that many times while in the field, and carrying on a conversation with a staff member, we could get the information that we needed from the respondent in the course of the conversation.

Through the use of conversational interview, we over the months developed relationships with members of the field who served the role of "informant". "Informants" were usually people who either had special knowledge, were more verbal than the rest of the staff, or as in some cases, with whom the fieldworker got along better than the rest of the staff. As noted by Zelditch:

> "Almost invariably he (the fieldworker) also develops informants, that is selected members of S (the social system) who are willing and able to give him information about practices and rules in S and events he does not directly observe." (Zelditch, 1969)

We were fortunate enough to develop informants at each level of the staff hierarchy. And contrary to what we had anticipated, most of the ER doctors were usually more than willing to explain things that we did not understand unless the caseload did not allow.

Our Methods

Whenever possible and relevant, we referred to records in the ER. Time was spent in reading the policy and procedures manuals for the ER. In comparing the formal rules with the way that the ER actually functioned we were able to see how much the formal rules were followed. In most cases when the written rule was not followed the reason was readily apparent -- such as in the case of a system overload, i.e. when the load in the ER was too heavy for the staff available to handle only their designated duties. We found that even a field worker's hands may be called on if two extra hands are needed.

Coding Systems

After several months in the field, we began the coding of our data. The method that we decided to use was the method used by William F. Whyte, The steps are as follows: "Whyte's system involves a page in three columns containing for each interview or observation report (1) its number, pages, and date of collection, (2) the person(s) interviewed or observed (together with, in parentheses, the names of people referred to in the interview or observation), and (3) the pertinent topics and social relationships. (Whyte, 1969: 75)

Validity

Validity is the extent to which data correspond with some criterion which is an acceptable measure of the phenomena being studied. The accuracy with which data represent what they purport to represent.

We used three types of checks during the course of our research: (1) the first consisted of cross checking what someone had told us with what another person had told us. Quite often this was done simply by being aware of what was said by people in the field. If someone made a statement about something and then

later the statement was repeated by someone else and then this happened again we usually accepted this as a pretty good test. (2) across notes--the second way that we found was a good test of reliability was checking each others' notes to see if we both saw the same things or if we saw the same thing the same way--allowing of course for personality differences, (3) verbal verification-- in constant touch with each other throughout the course of our research--exchanging information in conversations over coffee, on the phone etc.

Limits on Data

As always, the data collected was limited by several factors. The first and most apparent factor was that of time. The ER is a system that never stops to rest in the sense that it never shuts down at night. This along with the fact that both of us had obligations to meet in other courses at the University made it difficult for us to devote as much time to the project as we would have liked. Data was also limited by the fact that after being in the field for several months there was a tendency to take certain things for granted and even though we were aware of the fact that this often happens we are sure that this phenomenon had its effect on the type of data collected. As Geer states:

> "There is so much reiteration of findings in our findings that we sometimes think we have always known what we find (everybody knows it, why bother to write a book?) and at other times that it became clear some magical way on the very first day in the field." (Geer in McCall, 1969)

Anxiety probably had a great deal to do with the quality and amount of data that was collected at certain periods of the year. There were times when just going to the field was a major effort for both of us. From time to time there were personality clashes that made it very hard for us to see what was happening without distortion. We were also aware of the fact that as is always true, the data, no doubt, were affected by our own personal biases.

APPENDIX 2: EMERGENCY ROOM

POLICY & PROCEDURES MANUAL DESCRIPTIONS OF ROLES

Lastly, the data were affected by things that were going on in our personal lives outside the field.

RULES FOR THE EMERGENCY DEPARTMENT APPROVED BY THE EXECUTIVE COMMITTEE OF THE MEDICAL STAFF ON JUNE 12, 1967 UPON RECOMMENDATION OF THE EMERGENCY DEPARTMENT COMMITTEE

The outline covers certain points of relationship of the Corporation to the Staff and to the Executive Committee. (The Emergency Department Committee has no jurisdiction over the contractual relationship between administration of the Corporation.)

When the word "Corporation" is used, it refers to the 4, 5 or 6 members forming the Corporation and employees are considered to be those employed by these 4, 5 or 6 members.

Whenever the words "medical student" appears in the document, they refer to an individual assigned to the Emergency Department for an educational purpose. For example, the junior medical student from the surgery service assigned periodically to the Emergency Department for observation of patients and trauma.

I. DUTIES OF THE EMERGENCY DEPARTMENT COMMITTEE

a. The Emergency Department Committee will act as the liaison between the Executive Committee, Medical Staff and the Corporation that will provide medical care in the Emergency Department. This committee will assist the Corporation in the interpretation and development of the policies agreed upon by the Executive Committee and the Corporation. It will also assist in the resolution of misunderstandings between members of the Medical Staff and the Corporation, but not between the Corporation and the public. This committee may, if requested, transmit requests from or to the Executive Committee, Medical Staff and Corporation. This Committee will be informed of policy changes made by either the Staff or the Corporation.

II. OBLIGATIONS OF THE CORPORATION

a. The Corporation will have a member or one of its employees in the hospital and immediately available 24 hours a day and 7 days a week. When the patient load indicates, a second member of the Corporation will be available. The decision to call the second member rests with the Corporation.

b. If the Corporation needs to employ physicians, they may not be interns or residents under contract to this hospital, even if on vacation. Such employees must be members of the Medical Staff and approved in advance of their service by the Administration and the Executive Committee.

c. New members of the Corporation must be approved by the Administration and the Executive Committee.

d. The Corporation is responsible for all patients seen until the Corporation has concluded the emergency care or another physician has arrived to assume emergency care.

e. The Corporation will make every reasonable effort to continue the education of the medical students, interns and residents assigned to the Emergency Department. The Corporation will direct the work of the intern insofar as it concerns care of patients treated by the Corporation.

f. The work of the residents in the Emergency Room will be supervised by the specialist to whose service they are assigned.

III. GENERAL PRINCIPLES TO BE FOLLOWED BY THE CORPORATION

a. The service rendered is for the emergency care of the medical complaint that brought the patient to the emergency department. Continuing care will not be given. Charges to the patient will be commensurate to the services rendered.

b. The Corporation will maintain a card file for every member of the Medical Staff on which he will have indicated specific directions for the Corporation when his services are requested; or his services are indicated by an employer-Doctor agreement. It is the responsibility of each Medical Staff member to make known to the Corporation any changes desired in these directions.

Medical Staff members on the Specialist Call list are expected to also indicate specific direction to the Corporation. It is the responsibility of each specialist to make known to the Corporation any changes desired in these directions.

IV. SPECIALITY CALL LIST

a. A speciality call list will be continued in the same manner as currently used. Each Department Head is responsible for this list. If the physician listed as on call is not available, the Corporation will contact the Department Head or his representative for a replacement.

b. The present Rules and Regulations of the hospital as they pertain to the Emergency Department will be followed by the Corporation.

c. When no specific doctor is requested the Corporation will contact the man on call indicated by the call list. If the Corporation completes the emergency care the patient is given the name and instructed to make an appointment to see that physician. The return visit may be to one of the out-patient services of the hospital, if the physician on call so specifies.

If the physician on call assigns the case to another physician, the Corporation will remain responsible until that physician initiates treatment.

V. MISCELLANEOUS DIRECTIVES

1. A member of the Corporation will be a member of the Emergency Department Committee.

2. With the exception of the above mentioned addition, the membership of present Emergency Department Committee will follow the usual procedure for Committee appointments. (The additional member on the Emergency Department Committee will be the elected president of the Corporation.)

3. At no time will more than one Emergency Department Committee member, in addition to the Corporation member, be employed by the Corporation.

4. It is required that the Medical Staff member on the specialist call list direct the care and disposition of all patients referred to him from the Emergency Department.

AMENDMENT - MAY 17, 1968

The Committee for the Emergency Department presented to the Executive Committee at the May meeting the following rules and regulations which were approved, with the stipulation that they be published in the Medical Staff Bulletin. Adherence to the following directs is requested:

1. Patients are not to be sent to the Emergency Department for treatment by a nurse.

2. Patients are not to be sent to the Emergency Department to be seen in consultation by a resident. A staff member desiring consultation for a patient in the Emergency Department must notify the consultant requested.

3. When a staff member sends a patient to the Emergency Department, he must notify the clerk or registrar.

    a. That he will personally attend a patient not considered by him to be acutely or seriously ill. This patient will wait in the waiting room for the staff member. (Not to be seen by the Corporation.)

    b. That the patient is acutely or seriously ill and, therefore, the Corporation physician is to see the patient. The staff member in the same call is to inform the Corporation physician and suggest appropriate treatment until he personally arrives or until the Corporation physician has determined that another staff member be called. (Appropriated charges will be made by the Corporation physician for services rendered.)

4. If this privilege is abused by the staff man in that he fails to meet the patient or sends a patient too ill to wait in the waiting room, the corporation physician will then attend the patient, charge the patient accordingly, notify the staff man on his arrival, and report the instance to the Chairman of the Emergency Department Committee within twenty-four hours.

PHYSICIANS SUGGESTIONS FOR PROPER
PROFESSIONAL OPERATION OF EMERGENCY DEPARTMENT

1. Personnel will be fully aware of the existence and condition of all patients on the premises.

2. NO OTHER PHYSICIAN WILL BE CALLED to attend patients (i.e., Residents and other Staff Men) unless this call is authorized by the Emergency Physician on study.

3. Messages called in by phone will be received by physicians only when called in by physicians. In other words, DOCTORS WILL TALK TO DOCTORS. (Obviously there has to be some discretion in this order. A doctor cannot break scrub to take a message.)

4. All messages received will bear the following: 1) caller, 2) time of call, 3) name of patient, 4) orders or message content and 5) name of recipient of call.

5. Common courtesy will be maintained at all times. No interruptions of busy people with trivia. No feet on the tables and counters, etc. No more need be said!!!

WE ARE ALL MEMBERS OF A PROUD PROFESSION
LET US BE PROUD OF THE PROFESSIONAL JOB WE DO

Head Nurse, Emergency Department - Duties

GENERAL SUMMARY:

Responsible for the operation and functioning of the Emergency Department, exclusive of, but in cooperation with the physician's professional responsibilities. Responsible for the supervision, training and orientation of all assigned nursing personnel and the Chief Technician in regard to Emergency Technician Personnel. Assists the Manager in the general administration of the Department.

DETAILS:

1. Through nurses, technicians and in cooperation with the Manager , the supervisor of Outpatient Administrative Services, and the physicians, maintains a high level of patient care and public relations. Assists in planning for an environment conducive to the well-being of both patients and personnel.

2. Cooperates in the overall educational and research programs of the medical staff, school of nursing, and other paramedical departments of the hospital.

3. Directs the nursing and paramedical administrative activities of the department to insure adequate instruction, proper assignment, observation and evaluation.

4. Directs preparation of records and reports to insure completeness and accuracy. Assists in the periodic evaluation of records and reports to insure adequacy of aforementioned accuracy and completeness.

5. Evaluates and makes recommendations on new nursing methods and departmental equipment in the Emergency Care Field.

6. Responsible for the periodic inspection of existing facilities, equipment and supplies. Checking facilities, equipment and supplies for adequacy, maintenance, and cleanliness and general appearance. Furnishes inspection results and makes corrective recommendations to the manager of the Emergency Department.

7. Conducts interviews of prospective nursing employees. May assist the Chief Technician in interviewing of prospective employees.

8. Responsible for orientation, instruction and evaluation of newly assigned nursing employees. May assist Chief Technician with same, in regards to technicians.

9. Responsible for the ordering of drugs, solutions, expendable equipment, and supplies. Accounts for narcotics.

10. Investigates patient complaints against hospital or employees of same, makes adjustments or refers complaints to the Manager.

11. Determines work procedures, issues written and oral orders and instructions, assigns duties to nursing employees and the Chief Technician, adjusts errors and personnel complaints, evaluates employee suggestions and ideas. Keeps time reports and pertinent personnel records, trains, evaluates disciplining and recommends corrective action and discharge of nursing employees. May assist Chief Technician with same in regard to technician employees.

12. Works in cooperation with physician in charge in assessing the total needs of patients. Plans for and contributes to the learning experience of students in the school of nursing. Promotes the total learning experience of assigned personnel. Plan work schedules to insure adequate staffing to comply with established standards.

Emergency Nurse -- Duties

GENERAL SUMMARY:

Renders general emergency nursing care in the department, administers prescribed medications, treatments and procedures in accordance with approved nursing techniques. Prepares equipment and assists physicians in examination and treatment of patients. Observes, records, and reports to supervisor and/or physician, patients condition and reaction to drugs, treatment and significant incidents. May make beds, clean treatment area, and re-supply room.

DETAILS:

1. Responsible for giving nursing care to patients by performing various nursing tasks.

2. Examines patients' charts and doctors' orders, gives medications, and carries out nursing treatment as prescribed.

3. Obtains information on numbers, conditions, and needs of patients in department from previous shift. Inspects facilities to determine adequacy of supply, maintenance of equipment and work to be performed.

4. Keep adequate records in the patients' charts of service performed.

5. Gives instructions to, confers with, and oversees the work of the auxiliary nursing personnel by directing and advising on the proper performance of general and specialized nursing duties.

6. Maintains and submits records and reports.

7. Assists in keeping a comfortable, orderly, clean, and safe environment for the patients.

8. May perform certain procedures at the request of physicians such as drawing blood and starting intravenous fluid therapy.

9. Through emergency technicians insures that examination and treatment rooms are clean and fully stocked.

10. Assumes responsibilities as Charge Nurse when assigned by Head Nurse.

11. Performs related duties of a comparable nature as assigned.

Emergency Technician -- Duties

GENERAL SUMMARY:

Assists patients, nursing personnel and medical staff in the Emergency Department area in the receiving, diagnostic, examination, treatment, and referral procedures.

DETAILS:

1. Receives patients in a variety of physical and emotional states as they are presented to the Emergency Department; sees to their safety, comfort, and immediate needs, according to established procedures.

2. At the direction of nursing personnel, and medical staff members, assists in first aid, diagnostic, and treatment activities; obtains equipment and supplies; applies bandages and dressings; performs a variety of tasks on specific order.

3. Moves patients as directed, observing limitations imposed by their condition; may assist into and out of vehicles in the driveway; may transport and escort to Radiology, Admitting, or directly to nursing units; may secure patient records and charts.

4. Transports laboratory specimens from Emergency Department to laboratory. Returns completed reports to Emergency Department.

5. Makes up examining and treatment tables, assembles supplies, maintains and cleans equipment, and assists in maintaining cleanliness and readiness of the clinic area.

6. May perform a variety of tasks associated with the death of a patient; may transport bodies to the morgue.

7. Takes temperatures, pulse and respiration, and blood pressure readings of patients as directed.

8. Performs related tasks of a comparable nature as directed.

Staff Room Desk Clerk -- Duties

GENERAL SUMMARY:

The staff room desk clerk is responsible for all clerical and related duties within the Emergency Department proper to include: filling out of laboratory requisitions, x-ray requests, emergency call and referral slips, etc.; completing clerical duties related to admissions; answers the telephone takes and relays messages; locates physicians, etc.

DETAILS:

1. Answers department phones.
2. Receives messages in and outside the hospital, relays as necessary.
3. Locates physicians either by phone or page as directed.
4. Labels laboratory specimens as directed.
5. Completes assigned clerical duties relative to admissions to include relating of admitting information to relatives.
6. Completes appropriate requisitions for laboratory, x-ray, call and referral slips, etc.
7. Orders supplies to include necessary forms and other clerical items.
8. Maintains predetermined levels of supplies and properly stamped requisitions.
9. Performs certain clerk-typist duties as specifically directed by the Head Nurse.
10. Performs related tasks of a comparable nature as directed.

EMERGENCY ROOM VOLUNTEER

Reports to: Emergency Head Nurse and Director of Volunteer Services

Job Summary: To help relieve the anxieties of waiting patients and relatives, and to assist Emergency Room Personnel in caring for patients as directed.

Duties and Responsibilities:

1. Assist patients arriving via emergency entrance (greet, help with door, etc.)

2. Escort patient or other family of patient to waiting room while patient is being cared for.

3. Routinely, at least once an hour, (or even more often if busy) ask waiting patients and relatives if you can help them with anything -- if they have questions, get answers from desk clerk or nurse.

4. Direct waiting relatives to snack bar for hot or cold drinks if their wait is too long.

5. Assist patient with phone calls (sometimes they come alone and need help arranging transportation, etc.)

6. Assist with discharge of patients. (Help with doors, help into car or taxi.)

7. Visit with patient and family to help them feel at ease, remain with minor children in waiting room until relative arrives.

8. Keep waiting room in order.

The above are the most important duties of the Emergency Volunteer. Other duties, if time allows, may include:

1. Pick up supplies from pharmacy or central supply.
2. Take specimens to laboratory.

REFERENCES

Apple, Dorrian (ed.)

1960 Sociological Studies of Health and Sickness. New York: McGraw-Hill

Becker, Howard, et al.

1961 Boys in White. Chicago: University of Chicago Press.

Bloom, Samuel W.

1965 The Doctor and His Patient. New York: The Free Press.

Blau, Peter

1962 Formal Organizations. San Francisco: Chandler Publishing Company.

Broom, Leonard and Philip Selznick

1968 Sociology. Fourth Edition, New York: Harper & Row.

Buckley, Walter

1967 Sociology and Modern Systems Theory. Englewood Cliffs, N.J.: Prentice-Hall.

Carey, James T.

1972 Problems of Access and Risk in Observing Drug Scenes. In Research on Deviance, pp. 71-92. Jack D. Douglas (ed.), New York: Random House.

Coser, Rose Laub

1965 Some Social Functions of Laughter. In Social Interaction and Patient Care, pp. 292-305. J.K. Skipper and R.C. Leonard (eds.). Philadelphia: J.B. Lippincott.

DeFleur, Melvin L., William V. D'Antonio, and Lois B. DeFleur

1971 Sociology: Man In Society. Glenview, Ill.: Scott, Foresman and Company.

Douglas, Dorothy J.

1971 Managing Fronts in Observing Deviance. In Research on Deviance, Jack D. Douglas (ed.), pp. 93-115. New York: Random House.

Fox, Renee C.

1959 Experiment Perilous, New York: The Free Press.

Freidson, Eliot (ed.)

1963 The Hospital in Modern Society. New York: The Free Press.

Hall, Edward T.

1966 The Hidden Dimension. Garden City, N.Y.: Doubleday Anchor Books.

Hall, Oswald

1946 The Informal Organization of the Medical Profession. Canadian Journal of Economics and Political Science 12:30-44.

Hartog, Jan De

1964 The Hospital. New York: Atheneum Publishers.

Henderson, Lawrence J.

1935a Pareto's General Sociology: A Physiologist's Interpretation. Cambridge, Mass.: Harvard University Press.

1935b Physician and Patient as a Social System. New England Journal of Medicine 212:819-823.

Janes, Robert

1969 A note on Phases of the Community Role of the Participant Observer. In Issues in Participant Observation, pp. 52-60. George J. McCall and J.L. Simmons (eds.) Reading, Mass.: Addison-Wesley Publishing Company.

Junker, Buford H.

1960 Field Worker: An Introduction to the Social Sciences. Chicago: University of Chicago Press.

Kapplan, H. Roy

1970 Health Care in America: Anachronistic and Inequitable. Paper Presented at the 65th Annual Meeting of the American Sociological Association, Washington, D.C., September, 1970.

Kluckhohn, Clyde

1957 Mirror for Man. Greenwich, Conn.: Fawcett Publications.

Linton, Ralph

1936 The Study of Man: An Introduction. New York: Appleton-Century Co.

McCall, George J. and J.L. Simmons (eds.)

1969 Issues in Participant Observation. Reading, Mass.: Addison-Wesley Publishing Company.

Merton, R.K., G. Reader, and P. Kendall (eds.)

1957 The Student Physician. Cambridge, Mass.: Harvard University Press.

Miller, Sheldon, I., C.H. Browning and R.L. Tyson

1971 A study of psychiatric emergencies: Part III. Findings on follow up. Psychiatry and Medicine 2:133-137.

National Advisory Commission on Health Manpower

1967 Report of the National Advisory Commission on Health Manpower, November, 1967. Vol. I. Washington, D.C.: Government Printing Office.

Polsky, Ned

1967 Hustlers, Beats, and Others. Chicago: Aldine.

Parsons, Talcott

1951 The Social System. New York: The Free Press

Skipper, James K., Jr., and Robert C. Leonard (eds.)

1965 Social Interaction and Patient Care. Philadelphia: J.B. Lippincott.

Sommer, Robert

1969 Personal Space: The Behavioral Basis of Design. Englewood Cliffs, N.J.: Prentice-Hall Spectrum Books.

Spiegel, John P.

1954 The Social Role of Doctor and Patient in Psychoanalysis and Psychotherapy. Psychiatry 17:369-376.

Strauss, Anselm L.

1969 Field Tactics. In Issues in Participant Observation, pp. 70-76. George J. McCall and J.L. Simmons (eds.) Reading, Mass.: Addison-Wesley Publishing Company.

Sudnow, David

1967 Passing On: The Social Organization of Dying. Englewood Cliffs: Prentice-Hall

Susser, M.W. and W. Watson

1971 Sociology in Medicine. Second Edition. New York: Oxford University Press.

Walker, Lynn L., and Sheldon I. Miller

1973 Sensitivity to symptoms in patients utilizing an Emergency Department. Journal of the American College of Emergency Physicians 2 (5):321-326.

Weinderman, E.R., et al.

1966 Yale studies in ambulatory medical care: determinants of use of hospital and emergency services. American Journal of Public Health 56: 1037-1056.

Zelditch, Morris, Jr.

1969 Some Methodological Problems of Field Studies. In Issues in Participant Observation, pp. 5-18. George J. McCall and J.L. Simmons (eds.), Reading, Mass.: Addison-Wesley Publishing Co.