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PARENT-NURSE INTERACTIONS IN THE EMERGENCY DEPARTMENT: AN EXPLORATORY STUDY

by

(C) Sharon J. Toohey

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
OF MASTERS OF NURSING

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled

PARENT-NURSE INTERACTIONS IN
THE EMERGENCY DEPARTMENT:
AN EXPLORATORY STUDY

Submitted by Sharon Jeanne Toohey

in partial fulfillment of the requirements for the degree of MASTER OF NURSING.

Peggy Anne Field
Supervisor

Date: 25 July 1984

DEDICATION

To my husband, Jim, and my sons, Sean and Patrick, who were supportive and understanding; and to my parents who encouraged the pursuit of knowledge.

ABSTRACT

This exploratory study was undertaken to describe one aspect of the emergency nurses' role, the parent-nurse interaction in situations which involve pre-school children. There were three questions that guided the study: what are the characteristics of parent-nurse interactions in the emergency room? what are the parent's perceptions of nursing care in the emergency room? and how are these a function of the context and particular types of situation?

The researcher used the techniques of participant observation to gather data over a four-month period in the emergency department of a large urban hospital located in one of the prairie provinces. Goffman's communication framework was utilized to provide direction throughout the data analysis. The data were analyzed according to the backstage view, the frontstage view, and the success of the actors' performances, that is, the impression management in the emergency department.

The tentative propositions that were generated from the findings include: nurse-parent interactions in the emergency department are brief and episodic; the longer the parent and child remain in the emergency department, the more likely the interactions will be parent rather than nurse-initiated; the number of nurses interacting with a parent and child increases as the parents length of stay in the department increases; parents do not perceive emergency nurses as "care-givers"; the majority of parents seek a "cure" for their child when in the emergency department not "care" for their child; and the activity level in the department does not effect the frequency or

quality of nurse-parent interactions. Emergency nurses viewed their role in terms of medically-delegated functions. There was little evidence that emergency nurses provided supportive care to children or their parents in the emergency department. Further, nurses were not aware of child development or problems specific to pediatric patients. There was also little evidence that emergency nurses assessed parents' psychological and cognitive needs in the emergency setting.

Based on these conclusions the following implications for nursing were identified: there is a need for educational preparation for emergency nurses that will enable them to identify and respond to the supportive and teaching needs of children and parents. It is necessary for emergency nurses to recognize that they have the responsibility of caring for a diverse group of patients ranging from infants to senior citizens and consequently they must be knowledgeable about the stages of growth and development. Finally, it is important that emergency nurses begin to articulate what the role of the emergency nurse is and the dimensions of that role when caring for infants or adults.

The researcher recommended: that primary nursing care be implemented in emergency departments; that nursing administrators be made aware that pediatric patients have different needs from adult patients and that parents' psychological needs are also important; that consideration be given to establishing separate waiting rooms for parents and children; and that further descriptive studies be done in other emergency settings in order that comparisons can be made across hospitals.

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TABLE OF CONTENTS

CHAPTER		Page
1.	OVERVIEW OF THE STUDY	1
	Introduction	1
	Purpose of the Study	2
	Need for Study	2
	Statement of the Problem	4
	Theoretical Framework	4
	Assumptions of the Study	6
	Definition of Terms	6
	Methodology	7
	Limitations of the Study	9
	Organization of the Thesis	9
2.	REVIEW OF THE RELATED LITERATURE AND RESEARCH	11
	An Overview of Studies of Emergency Departments	11
	Studies Utilizing Observation Methods	20
	Children and Parents in the Emergency Department	28
	Summary	36
3.	THE SETTING	38
	Characteristics of the Emergency Department	38
	The Physical Environment	38
	The Nursing Organization	40
	The Emergency Staff	42
	Unit Supervisor	42
	Clinical Instructor	42

CHAPTER Page

Associate Unit Supervisors 42

Registered Nurses 42

Registered Nursing Assistants 42

Unit Clerks 43

Porters 43

Service Aides 43

Emergency Physicians 43

Emergency Patients 44

Patient visits 44

Patient flow in emergency department 44

Patient waiting areas 45

The Detoxification Unit 45

Summary 46

4. METHODOLOGY AND PROCEDURES 47

Introduction 47

Goffman's Framework 47

Participant Observation: Implications for Research 48

Reliability and Validity 51

The Setting 54

The Methodology 55

Negotiating Entry 55

Pilot Study 58

Summary of Entry into the Field 61

Presentation of the Study 62

Nurses 62

Parents 63

CHAPTER Page

Process of Data Gathering 64
The Observer's Role 64
Field Notes 66
Interviews 67
Emergency Chart 68
Data Analysis 68
Initial Phase of Data Analysis 68
The Interactions 69
Coding of Data 69
Ethical Considerations 72

5. DATA ANALYSES 74
The Backstage 74
Nurses' Impressions of Emergency Nursing 74
Nurses and Patients 78
"Real Emergencies" 78
"Routines" 80
"WODS" 81
Nurses, Children and Parents 81
The Frontstage 83
Patient Categories 84
Children with Lacerations 84
Nurse-Parent Interactions 84
Children with Possible Overdoses 87
Nurse-Parent Interactions 87
Children with Infections 92
Nurse-Parent Interactions 93

CHAPTER Page

Children with Medical Problems 95

Nurse-Parent Interactions 96

Children Admitted to Hospital 99

Nurse-Parent Interactions 99

Comparison of Patient Categories 108

Nurse-Parent Interactions: The Similarities 108

Nurse-Parent Interactions: The Differences 110

The Contextual Factors 111

Low Activity Level 111

Moderate Activity Level 116

High Activity Level 119

Impression Management 121

Parents' Perceptions of Emergency Nurses 122

Parents' Perceptions of Nursing Care 125

Parents' Perceptions of Emergency Physicians 127

Parents' Description of Child's Illness 128

Parents' Perceptions of Emergency Environment 130

Parents' Rationale for Using the Emergency Department 135

Summary 136

The Nurses as Actors 136

Impression Management 137

The Stage 138

6. DISCUSSIONS OF FINDINGS, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS 140

Limitations of the Study 140

Discussion of Findings 140

CHAPTER Page

Question 1: 141

Question 2: 143

Question 3: 145

Tentative Propositions 148

The Conclusions and the Related Literature 149

Implications for Nursing 155

Recommendations 158

BIBLIOGRAPHY 160

APPENDIX A 164

A-1 Information Letter: Nurses 165

APPENDIX B 166

B-1 Nurses' Consent Form 167

B-2 Parents' Consent Form 168

B-3 Parents' Consent Form (2) 169

APPENDIX C 170

C-1 Data Collection Sheet 171

C-2 Patient Information Form 172

C-3 Interaction Collection Sheet 173

APPENDIX D: Final Guide for Parents' Interview 174

LIST OF TABLES

TABLE		Page
4.1	The Relationship of the Research Questions to the Dimensions of Interactions, Dimensions of Goffman's Communication Framework, Major Data Gathering Techniques and Data Analysis	70
4.2	A Summary of the Cases	71
5.1	Children with Lacerations	85
5.2	Children with Overdoses	87
5.3	Children with Infections	92
5.4	Children with Medical Problems	96
5.5	Children Admitted to Hospital	100
5.6	Activity Levels in Emergency Department	112

LIST OF FIGURES

FIGURE		Page
3.1	Floorplan of the Grey Walls' Hospital Emergency Department	39
3.2	Nursing Organization of Emergency Department	41
4.1	Organization of the Emergency Department	56

CHAPTER 1

OVERVIEW OF THE STUDY

Introduction

The surge in emergency room utilization in Canada, a 78 per cent increase between 1969 and 1974 (Soderstrom, 1978), is one of the most striking developments in hospital utilization in the 1970's. Allentuck (1978) estimates that as many as ten million Canadians receive treatment each year in emergency facilities. There are numerous reasons cited for the increased utilization of emergency departments, such as, mobility of the population, changing patterns of medical practice, Canada's technology - centred medical system, and accessibility of the facility (Allentuck, 1978; Roth, 1978b, & Soderstrom, 1978). Lanros (1978) contends that the emergency department is now the key entry point to the health care system.

A new specialist emerged from the phenomenal growth in emergency services: the emergency nurse. It is suggested in the literature (Lanros, 1978; "Nursing Aspects of Emergency Services," 1975; Yoder & Jones, 1981) that the emergency nurse has a unique opportunity to play a major role in the patients' and communities' perceptions of acute care facilities. The definition of the emergency nurses' role tends to be limited in the literature to the performance of medically-delegated functions (Lanros, 1978) and/or traditional nursing tasks, for example, taking vital signs (Gray, 1976).

One aspect of importance that is not described in the literature is the nurse-parent interaction in the emergency department. It has

been suggested (Roskies, Bedard, Gauvreau-Guilbault, & Lafortune, 1975; Roth, 1972) that parents with children who can not articulate their needs to emergency staff are particularly vulnerable when utilizing emergency departments. The parents bring their child to emergency and may not be able to identify to staff the nature of their child's illness. The staff may assume control over the child without allowing the parent to participate in decisions about the child's care. It has also been suggested that parents abrogate their parental role in the emergency setting and assume "the passive role of information-giver" (Roskies et al., 1975). While several writers had made suggestions about parental behaviours it was apparent that little was known about the ways in which parents interact with nurses in emergency departments or on parents' perceptions of the nurse in the emergency room setting.

Purpose of the Study

To understand the realities of emergency nursing, it must be studied in the context within which it occurs. The purpose of this exploratory study was to discover how nurses interact with parents of children who can not articulate their own needs in the emergency setting; the relationship of the nurse-parent interactions to the parents' perceptions of nursing care; and the contextual factors which influenced the nurse-parent interactions.

Need for Study

A conceptual model for nursing practice "is a mental image of the

realm of nursing - how it is put together and how it works" (Riehl & Roy, 1980, pp. 6-7). A conceptual model is necessary to understand the reality of the practice environment and the nurse's unique role within that environment (Broncatello, 1980).

Emergency nurses function in an environment that is dominated by the needs of the urgent and emergent patients in the emergency department. The social mandate of an emergency department is "to provide immediate and temporary care to the acutely ill and injured" (Yoder & Jones, 1981, p. 160). The paradox that practitioners in emergency nursing confront daily is: the mandate of emergency departments is not a reflection of reality, that is, the majority of patients seeking care in emergency departments present with conditions that are nonemergent (Roth, 1978b). It is apparent that the domain of emergency departments is not limited to the care of the acutely ill and injured patients (Pisarcik, 1980) and there is a need to gain better understanding of the role of the emergency nurse within the constraints of the emergency environment.

For many children, it is suggested that the emergency department may be the child's only exposure to the hospital (Resnick & Hergenroeder, 1976). There is some evidence to suggest that emergency staff respond more positively towards children than towards adults and consequently are less likely to resort to control strategies (Roth, 1972, 1978a; Sudnow, 1978). Some researchers suggest (Nicklin, 1979; Roskies et al., 1975) that there is a need to improve the care of children in the emergency setting and for emergency nurses to be more cognizant of the needs of parents. In order to improve the quality of

pediatric care in the emergency department it is necessary to understand the characteristics of nurse-parent interactions.

Statement of the Problem

The focus of this study was the parent-nurse interactions in the emergency department and its relationship to the parents' perceptions of nursing care.

The exploratory questions that guided this study were:

1. What are the characteristics of parent-nurse interactions in the emergency room?

2. What are the parent's perceptions of nursing care in the emergency room?

3. How are these a function of the context and particular types of situation?

Theoretical Framework

Given that the problem for study was the nurse-parent interaction in the emergency setting, it was necessary to utilize a framework that facilitated analysis of interactions and the context within which the interactions occur. The particular framework chosen was Goffman's perspective for analyzing social interactions.

Goffman (1959, pp. 1-3) defined communication as verbal and non-verbal behaviors which express and give off the impression of role performance. He makes the following assumptions:

1. the human being makes a presentation of self and his

activities when in the presence of others;

2. the human being seeks to acquire information when in the presence of others; and

3. the human being attempts to guide and control impressions others form of him.

Goffman uses the language of the theatre, that is, actor, stage, performance, and audience to analyze interactions, which he views as performances staged to members of a audience in a particular setting. Performers may act individually or be united in a team. Performers maintain their roles through strategies such as information control. Other strategies that performers may use include: "making-work," here the performers give the impression that they are engaged in purposeful activities and "social distancing," by which they limit and regulate the contact between themselves and members of the audience in order to control the audiences' impressions of their roles. Within the emergency department, the nurse and physician may be viewed as performers acting individually or united in a team for the patients, i.e., assuming the patients accept their audience role. Successful staging of a performance provides patients with a "frontstage" view of the setting. "Performance disruptions" may occur when patients choose to become actors by creating a scene or when the united front of the team is broken, resulting in unsuccessful staging of the performance and providing the patients with a "backstage" view of the setting. Patients are members of the audience and observe the performance put on for their benefit by nurses and physicians. They are therefore led to define the situation in the way in which the performance of the

professionals leads them. This audience interpretation of the actors' roles is called "impression management."

Goffman (1959) contends that his perspective is valid for studying social life that is organized within an institution. Goffman's perspective for analyzing social life has been utilized in part by Soares (1978) to describe verbal useage in an intensive care unit and Rosenthal and her colleagues (1980) to analyze nurse-patient interactions on inpatient units in an acute care facility.

Assumptions of the Study

Assumptions underlying this study were:

1. That the human being makes a presentation of self and his activities to others in social interaction.

2. That the human being attempts to guide and control the impression that others form of him.

3. That the human being can recount his impressions of past events.

4. That human beings mutually influence each other when interacting in one anothers' immediate physical presence.

Definition of Terms

Important definitions that are used in this study are listed below. Other terms which arise in the course of this study are defined as they are introduced.

Interaction:	"The reciprocal influence of individuals upon one another's actions when in one another's immediate physical presence" (Goffman, 1959, p. 15).
Performance:	"All the activity of a given participant on a given occasion which serves to influence in any way any of the other participants" (Goffman, 1959, p. 15).
Parent:	The parent is the mother, father, or guardian with whom the emergency nurse interacts in the emergency department.
Context:	The variables in the physical environment that influence the nurse-patient interaction, e.g., high or low activity level in the department, availability of personnel, delays in support services, privacy of accommodation.
Patient:	Children that are from birth to 3 years of age.
Emergent patient:	A patient with "a condition requiring immediate medical attention . . . disorder is acute and potentially threatening to life or function" (Lanros, 1978, p. 10).
Urgent patient:	A patient with "a condition requiring medical attention within the period of a few hours; a possible danger exists to the patient if medically unattended" (Lanros, 1978, p. 11).
Nonemergent patient:	A patient with "a condition which does not require the resources of an Emergency Department . . . disorder is nonacute or minor in severity" (Lanros, 1978, p. 11).
Parent's perceptions:	The parents' recall of events that occurred in the emergency department and their responses to the nurses' behaviours.

Methodology

The problem posed in this study was to identify the

characteristics of parent-nurse interactions and the context within which these interactions occur in an emergency setting. In order to do this the investigator assumed the role of a participant observer in the emergency department of a large urban hospital located in the prairie provinces.

The term, participant observation, suggests direct involvement in the community life of the people being studied, i.e., observing and talking with people in an attempt to learn from them their view of reality (Agar, 1980, p. 114). The techniques utilized by the participant observer include direct observation of relevant events; informal interviews with members concerning their motives, intentions, and interpretations of events; indirect observations obtained by seeking out informants for their unique perspectives and by analyzing records and documents that pertain to the organization; and participation in the group activities (Denzin, 1978, p. 255; McCall & Simmons, 1969, p. 1-4).

In this study, a pilot study was carried out to:

1. acquaint the researcher with the environment of the emergency department.

2. test the feasibility of the observer role and data gathering techniques.

3. test observer reliability.

The researcher's notes on entry to the field and initial field notes were reviewed by the thesis supervisor to check on methods of recording data and the possibility of bias in initial interpretations of data.

During the study, 16 parent-nurse interactions were observed in

the emergency department during a period that extended over four months. There were a total of 31 different nurses observed during the parent-nurse interactions. The nurses' verbal and non-verbal behaviours were observed and recorded backstage (for example in the coffee room) and frontstage, in the emergency department itself. Data were gathered by observation (and recorded as field notes), through extraction of information from the patient's emergency record, and by semi-structured interviews with the parents following their child's discharge from the emergency department. The follow-up interviews with the parents were tape-recorded. The data were analyzed following each visit to the emergency department and the researcher's field notes were reviewed by the thesis supervisor to enable the supervisor to monitor and evaluate the observations and follow-up interviews. Goffman's framework was utilized throughout the data collection and analysis phases.

Limitations of the Study

1. This study is limited to emergency nurses working in a large urban hospital setting.

2. The study is focused on only one aspect of the emergency nurses' role, i.e., nurse-parent interactions.

3. Both nurses and parents participated voluntarily in the study and their responses may not reflect the population as a whole.

Organization of the Thesis

This thesis is organized into six chapters. The first two

chapters comprise the introduction and a review of related literature and research. Chapter 3 presents a description of the setting, that is, the emergency department. Chapter 4 describes the methodology and procedures. Chapter 5 details the data analyses and Chapter 6 presents the discussion, conclusions, and implications for nursing from the study.

CHAPTER 2

REVIEW OF THE RELATED LITERATURE AND RESEARCH

This literature review is divided into three sections. The first section presents an overview of studies of emergency departments, the methodologies utilized, and the findings that are specifically related to client satisfaction and/or to the role of the emergency nurse. The second section reviews studies that utilized observation methods to gather data on interactions within the emergency department. The third section focuses on literature that refers to children and parents in the emergency department.

An Overview of Studies of Emergency Departments

In this overview of studies undertaken in emergency departments, reference will first be made to quantitative studies that attempt to determine the efficiency and effectiveness of emergency departments, then to studies that identify patterns of utilization of emergency services. Finally, studies that focus on the role of emergency nurses will be presented.

Georgopoulos and Cooke (1980, pp. 3-37) utilized comparative organizational analysis, that is, cross-hospital comparisons or simultaneous study of emergency departments to "analyze the organization and evaluate the effectiveness of hospital emergency units" (p. 31). Utilizing questionnaires and information sources such as hospital records, the researchers collected data from 30 hospitals and approximately 1,500 individuals affiliated with these hospitals

(pp. 37-45). The data compiled from the patent respondents is summarized.

Georgopoulos and Cooke (pp. 245-247) administered an extensive questionnaire to determine patients' satisfaction with their emergency experience. There were 388 patient respondents ranging in age from 16 to 65 years or older. The results indicated that patients were most satisfied with the following aspects of their emergency visits: waiting time or length of visit (19%), staff's attitudes and actions (18%), quality of care (14%), emergency staff resources (10%), emergency physicians (8%) and emergency nurses (7%). When patients were asked to evaluate the overall care given to them by emergency physicians and by emergency nurses, the patients perceived that the nurses took slightly better care of them than did the physicians (pp. 253-256). The researchers noted that patients may be indicating their satisfaction with perceived clinical efficiency rather than evaluating how well the emergency physicians or nurses actually took care of them.

Georgopoulos and Cooke administered a questionnaire to 278 registered nurses in order to determine the emergency nurses' perceptions vis-a-vis the goals of emergency departments, job satisfaction, and their assessment of the quality of nursing care. When asked to rank seven goal priorities in order of their importance to the emergency department (pp. 114-117), the emergency nurses responses were: (1) Maintain high standards of patient care; (2) provide comprehensive emergency services; (3) maintain high level of patient satisfaction; (4) minimize patient waiting time, (5) maintain a good reputation in the community; (6) keep the costs of emergency

services down; (7) improve working conditions for the staff. The emergency nurses generally ranked the goal priorities the same as emergency physicians.

Overall, emergency nurses viewed emergency departments as "very good" places to work (pp. 258-261); were "very strongly" committed to their emergency department (pp. 262-263); and were "satisfied" with the non-financial aspects of their work (pp. 274-275). The nurses were asked to evaluate the quality of nursing care for the following categories of patients: (1) patients with myocardial infarctions; (2) patients with respiratory infections; (3) patients with facial lacerations; (4) patients with fractures; and (5) patients with psychiatric problems. The nurses identified that the quality of nursing care (pp. 339-342) was best for patients with infarctions and the poorest for psychiatric patients. Patients with facial lacerations, fractures, and respiratory infections were ranked second, third and fourth in terms of quality of nursing care received in emergency departments. The researchers found that the nurses' assessment of the quality of nursing care paralleled the physicians' assessment of the quality of medical care given to patients in these categories (p. 341).

Emergency Services in Canada, a six-volume report published by the Department of National Health and Welfare, did not attempt to analyze or evaluate the effectiveness of emergency departments in Canada. Although project and site-visit teams surveyed 84 hospitals across Canada, the report only contained recommendations that were made to the Federal-Provincial Sub-Committees on Quality Care and Research.

In volume six, Nursing Aspects of Emergency Services, it was suggested that emergency nurses have a unique opportunity to play a major role in the patients' and communities' perceptions of acute care facilities. There was no attempt; however, to define the role of emergency nurses or the scope of emergency nursing. The recommendations vis-a-vis emergency nursing were limited to organization, education, disaster planning, and policies and procedures.

During the latter part of the 1960's and early 1970's, researchers began to focus on utilization patterns of emergency services and the patients' rationale for using hospital emergency departments (Davidson, 1978; Jacobs, Garette, & Wersinger, 1971; Kirkpatrick & Taunbenhaus, 1967; Kluge, Wegryn & Lemley, 1965; Lee, Solon & Sheps, 1960; Robinson & Klonoff, 1967; Roth, 1978b). The major findings from these studies indicated that the volume of emergency visits had increased substantially and there was a change in the nature and use of emergency services, that is, the proportion of patients with non-urgent problems presenting for treatment increased while the proportion of patients who required urgent care decreased (Davidison, 1978; Kirkpatrick & Taubenhaus, 1967; Roth, 1978b, Yoder & Jones, 1981).

There were numerous reasons cited in the literature for the increased utilization of emergency departments, for example, mobility of population, changing patterns of medical practice, increased urbanization, and accessibility of the facility (Lee, Solon & Sheps, 1960; Roth, 1978b; Soderstrom, 1975, pp. 29-30). In Roth's study of five emergency departments, he listed the advantages that both patients

and medical personnel frequently attribute to such departments. These advantages included: open 24 hours a day; no appointment is required; specialists are readily available; urgent patients are attended to quickly; and treatment and diagnostic facilities are on site.

The advantages listed by Roth (1978b) are supported by patient respondents in the Georgopoulos and Cooke study (1980). The reasons most frequently identified by patients, (N=338), for utilizing a specific emergency department were: it was the nearest one (31%); they had previously used the emergency department (25%); they knew that the hospital was a good one (10%); they were told by the doctor to go there (8%); and it was the only available place to get care (6%). Pisarcik (1980) reported similar findings in a descriptive study of 29 nonemergent patients. Pisarcik found that the major reasons for non emergency visits to emergency departments were immediacy, that is "speedy service", followed by expediency or "hours available", and comprehensiveness of facilities (p. 19). Pisarcik also noted that patients chose emergency departments over clinics for subjective reasons, such as the atmosphere of emergency departments. The patients apparently felt that they received more personalized attention and the emergency staff were more sympathetic to their concerns.

The nonemergent patients' perceptions of the emergency staff in Pisarcik's study (1980) were not congruent with the findings of Yoder and Jones (1981). Yoder and Jones contended that nurses represent the largest group of health professionals in any emergency department and consequently the nurses' perceptions and attitudes influenced how patients were viewed and treated in the department. The purpose of

Yoder and Jones' study (1981) was "to determine the nurses' perceptions and attitudes relative to changing clientele" (p. 156). They distributed questionnaires to 75 nurses in emergency departments of three large general hospitals. Fifty-one nurses (68%) completed the questionnaire. The nurses identified three types of patient conditions that should not be treated in emergency departments. Ninety-three percent of the nurses identified patients with minor illnesses or injuries as inappropriate for emergency treatment. The other two types of patient conditions most frequently identified by the nurses as inappropriate for emergency treatment were chronic problems, for example, alcoholics and the use of emergency departments for convenience, for example, patients with toothaches. Yoder and Jones concluded that nurses were resistant to the nonemergent use of emergency departments and their "resistance is a source of subtle, if not open, conflict between staff and clients" (p. 160). In addition, they identified the need for emergency nurses to "re-define their roles and adapt their services to the changing needs of current emergency department clientele" (p. 161).

It was noteworthy that Yoder and Jones (1981) suggested the need to re-define the role of emergency nurses. Definition of the emergency nurses' role tended to be limited in the literature to the performance of medically-delegated functions (Lanros, 1978), and/or traditional nursing tasks, for example, taking vital signs. Gray (1976) acknowledged that a "definitive description of the nurses' role" was difficult (p. 25) particularly the emergency nurses' role. She contended that emergency nurses have more responsibilities than nurses

in other areas of the hospital. An example would be triaging patients.

In her study, Gray (1976) attempted to determine the functions in which emergency nurses are engaged. She developed a questionnaire that listed 75 tasks which emergency nurses performed and distributed the questionnaire to 24 emergency nurses. Twenty-one nurses completed the questionnaire and identified tasks which they actually performed and tasks that they considered to be nursing activities. Gray then followed the nurses during an eight-hour shift in an attempt to measure the amount of time nurses spent performing tasks. The results of her study indicated that emergency nurses only spent 22 per cent of their time performing nursing functions, such as relating to patients and families and 78 per cent of their time performing non-nursing functions, that is, filling out requisitions, obtaining equipment, or cleaning floors. Gray's study was focused on activities in which nurses are involved in one emergency department. She did not attempt to define the role of the emergency nurse. Lewis and Bradbury (1982), did attempt, however, to delineate the role of emergency nurses in their study of 19 emergency departments located in hospitals in the North West region of England.

The overall purpose of the Lewis and Bradbury study was "to ascertain attitudes towards, and expectations of, accident and emergency services among both client groups and professionals involved in the provision of the services" (p. 211). One element of their research was focused on a questionnaire based survey of 260 emergency nurses. Their structured self-completion questionnaire for nurses was constructed from information accrued from in-depth interviews with

senior members of the nursing profession at the national level and from information interviews with emergency nurses. The researchers distributed a total of 527 questionnaires and 260 (49%) of the nurses responded. In this study, the nurses were asked to identify: areas of emergency work preferred and/or disliked; expectations of and attitudes towards work; and perceptions of the nurses' role.

The nurses generally preferred performing technical procedures, such as suturing and cardiopulmonary resuscitation. They experienced job satisfaction when involved with patients who had multiple injuries or a serious medical emergency. They believed that critically ill patients presented a challenge to nurses and an opportunity to utilize their nursing skills. The nurse respondents also indicated that they enjoyed patient contact. The nurses particularly disliked working with nonurgent patients, such as alcoholics or drug abusers. Like the nurses in Yoder and Jones' (1981) study, the nurses considered nonurgent patients to be time consuming and inappropriate cases for emergency departments.

Lewis and Bradbury found that the nurses "had a number of pre-conceived ideas which contributed to their expectations of the nature of the work . . . and . . . the job satisfaction to be gained" (p. 215). Eighty-five percent of the nurses chose to work in emergency departments because they expected to deal "with patients in need of urgent/emergent nursing attention" (p. 215). The nurses also anticipated that the variety of work combined with elements of human interest and drama resulting from an unpredictable workload would provide them with the opportunity to utilize all their nursing skills.

Eighty-one percent of the nurses believed emergency work was always more demanding of their skills than work in other areas of the hospital. The majority of nurses believed that "they had acquired additional medical and technical skills" in the emergency department and also had "increased their communication skills with patients and medical staff" (p. 216).

To determine the nurses' perceptions of their role, the nurses were asked to indicate how strongly they agreed or disagreed with a series of statements about their role, for example emergency work "involves an extension of the nurses role for senior nursing staff" (p. 216). Almost all of the nurses agreed with statements that identified emergency work as interesting and satisfying, and the unpredictable workload as a challenge. More than a third of the nurses agreed that the work was frustrating because of the large amount of trivial nursing procedures that they were required to do. Additional problems in their work were inadequate nursing coverage and lack of medical support.

Lewis and Bradbury apparently based their questionnaire on input from nursing experts and emergency nurses. Statements about the nurses' role were limited to medically-delegated functions or administrative issues, such as adequate nursing coverage. Nurses were not asked to agree or disagree on statements related to interactions with patients and/or families. From the available literature found on the role of the emergency nurse, it would appear that the emergency nurses' role is limited to the performance of medically-delegated functions and traditional nursing tasks.

Studies Utilizing Observation Methods

The focus in this section is studies that utilized observation methods to gather data on interactions within the emergency departments. Descriptions of emergency staffs' response to patients will first be presented then strategies utilized by emergency staff to control clientele will be discussed.

Both Roth (1972, 1978a) and Miljman (1978) utilized participant-observation to gather data on interactions within hospital settings. Roth's data were collected from observations in six emergency departments over two to three month periods. Millman (1978, p. 18) gathered data from three university-affiliated hospitals over a period of two years. Roth and Millman (pp. 154-167) found that emergency nurses expend a great deal of time and energy morally and socially evaluating the patients' rights to be in emergency departments rather than providing care to patients.

Roth (1978a, p. 500) contended that the evaluation of patients and visitors by emergency staff can be divided into two categories: (1) staff's perceptions of the patients' social worth; and (2) staff's perceptions of their appropriate work roles. According to Roth, evaluations of patients' social worth were made quickly on the basis of readily perceivable clues, that is, race, age, mode of dress, word useage, and other information such as financial status, nature of medical complaint, marital status. Roth (p. 502) noted that it was not uncommon to hear emergency staff refer to particular patients as "garbage", "liars", "scum", or "deadbeats". Emergency staff also

apparently disliked caring for particular types of patients, like men who were drunk or women who had pelvic inflammatory disease. Both Millman (pp. 160-161) and Roth identified that emergency staff were quick to label patients and determine whether they were deserving of good treatment.

The moral and social evaluation of patients by emergency staff was not a new phenomenon in emergency departments nor was it restricted to particular types of patients. In Sudnow's (1978) formidable description of emergency staffs' response to patients who were "near death", he noted that there was "a rather strong relationship between age, social background, and the perceived moral character of the patients and the amount of effort" that was made to resuscitate patients when "clinical death signs" were detected (p. 174). To support his view, Sudnow detailed emergency staffs' approach to the admission of a young child and an elderly patient during the same evening. Sudnow stated that both patients were brought to the emergency department with no detectable heartbeat, pulses, or respirations. He noted that the emergency staff attempted to revive the child for 11 hours whereas no attempt was made to resuscitate the elderly patient. Sudnow also indicated that age was not the only factor in the emergency staffs' response to patients. He identified the fact that staff were less aggressive in their efforts to revive or treat patients such as alcoholics, drug abusers, or suicide victims. He commented that nursing staff particularly demonstrated a "high degree of distaste" when working with suicide patients. Millman (pp. 162-163) also identified that emergency staff were "especially uneasy"

with suicide victims and consequently treated them with anger and hostility.

According to Millman (p. 155), emergency staff complained most about the public "abuse" of their department, that is, using emergency services for non-emergent problems. Roth (1978a), too, noted that the universal complaint among emergency staff was "that hospital emergency rooms are 'abused' by the public" (p. 506). Roth contended that all workers have a notion of the demands which are appropriate in their work environment. In emergency departments, the public demanded treatment for injuries or illnesses that emergency staff perceived as too minor or lacking in urgency to warrant emergency care, that is, more appropriately treated in outpatient clinics or doctors' offices. The emergency staff, therefore, thought that the majority of the public's claims for service were illegitimate. When a patients' use of emergency was perceived as illegitimate, he typically received "hurried, routine processing" (Roth, 1978a, p. 507). For example, Roth described the examination of a child with a sore throat as a "quick look in the ears and throat with the otolaryngoscope" (p. 507). Roth further suggested that if a patient or visitor complained or created problems for the staff, the care given deteriorated below the routine level. Millman (pp. 156-157) quoted a conversation between a nurse and a patient who wanted to have wax removed from his ears. It was apparent from the dialogue that the nurse did not think it was appropriate for the patient to be treated in the emergency department and she informed the patient that he would have a long wait. According to Millman, there were no patients to be seen in the department. The

patient, however, was kept waiting while the nurses had a coffee break and finally left without treatment.

When Roth (1978a) grouped patients according to their diagnosis as illegitimate or legitimate cases for emergency services, he found that patients with medically-related problems, such as patients with urinary tract infections, were the highest in the illegitimate category. Cases lowest in the illegitimate category were pediatrics, which Roth noted was "another bit of evidence that children are more acceptable patients than adults" (p. 507), and surgically-related cases, for example, motor vehicle accidents. Roth suggested that surgical cases were generally easier to define and treat in a routine manner than patients with symptoms that were difficult to diagnose and treat. Roth also identified that patients who made illegitimate demands combined with an undeserving character received the strongest negative evaluation, for example, a welfare patient with a minor complaint presenting for treatment at an inconvenient time. In contrast, Roth noted that a patient perceived as a "real emergency" could overcome the staffs' moral repugnance and cited as an example the vigorous effort emergency staff made to prevent the death of a police prisoner suffering from a severe abdominal wound. Roth contended that the emergency staff responded quickly to the prisoner because the staff viewed the patient as "the kind of case" that justified "the existence of their unit" (p. 509). Roth, however, identified that even in cases that were "real emergencies" the emergency staff morally evaluated the work of the individual. He contrasted the staffs' response when they failed to successfully resuscitate a prominent citizen "who had been

stabbed by thugs" to the staffs' response to the prisoner's death. Roth noted that the staff were "greatly upset" by their inability to save the citizen who was "a worthy person" whereas the staff treated he prisoner as "simply a technical matter - an opportunity to display" their skills (pp. 509-510).

Millman (1978, p. 156) noted that emergency staff were more resentful towards patients during the night shifts and weekends when the staff believed patients "abused" their services most often. During the times that the emergency department was quiet, Millman (pp. 161-162) found that staff recounted stories about the most bizarre cases grouping patients into categories such as "crazy", "difficult", or "turkeys". Roth (1978a) identified that emergency staff perceived that approximately 70 - 90 per cent of their patients used emergency services inappropriately. When Roth classified 938 patients according to diagnostic categories, into staffs' perceptions of legitimate or illegitimate categories, he found that only 23 per cent were actually classified as illegitimate. Roth noted that it is common for work groups to exaggerate their difficulties with clients when generalizing about them. He suggested that emergency staff consistently exaggerated the numbers of patients with illegitimate demands, for example, psychiatric patients were referred to as major problems but actually made up only two per cent of the total emergency census. Roth (1978a) concluded that patients who present themselves (or are brought by others) to emergency departments inevitably set off a process by which their "worthiness and legitimacy" are weighed and become a factor in their treatment.

Both Roth (1972, 1978a) and Millman (1978) identified strategies that staff in emergency departments utilize to control clientele, such as withholding information. Roth (1972) suggested that emergency staff not only collaborate with each other to control patients and visitors but also collaborate with outside authorities such as police and ambulance personnel. Roth (p. 42) contended that the commonly accepted assumption was that all personnel "in authority within the hospital or connected with emergency services . . . should maintain a united front to control" the patient population.

The most effective control strategies utilized by emergency personnel at all levels were simply to ignore, avoid, or keep patients waiting. Roth (1972) noted that registration clerks in larger emergency departments exercised initial control over patients. The clerks pretended not to "see" the patient and delayed in processing patient information, particularly when patients were perceived as undesirable, for example, drunk, dirty, or psychotic. Doctors opted to select certain charts of waiting patients because they wanted cases of interest to them. Millman (pp. 158-159) noted that a phy ician kept a couple complaining of skin rashes waiting for five hours while he saw other patients who arrived after the couple because he did not think their complaint justified an emergency visit. Patients were frequently told that they would have a long wait when the emergency area was not actually busy. Roth (1972) suggested that this was a mechanism for "keeping the numbers down", that is, patients get tired of waiting and leave.

Other control mechanisms utilized by emergency staff included

"putting on an act" and "pulling rank" on patients and visitors (Roth, 1972, 1978a). Emergency staff "put on an act" for patients and family members to make them "think that the situation is being properly handled" (Roth, 1972, p. 44). For example, physicians give the impression that all doctors knew what they were doing and patients were reprimanded if they were not cooperative with diagnostic and treatment procedures. Nurses pretended to families of a critically ill patient that all was well until a physician was available to discuss the situation with the family.

Roth (1972, 1978a) believed that patients could be fooled by staff because staff controlled the information. It was apparently common practice not to give patients any information unless explicitly asked (Millman, 1978, pp. 156-157, p. 159; Roth, 1978a) and the patients sometimes were given misleading information. Emergency staff often involved visitors when attempting to fool patients, for example, used parents to deceive a child about the discomfort of a medical procedure. Roth (1972) noted that "nurses commonly make a point of giving a patient minimal information until the matter has been cleared by a physician" (p. 45). There was support for these findings in Rosenthal, Marshall, Macpherson, and Frenchs' (1980, pp. 111-117) study of inpatient units in an acute care facility. Rosenthal et al. noted that "nurses and doctors protect their professional aura and authority" (pp. 112-113) by controlling information to patients. Further, the investigators stated that "information control is fundamental to the maintenance of staff power over patients and families" (p. 112).

The emergency staffs' efforts to maintain control of the

information was also influenced by the physical layout of the department (Roth, 1972). Roth indicated that the location of the nursing station in the centre of the department permitted staff to survey most of the area from the station but also allowed patients and visitors to see and overhear physicians and nurses at the station. Patients and/or visitors could pick up information that may or may not be related to them and consequently made judgements about the appropriateness of their care and treatment in the department.

Emergency staff generally utilized the technique of "pulling rank" on patients and visitors when they perceived patients to be beneath them in status (Roth, 1972). "Pulling rank" on patients was a control strategy most frequently used by physicians and nurses, for example, overriding parents' objections to carrying out certain examinations or treatments on their children. When strategies failed to control patients or visitors, emergency staff tended to resort to physical force to maintain control (Roth, 1972).

Roth (1972) identified that emergency staff were quick to call security if they perceived a patient and/or visitors were physically threatening or even verbally abusive. Staff also threatened to have patients removed from the area if they refused to accept decisions or orders of staff members (Roth, 1972). In situations where there was controversy between staff and patients or visitors, security personnel apparently believed that the staff was right and the others were wrong. Millman (pp. 160-161) and Roth (1972) noted that emergency staff were particularly concerned about protecting themselves against "lawsuits on behalf of the patients" but there was little effort

expended to protect patient and/or visitors legal rights.

Both Millman (1978, pp. 154-156) and Roth (1972, 1978a), suggested that the emergency staffs' need to exercise control was reinforced by the lack of control that staff have over patients who came to their department and the constraints imposed by the organization within which they work. The emergency staff were expected by hospital administrators to examine and treat all patients because the hospital was legally at risk if patients were denied medical care. In addition, hospital administrators frequently reinforced that emergency staff influenced the communities' perceptions of the hospital and it was necessary for staff to be pleasant to the public (Millman, p. 155). Emergency personnel had very limited power of selection vis-a-vis patients and were "obliged to examine and treat anyone who comes, whether or not the case actually constitutes an emergency" (Millman, p. 155).

Children and Parents in the Emergency Department

In this section, studies that refer specifically to parents, children, and/or families in the emergency department will be presented. Descriptions of nurse-family interactions will be reviewed. Reference will also be made to observation studies that were not specifically focused on nurse-family interactions within the emergency department.

In a quantitative study that was done in the medical emergency department of a children's hospital, Alpert, Kosa, Haggerty, Robertson and Heagarty (1969) surveyed 4,320 parents over a six-month period in

order to determine why parents used the emergency facility. Alpert et al. grouped the parents into two major categories: (1) parents that had established relationships with a physician such as a general practitioner or pediatrician; and (2) parents that did not have a general practitioner and/or pediatrician for their child. For the parents that had a private physician (N=1,829), Alpert and his colleagues found that the parents' major reasons for using the emergency facility were: (1) they were referred by their physician (49%); (2) they had previously used the facility (23%); (3) the facility was recommended to them (18%); (4) the facility was the best place to take children (14%); and (5) they could not contact their own physician (8%). For the parents that did not have a private physician (N=2,431), Alpert et al. found that the parents' major reasons for utilizing the emergency facility were: (1) they had previously used the facility (46%); (2) the facility was the best place to take their children (24%); (3) the facility was recommended to them (21%); and (4) the parents viewed the hospital "as their doctor" (15%). Alpert and his colleagues' findings were similar to the findings of Georgopoulos and Cooke (1980) except that the parents did not identify proximity of the facility as a reason for utilization.

In contrast to Alpert and his colleagues' quantitative study of medical emergency facilities, Resnick and Hergenroeder (1976) conducted a descriptive study of parents and children in a pediatric trauma center. The researchers randomly selected 100 children between the ages of three and 13 and recorded information about the child's injury. In addition, the researchers recorded anecdotal records on the

behaviours and verbalizations of both the child and the accompanying parent. Resnick and Hergenroeder found that most children were admitted to the emergency facility between 3:00 and 11:00 p.m. and the majority of accidents occurred "shortly before the dinner hour or just before bedtime" (p. 38). The researchers identified that approximately half of the children presented at the facility with lacerations that were two inches or less in length and it was the amount of bleeding from the wound, rather than the actual size of the wound, that was "the major factor that caused parents to seek medical attention for the children" (p. 38).

Resnick and Hergenroeder (1976) identified five major themes vis-a-vis parents' reactions to their childs' injury: (1) quieting the child; (2) wanting the child to see the accident as a form of punishment or making the child feel guilty; (3) expressing their own feelings of guilt; (4) showing affection and concern; and (5) displaying anger (p. 39). The researchers found that the vast majority of the parents demonstrated affection and concern for their injured child and preferred to remain with their children during treatment. Twenty-two per cent of the parents asked, however, or were asked, to remain in the waiting room during treatment. The researchers also recorded questions that were asked by the children while care was being administered. The children's questions were related to five areas: (1) curiosity about the procedure and/or emergency room; (2) specific fears; (3) loss of support/mistrust; (4) diversionary tactics; and (5) concern about the immediate future (p. 39). Forty-six per cent of the children in the study had previously been treated in an emergency

room. Resnick and Hergenroeder concluded that the emergency room "is a common part of childhood" (p. 40). Although the researchers conducted the study in a pediatric trauma center, they suggested that the emergency staff needed education in child development and specific problems related to pediatric care in order to improve the care of children in the emergency environment. In addition, the researchers stressed the need for more research into children's reactions to emergency treatment because for many children the emergency department is their only hospital experience. Resnick and Hergenroder also suggested that the emergency staffs' psychological treatment of parents "may be as important as the medical treatment of the child-patient" (p. 40).

Although Resnick and Hergenroeder acknowledged the importance of parents in the emergency setting, they did not focus on the needs of parents or families in the emergency department. Nicklin (1979) conducted a study to determine the needs of families in emergency room waiting areas. Nicklin approached relatives in the waiting rooms one hour after their arrival with a patient to the emergency department. Nicklin's sample included 60 relatives, 30 from each of two emergency departments. Relatives who agreed to participate were telephoned the day following their visit to the emergency department and asked to respond to a questionnaire. Nicklin found that: (1) all waiting relatives wanted information about the patient's progress; (2) eighty-five per cent of the relatives wanted some degree of personal contact with the patient; and (3) only forty-five per cent of the relatives "initiated action to obtain information about the patient"

(p. 42). Nicklin identified three factors that seemed to influence relatives needs for information. First, relatives who had not previously been exposed to an emergency department tended to have a greater need for information, for example, the relatives needed to be familiarized with the "overall routine and process of delivering emergency care" (p. 42). Nicklin suggested that relatives would still require information on subsequent visits but that their need for information would be slightly less than during the first visit. The second factor that influenced the relatives need for information was the acuity of the patient's condition. Nicklin identified that relatives accompanying patients suffering from an acute asthmatic attack needed information more than relatives accompanying patients with a bad cold. Nicklin also noted that relatives who came with patients that had vague symptoms such as abdominal pain needed information. Nicklin suggested that the nonspecific nature of the symptoms was anxiety-provoking for relatives and there was often a long wait for the relatives while the patients underwent a series of diagnostic tests before a differential diagnosis could be made. The third factor that influenced the families' need for information was the physical environment in which the relatives waited. Nicklin found that a waiting room that met the basic needs of the users, that is, accessible washroom facilities, vending machines, and telephones seemed to reduce the relatives' anxiety level and consequently their need for information. Nicklin also noted that the visible presence of a nurse who could give the relatives information tended to reassure the relatives. In contrast, Nicklin identified that relatives' need for

information tended to increase when they waited in a facility that had no visible or readily accessible washrooms, vending machines, or telephones and the chief source of information for the relative was the registration clerk. Nicklin concluded that it was important for emergency nurses to assess the needs of relatives and develop a role for relatives in the emergency department. Nicklin emphasized that it was particularly important to involve the relatives in discharge teaching of the patients.

Only one study (Roskies, Bedard, Gauvreau-Guibault, & Lafortune, 1975) was found that attempted to describe the nature of nurse-parent interactions in the emergency department. Roskies et al. undertook a pilot study "to investigate the reactions of a sample of children, parents, and staff to the first six hours of emergency hospitalization, compared with those of a similar sample to elective admission" (p. 570). Although the researchers' initial focus was observation of the child's reactions, they broadened their study to include observations of the children's parents and the nursing staff in the emergency department and on the inpatient facility. In this study, the researchers observed eight children, ranging in age from 11 to 48 months, from the time of their arrival in the emergency department. The researchers noted that emergency nurses readily became accustomed to their presence in the treatment setting. In a few cases where nurses apparently tried to alter their behaviour, they had difficulty maintaining the change over the long period of observation. Roskies et al. (1975) found parents in the emergency department were preoccupied primarily with the many ramifications of their child's illness and

"less concerned with their child's feelings" (p. 577). In the study the researchers found that only two of the eight parents observed in the emergency department exhibited high levels of anxiety, for example, expressing concern about actions they could have taken to alleviate their child's illness. These two parents stayed with their child as long as they could. All the parents in the emergency department tended to become passive and helpless in the hospital environment abrogating the parental role and assuming the role of information-giver. The investigators also identified that the remaining six parents in the emergency department actually brought their children to the emergency department because they wanted them hospitalized. They noted that the parents' anxiety centered on "whether or not the attending physician would agree to their request for hospitalization" (p. 578) and they expressed considerable relief once the decision to hospitalize was made. The parents in this group were anxious to leave their child once the decision was made and were irritated by the number of questions they had to answer. Roskies et al. concluded that these parents had already abdicated their parental role when the child was discovered to be sick and "the purpose of the emergency visit was simply to get the hospital . . . to accept responsibility for a child that the mother could no longer manage" (p. 578).

Roskies et al. (1975, p. 579) found that emergency nurses tended to see their function primarily in terms of medical urgency. Unlike the nurses on the inpatient units, the emergency nurses did not appear concerned with the psychological wellbeing of parent and/or child in the emergency environment. Roskies et al. noted, however, that "given

a medical and mental health crisis occurring simultaneously," (p. 580) the emergency staff may be quite justified in opting to deal with the medical emergency at the expense of a patient's psychological wellbeing. As the focus of Roskies et al's. pilot study was not the nurse-parent interactions, per se, conclusions about the nature of the nurse-parent interactions in the emergency department cannot be readily determined.

The nature of nurse-parent, nurse-family interactions cannot be readily described by reviewing the literature on emergency services. In Rosenthal, Marshall, Macpherson, and Frenchs' (1980, pp. 87-110) study of inpatient units in an acute care facility, they found that the nurse-family interaction was difficult to define and as families were "outsiders" they were "less subject to control and therefore represent a threat to nurses" (p. 87). In their study, Rosenthal et al. analyzed 46 examples of problem families. Their data were collected in a hospital that had an open visiting policy, that is, no restrictions on visiting hours. The investigators identified that nurses gave families the combined roles of patient and worker simultaneously when family members slipped out of the role of visitors and the relative, rather than the patient, became the focus of the nurses' attention. In the role of worker or patient, a family member became part of the work context and thus more controllable by nurses (p. 101). There was a greater tendency to cast problem family members in the patient role rather than the worker role. Rosenthal et al. suggested that conferring the patient role on family members legitimated "withholding of information from them" (p. 109).

Summary

From the literature, it is apparent that patients' satisfactions with emergency services relate primarily to time spent waiting to be seen and the attitudes and actions of the emergency staff (Georgopoulos & Cooke, 1980, pp. 245-247). It is evident that there has been a significant change in the nature and use of emergency services, that is, the proportion of patients with nonurgent problems presenting for treatment increased while the proportion of patients who required urgent care decreased (Roth, 1978b; Yoder & Jones, 1981). Emergency nurses, however, expect to care for patients in need of urgent/emergent nursing attention (Lewis & Bradbury, 1982; Roth, 1972, 1978a; Yoder & Jones, 1981). As there is a discrepancy between emergency nurses' expectations and the reality of the emergency environment, nurses expend a great deal of time and energy morally and socially evaluating the patients' right to be in emergency departments rather than providing care for patients (Millman, 1978; Roth, 1972, 1978a; Yoder & Jones, 1981).

Emergency staff exercise little control over the types of patients presenting to the department for treatment. Consequently, emergency staff utilize control strategies, such as avoidance, to control patients and/or families (Millman, 1978; Roth, 1972, 1978a). Emergency nurses are described in the literature as "little doctors" (Roth, 1972). It is difficult to define the role of emergency nurses from the available literature. It would appear that the role of emergency nurses is limited to the performance of medically-delegated

functions and traditional nursing tasks.

From the literature, it is evident that families accompanying patients to the emergency department need information about the patient's condition in order to alleviate their anxiety (Nicklin, 1979). It is also apparent that the emergency staff need to be aware of the psychological needs of parents in the emergency department (Resnick & Hergenroeder, 1976). There is information in the literature that suggests parents abrogate their parental role in the emergency setting (Roskies, Bedard, Gauvreau-Guilbault, & Lafortune, 1975). For many children, it is suggested that the emergency department may be the child's only exposure to the hospital (Resnick & Hergenroeder, 1976). There is some evidence in the literature to suggest that emergency staff respond more positively towards children than towards adults and are less likely to resort to control strategies (Roth, 1972, 1978a; Sudnow, 1978). Some researchers (Nicklin, 1979; Resnick & Hergenroeder, 1976; Roskies et al., 1975) have suggested that there is a need to improve the care of children in the emergency setting and for emergency staff to be more cognizant of the needs of families and/or parents. In order to improve the quality of pediatric care in the emergency department, it is necessary to understand the characteristics of nurse-parent interactions.

CHAPTER 3

THE SETTING

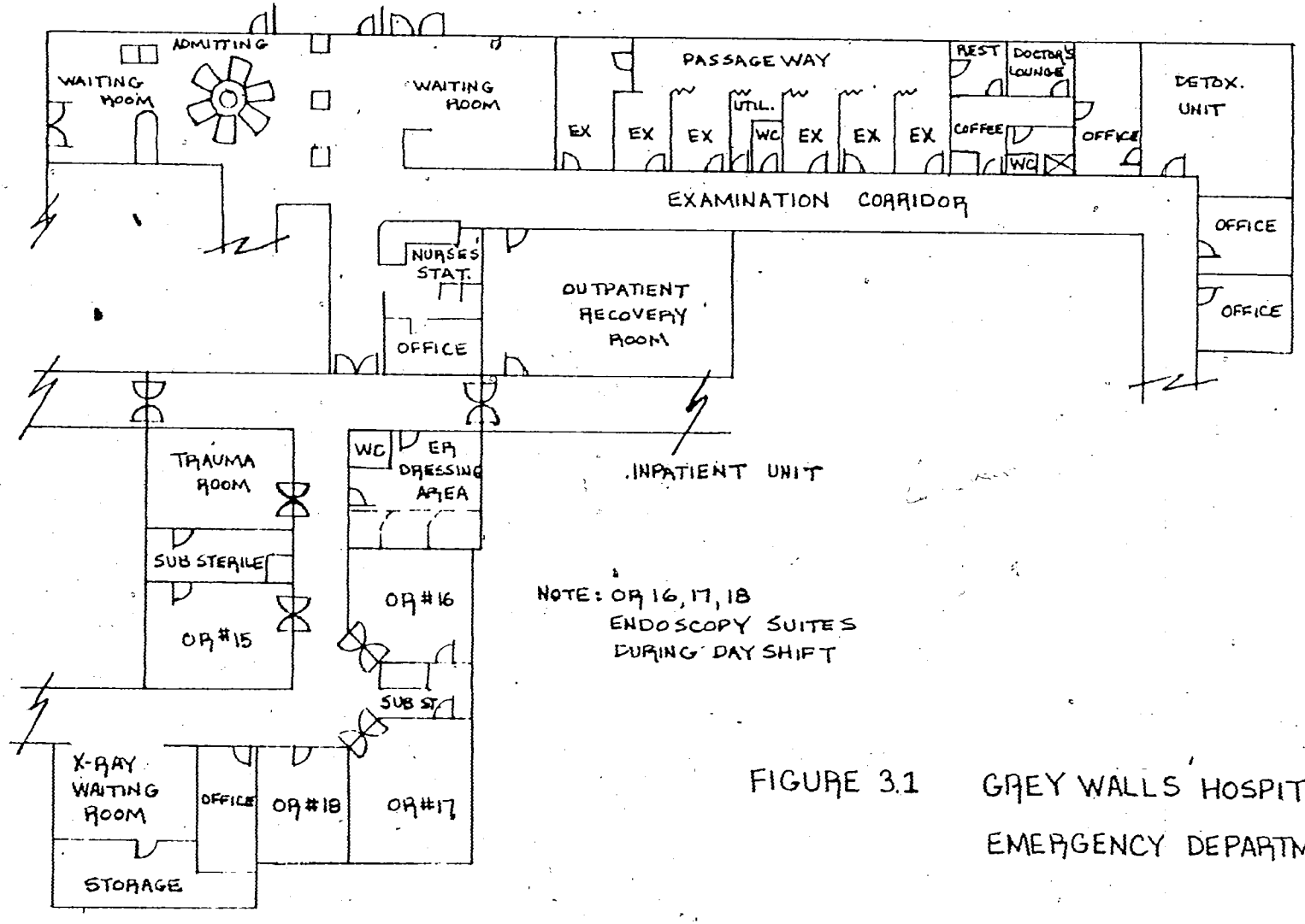
The setting for this study was the emergency department of a 750-1,000 bed urban hospital located in one of the prairie provinces. In this chapter the major characteristics of the setting are presented. Throughout this study, the hospital is referred to by the name Grey Walls' Hospital.

Characteristics of the Emergency Department

The Physical Environment

The existing emergency department at Grey Walls' Hospital was opened in the early 1960's. The physical space was designed to accommodate approximately 30,000 patients per year, but as the volume of patients has almost tripled to approximately 80,000 patients per year the available space has become inadequate. The hospital board has approved plans for a new emergency department and has submitted these plans to the provincial government for approval and funding.

The patients' waiting room is situated directly across from the nurses' station. There are two hallways converging at the nurses' station that divide the department into two areas designated as the examination side and the treatment side (Figure 3.1). On the examination side, there are six separate cubicles that are accessed from the hallway. Adjacent to the examination side is a detoxification unit which is also staffed by emergency nurses.



NOTE: OR 16, 17, 18
ENDOSCOPY SUITES
DURING DAY SHIFT

FIGURE 3.1 GREY WALLS HOSPITAL
EMERGENCY DEPARTMENT

On the dressing side is one room for trauma patients and/or patients requiring resuscitation and a second room which can accommodate ten patients sitting and three patients on stretchers. Stretchers are lined up in both hallways for patient overflow from the examination or dressing rooms. Other departments that are located on the same level or adjacent to the Emergency Department are Admitting, Outpatient Recovery Room, Endoscopy, Plaster Room, and an inpatient orthopedic unit.

The Nursing Organization

In the nursing organization, the Unit Supervisor reports to the Assistant Director of Nursing. The Assistant Director of Nursing is also responsible for the Intensive Care, Coronary Care, Outpatient, and Detoxification Units (see Figure 3.2). Reporting to the Unit Supervisor, Emergency, are four Associate Unit Supervisors and a Clinical Instructor. Other positions that report to the Unit Supervisor are Registered Nurses, (R.N.s), Registered Nursing Assistants, (R.N.A.s), Unit Clerks, Porters, and Service Aides. The emergency staff is divided into four teams each of which is headed by an Associate Unit Supervisor. On each team are nine R.N.'s, one R.N.A., one Unit Clerk, and one Porter. The teams work 12-hour shifts, have the same days off, and maintain a relatively constant composition in terms of their membership. As there are only three service aides, the aides are assigned to day and evening shifts and not designated to one team per se.

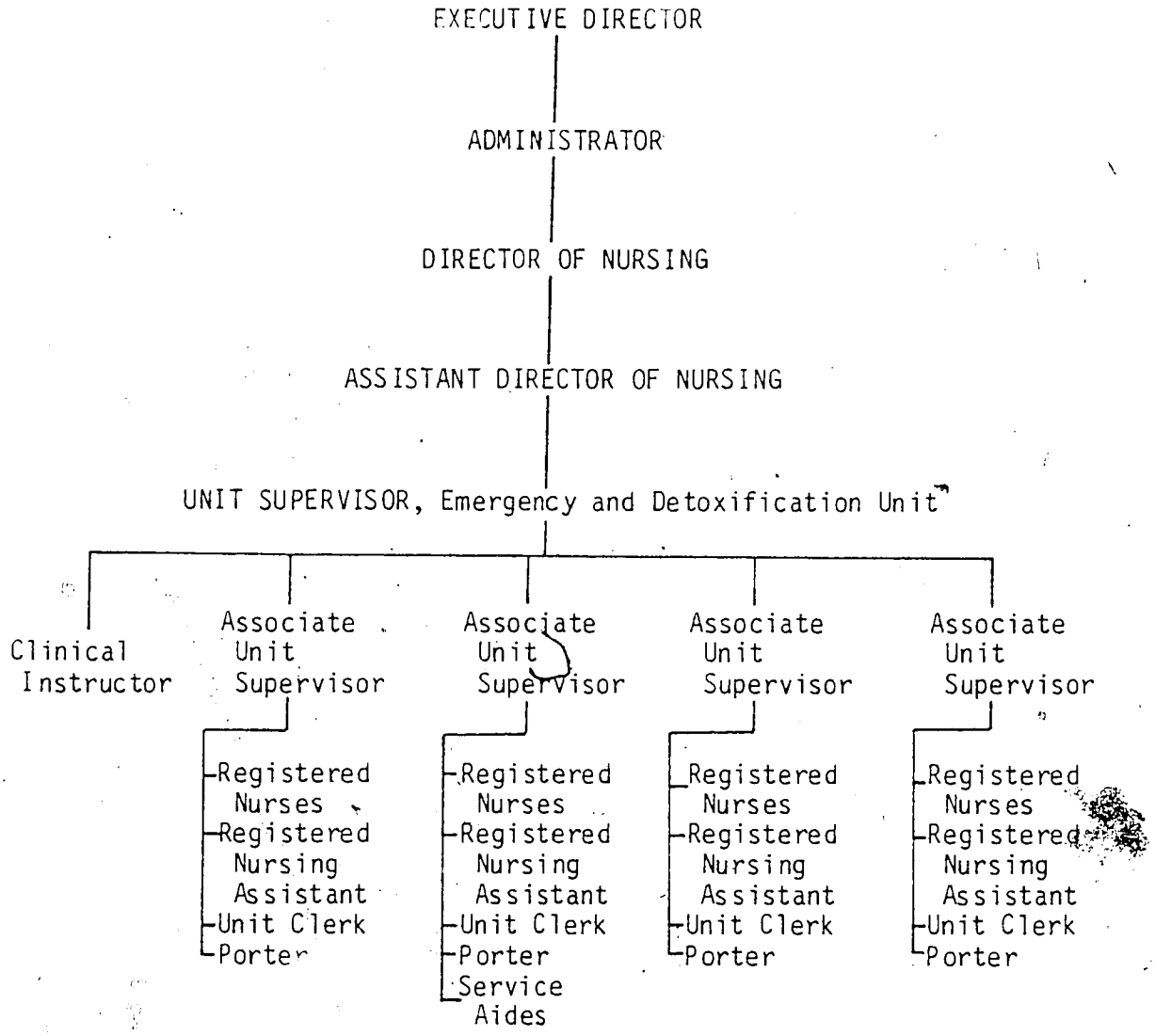


Figure 3.2

Nursing Organization of Emergency Department

The Emergency Staff

The total staff complement for the Emergency Department is 69.

Unit Supervisor	1
Clinical Instructor	1
Associate Unit Supervisors	4
Registered Nurses	45
Registered Nursing Assistants	5
Unit Clerks	5
Porters	5
Service Aides	3
Total	69

Unit Supervisor

The Unit Supervisor is accountable for the overall administration and maintenance of safe patient care.

Clinical Instructor

The clinical instructor organizes monthly inservice programs for the emergency nursing staff and orients new staff to the department.

Associate Unit Supervisors

The Associate Unit Supervisors (A.U.S.'s) primarily work at the nurses' station triaging patients and organizing patient flow through the department.

Registered Nurses

The registered nurses function under the direction of the Unit Supervisor. The nurses are responsible for the provision of safe patient care.

Registered Nursing Assistants

The registered nursing assistants (R.N.A.'s) apply casts and

splints on patient's and assist the registered nurses during cardiopulmonary resuscitation. There is an R.N.A. on each shift in the department.

Unit Clerks

The unit clerks answer the telephones, complete requisitions, and page for physicians and/or staff via intercom and telephone. There is a unit clerk on each shift. When the unit supervisor or associate unit supervisors are involved in other activities at the nurses' desk, it is the unit clerk who takes the patient's char and directs the patient to sit in the waiting room.

Porters

The porters transport patients, specimens, and equipment from the department to other areas in the hospital. There is a porter on each shift.

Service Aides

There are only three service aides working in the department. Consequently, the service aides usually work days or evenings. The service aides clean and stock the rooms, dismantle trays, and order supplies and equipment as needed.

Emergency Physicians

There are seven full-time emergency physicians in the department. The physicians provide emergency services to the hospital on a contract basis, i.e., the physicians are not hospital employees. The physicians work 8-hour shifts and there are three physicians on day

and evening shifts and two physicians on night shifts. To provide physician coverage, the emergency physicians employ general practitioners and/or senior medical residents to supplement their staffing. One emergency physician acts as the Director of Emergency Services. The full-time emergency physicians rotate through the position of Director every two years. The emergency physicians are trained as general practitioners and there are no physicians trained in emergency medicine.

Emergency Patients

Patient visits. Approximately 80,000 patients visited the emergency department during the past year. Forty per cent of the patients utilizing the emergency department were 18 years of age and younger. There was no breakdown of the patient visits according to specific age groups.

Patient flow in emergency department. The patients that enter the emergency department via ambulance are taken directly to the nurses' station. The Unit Supervisor (U.S.) or Associate Unit Supervisor (A.U.S.) assesses the patient and direct the ambulance personnel where to place the patient in the department. A registered nurse is then directed over the intercom system by the U.S. or A.U.S. to go to the area where the patient has been sent. The Admitting Department is notified that there is a patient in the department to be registered.

Patients who enter the department walking or carried by an adult are sent to the Admitting Department to be registered. The patient

and/or parent then brings the emergency chart to the nurses' station. If the U.S. or A.U.S. is busy, the Unit Clerk takes the chart from the patient and directs the patient to sit in the waiting room. When the U.S. or A.U.S. assesses the patient, she determines if space is available in the department to see the patient immediately. When patients can be seen immediately, a nurse is called to the desk by intercom. If no space is available and the patient does not appear to require urgent care, the patient is told to sit in the waiting room.

The U.S. or A.U.S. places the patients' charts on the desk according to whether the patient needs to be seen on the examination or dressing side of the department. When space is available, a nurse picks the patients' chart up at the desk and goes to the waiting room and calls the patient to accompany her to the appropriate area.

Patient waiting areas. The patients' waiting room is enclosed along one side by glass partitions. The nurses at the desk can view all the patients and/or relatives who are either waiting to be seen or are waiting for test results. The patients and/or relatives, in turn, can observe all the activities that are occurring at the nurses' desk. The patients can also observe all patients who enter the department for care either by ambulance or walking. Adjacent to the waiting area are washroom facilities, telephones, and vending machines. There is a separate area for non-smokers but there is not a separate area for parents with small children.

The Detoxification Unit

The Detoxification Unit is a six bed unit that is physically

isolated from the emergency department. One emergency nurse is assigned to care for the patients in the unit who are usually alcohol or drug abusers who have attempted suicide and/or overdosed on drugs or alcohol.

Summary

In this chapter, the major characteristics of the emergency department at the Grey Walls' Hospital were presented. In Chapter 4, the methodology and procedures used in data collection and analysis are presented.

CHAPTER 4

METHODOLOGY AND PROCEDURES

Introduction

The purpose of this study was to discover how nurses treat and respond to parents of children who can not articulate their own needs in the emergency setting and to identify factors that may influence the care provided. In this chapter, the research methodology will be presented. The applicability of Goffman's framework for analyzing social interactions in an emergency department will be reviewed and the procedures used in this study will be presented. The issues of validity and reliability will be discussed in relation to this study.

Goffman's Framework

In Goffman's (1959, pp. 1-3) analysis of social interactions he defined communication as verbal and non-verbal behaviours which express and give off the impression of role performance. The underlying assumptions in Goffman's framework for analyzing social interactions are:

1. the human being makes a presentation of self and his activities when in the presence of others;

2. the human being seeks to acquire information when in the presence of others; and

3. the human being attempts to guide and control impressions others form of him.

Goffman uses the language of the theatre, i.e., actor, stage, performance and audience, to analyze interactions. Goffman (1959) contends that his perspective is valid for studying social life that is organized within an institution. Goffman's perspective for analyzing social life has been utilized in part by Soares (1978) to describe verbal useage in an intensive care unit, and by Rosenthal and her colleagues (1980) to analyze nurse-patient interactions on inpatient units in an acute care facility.

Utilizing Goffman's framework one can view the nurse-parent interaction as a performance that is staged in the environment of the emergency department. The nurse and physician may be viewed as performers acting individually or united in a team, i.e., assuming the parents accepts their audience role. Within the emergency environment, nurses and physicians can maintain their performer roles through strategies such as information control. Successful staging of performance provides the parent with a frontstage view of the emergency department. Performance disruptions may occur when parents choose to become actors by creating a scene or the united front of the team is broken, resulting in unsuccessful staging of the performance and providing the parent with a backstage view of the emergency department.

Participant Observation: Implications for Research

The problem posed in this study was to identify the characteristics of parent-nurse interactions and the context within which these interactions occur in an emergency setting. In order to do

this, the investigator assumed the roles of a participant-as-observer and observer-as-participant in the emergency department. Gold (1969) describes four major roles that an investigator may assume when establishing relationships in the field. These roles include: the complete participant, the participant-as-observer, the observer-as-participant, and the complete observer. The complete participant immerses herself in the research environment, disguising her true identity and the purpose of the research from the informants in the field. In contrast, the complete observer withdraws totally from social interaction in the field. In the participant-as-observer role, the investigators' identity and purpose for being in the research environment are known and data are gathered both formally and informally. The role of observer-as-participant is most often assumed by field workers when there is only one or two interviews. In this study, the investigator assumed the role of observer-as-participant during observations of nurse-parent interactions and participant-as-observer during social interactions with the emergency staff.

The term, participant observation, suggests direct involvement in the community life of the people being studied, i.e., observing and talking with people in an attempt to learn from them their view of reality (Agar, 1980, p. 114). The technique utilized by the participant observer includes direct observations of relevant events; informal interviews with members concerning their motives, intentions, and interpretations of events; indirect observations obtained by seeking out informants for their unique perspectives and by analyzing records and documents that pertain to the organization; and

participation in the group activities (Denzin, 1978, p. 255; McCall & Simmons, 1969, pp. 1-4). The problem that the participant observer confronts when using participant observation techniques are:

1. gaining entry into the group to be studied;
2. establishing and maintaining a social identity that facilitates interaction and observation;
3. attempting to fit into the social structure without altering the behaviour of those observed;
4. maintaining objectivity when faced with new experiences;
5. developing a dependable method for recording field notes;
6. leaving the field situation at the appropriate time (Denzin, p. 256).

When using participant observation in research, it is important that the investigator maintain a quality of open-endedness in study design and receptiveness within the study to the subjects' conceptions of reality (McCall & Simmons, 1969, p. 19).

The process of participant observation involves three major phases. In the intitial phase of fieldwork, the investigator is involved in a period of general observation attempting to determine the meaning of events by listing and grouping behaviors. During the second phase, the investigator is beginning to make sense of the flow of events and identifying tentative propositions and developing categories. In the final phase, there is a systematic effort to identify propositions and develop categories (Strauss et al., 1969, pp. 24-25).

In this study, the observer sought to observe how nurses treated and responded to parents in an emergency setting. In the context of this study, participant observation is concerned with:

1. describing the characteristics of nurse-parent interactions and the content within which these interactions occur, and

2. identifying the parent's perceptions of nursing care in the emergency department.

Reliability and Validity

In research that uses participant observation, there are major problems associated with reliability and validity. The objective of such research is to interpret the world as perceived by its inhabitants (Field, 1980, p. 47). The intent of participant observation "is to prevent imposing alien meanings upon the actions of the subjects" (Vidich, 1969, p. 79). The standard measures of ascertaining validity and reliability of data collection, however, are not generally applicable to studies that use participant observation (McCall & Simmons, 1969, p. 77). Rubin and Erickson (1978, p. 139) contend that "validity is the essential criterion of the design" and "reliability is the essential criterion of data collection". As reliability "refers to the extent to which studies can be replicated" (LeCompte & Goetz, 1982), it is essential to thoroughly describe the strategies that were used to gather data. Duignan (1981) notes that it is incumbent upon the investigator to explicate the methods and procedures of recording and analysis. According to Zelditch (1969, p. 9), one criterion of "goodness" of a procedure is "informational adequacy, meaning,

accuracy, precision, and completeness of data." It is also critical to establish that the techniques used in participant observation were employed systematically, comprehensively, and rigorously (McCall & Simmons, 1969, p. 77). While LeCompte and Goetz (1982) acknowledge that "human behavior is never static" and consequently it is not possible to replicate exactly studies that utilize ethnographic techniques, they stress the importance of specifying "precisely what was done to avoid serious problems with reliability" (p. 36).

In this study, the investigator conducted a pilot study to test the appropriateness of data gathering techniques, observer reliability, and the suitability of the guide for use in the follow-up interviews with the parents. During the pilot study, the investigator's interpretation of events was checked with the subjects in the field. The data recorded in the field were reviewed by the thesis supervisor to monitor and evaluate the observations and follow-up interviews with the parents. Throughout the study, the investigator continually checked her interpretation of events through informal interviews with emergency personnel and follow-up interviews with parents who participated in the study. In all phases of data collection, the investigator's field notes and her analysis of events and interactions were reviewed by the thesis supervisor in order to evaluate the researcher's interpretations and perceptions of the data.

It is argued that once reliability is established, validity is not an issue in observational studies if the investigator explicates precisely "both the processes and evidence used in arriving at his conclusions" (Duignan, 1981, p. 294). LeCompte and Goetz (1982)

contend, however, that validity may be the major strength of studies that utilize ethnographic techniques. The authors note that validity is derived from the data collection and analysis techniques that are used by the researcher. LeCompte and Goetz identify that participant observation is a key source of data collection and the participant observer collects data in a natural setting that reflects "the reality of life experiences of participants" more accurately than in a contrived setting (p. 43). Further, the participant observer is continually analyzing, questioning, and re-evaluating the data throughout all phases of the research. LeCompte and Goetz discuss a number of issues that threaten the validity of research utilizing ethnographic techniques. The issues that are applicable to this study are reviewed and the measures taken by the researcher in this study to address the issues are presented.

LeCompte and Goetz (1982) identified that it was important when gathering data through participant observation to be aware of the impact of the observer's presence. In this study, the investigator withdrew from the field for one month in order to avoid "going native" (Gold, 1969) and to reconfirm her primary role as an objective researcher (LeCompte & Goetz, 1982). As the researcher's own work experiences were in an emergency setting, it was necessary to determine that the data collection techniques diminished researcher bias. The researcher's interpretations in the field were checked with more than one individual when in the emergency setting. Also, when the researcher grouped the data into categories, the researcher reviewed the data and the categories with the thesis supervisor in order to

reinforce that the categories were supported by the data and reflected the way participants experienced reality (LeCompte & Goetz, 1982).

The Setting

The setting for the study is the emergency department of a 938-bed hospital located in one of the prairie provinces. There are approximately 80,000 patients processed through the emergency department annually. Within the emergency department, there is also a detoxification unit.

The overall administrative responsibility for the emergency department and the detoxification unit is vested in the executive director of the hospital. Reporting to the executive director is an administrator. A director of nursing is accountable to the administrator, and is responsible, with an assistant director of nursing, for nursing services in the department. Within the emergency department, there is a unit supervisor, whose role is administrative, and four associate unit supervisors. Other staff reporting to the unit supervisor are registered nurses, registered nursing assistants, unit clerks, porters, and service aides. There is also a clinical instructor who is responsible for continuing education programmes for the staff.

The responsibility for medical administration in the hospital is vested in the associate executive director who reports to the executive director. In the emergency department, there is a director of emergency services and a physician in-charge of the detoxification unit. The director of emergency services is appointed for a two-year

period by the full-time emergency physicians. There are seven full-time emergency physicians who provide medical coverage on a contract basis with the hospital. The physician in-charge of the detoxification unit is appointed by the associate executive director, medical services, and is a permanent appointment (see Figure 4.1).

The Methodology

The key to effective observation and interviewing in a study setting depends on the methods used to gain entry, establish credibility and explain the study to all participants (Dean et al., 1969, pp. 68-70). In this study entry was negotiated at two levels, the hospital and the emergency department.

Negotiating Entry

The request to undertake the study was submitted to the hospital administrator. The administrator responded within one month and agreed that the study could be done if formal approval was granted by the hospitals' clinical investigation committee. The administrator also suggested that the study be discussed with the assistant director of nursing who was responsible for the emergency department. The assistant director of nursing was contacted and agreed to meet with the investigator, along with the unit supervisor in the emergency department once formal approval had been granted for the study by the clinical investigation committee.

Formal approval for the study was received from the hospitals' clinical investigation committee four months after the initial request

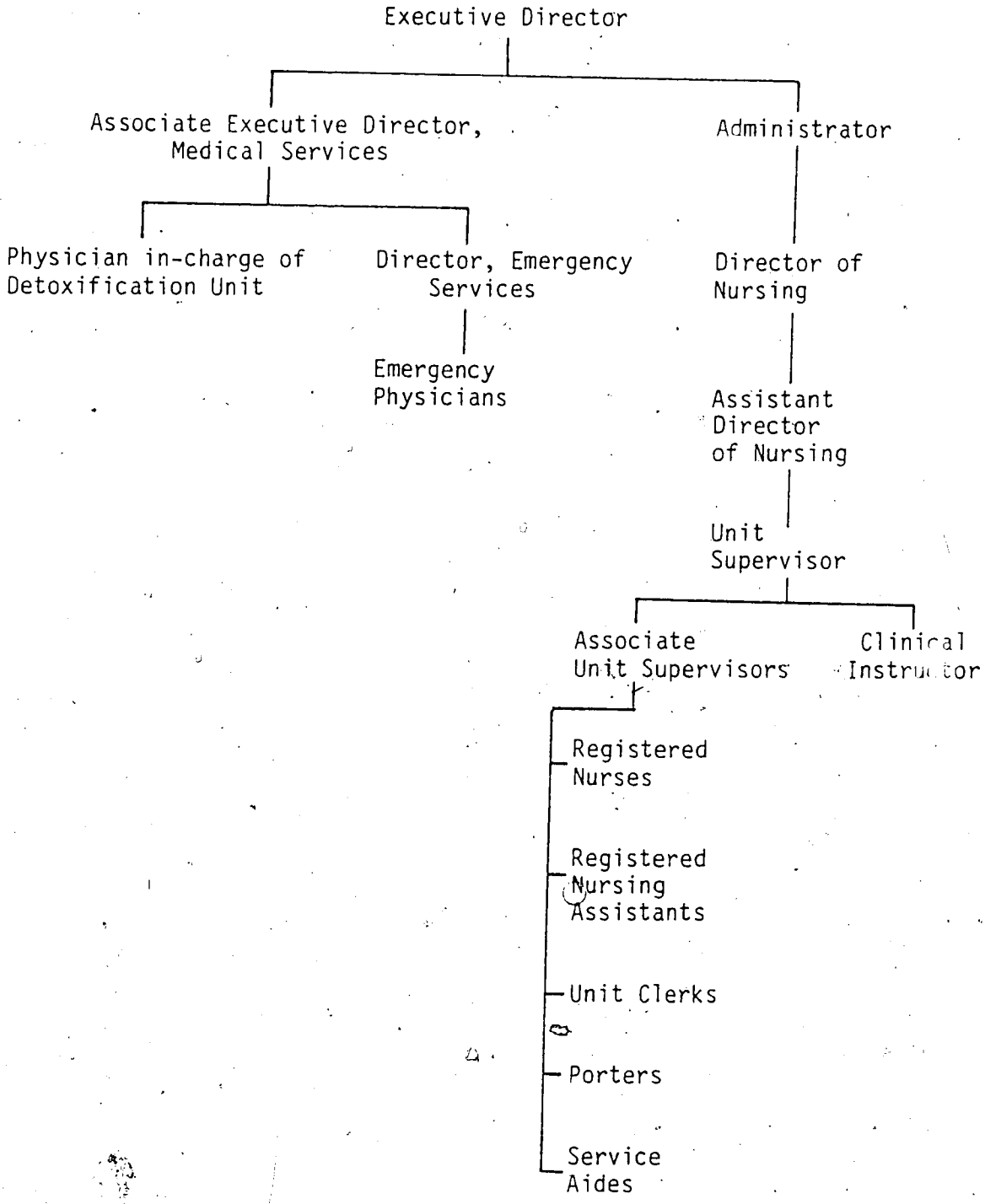


Figure 4.1

Organization of Emergency Department

to undertake the study. The committee chairman notified the investigator that the study could be undertaken but that there would be one restriction, only parents bringing their children to the emergency department to be seen by an emergency physician could be included in the study. The reason for the limitation was that over 300 private physicians used the hospital emergency facilities and the clinical investigation committee did not see that it was feasible to contact that large a group.

Following formal approval for the study, a meeting was held with the assistant director of nursing and the unit supervisor, emergency department to discuss the study. The purpose of the study was reviewed and it was agreed that:

1. an information letter (see Appendix A-1) explaining the study would be prepared for the registered nurses;

2. the unit supervisor would review the information letter for content;

3. the information letter would be distributed to the registered nurses along with the nurses' consent form (see Appendix B-1) by the associate unit supervisors;

4. the unit supervisor would orient the investigator to the physical environment of the emergency department; and

5. the unit supervisor would provide the investigator with a list of registered nurses and a set of blueprints of the department.

At subsequent sessions with the unit supervisor, the information letter prepared by the investigator was revised; agreement was formalized by letter on the schedule for observation periods in the

emergency department see Appendix A-2); and arrangements were made for the investigator to obtain an identification badge. Two weeks following the initial meeting, the investigator was oriented to the emergency department by the unit supervisor. Forty-eight envelopes containing the information letter, nurses' consent form, and a self-addressed envelope were also given to the unit supervisor for distribution to the registered nurses by the associate unit supervisors. The registered nurses who agreed to participate in the study returned their signed consents to the associate unit supervisors. The investigator collected the nurses' consents over a two-week period. All but one registered nurse agreed to participate in the study. Seven months after the initial request to undertake the study was submitted to the hospital administrator, the investigator commenced observation periods in the emergency department.

Pilot Study

During the first three observation periods in the emergency department, a pilot study was conducted. The purposes of the study were:

1. To acquaint the researcher with the environment of the emergency department at the hospital.

2. To test the feasibility of the observer role and data gathering techniques.

3. To test observer reliability.

The findings of the pilot study are presented.

Prior to the first observation period the investigator had not

been introduced to any members of the nursing staff except the associate unit supervisors. In the pilot study, the investigator met with the nurses in the informal environment of the coffee room. The purpose of the study and the investigator's role as an observer in the department were explained to the staff. The nurses clarified for the investigator their work assignment in the department and aided in the familiarization to the physical environment of the department. Throughout the pilot study, the investigator continued to meet with and explain the study to nurses, emergency physicians, and auxiliary staff. The nurses were generally positive in their response to the investigator and supportive of the purpose of the study.

In conjunction with the associate unit supervisors and nursing staff, it was agreed that the investigator would sit at the nurses' desk in order to identify parents who were possible participants in the study. It was found that the appropriate time and place for the investigator to approach parents and request the parent's written consent (see Appendix B-2) to observe nurse-parent interactions was primarily determined by the nature of the child's illness and the activity level of the department. The associate unit supervisors decided whether the child needed to be seen by a physician immediately or could wait with the parents in the waiting room. When the activity level in the emergency department was low, the parents and child would frequently be directly escorted to a treatment area. When the activity level was high, the parents and child would be directed to the waiting room until a treatment room was available.

If the parents were placed in the waiting room, the investigator

approached the parents and explained the purpose of the study, the investigators' role in the study, and then requested their written consent to observe the nurse-parent interactions. When children were taken immediately to a treatment area, the investigator explained the purpose of the study to the parents and requested oral consent to observe nurse-parent interactions. The parent's written consent was obtained after the nurse had completed her assessment of the patient. When the observation of the nurse-parent interaction was completed, the investigator requested the parent's oral consent to contact them by telephone and arrange a follow-up interview with them in their home.

During the pilot study, the observer tested three tools designed to facilitate collecting information and recording data. The data collection sheet (see Appendix C-1) was used primarily to record time and place of initial observation; activity level of the emergency department; and manpower information. The patient information form (see Appendix C-2) was completed from information on the patient's chart and supplemented with information from the parents. The interaction collection sheet (see Appendix C-3) was used to record the verbal and non-verbal behaviours during the observation periods.

When a child was taken to, or placed directly in, a treatment area, the observer found that the child was placed on a stretcher or an examination table by the nurse. The observer sat on a chair across from the nurse and parents and recorded the time and salient points about the interaction. In the pilot study, the observer identified that the interactions between parents and nurses occurred over short periods of time. When the nurse left the treatment area, the observer

also left and recorded the interaction in detail.

A guideline for the interview with parents that was developed was modified slightly following the first three interviews (see Appendix D). In the initial interviews, the parents were asked:

> After your child was seen by a nurse did the nurse tell you how serious your child's illness or injury was?

The parents found the question to be repetitive as they believed that they answered it when they were asked to recall what they remembered about the nurses who cared for their child. Consequently, the question was deleted from the guideline.

The observer's intent was to follow-up the parents within one week of their visit with their child to the emergency department. However, it proved not to be feasible to interview parents within one week when their child was admitted to the hospital. In the pilot study, one set of parents were interviewed seven days following their child's discharge from the hospital which was ten days after their visit to the emergency department. Prior to commencing the interview, parents were asked to sign a second consent form (see Appendix B-3).

A tape recorder was used during the interview with the parents. When parents refused to allow the use of the tape recorder, the responses to the questions were written and then recorded into the tape recorder in detail after the interviewer left the home.

Summary of Entry into the Field

Prior to formal data collection, the investigator met with the

unit supervisor on three separate occasions over a two-week period. During these meetings, the investigator became familiar with the organization of the department vis-a-vis assignment of nurses; scheduling of nurses; patterns of patient flow; physical facilities; and the coverage provided by physicians and auxiliary staff. Two weeks elapsed between the last meeting with the unit supervisor and the first observation period in the department. During this time period the investigator returned to the department to collect nurses' consents. The investigator tested the instruments used for data collection and interacted with nurses and other staff providing care in the department during the pilot study. The coffee room was identified as the best area to observe patterns of social interaction within the department. Entry into the department occurred over a six-week period. This time was essential for the investigator to gain acceptance by the staff and establish her role in the department.

Presentation of the Study

Nurses

In the emergency department, there was a work sheet at the nurses' desk for the nursing staff that identified the area to which the nurses were assigned and their schedule for coffee and meal breaks. When the investigator was observing in the department, it was noted on the nurses' assignment sheet.

The nurses in the emergency department worked in four teams on 12-hour shifts that started at either 0700 hours or 1900 hours. The investigator met the majority of registered nurses in the department

during the first three observation periods because there were two different teams of nurses in the department during the evening. Initial contact with the nurses was made in the coffee room. When asked about the reason for the study, the investigator explained the purpose of the study to the nurses and stated that she was attempting to describe only one aspect of emergency nursing, that is, nurse-parent interactions. Direct questions from the nurses about the investigator's qualifications to undertake a study of emergency nursing were answered honestly, but information was not volunteered. The nurses expressed concern about confidentiality of data and were reassured that they would not be identified by name in the study. The nurses were also told that they could withdraw from the study at any time.

Initially, exchange amongst the nurses in the coffee room was at a social level when the investigator was present. The nurses, however, rapidly became accustomed to the presence of the investigator and openly discussed their views on a number of topics, for example, physicians, patients, patients' families, and emergency nursing.

Parents

When parents were approached for consent to observe nurse-parent interactions, the investigator explained that she was a nurse doing a study on emergency nurses and their response to parents and children in the emergency setting. In the situation where parents were approached in the waiting room, they were also told that if they agreed to participate in the study, they would be contacted by telephone the

following week and a time would be set-up for a follow-up interview in their home. Two sets of parents chose not to participate in the study when approached in the waiting room.

In the situation where parents were approached in the treatment area, the investigator requested permission to contact them the following week for a follow-up interview when the observation period was over or at a time when there was no emergency personnel interacting with the parents. In one situation, the mother consented to participate in the study and the father refused when he arrived in the treatment area. All parents were assured that they would not be identified by name in the study and that they could withdraw from the study at any time.

Process of Data Gathering

Data were gathered through the techniques of participant observation which included direct and indirect observation in the emergency department such as extraction of information from the patient's emergency chart, and informal interviews with emergency personnel and with parents following their child's discharge from the emergency department or the hospital. Observations were conducted in the evenings over a five month period commencing in March and ending in July 1983.

The Observer's Role

In this study, the investigator took the roles of observer-as-participant and participant-as-observer in the emergency department.

In these roles the investigator identified the purpose of her presence with all staff members and the clients that were approached to participate in the study. It was necessary to reiterate throughout the observation period that the study was limited to parents with children who could not articulate their own needs and to parents who were seeing an emergency physician, not meeting their own physician in the emergency department. The investigator commenced the observation period by sitting behind the associate unit supervisor at the nurses' desk. During the observation period, the investigator engaged in social interaction with various staff members and accompanied nurses to coffee breaks if there were no clients in the department.

When the investigator approached parents to participate in the study, the observer identified that she was a nurse and that she was studying nurses and their response to parents in the emergency setting. The investigator also explained that she would be contacting them for follow-up interviews in their home. When the observer was involved in direct observation of parent-nurse interactions, the investigator did not participate in the nurses' assessment of the patient or in the provision of direct care to the patient. The investigator did assist the nurse and/or parent when invited to do so, for example, assisting a nurse to position a child being prepared for a lumbar puncture of the spine when the parent was requested to leave the room during the procedure.

The nurses were observed interacting with parents at the nurses' desk, in the waiting room, in the examination and/or treatment areas, in the hallways, and in the emergency x-ray waiting room. The pattern

and frequency of observations of parent-nurse interactions was determined by patient flow through the department and the activity level in the department. It was understood by the nurses that the observer was a participant primarily for research purposes, consequently the investigator was able to clarify with the nurses nursing actions and/or procedures observed during nurse-parent interactions. The research role also encouraged the nurses to share unsolicited information, particularly during coffee breaks, or in casual meetings at the nurses' desk, or in the hallways of the department. These casual meetings were useful as the observer was able to verify contextual factors that were affecting the child's stay in the department, for example, waiting for laboratory results or x-ray results. In addition, the casual contacts with nurses provided the observer with information on the role of the emergency nurse, the nurses' perceptions of the environment, and their reactions to patients or other personnel. Throughout the observation period, information was constantly being collected from the nurses.

Field Notes

Field notes were constructed from data recorded on tools (see Appendix C-1, C-2, C-3) designed to facilitate data collection from the beginning of the observation period. During observations of nurse-parent interactions, the investigator recorded salient points of verbal and non-verbal behaviour and reconstructed the interactions in detail when the interactions were completed. The observer excused herself from the parents' presence and sought out an area adjacent to

the parent to record details.

A closed notebook 11" x 7" with a clipboard and pockets was found to be the easiest method for recording field notes. Data collection sheets, patient information forms, parent consent forms, looseleaf paper, and additional interaction sheets were stored in the pockets of the notebook. Information gathered through casual meetings was briefly recorded on loose-leaf paper and reworked following the observation period.

Interviews

Semi-structured interviews were conducted with the parents during the week following their child's discharge from the hospital. The parents signed a consent form and the interviews were taped when the parents agreed. The follow-up interviews with the parents were arranged in the emergency department and confirmed by telephone the following week. The investigator encountered problems arranging the follow-up interview. The investigator observed 16 parents in the emergency department but successfully completed only 12 follow-up interviews. With the agreement of the thesis supervisor, two of the 12 follow-up interviews were completed by telephone when appointments with the interviewer were cancelled and could not be rescheduled. The reasons for not interviewing all of the parents were

1. Two mothers decided that they did not want to participate when they were contacted by telephone the week following their visit to emergency because they were too busy to schedule an interview.

2. One father was angry about his child's care in the emergency

department and refused to allow a follow-up visit when his child was discharged from the department.

3. One mother who had agreed to participate had apparently vacated the apartment the night prior to the interview with the investigator and there was no forwarding address.

Emergency Chart

The patient's emergency chart was used to extract information about the child's admission diagnosis, the home address, and treatments or procedures ordered for the child while in the department. Information related to the child's age, address, and telephone number was verified with the parents when the consent was obtained for observation of parent-nurse interactions. The nurses' recorded vital signs and neurological information on the emergency chart but did not record nurses' notes on the chart.

Data Analysis

Initial Phase of Data Analysis

In the initial phase of data analysis, the investigator read field notes looking for patterns of behaviour, significant incidents, and frequently recurring actions of the nurses in an attempt to generate tentative propositions. The field notes were reviewed with the thesis supervisor to enable the supervisor to monitor and evaluate the observation and follow-up interviews and recommend approaches for further observation and semi-structured interviewing.

Goffman's framework was utilized to provide direction throughout

the analysis. Throughout the analysis the following questions were considered:

1. What are the characteristics of parent-nurse interactions in the emergency room?

2. What are the parent's perceptions of nursing care in the emergency room?

3. How are these a function of the context and particular types of situation?

Table 4.1 shows the relationship of the research questions, to the framework, the data gathering, and the analysis.

The Interactions

There were 16 nurse-parent interactions recorded by the observer during the observation period. The interactions were coded according to case number, child's admitting diagnosis, age, and whether follow-up with the parents occurred. The age range of the children in t tudy was seven and one-half weeks to three years. Four of the children required admission to the hospital. The cases are summarized in Table 4.2.

Coding of Data

Using Goffman's framework, the data were analyzed according to the backstage view, the frontstage view, and the success of the actors' performances, i.e., impression management in the emergency department. The data were then colour-coded according to the perspectives of the actors and audience.

Table 4.1

The Relationship of the Research Questions to the Dimensions of Interactions, Dimensions of Goffman's Communication Framework, Major Data Gathering Techniques and Data Analysis

Research Questions	Dimension of Interaction	Dimension of Goffman's Communication Framework	Major Data Gathering Techniques	Data Analyis
Characteristics of parent-nurse interactions	Verbal and non-verbal actions	Processes by which actor establishes performance. Interaction[1] between actor and audience	Informal conversations observations. Nurse-client observations	Listing and grouping behaviours. Identifying tentative propositions
Parents perceptions of nursing care	Actions Judgements	Process by which audience responds to performance. Interaction between actor and audience	Nurse-client observations. Post-visit interview	Listing and grouping behaviours. Identifying propositions. Developing categories.
Context, type of situation	Actions Judgements	Processes of impression management, i.e., performance is successfully ("front stage" view) or unsuccessfully staged ("back stage" view)	Nurse-client observations. Post-visit interview	Listing and grouping behaviours. Identifying propositions. Developing categories.

[1] Interaction between the actor and her audience is observed as the nurse nurses the client and interacts with parents and team members.

Note. Adapted from An Ethnography: Four Nurses' Perspectives of Nursing in a Community Setting by P.A. Field, 1980, p. 68. Copyright by P.A. Field. Adaptation by permission.

Table 4.2

A Summary of the Cases

Case Number	Child's Diagnosis	Age	Follow-up Yes	Follow-up No
01	Possible overdose	18 mos.		x
02	Diarrhea	8 mos.	x	
03	Allergic reaction	10 1/2 mos.	x	
04	Cut lip	19 mos.		x
05	Bilateral ear infections	14 mos.		x
06	Ear infection	9 mos.		x
07	Influenza	7 mos.	x	
08	Possible overdose	2 years	x	
09	Lumps behind ears	2 years	x	
10	Eye infection	15 mos.	x	
11	Fever	16 mos.	x	
12	Cut chin	18 mos.	x	
13	Fever	4 mos.	x	
14	Hernia	7 1/2 weeks	x	
15	Cut forehead	3 years	x	
	Convulsions	22 mos.	x	

Ethical Considerations

In studies that utilize participant observation, it is imperative that the observer demonstrate respect for individual autonomy and the basic human right of privacy (Cassell, 1980; Fox, 1976, pp. 211-212). It is essential that all participants receive an explanation of the purpose of the research and consent to the researcher's presence in the field. In addition, it is critical that the participants realize that:

1. they are free to withdraw from the study at any time,
2. all information received by the investigator during the study is confidential,
3. their anonymity will be protected.

For the nurses that were involved in this study, the researcher drew up a consent form. The researcher explained to the nurses that participation in the study was voluntary. Further, they could initially decide to participate and then withdraw at anytime. Although verbatim quotes were used in the analysis of the data, the researcher did not refer to any nurse by name or use description that would comprise their anonymity.

As the circumstances of the child's admission to the emergency department were not known in advance, it was expected that the investigator would not always have the opportunity to explain the purpose of the study to the parents and obtain written consent in advance of the observation. In these situations, the researcher introduced herself to the parents, explained the purpose of the study,

and requested their permission orally to observe the nurse-parent interactions. The investigator followed up with the parents after the observation period and requested them to sign the consent. For the semi-structured interview, a second parent consent was utilized. Again, the researcher stressed to the parent(s) the voluntary nature of participating in the study and the confidentiality of information. The parents were informed that all data collected that identified their child or themselves would be destroyed when transcription and coding of information was completed. Access to the raw data was limited to the thesis supervisor and committee members.

Finally the hospital was not identified in the study by name or descriptive format that would comprise the anonymity of the institution.

CHAPTER 5

DATA ANALYSIS

In this chapter, the analysis of the data, utilizing Goffman's framework, will be presented. The data are organized according to the backstage view, frontstage view, and successful staging of the performance, i.e., impression management of the actors in the emergency department.

The Backstage

The backstage is the place where the actors (the nurses) may knowingly contradict the impression that they wish the audience to have of their performance when they are on stage (Goffman, 1959, p. 112). It was necessary to analyze the nurses' beliefs and impressions of the emergency setting in order to identify similarities and/or differences in the nurses' performances when they were backstage and when they were performing in front of the parents. The data were organized according to the nurses' impressions of emergency nursing; nurses' responses to patients; and finally the nurses' perceptions of children and/or parents.

Nurses' Impressions of Emergency Nursing

The nurses expressed ambivalence about emergency nursing and their contribution to patient care in the emergency department. It is evident in the following conversations:

1st R.N.: It's frustrating sometimes because you really know what you're supposed to be doing, what rea

emergency nursing about?

2nd R.N.: It isn't what I expected.

The second nurse continued to say that she expected to look after emergency patients, "you know, people who've been in accidents or having severe medical problems, like cardiac arrests" but that was "not what it's about" as "most of the people (who) come in could be seen in a doctor's office."

In the second example, a nurse said to the observer that she was interested in pursuing a degree programme in nursing.

> You know I [am] serious . . . I think I need to do it [a degree] or something, I'm stagnating here, work has become a hassle, I don't look forward to coming in but I really like most of the kids I work with . . . it would be hard to change . . . and I like never really knowing what's going to come through that door.

There was disagreement amongst the nurses about their contribution to patient care. One nurse argued that "nurses couldn't really help patients" because in the emergency department the "opportunity to be with one patient for a period of time was limited." This was because nurses were assigned by areas and therefore had little opportunity to discuss anything with patients. The nurse believed that "nurses couldn't make any decisions" about patients and noted that only emergency physicians made decisions about patient care. A second nurse stated that nurses "did contribute and could have the opportunity to give input" to patient care but it was dependent on the physician. The nurses' awareness that their role in patient care may be limited was apparent when a nurse asked the observer if parents in the study were

perceiving nurses "as good guys or bad guys?" A second nurse stated:

2nd R.N.: I bet that you're going to find that they don't remember anything about nurses.

1st R.N.: How can they? We're not exactly highly visible . . . running in and out of rooms, moving patients in and out.

2nd R.N.: I guess, but I think people only care what the Docs think and do.

The nurses agreed that there were "no easy answers" and they still liked emergency nursing because you "never really know what to expect."

There was a tendency for emergency nurses to link nursing care to performing technical skills for the patient. In one conversation a nurse was upset because she had not had the opportunity to care for a patient who had had a cardiac arrest and stated to her colleague:

1st R.N.: Geez, you guys have all the luck . . . just my luck to be on the wrong damn side (referring to her assignment to the examination side rather than the dressing side as all emergency cases are placed in the trauma room).

2nd R.N.: Ah, who cares, it was really neat.

Observer: Why do you say that?

2nd R.N.: Well, I felt like I was really doing something you know, this guy was really an emergency, what it's supposed to be all about (pause) this wasn't the usual crap.

In another situation, the observer asked:

Observer: What do nurses do when a patient like a trauma patient or one with chest pains is admitted?

1st R.N.: After you do vital signs, you will probably start an IV without a doctor's order, but most of the time the

doctor gets in the room quickly when the patient is really sick.

2nd R.N.: But it's okay to start IV's after you do the initial vital signs and get a history, you know.

One nurse argued that nurses should be trained at the level of the paramedics. When asked by the observer what specific skills nurses should be trained in, the nurse responded:

1st R.N.: Oh, you know . . . like A.C.L.S.,[1] starting caths[2] . . .that kind of thing.

2nd R.N.: I don't agree. To be good at those things you need to do them a lot, and we just don't see enough patients that we could stay good at doing things.

1st R.N.: Oh, bullshit! That's what it's all about.

Although one nurse viewed emergency nursing as "taking crap from the garbage of the world," the nurses generally seemed to like the environment of the emergency department particularly when the activity level was high. As one nurse succintly stated: "God, it's been a hell of a day, like the old days, bodies all over the place." During the observation periods in the department, the observer identified only four shifts of a total of eighteen shifts when the activity level in the department was high. During low levels of activity, the nurses complained that it was "a real drag when you're on a 12-hour shift" and they'd "rather be busy". Although the nurses apparently preferred to

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1 A.C.L.S. refers to Advanced Cardiac Life Support.

2 "Caths" refers to inserting arterial lines into patients to monitor blood pressures.

3 R.T. refers to respiratory technicians

work when the shift was busy, they expressed dissatisfaction about the utilization of the emergency department by physicians.

Physicians were perceived as using the department which "was a lot cheaper than keeping their offices open." As emergency nurses were involved in the initial assessment of the patients, the nurses believed that the doctors were getting free nursing service. The nurses thought that the practice "was stupid" and "typical that doctors think that they own the hospitals" and have the "right to do as they please." When physicians arranged to meet their patients in the department, the nurses called the patients WODS. The term WODS was defined as "Waiting on Doctors."

This seemed to be a contradiction in the fact that while the nurses were concerned about the "abuse" of the emergency department by physicians they were also concerned about the decrease in the number of patients attending the emergency department for care. They saw this to be due to the emergence of medicentres.

Nurses and Patients

The nurses grouped patients according to the nurses' perceptions of the patients' need for immediate medical attention. The major categories identified by the observer were "real emergencies," "routines," and "WODS."

"Real Emergencies"

The nurses defined "real emergencies" as "sick people . . .

M.V.A.'s,[1] codes,[2] stab wounds, people that really need care" or "people who've been in accidents or having severe medical problems such as convulsions." The patients who were referred to as "real emergencies" usually came to the emergency department by ambulance. The impending arrival of a "real emergency patient was often known in advance as the department was notified by telephone about the patient, the diagnosis, medical status, and expected time of arrival. The opportunity to be involved with patients who were "real emergencies" was generally viewed by the nurses as "what it's all about." One nurse when informed that an M.V.A. was coming in, jumped up and said "action at last." It was apparent during the observation period that "real emergency" patients were initially attended to quickly by both nurses and physicians.

Although patients who were bleeding were usually perceived on admission as "real emergencies," the cause of the patients' injuries influenced the nurses' response to the patient. For example, patients who were injured and had abused alcohol or drugs were often referred to in derogatory terms:

> 1st R.N.: Did you hear that jerk down the hall . . . who needs bastards like that in the department?
>
> 2nd R.N.: What's he in for?
>
> 1st R.N.: He was drunk and he fell through a window . . . he's all cut up . . . I'm fed up with taking shit from bastards like that . . . who needs it?

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1 M.V.A.'s refers to patients who have been in motor vehicle accidents.

2 Codes refers to patients who have had a cardiac arrest.

The majority of patients who came to the emergency department were not perceived by the nurses to be "real emergencies" and these patients were frequently referred to as "routines."

"Routines"

The patients referred to by the nurses as "routines" usually walked into the emergency department. Nurses often used derogatory terms backstage when referring to the "routine patients." The nurses perceived that they saw "the drunks and the stabbings," "the dregs of society," i.e., "a lot (of patients) from the rough section of the city" because the hospital was located near the core area of the city. Although the nurses appeared callous in their comments about patients, it was evident that they were also concerned about them. One nurse noted: "[illegible] come here for a reason" . . . "think they have tried to go other route like their G.P.[1]" The nurses tended to agree that people wanted to go to family doctors but many people around the hospital did not have family doctors therefore when "they get sick or didn't feel well" they came to the emergency department. Throughout the observation period, it was observed that patients who were perceived as "routine" were placed in rooms and moved quickly into the hallways after the doctor examined the patient to await test results. The rationale for moving patients into the hallways was that the rooms needed to be empty in case the next patient was a "real emergency." The observer noted that even when the activity was low the rooms were

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1 G.P. refers to a physician in General Practice.

empty, yet there was no need to provide space for additional patients. As one nurse stated you have "to be ready for 'what if'?" because you never know "what's going to come through that door." In reality, the nurses had acknowledged that the department received limited numbers of "real emergency" patients when they stated: "we don't see more than two or three a day that are emergencies." Like the adults, the children and their parents were moved into the hallways if there was a need to wait for test results or admission to the pediatric unit, even if the room they were in was not needed for another emergency patient.

"WODS"

Many parents were told by their physician to take their children to the emergency department and the physician would meet them in the department, these patients were known as WODS. One nurse suggested to the observer that it was "too bad" that the observer could not include "WODS patients" in the study because the observations could be completed in two weekends. A nurse at the desk stated on the observer's arrival one Saturday that there were "lots of kids but all WODS . . . actually it's 'pediatric clinic' day again." During every observation period in the department the observer identified children who were classified as "WODS." It was suggested by one nurse that the number of children seen in emergency who were WODS may have influenced the nurses' responses to children.

Nurses, Children and Parents

It was apparent during the observation periods that the nurses expressed disparate views towards children and their parents. In one

discussion two nurses were derogatory about children and their parents, but were challenged by their colleague:

1st R.N.: You know the usual crap, fever, sore throats, upset tummies.

2nd R.N.: Yeah, and the usual load of hysterical moms.

3rd R.N.: How would you know . . . you've never been a mother?

2nd R.N.: I suppose you think you're qualified? (laughs).

3rd R.N.: No but I hope to have kids some day.

2nd R.N.: You can have the little brats, runny noses and all.

In another discussion, the observer was asked what the parents remembered about emergency nurses but before the observer could respond:

1st R.N.: Not bloody likely they remember anything about nurses, besides, have you observed (emphasizing observed) any parents with really sick kids? You know, kids who have broken bones or bad accidents . . . that's why they should be here, not the usual garbage we get.

2nd R.N.: What would you know about kids? You're not a parent. You don't have any idea how scary it can be when they have a high temperature or a bad cough and you think they've got croup. It's bad enough when you're a nurse let alone someone who hasn't read a first aid manual.

1st R.N.: (laughs) You've got me there, no kids in the picture, I think they should give courses in parenting and teach people the basics so they don't go nuts and run to emergency everytime the kid sneezes.

3rd R.N.: Admit it _____ kids scare you . . . every time one comes in, you run in the other direction.

1st R.N.: It's not that . . . I just don't like kids that much that's all.

Like the adult patients, the nurses did not perceive the majority

of children "real emergencies" but nurses were also frightened by children. One senior nurse stated:

> There are nurses who don't feel comfortable with little ones . . . I think they're scared of them, I don't know but little ones are sometimes scary because you never know what's going to happen next, you know what I mean, one minute they're okay and the next minute they're convulsing.

This nurse's statement suggested that some nurses did not think they were in control of the situation when caring for children. Another nurse stated that physicians influenced the mothers' response to the child. This then became a factor in the nurses' responses towards children. One nurse commented on a baby who was crying loudly:

> Whew, kids' got a great set of lungs. I see his pediatrician is Dr. _____, he always gets his mom's uptight . . . sounds to me like the kid's a little colicky with an overprotective mom.

The Frontstage

The frontstage is the place where the performance is given (Goffman, 1959, p. 107). In the emergency department, the key actors are the nurses and the physicians. The parents and/or significant others are the members of the audience. The data were organized by grouping patients according to the nature of their illness or injury and then describing the behaviours of the actors and audience. The nurse-parent interactions were then analyzed for similarities and differences within the patient categories. Finally, the nurse-parent interactions, and the contextual factors influencing the interactions

were analyzed for similiarities and differences amongst the patient categories.

Patient Categories

The observer participated in 16 nurse-parent and physician-parent interactions in the emergency department. There were five categories of patients identified from the observations and these categories were based on the literature (Roth, 1978a). The five categories were:

1) children with lacerations;
2) children with possible overdoses;
3) children with infections;
4) children with medical problems, e.g., diarrhea;
5) children that were admitted to the hospital.

Children with Lacerations

There were three children in the study who were bleeding upon their arrival to emergency department. All three children were carried into the department by their mothers.

In Table 5.1, the case number, the child's sex, age, nature of the injury, and total length or time in the department are detailed.

Nurse-Parent Interactions

It was evident that the nurses perceived children who were bleeding to be "real emergencies" as the mothers and children were attended to quickly and accompanied by a nurse to the dressing area. In all three cases, there was only one nurse involved with the mother

and child. The nurses did not introduce themselves to the mother

Table 5.1

Children with Lacerations

Case Number	Sex	Age	Injury	Total Time In Emergency
04	F	19 months	Cut lip	15 minutes
12	M	18 months	Cut chin	10 minutes
15	M	3 years	Cut forehead	22 minutes

and/or child. The nurse's assessment of the child's injury was limited to a question about the child's allergies and a cursory examination of the laceration:

R.N.: Does he have any allergies that you know of?

Mom: No.

R.N.: Good. Can I just get you to sign here please to identify that he doesn't have any allergies (Holds out chart to Mom).

Mom: (Balances baby on lap, signs chart).

R.N.: Now, let's just have a look at this (bends down and removes washcloth).

Baby: (Starts to cry loudly).

R.N.: Well, that doesn't look too bad . . . let me just get you some gauze to hold on that until the doctor comes. (Goes to shelf and opens a package of gauze and returns to Mom with gauze).

There was no attempt by the nurses to determine where the accident occurred or the child's status immediately after the accident, that is, the child's level of consciousness after sustaining the injury. In all three cases, the nurses allowed the mother to hold the child in their arms.

Only one nurse referred to the child by name and commented on probable treatment for the child's injury:

R.N.: What's his name?

Mom: [Name].

R.N.: Well [Name] the doctor should be in shortly to have a look at that . . . I'm afraid you might have to have some stitches.

Child: (Has stopped crying, looking up at nurse).

R.N.: You're a real cutie [Name], do you have any brothers or sisters?

Child: (Child does not say anything, turns head into Mom's arms).

Mom: You're tired aren't you [Name]. It's been a long day.

Two of the childrens' injuries were treated by closing the cut with steri-strips that were applied by the nurse. The third child was sutured by the physician and the mother was not allowed to stay with the child. The nurse was concerned that the mother could not remain with the child and stated after the procedure "I'm sorry that you couldn't stay with him. The nurse did not however advocate that the mother remain with the child but only commented to the physician: "He (child) was pretty good with the mother around." During the observations it was noted that there was no parent teaching about the

care of the lacerations or recommendations for follow-up care by either the physicians or the nurses.

Children with Possible Overdoses

There were two children who were admitted to the emergency department with possible overdoses. One child was carried into the department by his father and the other child by her mother.

In Table 5.2, the case number, the child's age, sex, type of overdose, and total length of time in the department are listed.

Table 5.2

Children with Overdoses

Case Number	Sex	Age	Type of Overdose	Total Time In Emergency
01	M	8 months	Nitroclycerine tablets	1 hour
08	F	2 years	Shampoo	1 hour 10 minutes

Nurse-Parent Interactions

Children who had ingested potentially toxic substances were initially perceived as "real emergencies" by the nurses, as one child was attended to within five minutes of her arrival in the department and the other child was taken to a room directly on his arrival at the nurses' desk. There were two nurses involved with both children and

parents. None of the nurses introduced themselves to the parents. Although the parents were in the department for one hour or more, the total time that all four nurses spent with the parents and children averaged three minutes. Both parents were asked if their children were allergic to any medications and asked to signed the chart indicating that they had no known allergies. It was apparent for Case #1 that neither the nurses nor the physician established that the child actually ingested the nitroglycerine tablets. While the nurse and father were walking down the hall, the nurse asked:

R.N. #1: How many pills do you think the baby took?

Father: Not sure, 2 or 3, my mother-in-law didn't know how many were in the bottle, she thought there should be 3 left.

R.N. #1: Well, there are 3 in the bottle now (takes bottle and tips out 3 pills) see, they're really small so sometimes it's hard to tell.

Father: (Nods head). There was 1 beside him on the floor.

The nurse accompanied the father to a small room and completed her initial assessment by putting the baby on the floor and saying to the baby "Can you walk?" The nurse left the room and returned with a kidney basin, two containers of orange juice, a baby's gown, and a medicine cup that contained Ipecac and said to the Dad:

> Just put the shirt on and someone should be down shortly. Oh here's the woof basin.

There was no response from the father. The nurse left the room. One minute later, a second nurse entered the room.

R.N. #2: How many pills did the baby take?

Father: Maybe 1 or 2.

R.N. #2: That was 45 minutes ago?

Father: (Looks at watch). Yes.

R.N. #2: Has he thrown up since?

Father: No.

R.N. #2: What's the baby's name?

Father: [Name]

The second nurse left the room stating "someone should be down shortly." Both nurses had stated that "someone should be down shortly." It was assumed that "someone" referred to the physician as a doctor entered the room approximately three minutes after the second nurse had left the room. After introducing himself to the father, the physician asked:

Physician: Do you know how many pills he has had?

Father: Maybe 1 or 2.

Physician: We're going to make the baby vomit just to be on the safe side. Sometimes with nitro you get lower blood pressure. Were they your pills?

Father: No they were my mother-in-laws.

Physician: Okay, we'll give him some stuff to make him throw up. (Leaves the room).

Following the physician's examination, 15 minutes elapsed before a nurse returned to the room. The baby had not yet received the Ipecac. The observer noted that both the nurses were talking to each other in the hallway outside the room. It was evident that there was no

communication between the nurses about the baby or the treatment that he was to receive:

R.N. #2: Did they make a chart out on him?

Father: I'm not sure.

Observer: Yes, there's a chart for [Name].

R.N. #2: (Nods head and leaves the room).

Three minutes later the first nurse returned to the room:

R.N. #1: How's he doing?

Father: Nothings happened yet.

R.N. #1: (Yells out the door) [Name], weren't you going to give him Ipecac (Turns back to Father)

Sit him up on the stretcher (hands Father the medicine cup) there you go, here give him this and as much juice as he'll take (takes the medicine cup from Father and gives the Ipecac to child) The trouble with Ipecac is that if you follow it with something they like they'll forever associate it with Ipecac. (Hands Father the orange juice) Keep him drinking (leaves the room).

The nurse's verbal comments were in contrast to her actions. She handed the medicine to the father then took it back and proceeded to give the baby the medicine. Further, she identified that the baby would probably associate orange juice with receiving the medicine but she did not ask the father if he preferred another kind of juice for his child.

In Case #2, both the nurses and the physician verified that the child actually ingested shampoo. The nurse also attempted to determine the child's status following ingestion of the shampoo.

R.N. #1: Now, do you really think that she swallowed the shampoo?

Mother: Yes, I know that she did.

R.N. #1: Do you have any idea how much she took?

Mother: No, I don't.

R.N. #1: About how long ago did she take it?

Mother: Thirty minutes ago maybe more.

R.N. #1: What was she like after?

Mother: She kinda fell asleep after, like she was sitting in her chair and started to nod off.

R.N. #1: Was that normally a time she would have a nap?

Mother: No.

In both cases, once the child had been given the Ipecac, the parents were left alone with the child while the child vomited. For the time period that the children continued to vomit, there were no interaction observed between the nurses and the parents. The observer verified that it was the normal practice to leave the parents alone with their children while they vomited.

Observer: [Name] has been vomiting for about 10 minutes now what do you usually do with children once you give them Ipecac?

R.N.: Oh, we usually just let them continue to vomit and then someone will check on them in about a half an hour.

The absence of interaction between the nurses and the parents while their children filled the basin with vomitus suggested that the parents were being punished for their carelessness, i.e., allowing their

children to ingest foreign substances. In Case #1, the father was so irate with the treatment he received in the department that he refused to allow the observer to do a follow-up visit.

Neither the nurses nor the physicians asked the parents if they had any questions or concerns about the child's care following discharge from the department.

Children with Infections

There were four children in the study who were treated for infections. Two of the children were brought to the department by their mothers and two children came to the department with both parents.

In Table 5.3, the case number, the child's sex, age, type of infection, and total length of time in the department are summarized.

Table 5.3

Children with Infections

Case Number	Sex	Age	Type of Infection	Total Time in Emergency
05	M	14 months	Bilateral ear infections	20 minutes
06	M	9 months	Ear infection	1 hour 5 minutes
09	M	24 months	Lumps behind ears	45 minutes
10	F	15 months	Eye infection	1 hour 15 minutes

Nurse-Parent Interactions

The nurses tended to view children with infections as "routine" patients. In each case the parents and their children were placed in the waiting room by the nurse at the desk until there was a nurse available to take them to a room. The children and their parents were put in separate rooms on the examination side of the emergency department. The observer noted that the nurses did not introduce themselves to the parents in two of the cases. For the other two cases, the initial contact between the nurses and parents in the waiting room was not observed. In three of the cases, there was only one nurse involved with the parents and in one case there were two nurses. Each parent was asked if his or her child had "any allergies to medications." One parent identified that her child was allergic to sulpha drugs. In all cases, the nurses addressed the child by name when interacting with the parents. The actual time that nurses spent with the parents averaged seven minutes.

In all cases, the observer identified that the nurses maintained eye contact with the parents. The nurses' initial assessment of the children included taking the child's temperature, pulse, and respiration. In two of the cases, the nurses informed the parents where they would be if they needed them before the doctor arrived, for example:

> R.N.: The doctor should be with you shortly, if you need anything before he arrives, I or one of the other nurses are usually in the back here (referring to the area behind the examination rooms) so you can just call on us.

Mother: Thank you.

For two of the cases, there was a delay before the doctor arrived to assess the children. Although the nurses did not identify how long it would be before the children were seen by a doctor, they explained to the parents that "they're pretty busy on the other side . . . as soon as they get things under control someone should be in." In one case there was evidence of parent teaching by the nurse. The child had an infected eye and the physician had prescribed an ointment and an eye patch to treat the infection:

R.N.: [Name] has a slight infection in her eye, the ointment will help to fight the infection . . . now we'll also put a patch on her eye to give the eye a rest but because it's strange to [Name] she'll probably try to take it off, if you can it should be kept on for awhile tonight and you can take it off before you put [Name] to bed . . . Okay you can lie her down now . . . I think the best way is to show you how to do it then I'll let you show me that you can do it.

Mother: (Stands beside the R.N.).

Child: (Starts to cry when put on examination table).

R.N.: Now you hold her hands over her head like this and put a small amount of the ointment on her lower lid, it's thick stuff.

Child: (Starts to scream loudly).

R.N.: Now pick [Name] up for a minute.

Mother: (Picks up child and holds her . . . Child stops crying).

R.N.: Okay, one more time, lie her down now, you show me.

Mother: (Puts child on examination table, pulls hands over head with one hand and applies ointment to eye lid with other hand).

R.N.: That's good . . . now we'll just put this patch on and I'll give you the rest of the ointment to take home . . . leave the patch on if possible until later tonight . . . Okay [Name], Mom will hold you now . . . now do you have any other questions?

Mother: No.

R.N.: All right you can go now (opens door) bye [Name].

This was the only time over the 16 observations that the nurse was observed asking the parents if they had any questions.

The physicians allowed the parents to hold their children while they performed the initial physical examination, that is, listened with the stethoscope for chest sounds. When it was necessary to examine the child's ears and throat, the physicians had the mothers hold the child on the examination table.

Children with Medical Problems

There were a total of six children admitted to the emergency department with medical problems such as diarrhea. In order to facilitate the comparison of similarities and differences in the cases, it was decided to separate the children with medical problems into two groups as the severity of illness might affect the nurses' perceptions of the care needed:

1. Children who were discharged from the emergency department, and

2. Children who were admitted to the hospital.

There were three children with medical problems who were discharged from the emergency department. Two of the children were carried into the department by their mothers and the third child was

accompanied by both parents.

In Table 5.4, the case number, child's sex, age, type of problem, and total time in the department are detailed.

Table 5.4

Children with Medical Problems

Case Number	Sex	Age	Type of Problem	Total Time In Emergency
02	M	8 months	Diarrhea	45 minutes
07	M	7 months	Influenza	1 hour 40 minutes
11	M	16 months	Fever	5 hours 5 minutes

Nurse-Parent Interactions.

The nurses perceived children with medical problems as "routine" patients and all parents were placed in the waiting room with their children. The length of time parents remained in the waiting room ranged from 15 minutes to over one hour. The children and their parents were placed in separate rooms on the examination side of the department. None of the nurses introduced themselves to the parents on initial contact. In Case #2 (child with diarrhea), there were two nurses involved with the parents. In Case #7 (child with influenza), there was only one nurse and in Case #11 (child with fever), there were three nurses that interacted with the parents. All parents were asked if their child had "any allergies to medications." The actual time

that nurses spent with the parents ranged from three minutes for Case #2 to 26 minutes for Case #11 and averaged 12 minutes for all three cases. All of the nurses referred to the child by name when interacting with the parents. In two of the cases the nurses' assessment of the child was thorough and they also gave the parents an opportunity to ask questions and told the parents where they would be if they needed any assistance, for example:

R.N.: What's he been like?

Mother: Crying all the time. He stayed with my sister today because I was working and he never stopped crying . . . she said when he wasn't crying he was sleeping.

R.N.: Has he been pulling at his ears?

Mother: Yes, all the time.

R.N.: Is he pulling at both ears?

Mother: Yes.

R.N.: Have you been taking his temperature today?

Mother: No, my sister didn't but he felt hot . . . she gave him some Tylenol and he seemed to feel better.

R.N.: Can you just slip off his pants and I'll check his temperature.
(Nurse leaves the room and returns with an electronic thermometer)
If you just hold him I'll take his temperature this way.

Mother: (Holds baby over her shoulder and nurse inserts the thermometer . . . Baby does not cry).

R.N.: Has he had any diarrhea?

Mother: He had some a couple of weeks ago but not lately.

R.N.: Has he been coughing a lot?

Mother: On and off.

R.N.: What does he sound like?

Mother: Kind of barky.

R.N.: Is he bringing up anything when he coughs?

Mother: He sounds like he is but he swallows it before I can get him to spit it up . . . it sounds gucky.

R.N.: You haven't seen any of this guck so you don't know what colour it is eh?

Mother: No.

R.N.: Thank you, the doctor shouldn't be too long before he sees you . . . was there anything else that I can do for you?

Mother: No thanks.

R.N.: (Moves towards curtain at back of room) I'll be back here if you need me.

In all three cases, once the nurse had completed the initial assessment, there was minimal interaction between the nurses and parents. In Case #11 (child with fever), for example, the child had a chest x-ray and lumbar puncture done. A nurse was called to the room to assist the physician during the lumbar puncture. When the nurse arrived in the room, the physician was explaining to the parents that it was "probably better" if they left the room during the procedure. The nurses' only comment to the parents was: "What's the baby's name?" This was the third nurse that interacted with these parents. When the lumbar puncture was completed, the physician asked the parents to return to the room and explained that the spinal fluid would be sent for analysis. The nurse's comments to the parents before she left the room were limited to: "He was really good . . . What's his name again?" The parents waited for over two hours for the results of the

x-ray and lumbar puncture. The observer noted that there was no further nurse-parent interactions initiated by the nurses, that is, the nurses did not inform the parents about the reasons for the prolonged delay. Finally, the father approached the observer and stated:

> Do you have any idea how much longer it will take . . . this waiting is ridiculous . . . there's nothing worse than waiting.

At this point, the emergency physician approached the parents to discuss the test results.

Children Admitted to Hospital

There were four children in the study who were admitted to the hospital. Two of the children were carried into the department by their mothers. One child was brought to the department by both parents and one child came to the department by ambulance. The child was accompanied in the ambulance by her mother and her father followed the ambulance to the hospital in his car.

In Table 5.5, the case number, the child's sex, age, nature of the illness, and total time in the department are summarized.

Nurse-Parent Interactions

Only one of the children who required admission to the hospital was perceived by the nurses initially as a "real emergency." The child who was convulsing, arrived by ambulance and was placed in an examining room immediately upon her arrival to the department. The remaining three children and their parents were placed in the waitin In three cases, the nurses did not introduce themselves to the parents.

Table 5.5

Children Admitted to Hospital

Case Number	Sex	Age	Nature of Illness	Total Time In Emergency
03	F	10 1/2 months	Allergic reaction	2 hours 5 minutes
13	M	4 months	Fever	3 hours 10 minutes
14	M	7 1/2 weeks	Hernia	4 hours 58 minutes
16	F	22 months	Convulsions	4 hours 47 minutes

In the case of the fourth child, the observer was not present during the initial contact between the nurse and the parent. During the time that the parents and children were in the department, they interacted with four different nurses. In Case #13, there were two nurses, and in Case #14, there were three nurses that interacted with the parents. All parents were asked if their child had "any allergies to medications." One parent commented when signing the chart "same old routine, eh?" The actual time that the nurses spent with the parents throughout their stay in the department ranged from three minutes for Case #3 (child with allergic reaction), to 20 minutes for Case #16 (child with convulsions), and averaged 11 minutes for all four cases. The percentage of time that nurses spent with the parents averaged 5% of the actual time that the parents were in the emergency department.

Although there was a total of 13 different nurses who interacted with the parents in the four cases, only two nurses referred to the children by name.

The nurses' initial assessment of the children was minimal in two of the four cases. The nurses did not maintain eye contact with the parents nor was there evidence that the nurses were listening to the parents. For example in Case #3, it was apparent that the child had a severe allergic reaction. When the mother undressed the child there were multiple, large, raised, red spots on her body. The baby's hands and feet were so swollen that the baby's fingers and toes were bluish in colour. The nurse's assessment of the child was limited to taking the child's temperature:

R.N.: Does the baby have any allergies to medications that you know of?

Mother: No but we think she has an allergy to something as you can see.

R.N.: (Nods head and opens door to exam room) Just put her down there (pointing to the examination table) and take her diaper off so I can take her temperature (leaves the room through the back).

Mother: (Undresses the baby).

R.N.: (Returns to room with an electronic thermometer) Okay do you just want to hold her while I do this (places baby on her back and lifts her legs up and inserts thermometer rectally, then removes thermometer) You can put her diaper back on now . . . someone will be in to see her shortly (leaves room).

In Case #16 (child with convulsions), there were two nurses involved with the parents when the child was admitted with convulsions. Neither of the nurses maintained eye contact with the mother. Again, the

nurses' assessment was limited to taking the child's temperature. The nurses had received a detailed report from the ambulance attendant. When the ambulance personnel left the room the first nurse stated:

R.N. #1: So, is she on medications?

Mother: Yes, she takes phenobarb and we took her to the doctor yesterday to have her phenobarb level checked out.

R.N. #1: Okay Mom let's just have you undress her.

Mother: (Undresses baby, baby crying softly).

R.N. #1: So what happened to her?

All of the questions asked initially by the first nurse had been answered by the ambulance personnel when they gave report to the nurses. The nurses did not attempt to assist the mother while she undressed the child. When they took the baby's temperature and determined that the child had no allergies to medications, both nurses left the room and the second nurse simply stated: "Doctor should be here shortly." Neither of the nurses identified where they would be if the parents required assistance despite the fact that further convulsions could occur. Neither of the nurses gave the parents an opportunity to ask questions.

In contrast, the nurses involved initially with Cases #13 (child with fever), and #14 (child with hernia), maintained eye contact with the mothers throughout the interaction and attempted to determine the babies' status prior to their admission to the emergency department, for example:

R.N.: How long has he been sick?

Mother: Two or three days.

R.N.: What's he been like?

Mother: He had diarrhea and now he's got a fever.

R.N.: How long did he have diarrhea?

Mother: A couple of days.

R.N.: Is the diarrhea getting better now?

Mother: Yes.

R.N.: Is he eating or drinking milk?

Mother: No the doctor said I couldn't give him milk . . . he's drinking juices but he's got a fever.

R.N.: Have you taken his temperature at home?

Mother: No.

R.N.: You know . . . you can buy one [a thermometer] at a drug store and they aren't very expensive . . . you should have one when you have small children.

Mother: Nods head in agreement.

When the nurse took the baby's temperature, it was 40°C. The nurse immediately notifed the desk via intercom that the baby's temperature was 40°C and stated: "I think he should be seen fairly soon." When the nurse left the room she stated to the mother: "if you need me, just call out the back here." Thirty-five minutes elapsed before the baby was seen by a physician. During that time the nurse returned to the room twice to check the baby and the mother. In this case, the degree of fever appears to have been viewed by the nurse as sufficient to constitute a real emergency.

Medications were prescribed for two of the children: the child with an allergic reaction and the baby with the fever. Again, there

was a marked contrast in the nurses' approach to the parents and the children. The physician prescribed Benadryl liquid and Adrenalin for the child with the allergic reaction. The nurse who administered the Benadryl had not seen the parents or child before entering the room with the medication. The interaction between the nurse and the parent was limited to:

R.N. #1: Hello sweetheart. I have to do this to you . . . Mom will you put the baby down (pointing to the exam table) and hold her hands while I give her this.

Mother: (Puts baby on examination table, holding hands at her side).

R.N.: (Lifts baby's head up and pours liquid down her throat. Baby starts to cry loudly. Nurse leaves the room).

The nurse did not give the mother the opportunity to ask any questions nor did she tell the mother what medication she was giving the child. She did not ask the mother if she preferred to give her child the medication. It was also apparent that there was a breakdown in communications amongst the nurses as the child did not receive the Adrenalin until after the father asked the observer to "find out what's going on . . . like when is [Name] going to have her next medication?" When the observer asked about the medication, she was told "oh, that should have been given . . . someone will be right down." Two minutes elapsed before two nurses entered the room. One nurse was holding a syringe. Again, neither of the nurses had been involved before with the parents or the child. There was minimal verbal exchange between the nurses and the parents:

R.N. #3: You hold her and I'll hold her leg (to the mother).

R.N. #3: (looks at the other nurse) Give it in the thigh.

R.N. #4: Okay (gives the injection and both nurses leave the room).

The nurses gave the parents no opportunity to ask any question nor did they explain the delay between giving the medications. The Adrenalin was given to the child 35 minutes after the Benadryl liquid.

When Tempra liquid was ordered for the baby with the fever, the nurse involved the parent and did parent-teaching. When the nurse entered the room carrying a syringe that contained medication, she said to the mother:

R.N.: This is Tempra that the doctor ordered for his temperature . . . would you like to give him this or should I?

Mother: (Shrugs shoulders).

R.N.: I think it would be better if you gave it to him . . . you just sit down on the chair and I'll show you how . . . it's better for a child if he doesn't get meds from a stranger . . . now this is the plunger, sit him up (positions baby on mother's lap) all right now just push the medicine gently into the side of his mouth (hands mother the syringe).

Mother: (Pushes plunger slowly).

R.N.: That's good . . . very good . . . okay we'll just give the medicine a chance to work.

After the nurses completed the initial assessments of the children they left the room and the parents remained alone until the physician arrived to assess the child. In all four cases, it was found that the nurses did not return to the room when the physicians were

assessing the children. In Case #14 (child with hernia), the physician ordered x-rays. Following this a nurse who had not previously been in contact with the mother entered the room and stated:

R.N.: I don't know if Dr. _____ came down to talk to you or not but we're going to take the little one down for an x-ray of the tummy.

Baby: (Starts to cry).

R.N.: You really are upset aren't you? Would you like this? (picks up soother sitting on top of mother's bag and puts it in baby's mouth).

Baby: (Spits out soother and continues to cry).

R.N.: It's not exactly what you had in mind eh? O'kay Mom do you just want to come with me please.
(Nurse holds open the door but does not offer to help mother carry a large infant bag. Observer picks up bag. Nurse, mother and observer walk down hallway to x-ray).

At the radiology department, the nurse handed the x-ray requisition to the technician and left without making any further comments to the mother. The mother was not told what to do or where to go once the x-ray was done on her child. In this case, the mother met the physician in radiology and he told her to return to the nurses' desk in the emergency department. When the mother returned to the nurses'desk, she was told to "wait in the Waiting Room." Although the mother and baby were in the radiology area for over two hours, the observer noted that there were no nurse-parent interactions during that time.

It was observed that the frequency of nurse-parent interactions decreased as the parents' length of stay in the department increased.

Once the initial assessment was completed, the interactions tended to be initiated by the parents rather than the nurse unless she returned to provide treatment. In Cases #13 (child with fever), and #16 (child with convulsions), for example, the parents and children were moved into the hallways after the doctor completed his assessment. In Case #16, the nurse explained the rationale for moving the parents and child into the hallway by stating:

> I've got the crib . . . is it all right to move her into it or will she really get upset? . . . it's just that I don't want to move her out in a hurry if we need this room to suture someone.

The parents were moved into the hallway just prior to the nurses' shift change. When the nurse gave the report to the nurse coming-on-duty, she stood in front of the parents and stated:

> This child had convulsions witnessed by Mom and came in by ambulance . . . urine has been sent for phenobarb levels and we're waiting on results.

There was no introduction to the parents, or eye contact made with the parents, during the report. The nurse moved on down the hallway and discussed the next patient. There was no further interaction between the nurses and parents until the mother spotted the observer in the hallway and asked:

> Do you think we could get some food for [Name] from the cafeteria or something because she hasn't eaten anything since lunch?

The observer approached a nurse in the area and reiterated the mother's

request. Twenty minutes later the nurse approached the parents and asked what the child would like to eat. One hour after the original request for food, a nurse brought the food tray to the mother and stated: "Well here you are little one . . . enjoy." The parents and child remained in the hallway for two more hours. There were no further nurse-parent interactions observed. Similarly, in Case #13, the mother and baby were moved into the hallway and remained there for one hour and twenty minutes. During that time, the observer noted that there was only one interaction between the mother and a nurse. The nurse checked the baby's temperature and said to the mother: "Well, that's better . . . it is down to 38° . . . the blood results should be back soon." The nurse then walked back towards the desk area with the thermometer. Again, the nurse did not introduce herself, nor did she give the mother the opportunity to ask any questions.

Comparison of Patient Categories

Nurse-Parent Interactions: The Similarities

There were 31 nurses involved with the parents in the 16 cases that were observed in the emergency department. In three cases the initial contact the nurse had with the parents was not observed. In the remaining 28 observations the nurses did not introduce themselves to the parents on initial contact. During the nurses' initial contact with the parents, all the nurses asked the parents if their child "had any allergies to medications" and to sign the chart identifying that they had no allergies. Although the time that the nurses spent with parents ranged from one minute to 20 minutes, the average over all

cases was approximately four minutes.

The nurses' assessment of the children was usually minimal. In the majority of cases, there was no nursing history and/or physical assessment obtained except for taking the child's temperature. Generally, the nurses did not maintain eye contact with the parents during the interactions nor did they refer to the child and/or the parent by name. When a parent and child were placed in a single room, the nurses rarely informed them where they would be, or how to obtain help if the parents required assistance. It was observed that the frequency of nurse-parent interactions decreased the longer the parents were in the department and that the interactions tended to be initiated by the parent rather than the nurse. When parents were faced with delays that increased their stay in the department, the nurses generally did not inform the parents why they were still waiting or what was causing the delays. The majority of the nurses gave the parents few opportunities to ask questions or to express their concerns related to their child's illness. In all interactions with the parents nurses were observed to maintain control of the situation.

In seven of the 16 cases that were observed there was only one nurse involved with the parents. In the other nine cases there were two or more nurses involved. When families saw more than one nurse, it was apparent that communication amongst the nurses tended to break-down, for example, medications ordered by physicians were not given immediately by the nurses. Also, some parents were asked for the same information by more than one nurse. In 13 cases, the nurses asked the parents to undress the child and put a hospital gown on the child.

None of the nurses assisted the parents to undress the child nor did they explain why it was necessary or how to put the gown on the child. Although only four of the 16 children required laboratory tests and/or x-ray procedures, there was no attempt by the nurses to prioritize the procedures, i.e., request the technician to attend to the child before the adults. There was no evidence that the nurses perceived themselves as patient advocates when interacting with the parents. In addition, there was minimal evidence of parent-teaching by nurses and/or advice to parents on the child's care following discharge from the department.

There were only two children who had ingested poisonous substances but the nurses' response to the parents was the same in both cases. The parents were ignored once the child had received Ipecac. The observer verified that the practice in the department was for the nurse to leave the parents alone with the child while the child vomited. The practice of leaving the parents alone can be interpreted as a form of punishment to the parents for allowing their child to ingest a foreign substance.

Nurse-Parent Interactions: The Differences

The differences in nurse-parent interactions amongst the patient categories did appear to be related to the nature of the child's illness or injury. If the nurses perceived that the child was initially a "real emergency" the parents and child were taken to a room immediately upon their arrival in the department or within five minutes of their arrival, for example children with lacerations or overdoses.

Children who had infections and/or medical problems were usually

perceived by the nurses to be "routine" patients. There were 11 children who were perceived to be "routine patients". Within this group of "routine patients," there were two examples of parent-teaching. In six of the 11 cases, the nurses maintained eye contact with the parents and referred to the child by name during the initial interaction. In three of the cases, the nurses did a complete nursing history and informed the parents where they would be if they required assistance. In only one case was the parent asked if she had any questions. In three cases the nurses did explain that the parents would have to wait to see the physician and they gave reasons for the delay. Although the length of stay in the department was higher for children who were "routine patients", it was noted that the frequency of nurse-parent interactions decreased following the initial assessment.

The Contextual Factors

Analyses amongst patient categories of the similarities and/or differences in the contextual factors that influenced the interactions was facilitated by comparing patient categories according to the activity level in the emergency department. In Table 5.6, the category of patient, case number, total time in emergency, and the activity level are presented.

Low Activity Level

When the activity level was low, there were few patients waiting to be seen in the waiting room, no patients on stretchers in the hallways waiting for test results and/or admission to hospital, and no

Table 5.6

Activity Levels in Emergency Department

Category of Patient	Case Number	Activity Level	Total Time in Emergency	Treatment or Tests Ordered	Number of Minutes Spent With Parents or Children
1. Children with lacerations	04	Low	15 min.	x	6 min.
	12	Low	10 min.	x	8 min.
	15	Moderate	22 min.	x	20 min.
2. Children with overdoses	01	Low	1 hr	x	3 min.
	08	Low	1 hr/ 10 min.	x	2 min.
3. Children with infections	05	Low	20 min.		10 min.
	06	High	1 hr/ 5 min.		5 min.
	09	Low	45 min.		3 min.
	10	Moderate	1 hr/ 15 min.	x	10 min.
4. Children with medical problems	02	Low	45 min.		3 min.
	07	High	1 hr/ 40 min.		6 min.
	11	High	5 hrs/ 5 min.	x	13 min.
5. Children admitted	03	Low	2 hrs/ 5 min.	x	3 min.
	13	Moderate	3 hrs/10 min.	x	15 min.
	14	High	4 hrs/58 min.	x	7 min.
	16	Moderate	4 hrs/47 min.	x	20 min.

emergent cases, such as a patient in cardiac arrest, being treated in the department. Eight of the 16 cases, observed were in the department when the activity level was low. The children in the eight cases were from all five patient categories. Four of the eight children were from categories one and two, i.e., children with lacerations and overdoses. In the other three categories of patients, there were two children with infections, one child with a medical problem, and one child requiring admission to hospital. The time that the parents and children spent in the department ranged from ten minutes to two hours and five minutes and averaged approximately 48 minutes for the eight cases.

It was evident that the nurses initially perceived the four children from categories one and two to be "real emergencies," as they were placed in a room upon their arrival at the nurses' desk or within five minutes of their arrival in the department. The immediacy of the nurses' response was dependent on the assessment of the nurse at the desk. If the desk nurse perceived that the child should be seen immediately, she notified the nurses via intercom that there was a child waiting to be taken to a room. If the desk nurse perceived that the child was a "routine patient" who did not require immediate attention she placed the parents in the waiting room and put the child's chart on the nurses' desk. Nurses from the examination or treatment areas routinely came to the desk to see if there were charts sitting on the desk. Charts on the desk signaled to the nurses that there were patients in the waiting room. The four children who were perceived to be "routine patients" waited an average of 15 minutes in the waiting room before being taken to a room by a nurse.

Children were taken by the nurses either to the examination or dressing side of the emergency department. Children who were perceived by the nurses to be "real emergencies" were taken to the dressing side for assessment. Three of the four children in categories one and two were placed in a room on the dressing side that had seating space for ten patients and three stretcher bays. There were other adult patients in the room that were being examined and/or treated. The fourth child was placed in a separate room on the dressing side but the door was left open, consequently the father and child could be seen by other patients from the hallway. It was evident that there was little or no attempt made by the nurses to maintain privacy for the parents and children. It was also noted by the observer that all the children could have been placed in separate rooms on the dressing side because there were two rooms, in addition to the trauma-resuscitation room, that remained empty during the time that all the observed children were in the department.

The four children who were perceived to be "routine" patients were all placed in separate rooms on the examination side of the department. Three of the four children were assessed by the emergency physicians and discharged from the department. When the fourth child was assessed by the physician, he ordered Benadryl and Adrenalin "to be given now" and decided to admit the child. The Benadryl was given to the child by a nurse at 20:35 hours and the Adrenalin was given to the child at 21:15 hours. The 40-minute delay in administering the second medication was apparently due to the nurses in the area not following up on the physicians' medication orders. The observers' impression was

verified when she asked the desk nurse at the father's request about the child's second medication and was informed: "That should have been given." It was evident that there was a breakdown in communication that was probably related to the fact that nurses were not present in the room when the physician initially assessed the child. In addition, the nurses tended to perceive that children on the examination side of the department did not require any immediate nursing intervention, i.e., they were not "real emergencies." Following the administration of the Benadryl, the parents and child waited another hour and five minutes before the child was taken to the pediatric unit. Again, at the fathers' request, the observer approached the desk nurse to determine how long it would be before the child was taken to the pediatric unit. The observer was informed that the unit was not ready for the child and "we've been holding them until they were ready." The parents had not been updated by the nurses about the reasons for the prolonged delay. The activity level in the department, however, remained low throughout the parents stay in the department suggesting that the activity level was not a factor in the frequency of nurse-parent interactions.

Placement of the parents and children in separate rooms did not necessarily assist in maintaining privacy for the parents or isolate the parents as members of the "audience" from the actors. On the examination side, the doors were frequently left ajar and in one case the parents were in a position to view the backstage of the department when they overheard a physician ask about their child:

Did anyone find out what's wrong with the spotty kid in four?

Moderate Activity Level

When the activity level was moderate, there were more than ten [illegible] waiting to be seen in the waiting room, patients on stretchers the examination and dressing hallways waiting for test results and/or admission to hospital, and at least one "emergent" case being treated in the department. Four of the 16 cases observed were in the department when the activity level was moderate. The four children were from three patient categories, there was one child with a laceration, one child with an infection, and two children who required admission to hospital. The time that the parents and children spent in the department ranged from twenty-two minutes to four hours and 47 minutes and averaged approximately two hours and thirty minutes for all four cases.

Two of the four children were perceived by the nurses initially to be "real emergencies." The parent and child with the laceration were placed in a room on the dressing side upon their arrival at the desk. The other child had been convulsing and came to the department via ambulance. Prior to the child's arrival the desk nurse had notified the nurses about the child and the expected time of the child's arrival. The nurses from the dressing side were at the desk waiting to take the parent and child to a room when the child arrived. The other two children were perceived to be "routine patients" and the parents and children were put in the waiting room. Both parents waited approximately thirty minutes before being called by a nurse and taken

to a room on the examination side. It was noted by the observer that one of the children who waited for thirty minutes in the waiting room was a four-month old infant who had a temperature of 40°C. The nurse who assessed the infant notified the nurse at the desk and asked that the child be seen "fairly soon" by a physician. A physician was not available to assess the child for another 35 minutes.

When the activity level was moderate, physicians were not readily available to do the initial assessment of the child. The only child that did not wait for a physician was the child with the laceration. The child and parents were placed in the room with seating for ten patients. There was a physician in the room examining another patient. There were six other adults in the room. The physician assessed the child quickly and asked the nurse to take him into a separate room to be sutured. The child who was admitted by ambulance waited approximately fifteen minutes before being seen by a physician. In the remaining two cases, the parents and children waited more than thirty minutes for the physician because the physicians were treating patients in cardiac arrest.

For two of the children, there were tests ordered, such as urinalysis and C.B.C.[1] When tests were ordered, the parents and child's stay in the department was further increased. The delays were either waiting for the nurse or technician and then waiting for the results. Once the results were back it was necessary for the physician to review the results and discuss them with the parents. For the two

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[1] C.B.C. refers to complete blood count.

children who were admitted, the physician made the decision based on the results of the tests. The parents and children then waited in the department for the resident covering pediatrics to come to the emergency department and do an admission history and physical.

For both children who were admitted, once the physicians' initial assessment was completed and the tests done on the child, the parents and children were moved into the hallways. It was noted that the rooms remained empty during the time that the children and parents were in the hallway. Placement of the parents in the hallways exposed the parents to other members of the "audience." In one case, the parent viewed the backstage of the department when a patient refused to accept his role as a member of the audience and created a scene. In this situation the mother was feeding her child a sandwich and commented to the observer:

Mother: [Name] went to telephone some friends and then he's going to get us some food and a coffee . . . isn't this waiting ridiculous?

Observer: Yes, it has been a long wait for you.

Before any further comments can be made, there is a loud noise in the hallway. An adult male who is being transported via stretcher to a room attempts to get off the stretcher. The man is yelling and screaming, swearing continuously and is wrestled to the floor by two ambulance attendants. The attendants are joined by two security guards and a registered nursing assistant. They wrestle on the floor for approximately two minutes before the man is restrained. The man is forcibly moved into a room, still cursing loudly.

Mother: God, this is like [Name] on a Saturday night. (Laughs . . . baby starts to cry and mother picks her up and cuddles her turning her head away from the scene on the floor).

Again, it was evident that there was little or no attempt to maintain privacy for the parent and child. In addition, it was observed that there was no apparent rationale for placing the child and parent in the hallways. The statement of one nurse suggested that it was done because the room might be needed to suture patients. Patients in the hallways also gave the audience the impression that the emergency department was "busy" and it was apparent in some of the follow-up interviews that this impression management had its effect on parents.

High Activity Level

When the activity level was high, there were more than 20 patients waiting to be seen in the waiting room; patients on stretchers in the examination and dressing hallways waiting for test results and/or admission to hospital; patients waiting in the emergency x-ray for procedures; and urgent or emergent patients in the department being treated. Four of the 16 cases observed were in the department when the activity level was high. The four children were from three patient categories, there was one child with an infection, two children with medical problems, and one child requiring admission to the hospital. The time that the parents and children spent in the department ranged from one hour and five minutes to five hours and 48 minutes and averaged approximately three hours and ten minutes for the four cases.

All the children were perceived by the desk nurse to be "routine patients" as the parents and children were placed in the waiting room. All four parents and children waited more than 45 minutes before they

were called by a nurse and taken to a room. The children and parents were all put in separate rooms on the examination side of the department.

When the activity level was high, the physicians were not readily available to do the initial assessment of the child. While one parent and child only waited 20 minutes for the physician, the other three parents and children waited more than 35 minutes for the emergency physicians. In all four cases, the physicians were involved with patients who had been in motor vehicle accidents and/or patients in cardiac arrest. For two of the cases, there were no tests ordered by the physicians and the parents and children were discharged from the department. The length of stay in the department for both of these cases averaged approximately one hour and 20 minutes.

For the remaining two cases, the physicians ordered x-rays. When radiology procedures were ordered, it was identified that the waiting time for parents increased significantly. It was noted that there was no prioritizing of "routine patients" for x-ray procedures. Neither the physicians nor the nurses requested the radiology technician to do the children's x-rays before any of the other patients who were waiting for x-rays in the emergency radiology waiting room, yet, in one case, the physician suspected the child had meningitis and in the other case, the child was only seven weeks old. In addition, it was necessary for the emergency physician to review the films before discussing the results with the parents. When the activity level was high, an emergency physician went to the department and reviewed several films at one time.

When the mother and infant were finished in the radiology department, the mother was asked to go back to the waiting room. The child with possible meningitis was placed on a stretcher in the hallway until the physician was ready to do the lumbar puncture on the child. The waiting time for the parents and child was further increased while the laboratory analyzed the spinal fluid. Again, it was observed that there was no attempt to maintain privacy for the parents and children. Physician availability for initial assessment and follow-up of test results was a factor that increased the parents' and childrens' waiting time in the department.

Impression Management

Impression management is the impression and understanding fostered by the performance of the actors in the emergency department (Goffman, 1959). The staff are the actors while the parents, providing they accept the role, are the audience. As members of the audience, the parents observe the performance of the professionals and their interpretation of the situation will be based on their definition of the performance. A comparison of the parents' interpretation with the observed performance will indicate the degree to which the parents were guided in their perceptions by the actors' definition of the situation.

It was necessary to analyze the parents' perceptions of the nurses in the emergency setting in order to determine how the parents, in their role as the audience, interpreted the performance of the nurses in their role as actors. Twelve parents were interviewed following their child's visit and subsequent discharge from the

emergency department and/or hospital. The data were organized into the following categories:

1) parents' perceptions of emergency nurses: the actors
2) parents' perceptions of nursing care: the frontstage interpretation
3) parents' perceptions of child's illness: the focus of the play
5) parents' perceptions of emergency environment: the frontstage
6) parents' rationale for using the emergency department.

Where appropriate the data within the categories were analyzed to compare the parents' perceptions to their expectations of the actors (the nurses) and/or the stage (the emergency setting).

Parents' Perceptions of Emergency Nurses

The majority of parents that were interviewed had limited recall of the emergency nurse and/or nurses. When the parents were asked: "What do you remember about the emergency nurse or nurses?" the responses for ten of the 12 parents indicated the following:

> Mother: (Case #12) Not much . . . let's see . . . the one took us down to the room and had me sign something . . . oh yeah, about allergies.
>
> Mother: (Case #15) I know this is going to sound silly but I don't remember much . . . I'm sorry I couldn't even tell you what her (the nurse) hair colour was.
>
> Mother: (Case #8) Not very much . . . I remember the one asking about what juice to bring her to give with that stuff to make her throw up . . . not much else.
>
> Mother: (Case #2) Nothing . . . she took me to the room, that's all.

Only two of the 12 parents interviewed recalled that the nurses "were

pretty nice" and "seemed to be quite friendly." Both of these mothers stated that the nurses "were good" to their children.

Five of the 12 parents interviewed were in the department for a prolonged period of time waiting for test results and/or for their children to be admitted to hospital. These parents perceived they had "little contact" with the nurses and believed their contacts with nurses were episodic, for example:

> Mother (Case #3): I remember them (the nurses) popping in and out but I didn't know if they were nurses or what they were.
>
> Mother (Case #16): They seemed to be in and out of the room when we were in there and when we got moved out in the hallway I don't remember any one nurse that sort of stands out in my mind.

In addition, the parents perceived that "there were too many different nurses" and perhaps the nurses "were busy with someone they thought was sicker" as the nurses "didn't stand still long" and were "in and out through [the] curtain and up and down the hall and visiting others."

The parents expectations of emergency nurses tended to be linked to their previous experiences with nurses either in the hospital or the community setting. Two mothers frankly stated that they had few expectations of emergency nurses:

> Mother (Case #8): I don't expect much from nurses there [emergency department] and then I'm never disappointed.
>
> Mother (Case #12): I don't expect anything from nurses . . . I've never been impressed with any [nurses] that I've run up against in hospitals . . . less so with nurses in emergency.

Two other mothers identified that their experiences with nurses when

they were in labour influenced their expectations, for example:

> Mother: (Case #14) I've never been exposed to nurses that really seemed to care what was happening to me . . . when I was in the hospital giving birth to [Name] I wanted someone to talk to me as as human not as reproductive machine.
>
> Mother: (Case #12) I wasn't too impressed with them [nurses] when I had [Name] . . . I was so scared I thought I was going to die . . . they didn't do much for me then.

The majority of parents seemed to have low expectations of nurses because they were not "too sure what nurses are supposed to do in emergency departments or anywhere for that matter" and they did not "really know what nurses are all about." Three of the 12 parents perceived public health nurses in the clinic setting to be the role of the nurse because "that's where you go (clinic) to talk to nurses." Ten of the 12 parents were not concerned about their low expectations of nurses because they went to "emergency to see a doctor not the nurse" and their child's illness "didn't really require a nurse." Also the parents tended to believe that any questions they had about their child should be answered by the doctor, not the nurse, as they preferred "to hear it straight from the doctor's mouth instead of the nurse."

In contrast, the parents in two of the cases expressed that their expectations of nurses were high and their concerns about their child were not addressed by the emergency nurses:

> Mother: (Case #3) I expected some psychosocial support . . . like explaining the course of treatment or explaining what was happening while we were waiting . . . what was taking so long . . . someone to listen to us and help us sort out how we were feeling about [Name] being

admitted . . . talk to someone about how scared we were . . . they're wasn't really anyone to listen to us.

Father: (Case #3) I don't think it's good enough to put a child in a hospital and only check her temperature and not give anyone a chance to ask questions or get answers . . . none of the nurses acted like she was really sick.

Mother: (Case #9) [Nurses should] talk to you . . . when you go in there you're kinda worried . . . but maybe talk to you . . . and kinda keep conversation going . . . get your mind off that [child's illness] . . . they more or less leave you in a room by yourself to worry about it.

In Case #3, the parents were not only dissatisfied with the emergency nurses but believed "there wasn't really anyone to listen to us . . . thoughout [Name's] stay in hospital" and it was important that "someone show some interest" in them as parents and their child "as a patient." Consequently they "brought [Name] home" from the pediatric unit and still did not "have any idea about what caused her problem or what . . . to do so it would not happen again."

Parents' Perceptions of Nursing Care

Like the parents' recall of emergency nurses, the majority of parents perceived that the nursing care given to their child was minimal or non-existent. Eleven of the 12 parents interviewed typically described the nursing care in the following terms:

Mother: (Case #2) Nothing . . . just took me to the room.

Father: (Case #3) What care . . . all I remember is someone took her temperature and a couple more [nurses] ran in and gave her medicine.

Mother: (Case #8) . . . they did nothing for [Name] that I could see . . . they didn't even come in to see if she was okay

when she was really throwing up.

Mother (Case #10): I don't remember nothing about nurse . . . oh maybe yes . . . nurse put stuff in eye that's all.

Only one parent equated nursing care to a nurse who "knew how to handle babies . . . you could tell the way she played with him . . . she was really good with him."

As ten of the 12 parents "went to see the doctor not the nurse" they were not expecting that their child required nursing care in the emergency department. The parents did not "see what nurses could do" or what nurses "were supposed to do" because they did not think their children needed "any nursing care", for example:

Mother (Case #12): [Name] had a cut . . . he needed to have a doctor look at it . . . if I wanted a nurse I could have taken him over to my neighbour . . . she's a nurse.

Mother (Case #14): . . . he really didn't need any nursing care I was there for him . . . I took him to see the doctor that was what was important to me.

Two of the parents believed that nursing care should be more than "doing something" for their children, such as taking temperatures or giving medications, and they perceived nursing care as providing support to their children or themselves:

Mother (Case #3): . . . no nurse seemed to see [Name] as a little person who needed holding and comfort.

Mother (Case #16): . . . I think that a nurse should be . . . oh what's a good word . . . helpful . . . it would be nice if someone asked me how I was doing or did I need anything . . . I was scared to death riding in that ambulance . . . maybe they (the nurses) should try and talk to you . . . hospitals are necessary when you have a child who's sick but they should know they are

looking after people.

Parents' Perceptions of Emergency Physicians

As ten of the 12 parents took their children to the emergency department "to see the doctor" their perceptions of the emergency physicians were generally positive. The parents tended to recall the physicians as "quite nice," "really friendly with the kids," and "honest" in their explanations about their childrens' illness.

Four of the parents, however, perceived the physicians negatively, for example:

> Mother (Case #7): I wasn't too impressed with him (the doctor) . . . he seemed sort of unsympathetic but then I suppose you can't really expect them to be too gushy.
>
> Mother (Case #8): I hate the pious types who sit in judgement . . . that doctor talked to me like I didn't have a brain.
>
> Mother (Case #15): . . . that doctor what a jackass he was, I was furious that he wouldn't let me stay with [Name].

The parents' expectations of emergency physicians were also influenced by their previous experiences with physicians:

> Mother (Case #11): . . . he (the doctor) explained everything . . . and was quite blunt . . . I'm glad he did . . . wish they could (all) just tell it straight . . . if there is something wrong not just send you from here to there (referring to her child's referral by another physician to emergency).
>
> Mother (Case #16): It's really only the doctors who can give you the answers . . . at least you hope that they can and in my experience they can't often answer your questions . . . but if you're lucky and we sure are with Dr. _____ they're honest and say they don't know why this or that happens.

One parent was informed by an emergency physician that her son had a heart murmer. The mother had not been told by her family doctor about her child's murmur. The mother was reassured that it "might not be anything too serious" when she learned that her sister's son also had a heart murmur and the physician had told her sister not "to worry about it . . . it was not worth mentioning." There was no evidence to suggest that the parents were uncertain or confused about the role of the physician in the emergency department.

Parents' Description of Child's Illness

All the parents interviewed clearly recalled their child's illness that necessitated their visit to the emergency department, for example:

> Mother: (Case #3) [Name] woke up and I usually give her a bath then . . . but when she woke up her rash was so much worse and her hands and feet looked like her circulation was being cut off because of so much swelling and the colour was so dark, like bluish.
>
> Mother: (Case #10) [Name] had red eye and it was swelling . . . is that how [to] say it . . . puffed up so I wait for my husband come home and we go to emergency to see the doctor.

Four of the parents interviewed were placed in rooms immediately upon their arrival to the emergency department. The parents' perceptions of their child's illness and the initial responses of the nursing staff to their child in the department were congruent. The parents believed that it was important that their child receive immediate attention for example:

Mother (Case #12): Well he was bleeding and I thought he should be seen right away but I guess he really was . . . I was so scared that he might need stitches or had lost some teeth or something but you know I was always afraid that I'd faint or something at the sight of blood . . . I was so glad that I didn't.

The eight parents who were placed in the waiting room with their child were not in agreement with the nurses' initial responses to their child's illness. The parents tended to be concerned that no one "really looked" at their child upon their arrival to the nurses' desk in the department:

Father (Case #3): . . . if it was serious enough that they admitted [Name] I think that someone should have looked at [Name] right away.

Mother (Case #3): . . . we thought it was serious enough to bring her to Emergency . . . I think that someone should have at least looked at her on presentation and then decided if we should have to wait . . . no one really did that though and we thought maybe we were overreacting but [Name] is just a baby.

Mother (Case #10): thought [Name] was serious . . . I would not go if I didn't think she sick . . . she should be seen much sooner.

Although the parents who waited acknowledged that their child's illness was not necessarily "a matter of life and death," they generally agreed that as parents "even if their kids (illness) was a little thing automatically you make a big deal out of it because you don't really know how bad it is." One mother was not concerned with the difference between her perception of her child's illness and the nurses'. The mother believed "there wasn't really a hurry for him to be seen" because "he had been sick and he was still going to be sick by the time

he was seen anyway."

Parents' Perceptions of Emergency Environment

During the times that the parents and children were in the emergency department the activity level was low for five cases, moderate for four cases, and high for three cases.

The parents' perceptions of the emergency environment tended to be related to their previous experiences with emergency departments, the initial responses of the nursing staff, and the events that they observed during the time that they spent in the emergency department. Four of the 12 parents were taken to rooms immediately upon their arrival at the nurses' desk. In three of the four cases the parents expressed "surprise" because the last time that they visited the department they "had to wait and wait," for example:

> Mother: (Case #8) I was really surprised that she was seen right away.
>
> Mother: (Case #12) . . . geez it went so fast once I got there [referring to emergency] . . . it was quick and fast.
>
> Mother: (Case #15) Actually I was surprised that he was seen right away.

In the fourth case, the parent and child arrived by ambulance. The mother identified the immediacy of the response in her comment:

> . . . you have to admit bringing your kid in by ambulance sure gets attention at least in the beginning.

For all four cases, the children were initially perceived by the nurses to be "real emergencies" because two of the children were bleeding, one

child had ingested a foreign substance, and one child had convulsions.

Eight of the 12 parents and children were placed in the waiting room upon their arrival to the department. It was apparent that the nurses' perceived the children to be "routine patients." In two cases, the parents expressed dissatisfaction with the response of the desk nurse upon their arrival to the nurses' desk, for example:

> Father (Case #3): Someone should see you right away or at the very least look at you and your child when you go to the desk.
>
> Mother (Case #3): . . . she didn't even really look up at us . . . just told us to have a seat in the waiting room.
>
> Mother (Case #9): . . . sometimes they seem a little bit cold . . . you go in there and somebody says okay sit down and okay come here and wait for the doctor . . . kinda feel . . . they don't really care if my kid dies or not.

In four of the cases, the parents were concerned about the length of time they spent in the waiting room before their child was taken to a room. The parents perceived that the waiting time was especially difficult for their children. Comments from the parents about the waiting time included:

> Mother (Case #9): . . . with kids it's hard to wait too long . . . they get too restless.
>
> Mother (Case #10): . . . bad to wait so long . . . [Name] was serious . . . long wait scare her . . . she will be afraid the next time she go.
>
> Mother: . . . you sit and you wait and you wait . . . you can wait up to an hour . . . sitting there and the kids get cranky and bored.

For the remaining two cases, one mother perceived that "it was okay to

wait" because her child "wasn't crying" and the other mother identified that the "waiting around" was "frustrating but then I made the choice to go there." The mother also commented that she knew "it wasn't a life and death situation" and she felt "comfortable waiting around" because "just having him in there made me feel good . . . if a crisis did develop her child "would be well looked after."

In five cases, the parents and children were in the department an average of four hours and ten minutes. As the length of time in the department increased, the parents identified that "no one" seemed to know "what's happening." One mother described the department as "unorganized" when she discussed her time in the waiting room:

> Mother (Case #11): They [nurses] must have come in (to the waiting room) five or six times and called for all these people that weren't there . . . they ran through the same list five minutes later . . . the same list all over again and you thought oh my goodness that seems like it was all yesterday's patients.

It was evident that the parents perceived that there were communication problems within the department, for example:

> Mother (Case #11): . . . wait for 3/4 of an hour for your x-rays and no one knows what's happening . . . the doctor would ask five times if your x-rays (have) been taken . . . has it been taken . . . no.

> Mother (Case #14): . . . the long wait was after we saw the doctor and before the baby was admitted . . . it shouldn't take so long to make decisions . . . you have a sense that things could move faster.

> Mother (Case #16): . . . same old routine of repeating what happened to every new person that came along . . . long wait for results . . . nobody telling you what's going on.

In one of the five cases, the mother identified that she didn't know "why we had to move into the hall" from a separate room because she "didn't see anyone" go into the vacated room the "whole time" that she was in the department. Another mother recalled from a previous visit to emergency department that "sometimes they (referring to emergency staff) don't think" because:

> Mother (Case #7): When I broke my leg I had to walk to the cast room and x-ray . . . when I broke my arm I was wheeled around (in a wheelchair).

The parents' expectations of the emergency department tended to be related to their reasons for going to the emergency department, the length of time they anticipated that they would be in the department, and their previous experiences in the department. In five of the 12 cases, the parents expected "to see a doctor" and "not to wait too long." Four of the five children in these cases were initially perceived as "real emergencies" and consequently the parents and children were seen by the physician within a short time of their arrival in the department. One child was a "routine patient" but the mother and child were in the department when the activity level was low and were seen by a physician within twenty minutes of their arrival. Two of the parents in this group were satisfied because their child "needed to be seen by a doctor" and "the service was quick." Two of the parents were satisfied with the service but dissatisfied with the emergency physician, for example:

> Mother (Case #8): . . . when I go to emergency I go to see a doctor . . . I go because my kid is sick enough I think to

> need a doctor . . . even if it's necessary to also have to listen to that doctor . . . lecturing to me like a child and making me feel like I'd crawled out from somewhere.

Mother (Case #15): I expect . . . to be treated with courtesy . . . but I must say the courtesy was lacking . . . from the doctor anyway.

One mother's expectations of emergency department were "pretty much what happened." The mother identified "when you've been through it before you don't expect it to change" and in her opinion the emergency department was:

> (the) same old routine of repeating what happened to every new person that came along . . . long wait for results . . . nobody telling you what's going on . . . the usual.

Seven of the 12 parents expected not to wait as long as they did and would have liked the examination and treatment to have been provided in a shorter period of time. As one mother stated:

> . . . you have a sense that things could move along faster but maybe in a place that big . . . it's too much to expect.

Another mother stated:

> We waited a long time . . . too long . . . that's why I hate the emergency.

The parents believed that it was important that "someone should tell you what they think is happening" or "why you're waiting so long" because they needed "to have some idea about how long" they were "going to be there." Seven of the 12 parents were not impressed by the emergency department, for example:

Father: (Case #3) There should be an attempt to determine what caused the problem . . . with [Name] we didn't know where to start to figure out what was wrong . . . nobody seemed to care or be able to answer our questions.

Mother: (Case #10) I only go again if my doctor not . . . no can see her . . . not a very good place . . . not bad but not very good.

Mother: (Case #9) . . . [it's] so clinical I think that tends to scare parents more than . . . reassure them when you go in there."

Mother: (Case #14) . . . it shouldn't take so long to make decisions . . . it should be fairly clear . . . either the baby needs to be admitted or he can go home.

Four of the parents believed that there should be a hospital for children that was set up to respond to their special needs or at least a separate waiting area. As one mother succinctly stated:

> . . . it's a horror show having kids and adults together . . . especially with what can go on . . . like that poor guy they were beating on . . . no one should have to see another person's misery like that . . . let alone a kid.

It was apparent that the mothers were concerned about the lack of privacy and the impact on their children because "there were drunks wandering around" and "they're making a fuss and here's little kids watching them." The mothers identified that it was "bad enough having to go there" and "it would be better if kids weren't exposed to these things" because it was "traumatic for kids."

Parents' Rationale for Using the Emergency Department

Seven of the 12 parents went to the emergency department because it was the closest hospital to their home. Three of the seven parents also went because their child was born there and they were told by

their doctor to go to the department. Four of the 12 parents went to the department because their child was born there and their physician practiced in the hospital and as one father stated:

> As long as I can remember . . . if there was a pr m when was a kid . . . my Mom always took us to the [Name] (hospital).

One parent who was visiting from another province "just went where the driver took me." One mother noted that she "didn't normally go to emergency" but the doctor sent her there "so what can you do?"

Summary

In this chapter, the analysis of the data was presented utilizing Goffman's framework. The data were organized according to the backstage view, frontstage view, and the successful staging of the performance, i.e., impression management of the actors in the emergency department. A summary of the data analyses is presented.

The Nurses as Actors

It was necessary to analyze the nurses' beliefs and impressions of emergency nursing and the environment in which they worked in order to identify the similarities and/or differences in the nurses' performances when they were backstage and when they were performing in front of the parents.

The nurses expressed ambivalence about the role of emergency nurses. They perceived that their role was limited and identified that their expectations of emergency nursing did not match the reality of

the work environment. The nurses tended to link nursing care to performing technical skills for the patient. The nurses apparently preferred to work in the department when "it was busy" but expressed annoyance at referring physicians' "abuse" of the facilities. The nurses tended to group patients according to their perceptions of the patients' need for medical attention. The major categories of patients were "real emergencies," "routines" and "WODS." The nurses frequently used derogatory terms when referring to patients particularly when patients had abused alcohol or drugs. The nurses expressed disparate views in their reactions towards children and parents. Like the adult patients, the nurses perceived that children were "real emergencies," "routines," and "WODS." Some nurses appeared to be frightened of children. It was suggested that nurses did not think they were "in control" when caring for children.

Impression Management

The key actors in the emergency department were the nurses and physicians. The parents were perceived to be members of the audience. The observer participated in 16 nurse-parent interactions in the emergency department. There were five categories of patients identified. The frontstage data were organized by grouping patients, according to the nature of their illness or injury. The nurse-parent interactions were then analyzed for similarities and differences within the patient categories. Finally, the nurse-parent interactions, and the contextual factors influencing the interactions were analyzed for the similarities and differences amongst patient categories.

There were 31 nurses observed interacting with parents in the 16 cases in the study. The actual time that nurses spent with patients averaged approximately one minute over all cases although the range was from two minutes to 20 minutes. The nurse-parent interactions generally were brief and episodic. It was identified that the frequency of the nurse-parent interactions decreased the longer the parent was in the department and that, following the initial contact, the interactions tended to be initiated by the parent rather than the nurse. Parents were not kept informed about delays or why they were still waiting. Parents were rarely given the opportunity to ask nurses questions nor were parents told how they could get assistance from the nurse. There was minimal evidence found of parent-teaching by nurses and/or advice to parents on the child's care following discharge. No evidence was found that the nurses perceived themselves in the role of parent advocate. There was clear evidence of information control that prevented the parents from becoming involved in the child's care. Even when treatments were initiated which might best have been handled by encouraging parental involvement, the parent was left as the audience.

The Stage

The activity level in the emergency department ranged from low to high during the observation periods. It was observed that the activity level did not appear to influence the immediacy of the nurses' initial response to a child, that is, the nurses' initial response to the children was based on their assessment of the child's need for medical intervention. Children who were perceived to be "real emergencies"

were attended to by the nurses immediately upon the parent and child's arrival in the department. When the activity level was moderate to high, the major factors that influenced the parent and child's stay in the department was physician availability. When tests or procedures were ordered by physicians, the parent and child's stay in the department increased. When parents and children were waiting for test results, they were usually placed in the hallways and it was apparent that there was little effort taken to maintain privacy for the parents and child.

In Chapter 6, the findings are discussed and the conclusions, implications and recommendations are presented.

CHAPTER 6

DISCUSSION OF FINDINGS, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

The focus of this study was parent-nurse interactions in the emergency department. For the purpose of this study, an interaction was defined as the "reciprocal influence of individuals upon one another's actions when in one another's immediate physical presence" (Goffman, 1959, p. 15). The discussion of the findings, conclusions, implications and recommendations are presented in this chapter.

Liminations of the Study

1. This study was limited to emergency nurses working in a large urban hospital setting.

2. The study focused on only one aspect of the emergency nurses' role, that is, the nurse-parent interactions.

3. Both the nurses and parents participated in the study voluntarily and their responses may not reflect the population as a whole.

Discussion of Findings

The exploratory questions that guided this study were:

1. What are the characteristics of parent-nurse interactions in the emergency room?

2. What are the parent's perceptions of nursing care in the emergency room?

3. How are these a function of the context and particular types

of situations?

Question 1: What are the characteristics of parent-nurse interactions in the emergency room?

The emergency nurses' initial response to the parents and children depended on their assessment of the child's need for immediate medical attention. If the nurse at the desk evaluated the child as a "real emergency," the child and parent were placed in a room immediately upon their arrival in the emergency department or within five minutes of their arrival at the emergency department. The nurse's initial response to the child was also influenced by the mode of entry to the emergency, for example, a child brought in by ambulance was viewed as a "real emergency" and placed in a room immediately. If the nurse at the desk evaluated the child as "routine," the parent and child were asked to sit in the waiting room. The nurses initial evaluation of whether the child needed to be seen immediately or not was not necessarily based on a thorough assessment of the child. It was frequently noted that the nurse at the desk accepted the child's chart from the parent without making eye contact with the parent or child. Also, it was sometimes the unit clerk who accepted the chart from the parents if the nurse in-charge was busy. If the child was initially evaluated as a "real emergency," the nurse who took the parent and child to an examination or treatment room tended to remain with the parent and child until the physician arrived to decide on appropriate medical intervention, for example, a child with a laceration who was bleeding. Usually the nurses were not present when the physician initially assessed the child, particularly when the desk

nurse had evaluated the child as a "routine" patient. For the majority of cases observed, the nurses' initial assessment of the child was cursory, consequently the amount of time that nurses actually spent interacting with parents was very brief. By virtue of her role in screening the child the nurse had the power to set the stage and to determine the course of events while the parents were in the emergency department. When and how the child was seen by the physician was determined by the nurses' initial actions. When the nurses were interacting with the parents, they usually distanced themselves from the parents, that is: 1) they did not refer to the child and/or parent by name; 2) they rarely maintained eye contact during interactions; 3) they did not ask the parents if they had any questions or concerns; 4) they usually did not touch or hold the child; 5) they did not orient the parents to the routines (such as explaining why it was required that the parents sign the chart indicating that their child had no allergies to medications) and/or the physicial environment of the department (for example, nurses did not show parents that were placed in separate rooms where the patient call bell was located); 6) they did not introduce themselves to the parent and/or child or explain that they were nurses; and 7) they did not inform the parents where they could be found if the parents required assistance or how the parents could seek assistance when they were placed in a separate room and/or in the dressing area that contained seating space for ten people and three stretcher bays. These are all techniques that have been described as modes of information control (Goffman, 1959). Once the physicians' assessment of the child was completed and a course of

treatment decided upon, the nurse-parent interactions were usually non-existent, that is, the nurses ignored or avoided the parents and controlled information that could have been given to the parents. For example, parents remained in rooms or hallways or the x-ray waiting area and they were not approached by the nurses to determine if the parents required any assistance nor were the parents offered an explanation about why they were waiting or the reasons for delays in the department. In another example, a child was given a medication by injection by two nurses and neither nurse explained the purpose of the medication or spoke to the parents when they entered the room or during their brief time in the room. It was noted that the longer the parents stayed in the department with their child, the more likely it would be that the parents not the nurses initiated the interactions. In the majority of cases, more than one nurse interacted with the parents. By controlling information to the parents, limiting and regulating their contact between themselves and the parents, and acting as if they were too "busy" to talk to the parents because they were engaged in purposeful activities elsewhere in the department, the nurses reinforced the importance of their role as key actors in the emergency setting. Consequently, the nurses remained at centre stage and the parents were forced to remain in the role of audience.

Question 2: What are the parent's perceptions of nursing care in the emergency room?

The parents generally had little recall of the emergency nurses. They perceived that they had "little contact" with the nurses and thought their contact was episodic, characterized by the nurses'

"popping in and out of the room." They tended to view the nurses as being "in motion," that is, moving up and down the hallways. As the parents had little recall of the emergency nurses, they perceived that the nursing care given to their child was minimal or non-existent or they equated nursing care to traditional nursing functions such as taking their child's temperature or giving their child medication. In the backstage it was evident that nurses were not readily able to identify what their role was in the emergency department and they tended to perceive their role in terms of medically delegated functions. The impression management was compatible with the actors perceptions of their role. The factors external to the situation that influenced the parents' perceptions of nursing care were: parents' expectations of emergency nurses, parents' perceptions of the role of the nurse, and parents' reasons for taking their child to the emergency department. The parents' expectations of emergency nurses were limited to their previous experiences with nurses in the hospital or the community. The majority of parents had low expectations of the emergency nurses because they recalled negative experiences with nurses in the hospital environment, for example, a mother recalled that the nurses were not caring or supportive when she was in labour with her child. Generally the parents were not clear about the role of the nurse, that is, they did not know what nurses were supposed to do for them or their child. Three of the parents, however, linked the role of the nurse to the public health nurse and perceived nurses as someone that they could talk to about their child and who would listen to their concerns. Thus previous impression management influenced parents'

expectations. The major factor that influenced the parents' perceptions of nursing care was the parents' reason for taking their child to the emergency department. The majority of parents took their child to the emergency department to see a physician and consequently they did not think that their child required any nursing care. There were two sets of parents who did identify the lack of nursing care as a source of dissatisfaction with their experience in the emergency department. These parents perceived that nursing care should be more than "doing something" for their children. Both of these parents linked nursing care to providing support to themselves and their child by listening to their concerns about their child, giving them the opportunity to ask questions, asking them if they needed any assistance with their child, and providing them with information about delays in treatment. One mother viewed a performance disruption. In this situation, an adult patient created a scene and it was evident that the actors (nurses and physicians) were no longer in control of centre stage. The mother's recall of the scene reinforced the fact that a member of the audience had refused to accept his role and decided to become part of the drama on-stage.

Question 3: How are these a function of the context and particular types of situations?

It was noted that the activity level in the emergency department did not affect the frequency or the quality of nurse-parent interactions. The nurses set the stage and controlled the sequence of the acts in the emergency department. The nurses' initial evaluation of the child's need for immediate medical attention, that is, whether

the child was a "real emergency" or "routine" influenced the immediacy of the nurses' response to the child. A child who was perceived by the nurses to be a "real emergency" was placed in an examination or treatment area immediately and the activity level of the department was not a factor in the decision. When the activity level was moderate or high, there were patients on stretchers in the hallways waiting for test results and/or admission to the hospital. The parents perceived that the emergency department was busy and observed the nurses moving up and down the hallways and consequently believed that the nurses were also busy. Again, it was evident that the nurses were setting the stage and the impression management was compatible with the nurses' projection of their role, i.e., they were engaged in purposeful activities. When the activity level was high, there were no nurse-parent interactions. In addition, there was no effort made by the nurses to initiate interactions. The nurses did not approach the parents and explain the reasons for the delays, or ask if they required any assistance, or needed anything such as offering to hold the child while the parents used the telephone. When the activity level was moderate to high, the physicians were not available for follow-up on procedures or tests that were ordered for the child. The nurses generally did not explain to the parents that the physicians were a factor in the delays, such as informing the parents that the emergency physician would have to review the x-rays before further treatment measures could be initiated. The nurses' withholding of information related to the physicians suggested that the actors were attempting to maintain a united front and sense of cohesiveness as members of a

team. When the activity level was high, parents and children were not only delayed by waiting for results of tests or procedures but also waited to have the procedure done, for example, parents waited in the x-ray waiting area for x-rays to be taken. Again, the parents were not informed by the nurses that they would have to wait for a long period of time. As the length of time parents spent in the department the more likely it was that they would interact with more than one nurse. For this reason it is understandable that the parents had little recall of the nurses and identified that there were "so many different nurses." Although the nurses controlled the stage, it was evident that they were not perceived by parents to be the stars in the drama but rather were actors with small parts that were frequently upstaged by the star performers: the physicians. In addition, parents who waited for tests, procedures or treatments observed that there were communication problems amongst the actors on stage, for example, one mother identified that she was approached several times by a physician who asked if her child's x-ray had been done. In another example, the parents experienced a prolonged delay waiting for the nurses to administer medications to their child. As the nurses were not usually present in the room during the physicians' initial assessment, it was perceived by the parents that the nurses and physicians did not function as a team, which further contributed to the audiences' view of the nurse as a bit player and the physician as a star performer. Nurses not only set the stage but moved the stage props around on the stage. When physicians completed their assessments, the parents and children were frequently placed in the hallways to wait for test

results and/or admission to the hospital. Doorways to examinati rooms were left open. In the backstage, the nurses perceived the need to be ready for "what if," that is, for when a "real emergency" came through the doors. It was observed that the rooms frequently remained empty during the times that parents and children waited in the hallways. Moving the props into the centre stage contributed to the audiences' impression that the department was busy. As nurses were controlling the movement of the props it also reinforced, for the nurses, the importance of their role. Parents and children were not provided with any privacy which further reinforced their role as the audience. Emergency nurses "made-fun" of parents in the backstage and referred to children in derogatory terms, for example, "the spotty kid." For the nurses these behaviours reinforced that they were members of the same actors' group. The parents who overheard the comment, however, glimpsed the backstage of the setting because the actors had not sustained fronstage impression management.

Tentative Propositions

The tentative propositions that can be generated from the findings are:

- nurse-parent interactions in the emergency department are brief and episodic
- the frequency of nurse-parent interactions decrease the longer the parent and child remain in the emergency department
- the longer the parent and child remain in the emergency department, the more likely the interactions will be paren- rather than

nurse-initiated

- the activity level in the emergency department does not affect the frequency or quality of the nurse-parent interactions
- emergency nurses evaluate the legitimacy of the parent's and child's visit to the emergency department and this influences the priority that will be placed on the provision of care
- emergency nurses are not aware of parents' psychological needs, for example, need for anxiety reduction
- emergency nurses are not aware of parents' cognitive needs, for example, need for information
- the number of nurses interacting with a parent and child increases as the parents' length of stay in the department increases.
- emergency nurses do not spend time with parents providing supportive care
- parents do not perceive emergency nurses as "care-givers"
- the majority of parents seek a "cure" for their child when in the emergency department not "care" for their child but parents of seriously ill children want "care for themselves"
- parents are not encouraged by nurses to become involved in their child's care in the emergency setting.

The Conclusions and the Related Literature

The review of the literature supports the concept that emergency nurses perceive that their primary goal is to maintain a high standard of patient care (Georgopoulos & Cooke, 1980). The same researchers found that the quality of nursing care was best for emergent patients,

for example, patients with myocardial infarctions. In studies (Gray, 1976; Lewis & Bradbury, 1982; Yoder & Jones, 1981) that attempted to delineate the role of emergency nurses it was found that the nurses' role tended to be limited to medically-delegated functions and functional nursing tasks. There was evidence that the nurses' expectations of emergency nursing were not related to the reality of the work environment and nurses were resistant to the use of the emergency department by non-emergent patients (Lewis & Bradbury, 1982; Millman, 1978; Yoder & Jones, 1981). In this study, it was evident from the nurses' backstage behaviours that the nurses were confused about the role of the emergency nurse but, as in earlier studies, they also viewed their role in terms of medically-delegated functions. The nurses did not see supportive care and teaching as part of the emergency nurses' role. In the backstage, the nurses also acknowledged that they expected to care for emergent patients and expressed frustration about the abuse of the department by non-emergent patients.

Findings from previous studies (Millman, 1978; Roth, 1972, 1978a) indicate that emergency nurses refer to patients in derogatory terms and that they recount stories about the most bizarre cases, grouping patients into categories such as "difficult." Similarly, in this study, the nurses used derogatory terms when discussing patients and recounted unusual stories about patients in the backstage. There was some indication from previous studies that emergency staff responded more positively to children and were therefore less likely to resort to control strategies (Roth, 1972, 1978a; Sudnow, 1978). The children in this study could not articulate their own needs. It was expected that

the nurses would interact with the parents and that the nurses would probably not judge the legitimacy of the parents utilization of the emergency department, this was not the case. Roth (1978a) found when a patient's use of emergency was perceived as illegitimate, he typically received "hurried, routine processing" and this treatment also applied to children. Roth also noted that surgical cases were perceived to be more legitimate than medical cases. The nurses, in this study, classified the children and parents according to their perceptions of the legitimacy of the child's emergency visit. The nurses perceived children with lacerations as "real emergencies" and therefore as legitimate users of emergency. The nurses at the desk responded quickly to these children and they were processed through the department quickly. Children with medical problems, such as an allergic reaction were judged by the nurses to be illegitimate users, i.e., "routine patients" and typically received a cursory assessment by the nurses at the desk and the nurses attending them in the examination rooms. This judgement of the patients as legitimate or illegitimate users of emergency was used by nurses as a mechanism of control over the parents and children, i.e., the desk nurse controlled when and how the child would be seen by an emergency physician and influenced the other nurses' responses to the parents and children. It was the nurse at the desk who determined where the child would be placed in the department. Placement in the waiting room signalled to the other nurses that the child was "routine" and not in need of immediate nursing attention. The nurses also used other control strategies with the parents such as avoidance, withholding information, and limiting

their contacts with the parents to retain situational control.

The literature also suggested that parents tended to abrogate their parental role in the emergency department when their child required admission to hospital (Roskies, Bedard, Gauvreau-Guilbault, and Lafortune, 1975). The nurse-parent interactions were brief and episodic, but the control exercised by the nurses actually divested the parents of their role, for example, parents were not asked to participate in giving their child medication. The nurses did not explain to the parents what the medications were, the purpose of the medications, and the expected effects. Further, parents experienced lengthy delays waiting for their child to be admitted, but were not informed by the nurses about the reasons for the delays. In fact the nurses generally ignored the parents which was a common control strategy in this study.

Nicklin (1979) found that families need to know what is happening in the emergency environment in order to alleviate their anxiety and there was evidence that parents, in this study, were perturbed by the lack of information they received. The parents were not kept informed by the nurses about delays and/or procedures or tests planned for their child. The nurses generally did not attempt to alleviate parents' anxiety. The nurses did not demonstrate that they were aware of the parents' psychological needs and their backstage behaviour indicated that they did not see supportive care and teaching as part of the role of the emergency nurse. In a study of inpatient facilities (Rosenthal, Marshall, Macpherson, & French, 1980) it was suggested that nurses cast family members into the role of patients when the relative became the

focus of the nurses' attention. The researchers found that the nurses used this strategy in order to exercise control because the nurses perceived that the family members were "outsiders" and less subject to control and therefore represented a threat to the nurses. In the current study, the children could not articulate their needs consequently the nurses focused their attention on the parents. There was evidence to suggest that the nurses cast the parents into the role of patients given the number of control strategies that they utilized. There was also some evidence that nurses did not feel in control when dealing with children, thus the nurses may have operated on the assumption that controlling the parents equated to controlling the child. The nurses' response to parents whose children had ingested poisonous substances suggested that the nurses not only cast them in the role of patients but punished them for their "bad" behaviour by ignoring them and leaving them to deal with the child's vomitus.

Previous studies (Georgopoulos & Cooke, 1980; Roth, 1972, 1978a; Lewis & Bradbury, 1982) have shown that emergency nurses are closely aligned to the emergency physicians and that the nurses and physicians function as a team. Although there was evidence that the nurses witheld information from the parents related to the physicians, in order to present a united front as a team, the nurses and physicians were not perceived as a team by the parents. The nurses were rarely in the room with the parents and child at the same time as the physician which may have contributed to the parents' perceptions. Generally, the parents in this study did not view the emergency nurses as "care-givers" but then the parents generally were seeking a "cure" for

their child rather than "care" in the emergency department.

It was anticipated that the activity level in the emergency department would impact on the quality and frequency of nurse-parent interactions (Millman, 1978; Roth, 1978a). In this study, it was found that there was no difference in the frequency or quality of the parent-nurse interaction when the activity level was low, moderate, or high.

A review of earlier literature (Resnick & Hergenroeder, 1976; Roskies et al., 1975) suggests that there is a need to improve nursing care of children in the emergency setting, particularly as the child's only exposure to a hospital may be the emergency department. These researchers also suggest that the parents' psychological needs may be as important as the child-patients' needs. In this study, the parents and children who were in the emergency department for prolonged periods of time interacted with several different nurses, for example, there were 13 nurses involved with the parents of the four children who were admitted to the hospital. Consequently, not only were the nurse-parent interactions brief and episodic, but there were multiple nurses involved with the parents and their children which precluded the establishment of nurse-parent, nurse-child, and/or parent-nurse relationships. As there was little evidence of nurse-parent and/or nurse-child relationships, it was apparent that the emergency nurses were not assessing the child-patients' needs or the parents' psychological needs. Further, in the situations where any emergency nurse attempted to establish a relationship with a parent and/or child, there was little evidence that the nurses functioned in the role of

"care-givers" or acted independently based on the nursing diagnosis of a child's illness and a child's need for nursing intervention. For example, when a nurse identified that a child's temperature was 40°C, the nurse requested that a physician see the child as soon as possible, whereas an acceptable nursing intervention would have been to commence sponging the child with tepid water to reduce the fever. There was also little evidence that emergency nurses were aware of child development or problems specific to the pediatric patient. The nurses' lack of awareness about milestones in a child's development was apparent when a nurse placed an eight-month old child on the floor and asked the child if he could walk. Some of the emergency nurses admitted that either they disliked caring for children or that they were afraid of children.

Implications for Nursing

In this study, the researcher attempted to describe one aspect of the emergency nurses' role, the nurse-parent interactions in situations which involved pre-school children. It was observed that the nurse-parent interactions in the emergency department were brief, episodic, and non-supportive of the parents. Parents were not sure about the functions of nurses in the hospital setting and most parents were not expecting nursing care in the emergency department. Further, it was shown that emergency nurses were confused about their role in the emergency setting, that is, they expected to care for patients who were "real emergencies" not "routine" patients. The nurses perceived themselves to have a limited role and that was reinforced by the

parents' perceptions of the role. The nurses' expectations of emergency nursing were not congruent with the reality of emergency nursing. It is known that the utilization of the emergency department has changed dramatically during the 1970's and 1980's, but emergency nurses are apparently not prepared to recognize and/or accept that nursing care in the emergency department is not restricted to providing care to "emergent" patients. It is necessary for emergency nurses to recognize that they have the responsibility of caring for a diverse group of patients ranging from infants to senior citizens. Consequently, it is important that emergency nurses begin to articulate what the role of the emergency nurse is and the dimensions of that role when caring for infants or adults. In order to prepare nurses for the reality of emergency nursing and the multifaceted nature of the role of the emergency nurse, consideration must be given to the eduational preparation of emergency nurses and the focus in education programmes that are specific to emergency nursing. It is evident that there is a need to focus on the art of nursing as well as the technical aspects of emergency nursing. It is important that emergency nurses develop effective communication skills and utilize the nursing process to formulate a nursing diagnosis on which to base appropriate nursing intervention. It is suggested that nurses preparing at the baccalaureate level be encouraged to enrol in courses from faculties such as sociology, psychology, and anthropology, that not only expand written and oral communication skills but facilitate understanding of human behavior. It is apparent that patients need teaching and supportive care in the emergency department. In addition, it is

important that emergency nurses refrain from judging the legitimacy of a patient's or parent's visit to the department. Patients and/or parents should be accorded the courtesy of an initial assessment by the triage nurse that extends beyond a cursory glance. It is not acceptable for patients to be placed in a waiting area by a clerk.

To begin to resolve some of the problems experienced by parents in the study there is a need to consider changing the method of nursing assignment in emergency departments. In this study, nurses were assigned to certain areas in the emergency department, which resulted several nurses interacting with the parents, thus preventing consistent care. This method of assignment not only disrupted the continuity of patient care but appeared to result in lowered standards of nursing care as no one nurse was accountable for the nursing care or was in a position to establish a relationship with the parent and/or child. Nurses who did not care to work with children were also in a position to avoid them which may have contributed to delays in treatment. Certainly this assignment of nurses by area resulted in delays or omissions in treatments and explanations about what was happening, for example, why the parents were waiting so long for test results. The parents did not perceive emergency nurses in a caring, supportive role because there was minimal opportunity for parents to really assess the role of the emergency nurse. It is suggested that primary nursing care would begin to resolve the problems experienced by parents in this study. With primary nursing care, a nurse would identify with specific patients. The nurses would probably experience greater satisfaction with the role of the emergency nurse because they would establish a

relationship with the parent and child. The nurse would be accountable for updating the parents about the reasons for the delays and/or prolonged waiting times. It is also suggested that a core group of nurses on each shift be identified to work specifically with parents and children. It is expected that the nurses would volunteer and therefore it is assumed that the nurses would want to work with children.

Although not well documented in the literature, it is suggested that a play therapist assigned to work in emergency departments on days and evenings can assist the nurses in assessing and caring for children and parents in a emergency department. In the general hospital setting, in order to improve the quality of care for the pediatric patient, consideration should be given to identifying a specific area, for example, two examining rooms that will be allocated for use by children and/or parents. Consideration should also be given to establishing a separate waiting area for children that contains childrens' washroom facilities, appropriate toys, telephone service for parents, and has been decorated to appeal to a cross-section of children.

Recommendations

The researcher recommends that:

1. Primary nursing care be implemented in emergency departments and evaluated after a six-month period to determine whether improvements in care have been effected.

2. Screening procedures on admission should include an initial

assessment by a registered nurse of the patient's status and the reasons for attending the emergency department.

3. Nursing administrators be made aware that pediatric patients have different needs from adult patients and that the parents psychological needs are also important in the emergency setting.

4. Nursing administrators be made aware of the diversity of patients utilizing emergency facilities.

5. Hospital administrators consider establishing separate waiting areas for children and parents in the Emergency Department.

6. Emergency nursing programmes should be developed that include content relating to cultural diversities, emotional-supportive needs of patients in crisis, and developmental milestones which influence the approach that must be taken with children.

7. Further descriptive studies be done in other emergency settings in order that comparisons can be made across hospitals.

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Appendix A

A-1 Information Letter: Nurses

RESEARCH: Nurse-Parent Interactions
In The Emergency Department

My name is Sharon Toohey and I am a student in the Masters of Nursing Program at the University of Alberta. The topic of my Masters' Thesis is nurse-parent interactions in the emergency department. In this study, the intent is to describe how emergency nurses respond to parents of children, as children cannot identify their own problems, for example, babies and children up to 3 years of age. To describe what emergency nurses do it is necessary to observe them interacting with patients and/or families. I have been given clearance by the Director of Nursing, Assistant Director of Nursing, and the Unit Supervisor to observe and collect data on nurse-parent interactions in the Grey Walls' Hospital emergency department.

When parents bring their children to the emergency department, I will accompany the nurse and the patient as an observer to the area where treatment will commence. When the nurse has completed her work with the child, I will ask the parent to sign a consent form to interview them within a week of their emergency visit.

All data gathered will be strictly confidential and no participant (i.e., you the nurse) will be identified in my report on the study findings. Because I am observing nursing care, I am asking you to sign the consent enclosed. Please return the consent to your Associate Unit Supervisor.

I will be picking up the consents the week of March 21st, 1983. I will start my first observation period on Tuesday, March 29th, 1983 at 1600 hours. The next observation period wil be Thursday, March 31st, 1983 at 1600 hours. I have clearance to obtain additional information from the charts, so I will also be looking at the patients' charts.

If you have any questions or concerns, please do not hesitate to contact me.

Telephone numbers: Home-434-4058
Other-432-8435

Appendix B

B-1 Nurses' Consent Form

B-2 Parents' Consent Form

B-3 Parents' Consent Form 2

Nurse Consent Form

Project:	Study of Emergency Nursing
Investigator:	Sharon J. Toohey Masters in Nursing Student Faculty of Nursing University of Alberta Edmonton, Alberta T5J 2L5
Under the Supervision of:	Dr. P.A. Field Faculty of Nursing University of Alberta

I hereby consent to participate in this study and to allow the researcher to observe my nursing care in the Emergency Department. I understanding that whatever information I give is considered confidential and will be used in such a way as to protect my anonymity.

I understand that I may refuse to answer any questions, and that I may withdraw from the study at any time, without penalty.

I have been given the opportunity to advance to ask questions of Ms. Toohey, about her reserach and these have been answered to my satisfaction.

_____ _____

Date Nurse

Parent Consent Form

Project:	Study of Emergency Nursing
Investigator:	Sharon J. Toohey Masters in Nursing Student Faculty of Nursing University of Alberta Edmonton, Alberta T5J 2L5
Under the Supervision of:	Dr. P.A. Field Faculty of Nursing University of Alberta

I hereby consent to participate in this study and to allow the researcher to observe me and my child's treatment in the Emergency Department. I understand that whatever information is collected will be considered confidential and will be used in such a way to protect my anonymity.

I understand that I may refuse to answer any questions, and that I may withdraw from the study at any time, without penalty.

I have been given the opportunity to advance to ask questions of Ms. Toohey, about her reserach and these have been answered to my satisfaction.

Dat	Parent
Researcher	Witness

Parent Consent Form (2)

Project:	Study of Emergency Nursing
Investigator:	Sharon J. Toohey Masters in Nursing Student Faculty of Nursing University of Alberta Edmonton, Alberta T6J 2S5
Under the Supervision of:	Dr. P.A. Field Faculty of Nursing University of Alberta

I hereby consent to participate in this study and to allow the researcher to visit my home and tape record the interview. I understand that whatever information I give is considered confidential and will be used in a way to protect my anonymity.

I understand that the interviews will be tape recorded, and at the end of the project these tapes will be erased.

I understand that I may refuse to answer any questions, and that I may withdraw from the study at any time, without penalty.

I have been given the opportunity to ask questions of Ms. Toohey, and these have been answered to my satisfaction.

Date	Parent
Researcher	Witness

Appendix C

C-1 Data Collection Sheet

C-2 Patient Information Form

C-3 Interaction Collection Sheet

DATA COLLECTION SHEET

DATE: _____

TIME OBSERVATION STARTED: _____

WHERE OBSERVATION STARTED:
ENTRANCE TO E.R.: _____ WAITING ROOM: _____ NURSES' DESK: _____
EXAM. AREA: _____ DRESSING AREA: _____

MECHANISM FOR ENTRY TO E.R.:
VIA AMBULANCE: ____ CARRIED BY PARENT: _____ WALKING WITH PARENT: ____

E.R. ENVIRONMENT:
ACTIVITY LEVEL: HIGH: _____
MODERATE: _____
LOW: _____
MANPOWER: SHORTAGE OF NURSES: _____ PHYSICIANS: _____
AUXILIARY PERSONNEL: _____

RESPONSE TO PARENT BY R.N. AT DESK: _____
_____

RESPONSE TO PARENT BY R.N. IN AREA: INTRODUCE SELF TO PARENT: YES__ NO__
_____

CONSENT FROM PARENT FOR OBSERVATION: YES: _____, NO: _____, TIME: _____
LOCATION: _____
CONSENT FROM PARENT FOR FOLLOW-UP VISIT: YES: _____, NO: _____

TIME OBSERVATION COMPLETED: _____

CASE NO.: _____

Patient Information Form

Name: _____

Age: _____

Siblings: Brothers: _____ Sisters: _____ Order _____

Racial background: _____

Occupation (or previous occupation) Mother: _____
_____ Father: _____

Address: _____

Telephone No.: _____

Diagnosis: _____

Treatment in E.R.: _____
_____
_____

Previous Use of Emergency by parents for child/children _____
_____

Parents verbally agreed
to follow-up visit Yes _____ No _____

INTERACTION COLLECTION SHEET

DATE: _____ CASE NO.: _____

TIME:

Appendix D

Final Guideline for Parent's Interview

GUIDE FOR FOLLOW-UP INTERVIEW WITH PARENTS

1. Can you describe as clearly as you can your child's specific illness or injury that was you main reason for your visit to the emergency department?

2. What made you decide to take your child to Grey Walls' Emergency Department for treatment (rather than go elsewhere)?

3. Can you describe to me what happened after you arrived in the emergency department with your child?

4. Do you remember how long you had to wait with your child before you and your child were seen by a nurse?

5. As far as you can tell now, how important was it that your child receive immediate attention at that time?

6. Can you tell me what you remember about the nurse (nurses) who took care of your child in the emergency department?

7. How would you describe that care that the nurse (nurses) gave to your child while she (he) was in the department?

8. Do you think that the nurse (nurses) gave you the opportunity to ask questions about your child's injury or illness?

9. What do you expect as a parent when you take your child to the emergency department?

10. How do you expect the nurse (nurses) to act towards you as a parent?

11. If you were in-charge of the emergency department, can you tell me as a parent, what changes you would make in the department?

12. Do you have any questions?