Title
Emergency treatment of elders in a managed care environment

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Publication Date
1996

Peer reviewed|Thesis/dissertation

EMERGENCY TREATMENT OF ELDERS IN A MANAGED CARE ENVIRONMENT

by

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DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

NURSING

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

San Francisco

Date

University Librarian

Degree Conferred: . . . . . .

Acknowledgments

This study has evolved out of an interest in ethnography, and later gerontology, which was nurtured by Jeanie Kayser-Jones. Our relationship was borne out of a qualitative methodology course, however, her consistent mentorship has brought me to this final phase of doctoral studies. I am grateful for her support and encouragement. I also wish to thank Jeanie for her sponsorship. Her recommendation and mentorship were key factors in my appointment as the 1995 ANF/Sigma Theta Tau International Scholar. This award has partially funded this research project.

I am also grateful to the members of my dissertation committee. Juliene Lipson has been a valuable resource throughout my doctoral studies and a tireless supporter through the final writing process. Sharon Kaufman has been an outstanding mentor. I am in awe of her scholarship. Catherine Chesla was an excellent guide in the early phases of the doctoral program. I also wish to thank the members of the Qualitative Analysis Group: Chris Bolla, Irene Hurst and Chris Wood.

On a personal level, I want to thank my husband, Bob, and my children, Sarah and Scott, for their support, encouragement, and love.

Abstract

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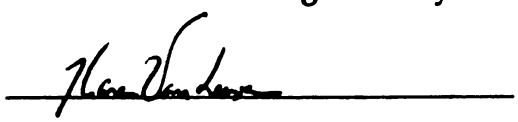
EMERGENCY TREATMENT OF ELDERS IN A MANAGED CARE ENVIRONMENT

Karen Van Leuven, RN, PhD

University of California, San Francisco, 1996

Research on the use of health care services by the elderly has focused on long-term and chronic care and under-emphasized acute care. Emergency care, a specialized form of acute care, was the focus of this research. Approximately 15% or 13.5 million ED visits are made nationwide by persons 65 years or older. The purpose of this ethnographic study was to examine the health care environment through the lens of older adults within a metropolitan Emergency Department (ED). Using participant observation, semi-structured interviews and event analysis data collection strategies, the care of 18 adults, aged 69-93 years old, was observed and analyzed. The assumptions about the purpose of the ED and the meaning of "care" and "managed care" were analyzed through a theoretical framework of social worth from the perspective of patients, families, staff, and administrators. Organizational changes as a result of managed care, cultural devaluation of the aged, and limited geriatric/gerontology knowledge among staff were found to significantly influence care.



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EMERGENCY TREATMENT OF ELDERS IN A MANAGED CARE ENVIRONMENT

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Introduction

This is an ethnographic study of an urban Emergency Department (ED). Its original purpose was to investigate the issues and problems that arise when older adults are treated in a metropolitan ED, during the course of the research however, a second tale emerged. The second tale recounts the painful evolution of a community hospital into an urban medical center, a transition intertwined with social, political, and economic issues at the local, state, and national levels. These larger concerns directly impinge on the work environment, the attitudes of employees, and the delivery of emergency care. While these two tales are seemingly distinct, they intersect at each ED visit.

The evolving health care system is described and analyzed through the lenses of 18 elders who encountered this ED and members of the health care team. This present research aims to describe, analyze and evaluate:

1) the ED environment as a site for health care delivery;
2) the challenges and concerns of health care professionals who provide emergency treatment within this system; and
3) the issues that clients face when receiving treatment in an ED that is part of an evolving health care system.

This study was conducted at a 500^{+} bed community medical center in an ethnically diverse West Coast metropolitan area. A single site was chosen to permit in-depth research at a representative urban ED. This ED averages 150 emergency visits per day or approximately 55,000 visits annually -- a volume consistent with a moderate-size ED.

Overview

While the pages of this manuscript describe my observations and interviews with elders, family members, and staff about their experiences in an urban ED, they also analyze the significance of this data and place it within a theoretical framework.

Chapter 1 presents a typical day in the ED at Western Community Medical Center, a pseudonym used to describe the research site. Pseudonyms have also been used for all staff and participants. The pseudonyms for ED physicians, nurses, and other health professionals are first names. This convention was chosen because staff members in the ED communicate on a first name basis. Staff also call clients by their first name; however, to aid the reader, I have used the titles of Mr. and Ms. when I refer to participants. The reader will find a summary of demographic data for each participant in Appendix A.

Chapter 2 explores the history and evolution of EDs in the United States, clarifies key points from the previous chapter, and explains the methodology used to conduct this study. In Chapters 3, 4, 5 and 6 the issues and dilemmas faced by clients, families, staff, the medical center, and the health care system are discussed in light of a theoretical framework of social worth. Chapter 7 extends the discussion beyond the boundaries of the ED at Western Community Medical Center to examine the generalizability and limitations of this research as well as conclusions, implications and recommendations that can be drawn from this study.

Chapter 1

A Day in the Emergency Department

In Room 2, Mr. Wayne, a 59 year old man, had been admitted for chest pain during the 3 - 11 PM shift. As report from that shift was finishing, he began to have runs of ventricular tachycardia, a potentially lethal cardiac dysrhythmia. Erin, an experienced night shift Registered Nurse (RN), quickly administered a loading dose of xylocaine and began a continuous drip. Despite her prompt treatment, Mr. Wayne's condition deteriorated and multiple medications were required to support his falling blood pressure.

While Erin closely monitored him and administered medications, John, the Emergency Department (ED) physician, called several local cardiologists before he found one available. He described Mr. Wayne's continuing decline despite all standard protocols. Together, John and the cardiologist decided to start Mr. Wayne on an experimental drug and to support his breathing by placing him on a mechanical ventilator. While the cardiologist was driving to the hospital, John inserted a tube into the patient's trachea that was connected to a mechanical ventilator. He then inserted a large bore catheter into Mr. Wayne's right subclavian vein, a major vessel leading directly to the heart. The catheter would be used to administer medications and monitor pressures in the right side of the heart.

As the physician performed these tasks, Erin explained each procedure to Mr. Wayne. Although he made eye contact with her, she was convinced that he did not understand what was going on. Erin tried to be therapeutic as she spoke, but

Mr. Wayne's monitor kept beeping as his blood pressure dropped and his heart rate rapidly increased. As she spoke to Mr. Wayne, Erin tried to exude confidence, but her hazel eyes kept darting to the monitors. Her monologue with him was punctuated by her constant readjustment of the medications that maintained his blood pressure and by updates to John. Erin knew how chaotic it must sound to him:

> [Looks at patient] Mr. Wayne, the doctor is going to be putting a tube in your mouth to help you breathe. [Alarm beeps, indicating the patient's blood pressure has dropped.]
>
> [Faces John] John, I turned up his Dopamine again. His BP keeps falling. You gotta hurry up, he can't tolerate this position much longer.
>
> [Looks at patient] As soon as we get you settled, we'll let your wife come in here to see you, but right now we need to get some things done.
>
> [Faces John] John, does his wife know how things are going? Do we need to get someone out there to brief her? There's no support services on at night, so I don't know who that would be, but it sounds like a good idea.

After several hours of constant drug titration and vigilance, Mr. Wayne was critical but stable. At around 3 AM he was transported to the Coronary Care Unit.

Erin's other patient, a young man, had been brought to the ED by a police officer. He had been found lying unconscious on the curb in front of a small grocery store, his breath reeking of alcohol, and fresh injection sites pockmarked his left arm. While Erin was caring for Mr. Wayne, her co-workers, two fellow RNs and a Licensed Vocational Nurse (LVN), looked after the other patients in the unit and took over the care of the intoxicated young man. The unit clerk

coordinated the phone calls, brought specimens to the lab, and attempted to assign beds to patients requiring admission.

John, the ED physician, was relieved to let the cardiologist take over Mr. Wayne's care. Since he was the sole physician on the night shift, he had been unable to evaluate most of the other patients in the unit, even though many of them had been waiting for hours.

Often night shift is slower than this. When it is, the staff care for the patients who remain from the evening shift and see, perhaps, only 5 to 10 new patients over the course of the night. On the earlier shifts, patients who arrive at the ED entrance, which faces a noisy urban thoroughfare, are greeted by a security guard who directs them to a waiting area and triage station. At night, however, the system runs differently. A guard is stationed at the entrance and all the staff members are located in the main department. When a patient arrives, the guard must phone into the department to inform the staff. Depending on the nature of the complaint and the number of patients already in the ED, the patient is either escorted into the department by the guard or asked to wait until a staff member can come out.

If the night is slow, staff are responsible for conducting chart audits and collating records. On such a night the physician often sleeps in the call room.

Since nursing and medical management all work during the day, no administrators are present on the night shift. Many of the staff see this as a good reason for working nights. They can dress very casually – scrub pants, jeans and a T-shirt, or even everyday casual clothes. After all, who will know? When

things are slow, staff members can listen to music, have pot lucks, or even read books.

Working at night is rarely so pleasant. Erin captured the feelings that many of the night shift staff have about their work.

> You can't have a normal life. I'm single and this schedule plays havoc on my social life. My married co-workers say they kiss their kids and spouse goodnight and come to work. They come home exhausted just as everyone else is eating breakfast and ready to start their day. I know we get paid more for working these hours, but we earn it! The only other workers up all night are cops. Many of the local ones stop in and have coffee with us at night, or come in to use the bathroom. It's good to know that somebody else has to be at work all night.

Aside from the personal cost of working nights, there are other largely institutional drawbacks. Social services and discharge planning are not available after 4:30 PM. The food service closes after the evening meal has been served, so the ED staff have to stockpile food and drink in order to provide these services. Minimal housekeeping staff are present on the night shift, and ancillary services -- such as radiology, laboratory, respiratory therapy or pharmacy -- are staffed by skeleton crews or, in the case of physical therapy, completely closed. As a result, the night shift staff are forced to be independent and resourceful.

Erin glanced at her watch, knowing she needs to check on the status of the bed for the admit to the orthopedic unit and complete her charges before her shift ends. The other patients in the unit are in a "holding pattern." They've been assessed by the nurse and physician and their lab work is pending. All lab work from the Emergency Department is STAT, or requiring immediate attention. However, this is an especially busy time for the lab. Lab work has been pouring in from the critical care units, the preoperative unit, and the general wards, much

of it labeled STAT.

Knowing there are several empty beds in the orthopedic unit, Erin called only to discover they are not available. "We're terribly understaffed again," the charge nurse said. "We've got three patients to prep and ready for surgery. Besides, I don't even know if the empty beds have been cleaned. Housekeeping has been cut back too." Erin hung up, frowning. She knows the day shift staff will be annoyed that this patient hasn't been transferred. She wonders if they understand her own annoyance. Like many of the ED staff, she is frustrated about their inability to get patients promptly admitted to the hospital. It doesn't seem to make sense. The hospital is busy; more and more patients are being seen in the department. Yet, they've just had another round of lay-offs that has further reduced staffing. As a consequence, the ED often warehouses patients for 6 -12 hours before a bed is ready.

Daylight Hours

The day shift staff begins to trickle into the unit. The staffing pattern on that shift is staggered to parallel the typical surges in the number of patients. At 7:00 AM three RNs, 1 LVN, a ward secretary, and a unit clerk are scheduled to begin their shift. Typically the staff drift in between 6:30 and 7:15 AM. Unlike traditional hospital units, report is very informal. All of the nurses from the oncoming shift cluster at the front desk area as each night shift nurse gives a brief oral synopsis of her patients. When the reports are complete, the oncoming charge nurse assigns staff to the existing patients and determines who will receive the next series of admissions.

As a group, the day shift staff have decidedly different personalities than their nocturnal counterparts. Many of them have been long-time employees of one of the three competing community hospitals that, in 1993, merged to form Western Community Medical Center, which is licensed to operate over 500 acute care beds. Before the merger, these three hospitals stood as independent entities, each with its own personality and flavor, within a single community for almost seven decades.

Facility A was a community hospital offering comprehensive care. It was proud of its reputation for innovation. In that community, this was the hospital that strived to be first, an effort reflected in a string of regional accomplishments, such as first cardiac surgery in a community hospital, first MRI scanner in the area, and first community hospital to offer joint replacement surgery. Before becoming part of Western Community Medical Center, this hospital was known as "the doctor's hospital" in the community. Health care personnel in the area, including physicians, felt that it understood the needs of the physicians. The ED at Facility A was also doctor-oriented. Many of the patients it treated were sent by their private physicians. Clients were often seen for treatments or suturing or if they needed treatment after their physician's regular office hours. The ED, being small, could not care for many patients. Nor was it designed to handle high acuity patients, for it had poor access to surgery and support services. In addition, its entrance was difficult to reach due to the maze of one-way streets surrounding the hospital.

In contrast, Facility B, a modern facility, was part of a chain of religiously affiliated health and education centers. It was designed with nursing and medical

input. The in-patient rooms were mostly private; each had a view of the surrounding hills or an interior courtyard and garden. Historically, this hospital was strongly committed to serving the poor, the elderly, and underserved. Religious personnel were on site and strongly committed to patients and staff. Consequently, a large percentage of employees had many years of service. The spacious ED in Facility B was located next to an ambulatory care unit. Lab and radiology services adjoined the ED, and a private elevator connected the ED to the operating room below and the Intensive Care Unit above. Facility B ran an active ED for decades. The department was equipped to handle trauma, medical, surgical, and obstetrical emergencies, as well as non-urgent care. It also served as a training station for pre-hospital emergency medical services personnel (paramedics and emergency medical technicians).

Facility C was a small community hospital that served mostly the well-to-do in the area. Since it was an older facility, at the time of the merger it required significant structural upgrading to qualify for continued inpatient use. This hospital had never run a full-service ED. Instead, its ED was used for minor procedures or scheduled treatments offered by area physicians.

At the time of the merger, Facility A had the most assets and money in reserve. Consequently, this facility became the acute care facility for the newly formed medical center. Unfortunately, this meant that the volume of patients from all three EDs were now being funneled into one small department that had already been overcrowded before the merger. Given their discrete histories, these three separate cultures have yet to coalesce, and the occasional tensions between them affect the tone of the department.

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At 7:30 AM, another RN arrived to assume the role of triage nurse. Triage, a French term, means to pick or sort. Historically, triage was conducted to differentiate high quality products from similar products of lower quality. For example, in 18th century Europe, produce and imported goods were evaluated at a triage station and ranked in both quality and price.

The notion of triage in health care originated in the military. Baron Dominique Jean Larrey, Napoleon's chief medical officer, is credited with being the first to classify wounded soldiers based on medical need without regard for rank. Triage became part of the American health care system during World War I. Wounded soldiers were evaluated in the field and sorted into groups. Soldiers with minor injuries were treated in the field and rapidly returned to the front. Others were transported for further care or burial. Later, in the early 1960s, the concept of triage was brought to hospital emergency departments as a means to deal with the rapidly increasing number of ED visits (Mezza, 1992; Thompson & Dains, 1982).

The triage nurse is housed in a booth that adjoins the ED waiting area. Jack, a grizzled ex-military corpsmen who has become an RN, was working triage, a job he likes.

> It reminds me a lot of being on point when we were on the move in Vietnam. Point is the front position, the first to venture into the area. When you work triage you're the first to hear the story. Just like when you're on maneuvers, you've got to stay alert. A lot of people that come in here want to scam you. You've got to listen to their story and take a look at them. In triage you decide who needs to get seen now, who can wait a little, and who can wait all day.
>
> This is a medium size ED. We actually see and treat about 150 patients every day. Quite a few more come in here and leave before

> they've been seen. We get all kinds of people. A lot of nurses don't like to work triage because you have to hold your ground. Many people who come in here think they should be seen right away and they fuss and holler to get their way. If you think it can wait, you've got to stick to your guns and take the verbal abuse.

Jack, in his mid-forties, dresses casually in jeans and a scrub top. Like most of the ED staff, he is Caucasian, unlike most of the clients seen at this site, 85% of whom are members of ethnic minorities. Approximately 60% of the clients seen in this ED are African-American, 16% are of various Asian descents, and 15% are Caucasian. The remaining 9% of clients represent a multitude of other ethnic backgrounds. The ethnic mix of the clients at this site reflects the diversity in the community surrounding Western Community Medical Center.

When Jack arrived on duty at 7:30 AM, several patients were already in the waiting room, an open area immediately off the northeast entrance of the hospital. The area, approximately 30 x 40 feet, is sparsely outfitted with chairs, a television set, old magazines, several pay phones and public restrooms. The area is lit by ambient light coming in the windowed entrance and large fluorescent lights that frequently buzz and hum. The room is warm and stuffy, its ventilation problem exacerbated by hospital employees who cluster near the entrance to smoke cigarettes.

Seated at a desk in the waiting area is a uniformed guard. During the day, the role of the guard is very different. In the evening, though, the guard usually sits, reading a magazine or watching the television that is almost constantly on. Only occasionally does he make eye contact with people entering the building. Jack noticed that the guard was reading a sports magazine and eating breakfast at his

desk. Like most of the ED staff, Jack is upset with – and complains about -- the lack of adequate security in the department. Frequently the staff have to deal with intoxicated and belligerent patients; often as they undress or examine patients, they find weapons on them. Almost all the staff feel that the security guards employed by the hospital are useless.

As Jack talked with a young woman who was complaining of a rash, he saw more staff arriving. Anita, an experienced RN, has arrived for her shift that begins at 8 AM. Bruce and Bob, the daytime physicians, are chatting as they stroll from the parking lot into the waiting area. Jack recorded the woman's vital signs on the ED record. The woman explained that she has had a rash for almost two weeks. Jack asked her what, if any treatments, she has tried since she first noticed the rash. She replied, "I haven't done anything. I'm pretty sure it's scabies, but I haven't had time to get to a clinic. It was really itchy today so I thought I'd come on down here before it gets too busy." Jack grunted and placed a green sticker on her chart. He told her to take a seat in the waiting area. "It's gonna be quite a while before you'll be seen. We have sick patients ahead of you," he said with thinly veiled irony. She reluctantly picked out a seat in the waiting room.

Jack's green sticker is a signal to the staff. All the patients evaluated by the triage nurse have colored stickers placed on their record. A red sticker indicates that the patient requires immediate care. A client with severe chest pain or shortness of breath would receive a red sticker and be taken into the department by the triage nurse for immediate treatment. A yellow sticker indicates that the patient is acutely ill and needs to be seen within 1 to 2 hours. A green sticker denotes that the client could be seen at a clinic.

Many of the triage nurses joke about the sticker system. The sticker system uses the same colors as a traffic light. Patients meeting criteria for a red sticker need you to stop and pay attention; they need care now. Those with yellow stickers require caution. Right now the patient is stable but quite sick. In a traffic light, green means go. Most of the staff wish that these clinic patients would go elsewhere.

In the department, the "Med-Net" radio system alerts staff about incoming ambulances. Patients arriving by ambulance are rarely seen by the triage nurse. Instead, the ambulance crew rolls the patient into the department on a gurney. The patient is briefly assessed by the charge nurse and assigned a room. If the 20 rooms are already occupied, the gurney is placed against the wall in a hallway. Required equipment is moved next to the gurney and all care is rendered in the hall.

If a patient arriving by ambulance does not require prompt care, the charge nurse asks the ambulance crew to escort the patient to the waiting area. Once in the waiting area, such patients are screened by the triage nurse and called into the department when space is available for those with green stickers. The ambulance crews and the ED staff know that many patients with minor complaints try to "outsmart the system" by calling an ambulance and "putting on a good show." The charge nurse and paramedics work together to determine who "really" requires prompt care.

At 8:00 AM, an ambulance crew notified the department that they were in transit with a 75-year-old man complaining of chest pain and swelling in his lower extremities. Several minutes later, they arrived with Mr. Mason, a thin

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African-American male dressed in dirty, thread-bare pajamas. Mr. Mason is in a semi-upright position on a gurney with a blanket draped around him. Since Mr. Mason has been reporting chest pain, he is wheeled into a room containing cardiovascular monitoring equipment.

The charge nurse asked Anita Wood, an RN, to care for Mr. Mason. As she attempted to hook him up to the cardiac monitor, she noted that he is covered in stool up to his mid-chest. The paramedics watched as Anita quickly surveyed the extent of soilage. Because of the excrement, she was unable to attach the leads to the cardiac monitor. Anita quickly checked Mr. Mason's vital signs while the paramedic explained that his son had called 911 and said his father was having chest pain. However, Mr. Mason hadn't complained of any chest pain. "My body hurts. I've got pain all over. There's nothing particular about my chest, it isn't hurting now. I just ache all over and I'm hungry. I'd like to be cleaned up and eat," he said. The paramedic shrugged his shoulders and told Anita he's unsure what to think:

> The son met us at the door and told us his father was sick and having chest pain. We scooped him up based on that, but the old guy's story doesn't match. He was covered in stool and the house was a mess. The son told us he would come to the hospital. I guess he's out registering his dad now. Either the son's lying or the old guy's a bit off.

Anita gave Mr. Mason some supplemental oxygen through a nasal cannula, a tube worn around the face and nostrils. She spoke with him as she applied the oxygen. "Mr. Mason, do you know where you're at?" Mr. Mason replied, "No. They didn't tell me where they took me." She shrugged and spoke to the paramedic, "I guess we should rule out cardiac problems. I'd like to talk with the son because he [gesturing to Mr. Mason] doesn't know what's going on." Anita

called out to the unit secretary and asked her to locate Mr. Mason's son. Meanwhile she and the charge nurse cleaned up Mr. Mason. When they were finished, Anita ran an EKG, drew blood, and inserted an intravenous line.

Mr. Mason was alert and followed commands but he appeared bewildered about his situation. "I don't know what's going on; my son called the ambulance. Why am I here? I want to talk to my son. What's going on?" Although Anita and the ward clerk were unable to locate his son, Mr. Mason managed to tell Anita that his son "takes care of him." When questioned about his living arrangement, he offered the following story.

> I live with my son. I'd like to be able to take care of myself, but I need help doing some things. Oh, I can eat. I don't need nobody to feed me and I can stay to myself during the day. But I can't get dressed or get to the bathroom without help and I need him to fix the meals. ... I stay with my son, but I take care of myself when he goes out in the morning to go to work and then I'm home by myself.

Anita tried to focus the dialogue on Mr. Mason's current condition. He didn't seem to be having any chest pain. She explained the circumstances to Bob, the ED physician. "It looks like this guy doesn't have chest pain. He doesn't want to be here, but his son called the ambulance claiming this chest pain thing. I ran an EKG but I don't see anything." Bob and Anita examined the EKG and agreed that it was normal. Anita explained Mr. Mason's state of hygiene and the absence of Mr. Mason's son. Bob briefly chatted with Mr. Mason and listened to his heart and lungs. As he removed the stethoscope from his ears, he looked to Anita. "Well, I guess we should see if there is anything going on. Let's send some basic lab work out, get a chest X-ray and some blood gases. Maybe he's got an old chart. But let's find this son."

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As Mr. Mason was being initially evaluated, the pace of the ED began to pick up. By 10 AM all of the rooms were full and several patients were being treated in the hall. Two additional staff nurses arrived on duty at 10 AM to cover the upsurge in numbers. The charge nurse and Anita agreed that Mr. Mason was "not sick, just a disposition case." Since he wasn't sick, he didn't need a room. He was moved on his gurney into the hallway.

Bob and Bruce each grabbed a cup of coffee. "This place is really humming now," said Bob. A constant stream of people flowed in and out of the department, and the noise level was very high. Staff were clustered around the nursing station. Jill, the charge nurse, remarked that most of the patients were in a "holding pattern." The staff nodded in agreement. All the patients had been seen and evaluated by a member of the nursing staff. Preliminary lab work, X-rays or treatments had been initiated. The physicians were consulted when a question about the best approach for the patient had come up. The nursing staff, however, usually did the preliminary evaluation and presented the patient to the physician when the lab and tests results returned.

While the results are pending, the patients wait. Most wait alone. However, if the patient is critically ill, the nurse and often the physician are at the bedside. Family members are rarely allowed in the department unless staff believe they will be helpful in caring for the patient. In most cases, they are viewed as an annoyance -- more people in an already crowded place.

As the patients wait, the staff talk about all the changes at the Medical Center. All this change has been unsettling. The physicians and nurses often talk about how things used to be and what was better about those times -- better staffing,

better morale, better working conditions, greater job security. One rarely hears a positive comment about the merged medical center.

Nursing staff tend to cluster at the desk area or in the break room. Local police officers, firefighters, and paramedics pass through the department regularly. They usually have coffee or lunch and use the restroom before returning to the field. Often their banter with the nurses is flirtatious. The ED physicians either participate with the group at large or sit together by their transcription phone lines. Local physicians also often hang out in the department. As managed care has become prevalent, many specialists are finding their practices and incomes dwindling. They will frequent the ED, chat with the physicians, nurses and unit secretary and attempt to pick up patients who need ongoing care but lack a private doctor. Other hospital staff, such as X-ray technicians, respiratory therapists, and social workers are called into the department as needed. During the daytime there is also an administrative presence in the department. Both the Nursing and the Medical Director can be seen as they talk with staff and engage in problem-solving and budgeting issues. A roving security guard also walks a beat that takes him through the ED at regular intervals.

These daily interactions seem to engender additional noise. Staff often yell out to each other to pass on patient and personal information. The telephones steadily ring and the Med-Net radio system sounds with each call from an ambulance. The monitors in the patient rooms and around the desk beep with real problems as well as artifact caused by the sensitivity of the instruments.

The unremitting noise affects patients. Many comment that the department is

"chaotic," "incredibly busy and noisy" or "overwhelming." Patients who are treated in the hallways are especially vulnerable to the noise level. The charge nurse is responsible for keeping this pandemonium under control. Jill, the regular day shift charge nurse, described her role as similar "to an air traffic controller job -- responsible for directing patients in and out of the department and safely landing people where they belong."

Mr. Mason was in the middle of the noise and traffic. Since he was "not sick," he had been left in the hallway, his oxygen and cardiac monitor turned off. An IV bag hung from a pole connected to his gurney, evidence of his original complaint. Neither Mr. Mason's son nor an old chart could be found. The records clerk informed Anita that she had a "near match." A chart was found for a patient with the same name who was 90 years old. Anita questioned Mr. Mason about his date of birth and address. He could recall that he was born in January. He thought the day was the 28th but he couldn't be certain. As to the year, he just laughed, "Honey, it was a long time ago. What difference does it make? I'm legal for everything." When questioned about his address, he quickly responded with a street address and phone number. The address and telephone number matched the one on the old chart. Anita and Bob, the physician, concluded that Mr. Mason was an unreliable historian. After this confusion, they spoke about him while in his presence, but did not consult him about his condition or their plans for his care.

Anita called in a social worker to see Mr. Mason. Since there was no room or private area in which to meet, the interview was conducted in the hallway where Mr. Mason was positioned, across from the critical care rooms and in the

pathway of all ambulance gurneys entering the department. The social worker attempted to determine his orientation and his care needs. Mr. Mason was affable and said that his son "does the best he can." The social worker asked, "Do you get along with him? Is he good to you?" Mr. Mason replied, "I get along with him okay. We fight sometimes, like kin fight. Sometimes he hits me. But if he hits me, I hit back." The social worker attempted to draw him out about the fighting and hitting. She asked a storm of questions about fighting and discomfort associated with living with his son. However, Mr. Mason was unable to get specific. He kept replying, "I told you everything. There's nothing to it. We fight like kin."

The social worker told Anita that she suspected Mr. Mason was abused. She questioned Anita about signs of abuse. Anita chuckled. "I don't think he's abused," she said. "I think he's neglected." As they were talking, Mr. Mason's X-ray and blood gas results printed out in the department. So far everything was normal. Anita and the social worker agreed that Mr. Mason obviously needed ongoing assistance with activities of daily living (ADLs), but so far there was no evidence that he would require hospitalization. As they continued to examine the old chart, they discovered that Mr. Mason had been brought to the ED only three weeks before. On that occasion, the son had called for an ambulance, reporting that his father was "combative" and his "skin was hot." When Mr. Mason had arrived in the ED, he was covered in urine and stool. The son insisted that this combative behavior along with incontinence had just begun and was quite worrisome. "I'm afraid he's going to hurt himself or me," the son admitted. Mr. Mason was admitted to the hospital with a diagnosis of "R/O CVA," rule out cerebrovascular accident, or stroke. After six days in the hospital, Mr. Mason had

been transferred to the Skilled Nursing Facility (SNF)., where he spent an additional eight days. As they studied his old chart, Anita and the social worker quickly realized that Mr. Mason had been home for only one week.

On the old chart were detailed notes about Mr. Mason's living situation. According to the record, he was often left at home alone, in spite of the fact that he "requires assistance with just about everything." Mr. Mason's son did not offer information about where he spends his days, although he does not work. The previous social worker had suggested that Mr. Mason be moved to a board and care facility or convalescent hospital. However, the son refused, admitting that he needed his father's pension to live on since he did not work. The old chart also contained the son's pager number. Anita placed a call and waited. There was nothing to do but wait.

Shortly before noon, the nursing and medical staff began to rotate through luncheon breaks. The "holding pattern" of patients was beginning to break up. Patients who arrived in the early morning were ready for discharge. These patients had spent an average of four hours in the department. Others were being admitted to acute care beds. The admitted patients often had long delays before they reached their assigned bed. Although Western Community Medical Center claimed that declining occupancy rates and shorter lengths of stay were creating a financial hardship, that was impossible to believe in this ED. Many patients wait for hours before an acute care bed is available. The medical center claims that it averages a 60% occupancy rate, but this statistic is misleading. Whilt the utilization of open and staffed beds is extremely high, the medical center holds a license for far more beds than it actually uses on a day-to-day basis

and includes them in its claims. Many licensed beds are unavailable for acute care use because they exist in Facility B or C.

As patients were discharged, rooms became available for seeing new patients. Ten patients were in the waiting room. However, with the lunch breaks, new patients were not being brought into the department.

Anita ordered a lunch tray for Mr. Mason. She discontinued his IV fluid and capped the IV port. As she assisted him to the bathroom, she noted that he is quite frail and thin. His movements are slow and tentative. "I usually use a walker. If I can get to my walker, I can help myself more," he said. The area around his buttocks was excoriated and on his elbows were signs of healed pressure sores.

Mr. Mason seemed unfazed by the chaos of the department. Ambulance crews navigated around his gurney and staff carried on personal and professional conversations in his presence. "I don't mind," he said. "I'm usually by myself so I enjoy being out."

After lunchtime, the pace of the department began to pick up. Staff attempted to catch up on the backlog of patients. Jack, the triage nurse, was in the department checking the situation out and conferring with the charge nurse and the MDs. "The natives are getting restless out there," he said. "I'm sick of getting yelled at. You gotta start getting some patients in here or there's going to be a war out there."

Mr. Mason remained in the department. His son had not returned the page; Anita was getting worried. It was Friday afternoon, and social services and

discharge planning would be unavailable after 4 PM. She knew something had to happen soon. Bob, the ED physician was reluctant to admit the patient:

> There's nothing really wrong with him. His lab work, x-ray, and blood gases are all fine. There's no sign that he ever was having cardiac problems. I think he just got dumped here. Now we have to figure out what to do with him.

The social worker felt that the situation was beyond her scope. "I've got nothing to work with. He'll just have to get admitted; then I'll deal with this on Monday." Unsatisfied with this response, Anita called the Discharge Planning Nurse and explained the situation. Pat, the Discharge Planning Nurse, was adamant, "We can't admit! We'll never get paid for it. We have to get him placed right away." In a few minutes she was in the department and began calling Board & Care Facilities in the area. Each was reluctant to accept the patient because his financial picture was unclear. According to the old chart, Mr. Mason received a small pension. When Mr. Mason was discharged from the hospital one week ago, his son was scheduled to meet with a financial counselor to arrange Medicaid coverage and in-home support services. However, the son didn't show up at the meeting. Without Medicaid in place, the Board and Care Facilities refused to accept him. Pat knew that since Mr. Mason had been hospitalized for more than 3 days less than 30 days ago, he could be transferred to a SNF. However, the SNF associated with the hospital was also hesitant to accept him. "You've told me there's nothing wrong with him. I can't accept a patient who doesn't have skilled needs. He must have a need for skilled care before we can accept him," said the SNF director.

Anita was disgusted. "I don't have time to find living arrangements for all

these old folks who come in here," she said, her irritation seeping out. "His son can't just drop him off. This isn't a hotel!"

Mr. Mason remained on a gurney, in the hall by the ambulance entrance. No one knew what to do with him. However, the nurse, the physician, the discharge planner, and the social worker all knew they would have to act in some way. His son had still not been heard from. Unfortunately since it was Friday afternoon, if movement didn't come soon, they would have no options; social service and discharge planning only work weekdays. Anita and Bob knew that Mr. Mason's placement would ultimately fall to the ED staff. This was one of the chief complaints from ED staff about caring for "these patients with social problems." In the meantime, they had a department full of people who were "truly sick" and a full waiting room.

At 1:30 PM, an ambulance arrived with Regina Castle, a 79 year old woman who had fallen and was now complaining of severe pain in her lower left leg. Ms. Castle, awake and alert, was extremely hard of hearing. She wore bilateral hearing aids and had poor enunciation. Terry, the staff nurse, noted on the chart that she had "slurred speech." In reality, Ms. Castle's "slurred speech" was the result of a life-long hearing impairment.

Ms. Castle was placed in Room 12, a large open room that could accommodate several gurneys. This room, usually reserved for clients with orthopedic problems, was well-stocked with casting materials.

Ms. Castle had been brought in by ambulance. The night before, while preparing an evening snack around 10 PM, she had slipped and fallen in her

kitchen. She was unable to stand after she fell, so she dragged herself to the couch in the living room where she spent the night. In the morning she found her leg swollen and was unable to stand due to the intense pain. Fearing the worst, she called her friend Sheila.

Sheila, a young woman who lived on her street, was a single mother in her thirties. Sheila and Ms. Castle enjoyed spending time together; they would meet for lunch or go to the movies. Ms. Castle used to have a domestic worker come to her house to help with cleaning and grocery shopping, but she had poor experiences with several workers. She would often give them money to purchase groceries and household items and they would go to the store and forget many of the things on her list. Usually she did not get her change back either. Ms. Castle was aware that Sheila's finances were tight, so she had asked Sheila if she would like the work. Sheila gladly accepted the offer. After all, she enjoyed being with Ms. Castle and could use the extra money. Ms. Castle would often ask Sheila to get food for an elaborate meal and then she would invite Sheila and her son over for it. Ms. Castle thought it was a wonderful arrangement; she had a true friend that would help her. Sheila thought it was a wonderful arrangement as well.

When Sheila and her toddler son arrived at Ms. Castle's apartment in the morning, she wanted to call an ambulance right away, but Ms. Castle thought she was being overly solicitous and insisted Sheila help her elevate her leg and put ice on it. "If it doesn't get better after a couple hours of that, then I'll give in," she told Sheila.

When Ms. Castle arrived in the ED, she brought her walker, a bag of medications, a list of names and numbers of all of her physicians, a change of

clothes and a toothbrush. Terry, the ED nurse asked, "Are you planning on staying?" Ms. Castle responded, "I just tried to bring what you might need, but I don't want to stay. I just brought a change of clothes because I thought I might need to put on a dress if you cast my leg." Ms. Castle had a history of epilepsy and was on numerous medications. "I can't remember all the names of the medicines so I thought it would be easier to just bring them since I knew you'd ask."

Terry continued to quiz Ms. Castle about her injury. As Ms. Castle explained the sequence of events, Terry interjected, "You mean you live alone? How can that be? Who takes care of you?" Ms. Castle chuckled heartily, "I take care of myself."

Terry ordered an X-ray and drew some lab work. She reported to Bob, the ED physician. "It looks like the old lady in 12 broke her leg," she said. "She's a crazy old thing, out tootling around on city streets with a walker and living alone, so I guess it was a matter of time." When the X-ray revealed a complicated fracture involving the tibia and fibula, Bob called an orthopedic surgeon to see Ms. Castle. He knew that she would need more than a simple cast and surgery was likely. He broke the news to her:

> You're going to have to stay with us to get that leg fixed. I've got an orthopedic surgeon coming to see you. So it'll be a few days here and then you'll go over to the Skilled Nursing Facility. In the meantime, we need to look at your living arrangement. Do you have any children or family you could move in with? [Ms. Castle shakes head no.] Then it's probably time for you to think about moving someplace where you can be taken care of.

It was now almost 3 PM. Terry knew she could not send Ms. Castle upstairs

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because of the change of shift. It was an unwritten rule that the ED staff knew they could not violate; none of the floors or the critical care units would accept patients around the change of shift. The scheduled overlap between the day and evening shift was between 3 and 3:30 PM. In reality, however, movement of patients between 2 PM and 4 PM was hampered due to the change of shift.

Evening Hours

In the ED, shift change was casual. Staff drifted in between 2:45 and 3:15 PM. The evening shift is much more casual than the day shift. They often wear jeans and shirts or scrub clothes. Sometimes staff show up in casual attire and change after report. On the evening shift there isn't much contact with administration. The nurse manager is frequently the only administrator seen after 3 PM.

Evening shift has "a personality of its own." The ED Clinical Nurse Specialist claims that all "the problem children" work this shift. The nursing staff on this shift are younger than on either days or nights, and there are more men on this shift than on the others. The ED physicians also tend to be younger; working permanent days for the MDs comes with seniority. In this hospital as in many, ED physicians are contracted through a physician group.

At 3 PM, 7 new people come on duty: 5 RNs, 1 LVN, and 1 clerk. The overlap between the staggered day shifts and the PM shift provides maximum staff coverage between the hours of 3 PM and 6:30 PM. In this ED, as in many, these are often the busiest hours. The hectic pace continues until approximately 9 or 10 PM and then seems to level off. Many of the patients seen during these peak times are not "true emergency patients." They are often sick, but could be treated

in a clinic or at an office visit. However, in many cases they have no insurance and/or limited resources, so they know they may have to wait but eventually will be seen. Staff also know that they must see these patients. There is a constant tug of war between staff and these patients who are not "true emergency patients." Often, these patients are forced to endure prolonged waits constructed by staff, that is, even if it is not very busy they will still have to wait. One staff member summed it up, "If it's too easy they'll keep doing it. It doesn't make sense to make it a great experience for them."

Ms. Castle was stuck in a holding pattern. Technically, she was ready to be transferred to the orthopedic unit. However, the orthopedic unit was never out of report until at least 4 PM. After that they stated they could not accept her because they were receiving several surgical patients. "We just don't have the staff to take all three admits at one time," said the floor nurse. Terry was resigned to this delay. Since she was leaving, someone else would have to transfer Ms. Castle.

The oncoming PM shift was slow to start assuming care. Instead, there was a lot of dialogue between the two shifts about the new computer system scheduled to go on-line that week. They were all expected to start using it but felt inadequately prepared. Charise, the PM charge nurse, was angry at the PM shift's sluggishness. Twenty-two non-urgent, green stickered clients were waiting to be seen. Jack, the triage nurse who was scheduled to go off at 4 PM, was reading magazines in the break room and chatting with the PM staff. "I'm not going out in the waiting room. It's like an angry mob out there. I told the guard to call back here to let me know if anyone new arrived."

In the meantime, a crew from the Plant Services Department had arrived to install electrical outlets and a new desk area that would accommodate the computer terminals. Their arrival infuriated the nursing and medical staff. This was their busiest time and now there was construction!

The head of the crew seemed surprised. He had been the head of Plant Services at Facility C before the merger. Since he had the greatest seniority at the time of the merger, he had assumed the role of Supervisor of Plant Services for the medical center. At Facility C, this would have been the slow time for the ED. Facility C's small back-up ED had functioned as a clinic. He was surprised to see the number of patients, but he had brought in a crew to do this work, so the staff would have to work around them. Charise paged the ED Manager. She was outraged that this crew was going to be in the ED during this busy time. The Manager arrived and surveyed the situation. While Charise and the staff ranted about the confusion this would cause, the Manager spoke with the Facilities Supervisor. They concluded that this project was "bigger than both of them." The Manager told the staff, "You can bitch and moan, but it's gonna happen. This is all part of the changes we're making. If you think this is bad, just wait until we start our major remodeling." She was referring to the multi--million dollar planned renovation of the ED. With the merger, the ED had outgrown its space, becoming cramped and inefficient. If the medical center was successful with its fund raising activities, the renovation would start early next year.

At 5 PM, Mr. Mason was still on his gurney. In spite of the noise, he had fallen asleep. His son had not been heard from yet. Ms. Castle was hungry and thirsty. Since the orthopedist hadn't arrived, no one knew if she would have

surgery that evening or the following morning. If she was going to surgery that evening, she wouldn't be able to have anything to eat or drink. Staff members told her, "It's all up to your doctor. We have to wait for him to come in." Ms. Castle didn't know why she couldn't have a drink of water.

The Med-Net announced the approach of an ambulance. Charise, the charge nurse answered the call. "We're Code 3 on your back door with a 69 year old woman from Broadway Convalescent. She's in extreme respiratory distress. Respirations are rapid and labored." Charise knew that Broadway Convalescent was only a few blocks away. They would be here any second. Since they were coming Code 3, meaning as fast as possible with lights and sirens, she knew this patient was critically ill. Containing her frustration, Charise moved a patient out of a high visibility room equipped with hemodynamic monitoring equipment, notified the staff member who was open for an admission, and warned both of the physicians. With a Code 3, they needed to be ready for anything.

The ambulance arrived moments later. On board was Matilda Scott, a 69 year old African-American woman. Ms. Scott was upright in the gurney. Her respirations were labored; she appeared to be gasping with each breath. Her eyes were closed and she did not respond to verbal or tactile stimulation. The paramedics explained that according to the SNF staff Ms. Scott had become increasingly congested over the last 24 hours. A call had been placed to her physician last night and again in the morning. He never returned the calls.

Ms. Scott had suffered a massive myocardial infarction, or heart attack, 6 months ago. As her daughter was bringing her to the hospital, she ceased breathing. Although ED staff were able to resuscitate her, she had suffered

anoxic brain damage. At best, Ms. Scott opened her eyes and appeared to mouth words. She received all fluid and nutrition through a gastrostomy feeding tube that was inserted directly into her stomach.

Irene was assigned to receive the new patient. She took a set of vital signs. Ms. Scott's blood pressure was low, her respiratory rate was 50 per minute, and her temperature was 105°. Irene placed EKG patches on her chest and connected them to the cardiac monitor. Her heart was racing and irregular. Joel, the PM physician, asked for a status report. Irene reported the vital signs, and the paramedics shared the information they had received from the SNF. Irene and Joel briefly discussed the situation. They knew she would not live long if they did not intervene. Joel was first to speak, "What's her code status?" he inquired. The paramedic reported that according to the SNF nurse, Ms. Scott was "a full code." Full code status implies that the patient will receive aggressive intervention and resuscitation if the need arises. One paramedic added that Ms. Scott had a daughter with her in the SNF when they picked her up. "We couldn't take her in the ambulance so she's probably in the waiting area now," said the paramedic. Joel had the unit secretary attempt to locate the daughter while he placed a call to Ms. Scott's physician. Unable to reach the physician, he left an urgent message with the service.

Irene quickly drew arterial blood gases and started an IV. She perused the paperwork that had been brought by the paramedics. In several minutes, Ms. Scott's daughter, Martha, arrived at the ED, sweaty and breathless. She had no car and had run from the SNF to the hospital. The guard let her into the department. When Martha saw her mother, she quietly wept.

Irene talked quietly to Martha. "How is she usually? Does she know you when she sees you?" Martha replied:

> Better than this. Oh, yeah! She knows when I come and she tries to talk. She's usually much better. I try to see her everyday. The past couple of days she's been coughing a lot. And today she seemed so bad. The nurse at the convalescent home tried to call Dr. Bacon last night. But he never called back. When she seemed so bad today, the nurse told me she would have to go to the hospital.

Joel, the physician, entered the room and spoke directly to Martha. There was no time for introductions or preliminary discussion. He launched right into the painful subject.

Joel: Your mom is very sick. If this was a young healthy person I might put a tube in her windpipe and put her on a machine. But she's older and very sick. I think that might be cruel. What do you want?

Martha: I want you to give CPR and everything. [looks toward her mother]

Joel: [makes direct eye contact with daughter] I think that's cruel.

Martha: [still looking toward mother] I have to live with myself. I want you to do whatever you can do to help her.

Joel: [maintains direct eye contact] Sometimes the best thing to do is let her go. I think you're doing the wrong thing. [Walks over to Ms. Scott and places his right hand on top of her head, with his thumb and index finger he pulls her eyes open. With her eyes in an open position, he rapidly moves her head side-to-side as he looks at her pupils.]

Martha: [speaks to MD] She was fine up until a heart attack this year. I mean fine. You will give her CPR and do everything?

Joel: Yeah, I told you we would. [leaves room]

Irene: [to Martha] I like what you said. You have to live with yourself. It's OK, you can say that. It's OK.

Irene left the room to inform the charge nurse of the uncertainty about Ms. Scott. The paramedics who brought Ms. Scott in joined her to discuss the situation. One of the paramedics was firm in his conviction. "I can understand where the daughter's coming from. She really is only 69." The charge nurse didn't agree. "The problem is that all these SNFs expect us to do heroics. They call 911 and dump their problems on us. I'm tired of this." Irene was more pragmatic in her approach. "We could stand here all day and talk about how bad the SNFs are with all their vegetative patients, but I got a problem. What am I gonna do if this woman codes on me?"

As Irene and the others continued their debate about Ms. Scott, Mr. Mason observed much of this action. He pleaded to each passing staff member, "Please let me go home. Just call my son. He'll come get me." Mr. Mason had now been in the department over 10 hours.

Shortly after 6 PM, Mr. Mason's son arrived at the main entrance of the hospital. He told the information desk that his father had been admitted to the hospital earlier that day and asked for his father's room number. When the receptionist informed him that his father was still in the ED, the son seemed shocked.

As soon as he arrived in the ED, he spoke directly to his father. "What are you still doing here? Why didn't they put you in a real bed upstairs?" Before Mr.

Mason could answer, Charise approached the son. "Nice of you to join us, Mr. Mason," she said dripping vitriol. "Your father has spent the day with us after you said he had chest pain. We haven't found anything wrong with him. We've been paging you all day." The son stammered his reply: "I've been busy." Charise noted that he appeared disheveled and she could detect alcohol on his breath. As she observed him, she realized he was intoxicated. She conferred with Jeff, the other evening physician. Although there was no medical reason to keep Mr. Mason, he could not be released in his son's custody. They agreed to call the in-house physician group to take charge of Mr. Mason. Together they would concoct some skilled need requirement that would allow Mr. Mason to be admitted to the SNF.

The on-call physician answered promptly. When she arrived in the unit, she was quickly informed by Charise about the politics of Mr. Mason's case. She briefly examined Mr. Mason and spoke with the son. The son admitted that he was unable to take care of his father. "I just can't do it anymore. He needs everything done for him and that means I never have any time for me. It's just too much."

Charise and the physician conferred and examined Mr. Mason's current chart, talking in quiet tones. They both felt like they were being coerced into inventing a patient problem. Anita, the day shift nurse, had documented Mr. Mason's frail status and tentative gait. The physician agreed to order physical therapy so that Mr. Mason could go directly to the SNF. The SNF was notified of the circumstances and a bed was arranged. Although the SNF was part of Western Medical Center, it was located at Facility B. This move would require an

ambulance. On a busy Friday night that was going to take some time to arrange. Charise offered Mr. Mason a sandwich and juice. Mr. Mason's son had disappeared again.

Charise checked in with the RN who had just come on at 6 PM and taken over all the patients that were being cared for by the two nurses scheduled to leave. She also checked on Ms. Castle. They had gotten so overwhelmed with other patients that no one had been able to see if her room was ready. By now Ms. Castle was angry and tearful. She was cold, hungry, thirsty and in pain. Charise thought the best thing she could do is get her out of the ED. The floor could deal with these complaints. The bed had been ready for hours. Charise called transportation to move Ms. Castle who was full of questions. "What's going on? ... Where am I going? ... Am I having surgery tonight? ... My leg is killing me. Can I get something for pain?" Charise replied, "This is an Emergency Department. We take care of people who are very sick here. They'll take care of your day-to-day needs upstairs." Ms. Castle was frustrated. She knew she was being admitted to the hospital, but not much more. She voiced her frustration to the transporter. "That was one of the most confusing places I've ever been. I don't know what's going on. I'm all turned around." Ms. Castle had been in the ED slightly more than five hours.

Ms. Scott's daughter was not faring very well either. She too felt confused. How could they be so indifferent to her mother? The staff just didn't understand. This was **her** mother. She was fine up until she had that heart attack six months ago. There was nothing wrong with her before that. Everything was great then, but now her mom was really sick. Why couldn't she just get better?

Martha knew that if she just was patient and prayed real hard her mother would get better; then she could come home again and everything would be fine.

While Charise was dealing with Mr. Mason and Ms. Castle, Irene had been busy with Ms. Scott. A chest X-ray showed evidence of pneumonia. Ms. Scott was receiving IV antibiotics and fluid. Joel had spoken with the SNF physician. He echoed Martha's wishes; he wanted everything done for Ms. Scott. Joel was furious. This physician made rounds once per month in the SNF. He never went to see his patients at other times. If the patient's condition was deteriorating or if the SNF staff was calling frequently, he would have the patient sent to the ED. He never checked on his patients in the ED; and if they were admitted, he asked the in-house physician group to follow the patient. Joel slammed down the phone. "That bastard's done it again. He wants everything done but he doesn't have to see the situation. He doesn't know how useless it is. What a waste!" After he finished venting his feelings, he called the in-house physician group. He wanted no more of this case.

The ED nursing staff and in-house physician agreed with Joel. The physician was especially frustrated. "I have to follow this guy's patients all the time, but I wouldn't know him if I fell over him. It's all a use job." Although staff were angry at Ms. Scott's physician, they believed they understood his position. "The more patients he keeps alive, the more money he makes," explained Joel. However, Martha, the daughter, was a mystery to them. "Why does she want everything done? Doesn't she understand her mother is a vegetable?" After the in-house physician spent 15 minutes talking to Martha about advance directives and quality of life, Martha's position remained unchanged.

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The in-house physician knew how to handle this problem. She would admit Ms. Scott, but not to Intensive Care, just to a regular ward bed. Then things could "take their natural course." She had the ward clerk order a bed on a medical floor. "Let's get her upstairs as soon as possible," she called to the ED nurse. She told the daughter she would see her tomorrow. "In the meantime, I'd like you to think about what we talked about tonight."

Charise worked on getting Mr. Mason and Ms. Scott out of the unit. The nursing staff was swamped with other patients. The physicians hadn't seen half of those already in the unit and there were at least a dozen more patients in the waiting room. The facilities people were still in the department working on construction. One of the biggest problems with this merger, Charisse thought, was that they ended up trying to see too many people, in too small a space, using a system that was already outdated with far fewer patients.

A little past 9 PM, after Mr. Mason had spent over 13 hours in the ED, an ambulance arrived to take him to the SNF. A bed for Ms. Scott would also be ready shortly. Charise and the rest of the staff knew they would be relieved when she was gone too.

The evening shift concentrated on getting as many patients processed and discharged as possible. They knew that staffing was much lighter on the night shift and if they couldn't get some of these patients out of the department, they might need to stay overtime.

Erin arrived at 10:45 PM and surveyed the unit as Irene and Charise explained how the evening had gone. "It's been really busy," Irene said. "We've

had a lot of patients in here that were baloney; the rest were old and falling apart. There hasn't been a dull moment." Erin sighed and plodded over to the coffee machine.

Chapter 2

Emergency Departments: Past & Present

Chapter 1 presents a composite of a typical day in the ED at Western Community Medical Center (WCMC). Although the names of staff and clients have been changed to provide anonymity, all of the events and dialogue are real. Mr. Mason, Ms. Castle and Ms. Scott are participants in this study; however, they were not seen in the ED on the same day; creative license was used to present their stories together. The liberties taken in this approach, however, do not alter significantly the ED experience. The pace, variety of clients and staff, and dilemmas faced are accurately portrayed. To gain perspective on how and why this ED exists and functions as it does, this chapter will explore the historical development of emergency care in general and the evolution of the ED at WCMC. To aid the reader, my role in the research site and my data collection strategies will also be presented.

An Historical Perspective

The current manifestation of EDs is closely linked to recent changes in public policy and the development of hospitals as a major locus of health care services and technology. Historians note that hospital records of the early 19th century document the need for emergency services. In 1807, Pennsylvania Hospital, located in Philadelphia, became the first hospital to provide emergency services through the hiring of an experienced physician to "attend outpatients, treat and admit emergencies, and oversee the carrying out of attending physician's orders" (Rosenberg, 1987, p. 67). Success with this project led other hospitals to adopt this

practice and by the 1850s on-site emergency physicians became widely accepted in urban hospitals. The presence of this emergency physician, however, did not significantly affect the high morbidity and mortality rates present in early American hospitals (Rosenberg, 1987; Starr, 1982).

During the 1800s, emergency treatment, as well as admission, death, diagnosis, surgery, and wound care took place on open wards. Ambulances delivered patients requiring emergency care to the main hospital entrance where they were placed in beds on the open ward. All procedures were performed in full view of the other patients. Even minimal attempts to provide privacy through the use of curtains or screens were rare; their use emerged in some hospitals in the 1870's, but only for "naturally modest women" (Rosenberg, 1987, p. 292). Although these conditions seem onerous compared to contemporary standards, the absence of privacy was a godsend to patients and nursing staff. Patients were able to monitor each other and seek help from staff if a fellow patient was in distress. Similarly, hospital staffing was minimal and large open wards allowed the few nurses on duty the opportunity to rapidly survey all of their charges (Blaisdell, 1994).

Although these open wards were very functional, accounts from this era reveal that patients found it very disconcerting to observe fellow patients suffer and die. In answer to growing complaints, hospitals began to physically separate functions. Not surprisingly, the first distinct hospital area was a unit for dying patients. As the usefulness of functional separation was realized, hospital supervisors began to cluster patients based on diagnosis or health care needs. In 1897, the precursor to the modern ED emerged. Germantown Hospital, located

just outside of Philadelphia, reported the establishment of a separate receiving area for ambulances and admissions (Rosenberg, 1987). Each patient received in this department was undressed, separated from his personal effects, bathed, and physically examined. This admission ritual was designed to neutralize class distinctions among patients that would be mixed together on open wards.

Private ambulance companies predominated in the early and mid-1800s. These first ambulances were horse-drawn wagons operated most commonly by morticians, and occasionally volunteers (McKay, 1985; Haller, 1990). High mortality rates were widely acknowledged; therefore it was no surprise that morticians were actively involved in the transport of patients. Hospital morbidity and mortality improved dramatically between 1865 and 1925 due to the incorporation of sanitation, hygiene, surgical antisepsis, and anesthesia. These improved outcomes led to a rapid expansion of hospitals. As part of that expansion, hospitals took over the role of running ambulance services and designated separate receiving areas for these ambulances. As ambulance volume increased, many hospitals further separated functions by creating distinct sections for hospital admissions and emergency treatment (Starr, 1982).

The first half of the 20th century ushered in vast changes in health care in the United States: the number of hospitals rapidly expanded, medicine emerged as the dominant profession in health care, nursing became a respected career for women of all classes, and the use of hospitals for medical, surgical, and obstetrical patients escalated among all classes. During this time frame the hospital was established as the major source of medical and health care services. As hospitals concentrated their efforts on specialized services and increasing use

of technology, they relinquished their role in patient transport. Between 1925 and 1950, hospital-owned ambulances began to disappear as patients were transported to hospitals for emergency treatment in private cars, ambulance services operated by police and fire departments, or commercial ambulance companies owned by taxicab companies (Starr, 1982; McKay, 1985; Edlich, 1991).

Since 1950, increasing medical specialization and public policy have largely shaped emergency care. Among the health professions, medicine was the first to embrace emergency care as a discrete specialty approximately 30 years ago. James Mills, a former Navy physician and family practitioner, left private practice in 1962, and together with two other physicians, agreed to become full-time emergency department physicians in an urban community hospital in Alexandria, Virginia. This was the first time in the history of U.S. hospitals that a physician worked full-time in the ED. ED medical staff needs had previously been met by students, interns and residents in teaching hospitals and by "moonlighting" physicians in community hospitals. Preliminary reports of the Alexandria project were reported in the *Journal of the American Medical Association*, creating a national focus on the development of emergency medicine as a clinical specialty (Edlich, 1990). Through this spotlight, Mills went on to champion the development of emergency medicine residency programs and certification of emergency medicine as a specialty. As EDs grew and physicians began to specialize in this area, other health providers followed. The development of emergency nursing as a specialty followed closely behind the growth of emergency medicine and field positions, such as emergency medical technicians (EMT) and paramedics, arose (McKay, 1985).

Public policy and federal health insurance initiatives have also been instrumental in the ED evolution. Prior to the advent of federal health insurance, specifically Medicare and Medicaid (programs designed to provide health care services to elders, the chronically ill, and indigent persons), major EDs were found only in public hospitals. Privately insured clients were either treated in physicians' offices or admitted directly to the hospital. With the initiation of these programs in 1965, patients previously treated in physicians' offices could now be treated in the ED. Hospitals embraced this change, for they were assured reimbursement at a fee several times the rate paid private physicians. As a result, most community and small general hospitals opened EDs. To meet the needs of the growing number of people now being treated in EDs, many EDs expanded in size, added new equipment, and upgraded the number and skill level of personnel (Blaisdell, 1994).

Other federal programs assured the proliferation of EDs. The 1966 report by the National Research Council identified injury as the "neglected disease of modern society" (Champion, 1994, p. 681). This report noted that the chances of survival from accidents or trauma on American city streets were far less than in the combat zones of Korea and Vietnam. Outraged by this report, Congress included funding in the Highway Safety Act of 1966 for the purchase of life-saving ambulance equipment and additional medical training for field personnel as well as ED staff. This report relied heavily on the expertise of military medical personnel with combat experience and positioned them prominently in the evolution of EDs (Blaisdell, 1994; Champion, 1994; Edlich, 1990; McKay, 1985).

Federal policy continued to support the growth of emergency services

through the Emergency Service Systems Act of 1973 which provided federal funding to develop, implement, and link emergency response systems in communities throughout the nation. The purpose of this act was to initiate a coordinated approach to disaster and trauma (Edlich, 1990), although an unintended effect was the infusion of federal funds which resulted in an explosion of emergency services throughout the 1970s.

The development of EDs with a specialized focus on trauma quickly ensued. Not surprisingly, military personnel were very influential in this transition. R Adams Cowley, an army surgeon during World War II, was one of the pioneers of trauma care. Upon leaving the military in the mid-1960s, Cowley accepted a position at the University of Maryland to pursue an academic surgery career and to research trauma care. His research led to tremendous improvement in trauma care and resuscitative efforts and led to the establishment of the first university trauma center in 1973 (Edlich, 1990).

Today, the ED stands as a monument to technology. A visitor to a modern ED is instantly assaulted by the noise, chaos, and mass of elaborate equipment that seems ubiquitous. Hospital personnel scurry among patients lying on gurneys and seated in wheelchairs that occupy all available space. Cries of pain and anguish are audible, but so too are harsh words and sighs of frustration. Although often thought of as a glamorous place, this monument to technology has lost its luster. This contemporary health care setting is struggling to understand its purpose in an evolving health care system. As it struggles, a steady stream of sick and injured patients continue to enter the doors. These patients arrive with expectations that the ED can and will provide effective and

compassionate care. Yet an increasing number of constraints on health care -- cultural, organizational and financial -- intrude into the relationship between patients and health care providers. This interface is the subject of this study.

The ED at Western Community Medical Center

As discussed in Chapter 1, Western Community Medical Center (WCMC) is the product of the merger between three previously competing health care facilities. The consolidation of these facilities has produced a 500^{+} bed community medical center which occupies a sprawling urban campus in an ethnically diverse West Coast metropolitan area.

The ED at WCMC averages 150 emergency visits per day or approximately 55,000 visits annually -- a volume consistent with a moderate size ED. Adults from diverse ethnic backgrounds are represented in the population it serves. Approximately 60% of clients seen in this ED are African-American, 16% are of various Asian descents, and 15% are Caucasian. The remaining 9% of clients represent a multitude of other ethnic backgrounds. Clients range in age from adolescence (13 - 19 years old) to the oldest-old (> 85 years old). Unlike the clientele, the professional staff at WCMC are predominantly Caucasian. Assistive staff, however, are much more ethnically diverse and support staff, such as housekeeping, dietary, and lab services are largely minority (Administrative Director, personal communication, June 1, 1995).

WCMC is a community medical center, not a university affiliated medical center or a designated trauma unit. Its roots are three smaller community hospitals, each of which had its own identity, philosophy, reputation and clinical

focus. It is the type of ED frequented most by citizens in the United States (Padgett & Brodsky, 1992). Over the last fifteen years, the climate of health care has changed dramatically. Once these three hospitals competed among themselves and with seven other hospitals in the same city. Neighboring cities in this metropolitan area also sought to entice patients to their facilities. Now, however, there is limited competition. A county-owned public hospital in serious financial distress, a regional pediatric facility, and one other hospital, which is currently engaged in affiliation discussions with WCMC -- these are all that remain in the city. Surrounding cities have also experienced hospital closures and consolidation. Consequently, prospective patients have far fewer choices when considering where they will seek emergency treatment or acute care services. A steady stream of clients funnel into the ED. The majority are citizens who live in the surrounding community. A minority are from institutions, such as Skilled Nursing Facilities. The number of patients seen in this ED has steadily increased since the hospital merger.

The pace of this ED is accurately depicted in Chapter 1. The night shift treats the least number of patients and is the most sparsely staffed with 3 RNs, 1 LVN , 1 MD, and a unit clerk. Although consultants, most supportive services, and clinical back-up are absent during these hours, the majority of nurses and physicians working at night are the least experienced. Night shift hours are the least desirable. Accrued seniority allows physicians and nurses the opportunity to move onto more desirable shifts.

In contrast, the day shift is staffed by the most experienced nursing and medical personnel; support services and clinical consultation are readily

available, ED and medical center administration are present, and clinical triage is operational. Two physicians provide medical coverage and nursing staff have staggered work schedules to accommodate the ebbs and flow of patient volume. Around 10 AM the volume of patients begins to sharply rise. Peak volume is usually reached between 3 and 6 PM.

The early evening hours are characterized by a frantic pace. This hectic feeling is exacerbated by the loss of many support services, such as social services and discharge planning, between the hours of 4 - 5 PM. Patients continue to steadily flow into the waiting room until around 9 PM. The remainder of the evening shift is spent trying to catch up on the backlog of patients, for staff are keenly aware that the number of staff begins to dwindle as those completing a staggered shift are not replaced. Two physicians remain on-duty until 12 midnight.

Physical placement of a patient is a strong indicator of the clinical assessment of the triage nurse. Patients with serious health concerns or "worrisome" problems are placed in the front rooms of the department. These rooms are stocked with specialized equipment and are readily visible to nursing and medical staff. In contrast, patients placed in the back of the department are only visible when a staff member is in the room. Similarly, a call for help from one of the back rooms may not be heard over the volume of noise in the department. A connecting hallway between the front and back of the department is lined with rooms containing patients who fall somewhere in the mid-range.

On the surface this medical center is growing and bustling. Underneath its veneer, however, there is much discontent. Many of the staff are disgruntled due

to the massive amount of change taking place. Morale is low as staff feel they are working harder, yet are valued less. Many express fear of being laid off with the next round of cost containment measures. Others are mindful that the medical center has begun to employ more unlicensed personnel to perform work that was formerly completed by professional staff. Most of the patients are unaware of all of these changes.

Significance

This research project aims to examine the health care environment through the lens of 18 elders who were treated in the ED at Western Community Medical Center. Interest in this topic emerged from data collected in a pilot study conducted while enrolled in a qualitative methods class as a doctoral student at UCSF. In that study, 10 staff members of the Western Community Medical Center ED were interviewed and a moderate amount of participant observation took place. The pilot study focused on the culture of the ED as a site for delivery of care. Age, race/ethnicity, attitude and socioeconomic status were found to affect the interaction between staff and clients significantly. Age was found to be the single most influential factor, with staff openly commenting on the wastefulness of caring for the elderly population in an ED setting. This study seeks to expand upon the findings from the pilot study.

At first glance, gerontology and emergency health care services appear to be widely divergent topics or at best strange bedfellows. However, a recent investigation by the Geriatric Emergency Medical Task Force concluded that:

> Older patients are a unique population with special needs that are not being met in the emergency care system. Furthermore, the

> demographics of the aging population will make care of the elderly a major concern of emergency medicine for at least the next 50 years, with the number of elderly needing emergency care continuing to increase rapidly (Sanders, 1996, p. viii).

Earlier, the Geriatric Emergency Medical Task Force conducted a multi-centered study of ED utilization in the United States. The study concluded that elderly clients account for approximately 15% of all ED visits nationwide and comprise 43% of all hospital admissions and 48% of all intensive care admissions (Sanders, 1996; Strange, Chen & Sanders, 1992). Recent statistics from the U.S. Department of Health and Human Services (1996) report that 90.3 million visits were made to hospital EDs in 1993. Assuming the accuracy of these figures, each year 13.5 million ED visits are made by persons 65 years or older. The report of the Task Force needs to be put into perspective since it focuses largely on university teaching facilities, which are known to attract distinct populations. At Western Community Medical Center, 31% of all clients treated in the ED are 65 or older. Competing community hospitals in nearby areas report similar or higher proportions of the elderly among clients served in their EDs.

Methodology

To accomplish this research project, I employed ethnographic methodology. Ethnography is a form of qualitative research that aims to portray the way of life of a group or culture. It is both a process and a product. As a process, ethnography entails extensive fieldwork. As a product, an ethnography is a rich description and analysis of a field experience that aims to decode one culture for the understanding of another (Malinowski, 1922; Spradley, 1979; Hammersley & Atkinson, 1983; Van Maanen, 1988).

Participant observation, ethnographic interviews, review of records and policy manuals, chart review and event analysis were the principal data collection strategies. Data were collected in three phases. Phase 1 began with a one month period of intensive participant observation. As this was the same site used for the pilot study, it was very easy to gain access to personnel and materials. Phase 2 consisted of a mini-pilot study in which one elder was followed from the time of presentation to the ED through discharge from the department. After the client was discharged, arrangements were made to interview the client and staff involved in his treatment. The lessons learned from this one experience enriched the collection of future data. In Phase 3, 17 elderly clients were followed in the same format as the client in Phase 2. A more complete description of the research methodology is included as Appendix B and a schematic of the research process is presented in Figure 1.

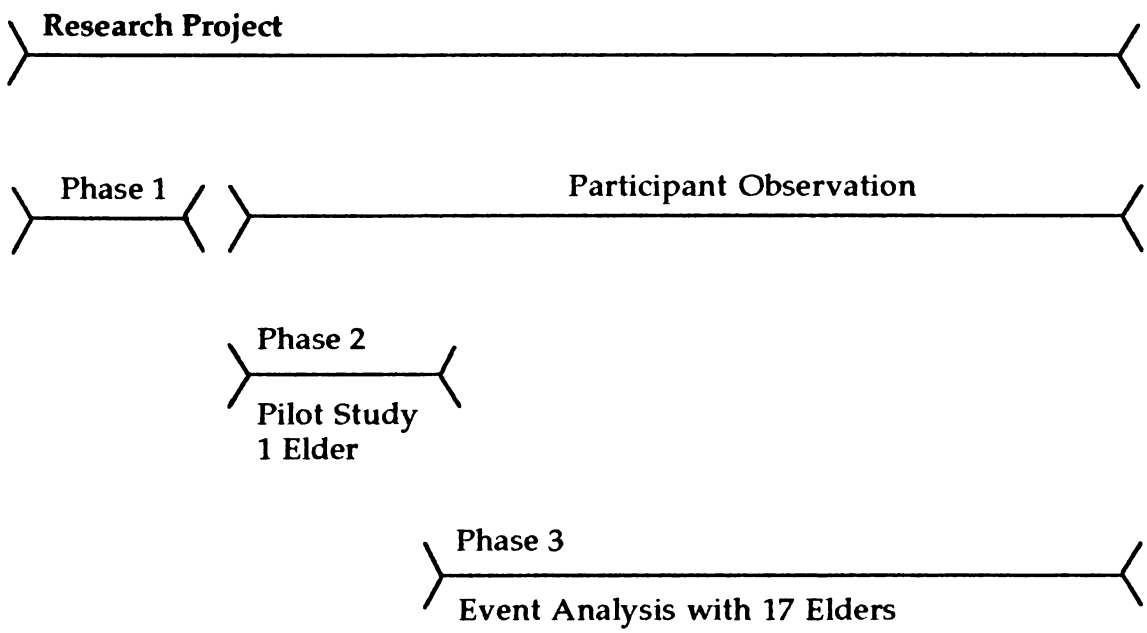

Figure 1: Research Project Schematic

Sample

A total of 18 adults 65 or older admitted to the ED were included in the study: 1 elder in Phase 2 and 17 elders in Phase 3. Purposive sampling was used to select participants from among the young-old (65-74), middle-old (75-84), and oldest-old (> 85) age groups. Participants ranged in age from 69 to 93 years of age with a mean age of 80.2 years.

According to a departmental report, 85% of clients seen in this ED are ethnic minorities. However, this statistic includes clients of all ages. Based on observation, the diversity of elders does not parallel the population as a whole in this department. The majority of elders seen in this site are African-American or Caucasian. Small numbers of non-English-speaking elders were also seen. Due to the scarcity of translator services, only elders who spoke English or had English-speaking family members present were included in this study. However, observations about non-English-speaking elders were recorded as field notes and are included in some of the vignettes.

Participants are a representative sample of the elders served at this site. Among the 18 participants, 8 (44.4%) are African-American, 8 (44.4%) are Caucasian, and 2 (11.1%) are of Asian descent. They manifested a full range of cognitive and functional abilities. Table 1 summarizes the demographic characteristics of the sample.

Participants in the study came from a variety of living arrangements. Two-thirds (12) were community-dwelling elders. The remaining one-third (6) resided at a SNF. Among the community-dwelling elders, the sample was evenly divided

between those who lived independently and those who lived with a family member. Of the participants, 12 (66.7%) were women and six (33.3%) were men.

Table 1

Demographic Characteristics of Participants

Characteristic	n	%	Mean
Age			80.2
65-74	5	28	
75-84	7	39	
> 85	6	33	
Gender			
Female	12	67	
Male	6	33	
Race			
African-American	8	44	
Asian	2	11	
Caucasian	8	44	
Living Situation Before ED visit			
Community Dwelling			
Lives Alone	6	33	
Lives With Family	6	33	
Skilled Nursing Facility (SNF)	6	33	

Chapter 3

Theorizing About the ED

The ED is a unique setting within the health care system. Due to the many, often contradictory, forces that helped develop this setting, it is a place which lacks clear focus. It appears to be struggling with the questions: What is this place? What is our purpose?

Emergency care grew out of a desire to provide service to hospitalized patients and community members who were ill or injured and required treatment. As a result of Medicare and Medicaid legislation enacted in 1965, hospitals were financially rewarded for caring for elders, chronically ill, disabled, and indigent members of society. Due to these financial rewards, ED services rapidly proliferated in the United States. In this respect, most EDs are indebted to some of the most vulnerable members of society for their very existence.

Over the past 30 years, members of the community have come to expect the ED to be open at all times and to provide medical treatment ranging from minor to extensive. Many clients report to the ED with health problems or injuries that frighten them or their families, but are minor to the trained health professional. Others have health concerns that require treatment, but their work or personal schedule does not allow them to be seen at a clinic. Indigent clients often rely on the ED as a place to meet basic social needs, such as a bath, clothing, or warm place to stay. Meanwhile, police, fire and ambulance crews frequently arrive in the ED with persons they have found intoxicated or otherwise unable to care for

themselves. In essence, the ED has become a catch-all, a great safety-net for some, but also a technically-oriented treatment stop.

Our society tends to romanticize care in the ED. This romance is evident in the widespread popularity of television programs such as *ER* and *Chicago Hope.* Such contemporary shows depict the ED as a locus of non-stop heroic action. Most ED health professionals say they were drawn to this setting by their perceptions that ED work was glamorous, highly autonomous, and brimming with heroics. A large percentage of practicing ED health professionals acknowledge that they are "adrenalin junkies," even though the reality of their work does not mesh with the popular fabulous images. The ED has become a multi-purpose site serving diverse clientele; staff, however, appear to be drawn to it for the heroics. They admit they like taking care of the critically ill and clinically challenging patients. Equipment in the department, job requirements, and popular beliefs appear to reinforce the notion that the ED is a place of action, drama and suspense. Yet, upon careful observation it is hard to deny that the majority of patients fail to measure up to the drama and suspense hoped for by staff. Clearly, the public view of the ED differs from the view held by those who work there. This disparity in perception creates confusion about the purpose of the ED.

This confusion about purpose is further compounded by the prevailing messages within the present health care system. The value system in health care is changing. Previously, the ED was charged with providing care to all who arrived at its doors, but now the incentives in health care have changed. As a system of managed care unfolds, patients and staff are caught in this transition.

The old system, based on a fee-for-service structure, rewarded health care providers and organizations for providing comprehensive care. The new system is fundamentally different. In this revised system, less is better. This new system arose out of a strong desire to control the costs of health care. Consequently, fiscal concerns are paramount. Evidence of this changing value system is everywhere. Clear examples include ongoing layoffs, organizational down-sizing, and a decreasing skill-mix of patient care providers in spite of ever-increasing ED visits and high patient acuity. As this change in health care evolves, patients and staff are at various points in their acceptance of it. Those that are most vulnerable in this time of transition are persons who have been traditionally devalued, such as the poor, elderly, and other marginalized groups.

Among the varied people who are treated in the ED, some patients are clearly preferred. Desirable patients have one or more of the following attributes: youth, productive life-style, independence, cooperative behavior, a clinically challenging condition, or a health care concern that is not a burden on the department or the system. Conversely, devalued patients are old, unproductive (such as unemployed, retired or disabled), dependent on others for care or finances, uncooperative or demanding in behavior; they often complain about health care concerns that could be easily treated at a clinic or physician's office, or require care that staff deems excessive, fruitless, or social in nature. Staff have clear expectations of what constitutes a good patient; however, their expectations are not overtly communicated to patients or the community. Consequently many patients are confronted by care providers they perceive as impersonal, rude, or intolerant.

Evaluation of the patient begins at the time of presentation. Although triage was originally developed to screen injured patients on the battlefield, modern-day triage is more than just a clinical evaluation. After being screened by the triage nurse, patient charts are marked with a color-coded sticker that signifies more than just the nature and severity of their clinical complaint. Subjective cues, such as personal attributes, attitude, behavior and presentation of the clinical story figure prominently in the sticker assignment; social evaluation is a major aspect of the triage system. Patients who frequent the system have learned to manipulate the subjective evaluation. They may arrive well-dressed, embellish their clinical story, or call an ambulance for a minor complaint in an attempt to be seen promptly. Others attempt to be extremely courteous or scream and holler demanding immediate assistance. Staff are certainly aware that many patients attempt to manipulate the system. That's why the role of the triage nurse, the gatekeeper, is considered a crucial position in the ED system. Only those with strong clinical skills and character are assigned to it. Staff, in general, are often skeptical of all patients. Patients who know the system or cultivate desirable attributes can take advantage of it.

History reminds us that class/socioeconomic distinctions have been important and constant factors in the delivery of health care. As you may remember from the previous chapter, EDs and Admission Departments developed the ritual of removing clothing and personal belongings as a method to neutralize class distinctions. Ironically, these class distinctions remain paramount in the delivery of health care.

In the ED, triage is a quick survey, often described as "a once over."

Apparent characteristics, such as age, are paramount in a quick survey. Although clients spend a greater amount of time in the ED with professional staff, the triage station is the site of the first evaluation of social worth. At this time a judgment is made about the person's clinical condition, veracity, and personal and social characteristics. All of these figure prominently in the color-coded sticker assignment and in the choice of words used to describe the client on the triage evaluation form. This initial label is an official signal to all other ED staff members. Before seeing a new client, each staff member views the chart with the sticker and preliminary evaluation. As a result the client is judged by this label, a label too often based on class or personal reaction.

The power of this evaluation cannot be underestimated. Foucault (1975) referred to it as the use of the "clinical gaze," the power to define reality in the professionals' own terms and to administer treatment through this lens. (Illich, 1976; Johnson & Webb, 1995). Clearly, this places the assigner of these labels in a crucial position.

Elderly clients frequently create turmoil in the ED due to the many undesirable attributes they possess. Youth has left them and they are often unemployed, retired, disabled, or experiencing chronic health conditions which may make them dependent on others for assistance. In addition, they challenge the system by largely relying on public subsidies to finance their health care. Elderly clients further disrupt the ED system by the way they present themselves clinically. Often elders exhibit different signs and symptoms from younger counterparts with the same clinical problem. In addition, the presence of co-morbidities, which increases in frequency with age, makes diagnosis and

treatment very complex.

Among the elderly, a spectrum of undesirability exists. Those elders with characteristics most like the desirable group fare best in the system, whereas elders with many undesirable characteristics fare worst. Independent community-dwelling elders with health concerns that are amenable to rapid treatment are received best by staff members. In contrast, frail institutionalized elders with chronic health concerns are viewed as a burden by staff members.

It would be easy to conclude that staff are cruel and insensitive to the needs of many clients. Such a simplistic interpretation ignores the fact that the actions and attitudes of the ED staff reflect a larger picture; the values they endorse are those present in the larger culture. Clark (1967, 1972) has written extensively about the importance of independence as an American cultural value and Callahan (1987, 1994) has openly discussed the dilemmas and futility associated with unrestrained health care for the elderly. Our current revolution in health care reinforces these values. With managed care, desirable clients are those that stay out of the health care system or enter briefly for acute problems but return to independence. By the nature of their illness they are profitable patients for health care facilities.

Managed care appears to encourage devaluation of clients with negative attributes. It seems to blame the victims. If this is true, then who steps forward to advocate for clients? Client advocacy has always been an aspect of health care. From its beginnings nursing has embraced this concept and speaks to it. The nurse practice acts of all 50 states stress it as a key aspect of the role of the professional nurse. Physicians, too, espouse these beliefs in their code of ethics.

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However, the ability of health care providers to successfully act as advocates in the current health care climate is questionable.

In the past, physicians and nurses have been sought after health professionals. Due to their possession of desired skills and talents, they have had the freedom to espouse unpopular views or operate as strong client advocates in the face of opposition. Now, however, the table has turned. As managed care has permeated health care, ED nurses and physicians have experienced a shrinking market. Historically, nurses have functioned predominantly as employees of hospitals and health care facilities. Literature on ethical dilemmas among nurses is replete with the problems associated with conflicts of interest that develop when attempting to function both as an employee and a client advocate. Like their nurse colleagues, physicians have increasingly found themselves in the role of employee. ED physicians usually work directly for the institution or through an agency that contracts with the facility to provide ED service. In either case, the health facility may unilaterally terminate the relationship. In addition, specialty physicians find their referral rates plummeting due to cost consciousness. In order to pick up patients, they often "hang out" in the ED looking for patients. In this environment, none of the health providers are free to operate with just the patient's interests in mind.

This research is focused on the flaws in health care that affect the care of elders in the ED, and the scenarios depicted in Chapter 1 clearly illustrate these dilemmas within our present system. Mr. Mason challenges the system by asking the ED to define its purpose. A visit such as his is common in this ED. He illustrates the illusive boundary between social and medical problems and the

dilemmas these problems raise in a managed care environment. Ms. Castle clearly illustrates the rampant ageism present in health care and the conflicting values held by providers as they reward independence yet, push elders toward supervision. Ms. Castle's treatment also begs the question: What is care? In contrast, Ms. Scott's experience in the ED highlights ethical concerns about individual social worth and withholding treatment for elders.

Evaluation of an individual's social worth is a major underpinning in all of these cases, an underpinning that becomes more evident in stressful times like ours. To facilitate further discussion of these dilemmas and case illustrations, a discussion of the literature on social worth follows. Using social worth as a foundation, the literature on elders in the ED is then examined.

Social Worth

References to the concept of social worth appear in diverse literature. Various key terms elicit related literature: social loss, social judgment, social evaluation, moral judgment, moral evaluation, moral decision-making, perceived value, attitudes toward patients, and clinical judgment. In addition, the concept of social worth is embedded in literature on clinical ethics and labeling.

Judgment of social worth has been discussed in a variety of works. The focus of many of these studies has been a hospital ward (Bowie, 1996; Johnson & Webb, 1995; Grief & Elliot, 1994; Kelly & May, 1982; Roth, 1972, 1983; Stockwell, 1972), a specific population (Goffman, 1963, 1968, 1971; Glaser & Strauss, 1964; English & Morse, 1988; Topham, 1989; Kienow, 1992; Stevens, 1994), a health care organization (Weber, 1996; Olson, 1995), and among health professionals

(Cady, 1991; Mahony, 1991; Parker, 1990).

In a study of nurses' reactions to dying hospitalized patients, Glaser and Strauss (1964) used the concept of social worth to explain the impact of the dying patient on the nurse. They (Glaser & Strauss, 1964) note that on units with short lengths of stay, such as the emergency department, "nurses may act and feel mainly on the basis of apparent characteristics" (p 120). They state:

> In our society we value people, more or less, on the basis of various social characteristics: for example, age, skin color, ethnicity, education, occupation, family status, social class, beauty, 'personality,' talent and accomplishments. .... The total of the valued social characteristics which the dying patient embodies indicates the social loss to family, occupation and society on his death (p. 119).

The pilot study which preceded this current research project supports the notion that social worth is an important factor in the patient-professional relationship in the ED. Since time spent with the client is limited, and there is often no prior or planned future relationship with the client, apparent characteristics are a strong force in the way staff react to clients. Glaser and Strauss (1964) claimed that there is a strong temporal element to social evaluation, for as professionals spend more time with clients apparent characteristics carry less weight. In more recent work, Johnson and Webb (1995) acknowledge that social judgments about clients do change over time; however, the opinion of highly regarded staff members strongly influences the overall reaction to the client. In the ED, the triage nurse is often one of the "most seasoned" professionals whose judgment is respected.

In a thoughtful review of social evaluation research, Johnson and Webb (1995) conclude that social judgment is a universal phenomenon that health professionals prefer not to acknowledge. Based on research focused on

delineating the elements that make patients popular or unpopular, they note that all health professionals make evaluative remarks about patients. They also reflect upon their own use of social judgment, noting that their field notes are filled with judgments and evaluative statements about patients as well as staff. I, too, must recognize that this is part of my own data.

Relying heavily upon the work of Stockwell (1972), Kelly and May (1982), and Goffman (1971), Johnson & Webb (1995) note:

> As performers we are merchants of morality ... meaning that underlying all social interaction there is fundamental dialectic. This is that whenever individuals enter the presence of others, they need to 'assess' them, that is, they need to discover as well as they can the facts of the situation. Indeed, both actors in such an interaction are party to both assessing and being assessed. The practicality of assessing is that all possible data are never available, so that we rely upon cues, hints, gestures and status symbols as predictive devices. ... The notion of performance implies an active process of projection of an image rather than a passive possession of a trait or stereotype which may be observed ... and presumed to carry a particular social evaluation (p. 473).

This recent work by Johnson and Webb appears to support the earlier work by Glaser and Strauss and explain why clients attempt to influence clinicians by their dress, approach, and clinical story.

Elders in the ED

Although limited information is available on the subject of elderly persons in emergency care, this literature does support the notion that social evaluation is prevalent. Several classic studies report that ED personnel value young clients more than older ones (Glaser & Strauss, 1964; Sudnow, 1967; Roth & Douglas, 1983). While numerous journals from several disciplines focus on emergency

care, little attention has been paid to the needs of elderly clients. A review of biomedical and psychosocial literature since 1983 identified 16 research studies, in English or translated into it, in which the research subjects were elderly clients seeking emergency care. A summary of the major findings of each of these studies is included as Appendix C. Two major groups of studies are present: those that portray the elderly client in the ED and those that compare the elderly ED client with the younger adult ED client. Arthur Sanders (1992), chair of the Geriatric Emergency Medicine Task Force of the Society for Academic Emergency Medicine, recently stated:

> Little attention is being paid to the special needs of elderly persons in EDs. The Task Force found few studies in the literature addressing the care of the elderly in emergency departments. There is little evidence of planning to meet the emergency care needs of the elderly or to anticipate the future needs of an increasingly elderly population. No advocacy groups within emergency medicine, geriatrics, or the health care system appear to be concerned with the emergency health needs of the elderly (p. 830-831).

A number of observations can be drawn from the current body of research on elder ED care. First, all data in the present review are derived from survey research. Therefore, findings are general. The current review indicates a strong need to explore acute and emergency care of the elderly and to address the shortcomings of the current data base.

Unfortunately, many of the studies contained in this review were poorly designed and generated more questions than they answered. For example, in Hedges et al. (1992), a comparative study of older and younger adults in six EDs, older clients were questioned on their understanding of discharge instructions, but younger clients were not asked this question. The omission of this comparative data is curious. It is unclear whether the problem points to poor

study design or reflects devaluation of elderly clients. Similarly, Bassuk et al. (1983) compared older and younger patients seen by the psychiatric service in a teaching hospital ED. They discussed at length the elderly psychiatric client who repeatedly visits the ED. However, they did not touch upon the profile of the younger repeat visitor. In essence, the focus has been on the negative aspects of elderly clients rather than on comparative evaluations of younger and older clients in order to provide improved care for both groups.

The current body of literature attempts to describe the older client in the ED. The studies generally agree that age is an important determinant in the frequency and variety of ED presentation. Elderly clients more often arrive by ambulance, spend a longer time in the ED, undergo extensive evaluation and are more likely to be admitted to the hospital than younger ED clients (Lowenstein, Crescenzi, Kern & Steel, 1986; Baum & Rubenstein, 1987; Beland, LeMay, Philibert, Maheux & Gravel, 1991; Stern, Weissman & Epstein, 1991; Hedges et al., 1992; Richardson, 1992; Singal et al., 1992; Strange, Chen & Sanders, 1992; Eagle, Rideout, Price, McCann, & Wonnacott, 1993). Elderly clients present to the ED with different complaints than their younger counterparts and are more likely to complain about somatic ailments even if the origin of the problem is psychiatric (Bassuk, Minden & Apsler, 1983; Ettinger, Casani, Coon, Muller & Piazza-Appel, 1987; Brokaw & Zaraa, 1991; Stathers, Delpech & Raftos, 1992).

The present body of research has attempted to identify patterns of patient problems and relate them to use of services. Although some findings agree, many of them are contradicted by other work. It is important to ask whether it is appropriate to expect a typical pattern. Padgett and Brodsky (1992) have found

that regional and local patterns of ED use vary. More importantly, literature on the aged supports the notion that the elderly population is extremely heterogeneous. Therefore, it may be more appropriate to look at the elderly as a constellation of many age groups. This recognizes that the health care needs of a 65 year old differ sharply from the health care needs of an 85 year old, or a 100 year old (Barer, Evans, Hertzman, & Lomas, 1987; U.S. Senate Special Committee on Aging, 1991; Castillo & Pousada, 1993; U.S. Department of Health and Human Services, 1993). Although gerontologists and geriatricians have long recognized the diversity among the elderly population, this knowledge has not found its way into the literature on elders in the ED, even though many of these studies have been conducted by respected researchers and appeared in prestigious journals.

Current research has tended to paint a superficial picture of the elderly client in the ED. It has not analyzed the needs of elders in the ED and the adequacy of ED services for them. Similarly, we know little about the perceptions of older clients seeking emergency care. Since the studies of Glaser and Strauss (1964), Sudnow (1967), and Roth and Douglas (1983), no one has investigated the attitudes and beliefs held by ED personnel about the care of the elderly. This present study extends the scope of knowledge about social judgment through the eyes of elders who seek care in the ED. In the light of its findings, it points to new directions for interventions and research. In order to clarify these new directions, the following three chapters will discuss the questions that arise in the ED about the purpose of the department, the nature of treatment, and the affect of managed care on the health encounter.

Chapter 4

Can't They See This Is An Emergency Department?

> I live out of town but about two weeks ago she told me over the phone that she had hurt her knee and leg. She said she fell while out gardening. My mother always tries to downplay things, but I got suspicious when every time I'd call, I'd hear about how her leg was bothering her. She tried to tell me it was okay, just bothersome, but when I pushed for details her story didn't hang together. I thought she was being stubborn so I finally jumped on a plane to come have a look for myself. When I got one look at her leg, I picked up the phone and dialed 911. The ambulance came quickly to take her to the Emergency Room. She needed to be seen right away and that's what they're there for. My mother had let things go too far.

Ms. Parker, a 73 year old Caucasian female, was wheeled into a treatment room by the ambulance crew shortly before 8 AM. Only a few patients were present in the department, and most staff members were clustered around the front desk, discussing the latest changes at the medical center. The triage nurse and department manager were having a discussion behind the closed door to the staff lounge.

A paramedic transferred Ms. Parker to the gurney in the treatment room. "They'll have a look at you," he explained to her. Nodding toward her daughter, he exited the room and approached the staff clustered at the front desk. "Just a little boo-boo," he explained to the group as he gestured toward Ms. Parker's room. Jody, the nurse assigned to care for the first admission, acknowledged his statement, "Okay, anything else I should know?" The paramedic shook his head and headed to the coffeepot.

Several minutes later, Jody entered Ms. Parker's room. "What brought you

here today?" she inquired. Ms. Parker's daughter blurted out an answer: "She needs this leg problem looked at right away." Jody peeled back the blanket to examine Ms. Parker's left leg. It was reddened and swollen from mid-thigh to ankle. Fluid oozed from abraded areas around the knee. "How did you hurt your leg?" she asked. Ms. Parker proceeded to explain her misfortune while gardening. "When did this happen?" Jody asked. "It's been almost two weeks now," answered Ms. Parker. "Yeah, it'll be two weeks on Saturday." "Has it suddenly gotten worse?" queried Jody. "No, it's about the same. It just doesn't seem to be getting better," replied Ms. Parker. "If this happened two weeks ago and it's stayed about the same, why do you suddenly think this is an emergency?" Jody asked flatly.

The daughter quickly intervened, saying that she had insisted her mother be seen now. "My mother should have had it looked at two weeks ago. Ideally that's when she should have been here, but that didn't happen." Jody seemed to have tuned out as she wrote some brief notes on the chart. As the daughter continued to explain why they were here now, Jody interrupted: "All right, okay; we'll get an X-ray and see about this." Her sentence trailed off as she exited the room.

The night shift ED physician was dictating at the front desk. He looked up as Jody walked by. "Anything I need to look at in there?" he asked. "No, she fell two weeks ago and now she's finally getting around to doing something. If she waited that long, she can wait a little longer. I'll get an X-ray and the day-shift doc can take care of it."

Jody ordered an X-ray and set Ms. Parker's chart aside. For the next hour and

a half she busied herself seeing other patients in the department, chatting with colleagues and taking a coffee break. The other nurses and the two physicians were moving at a similar pace. "It's a kick-back day," remarked Jason, one of the physicians. "Nothing's really happening," he continued. At around 10:30 AM, Jason and Jody sat down to talk about a number of patients. Then Jody placed a call to the X-ray department and was informed that Ms. Parker's left patella was fractured. Jason brought this news into Ms. Parker and her daughter. When he entered the room, the daughter exploded: "We've been here over two and one-half hours. What's taking so long?" Jason avoided the question and explained that Ms. Parker's kneecap was fractured. "There's not much to do for it. We'll put her in a leg immobilizer and she should get some antibiotics for those oozing areas. We can get you out of here quickly."

Jason's answer did not elicit the response he had hoped for. Instead of appeasement, the daughter became even more agitated insisting that her mother could not possibly go home. "She lives with my dad, who's not well himself. I'm not taking her home. It's your job to take care of this!" Jason left the room shaking his head. He stopped at the desk to place a call to the in-house medical group. In approximately 20 minutes the in-house physician arrived to meet Ms. Parker and her daughter. After a brief conversation, she wrote admission orders and left the department. Jody called the transportation team to move Ms. Parker upstairs; there was minimal exchange of words between staff and Ms. Parker. Jody was steaming. "This is a waste," she muttered quietly.

Staff Speak

Although Ms. Parker and her daughter believed the ED was the best place for

them to seek treatment, ED staff disagreed. The paramedic who had brought Ms. Parker to the ED described her problem as "just a little boo-boo." Jody, the nurse caring for Ms. Parker, was very clear about her perception of the situation: "She waited two weeks and now all of a sudden her daughter wants it looked at immediately. The lady has a primary doctor; that should have been the first place they went. Can't they see this is an Emergency Department?" As I probed further, I asked her to describe an ED. She answered cryptically: "Well, it's not a clinic or hotel like so many of these people seem to think."

Jason, the ED physician in charge of Ms. Parker, echoed her remarks. Shaking his head, he said:

> What can I say? This was a simple problem that probably didn't belong here. Yet, we end up having to admit her. It's all a game. Administrators and insurance companies want everything done quickly and cheaply, but the patients are hollering for service. If I hadn't played along, that daughter would have been on her way to administration to complain. When someone complains like that, they (administration) always give in. That's the big joke; it's OK for them to give in. They call it public relations; but since I gave in, I'll probably get yelled at tomorrow for not being cost-effective.

Jason seems accurate in his assessment that administration is very concerned with cost and unnecessary admissions. The Manager of the department had this to say about the case of Ms. Parker:

> This place has got to change. Staff keep these patients in the department too long. They need to learn to get them in, treated, and released much quicker. The physicians and nurses need to be less ready to admit patients. Sometimes they use that as an easy out, but many of these cases should just be treated and released from the ED. I think we need to seriously work on upgrading skills of staff. They need to learn that you can be customer service oriented without admitting all these people.

Jason and Jody hold similar beliefs about what is appropriate in the ED. Their position differs from that of Ms. Parker and her daughter; it's also far removed from the administrative perspective. Overwhelmingly, staff seem to agree that the ED is not what patients think it is. Staff members not involved in Ms. Parker's case offered similar opinions about the nature of the ED -- or at least about what it should be.

Sharon, an ED nurse for almost three years, works the evening shift. "I like the variety that this job offers," she explains. "There's something different everyday." When asked to define what she likes most about her job, she confided: "I like the really sick patients, the MIs (myocardial infarction or heart attack), the unstable ones. I like trauma too, but we don't get too much of that here." Later she added, "it's mostly chronic or clinic stuff that comes in. Not much challenge."

Marilyn, a staff nurse with over 15 years of experience explains her perceptions of the most appropriate use of the ED: "We get a lot of people who abuse this place. They don't seem to get that this is an *emergency* department; that means there's a *real* problem, not that it would be convenient to be seen now."

Numerous other staff members expressed similar opinions. Many defined the ED by describing the types of conditions it is designed to treat. "The ED is a place where emergencies get treated, like major medical, surgical, or trauma cases." Others named conditions appropriate for treatment in the ED such as acute MI, acute abdomen, trauma, and industrial accidents. Some staff explained what they like best about the ED by describing a patient treatment scenario as "crash and

burn time," "tube time -- you know, everyone's flailing to get tubes in the guy; IVs, ETs (endotracheal tube - inserted into the trachea to allow ventilation), chest tubes, you name it," "full-tilt boogie," and "full court press." One staff member compared her experience at Western Community Medical Center with a previous worksite:

> When I worked at (named urban East Coast university medical center), that was a real ED. All this other stuff was triaged into the appropriate section and all the major stuff went to one area. If you could work with the major stuff, you were really doing ED care.

An ED physician explained his opinion: "In my residency, they prepared us to handle the fast action stuff. Emergency medicine was portrayed as heroics and sleuthing. In reality, it's a lot of day-to-day mundane stuff."

What is this place?

Ms. Parker's case is evidence that the ED site is inconsistently characterized. Each of the persons commenting is operating under the belief that he or she knows what an ED is and that others share this definition. To Ms. Parker's daughter, the ED is a place to bring her mother for immediate attention. She believes that her mother had dangerously delayed treatment and needed to be immediately dealt with. To her, the ED is a site for prompt treatment. Although Ms. Parker was passive in the decision to seek treatment, she concurs with her daughter's opinion. During an interview the following day in her hospital room, she expressed relief that treatment was underway: "Well now I know what's wrong and it's getting taken care of. My daughter was right to insist we come." In contrast, staff members see patients such as Ms. Parker, as inappropriate users of the department. Administration offers a third viewpoint. From the managerial

perspective, clients can often be demanding and staff do not know how to resist these demands. The manager believes that clients must be treated courteously, yet firmly.

Patients, family members, staff and administrators are each operating under different assumptions. Each group defines the purpose of this place differently and hence has different expectations about what is appropriate. Although these groups co-mingle at each ED visit, their apparent lack of appreciation for the perspective of the other groups is disconcerting. Neither of Ms. Parker's health care providers understood the perspective of the client or her daughter. They failed to see that the daughter's assertive pursuit of treatment was triggered by a real concern for her mother. Likewise, Ms. Parker and her daughter did not grasp the concerns and feelings of staff or administration. Each group operated from its own perspective. Although treatment was rendered, no one was pleased with the tone of the visit.

Real Emergencies

Staff consistently expressed discontent with the constraints of their positions. Overwhelmingly they desired to care for "real emergencies." None of the 18 elders followed in this study were deemed "real emergencies" by the staff involved in delivering treatment. Even though several of these clients would have experienced additional pain or anguish or may have died without prompt treatment, the necessity of their visit was not appreciated. For example, Ms. Scott, the 69 year old woman in respiratory distress discussed in detail in Chapter 1, was seriously compromised when she arrived in the ED. As the vignette illustrates, however, Ms. Scott's chronic condition dissuaded staff from

aggressive treatment. Although she required prompt treatment, she was deemed "a waste of time" by the physician in charge of her treatment.

Other clients such as Mr. Jones, a 75 year old man with chest pain and atrial fibrillation, and Mr. Bird, a 77 year old man with severe hypoglycemia, required immediate treatment. While acknowledging that they required prompt intervention, staff members still did not classify them as "real emergencies." Mr. Jones was experiencing acute chest pain, but his age and history of smoking were mentioned as factors mitigating against him. Mr. Bird's condition was dismissed as evidence that he "wasn't properly taking care of himself." Dismissing the claims of elders as a "waste" was a common response.

Ms. Song

Ms. Song, an 81 year old Korean woman, was brought to the ED by two concerned daughters. A domestic helper employed by Ms. Song had contacted the daughters when she found her confused and incontinent in her apartment. Concerned about their mother's welfare, the daughters brought Ms. Song to the ED for evaluation. They arrived in the ED at 1:30 PM, one of the busiest times of day. The department was full, so the daughters were unable to stay with their mother.

The charge nurse informed me that she had "another old lady for my study." Ms. Song, a petite Asian woman tied to all four corners of the gurney, was actively trying to free herself. I introduced myself and asked how she was. "No good. No good. No good," she yelled. But she was unable to explain the nature of the problem. Shaking her head repeatedly, she answered, "I don't know." The

staff nurse in charge of Ms. Song stormed into the room. "You're talking to her? I just heard her. I didn't think she spoke English. I didn't even try," she said. She urged me on, "Ask her some more questions, she seems to respond to you." I began gently, "Ms. Song, can you tell me how you feel?" "Sick, very sick," she answered.

Lynn, the staff nurse, excitedly pulled the charge nurse and physician into the room. They fired a barrage of questions at Ms. Song; often several people spoke at one time. "I don't know," she repeated. "Feel sick," she continued. To each question she repeated her answers: "Feel sick," "I don't know." Her interrogators quickly concluded that she didn't understand what was going on.

Ms. Song continued to pull at her restraints. When she successfully freed her right arm, she pulled out her IV and threw the blanket and sheets off the gurney. Then she began to work on freeing her other limbs. In a matter of moments she was sitting up yelling to all who would hear. Her calls were frantic but unclear. Was she speaking English with difficulty? Was she speaking another language?

No attempts were made to determine what language she usually spoke, and her daughters were kept in the waiting area. Lynn, the staff nurse, and Jill, the charge nurse, entered the room and re-applied restraints. John, the physician, sat at the dictation desk and observed the action. As Lynn exited the room, she realized that I was observing Ms. Song's care. "She's restrained because she's confused," Lynn explained. "If we didn't tie her down she'd probably really hurt herself. Look at her, she's wild." Lynn chuckled when I asked about Ms. Song's baseline mental status. "For Christ sake, she's 81 years old," snickered Lynn. "Can't you see? She's wacko." When the older daughter was briefly allowed in

the department to visit her mother, she told Lynn about her mother's usual status:

> I just had dinner with my mother last night. She was fine. We went to church, had dinner, and went back to her place, where we talked. When I left her, all was fine. This morning I got a phone call from the girl who comes in to help her a little bit in the morning. She said my mother was crazy; she didn't know what was going on. She was on the floor and she had soiled herself. She said, "Please get here, please get here." This is not my mother. This is not what she's like. She's been fine. I don't understand what's going on. Please help me.

John, the physician, briefly chatted with each of the daughters when they were in the department. They repeated their frustration about their mother's condition. "She's actually a little vain usually -- always with her hair done and a little make-up -- but look at her. Something's happened to her. She was fine last night," explained the older daughter. John tried to calm them. "We'll run some tests and see what's going on. Why don't you go to the cafeteria or take a walk while we wait for the results? We'll look after her," he reassured them.

Ms. Song remained restrained. A team of four staff members entered the room to hold her down while Lynn drew blood from her left arm and restarted the IV line. When they completed their tasks, they reapplied the restraints. With more staff in the room they were able to pin Ms. Song down and apply the restraints even tighter than before. As I walked with Lynn from Ms. Song's room, I asked her to share her plan of care with me. "I'm going to wait for the lab," she responded flatly. I reminded Lynn that Ms. Song's mental status was markedly different than the previous day according to the family. "Yeah, yeah, I heard that too," she answered.

John and Lynn briefly conferred. They agreed that she was "just a confused

old lady." Lynn asked the charge nurse to "keep an eye on her" since she and John were busy with other patients. No one on staff considered her confusion a key symptom. No one performed a neurological assessment or got a detailed history from the family. A confused and incontinent 81 year old seemed normal to them.

Several hours later, the hectic pace began to slow. Lynn had been too busy to check on Ms. Song, so when John grabbed Ms. Song's chart to review the returned lab work, he was shocked to find her hemoglobin was 5.5 g/dl (normal range 13 - 15 g/dl). Something was seriously wrong. Suddenly he realized that her confusion was not part of being old. He set in motion rapid evaluation of her condition. An MRI scan of the brain was ordered and a gastroenterologist was emergency paged to the department. "I guess it's time to CYA" (cover your ass), remarked Lynn. "We blew it, now we need to cover our asses and get her safely out of here."

Ms. Song was found to have a massive gastrointestinal bleed. Her daughters had mentioned to ED staff that she had been incontinent of a large amount of "diarrhea," but staff had not investigated this complaint. Her daughters had bathed and dressed her in a clean purple sweat suit, prior to bringing her to the ED. "I couldn't bring her to Emergency like that," commented the younger daughter. As staff began to realize the severity of Ms. Song's illness, they berated family members for their actions. "If you hadn't cleaned her up and hid all the evidence, we could have taken care of her problem quicker," explained Lynn. "You don't understand. My family is proud. I know my mother was sick but she needed to be presentable before we left the house. She would have been

embarrassed to be seen dirty," explained the younger daughter.

Ms. Song required a five-day stay in the intensive care unit and an additional four days on a telemetry unit. Her daughter described the ED as "a place where they don't listen. We tried to tell them what she was like, but they didn't hear us."

ED staff failed to appreciate the severity of Ms. Song's illness. Her confusion and incontinence were passed off as normal behavior for an 81 year old. Objective data, in the form of a lab report, finally alerted staff who then intervened. Ms. Song then required intensive intervention. Why wasn't she a "real emergency?"

In search of "real emergencies"

The search for the "real emergencies" seems to be elusive. Based on survey data, Padgett and Brodsky (1992) report that in metropolitan EDs in the United States up to 86% of care delivered is neither urgent nor emergent. Reality and romance collide on a daily basis in the ED. Most clients seeking treatment do not fit the staff's image of a "real emergency."

Clients in this study with conditions that staff mentioned as interesting or appropriate for treatment in the ED still did not measure up to the "real emergencies" standard. Mr. Jones, for instance, was being evaluated for a myocardial infarction, a condition frequently mentioned by staff as appropriate for the ED. Although his clinical picture was appropriate, why was he so readily dismissed? Staff appear to value more than just a clinically challenging condition. Mr. Jones' age and smoking history were negatively viewed by staff. Apparent

characteristics and behaviors factored prominently in the evaluation of these patients.

Clients of all ages faced this social judgment. Young adults brought to the ED by ambulance and found to be suffering from an overdose of illegal drugs were frequently referred to as "scum" or "worthless asshole." Although their condition required immediate intervention, their presence in the ED was annoying to staff. Age, however, was repeatedly used as a point of consideration when discussing patients' conditions. Staff value patients that are "real emergencies" -- patients that are clinically challenging and socially valuable.

This study, which focused on elders treated in the ED, confronts the disparity between romance and reality. Because these elders were not valued, they were not deemed to be appropriate for the ED. Caring for the elderly and chronically ill is the antithesis of the popular image of emergency care. Recently, I heard an ED staff member remark, "If I wanted to take care of old people, I'd work in a SNF."

Devaluation of Elders

As the literature illustrates, elders utilize more ED resources and are more frequently hospitalized than other age groups (See page 64). Due to the nature of the setting, ED staff have either limited or no previous relationship with the elders they serve. This is evident in the detailed account of a typical day described in Chapter 1. The knowledge that staff obtain about the elder must be drawn from physical assessment or interview -- a process that is often hurried due to the number of clients waiting to be seen, and difficult due to the crowded

and noisy physical environment, as well as the current health concern.

Elders have limited or no previous relationship with ED health care providers, having usually received health care from a primary physician. In the ED they are cared for by unfamiliar providers who rarely introduce themselves and do not wear a name badge, or wear one that is intentionally defaced. Staff often cover their names and titles with tape or stickers. "I don't want any of these patients to know my name," explained one staff nurse. "They can look you up in the phone book and find out where you live."

The older adult in the ED is at risk for stereotyping and ageism based on visible characteristics or on chronological age. Butler (1994) reports that one of the principal sources of ageism, the systematic stereotyping and discrimination against the elderly, is the educational system for health care providers. He asserts that physicians develop ageism in their professional training since negative stereotypes of the elderly are frequently heard and reinforced in all aspects of medical school – in the classroom, in the lab, and in clinical internships. Similarly, Kayser & Minnigerode (1975) found that undergraduate nursing students had little interest in working with the elderly. In addition, Kayser & Minnigerode (1975) found that attitudes about the elderly did not improve among nursing students after completing coursework in gerontology and growth and development. Students with the most stereotyped images of the elderly were most likely to express interest in working with older adults.

Attitudes toward the elderly have been explored in virtually all of the health professions, and negative stereotypes of aging are pervasive among health care providers (Glasspoole & Aman, 1990; O'Malley, 1991). Butler (1994) adds that in

the basic education programs for health providers, negative commentary about the elderly is prevalent and is one of the roots of ageism among professional caregivers.

Ageism among health professionals may be compounded by their limited knowledge about elders. Jones, Rousseau, Schropp & Sanders (1992) surveyed directors of all 85 U.S. emergency medicine residency programs. Forty percent of them felt that the teaching of geriatric emergency care was inadequate. Sixty-five percent believed research on geriatric emergency medicine was insufficient. Among educational programs in nursing, there is wide variation in the level and detail of geriatric content. For example, recent mandates by the Board of Registered Nursing (1991) in the state of California which prescribed a mere 60 hours of geriatric clinical contact for entry-level nursing programs have been rescinded. In contrast, it is interesting to note that the Bureau of Health Professions recommends a geriatric/gerontology focus for a minimum of 20% of undergraduate clinical content (U.S. Department of Health & Human Services, 1995).

Staff members routinely expressed concern about the number of elderly patients they saw. One nurse estimated the number of elderly patients in the department as "almost all." Others noted that "many of the clinic-types are young, but the ones who get all the care and service are the old." An ED physician commented that "the old ones take most of the time. They're complex. It's never just one little thing that's easy to fix."

Staff and ED management felt that the elderly constituted a block of patients that required an enormous amount of care and coordination of services. Many

staff commented on the wastefulness of this care. "Most don't know when to say when," explained an ED physician. "They're old, that's it, there's nothing to fix." One physician suggested that my study was "all in the wrong place" -- I ought to be doing a study on why these patients did not have advance directives. This particular physician felt the majority of these patients would benefit by having nothing done for them . "It's time for them to go. They should just pass away," he added.

ED staff reflect American cultural values among which ageism is prevalent, both within the broader culture and among health care providers. Staff routinely refer to elders as "the crazy old lady," "the wacko," "the old biddy," or "the demented old fart in Room 6." Their care reflects their ageist attitudes. Staff members tend to assume that elders are senile and demented. They demonstrate their assumptions by excluding elders from decision-making about their own care, by talking about elders in front of them, and routinely restraining them.

To many of the staff, elderly clients embody the elusive boundary between social and medical problems. These clients may require medical intervention, but they also raise concerns about "placement" or "disposition." Ms. Parker's case is a good example. The ED physician felt her ongoing treatment needs could have been managed at home; however, because she was old and lived with an elderly spouse who was described as "not well," she was admitted to the hospital and later transferred to a SNF. Many staff members feel these situations generate an irrelevant burden on a department designed to care for the sick. They describe these problems as "a waste of a hospital bed," "inadequate self-care," or "a good example of why Medicare is broke." Jody, the staff nurse involved in Ms.

Parker's treatment described her feelings:

> It's really hard. Some of these old folks don't need to stay here, like Ms. Parker. ... But you gotta do something with them. Sometimes it feels like they think the hospital is a hotel. They come to the ED and treat us like front desk staff. They want a room, meal service, and someone to do their laundry. In the ED they present us with their Medicare card and demand treatment. It's not a fucking VISA card. We all end up paying for it. The hospital loses money on these folks and then they take it out on us by laying us off.

Several ED physicians openly admitted that they often write hospital admission orders for these clients because it is easier than dealing with the issue in the ED. Josh, an experienced ED physician, explained:

> We've got some access to social service people down here, but most of the burden falls on us. If you don't admit them, we've got to find a way to get them home. Sometimes it's hard to look someone in the eye and tell them you think they can manage at home when you know they can't. But if we admit them it buys time. The old person gets some care and the discharge planners and social workers can jump in to do their part. It's not a great solution. In fact, it's lousy.

The literature on ED utilization supports the claim of staff that self-care problems among elders account for a substantial percentage of their visits. These studies define self-care problems as falls, dehydration, poor food or fluid intake and disposition problems (Richardson, 1992; Stathers, Delpech & Raftos, 1992; Lowenstein et al., 1986). It is imperative to ask whether these self-care problems truly point to larger social problems or whether they are evidence of ongoing ageism? Would a fall by a younger adult be considered a social problem or minor trauma? Similarly, poor fluid or food intake could be symptomatic of poverty or other social ills, but it may also be consistent with acute illness, reaction to medication, or symptomatic of chronic disease.

Estes, Swan & Associates (1993) note that Diagnostic Related Groupings (DRGs), a cost-containment program affiliated with Medicare, attempts to control costs by limiting lengths of stay in acute care, but may have actually fostered increased use of the ED for social problems. Under DRGs, older clients are discharged from the hospital early in their convalescence. One effect of a decreasing length of stay is the creation of a new role for the ED, that of safety net. The ED functions as a safety net by providing 24-hour phone consultation and care for recently discharged clients who are concerned that they are not progressing appropriately. Wofford, Schwartz & Bynum (1992) describe this role as "the failsafe mechanism for elderly patients" (p. 318), noting that this role emerged due to the health care system's inadequate mechanisms for ensuring safe and appropriate care of the elderly.

In essence, the role of the ED, which provides one of the most costly forms of care, has grown due to the mismatch between services available through Medicare and those needed by its recipients. Gilford (1988) reports that the common practice of identifying the type of care given by its site is extremely misleading. She notes that many elders receive chronic care services in acute care facilities. Similarly, long-term care facilities are faced with providing acute care, especially postoperative care, in spite of inadequate facilities and staff training. O'Malley (1991) calls for further development of home care, respite care, and foster care to meet the needs of elders at a lower cost.

Epidemiological studies have demonstrated that older adults are more likely to exhibit chronic rather than acute conditions (U.S. Department of Health and Human Services, 1993; U.S. Senate Special Committee on Aging, 1991). Other

researchers have found that up to 94% of older adults report to the ED with one problem (i.e., abdominal pain), but are also grappling with ongoing chronic conditions (i.e., hypertension) that may be poorly managed (Singal et al., 1992), and that the majority (65%) of older ED clients are on one or more prescribed medications (Bassuk, 1983). The ED, however, is designed to care for clients with urgent and emergent concerns (Padgett & Brodsky, 1992).

The key question is, how well does an older adult, often with chronic conditions, fare in an environment that encourages rapid turnover and quick resolution? Johnson (1987) has reported that traditional medical approaches are more appropriate for caring for and treating acute illness than chronic disease. She notes:

> American values that emphasize mastery over nature and instrumental activism are consistent with the emphasis in medical training and clinical practice on technological interventions aimed at curing acute illnesses. The patients with chronic illness, who cannot be cured, become an accusation of failure to the physician (p. 379).

The older ED client challenges the standard approach of triage, treat, and release. Chronic conditions require ongoing management which this environment cannot offer.

A Hierarchy Emerges

Each time I initially met with a staff member to discuss my research project, I found one constant. Staff volunteered their opinions about Skilled Nursing Facilities and the problems with providing treatment for elders from these sites. At the mention of elders, their first thought was of frail, institutionalized elders. None of the staff members seemed aware that the majority of elders are

community-dwelling. When I questioned one staff member about her assumption, she just laughed, "Well it seems like these are the type we get all the time." Another explained, "They're the ones you remember the most; they take so much time, you do so much, and it's all for naught."

ED staff made frequent negative comments about SNFs and their residents. Assertions such as "those screwball SNF nurses can't assess anything" were commonplace. In interviews, ED staff complained loudly about the quality of care SNFs offered elders. The day shift charge nurse described the situation :

> Those ones from the nursing homes are a mess. They need everything because all their systems have failed and their thinking processes are gone. The nurses that work in those homes are half-assed, they couldn't get a real job, and the old farts are so demented they don't know how bad the staff is.

An ED physician commented that a SNF was like "a vat for all that is useless."

Six elders participating in this study resided in SNFs. They ranged in age from 69 to 93, with all but one female. (See Table 2.) Institutionalized elders were seen in the ED for a variety of concerns: cellulitis, respiratory distress, pulmonary congestion, altered mental status, and leg edema. In spite of the variety of clinical concerns, each was considered a burden on the department.

As you may recall from Chapter 1, Matilda Scott, a 69 year old woman, was seen in the ED in acute respiratory distress. Her condition required emergency intervention. However, because of her frail status and poor prognosis, ED staff and house staff felt that she was inappropriately sent to the hospital.

Ms. Island's visit to the ED was also deemed inappropriate. Nursing staff at a

local SNF summoned an ambulance after reporting to Ms. Island's primary physician that she was unresponsive and hypertensive. ED staff scoffed at this complaint because her history described her as a 79 year old woman in a "persistent vegetative state secondary to multiple cerebrovascular accidents."

When the paramedics arrived to transport Ms. Island to the ED, they were told by staff at the SNF that Ms. Island had begun to leak around her urinary catheter and was not tolerating her tube feedings. Before they could transport her, additional saline was instilled into the balloon of the urinary catheter to prevent leakage.

Ms. Island's abdomen was bloated and distended. When Diane, the ED staff nurse, attempted to irrigate the urinary catheter, she found it was completely occluded. Diane inserted a new catheter and immediately 1800 cc's of cloudy, foul-smelling urine returned. With her bladder emptied, Ms. Island's blood pressure returned to normal. "No wonder she wasn't able to tolerate her tube feedings. Her bladder was up in her chest!" said Diane. Later at the desk, she discussed Ms. Island's condition with the ED physician, "All she needed was a new foley [catheter]; that ALOC [altered level of consciousness] complaint was a ruse to get her here. If they knew how to do basic care at that SNF she wouldn't be here."

ED nursing and medical staff reported numerous stories of "abuse" of the ED by SNF staff. "Anytime they have a problem, they call 911. If they're short-staffed or they've got a sick patient, they just dial the phone and take care of their problem," complained a nurse on the evening shift. According to staff, an ED visit by an institutionalized elder was a universal signal that the SNF staff felt

Table 2

Demographic Characteristics of Elders from SNFs

Elder	Age	Chief Complaint	Discharged to:	
Ms. Abbott	93	Pulmonary congestion	SNF	
Ms. Florence	78	Severe Cellulitis	Hospital	» SNF
Ms. Island	79	Hypertension/ALOC Urinary catheter obstruction/sepsis	Hospital	» SNF
Mr. Lawrence	72	Left leg edema Bronchial tumor found on X-ray	Hospital	» SNF
Ms. Scott	69	Respiratory distress	Hospital	» SNF
Ms. Washington	92	Confusion Hypoglycemia	Hospital	» SNF

that they could no longer care for the individual – that they were being pushed beyond their limits.

Although the elderly were uniformly devalued, a hierarchy of devaluation was apparent. The greatest amount of negative commentary and discontent was engendered by institutionalized elders. They were the most devalued of all clients seen in the ED. One staff member clearly articulated this view:

> It's hard to get worked up about trying to save someone who can't do anything for themselves. I think we say we're fair to all, but if we've got to get gung-ho with a really old person, it really helps to know they don't just sit in a wheelchair and drool.

Staff members prefer to treat independent elders. A staff nurse, who is an informal leader on the day shift, illustrates this belief:

> With the old folks who are trying to make it on their own, they get cabs, bus vouchers, lots of things. ... We get a lot of patients from Board & Care, or they live by themselves. We go out of our way to take care of these people.

The six independent living elders who participated in this study ranged in age from 69 to 92 years of age. They came to the ED for a variety of complaints: two for diabetes control issues, three for complications secondary to a fall, and one for altered level of consciousness (ALOC), which was later determined to be secondary to an acute gastrointestinal bleed. Table 3 presents demographic characteristics of the community dwelling elders who live alone.

Although staff state they prefer to care for community dwelling elders who live independently, each of these elders who lived alone was the object of discussion and/or interventions designed to move them out of their current

independent living status. Mr. Albert illustrates this point.

Mr. Albert

Mr. Albert, a 90 year old African-American man, lived alone in a small downtown studio apartment. At lunchtime he walked one-half mile to the neighborhood grocery store. "I was making soup in my apartment and I needed some vegetables to put in the soup," he explained. The sidewalk in front of the store was wet from a recent cleaning by the store staff. "Before I got into the store, I fell," continued Mr. Albert. As he fell, he hit his forehead, knees, and hands. A gash ran across the left side of his forehead and the knee of his right pant leg was torn.

Blood dripped steadily from the forehead gash. Fearing liability, the store manager called 911 to request an ambulance, but Mr. Albert just wanted to go home. When the paramedics arrived, they agreed that Mr. Albert should be seen in the ED for evaluation and suturing. "I'm afraid the house is going to burn down," he hollered. "Let me go home and turn the soup off and then I'll come right back."

Mr. Albert became more irritated as he was wheeled into a treatment room. "It'll be okay, honey, we'll get you taken care of," cooed the charge nurse. "I'm sure everything will be fine," she continued. Mr. Albert hopped off the gurney and followed her out of the room. "You don't understand! I'm afraid I'm gonna set the place on fire if I can't get home to turn the stove off," he explained. "Your nurse will be in to see you in a minute," answered the charge nurse. As she walked away from him, she signaled to Terry, a tough-talking experienced nurse.

Table 3

Demographic Characteristics of Community Dwelling Elders Who Live Alone

Elder	Age	Chief Complaint	Discharged to:	
Mr. Albert	90	Fall with laceration	Home	
Mr. Bird	77	Hypoglycemia	Home	
Ms. Castle	79	Fall with fractures	Hospital	» SNF
Mr. Robbins	69	Hyperglycemia	Hospital	» SNF
Ms. Ross	92	Fall with fracture	Hospital	» SNF
Ms. Song	81	R/O CVA, GI bleed	Hospital	» SNF

"I've got a real live wire for you in 14. He thinks his house is on fire. Let's see if we can get him out of here before he sets the others off," said the charge nurse.

Several minutes later, Terry returned to speak with the charge nurse and physician. She explained that Mr. Albert was insistent that his home be checked before he would submit to any treatment. Medical and nursing staff debated about restraining him and forcing him to be treated, or letting him leave the ED "AMA" (against medical advice) thereby relieving them of liability. Kyle, the physician, offered to speak to him. "I'll go check him out real quick," he commented.

Approximately five minutes later, Kyle returned to the front desk. "The guy says he lives in an apartment building with a lot of older people who don't get around well," explained Kyle. "He's afraid they're gonna be hurt if he doesn't get home to prevent a fire. He's real convinced of this and he seems oriented," continued Kyle. Kyle placed a call to the building manager but was unable to reach anyone. The Police Department told him they had no staff available to check on such things. Mr. Albert came to the front desk to announce his intention to leave. "I got to go. This is it," he said. Kyle intervened, "Sir, you hit your head. I can't let you leave here." "Then get somebody over to my house," bellowed Mr. Albert.

Kyle entered the break room. In a few moments he returned smiling. "I got it covered, Mr. Albert," he beamed. Kyle had convinced a team of paramedics to check on Mr. Albert's house. Mr. Albert gave them directions to the apartment and handed them the keys. Turning to Kyle, he said, "Okay, you did what I

asked, I'll stay." Mr. Albert grabbed his hat and coat and sat in a chair in the hallway.

The paramedics found a thick cloud of dark smoke as they entered Mr. Albert's apartment. They successfully turned off the stove and opened doors and windows to air out the smoke. When they returned to the ED, they handed the keys to Kyle, "The old guy was right, the place was full of smoke. We got there just in time."

In spite of Mr. Albert's obvious orientation, the following conversation occurred as Kyle was suturing the gash. "You know, if you lived in one of those places where they provide you with meals, but you have an apartment, this wouldn't have happened," said Kyle. "I'm fine," answered Mr. Albert. "A rest home would also be good for you. They take care of you there. You wouldn't have to go to the store or cook for yourself," continued Kyle. "No thanks," Mr. Albert replied, "I've made it to 90 on my own. I think I can make it the rest of the way."

Kyle tried several other times to convince Mr. Albert that he should not be living independently. Terry, the staff nurse, also became part of this discussion. "He hit his head. I don't think he should go home to a place by himself," she said to Kyle as he was suturing Mr. Albert's laceration. "He needs to live where someone can watch him," she concluded. When the suturing was complete, Mr. Albert hopped off the gurney. "I'm leaving now," he declared. Terry protested to Kyle. She felt he was not capable of going home alone. She claimed he was only "oriented times two" and needed "placement." Mr. Albert shook his head and backed away from them. Kyle sighed, "He was oriented enough to know that his

house was on fire, so I guess he can fend for himself." However, as Mr. Albert was leaving he reminded him to consider relocating.

Although staff state they value independence, they seem to push elders toward supervision. Ageist stereotypes appear to take precedence over individual support for independence. In general, however, independent community dwelling elders are received better than all other elders. Interviews with staff members about this group of seniors yielded comments that illustrate this struggle between overall support of independence and devaluation of the aged. Comments such as, "You know, he's really an old guy, it's great how he gets around," were mixed with others such as, "I wonder how much longer he can keep it together?"

Community Dwelling Elders Who Live With Others

The six community dwelling elders who lived with others, spanned an age range from 73 to 90. Three were widowed and lived with one or more children, three were married and lived with their spouses. The presentation and tone of their ED visit was markedly different from the previous two groups. See Table 4.

Elders living with others presented to the ED with clinical problems similar to other elders; however, each of these visits appeared to entail a tug of war over the assignment of responsibility for the elder. An example is Mr. Mason, the 90 year old gentleman introduced in Chapter 1. Mr. Mason was abandoned in the ED after his son summoned an ambulance, claiming his father was having chest pain. Later, the son admitted he could no longer care for his father. "It's just too much," he explained, yet he required his father's pension to make ends meet

Table 4

Demographic Characteristics of Community-Dwelling Elders Who Live With Others

Elder	Age	Lives With:	Chief Complaint	Discharged to:
Ms. Chow	85	child	Pulmonary congestion	Home
Mr. Jones	75	spouse	Cardiac dysrhythmias	Hospital » SNF
Ms. Martin	76	child	Confusion/ALOC	Home
Mr. Mason	90	child	? Chest Pain Placement concerns	SNF
Ms. Parker	73	spouse	Fall with fracture	Hospital » SNF
Ms. Nourn	74	spouse	Weakness/dizzy	Hospital » SNF

since he was out of work. In this case, Mr. Mason's son was no longer able to deal with the strain of providing care to his increasingly dependent father. This ED visit was a cry for help by a family member. The son actively sought institutionalization, although his father asked "Why does this have to be?"

For all of the elders who lived with another in the community, the decision to seek care was made by someone else. Elders living with their children, such as Mr. Mason, were brought to the ED when their children were overwhelmed by the task of providing care. On the other hand, elders living with their spouse, such as Ms. Parker (discussed at the opening of the chapter), were brought to the ED when a family member believed the elder was inadequately caring for his/her self. In each case, a family member experienced discomfort with the health situation of the elder. Children felt exhausted from caring for their frail aging parent. They described the situation as "too much," "desperate," and "impossible." Each expressed concerns about feeling overwhelmed or frustrated by the task. In contrast, elders who lived with their spouses were brought to the ED when a family member felt the elder was too sick to remain at home.

In the ED, staff frequently articulate their hierarchy of preferred patients. Elderly persons are not on that list. Devaluation of the old is routine; however, within this group a ranking emerges. The most desirable are community dwelling independent elders. Community dwelling elders who live with others pose problems for ED staff, but are clearly preferred over institutionalized elders. Residents of SNFs are the least desirable patients.

Chapter 5

What is care?

As the previous chapter demonstrated, staff, patients, families, and administrators have different perceptions of the purpose of the ED. If these groups disagree on its purpose, then it is imperative to ask about the assumptions underlying their differences. This chapter will focus on care, discussing and analyzing assumptions about it from the perspective of each of these groups.

Mr. Vasquez

After experiencing a sensation of pressure in his mid-chest region for over three hours, Mr. Vasquez was brought to the ED by ambulance. He hadn't wanted to go to the hospital, but when his wife had called an area clinic to explain his condition, the advice nurse told her to call 911 immediately. Neither Mr. Vasquez nor his family spoke much English, but when he held his chest and moaned softly, the paramedics understood that he was experiencing chest pain.

He was brought into the department by the ambulance crew and placed in one of the front rooms. These rooms are reserved for the most seriously ill because they are most readily visible and contain an extensive array of cardiac monitoring equipment. Jane, the ED nurse, hooked up the equipment and placed an oxygen mask over his nose and mouth. The monitor showed a rapid and irregular heart rate. As Jane checked his vital signs, the paramedics stood by and watched. When she had finished, one of them informed her that Mr. Vasquez

spoke no English. Since Jane did not speak Spanish, she made no attempt to communicate with him. Even as she drew blood and started an IV, she made no attempt to communicate -- even nonverbally.

In spite of Mr. Vasquez's condition, Jane spent most of her time away from his room. She positioned herself at the front desk where she could keep an eye on him while conversing with her colleagues. Periodically, she would enter his room, check his blood pressure, give a medication, or titrate an IV drip. Once these tasks were completed, she would rejoin her colleagues to discuss their concerns about the newly hired manager and recent firings in the department. They were also very apprehensive about a new computer billing system which would operate throughout all the campuses of the medical center.

Although Mr. Vasquez was seriously ill, Jane was preoccupied with all these changes. "We're so busy now, how do they expect us to learn this new system?" she asked. "I hear we're going to have to do everything on the computer from now on," another nurse chimed in. The physician nodded, adding "The medical staff got a notice saying all lab work, charges, registration, and charting were going on-line. There'll be no more paper charts." The charge nurse snorted, "How are we supposed to learn this new thing and do our jobs at the same time? This is typical: some Pooh Bah makes a decision and we suffer the consequences! I'm sure nobody bothered to ask staff how they felt about this," she sneered. "This will probably be like all those other great ideas they've had," the physician scoffed. "Oh yeah," Jane said. "Remember campus-wide dietary and campus-wide housekeeping? Huh! How long did they last?" Both of these services had failed due to numerous complaints by patients, staff, and visitors.

Jane went back to Mr. Vasquez's room in response to an alarm indicating that his oxygen saturation was dropping. She quickly checked the oxygen supply and repositioned the sensor for the saturation monitor. Before she could return to her colleagues, the alarm beeped again. As Jane assessed Mr. Vasquez, she maintained her role in the discussion by calling out comments.

Mr. Vasquez continued to deteriorate. As the alarms kept beeping, the staff found it harder to continue their conversation; eventually they all entered Mr. Vasquez's room. He required endotracheal intubation and mechanical ventilation -- the insertion into the trachea of a tube connected to a machine that assumes the work of breathing. Jane and her colleagues, as well as a respiratory therapist, performed the tasks. However, during the crisis they continued to discuss their concerns about the computerized system coming into Western Community Medical Center. Even as family members were brought into the room, staff ignored them and maintained their dialogue about the computer system and staff changes.

As Mr. Vasquez's condition changed, staff responded with the requisite steps. His falling blood pressure was treated with IV fluid and medications; as he struggled to breathe, the amount of oxygen supplied to him was increased and eventually he was intubated and mechanically ventilated. Each sign of physical deterioration received a response; however, staff were grossly insensitive to the needs of the patient and his family. They failed to focus on him, preferring to continuously air their anxieties about changes at work. Although Mr. Vasquez finally stabilized and was transferred to the intensive care unit, this scenario illustrates an unresolved conflict in the ED: namely, the definition of care. If staff

respond to physical signs with medical and nursing intervention, but fail to acknowledge the humanity of their patients, is this care?

Defining Care

Care is a term used freely in the health system. In a thoughtful review of the literature, Kyle (1995) asserts that caring is an elusive concept that includes specific behaviors as well as their moral, cognitive, and emotional components. Watson, who has developed a model for caring, concedes that "caring is one of the least understood ideas used by professionals" (Watson in Kyle, 1995). Leininger, a nurse anthropologist, claims that care is the defining characteristic of nursing, but states: "It is paradoxic that nurses have not investigated a term that they use daily and by which they would be expected to defend their professional activities" (Kyle, 1995, p. 506). Weiss (1988) has recently proposed a model in which she asserts that caring has three components: verbal caring, non-verbal caring, and technically competent behavior. According to Weiss, all three must be present for caring to occur.

The term care, is often used synonymously with treatment, or to denote being responsible for someone, but it is also laden with overtones of compassion and concern. In the ED, health providers use this term to denote activities that fall under each of these definitions. However, as the vignettes illustrate, in most cases, care is used to denote treatment -- medical care or nursing care, or responsibility. For example, Jane was assigned to care for Mr. Vasquez. Using Weiss' model, her care was consistent with technically competent behavior, but evidence of compassion and concern, demonstrated through verbal and non-verbal caring, are sorely lacking from most patient encounters in the ED. Instead,

most encounters are abrasive.

Many authors have provided us with evidence of patients being treated with callousness and insensitivity. In a monograph detailing her encounters as a patient in a SNF, Laird recounts her experience with insensitive health care providers. She introduces this monograph with the following passage: "This is ... an account of one person's efforts to hold onto sanity and identity in an atmosphere which was, by its very nature, dehumanizing" (Laird, 1979, p. 1). Kayser-Jones (1981) also found rampant evidence of dehumanizing treatment in a SNF. Insensitive treatment has not, of course, been confined to the SNF. Stevens (1994) reported grossly insensitive treatment of lesbians seeking health care, and Fisher (1986) reported callous treatment of poor and minimally educated women and families around the subjects of birth control and sterilization.

Dehumanization, or the loss of humanity, "is what follows when a person is treated insensitively, callously, and when he is subjected to experiences that are an affront to his dignity and sense of self-worth" (Kayser-Jones, 1981, p.46). In the ED, insensitivity toward patients is common. As a rule, staff seem to focus on the tasks of treatment but fail to acknowledge the humanity of the patients before them. My field work yielded countless examples of dehumanizing treatment. The case of Ms. Shenevsky is typical.

The Patient's Encounter

Ms. Shenevsky, an 80 year old Russian woman, reported to the ED for vaginal bleeding. A Russian translator was unavailable within the medical center, so a translator was obtained through the telephone company. In order to

accommodate staff, Ms. Shenevsky was brought to the front desk to speak to the translator over a speakerphone. The staff involved in her care were working at the front desk; Jim, the physician, was catching up on his charting and Dana, the staff nurse was mixing up a medication for another patient. Ms. Shenevsky explained in Russian, that she was a widow but had recently met a wonderful man. After having sexual intercourse for the first time in 30 years, she was now experiencing significant vaginal bleeding. The translator repeated this story in English to the staff members, however, the speaker was also audible to everyone in the front half of the department. Ms. Shenevsky's very personal problem raised eyebrows and chuckles among staff and clients who were privy to this discussion.

Ms. Shenevsky was given a pelvic examination by the ED physician and the interpreter was contacted again. Once again, dozens of people overheard as she was assured that all was well and referred to a local gynecologist for additional follow-up. Ms. Shenevsky hid her face as she left the department. Her male partner gently held her elbow and passed by with his head bowed.

The insensitivity toward Ms. Shenevsky, while shocking, is not unusual. The previous vignettes have highlighted other strong examples of dehumanizing treatment on the part of staff. It is further evidence that these elders are not valued, that in the eyes of staff, they have limited social worth. This devaluation is not lost on the elderly, many of whom voiced their awareness of these feelings.

Ms. Castle, one of the patients portrayed in Chapter 1, complained that she had "no idea of what was going on. They never bothered to tell me. I guess they thought I didn't matter." Mr. Albert, the 90 year old who required suturing after

a fall at the supermarket, commented: "They didn't seem to notice me. They treated me like a frail old man. That's not me. Nobody bothered to notice what I'm really like." Mr. Robbins, a 69 year old man, was brought to the ED after a visiting nurse summoned an ambulance. The visiting nurse, who was providing treatment for a healing diabetic ulcer, noticed that Mr. Robbins, who is usually oriented and independent in his ADLs, was suddenly disoriented and incontinent. When Mr. Robbins was brought to the ED, he told staff he was an insulin dependent diabetic. In spite of his protests, staff assumed he had forgotten to eat and administered intravenous glucose. "I ate. I know my sugar is too high," he explained. Lab results later confirmed that Mr. Robbins' blood sugar was dangerously high. Later he reflected on his experience: "I got my problem taken care of, but not without getting some licks. I've been a diabetic for a long time. I think I know something about my sugar levels, but I got treated like a dumb shit."

Mr. Mason is yet another prime example of devaluation of elders. As you may recall, Mr. Mason spent over 13 hours in the ED. Although his son told the ambulance crew that his father had chest pain, no physical malady was detected. So Mr. Mason spent the majority of his time lying on a gurney in the hallway, being ignored; staff members regularly walked by him. Ms. Castle, too, was dehumanized as Terry, the staff nurse, forgot about her. With the busy pace of the department, Terry became occupied with other patients and tasks. Only after two hours had passed did she realize that Ms. Castle was still there.

Staff also illustrate their devaluation of patients through their routine failure to introduce themselves. In spite of the lack of introductions, staff usually refer to

patients by their first name. If patients attempt to discern staff names and titles from identification badges, they frequently find the badge obscured by stickers or pasted on pictures of celebrities. Staff claim they hide their identity to prevent contact by clients outside of the ED. It appears, however, that this distancing also prevents clients from contacting them in the ED. Participants in this study frequently commented they were unsure of the names or roles of their ED care givers. This practice reflects one of the saddest truths about ED care for the elderly: in the words of one of my participants, "Nothing's gonna change until people start seeing a value in the elderly."

The Family Encounter

For family members, a trip to the ED is a stressful time. It is an indicator that a loved one is seriously ill and/or the family's ability to cope with the situation is in jeopardy. This situation is compounded by the ED routine of keeping family members out of the department. Staff claim that the overcrowded department cannot accommodate additional people and excluding family members helps protect the privacy of other clients. The net effect, though, is that patients are isolated from their key support people at the time they need them most.

Occasionally family members are permitted in the department for the duration of the patient's visit. This only occurs when the department is not busy *and* certain staff members are working. These staff members are highly experienced nurses; they worked in this ED when it was merely Facility B and have a reputation of "marching to their own drum." Although they violate the accepted and unwritten no visitors policy, they readily admit they "have no problem throwing someone out of the department." When they do permit

visitors, this privilege is easily rescinded if they find that the family member is "in the way" or "being overly nosy."

Now and then, family members are invited into the department to visit, but this occurs when staff believe they will be helpful or have information that is needed. For example, Ms. Ross, a 92 year old woman with a hip fracture, was permitted to have her cousin visit in the department because Ms. Ross was deemed an annoyance to the staff. "I gave her some pain medicine, but she's still whimpering. I don't have time to be warm and fuzzy," said her nurse. "I'll let her cousin baby-sit her for a while."

As we saw in the case of Ms. Song, the 81 year old woman who was treated as a confused old lady until lab work revealed that she was seriously ill, family members were brought into the department to provide information and then dismissed. Ms. Song's daughter described the ED as "a place where they don't listen. We tried to tell them what she was like, but they didn't hear us." Other participants were treated in similar fashion. Ms. Nourn's daughter was allowed to visit in the department because her mother spoke almost no English. "I don't have to worry about an interpreter if I have her here," justified the physician.

In other cases, family members appeared to be brought into the department to be chastised. Mr. Mason's son was interrogated about the care he delivered and his decision to send his father to the ED, even though staff had already begun to work on placement for the father. The visit by the son did not alter the discharge plan.

Many family members were quite distraught about their ED experience. Mr.

Martin, the son of a 76 year old woman who had a seizure, was allowed into the ED only to receive a lecture about his mother's incomplete adherence to her medication schedule. He described his feelings about his experience: "I thought they were supposed to help. ... Isn't that what an Emergency Room is all about? ... I felt like I got slapped."

The comments of Mr. Martin and other family members clearly illustrate the difficulty they face as they attempt to deal with the dehumanizing experience of being the relative of an ED patient. Several key points are important to restate and analyze. First, the majority of elders are not permitted to have family members accompany them in the ED. Second, when family members are permitted in the department, they are there to benefit staff and generally utilized for information, translation services, or "baby-sitting." Sometimes, as the above two examples illustrate, they serve as punching bags, as the recipients of vented anger. The relatives appear to get a direct and verbal dose of what patients receive more indirectly.

It is curious that family members are not allowed in the department. Staff claim they restrict visitors because of space limitations, yet they bend this rule for their own convenience. In general staff fail to see the perspective of patients or families because they are so focused on their own needs. The exclusion of family from the ED is further evidence that staff fail to see the value of the elderly patients they treat, or the depth of their connections to others. After all, why should a devalued elder deserve such assistance?

It is also important to speculate on the effect family would have in the department. Would the presence of a family member force staff to recognize the

humanity of those they treat? Would such openness change the tone of the ED and threaten the mystique of scientific clinical care as the best kind of care? Some researchers who study long-term care have suggested that staff might be more sensitive to patients if they were aware of their life history and value to others (J. Kayser-Jones, personal communication; T. Hill, personal communication). Given the limited duration of an ED visit, it is unclear whether this would have a similar effect in the ED.

A Staff Perspective

As the preceding vignettes illustrate, the majority of staff members use care as a synonym for treatment or to designate their assignment. The comments of most staff members, however, lack compassion and concern. When speaking of patients, the language of staff is often harsh and cynical. In this social environment it is hard to discern the rules of etiquette. There are no clear boundaries or taboo topics. Highly personal conversation is juxtaposed with clinical discussion; sometimes barely a breath is taken between subjects. Boundaries of decorum are also absent in the immediate patient environment. Personal conversations often occur as staff stand over patients, a pattern clearly illustrated in the treatment of Mr. Vasquez. These interactions are further evidence of devaluation of elderly patients.

Although patients and family members perceive that staff are rude and insensitive to their needs, staff believe they work very hard and provide good care. "We bust our asses in this place," explains the evening charge nurse. Although staff members state they prefer to treat "real emergencies," they do not believe that this bias affects the way they treat most patients at the site. Jeff, a

nurse on the evening shift, explains this:

> I think most people like the real stuff. Most of these patients are just not challenging. In the ED, you have to get all these certifications to work and stay here, you know: advanced life support, intubation skills, pacemaker insertion, disaster preparedness. So you get all this stuff and then you hardly ever use it. You run around treating vaginal infections, sniffles and boo-boos. I don't think anybody here really likes that part of the job, but we just grin and bear it. Sometimes we mouth off about it, but that's just blowing off steam; we still take care of them. ... As for the old folks, they're really tough to deal with. So many of them are just vegetables and we really shouldn't do anything to keep them alive. But you know you really can't get away with that, so we do what we have to get them through this time.

As Jeff explains, staff do not believe that their remarks or behavior are indicative of poor care. Instead, they feel that they hide their feelings from patients and families and provide the required care. Jeff explicitly states "We do what we have to," but this statement is quite profound, for it communicates a lack of engagement in the work. Jeff and others feel they "have to" perform many tasks and interventions, but they clearly have no interest of desire to do so. Jeff's comments illustrate that staff feel caught in the middle; they have a professional obligation to treat all patients that arrive in the ED, but they find this situation undesirable. Jeff also reiterates the strong negative perceptions held by staff toward the elderly.

Although the comments of Jeff and others appear callous, it would be unfair to accuse staff of being completely insensitive. There are glimpses of compassion. Josh, an ED physician, has commented: "It's hard to look someone in the eye and tell them you think they can manage at home when you know they can't." Jody, the staff nurse discussed in the previous chapter, is very angry with elderly patients who demand service, but she also sees that the issue cannot be easily

fixed: "It's really hard. Some of the old folks don't need to stay here, ... but you gotta do something with them." On occasion staff appear to have flashes of recognition of the issues their patients face, yet they wall off these concerns with harsh words and language.

In many ways staff resemble patients; they believe that their view about the nature and purpose of the ED is correct and that their concerns and feelings are not appreciated by the others involved (patients or administration). To staff, inappropriate patients gnaw away at their time and prevent them from doing what they are trained to do. As a result, they are professionally devalued. Furthermore, administrators have created onerous working conditions which make this situation even more difficult to bear.

Interviews with staff members were laden with frustration about their inability to do "a good job" because of all the demands placed on them. Staff commented openly about their professional devaluation: "I hope I remember what to do if I ever see a real emergency," said a novice ED nurse. "It's hard to get excited about your work," an experienced ED physician explained. "There's lots of crap to occupy your time, but little challenge. It's not as sexy as I thought it would be." Staff also speak freely about a lack of concern about their welfare on the part of administration. This staff member typifies the feelings of nurses and physicians in the ED:

> My job is moment-to-moment. I have work now, I have a job, I get paid, I can pay my mortgage, and take care of my kids. What will happen tomorrow, God only knows. Every night I turn on the news and hear discussion about health care reforms: Medicare this, Medicaid that, insurance this, insurance that. If we don't get some kind of solution to this, I don't know how much longer I can hold out. My stress level is so high from worrying about whether I have work. When

> I'm there, I should be worrying about what's going on with patients, and I do somewhat, but I work days and all the administrative folks are there. I'm constantly getting hounded about what I'm doing, how I need to do more, and how much what I do costs. I can't take it anymore. It's just too stressful. If I had another job, if things were good to go elsewhere, I'd go, but I don't have any sense that anything else is better so I just hang on, I go to work, I do my time, I come home, and I worry about whether I've got work tomorrow.

As this comment illustrates, the sheer weight of the ongoing organizational changes has created an ED work force that strives to "get by." Staff increasingly find themselves devalued in this new environment. In essence, they too are suffering from a negative social judgment that labels them as persons of limited value. From the perspective of staff, the burden of hanging on in this system prevents them from providing their concept of care as they would like to.

An Administrative Encounter

Administrators at Western Community Medical Center define care quite differently than patients, family, or staff. The Medical Director speaks of providing treatment: "We care for about 150 visits per day. The majority of our patients are covered by Medicare, Medicaid, or both. There's a small percentage of private pay patients." The Nursing Director speaks in similar fashion:

> This place is very busy. We care for a lot of patients in a very small space. In general we do okay here, our care is good. We have very few incident reports and our quality improvement program looks good. But we need to step up the care. We keep people too long and staff admit too readily.

The Administrative Director for Outpatient Services also spoke in financial terms, reflecting a business orientation. She describes the ED based on the number of visits per month and per year, the ethnicity and payer source of

clients, and the percentage of clients treated who are admitted to the acute care facility. To these administrators, care is spoken of as a visit which generates charges and outcomes. Each of these statements emphasizes the economic aspects of health care.

Although each of these administrators is a licensed health care provider, their work, which is focused on the executive functions of the department and medical center, distances them from patients or families. To these administrators, Mr. Mason, Ms. Castle and Ms. Scott, are simply line items on a census report or budget. Many staff members are convinced that this physical separation from the patient care environment makes it easy for administrators to insist that clients must be moved through the department quicker or discharged home rather than being admitted. "They don't work in the trenches. They really don't know what it's like," claim staff. In the words of one physician, the administrators do not "have to look them in the eye" to explain that their needs are not valid. From the perspective of staff, administrators remain aloof from the client care and fail to grasp its demands.

Administrators are focused on cost-effective care. Within this schema, patients with the highest value are either those most economical to treat or those with the highest reimbursement rates. By these criteria, elders maintain a low social standing since they are more difficult to treat due to co-morbidities and are predominantly insured through governmental social welfare programs.

Administrators, unlike staff, appear to devalue patients from afar. Their economic orientation places a value on reimbursement. They manifest their value system as they mandate shorter lengths of stay, demand quality improvement

programs that focus on patients who are financially unrewarding, and actively market services to groups that are financially rewarding. The Administrative Director for Outpatient Services explains this perspective:

> Our biggest problem in the ED is what to do with all these people who are chronically ill. They need services, but not acute care. But they show up in the ED and expect us to do something for them. We lose money on patients like that all the time. The biggest money loser right now is an older patient on Medicare with CHF (Congestive Heart Failure). We lose money on that DRG (Diagnostic Related Grouping) all the time.

The Director later went on to explain that she had requested that the Clinical Nurse Specialist put together an educational program on the top five "DRG losers. It's something we're doing throughout the house. Each unit needs to identify the problems and put their attentions there," she explained. "Our plan is to work on losing less while we market to the private pays and self-pay patients. This is managed care," she continued. "It's bottom-line driven."

Managed care and financial concerns appear to be major driving forces in this environment. Although the Medical and Nursing Directors are in the ED each day, they each spend over 50% of their time working with other administrators. The Nursing Director explains that she draws support from other administrators who understand the unique demands of her position. "Most of my staff don't get it. They don't understand that I have to justify every budget variance. On a daily basis I have to account for what goes on in this unit." The Medical Director feels similarly caught. "I have multiple masters: the individual doctors, the physician group, and hospital administration. It's pretty much a no win. The group and administration make the rules, and I'm supposed to let the physicians know the new rules."

An interesting conundrum is apparent. Staff feel that administrators do not appreciate the demands of their work and administrators feel that staff do not understand the demands of their positions. Staff blame administrators for many of their problems, but administrators point the finger at managed care and its effect on hospital reorganization:

> I have a lot of staff that don't even want to be here. With the merger, many of the good nurses left or were laid off. Everyone had to rebid for jobs and it all went on seniority. So I got a crew, many of whom know nothing about emergency care and aren't willing to put out the effort. The merger killed this place. You could be a great labor and delivery nurse, but you might end up working telemetry because of seniority issues. If your job changed, you got two days of orientation to the new place. It killed this place and destroyed the staff spirit.

Both administrators and staff feel trapped in this new system. One physician aptly described the situation:

> There's lots of patients to be seen here. There's plenty to do. The big problem is whether we're going to get paid to do any of it at all. Right now, we're being forced to do more, for less, with less.

What is Managed Care?

Underlying much of the confusion about the role of the ED and the meaning of care is the ongoing chaos within the health care system. Our contemporary health care system has been called "a paradox of excess and deprivation" (Enthoven & Kronick, 1989). Excess is evident in both administrative oversight and actual care delivered. Estimates of the price of administrative oversight range from a conservative 19-24% of all health care dollars (Bodenheimer & Grumbach, 1995), to a high of 40% (Public Agenda Foundation, 1992). Woolhandler & Himmelstein (1991) comment that administrative costs of health

care are rising more rapidly than the costs of the medical care administered. They note:

> Medicine is increasingly a spectator sport. Doctors, patients and nurses perform before an enlarging audience of utilization reviewers, efficiency experts, and cost managers. A cynic viewing the uninflected curve of rising health care spending might wonder whether the cost-containment experts cost more than they contain (p. 1253).

Rising administrative costs go hand in hand with increased use of health care by a decreasing number of insured persons. Experts attribute this to an oversupply of specialized facilities and technology and over-prescription of hospitalization, procedures, and medications (Bodenheimer & Grumbach, 1995; Brook, 1989). Gazing up at this seeming hall of plenty are approximately 39 million Americans who are completely uninsured; an equal number are estimated to be under-insured (Bodenheimer & Grumbach, 1995). Lack of insurance or inadequate coverage prevents this group of approximately 80 million Americans from accessing needed and/or wanted care.

Managed care, a cost-reducing strategy, shifts the method of reimbursement for health care costs away from a fee-for-service basis. Under a fee-for-service system, reimbursement is directly correlated with the amount of service delivered: the more service, the greater the reimbursement. In managed care, however, health care organizations and providers are paid a predetermined amount, usually on a per member/per month basis, to coordinate and deliver a full spectrum of care. The burden of financial risk is shifted to providers and away from the insurers (Estes & Swan, 1993; Robinson & Casalino, 1995). Managed care also includes a multitude of other strategies to control rising health care costs. These strategies include increased competition among health

providers and facilities, price control of reimbursements, patient cost sharing, utilization surveillance, and supply limits (Bodenheimer & Grumbach, 1995).

At the 1995 Annual Meeting of the American Geriatric Society, Dr. Gail Povar, clinical professor at George Washington University, described the unique issues for the elderly related to managed care:

> Managed care is a supply response to demand. It produces a new type of conflict because instead of rewarding explicit overutilization, which is what the fee-for-service system traditionally encouraged, managed care rewards underutilization. For the elderly there are several specific problems related to advocacy. Foremost is that underservice is rationalized already by many caregivers on the basis of ingrained beliefs about the elderly. It takes time and energy to be an advocate, and there is the perception that the elderly cannot benefit as much as younger patients from medical intervention (Ethical Issues in Managed Care, 1995, p. 21).

Although managed care has become a household term, it is questionable whether the concept is well understood. As this and the preceding chapter demonstrate, terms such as "emergency department" and "care" carry multiple meanings. "Managed care" is also viewed differently by patients, family, staff, and administrators. The case of Ms. Chow illustrates the dilemmas faced by each of these groups in a managed care environment.

Ms. Chow

Ms. Chow, an 85 year old Caucasian widow, lived with Ben, the oldest of her two sons. For the last six months, Ben had been the full-time caretaker for his mother; previously he had worked as an airline mechanic. However, he had been disciplined and finally fired due to frequent absence, tardiness, and excessive use of breaks. Ben explained that he would call in sick if his mother wasn't feeling

well and often drove home at lunch to check on her. As his mother's care needs increased, his availability to perform his job declined. Although his employer knew that he was juggling work and home care, his attendance had become too variable to justify keeping him on. Six months later, Ben still felt angry about losing his job.

Ms. Chow arrived in the ED by ambulance accompanied by Ben. Dressed in her plain white nightgown, silk kimono and turban, she appeared frail. She answered questions with simple one- or two-word responses, her answers punctuated by frequent bouts of coughing. As her coughing increased, the nurse turned to Ben for answers. "Mother was coughing so much," he explained. "I was afraid she'd drown in her own fluid. I was up all night watching her." Ben said they had been to Dr. Faust, their private MD, the day before, and he had given them a prescription for antibiotics and some samples. Ms. Chow had taken two doses of the antibiotic, but Ben felt that she had taken "a turn for the worse."

As a courtesy, the staff nurse notified Dr. Faust's office that Ms. Chow and her son were in the ED due to worsening pulmonary congestion. Several minutes later, Dr. Faust called the ED and told the staff nurse that he did not approve of this visit. "That son's like an old hen," he said. "I gave her medicine. All she needs to do is take it. Tell them that this visit must be paid for out of their pockets. I will not approve the plan paying for this unnecessary visit."

Given Dr. Faust's response, ED staff were unwilling to be aggressive in their approach. A chest X-ray was ordered and Ms. Chow was discharged against her son's desires. "It's too much. I need help. I can't manage it anymore," he moaned. "Can't they see she's sick?"

The following day, in a telephone interview, Ben offered his feeling as about his ED experience:

> My mother is old and frail. I know that. I didn't expect miracles when I brought her in, but sometimes it frightens me to see her have such difficulty. But they didn't seem to understand what it's like to experience this. She's my mother, she raised me, she stood by me over the years; the least I can do is stand by her now.

To Ben and his mother, managed care resulted in limited ED service, an unpleasant encounter with ED staff, and a brewing rift between patient, family and primary physician. To ED staff, managed care meant the intrusion of an insurance company into the provider-patient relationship. To administrators, who are focused on cost-effective treatment, came the recognition that reimbursement for this limited visit was questionable and any attempt at comprehensive care would result in denial of services by the insurance company and the need to seek reimbursement from a frail patient and her unemployed caretaker son. From each perspective the focus of attention was not on the needs of Ms. Chow or Ben, her struggling caregiver. Instead the emphasis was on the flow of cash within the health care system.

Managed Care: An Oxymoron?

As Ms. Chow's case suggests, "care" is used differently by patients, family, staff, administrators, and insurance companies. It can be a synonym for responsibility, compassion, treatment, a visit associated with a charge and outcome, or a service that needs to be rationed. This next section will explore the meaning of "managed care" to each of these groups.

Among ED staff, and in nursing and medical literature, care is most

commonly used to mean treatment. If care is synonymous with treatment, then managed care implies control over treatment, including choices offered as well as the duration and quality of treatment. In the ED, there is continuous evidence of this form of managed care. As you may recall, Ms. Scott, a 69 year old woman with cerebral anoxia, was subjected to this form of managed care. The ED physician attempted to control her treatment by limiting the extent of treatment offered. Although her daughter wanted aggressive treatment and resuscitation if required, medical staff maintained control of treatment options by admitting the patient to a low visibility ward room where signs of distress would not readily be seen.

Other examples of managing treatment include the following: mandating pre-authorization by the insurer, requiring all referrals to be approved by a primary care provider, or offering incentives (and, in some cases, disincentives) to use specific providers, services or facilities. Ms. Chow experienced this type of control over her treatment as she was hastily processed through the ED when her care was not approved by the primary care provider.

If care is used as a synonym for responsibility -- as in Jane is caring for Mr. Vasquez -- managed care implies manipulation of staffing and authority. In the ED, patient volume is increasing without the addition of staff. At the same time, health providers are being laid off or replaced with lesser skilled personnel. Managed care also undermines authority. Health care providers have responsibility without authority; that is, they must provide treatment but the treatment provided is dictated by a third party. To compensate for this situation, health care providers have learned to manipulate the health care encounter. We

saw evidence of such manipulation when the ED nurse and in-house physician invented a plausible excuse for admitting Mr. Mason to the SNF.

If care is viewed as compassion or concern, then managed care controls compassion. In the ED, there is strong proof that this form of managed care is being embraced. The vast number of changes and high volume of work have over-taxed the ability of staff to deliver compassionate care. More often than not they are too busy, too concerned about their own status, or too frustrated by the changes to do so.

If the term care is viewed as a visit with outcomes and charges, then patient care has been reduced to a process. Care has become a commodity that is produced on the assembly line. In this process, from which compassion has been eliminated, patients, families, staff, and administrators have been subjected to the ultimate devaluation. They are merely widgets interacting in this complex assembly process. As with all assembly lines, there are production and quality goals. Ultimately each worker is subject to replacement in the search to produce a product cheaply and efficiently. Similarly, if a product is too costly to produce, it is subject to discontinuation from the product line and its producers, of course, are expendable.

In each of these versions of managed care, the health care encounter is reduced to a financial equation. The persons involved in each event are dehumanized and devalued. Managed care is a supreme form of social devaluation. With this in mind, it is imperative to ask if the term managed care is an oxymoron. Can something so focused on financial management simultaneously take into account the unique needs of a human being?

The next chapter will further explore the effect of all of these changes on the treatment of elders in the ED.

Chapter 6

Being There: Between Privilege and Discomfort

In the previous chapters, I have attempted to portray the world of the ED through the eyes of four groups: the patients, family members, staff, and administrators. Although each group operates under different assumptions about the purpose of the ED and what constitutes care, each is certain that its needs are not being met. As a participant observer, I have interacted with members of each group in the process of gaining a panoramic view of the ED. In the preceding chapters, I have described and reflected on the physical characteristics of the ED, the activities of the participants and their assumptions. This chapter will discuss the cumulative effect of these conditions on the participants and the researcher.

Being There

As a catch-all that provides treatment for a wide variety of clients under varying circumstances, the ED is a fertile site for examining the health care system. Due to its historical roots and location at the juncture of acute care and public health, it has become a key part of the health care system. Now, however, it is questionable whether the ED can continue to deliver such diverse service.

As we have seen, there is little satisfaction with the current state of the ED at Western Community Medical Center. Patients and family members who arrive at the ED for treatment are largely unhappy with their dehumanizing experience there. Unfortunately, the ramifications of their unhappiness don't go very far, for

it is no longer possible to just choose another health care facility; usually, the competition has closed its doors. Similarly, staff and administrators are unhappy. Staff, who feel increasingly insecure, claim their work is no longer challenging, yet in a contracting health care system they have limited job options. Administrators must enforce changes that place them at constant odds with staff; refusing to enforce them would jeopardize their own positions.

The pervasive feelings within the ED are ambivalence and ennui. Each group feels locked into an unsatisfactory mode of participation. No one wants to be there, no one is happy with the present state of the ED, but no one is clear on how to improve the situation. Although change is ever-present, the changes seem to reinforce the negatives. The installation of a new computerized system, designed to provide more accurate tracking of finances, has been justified because the staff have been "ineffective" in curtailing costs. The departmental remodeling is required in order to accommodate more patients, but as the number of patients grows, the number of staff dwindles and the skill mix changes in favor of lesser qualified personnel. An incredible mismatch is evident; the number of patients treated at the medical center is increasing, but the number of staff is decreasing.

On the surface, the ED is prospering. The number of ED visits is rising, the length of stay has decreased, and quality improvement programs have enhanced outcomes. However, staff methodically, often grudgingly, move through their paces; management changes frequently; and patients and families regularly complain that "things aren't like they used to be." The negativity at this site is pervasive.

The position of researcher is a position of both privilege and discomfort. The privilege is implied in the preceding chapters, in which patients, families, staff, and administrators generously shared their candid views of the ED encounter. It was difficult, however, to listen to ongoing dehumanizing and devaluing comments. Remarks by staff were often peppered with racial slurs and derogatory comments about the appearance, attitude or lifestyle of clients. Staff were generally uninterested in clients they deemed boring and professionally unchallenging and they frequently lashed out at administrators. Comments by administrators were tinged with frustration and anger directed at staff and the changing scene of health care. Clients and families often spoke of exhaustion, pain, and sadness. It is discomforting to realize that in situations of constant stress so many are oblivious to the humanity of others.

Other ethnographers, of course, have encountered uncomfortable surroundings and situations that tear at their own ethical beliefs (Van Maanen, 1988, 1983; Kayser-Jones & Koenig, 1993; Lipson, 1993). Within the ED setting, Roth & Douglas (1983) also encountered frank social judgment and devaluation. They conclude:

> The hospital emergency service is a setting where a minimum of information is available about the character of each patient and a long-term relationship to the patient is usually not contemplated. Even under these conditions, judgments about a patient's moral fitness and the appropriateness of his visit to an emergency service are constantly made and staff action concerning the patient – including diagnosis, treatment, and disposition of the case -- are in part affected by these judgments (p 72).

In the ED at Western Community Medical Center, patients and families blame staff for its current conditions. Staff, in turn, staff blame hospital management.

Management, however, feel staff are insensitive to the constraints of their positions. In their administrative roles, they are required to enforce changes stipulated in contracts with insurers and managed care organizations. These key people, the insurers and managed care organizations, are not on-site.

Not There

The real decision makers in health care, insurers and the managed care organizations, are noticeably absent. They do not provide treatment; in most cases they do not have face-to-face contact with patients, family, staff, or administrators. They manage the ED from a remote location, influencing care by controlling reimbursement. Vicente Navarro (1993), a well-known physician and professor of health policy at Johns Hopkins University, describes this relationship:

> The dominance of the insurance companies in the health care sector has meant that they, rather than the providers of care, are the ones who have a commanding voice in that sector. As a result, it is frequently not physicians and other health professionals who decide what their patients need; it is the insurance companies. What many people do not realize is that any procedures a physician recommends must be approved by the patient's insurance company. A physician can spend up to an hour a day seeking permission to do what he or she considers best for the patient. The insurance companies base their decision on their own criteria of cost-effectiveness, which are not disclosed to either the patient or the physician. This degree of intrusion into the relationship by a third-party -- the insurance company -- is unheard of in other countries (p. 31).

The payers' physical separation from the provision of health care is symbolic of their appreciation for the patient experience. They are even further removed than administrators, who are on-site but detached from patient and family contact; and many, especially staff, question the administrator's ability to

understand the treatment issues and interpersonal relations that affect the health care encounter. The physical distance between payers and patients is even greater and thus facilitates complete dehumanization of the encounter. To payers, each patient visit to the ED is an expense that must be minimized. This control is exercised from centralized offices staffed by utilization management and financial personnel. This is more than just a remote location; it is remote control of health care. Video games and electronic toys are also run by remote control. A wrong move, however, by a remote control car does not carry the same import as a wrong move in the care of an ill elder or other ED client.

A health care system that is completely focused on the bottom-line and orchestrated by people at remote sites encourages social evaluation of patients based on apparent characteristics. From a remote location, the most readily apparent characteristics are age, finances, and diagnosis. These three characteristics, however, do not adequately describe the complexity of any patient's situation. Age is a grossly inadequate marker for social value. To say that a patient is 75 merely acknowledges that he or she has lived for that long; it does not convey the status of the individual. The fallacy of this reasoning is apparent within the sample for this study. Ms. Scott, a 69 year old woman with cerebral anoxia, was the youngest participant in this study. Yet, she is frail and institutionalized due to her physical condition. In contrast, Mr. Albert, a 90 year old man, was the oldest male participant. Mr. Albert, however, lives independently in an inner city apartment.

Financial characteristics -- indirectly apparent through insurance coverage -- and diagnosis are objective data that also fail to provide insight into the person

they describe. The essence of an individual elder is masked through elders' almost uniform participation in Medicare and the high incidence of chronic conditions and co-morbidities present among them (U.S. Senate Select Committee on Aging, 1991). Each of these pieces of factual data fails to capture the client as an individual.

Within this kind of system, anyone with multiple health problems, chronic conditions, or large health care expenditures is devalued. This system reinforces the already prevalent cultural devaluation of elders, and others with chronic illness. Not surprisingly, the previously mentioned hierarchy among elders is reinforced in this business-oriented health care system. Elders who live in the community and need minimal care and services are the least expensive to insure and therefore the most profitable. Conversely, institutionalized, dependent, or frail elders generate large health care expenditures, thus thwarting efforts to control costs. In a system that is driven to contain costs, the most vulnerable are at greatest risk for having services to them rationed.

In this new system, health care is a contracting enterprise. Mergers, consolidation, and down-sizing of facilities are commonplace, and fees paid to providers for delivering care to elders under Medicare are scheduled to be reduced. Yet, Medicare costs continue to rise at 10% per year. Rising costs for elder care have rendered Medicare an easy mark as politicians call for a balanced budget (Cornman & Kingson, 1996; Hudson, 1996; Ethical Issues in Managed Care, 1995). Given this population that is often characterized as frail, sick, and unproductive, it is easy to see why age-based rationing of health care is seriously contemplated (Callahan, 1987, 1994; O'Malley, 1991). Medicare studies already

demonstrate that the oldest-old have lower health care costs in their last year of life than do the young-old, which suggests that some treatment limitations based upon age are already being enacted (Callahan, 1994).

An entire industry of consultants has evolved to help hospital administration deal with the changes associated with managed care. These consultants recognize, and make suggestions for dealing with, the difficulties that result from remote management of health care. For example, in a newsletter focused on ED management, the following suggestion was offered for dealing with managed care organizations:

> Once the registration clerk gets the gatekeeper on the phone, he or she encourages the gatekeeper to talk to the patient by saying, 'Dr. Smith, maybe it would be good if you talked to Mrs. Doe directly.' Then while the gatekeeper is saying, 'No, no, no,' the clerk hands the phone to Mrs. Doe, so she can explain her problem directly to the gatekeeper. ... The strategy is that gatekeepers may be more reluctant to defer patients when they have to do the deferring themselves ("Managing managed care," 1995, p. 15).

Even the consultants realize the danger of care managed by remote control.

Managed Care at Western Community Medical Center

From a strictly financial perspective, the merger of these three facilities was essential; as independents they were competing for shrinking health care dollars. Efficiency and economy were significant factors in their decision to merge. Ehrhardt and Fish (1990) report that greater coordination and communication in local health care delivery, economies of scale for purchasing, centralized support services and human resources, improved use of personnel, and elimination of duplication are factors that make mergers economical. However, they caution

that these financial issues are really only the tip of the iceberg when looking at a merger. Personnel issues – such as changing jobs, new policies, loss of identity, and changing loyalties -- are crucial in any merger. Larkin (1990) comments that incompatible goals between organizations, unequally trained professional staff, and medical staff squabbles often impede service consolidation when mergers occur. Anderson (1991) states that perhaps one of the largest problems facing hospitals that choose to merge is a breakdown of trust. Each of these problematic areas has arisen as Western Community Medical Center has attempted to coalesce.

An almost palpable sense of distrust permeates the ED. Triage nurses, like Jack, attempt to sort out who is "really sick" from those that are "abusing" the ED as a clinic. Staff physicians and nurses spend much of their time huddled, trying to find out what is really happening at Western Community Medical Center and in the health care system.

Many ED staff, understandably, feel they are inadequately prepared to deal with their changing role. They have been charged with the very important task of providing emergency services to a growing population, but they have become victims of a merger brought on by the advent of managed care. Their changing workplace so overwhelms them that it inhibits their ability to perform their professional duties. At work, anxiety-ridden ED nurses and physicians spend relatively little time with patients; they prefer to huddle, sharing their concerns and reinforcing their own fragile community.

Elders seeking treatment in this ED enter an unhealthy environment, hoping to be treated adequately, appropriately, promptly, and with respect. Instead, they

are treated as widgets in the system, for the environment that delivers treatment to them at Western Community Medical Center is strained beyond its limits. The volume of care delivered exceeds the maximum capacity of the physical environment. Simultaneously, an organizational evolution brought on by strained political and economic conditions has created an unhealthy environment for ED care of elders and for the day-to-day existence of ED staff. This new chaotic entity continues to deliver care to an increasingly aging population amidst cultural beliefs that denigrate elder care. This strain is evident in each patient encounter in the ED.

Within this uncertain health care environment, the role of the ED is in flux and its contradictions are increasingly blatant. While the ED is used as a safety net, an entry point into the health care system for those without access to primary care, it is also a site for trauma care, a function that draws most staff to this work. Moreover, for those who have access to facilities yet choose not to wait for an appointment, EDs serve as surrogates for doctor's offices and clinics. Community policing also impinges on the ED, as law enforcement agents bring in patients to be evaluated for public intoxication, homelessness, or drunk driving. Although various agencies attempt to dictate what the ED should do, physicians and nurses in the department are left to negotiate their own roles in this often contradictory environment. This uncertainty is compounded by the glorified images of EDs apparent in the media. The image of the ED as a place of nonstop, heroic action, is inapplicable at Western Community Medical Center, as it is at most health care facilities (Padgett & Brodsky, 1992).

Chapter 7

Beyond Western Community Medical Center

The preceding chapters have discussed the major conflicts present in the ED at Western Community Medical Center. From this discussion it is apparent that the nature, purpose, and role of the ED are currently being renegotiated as a new health system emerges. In this chapter I shall discuss generalizations, limitations, and recommendations arising from this study.

Although the small sample size (N = 18) and single site may make it difficult to generalize beyond the boundaries of the ED at Western Community Medical Center, the types of dilemmas I observed may be suggestive of those that take place in other EDs. For example, the ED nursing director described her department in the following way:

> I have a lot of staff that don't even want to be here. With the merger, many of the good nurses left or were laid off. Everyone had to rebid for jobs and it all went on seniority. So I got a crew, many of whom know nothing about emergency care and aren't willing to put out the effort. The merger killed this place. You could be a great labor and delivery nurse, but you might end up working telemetry because of seniority issues. If your job changed, you got two days of orientation to the new place. It killed this place and destroyed the staff spirit.

Circumstances such as these, however, are not unique to this setting. When I read the above passage to three colleagues, two nurses and one physician, each thought the nurse manager was describing a site they were familiar with. Of the three separate sites they mentioned, none was the actual setting for the study.

Several constants in health care also suggest the generalizability of these

findings. First, devaluation of elders is rampant throughout American culture and health care. Second, ED journals support the views expressed by staff; the majority of their articles are focused on trauma, critical care, and rare case presentations. Third, managed care is rapidly permeating the health care system. Given these constants, it seems likely that many of the dilemmas faced at Western Community Medical Center are simultaneously occurring in other EDs across the United States.

Several limitations of this study must be acknowledged. A small sample size (N=18) limits generalizability. A larger sample size would strengthen the credibility of my findings. Similarly, the use of one setting may suggest that these findings are unique to this setting. A comparative study between two or more urban EDs would help distinguish the effect of managed care versus more traditional organizational change. The most significant limitation, however, is the focus on care in the ED. It is clear from this study, that health care changes are affecting the entire system. To capture the effects of managed care on client outcomes, clients must be followed throughout their health care encounter.

Recommendations: Western Community Medical Center ED

Numerous suggestions arise from this study. Perhaps the most readily feasible concern the physical environment of the ED. The current ED environment is crowded, dark, and inefficient. Improved lighting would assist staff in assessing clients and aid elders as they orient to the ED environment. Increased space would insure privacy and decrease the din that often makes it difficult for elders to hear what is being said to them.

Sanders (1996) has suggested that elders might benefit from specialized EDs designed exclusively for geriatric clients. He notes that pediatric EDs and designated trauma units have substantially improved the care provided to these groups of patients. Although I would not dispute his implication that specialized units would benefit elders, as pediatric EDs have benefited children, I seriously doubt whether the current health care system will support another specialized service.

Freeman (1994) has suggested an alternative to separate ED s for elders. She suggests the development of a "Quick Response Program (QRP)" to provide assessment, education, counseling, and referral in the ED for older adults. QRP is an actual project that Freeman developed at Hotel Dieu of Windsor, Canada. This program was staffed by a team of Geriatric Clinical Nurse Specialists and Geriatric Nurse Practitioners. Each elder seen in that ED was referred to a QRP geriatric specialist for evaluation. Evaluation focused on function, mental status, depression, living status, health promotion, social support, finances, current health status, and wishes of the elder. A key premise of this program was that elders were viewed as competent in making their own health care choices and deemed to have the right to live at risk (Freeman, 1994; Dawson & Critchley, 1992; LeBourdais, 1991). This program has been highly successful at keeping elders in the community and out of hospitals and institutions. Perhaps even more gratifying, elders who have participated in this program feel they have been treated with respect and dignity (M. Freeman, personal communication, November 5, 1995).

A less extensive organizational change would entail increasing

geriatric/gerontology knowledge among ED health providers. Strange, Chen & Sanders (1992) note a consistent pattern of limited geriatric knowledge among ED physicians. Similarly, McNamara (1992) saw little evidence of change in ED residency programs to accommodate a growing population of elders. At Western Community Medical Center, none of the ED physicians have training in geriatrics. Similarly, the majority of ED nurses had limited knowledge of the special needs of elders. Jeff, one of the newest staff nurses in the ED, graduated from a baccalaureate nursing program whose regulations mandated a minimum of 60 hours of geriatric clinical experience. However, he offered the following response to my query about his knowledge of geriatrics/gerontology:

> What's to know? Old people are adults just like all the others we treat here. The only difference is that you gotta be careful. Usually they take a little less dosing on big guns medicines; you know, the kidneys and heart. Well, everything begins to fall apart as you get old. What else would I need to know?

It appears that staff are in need of basic knowledge about elders as well as specific health-focused content. As Jeff's comments illustrate, current professional preparation for nurses is also inadequate. As a first step in upgrading geriatric knowledge and sensitivity of health care providers, basic professional educational programs need to re-examine the nature and amount of their geriatric/gerontology content. Based on my personal experience as a faculty member in a professional preparation program for RNs, current offerings on elders and elderly care often reinforce prevailing negative stereotypes rather than educate.

Initiation of geriatric-sensitive programs at Western Community Medical Center, would have limited value. Until staff can feel more committed to their

work, new programs are likely to fail. Clearly, these health care workers are in need of some support and nurturing themselves.

During the time I collected data for this project, massive personnel and organizational changes were occurring. Yet, it would be hard to fault administrators for inadequate dialogue or counseling about these changes, for they too are undergoing rapid change. In the course of my data collection (October 1993 - December 1995), the ED was managed by three different people, and the Director of Patient Care Services changed twice during that time frame. Broad-sweeping changes at the macro level are required to stop this hemorrhage of enthusiasm and interest among ED health professionals.

Although the above recommendations are derived from field work focused on elders at WCMC, many of them would also improve conditions for younger clients. The constraints of the physical environment, for example, undoubtedly affect all clients and staff.

On a more global note, I would recommend facilitated discussion among nursing and medical staff and administrators on the nature and purpose of the ED and the meaning of care. Consensus on the goals of the ED and clear demarcation of boundaries of decorum and conduct will yield vast improvements at this site.

Recommendations: Health Care System

The most striking aspect of this field experience has been the discovery of how changes in the health care system affect the patient encounter. Changes at the national level significantly impact each patient's visit. It is clear that most

staff find these changes unsettling. Health care providers, especially physicians and nurses, have been educated in applied and clinical sciences. Although this education prepares them for patient interactions and treatment, it is often woefully lacking in business content. Rather than blithely recommend increased business content for health professionals, I would encourage examination of more difficult questions. Is this system, centered in business and economics, a system that most Americans want? Clearly, the participants in this study are unhappy with the current status of health care. I suggest that the evolving system is counter to the values that draw most health professionals to their work.

During the course of this study, I was able to conduct a member check interview with three Catholic nuns, aged 40 - 56. These three Sisters are employed at Convent Care Centers, which are privately owned nursing homes for elderly institutionalized Sisters. As part of their work, they coordinate the health care services for the residents at these facilities. In this capacity, they have accompanied a number of elderly sisters to this ED and others. In contrast to the elders depicted in this study, these Sisters have positive experiences which suggest some possible approaches.

Given the contrast between the nuns and the elders in this study , it is imperative to ask why their experiences are so different. The nuns who have been treated at Western Community Medical Center have ranged in age from 76 to 94 and were frail and institutionalized. Approximately one-third were cognitively impaired. Based on this description, these nuns should have experiences similar to the institutionalized elders in this study, the most devalued group observed. Yet in spite of the physical and cognitive condition of

the elderly nuns requiring treatment, these patients and their family members (the younger nuns who accompany them) were very pleased with the entire experience. By virtue of their role, these Sisters did not receive the dehumanizing treatment meted out to other elders. Instead, they were treated with dignity and respect. This status was communicated in several ways, including a noticeable absence of disrespectful comments about them and giving the younger nuns permission to accompany their colleague into the department throughout the ED visit.

Several other elements distinguish the experience of these nuns from other elderly ED clients. First, these nuns arrive at the ED with a complete set of medical records. The younger nuns who coordinate care firmly believe in the necessity of full records. "It helps the ER staff if they know the medical history," explained Sister Theresa. "They can make decisions quicker and know what they're dealing with," she continued. A second difference is that each elderly Sister has an advanced directive which clearly states her wishes in regards to treatment and end-of-life plans. These plans are contained within the medical record that is brought to the ED. While in the ED, the younger Sister serves as an advocate for compassionate care delivered in a manner consistent with the advance directive.

After each ED visit, the younger advocate Sisters routinely send thank you letters to all staff involved in the care. On units that they frequent, such as the ED and some inpatient units, these nuns have developed an ongoing relationship with the manager and key staff members. "When we come in, people know us," explained Sister Theresa. "We send cards, little crafts we make, and always thank

you cards. The staff work so hard, they need some strokes occasionally." These sisters have recognized that staff are in need of care due to the difficulty of their work situation. They are rewarded for their kindness by pleasant treatment in the ED.

The experience of these nuns is vastly different than most patients at Western Community Medical Center. Although we can not all be nuns, several lessons can be learned from their experience. First, it appears to be helpful to have clear directions for health care providers in this time of turmoil. These elderly nuns provide this direction in the form of advanced directives and by their ability to provide accurate information about their health status. This expedites their assessment and treatment, but more importantly, makes them partners in the treatment plan. Second, the presence of an informed advocate does appear to make a difference. Last, mutual recognition of personhood appears to favorably influence social evaluation and treatment.

Future Research

Drawing on these acknowledged limitations, several future research projects are suggested:

1) A project focused on following the health care of elders over time. Unlike the current study, elders would be inducted into the study when they enter the ED and followed for a pre-determined length of time, such as six months. This type of study would allow comparison of attitudes, values, and beliefs about health care for elders among multiple sites.

2) A comparative study of health care for elders among urban ED sites. This

study would strengthen the generalizability of the present study and allow comparisons to be made about the effects of managed care on each site.

3) A participatory action research project. This study would investigate the effect of increased geriatric/gerontology knowledge on the delivery of care to elders in the ED.

4) A study focused on the experience of sub-groups of the sample (i.e., community dwelling elders, institutionalized elders). This study would permit further delineation of the characteristics that affect the determination of social worth.

5) A comparative study of the ED health care encounter among differently valued patient populations. This study would help determine if valued groups, such as younger trauma patients, really do receive substantially different care than devalued groups, such as elders.

Concluding Thoughts

Although this study began as an exploration of the experience of elders in an urban ED, the most compelling findings are related to changes in the health care system. Patients, family members, staff, and administrators all feel caught in this vortex of change. To each, these times are troubling and show no signs of resolution. All participants in the health care encounter are victims of our society's inability to answer core questions about the nature and purpose of health care. Is health care a business or is it an humanitarian mission, a service to people in times of need, founded on the belief that all are worthy regardless of

age?

Perhaps one of the saddest truths about these findings is that they affect us all. We are all caught in these changing times, and barring trauma or serious illness, we are or will all eventually get old. Given this fact, it is imperative to ask if this is the way we would like to be treated.

Chapter 8

References

Aamodt, A.M. (1991). Ethnography and epistemology: Generating nursing knowledge. In J.M. Morse (Ed.), Qualitative Nursing Research: A Contemporary Dialogue (pp. 11-25). Newbury Park: Sage.

Agar, M. (1986). Speaking of ethnography. Beverly Hills, CA: Sage Publications.

Agar, M. (1990). Text and fieldwork: Exploring the excluded middle. Journal of Contemporary Ethnography, 19(1), 73-88.

American Hospital Association. (1990). Hospital statistics. Chicago: AHA.

Amoss, P.T. & Harrell, S. (1981). Introduction: An anthropological perspective on aging. In P.T. Amoss & S. Harrell (Ed.), Other ways of growing old (pp. 1-24). Stanford: Stanford University Press.

Anderson, H.J. (1991, September 20). Hospitals face tough issues in years following mergers. Hospitals, 24-32.

Anspach, R.R. (1993). Deciding who lives: Fateful choices in the Intensive Care Nursery. Berkeley: University of California Press.

Arluke, A. & Peterson, J. (1981). Accidental medicalization of old age and its social control implications. In C. Fry (Ed.), Dimensions: Aging, culture and health (pp. 271-284). New York: Praeger.

Atkinson, P. (1992). Understanding ethnographic texts. Newbury Park: Sage Publications.

Baraff, L.J., Bernstein, E., Bradley, K., Franken, C., Gerson, L.W., Hannegan, S.R., Kober, K.S., Lee, S., Marotta, M. & Wolfson, A.B. (1992). Perceptions of

emergency care by the elderly: Results of multicenter focus group interviews. Annals of Emergency Medicine, 21(7), 814-818.

Barer, M.L., Evans, R.G., Hertzman, C., & Lomas, J. (1987). Aging and health care utilization: New evidence and old fallacies. Social Science and Medicine, 24, 851-862.

Bassuk, E.L., Minden, S., & Apsler, R. (1983). Geriatric emergencies: Psychiatric or medical? American Journal of Psychiatry, 140(5), 539-542.

Baum, S.A. & Rubenstein, L.Z. (1987). Old people in the emergency room: Age-related differences in emergency department use and care. Journal of the American Geriatric Society, 35(5), 398-404.

Becker, G. (1980). Growing Old in Silence. Berkeley: University of California Press.

Beland, F., Lemay, A., Philibert, L., Maheux, B. & Gravel, G. (1991). Elderly patients' use of hospital based emergency services. Medical Care, 29(5), 408-416.

Blaisdell, F.W. (1994). Development of the city-county (public) hospital. Archives of Surgery, 129, 760-764.

Bodenheimer, T.S. & Grumbach, K. (1995). Understanding Health Policy. Norwalk, CT: Appleton & Lange.

Bogue, R.J., Shortell, S.M., Sohn, M.W., Manheim, L.M., Bazzoli, G. & Chan, C. (1995). Hospital reorganization after merger. Medical Care, 33(7), 676-686.

Borup, J.H. (1981). Relocation: Attitudes, information network and problems encountered. The Gerontologist, 21, 501-511.

Bouchard, L. (1993). Patients' satisfaction with the physical environment of an oncology clinic. Journal of Psychosocial Oncology, 11(1), 55-67.

Bowie, I. (1996). Terms of address: Implications for nursing. Journal of

Advanced Nursing, 23(1), 113-119.

Brady, J. (1993). Band-Aids, Bullets, and Booze. San Diego, CA: Nurses Book Shelf.

Brandriet, L.M. (1994). Gerontological nursing: Application of ethnography and grounded theory. Journal of Gerontological Nursing, 20(7), 33-40.

Brink, P.J. & Wood, M.J. (1988). Basic steps in planning nursing research: From question to proposal. Boston: Jones and Bartlett.

Britten, N. & Shaw, A. (1993). Patients' experiences of emergency admission: How relevant is the British government's Patients Charter? Journal of Advanced Nursing, 19(6), 1212-1220.

Brokaw, M. & Zaraa, A.S. (1991). A biopsychosocial profile of the geriatric population who frequently visit the emergency department. Ohio Medicine, 87(7), 347-350.

Brook, R.H. (1989). Practice guidelines and practicing medicine. Journal of the American Medical Association, 262, 3027-3031.

Burgess, R.G. (1984). In the field: An introduction to field research. London: George Allen & Unwin.

Burns, R. (1989). Standards for qualitative research. Nursing Science Quarterly, 2, 44-52.

Burrell, L. (1992). Adult nursing in hospital and community settings. Norwalk, CT: Appleton-Lange.

Butler, R. (1975). Why survive? Being old in America. New York: Harper.

Butler, R. (1994). Dispelling ageism. In D. Shenk & W.A. Achenbaum (Eds.), Changing perceptions of aging and the aged (pp. 137-143). New York: Springer.

Cady, P.A. (1991). An analysis of moral judgment in registered nurses:

Principled reasoning versus caring values. (Doctoral dissertation, Boston College, 1991). Dissertation Abstracts International, UMI # PUZ9131520.

Callahan, D. (1987). Setting limits: Medical goals in an aging society. New York: Simon & Schuster.

Callahan, D. (1994). Setting limits: A response. The Gerontologist, 34(3), 393-398.

Cameron, C. (1990). The ethnographic approach: Characteristics and uses in gerontological nursing. Journal of Gerontological Nursing, 16(9), 5-7.

Castillo, P.A. & Pousada, L. (1993). Emergency services use by elderly individuals. Clinics in Geriatric Medicine, 9(3), 491-497.

Champion, H.R. (1994). Trauma research ascendancy. Archives of Surgery, 129, 681-682.

Chopoorian, T.J. (1986). Reconceptualizing the environment. In P. Moccia (Ed.), New approaches to theory development. New York: National League for Nursing.

Clark, M. (1972). Cultural values and dependency in later life. In D.O. Cowgill and L.D. Holmes (Eds.), Aging and Modernization (pp. 263-274). New York: Appleton-Century Crofts.

Clark, M. & Anderson, B. (1967). Culture and Aging. Springfield: Charles Thomas.

Coe, R. (1965). Self-conception and institutionalization. In A. Rose & W. Peterson (Eds.), Older people and their social world. Philadelphia: F.A. Davis.

Cohen, M.Z. & Knafl, K.A. (1986). In P.L. Munhall & C.J. Oiler (Eds.), Nursing research: A qualitative perspective (pp 476-491). Norwalk, CT: Appleton-Century-Crofts.

Cole, J.B. (1982). Aspects of culture. In J.B. Cole (Ed.), Anthropology for the eighties (pp 61-64). New York: Free Press.

Conn, V.S., Taylor, S.G. & Messina, C.J. (1995). Older adults and their caregivers: The transition to medication assistance. Journal of Gerontological Nursing, 21(5), 33-38.

Cornman, J.M. & Kingson, E.R. (1996). Trends, issues, perspectives and values for the aging of the baby boom cohorts. The Gerontologist, 36(1), 15-26.

Dawson, J.I. & Critchley, L. Community-hospital partnerships: The quick response team. Journal of Nursing Administration, 22(11), 33-39.

Denzin, N.K. (1989). Interpreting Interactionism. Newbury Park, CA: Sage.

Deyo, R.A. (1984). Measuring functional outcomes in therapeutic trials for chronic disease. Controlled Clinical Trials, 5(3), 223-240.

Diamond, T. (1992). Making gray gold: Narratives of nursing home care. Chicago: University of Chicago Press.

Dougherty, M.C. & Tripp-Reimer, T. (1985). The interface of nursing and anthropology. Annual Review of Anthropology, 14, 219-241.

Eagle, D.J., Rideout, E., Price, P., McCann, C. & Wonnacott, E. (1993). Misuse of the emergency department by the elderly population: Myth or reality? Journal of Emergency Nursing, 19(3), 212-218.

Edlich, R.F. (1990). Three giant steps toward the development of a modern emeregncy medical service system. The Journal of Emergency Medicine, 9, 61-66.

Ehrhardt, M. & Fish, R. (1990). Hospital mergers: Legal and personal implications for emergency physicians. The Journal of Emergency Medicine, 8, 781-784.

Eliastarn, M. (1989). Elderly patients in the Emergency Department. Annals of

Emergency Medicine, 18(11), 1222-1228.

Ellis, C. (1994). Feeling our way through the field. Qualitative Sociology, 17(3) 311-313.

Emerson, R.M. (1983). Contemporary field research: A collection of readings. Boston: Little, Brown and Company.

English, J. & Morse, J.M. (1988). The 'difficult' elderly patient: Adjustment or maladjustment? International Journal of Nursing Studies, 25(1), 23-29.

Enthoven, A. & Kronick, R. (1989). A consumer-choice health plan for the 1990s. New England Journal of Medicine, 320, 29.

Erlandson, D.A., Harris, E.L., Skipper, B.L. & Allen, S.D. (1993). Doing naturalistic inquiry: A guide to methods. Newbury Park: Sage.

Estes, C. L. & Binney, E. A. (1989). The biomedicalization of aging: Dangers and dilemmas. The Gerontologist, 29(5), 587-596.

Estes, C.L., Swan, J.H. & Associates. (1993). The long term care crisis: Elders trapped in the no-care zone. Newbury Park, CA: Sage.

Ethical issues in managed care environments. (1995). AGS Symposia Highlights, 21-22.

Ettinger, W.H., Casani, J.A., Coon, P.J., Muller, D.C. & Piazza-Appel, K. (1987). Patterns of use of the emergency department by elderly patients. Journal of Gerontology, 42(6), 638-642.

Evaneshko, V. & Kay, M.A. (1982). The ethnoscience research technique. Western Journal of Nursing Research, 4(1), 49-63.

Evans-Pritchard, E.E. (1976). Witchcraft, oracles, and magic among the Azande. Oxford: Clarendon.

Fajemilehin, B.R. & Fabayo, A. O. (1991). Perception of situational stress

associated with hospitalization among selected Nigerian patients. Journal of Advanced Nursing, 16(4), 469-74.

Ferraro, K.F. (1982). The health consequences of relocation among the aged in the community. Journal of Gerontology, 38(1), 90-96.

Field, P. A. (1991). Doing fieldwork in your own culture. In J.M. Morse (Ed.) Qualitative Nursing Research: A Contemporary Dialogue (pp. 91-105). Newbury Park: Sage.

Fine, G.A. (1993). Ten lies of ethnography: Moral dilemmas of field research. Journal of Contemporary Ethnography, 22(3), 267-294.

Fisher, S. (1986). In the patient's best interest. New Brunswick, NJ: Rutgers University Press.

Flaskerud, J.H. & Halloran, E.J. (1980). Areas of agreement in nursing theory development. Advances in Nursing Science, 3(1), 1-7.

Foner, N. (1984). Ages in conflict. New York: Columbia University Press.

Foner, N. (1994). The caregiving dilemma: Working in an American nursing home. Berkeley: University of California Press.

Foucault, M. (1975). The birth of the clinic. New York: Vintage.

Fraser, M.C. (1988). Measuring mental status and level of consciousness. In M. Frank-Stromberg (Ed.) Instruments for Clinical Nursing Research (pp. 47-78). Boston: Jones-Bartlett. Fries, J.F. (1980). Aging, natural death, And the compression of morbidity. New England Journal of Medicine, 303(3), 130-135.

Freeman, M. (1994). Quick response programs: Effective management of a population in crisis. Leadership, 3(5), 36-39.

Fulmer, T., McMahon, D.J., Baer-Hines, M. & Forget, B. (1992). Abuse, neglect, abandonment, violence and exploitation: An analysis of all elderly patients seen

in one emergency department during a six-month period. Journal of Emergency Nursing, 18(6), 505-510.

Geertz, C. (1988). Works and lives: The anthropologist as author. Stanford: Stanford University Press.

Germain, C. (1986). Ethnography: The method. In P.L. Munhall & C.J. Oiler (Eds.), Nursing research: A qualitative perspective (pp 147-162). Norwalk, CT: Appleton-Century-Crofts.

Gilford, D. M. (1988). Social, economic, and demographic changes among the elderly. In D.M. Gilford (Ed.) The aging population in the twenty-first century: Statistics for health policy (pp. 52-64). Washington, D.C.: National Academy Press.

Glaser, B.G. & Strauss, A.L. (1964). The social loss of dying patients. American Journal of Nursing, 64(6), 119-121.

Glaser, B. & Strauss, A. (1966). The purpose and credibility of qualitative research. Nursing Research, 15, 56-61.

Glasspoole, L.A. & Aman, M.G. (1990). Knowledge, attitudes, and happiness of nurses working with gerontological patients. Journal of Gerontological Nursing, 16(2), 11-14.

Goffman, E. (1963). Stigma: Notes on management of spoiled identity. New York: Prentice Hall.

Goffman, E. (1968). Asylums. Middlesex: Penguin.

Goffman, E. (1971). The presentation of self in everyday life. Middlesex: Penguin.

Goodenough, W.H. (1957). Cultural anthropology and linguistics. In P. Garvin (Ed.), Report of the seventh annual round table meetings on linguistics

and language study. Washington, DC: Monograph Series on Language and Linguistics.

Gould, M.T. (1992). Nursing home elderly: Social-environmental factors. Journal of Gerontological Nursing, 18(8), 13-20.

Grief, C.L. & Elliott, R. (1994). Emergency nurses' moral evaluation of patients. Journal of Emergency Nursing, 20(4), 275-279.

Grills, S. (1994). The promise of ethnography. Qualitative Sociology, 17(2), 193-196.

Gubrium, J.E. (1975). Living and dying at Murray Manor. New York: St. Martin's Press.

Haavi Morreim, E. (1995). Balancing act: The new medical ethics of medicine's new economics. Washington, DC: Georgertown University Press.

Habermann-Little, B. (1991). Qualitative research methodologies: An overview. Journal of Neuroscience Nursing, 23(3), 188-190.

Haller, J.S. (1990). The beginnings of urban ambulance service in the United States and England. The Journal of Emergency Medicine, 8, 743-755.

Hammersley, M. & Atkinson, P. (1983). Ethnography: Principles in practice. London: Routledge.

Harper, D. (1994). "What problems do you confront?" An approach to doing qualitative research. Qualitative Sociology, 17(1), 89-95.

Hazan, H. (1994). Old age: Constructions and deconstructions. Cambridge: Cambridge University Press.

Hedges, J.R., Singal, B.M., Rousseau, E.W., Sanders, A.B., Bernstein, E., McNamara, R.M. & Hogan, T.M. (1992). Geriatric patient emergency visits part II: Perception of visits by geriatric and younger patients. Annals of Emergency

Medicine, 21(7), 808-813.

Hochschild, A. (1973). The unexpected community. Berkeley: University of California Press.

House, J.S. (1991). Social stratification, aging and health. The Sociology of Aging Newsletter, Spring, 7-9.

Hudson, R.B. (1996). The changing face of aging politics. The Gerontologist, 36(1), 33-35.

Illich, I. (1976). Medical Nemesis. New York: Pantheon Books.

Inouye, S.K., Acampora, D., Miller, R, Fulmer, T., Hurst, L.D., & Cooney, L.M. (1993). The Yale geraitric care program: A model of care to prevent functional decline in hospitalized elderly patients. Journal of the American Geriatric Society, 41, 1345-1352.

Jacelon, C.S. (1995). The effect of living in a nursing home on socialization in elderly people. Journal of Advanced Nursing, 22, 539-546.

Jecker, N.S. & Pearlman, R.A. (1989). Ethical constraints on rationing medical care by age. Journal of the American Geriatrics Society, 37, 1067-1075.

Johnson, C.L. (1987). The institutional segregation of the aged. In P. Silverman (Ed.), The elderly as modern pioneers (pp. 375-388). Bloomington. IN: Indiana University Press.

Johnson, M. & Webb, C. (1995a). The power of social judgment: Struggle and negotiation in the nursing process. Nursing Education Today, 15(2), 83-89.

Johnson, M. & Webb, C. (1995b). Rediscovering unpopular patients: The concept of social judgment. Journal of Advanced Nursing, 21(3), 466-475.

Jones, J.S., Rousseau, E.W., Schropp, M.A. & Sanders, A.B. (1992). Geriatric training in emergency medicine residency programs. Annals of Emergency

Medicine, 21(7), 825-829.

Katz, S., Ford, A.B., Moskowitz, R.W., Jackson, B.A., & Jaffee, M.W. (1963). Studies of illness and the aged. The index of ADL: A standardized measure of biological and psycho-social function. Journal of the American Medical Association, 185, 914-919.

Kaufman, S.R. (1987). The ageless self. New York: American Library.

Kaufman, S.R. (1994a). The social construction of frailty: An anthropological perspective. Journal of Aging Studies, 8(1), 45-58.

Kaufman, S.R. (1994b). Old age, disease, and the discourse on risk: Geriatric assessment in U.S. health care. Medical Anthropology Quarterly, 8(4), 430-447.

Kayser, J.S. & Minnigerode, F.A. (1975). Increasing nursing students' interest in working with aged patients. Nursing Research, 24(1), 23-26.

Kayser-Jones, J.S. (1981). Old, alone, and neglected. Berkeley, CA: University of California Press.

Kayser-Jones, J. (1989). The environment and quality of life in long-term care institutions. Nursing and Health Care, 10(3), 125-130.

Kayser-Jones, J.S. (1991). The impact of the environment on the quality of care in nursing homes: A social-psychological perspective. Holistic Nursing Practice, 5(3), 29-38.

Kayser-Jones, J. (1992). Culture, environment, and restraints: A conceptual model for research and practice. Journal of Gerontological Nursing, 18(11), 13-20.

Kayser-Jones, J. & Koenig, B. (1993). Ethical issues in qualitative work with the aged. In J.F. Gubrium & Andrea Sankar (Eds.), Qualitative Research Methods in Aging. Newbury Park: Sage.

Kayser-Jones, J., Weiner, C. & Barbaccia, J. (1989). Factors contributing to the

hospitalization of nursing home residents. The Gerontologist, 29, 502-510.

Keith. J. (1981). The "back to anthropology" movement in gerontology. In C.L. Fry, (Ed.), Dimensions: Aging, culture, and health (pp. 285-302). New York: Praeger Books.

Kelly, M.P. & May, D. (1982). Good and bad patients: A review of the literature and a theoretical critique. Journal of Adbanced Nursing, 7, 147-156.

Kerr, J.A.C. (1985). Space use, privacy, and territoriality. Western Journal of Nursing Research, 7, 199-219.

Kienow,N.L. (1992). Death education and death anxiety in student nurse aides. Dissertation Abstracts International. (University Microfilms No. PUZ9227302).

Kinsella, K. & Taeuber, C. (1993). An aging world II. Washington, DC: U.S. Department of Commerce.

Kirk, J. & Miller, M.L. (1986). Reliability and validity in qualitative research. Newbury Park, CA: Sage Publications.

Kleffel, D. (1991). Rethinking the environment as a domain of nursing knowledge. Advances in Nursing Science, 14(1), 40-51.

Kobasa, S.C., Hiker, R, & Maddi, S. (1979). Who stays healthy under stress? Journal of Occupational Medicine, 21(9), 595-600.

Kolanowski, A., Hurwitz, S., Taylor, L.A., Evans, L., & Strumpf, N. (1994). Contextual factors associated with disturbing behaviors in institutionalized elders. Nursing Research, 43(2), 73-79.

Kowalski, N.C. (1981). Institutional relocation: Current programs and applied approaches. The Gerontologist, 21, 512-519.

Kroeber, A.L. & Kluckhohn, C. (1963). Culture: A critical review of concepts

and definitions. New York: Vintage Books.

Kyle, T.V. (1995). The concept of caring: A review of the literature. Journal of Advanced Nursing, 21, 506-514.

Laird, C. (1979). Limbo. Novato, CA: Chandler & Sharp.

Larkin, H. (1990). Mergers = cuts and consolidation: Reconciling service cuts with a hospital's mission can be painful. Trustee, 1, 12-13.

Lawlor, E.F. (1992). What kind of medicine? The Gerontologist, 32, 131-133.

Lazarus, R. (1981). Little hassles can be harmful to your health. Psychology Today, 58-62.

LeBourdais, E. (1991). "SWAT team" helps Victoria solve problems caused by geriatric "bedblockers." Canadian Medical Association Journal, 145, 1493-1495.

Lehr, U. (1988). Stereotypes of aging and age norms. In P.T. Amoss & S. Harrell (Ed.), Other ways of growing old (pp 101-112). Stanford: Stanford University Press.

Leininger, M. (1984). Care: The essence of nursing and health. Detroit: Wayne State University Press.

Lévi-Strauss, C. (1974). Tristes Tropiques (John & Doreen Weightman, Translation). New York: Atheneum. (Original work published 1955).

Levinsky, N.G. (1990). Age as a criterion for rationing health care. New England Journal of Medicine, 322, 1813-1815.

Lincoln, Y.S. & Guba, E.G. (1985). Naturalistic Inquiry. Newbury Park: Sage.

Lindheim, R. & Syme, S. (1983). Environments, people, and health. Annual Review of Public Health, 4, 335-359.

Lipson, J. (1993). Ethical issues in ethnographic research. In J.M. Morse (Ed.) Critical Issues in Qualitative Research. Newbury Park: Sage.

Lowenberg, J.S. (1993). Interpretive research methodology: Broadening the dialogue. Advances in Nursing Science, 16(2), 57-69.

Lowenstein, S.R., Crescenzi, C.A., Kern, D.C., & Steel, K. (1986). Care of the elderly in the emergency department. Annals of Emergency Medicine, 15(5), 528-535.

Mahony, K.M. (1991). Life experiences and moral judgment in registered nurses. (Doctoral dissertation, University of Denver, 1991). Dissertation Abstracts International, UMI #PUZ9131520.

Malinowski, B. (1922). Argonauts of the Western Pacific. Prospect Heights, IL: Waveland Press.

Managing managed care in the emergency department. (1995, February). ED Management, p. 13-16.

Marcus, G.E. & Cushman, D. (1982). Ethnographies as text. Annual Review of Anthropology, 11, 25-69.

McDonald, A.J. & Abrahams, S.T. (1990). Social emergencies in the elderly. Emergency Medicine Clinics of North America, 8(2), 443-459.

McGoldrick, A.E. (1989). Stress, early retirement, and health. In K.S. Markides & C.L. Cooper (Ed.), Aging, stress and health (pp. 91-118). London: John Wiley & Sons.

McKay, J.I. (1985). Historical review of emergency medical services, EMT roles, and EMT utilization in emergency departments. Journal of Emergency Nursing, 11(1), 27-32.

McNamara, R.M. (1992). Geriatric emergency medicine: A survey of practicing emergency physicians. Annals of Emergency Medicine, 21, 796-801.

Meleis, A. I. (1992). Directions for nursing theory development in the 21st

century. Nursing Science Quarterly, 5, 112-117.

Melnyk, K.A.M. (1988). Barriers: A critical review of the literature. Nursing Research, 37(4), 196-201.

Melnyk, K.A.M. (1990). Barriers to care: Operationalizing the variable. Nursing Research, 39(2), 108-112.

Mezza, I. (1992). Triage: Setting priorities for health care. Nursing Forum, 27(2), 15-19.

Miller, B., Glasser, M. & Rubin, S. (1992). A paradox of medicalization: Physicians, families and Alzheimer's Disease. Journal of Aging Studies, 6(2), 135-148.

Miller, C.A. (1995). Nursing care of older adults: Theory and practice. Philadelphia: J.B. Lippincott.

Mitchell, G.J. & Cody, W.K. (1993). The role of theory in qualitative research. Nursing Service Quarterly, 6(4), 170-178.

Moos, R.H. (1980). Specialized living environments for older people: A conceptual framework for evaluation. Journal of Social Issues, 36(2), 75-96.

Morse, J. (1991). On the evaluation of qualitative proposals. Qualitative Health Research, 1, 147-151.

Myerhoff, B. (1978). Number our days. New York: Simon & Schuster.

Navarro, V. (1993). Dangerous to your health: Capitalism in health care. New York: Monthly Review Press.

Newbern, V.B. & Burnside, I. (1994). Needs of older persons in the Emergency Department. Journal of Gerontological Nursing, 20(7), 53-56.

Nightingale, F. (1946). Notes on nursing: What it is and what it is not. New York: Churchill Livingstone, Inc. (Original work published 1859).

Obligacion, F.R. (1994). Managing perceived deception among respondents: A traveler's tale. Journal of Contemporary Ethnography, 23(1), 29-50.

Olson, L. (1995). Ethical climate in health care organizations. International Nursing Review, 42(3), 85-90.

O'Malley, N.C. (1991). Age based rationing of health care: A descriptive study of professional attitudes. Health Care Management Review, 16(1), 83-93.

Omery, A. (1988). Ethnography. In B. Sarter (Ed.) Paths to knowledge: Innovative research methods for nursing (pp 17-31). New York: National League for Nursing.

Östör, A. (1984). Chronology, category, and ritual. In D.I. Kertzer & J. Keith (Ed.), Age & Anthropological Theory (pp. 281-304). Stanford: Stanford University Press.

Padgett, D.K. & Brodsky, B. (1992). Psychosocial factors influencing non-urgent use of the emergency room: A review of the literature and recommendations for research and improved service delivery. Social Science Medicine, 35(9), 1189-1197.

Parker, R.S. (1990). Measuring nurses' moral judgments. Image: Journal of Nursing Scholarship, 22(4), 213-218.

Pelto, P.J. & Pelto, G.H. (1978). Anthropological research: The structure of inquiry. Cambridge: Cambridge University Press.

Pfeiffer, E. (1975). A short portable mental staus questionnaire for the assesment of organc brain deficit in elderly patients. Journal of the American Geriatric Society, 23, 433-446.

Pollitt, C., Harrison, S., Hunter, D.J. & Marnoch, G. (1990). No hiding place: On the discomforts of researching the contemporary policy process. Journal of

Social Policy, 19(2), 169-190.

Public Agenda Foundation. (1992). Condition critical: The American health care forum [Documentary]. Boston: WGBH Productions.

Pursey, A. & Luker, K. (1995). Attitudes and stereotypes: Nurses' work with older people. Journal of Advanced Nursing, 22, 547-555.

Rhodes, L.A. (1993). Ethnography. Social Science and Medicine, 37(12), vii-viii.

Richardson, D.B. (1992). Elderly patients in the emergency department: A prospective study of characteristics and outcome. The Medical Journal of Australia, 157(8), 234-239.

Robinson, J.C. & Casalino, L.P (1995). The growth of medical groups paid through capitation in California. The New England Journal of Medicine, 333(25), 1684–1687.

Roget's international thesaurus. (1989). New York: Thomas Crowell Company.

Rosenberg, C.E. (1987). The care of strangers: The rise of America's hospital system. New York: Basic Books.

Roth, J.A. (1972). Some contingencies of the moral evaluation and control of clientele. American Journal of Sociology, 77, 839-856.

Roth, J.A. & Douglas, D.J. (1983). No appointment necessary. New York: Irvington Publishers.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Research, 8(3), 27-37.

Sanders, A.B. (1996). Emergency care of the elder person. St. Louis, MO: Beverly Cracom.

Sanders, A.B. (1992). Care of the elderly in emergency departments: Where do we stand? Annals of Emergency Medicine, 21(7), 792 -794.

Sands, R.G. (1990). Ethnographic research: A qualitative research approach to study of the interdisciplinary team. Social Work in Health Care, 15(1), 115-129.

Sanjek, R. (1990). On ethnographic validity. In R. Sanjek (Ed.), Fieldnotes: The makings of anthropology (pp. 385-418). Ithaca, NY: Cornell University Press.

Sankar, A. (1984). "It's just old age": Old age as a diagnosis in American and Chinese medicine. In D.I. Kertzer & J. Keith (Ed.), Age & Anthropological Theory (pp. 251-280). Stanford: Stanford University Press.

Savishinsky, J.S. (1991). The ends of time: Life and work in a nursing home. New York: Bergin and Garvey.

Schatzman, L. & Strauss, A.L. (1973). Field research: Strategies for a natural sociology. Englewood Cliffs, NJ: Prentice Hall.

Schneider, E.L. & Guralnik, J.M. (1990). The aging of America: Impact on health care costs. Journal of the American Medical Association, 263, 2335-2340.

Schulz, R. & Brenner, G. (1977). Relocation of the aged: A review and theoretical analysis. Journal of Gerontology, 32, 323-333.

Schumacher, K.L. & Meleis, A.I. (1994). Transitions: A central concept in nursing. Image, 26(2), 119-127.

Schwarz, B. (1992). Designing public places for private lives: A study of the design processes of long-term care settings. (Doctoral dissertation, University of Michigan). UMI, PUZ9308441.

Searight, H.R. & Campbell, D.C. (1992). Ethnography and family medicine: Issues and overview. Family Practice Research Journal, 12(4), 369-382.

Seuss, T.S. (1986). You're only old once! New York: Random House.

Seymour, E.M. & Grief, C.L. (1995). More on moral evaluation of patients study. Journal of Emergency Nursing, 21(3), 195-196.

Singal, B.M., Hedges, J.R., Rousseau, E.W., Sanders, A.B., Bernstein, E.W., McNamara, R.M. & Hogan, T.M. (1992). Geriatric patient emergency visits part I: Comparison of visits by geriatric and younger patients. Annals of Emergency Medicine, 21(7), 802-807.

Soldo, B.J. & Manton, K.G. (1985). Health status and service needs of the oldest old: Current patterns and future trends. Milbank Memorial Quarterly, 63(2), 287-319

Sommers, T. & Shields, L. (1987). Women who take care: The consequences of caregiving in today's society. Gainesville, FL: Triad Publishing.

Sonn, U. & Asberg, K.H. (1991). Assessment of activities of daily living in the elderly. Scandinavian Journal of Rehabilitation Medicine, 23, 193-202.

Sorensen, L. (1991). Nursing and computers: Caring in the context of information technology. (Doctoral dissertation, City University of New York). UMI, PUZ9207125.

Spradley, J.P. & McCurdy, D.W. (1972). The cultural experience: Ethnography in complex society. Chicago: Scientific Research Associates.

Spradley, J.P. (1979). The ethnographic interview. New York: Holt, Rinehart & Winston.

Spradley, J.P. (1980). Participant observation. New York: Holt, Rinehart & Winston.

Starr, P. (1982). The social transformation of American medicine. New York: Basic Books.

Stathers, G.M., Delpech, V., & Raftos, J.R. (1992). Factors influencing the

presentation and care of elderly people in the emergency department. The Medical Journal of Australia, 156(2), 197-200.

Stern, R.S., Weissman, J.S. & Epstein, A.M. (1991). The emergency department as a pathway to admission for poor and high-cost patients. Journal of the American Medical Association, 266(16), 2238-2243.

Stevens, P. (1989). A critical social reconceptualization of environment in nursing: Implications for methodology. Advances in Nursing Science, 14(4), 1-11.

Stevens, P. (1994). Lesbians' health-related experiences of care and noncare. Western Journal of Nursing Research, 16(6), 639-659.

Strange, G.R., Chen, E.H., & Sanders, A.B. (1992). Use of emergency departments by elderly patients: Projections from a multicenter data base. Annals of Emergency Medicine, 21(7), 819-824.

Strauss, A. & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park: Sage.

Strawbridge, W.J., Camacho, T.C., Cohen, R.D., Kaplan, G.A. (1993). Gender differences in factors associated with change in physical functioning in old age: A 6-year longitudinal study. The Gerontologist, 33(5), 603-609.

Sudnow, D. (1967). Passing on: The social organization of dying. Englewood Cliffs, NJ: Prentice Hall.

Thompson, J.D. & Dains, J.E. (1982). Comprehensive triage: A manual for developing and implementing a nursing care system. Reston, VA: Prentice-Hall.

Thorne, S.E. (1991). Methodological orthodoxy in qualitative nursing research: Analysis of the issues. Qualitative Health Research, 1(2), 178-199.

Topham, D.L. (1989). Nurses' moral values and the care of patients with sexually transmitted diseases: A historical perspective. (Doctoral dissertation,

University of Texas at Austin). UMI, PUZ9016991.

Uden, G., Svensson, B., Jonsson, P.O., & Johnell, O. (1990). Elderly people in an orthopedic emergency room -- assessment of quality. Quality Assurance in Health Care, 2(3-4), 411-417.

U.S. Department of Health and Human Services. (1996). National hospital ambulatory medical care survey: 1993 Emergency Department summary. Advance data from vital and health statistics. (DHHS Publications No. (PHS) 96-1250). Hyattsville, MD: National Center for Health Statistics.

U.S. Department of Health and Human Services. (1995). A National Agenda for Geriatric Education: White Papers (Health Resources & Services Administration, Bureau of Health Professions). Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (1993). Health data on older Americans: United States, 1992 (DHHS Publications No. (PHS) 93-1411). Hyattsville, MD: U.S. Government Printing Office.

U.S. Senate Special Committee on Aging. (1991). Aging America: Trends and Projections (DHHS Publications No. FCOA 91-28001). Washington, DC: U.S. Government Printing Office.

Van Leuven, K. (1994). The emergency care environment: Who is worth the effort? Unpublished manuscript, University of California, San Francisco.

Van Maanen, J. (1983). The moral fix: On the ethics of fieldwork. In Robert Emerson (Ed.), Contemporary field research: A collection of readings. Prospect Heights, IL: Waveland Press.

Van Maanen, J. (1988). Tales of the field: On writing ethnography. Chicago: University of Chicago Press.

Wallace, R. B. (1992). Aging and disease: From laboratory to community. In Robert B. Wallace & Robert F. Woolson (Eds.), The epidemiologic study of the elderly (pp. 3-10). New York: Oxford Press.

Watson, J. (1979). Nursing: A philosophy of science and caring. Boston: Little Brown.

Wax, R. (1971). Doing fieldwork: Warnings and advice. Chicago: University of Chicago Press.

Webb, C. (1993). Feminist research: Definitions, methodology, methods and evaluation. Journal of Advanced Nursing, 18(3), 416-423.

Weber, J. (1996). Influences upon managerial moral decision making: Nature of the harm and magnitude of consequences. Human Relations, 49(1), 1-22.

Webster's third new international dictionary. (1986). New York: Merriam-Webster, Incorporated.

Weiss, C.J. (1988). Model to discover, validate, and use care in nursing. In M. Leininger (Ed.), Care, Discovery and Uses in Clinical and Community Nursing (pp. 139-149). Detroit: Wayne State University Press.

Williams, M.A. (1988). The physical environment and patient care. Annual Review of Nursing Research, 6, 61-84.

Wingard, D.L., Cohn, B.A., Kaplan, G.A., Cirrillo, P.M., & Cohen, R.D. (1989). Sex differentials in morbidity and mortality risks examined by age and cause in the same cohort. American Journal of Epidemiology, 130(3), 601-609.

Wofford, J.L., Schwartz, E., & Bynum, J.E. (1993). The role of emergency services in health care for the elderly: A review. Journal of Emergency Medicine, 11(3), 317-326.

Wolcott, B.W. (1979). What is an emergency? Depends on whom you ask?

Journal of the American College of Emergency Physicians, 8(6), 241-243.

Wolcott, H.F. (1990). Writing up qualitative research. Newbury Park: Sage Publications.

Woods, N.F. & Catanzaro, M. (1988). Nursing Research: Theory and practice. St. Louis: C.V. Mosby.

Woolhandler, S. & Himmelstein, D.U. (1991). The deteriorating administrative efficiency of the US health care system. New England Journal of Medicine, 324, 1253-1257.

Wray, L. (1992). Health policy and ethnic diversity in older Americans: Dissonance or harmony? The Western Journal of Medicine, 157(3), 357-361.

Yazdanfar, D.J. (1990). Assessing the mental status of the cognitvely impaired elderly. Journal of Gerontological Nursing, 16(9), 32-36.

Zola, I.K. (1972). Medicine as an institution of social control. Sociological Review, 20(11), 487-504.

Appendices

Name	Age (in years)	ED Diagnosis	SPMSQ in ED *	Katz ADL score °	Living arrangement prior to ED	Discharged from ED to:
Ms. Abbott	93	Pulmonary congestion	4	0	SNF	discharged back to SNF
Mr. Albert	90	Fall with laceration requiring sutures	8	0	Community dwelling; lives alone	discharged home
Mr. Bird	77	Hypoglycemic reaction	7	0	Community dwelling; lives alone	discharged home
Ms. Castle	79	Left leg mid-fibula & distal tibia fractures	10	0	Community dwelling; lives alone	admitted to hospital
Ms. Chow	85	Pulmonary congestion	5	7	Community dwelling; lives with son	discharged home against patient & son's wishes
Ms. Florence	78	Bilateral cellulitis lower extremities	10	5	SNF	admitted to hospital
Ms. Island	79	Azotemia secondary to obstructed catheter; sepsis	0	12	SNF	admitted to hospital
Mr. Jones	75	Chest pain; Atrial fibrillation	10	6	Community dwelling; lives with spouse	admitted to hospital
Mr. Lawrence	72	Left leg edema; ? bronchial tumor	2	10	SNF	admitted to hospital
Ms. Martin	76	Altered level of consciousness; psychiatric disorder, noncompliant; deafness	5	2	Community dwelling; lives with son	discharged home against patient & son's wishes
Mr. Mason	90	Body pain; placement concerns	3	9	Community dwelling; lives with son	admitted to SNF

Ms. Nourn	74	Weakness/dizzyness	7	6	Community dwelling; lives with spouse	admitted to hospital
Ms. Parker	73	Left patella fracture & left leg cellulitis	10	0	Community dwelling; lives with spouse	admitted to hospital
Mr. Robbins	69	Severe hyperglycemia with acidosis	9	0	Community dwelling; lives alone	admitted to hospital
Ms. Ross	92	Acute left hip fracture	8	0	Community dwelling; lives alone	admitted to hospital
Ms. Scott	69	Rule out aspiration pneumonia; sepsis; status post anoxic encephalopathy	0	12	SNF	admitted to hospital
Ms. Song	81	Altered level of consciousness; Severe anemia; Rule out CVA or GI bleed;	1	12	Community dwelling; lives alone	admitted to hospital
Ms. Washington	92	Confusion/disorientation; Diabetes Mellitus	0	12	SNF	admitted to hospital

• SPMSQ = Short Potable Mental Status Questionnaire

Scoring: 8 - 10 = intact mental function
6 - 7 = mild intellectual impairment
3 - 5 = moderate intellectual impairment
0 - 2 = severe intellectual impairment

Note: The SPMSQ score recorded in this table was measured while the elder was in the ED. In subsequent contact, some elders did have improved mental function.

° Katz ADL score: Scores range from 0 - 12. A score of 0 signifies complete independence in bathing, dressing, toileting, transfer, continence and feeding. Whereas a score of 12 signifies a need for supervision, direction or personal assistance in each of these activities of daily living.

Appendix B: More on Method

In this research project, data were collected in three phases; each phase being informed by the preceding one (Kayser-Jones, Weiner, & Barbaccia, 1989). Phase 1 began with one month of intensive participant observation in the ED. Data were collected 3-4 days per week, and observation took place on all shifts and days of the week. These sessions provided data on all specific aims of the research project. Observations focused on, but were not limited to, the ED setting, staffing, volume of clients seen, milieu of the department, profile of clients seeking care at the ED, staff-client interaction, and staff-staff interaction. Detailed field notes, recorded after each participant observation session, were transcribed and initially catalogued by date of observation.

This initial participant observation period was an important prelude to additional strategies of data collection. Experienced ethnographers have commented on the value of preliminary participant observation as a means of sensitizing the researcher to the issues and language of the environment, (Germain, 1986; Omery, 1988; Van Maanen, 1988) allowing the researcher time to develop rapport with informants, and enabling them to become accustomed to the presence of the researcher (Schatzman & Strauss, 1973; Kirk & Miller, 1986; Kayser-Jones, Weiner, & Barbaccia, 1989). In addition, participant observation illuminates what is pertinent and should be further pursued in interview questions or other data collection strategies. In this way, preliminary participant observation enhances the value of other data collection strategies (Hammersley & Atkinson, 1983; Germain, 1986; Omery, 1988; Van Maanen, 1988).

Following participant observation, Phase 2, a mini-pilot study began. During this phase, data collected built upon the information that had been gathered through ongoing participant observation. One client was observed, the medical record was reviewed, and later, the client was interviewed along with any family/support person present in the ED or involved in the decision to seek care at the ED. Staff members who provided this care were interviewed separately.

The elderly client was followed from the time of presentation at the ED until discharge from the department. All aspects of the client's care were observed, including but not limited to, wait time, client-staff interactions, client-family interactions, type of care required, length of time in the department and the outcome of care.

Data observed or obtained from the medical record were recorded on the Event Analysis Protocol (Appendix E), and additional comments were recorded as field notes. The client and/or accompanying family member were asked the general questions listed in Appendix D: Sample questions for older ED clients. These questions served as a launching point for discussion. Each elder was also asked to speak freely about his/her ED experience and suggestions for improvement of health care for elders. These interviews were used to explore attitudes, values, and beliefs of elders and to pursue theoretical leads that had been suggested by observations. Data on functional and cognitive status were also obtained and used as context for analyzing the event.

Functional status was assessed through use of the Katz Index of ADL (Katz, Ford, Moskowitz, Jackson & Jaffee, 1963). The Katz Index is a well-known scale used to evaluate the individual's actual performance in bathing , dressing, toileting, mobility, continence, and feeding. Personal experience has demonstrated that this tool is simple to use and quick to complete. Reports of reliability and validity are favorable; Deyo (1984) notes that interrater reliability ranged from .68 -.98, while Sonn and Asberg (1991) note a coefficient of reproducibility of .99 with internal consistency of .84. The Short Portable Mental Status Questionnaire (SPMSQ) (Pfeiffer, 1975) was used to assess mental status. The SPMSQ consists of ten questions that evaluate awareness of current events, remote memory, and mathematical ability. Indices of reliability and validity include criterion-related validity of .63 -.71; construct and concurrent validity of .84; test-retest reliability of .80 -.83; inter-rater reliability of .62 -.87, and internal consistency reliability of .897 (Fraser, 1988; Yazdanfar, 1990). The SPMSQ and Katz Functional Status scores were recorded on Appendix E: Event Analysis Protocol.

Staff members involved in the delivery of care to the elder were also interviewed. They were asked the questions listed in Appendix D: Sample questions for staff as well as open-ended questions about the current status of the ED. These interviews were used to explore attitudes, values, and beliefs of staff and to pursue theoretical leads that had been suggested by observations. Data concerning staff members were derived from interviews and participant observation. No procedures or protocols were followed for staff members in this study.

Individual arrangements were made for interviews. Interviews were conducted away from the ED at a mutually agreed upon site once each individual had consented. Each interview session was tape recorded for future transcription. The preliminary interview guide (Appendix D) was followed; however, participants were encouraged to add other comments they considered relevant to the study.

Information obtained from Phase 2 was used to determine if: (a) the Preliminary Event Analysis Protocol (Appendix E) required modification, (b) the sample questions for older ED clients required modification, or (c) the sample questions for staff members required modification.

During Phase 2, I encountered marked resistance to formal tape recorded interviews from ED staff members. Although I had perceived no difficulty in communicating with them while conducting participant observation, each staff member involved in this elder's care declined to be interviewed formally; they considered the time commitment burdensome. "I work hard when I'm here. I'll be happy to talk with you as we go along but I don't want to deal with this place when I don't have to," commented the nurse. The physician echoed similar thoughts. "Follow me around and ask questions. That's the best. We're all pretty burned out with how busy this place is and all the changes. I think more people will talk to you if you make it less formal."

I was able to interview each of the staff members involved in this elder's care by spending time with them. The physician talked with me informally over a cup of coffee during a slow period the following day. The staff nurse

answered my questions in a piecemeal fashion over the next several days. The charge nurse suggested that I accompany her as she ran errands.

In Phase 3 of the study, the sample questions and Event Analysis Protocol Guide were not altered. An additional 17 elderly clients were followed in the same manner as the client in phase 2. Each client was observed in the ED, the medical record was reviewed, and later, each client was interviewed along with any accompanying family/support person(s) as well as the staff involved in the care. In Phase 3, staff members were offered a choice of a scheduled formal interview or an informal interview conducted by shadowing the staff member at work.

All elders asked to participate consented to be part of the study. This remarkable consent rate is attributable to several factors. First, preliminary participant observation and prior experience in the department during the pilot study sensitized me to the pace of the department, staff personalities, and client care issues. If I had any suspicion that my presence as a researcher would negatively affect care, I did not attempt to enroll the client. Second, I felt no pressure to recruit participants as the number of potential participants was tremendous. According to departmental reports, 42% of clients seen in this ED are 65 or older (Administrative Director, personal communication, June 1, 1995). However, my observations and the ED log do not support this reported statistic. During my field work, I observed that the percentage of elderly treated in the department ranged from 25% to 41% on any given day. On average, 31% of clients were elderly. The discrepancy between the reported statistic and the log is a result of categorization. Elderly clients admitted to a

short-stay geriatric unit are admitted through ED registration and included in the departmental report. So each day, approximately 46 clients aged 65 or older are treated in this ED.

Human Subjects Protection

This project was approved by the Institutional Review Board at the research site and by the Committee on Human Research at UCSF (H721-12250-01). All participants in the study gave their informed consent and every effort was made to maintain confidentiality. All participants were assigned code numbers which were used to identify them in field notes, interview transcripts, and event analysis materials. All data were kept in a locked file cabinet.

Participants in the study faced no physical risks. While I had anticipated that some participants might feel uncomfortable during the interview, I encountered no adverse reactions or complications. None of the participants declined to answer any specific questions, nor gave any indication of desire to terminate the interview process, or withdraw from participation altogether.

Data Analysis

In qualitative research, data collection and analysis occur simultaneously. Ongoing analysis informs subsequent data collection. Analysis involves coding the data by sorting it into categories, which are then clustered in order to identify themes (Strauss & Corbin, 1990; Spradley, 1980).

In this study, field notes and interview data were transcribed and then evaluated individually and in relation to one another. Transcribed notes were coded and themes and relationships between codes were analyzed. As new data were collected, existing themes and relationships were re-analyzed. A memo process was used to track ongoing data analysis, theoretical insights, and personal awareness.

As participants were inducted into the study, the Event Analysis Protocol form (Appendix E) was used to record data. Field notes, as well as staff and client interviews, were then cross-referenced to allow clustering of information. A summary memo was written about each participant followed through the Event Analysis Protocol. These summary memos were constantly compared to identify and refine emerging themes.

As a researcher operating within the naturalistic paradigm, I believe that quality and attention to detail must be assessed from this vantage point. Ethnographic research should be judged "based on generic elements of qualitative methods for collecting, analyzing, and presenting data" (Glaser & Strauss, 1966, p. 56). Lincoln & Guba (1985) have developed criteria to evaluate qualitative research based on this plan, a plan, Cohen & Knafl (1986) note, qualitative researchers and reviewers of qualitative research proposals widely use. Lincoln & Guba (1985) propose that credibility in ethnographic research is established through multiple techniques including prolonged engagement, persistent observation, thick description, triangulation of data sources, peer debriefing, member checking, use of a reflexive journal, and the

establishment of an audit trail (Lincoln & Guba, 1985; Kirk & Miller, 1986; Erlandson, Harris, Skipper & Allen, 1993).

In this study, all of the recommended strategies to establish credibility were employed. During the initial pilot study, I spent a total of six months (October 1993 - March 1994) observing the ED milieu and groups of clients of all ages identified as problematic. Subsequently, elders were chosen as the focus for study. I spent an additional seven months in the field examining the experience of elders (June 1995 - December 1995). These two phases of participant observation generated an opportunity to examine the site over time.

Data were collected at all times of day, every day of the week. Detailed field notes were recorded, transcribed and catalogued. Data were triangulated among sources (field notes, interviews, event analysis, departmental reports, ED log, archives). For example, numerous nursing staff members expressed concern that organizational changes in the department had negatively affected their ability to care for clients. Their perspective was compared with the opinions expressed by the physicians, the nurse manager, the administrative director, departmental reports, ancillary personnel working in the department, hospital-wide memos, and external materials. Comparing information across sources allowed me to examine the multiple perspectives operating on a single phenomenon.

A Qualitative Analysis Group was used for peer debriefing. This group consisted of myself as well as three other doctoral candidates currently engaged in research projects. Two members were conducting ethnographic

research, while the third was engaged in narrative analysis. This group was also frequented by experienced faculty researchers. In group meetings, data were analyzed, discussed, and coded. Emerging themes were presented for discussion and feedback. Research dilemmas and progress were evaluated. This group was an invaluable resource.

Member checks occurred at intervals throughout the study. As themes began to emerge, questions were added to staff and patient interviews, enabling me to delve more deeply into emerging themes. In addition, interviews were conducted with "insiders" to assess my understanding of the site and the experience of the elders. For example, an interview was conducted with a former staff nurse at the site, now employed as a nurse manager in another ED. During this interview, I discussed my observations and perceptions. This informant was able to reflect on her former work site and compare and contrast it with her present site. This experience helped to sharpen the focus of ongoing data collection and suggested the generalizability of my findings.

Member checks were also conducted with a geriatrician on the medical staff of Western Community Medical Center and a group of Catholic nuns who were responsible for accompanying elderly members of their community to health care encounters. The geriatrician was able to offer his perspective on the ED, react to my emerging themes, and share a compilation of comments about the ED made by his clients. The nuns provided the perspective of elderly advocates. As part of the privilege of their position, they have been able to stay in the ED with their senior members. Based on experience, in this

ED and in others, they have acquired knowledge about care of elders in the ED. (The experience of the Catholic nuns is further discussed in Chapter 7).

As data were collected, I kept a reflexive journal in which I recorded my reactions to the research process, my reflections about the Qualitative Analysis Group, and ideas for future research projects that could emerge from this study. In a separate section of the journal, I maintained an audit trail, a record of progress as well as strategies for future data collection and the status of emerging themes.

Role of the Researcher

In order to collect data, I predominantly played the role of observer-as-participant. In this role, my presence and purpose were publicly known. I acted primarily as an observer, although I did participate to a limited degree. For instance, I would help move the gurney of a patient that I was following, or I would carry lab reports from the ward clerk to nursing or medical staff. Since I had never worked in this site, I had no problems functioning as a researcher and not a care provider. I found this role exposed me to a wide variety of information and allowed me to participate in activities selectively (Emerson, 1983; Hammersley & Atkinson, 1983; Germain, 1986; Kirk & Miller, 1986; Omery, 1988; Van Maanen, 1988).

Schatzman & Strauss (1973) note that a research scientist must maintain appropriate deportment to minimize interference with the natural setting. They recommend that a researcher act humanly and humbly, and take cues from the informants about what is disruptive. For example, I found that open note-taking and formal tape recorded staff interviews were unsettling to

staff members. In order to build trust and gain greater access to information, I conducted many informal unrecorded interviews and limited note-taking while in the field.

During this investigation, I attempted to be vigilant about monitoring my reactions to the study. Byrun describes this challenge:

> While the traditional role of the scientist is that of a neutral observer who remains unmoved, unchanged, and untouched in his examination of phenomena, the role of the participant-observer requires sharing the sentiments of people in social situations; as a consequence he himself is changed as well as changing to some degree the situation to which he is a participant (Byrun in Germain, 1986).

The Qualitative Analysis Group helped me monitor my reactions to the study. For example, many elders found participation in the study therapeutic. At the conclusion of the follow-up interview, several invited me to visit again. One elder openly admitted that she benefited from participation. "I think we need each other," she said. "I have information that you want and I like the fact that you're interested. I think you should come see me again." Staff were also affected by the research project. Although many staff thought my focus on the elderly was fruitless, they were intrigued that they were research subjects. They comfortably ventilated their concerns about the current status of health care. "I hope someone is going to read this and see the sorry state things are in. Someone, or group, must be doing well with all this change. But it's not us," said a senior ED physician. In the Qualitative Analysis Group, I was able to discuss my evolving role with the study participants and monitor my focus.

Research on the Elderly in the Emergency Department

Studies Focused on the Elderly

Authors	Design	Major Findings
Baraff et al., 1992	Focus group interviews of seniors (> 65) who were recent ED clients; conducted in 5 cities	Seniors were concerned about lengthy wait times, negative treatment by staff, lack of privacy in the ED, difficulty getting information about their condition, personal safety in and around the ED, and the financial cost of care
Brokaw & Zaraa, 1991	Retrospective chart review of seniors (>65) with multiple non-urgent visits to an urban teaching hospital	Elderly "frequent fliers" presented with a variety of complaints. The most prevalent ED diagnosis was psychiatric. Most clients (88.5%) were under the care of a primary MD, however, 45% of the visits occurred between 9 AM- 5 PM.
Fulmer, McMahon, Baer-Hines, & Forget, 1992	Retrospective chart review of all ED patients >65 yo at an 875 bed tertiary care facility	Charts examined for evidence of abuse, neglect, and violence; Features associated with high risk for mistreatment: nonwhite ethnicity, unmarried status, lack of insurance, and delirium or dementia

Richardson, 1992	Chart review of all clients >75 yo presenting to a public hospital in Tasmania over a 4 week period	No significant relationship between living arrangement before ED visit & likelihood of admission or death within 90 days; 5% of visits related to "social problems"
Stathers, Delpech & Raftos, 1992	3 part study Part 1: chart review of all clients >60 yo admitted from the ED in 1987 from a community hospital in Australia Part 2: prospective tracking of clients > 65 who presented to same ED over a 3 week period Part 3: prospective tracking of clients > 70 who presented to same ED over a 19 day period	The rate of hospital admission rose as the age criteria for inclusion increased. Most clients reported for medical rather than surgical conditions. A fall was the 3rd most common reason to be seen in the ED. Over 90% of clients were under the care of a general practitioner and most presented to the ED during "working hours'.
Uden, Svensson, Jonsson, & Johnell, 1990	Prospective chart review of all clients >70 yo at a university teaching hospital ED in Norway over a one month period Exit interviews at the conclusion of care	Patients identified three problem areas: long waits, a limited approach to the presenting problem and lack of follow up care

Comparative Studies

Authors	Design	Major Findings
Bassuk, Minden & Apsler, 1983	Comparative study of patients > 65 yo with those 14-64 yo seen by the psychiatric service in the ED; data collected through clinician completed questionnaires	Both groups had scanty social support. Diagnosis between the groups varied widely. The clinicians subjective reaction to both groups showed no difference
Baum & Rubenstein, 1987	Retrospective chart review of all clients seen in the ED during a 22 day period	Patients > 75 yo were seen at twice their proportion in the community. Those >65 were more likely to arrive by ambulance and be admitted.
Beland et al., 1991	Retrospective chart review of clients >26 yo seen at two EDs in Canada	Regardless of age, clients who used the ED at night utilized less resources. The greatest consumers of resources were adults >65 yo requiring care in the evening. Clients > 65 were more expensive to diagnose & treat than those < 65. As age increased the likelihood of arriving by ambulance increased.

Eagle, Rideout, Price, McCann, & Wonnacott, 1993	Retrospective chart audit comparing individuals > 64 yo with individuals 16-64 yo seen in a Canadian teaching hospital over a 4 month period	Older clients had longer lengths of stay in the ED, utilized more services and were more likely to have non-deferrable health care needs. Most older clients were seen during the day time whereas younger adults most often sought care after 7 PM.
Ettinger, Casani, Coon, Muller & Piazza-Appel, 1987	Retrospective chart review of all visits to the ED by persons > 65 every other day of January, April, August & October 1984 compared to an equal number of randomly selected 18-64 yo adults seen on the same days at an East Coast teaching hospital	Elderly clients had more emergent and urgent visits to the ED than younger clients and were more likely to be admitted. Elderly clients with non-urgent concerns were more likely to arrive by ambulance than younger clients with non-urgent concerns.

Hedges et al., 1992	Telephone interviews of ED clients from six sites - 3 urban, 3 suburban; 2 East Coast, 2 Mid West, 2 West Coast N = 600; 100 per site 70 subjects > 65 yo/site 30 subjects 21-64 yo/site	For both age groups, the majority of clients had a source of primary care. However, most subjects felt they were too sick to wait for an office visit. The elderly were less likely to consider their problems resolved after the ED visit. Over 70% of elderly ED clients were not asked about their self-care abilities or support systems; 20% of the elderly did not understand home care instructions.
Lowenstein et al., 1986	Chart review & retrospective MD evaluation of necessity of visit of patients >65 yo who presented to an urban teaching hospital over a 6 week period; an equal number of 16-64 yo clients were selected for comparison	There was little agreement between MD and patient rating of urgency. Visits of an emergency nature (per the MD) were more common in the younger age group; 19% of clients > 75 yo were seen for self-care problems

Singal et al., 1992	Retrospective chart review of elderly (>65) and non-elderly (21-64) clients at 6 sites (using the same sample as Hedges et al)	The elderly were more likely to arrive by ambulance, have emergent or urgent conditions, and require more services than younger age group.
Stern Weissman, & Epstein, 1991	Prospective study of all patients admitted to 5 Massachusetts hospitals (3 community, 2 tertiary care) over a 6 month period N= 20, 089	51% of all admits entered the hospital through the ED; elderly patients (.65) and patients of low SES were more likely to enter the hospital via the ED
Strange, Chen, & Sanders, 1992	Retrospective chart review from a 1990 computerized billing data base. Information was compiled from 70 hospitals, located in 25 states	15% of all ED visits were made by clients >65. The older client is more likely to arrive by ambulance, be admitted, and require comprehensive care than clients < 65 years old.

Preliminary Interview Questions

Sample questions for older ED clients:

What brought you to the Emergency Department for care?

How was the decision made to seek care in the Emergency Department?

How would you describe the type of care you received?

Please comment on the quality of the care in the Emergency Department.

How do you feel about the care you received in the Emergency Department?

Describe any follow up care you will require.

Compare this experience in the Emergency Department with other health care experiences you have had.

What suggestions would you offer to improve care for older people in this Emergency Department?

Sample questions for staff:

Please describe the typical ED patient seen at this facility.

How often do you believe elderly patients are seen in this department?

What special needs do elders have when they arrive at the ED?

What are the rewards and problems associated with caring for elders in the ED?

What aspects of care do you enjoy or feel proficient at when delivering care to elders in the ED? Explain.

What aspects of care do you dislike or feel uncomfortable with when delivering care to elders in the ED? Explain.

How do you feel about caring for elderly clients?

Client Code #: _____ Date of visit _____

Age: _____ M F Ethnicity: _____

Katz Functional Status: _____ SPMSQ Cognitive Function: _____

Marital status: S M W D Source of payment for care:

Medicare VA

MedicAid Kaiser

Pvt Ins _____

ED arrival time:	Time entering care unit:	Time seen by MD:	Time discharged from ED:

Mode of arrival: Ambulatory Wheelchair Ambulance
brought by family

Coming from: Home Senior Housing SNF Board & Care
Asst Living Other: _____

Accompanied by: Friend Child
Grandchild Spouse
Other _____

Presenting complaint:

How long has complaint been present?

Description of presentation to ED:

Diagnosis(es) in ED:

Type of care rendered:

Nursing care:

MD care:

Lab tests:

Xrays:

Special studies:

Supplies required to deliver care

Personnel involved in care/ Scheduled interview time & date

1. _____

2. _____

3. _____

4. _____

Persons accompanying client/ scheduled interview time & date

1. _____

2. _____

Disposition of client (i.e. admit, discharge home, etc.):

Comments about observed interactions among staff related to client care:

Comments about observed interaction between client and staff:

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

CONSENT TO BE A RESEARCH SUBJECT

CLIENT CONSENT

A. PURPOSE AND BACKGROUND

Karen Van Leuven, PhDc, RN, a doctoral student at UCSF, and Jeanie Kayser-Jones, PhD, RN from UCSF Department of Physiological Nursing are conducting a research study to help understand the care of patients over the age of 65 in the Emergency Department. I am being asked to participate in this study because I received care in the Emergency Department.

B. PROCEDURES

If I agree to be in the study, the following will occur:

I will take part in an interview in which I will be asked to discuss my present and any past Emergency Department experience as well as my mental and functional abilities. In addition, my medical records will be reviewed. An audiotape will be made of this discussion. This discussion is expected to last about thirty minutes.

C. RISKS/DISCOMFORTS

1. Some of the questions may make me uncomfortable or upset, but I am free to decline to answer any questions I do not wish to answer or to stop the discussion at any time.

2. Confidentiality: Participation in research may involve a loss of privacy; however, my records will be handled as confidentially as possible. Only Dr. Kayser-Jones and Karen Van Leuven will have access to my study records and audiotapes. After the discussion has been transcribed from the tapes, the tapes will be destroyed. No individual identities will be used in any reports or publications that may result from this study.

D. BENEFITS

There will be no direct benefit to me from participating in this study. However, the information that I provide may help health care providers understand the concerns of elders seeking care in the Emergency Department, and appreciate the client's perspective on emergency care. Results of the study may contribute to future studies aimed at improving emergency care for elders.

E. COSTS

There will be no costs to me as a result of taking part in this study.

F. PAYMENT

There will be no payment for my participation in this study.

G. QUESTIONS

I have talked to Karen Van Leuven, PhDc, RN about this study and have had my questions answered. If I have further questions, I may call Karen Van Leuven at (510) 869-6511 EXT 4705 or Dr. Kayser-Jones at (415) 476-4280.

If I have any comments or concerns about participation in this study, I should first talk with the investigator. If for some reason I do not wish to do this, I may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. I may reach the committee office between 8:00 and 5:00, Monday through Friday, by calling (415) 476-1814, or by writing: Committee on Human Research, Box 0962, University of California, San Francisco, CA 94143.

H. CONSENT

I will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I may chose not to participate. I am free to decline to be in this study, or to withdraw from it any point. My decision as to whether to participate in this study will have no influence on my present or future status as a patient.

If I agree to participate I should sign below.

_____ _____

Date Signature of Study Participant

_____ _____

Date Signature of Person Obtaining Consent

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

CONSENT TO BE A RESEARCH SUBJECT

STAFF MEMBER CONSENT

A. PURPOSE AND BACKGROUND

Karen Van Leuven, PhDc, RN, a doctoral student at UCSF, and Jeanie Kayser-Jones, PhD, RN from UCSF Department of Physiological Nursing are conducting a research study to help understand the care of patients over the age of 65 in the Emergency Department. I am being asked to participate in this study because I work in the Emergency Department.

B. PROCEDURES

If I agree to be in the study, the following will occur:

I will take part in an interview in which I will be asked to discuss my work and my thoughts and feelings about caring for elderly clients. An audiotape will be made of this discussion. This discussion is expected to last about thirty minutes.

C. RISKS/DISCOMFORTS

1. Some of the questions may make me uncomfortable or upset, but I am free to decline to answer any questions I do not wish to answer or to stop the discussion at any time.

2. Confidentiality: Participation in research may involve a loss of privacy; however, my records will be handled as confidentially as possible. Only Dr. Kayser-Jones and Karen Van Leuven will have access to my study records and audiotapes. After the discussion has been transcribed from the tapes, the tapes will be destroyed. No individual identities will be used in any reports or publications that may result from this study.

D. BENEFITS

There will be no direct benefit to me from participating in this study. However, the information that I provide may help define the knowledge and skills required to deliver care to elders in the Emergency Department. Results of the study may contribute to future studies aimed at improving emergency care for elders.

E. COSTS

There will be no costs to me as a result of taking part in this study.

F. PAYMENT

There will be no payment for my participation in this study.

G. QUESTIONS

I have talked to Karen Van Leuven, PhDc, RN about this study and have had my questions answered. If I have further questions, I may call Karen Van Leuven at (510) 869-6511 EXT 4705 or Dr. Kayser-Jones at (415) 476-4280.

If I have any comments or concerns about participation in this study, I should first talk with the investigator. If for some reason I do not wish to do this, I may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. I may reach the committee office between 8:00 and 5:00, Monday through Friday, by calling (415) 476-1814, or by writing: Committee on Human Research, Box 0962, University of California, San Francisco, CA 94143.

H. CONSENT

I will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I may chose not to participate. I am free to decline to be in this study, or to withdraw from it any point. My decision as to whether to participate in this study will have no influence on my future status as a patient.

If I agree to participate I should sign below.

_____ _____

Date Signature of Study Participant

_____ _____

Date Signature of Person Obtaining Consent