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NURSES' ASSESSMENT OF PATIENT CHARACTERISTICS IN AN EMERGENCY DEPARTMENT

BY 

C. LYNNE GRIEF

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment of the requirements for the degree of MASTER OF NURSING.

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DEDICATION

To Gordon, for everything . . . .

Utrinque Paratus

ABSTRACT

Moral evaluation (i.e., the appraisal of the goodness or badness of character or disposition) by health care professionals is a regular feature of emergency settings. While nurses are taught to be non-judgemental, unbiased, and objective and to overcome any natural or culturally learned reactions to patients, empirical evidence suggests that nurses' actions towards patients are often biased and prejudiced. Judgements concerning patients' moral fitness and the appropriateness of their visit to the Emergency Department are constantly made and the treatment rendered to the patient is consequently affected by these judgements.

The purpose of this study was to explore three aspects of moral evaluative behavior. These include patient characteristics emergency nurses use to morally evaluate Emergency Department patients, the rationale emergency nurses give for their behavior, and factors which influence the nurses' behavior.

The research took the form of a descriptive study using a mailed questionnaire. It was conducted on nurses working in Emergency Departments in hospitals throughout Alberta. Eighty-three questionnaires were completed and returned representing a response rate of 55%. Data were collected on emergency nurses' demographic and personal characteristics, personal and professional experiences and behaviors, attitudes towards caring for specific types of patients, and reasons for moral evaluative behavior.

A definite hierarchy emerged from the data validating previous research which found that the nature of the illness and diagnosis in addition to certain patient

characteristics are critical in determining emergency nurses' attitudes. Data analysis revealed that many emergency nurses are unaware of their evaluative actions and that neither external nor factors innate to the nurses played a significant role in their judgements of patients.

The findings of the study have implications for the quality of nurse-patient behaviors and relationships. If patients are aware of being disliked by the nurse caring for them, the nurse-patient communication and ultimately their relationship is jeopardized. Recommendations for nursing education included encouraging nurses to recognize the dynamics, consequences, and inherent dangers of labelling patients, and to improve understanding of patients who were identified as unfavorable, but who will be needing and using health care services in the future.

PREFACE

If there were no difficulties, there would be no triumphs . . . .

Anonymous

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CHAPTER I

INTRODUCTION

Background and Statement of the Problem

Despite our claims to the contrary, there is evidence that patients are treated differentially according to their illnesses, putative social class, occupation, -2 appearance, age, attitudes, gender, and behavior (Glaser & Strauss, 1964; Jeffery, 1979; Kelly & May, 1982; Peternelj-Taylor, 1989; Ritvo, 1963; Roberts, 1984; Roth 1971, 1972a, 1972b, Roth, 1974; Roth & Douglas, 1983; Yoder & Jones, 1981). In our society we value people more or less on the basis of social characteristics and accomplishments. A social value is placed on a patient (i.e., moral evaluation) and that value frequently has much to do with the care he/she receives (Glaser & Strauss, 1964; Roth 1971, 1972a, 1972b, 1974; Roth & Douglas, 1983).

Nurses represent the largest group of health professionals in the Emergency Department (ED). Consequently their perceptions and attitudes influence greatly how patients are viewed, assessed, and treated within that department and play a crucial role throughout their hospitalization (Roth & Douglas, 1983; Yoder & Jones, 1981). Staff members at later stages of the processing tend to accept earlier moral categories without question unless they detect vivid evidence to the contrary (Roth, 1972a).

Nursing requires interaction between a nurse and patient with each bringing a set of expectations and beliefs about the other. In today's society, because of the number of strangers we meet, we tend to form rapid opinions of others based on previous experience (Roberts, 1984). These are not always accurate or relevant and

may create faulty prejudgments. Prejudicial behavior is present in nursing and has serious implications for nurses who are entrusted with the physical and psychological care of people (Glaser & Strauss, 1964; Peternelj-Taylor, 1989; Roberts, 1984). It is possible that the nurses are not even aware of their prejudicial ways (Roberts, 1984).

It is crucial to identify aspects of the nurse-patient relationship that may account for differentiation in quality of care rendered to patients (Kelly & May, 1982; Peternelj-Taylor, 1989; Roberts, 1984). By identifying characteristics that nurses use to evaluate patients morally it may be possible to encourage critical self-examination of negative and positive feelings and attitudes towards patients with certain characteristics with the hope of their amelioration.

Implications For Nurses

The way nurses practice with regard to nurse-patient relations is often different from the way nurses were educated. The researcher felt that it would be useful to see which factors affect this and how nursing education curricula could be altered to increase nurses' understanding of the dynamics of "labelling" (i.e., applying a classifying phrase to their patient). Additionally through continuing education, emergency nurses can be helped to more fully understand the dynamics of the non-urgent patient (Jones, Yoder, & Jones, 1984).

Discussion of research findings with emergency nurses could result in increased insight into who, when, how, and why patients are morally evaluated. Although it is recognized that there are some patients who will always be difficult to work with, by recognizing those characteristics that cause them to react negatively,

nurses may be better able to care objectively for all patients. Conversely, if nurses recognize that they react negatively to patients for reasons they cannot change (i.e., an unpredictable, uncontrollable work environment or increasing numbers of non-urgent patients) they may decide that they are better suited to a different environment. Bell (1988) determined that probably the most significant area for improvement in the delivery of nursing is in the re-education of the emergency nurse for a changing nursing role. Indeed, Toohey (1984) concluded that the nurses' expectations of emergency nursing were not related to the reality of the work environment. Although the ED patient population has changed considerably over the last few decades, the expectations of the emergency nurse have not. The nurse finds the greatest job satisfaction in taking care of the traditional, trauma patient although this patient constitutes a declining proportion of the emergency patient population (Jones, Yoder, & Jones, 1984).

Aamodt (1982) maintains that we have yet to confront the full potential of caretaking as a human response. She argues that a study such as this is the first step toward generating a framework that can contribute to nursing ideology. A clear recognition by nurses of the evaluating that they do can help buffer the impact of such evaluations. This is relevant because all individuals are aware of being judged by others in society.

Implications For The Public

Today's public generally has become more aware of its role and its rights with regard to health care. Expectations of the health care system continue to rise. These

consumers expect to be respected as individuals and to have equal access to health care regardless of economic status, sex, age, creed, ethnic origin, and location (Alberta Hospital Association, 1990). They do not intend to seek the permission of health care professionals to obtain equal access. The ED is a major initial source of patient contact and the hospital's reputation will be determined, in part, by the care given in its ED. Good public relations must be maintained. Kirkpatrick and Taubenhaus (1967) identified two ways of caring for non-urgent patients in the ED. The first involved seeing them, treating them, and attempting to educate them not to "misuse" the ED in the future. It was recognized that this approach did not appear to be successful and served only to alienate the patients and open the hospital to criticism. Kirkpatrick and Taubenhaus (1967) subsequently advised that emergency nurses accept as fact that the non-urgent patient will continue to use the ED and should therefore structurally and functionally organize the department in such a way that these patients receive the same quality of care as do the minority patients (i.e., the acutely injured/ill).

It is expected that the health care system of the future will be even more citizen/consumer-driven (Adams, O., Ramsay, T., & Millar, W., 1992; Alberta Hospital Association, 1990). Consumers are expecting not only quality care, but the opportunity of making decisions as to where they seek their health care. The ED increasingly suits their purposes in that there is access to a physician at all times, no appointment is necessary, and it provides diagnostic, treatment, and referral facilities 24 hours a day, seven days a week. It is only reasonable to expect that the usage of

the ED will increase for non-urgent patients. Indeed personal experience of the investigator is that many emergency nurses and their families are using the ED in such a manner.

Medicentres (i.e., medical clinics which operate on a "walk-in" basis) developed partially in response to public demand for convenient access to medical care. However, they do not operate 24 hours a day nor do they have a complete array of diagnostic equipment and treatment facilities. Consequently, many patients prefer to use the ED for their health care as it continues to be thought of as the optimal facility for their health care needs.

Health Care Trends

It is reasonable to expect that this trend meets with the approval of health care economists. The cost of an outpatient visit is reported to be less than one-half the cost of an inpatient day (MacLean & Mix, 1991). An examination of input and output costs showed a decline in the productivity of inpatient care (i.e., a 16.3% increase in the inpatient cost per patient day) whereas the outpatient cost per outpatient visit declined 2.3% (MacLean & Mix, 1991).

In the early 1970s patients' bills of rights emerged, making more explicit the rights of patients. In the United States, the American Hospital Association adopted a 12-point statement of patients' rights and in Canada the Consumer's Association of Canada developed a four-point statement (Baumgart & Larsen, 1992). These associations claimed that such guidance was necessary as the health care professional codes of ethics did not sufficiently address issues of patients' rights (Baumgart &

Larsen, 1992).

Factors Affecting Emergency Department Usage

Today's economic climate affects ED usage. Financial cutbacks have necessitated bed closures. Although the total number of beds operating has been reduced, the number of cases treated per annum remains relatively constant (R. Plain, personal communication, August 25, 1992). This impacts on the ED as patients are ultimately discharged earlier. They arrive in the ED with complications or seeking information. For instance, new mothers discharged 24 hours post-delivery, often seek reassurance and information in the ED where in previous years, the nurses on the post-partum wards met these needs.

Technological advances affecting surgery have also affected the ED. The whole concept of Day Surgery and the advent of laparoscopy techniques result in earlier patient discharge post-operatively. If these patients develop complications or require information, they often turn to the ED. Heretofore it was the nurses on the surgical wards that attended to their concerns.

The reduced number of hospital beds also means that people are waiting longer to reach the top of the waiting list for elective surgery. Some, on the advice of their physician, try to "beat the queue" by arriving at the ED. Whether or not they are successful, they are still classified as an "outpatient visit".

Additionally many treatments, once delivered as inpatient care, are now being handled as an outpatient procedure. One such common example is the intravenous (I.V.) antibiotic regimen. In previous years patients were admitted to the hospital to

receive I.V. antibiotics every four to six hours. Today they return to the ED every four to six hours, with heparin/saline lock in situ, to receive their course of antibiotics for 48 to 72 hours or longer if necessary.

Effects On Emergency Department Funding

The emerging characteristic of the patient population in the ED (i.e., the increased numbers of "non-urgent" patients) is such that a change in the funding system of hospitals in this province has become necessary. In the past, EDs were allocated funds according to the number of patient visits per year, regardless of patient diagnosis and/or acuity. This was found to be increasingly inadequate and non-reflective of the EDs' needs. One "emergent" patient is much more labour-intensive and requires more supplies and procedures than many non-urgent patients. It was discovered that EDs seeing more, but less acute patients were receiving more money from the government than those that were dealing with the acutely ill and injured patients (A. Krauskopf, personal communication, August 26, 1992).

Consequently the Alberta Government attempted to allocate monies in a manner more reflective of each ED's need. Each ED was to classify every patient as either non-urgent, urgent, or emergent but again the results were unsatisfactory (A. Krauskopf, personal communication, August 26, 1992). This was attributed to the fact that the various EDs were using a variety of staff (i.e., nurses, orderlies, registration clerks, physicians) to categorize the patients. In addition there was no objective criteria with which to classify the patients.

In an attempt to obtain a more accurate reflection of patient acuity and

therefore financial requirements, the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) was adopted as the reference in April, 1992. This tool was designed for the international classification of morbidity and mortality information for statistical purposes. Patients are presently being classified as 1 (minimal amount of nursing care required), 2 (moderate), 3 (complex), 4 (extensive), and 5 (critical).

Local Emergency Department Usage

To date, statistics from two hospitals (i.e., Hospital A and Hospital B) in Edmonton, Alberta which have been designated by the government as trauma centres, support the trend of increasing numbers of non-urgent patients utilizing the EDs. These hospitals receive all trauma victims from within the city and its surrounding areas, as well as those patients injured in the northern parts of the province. That is, they accept the most critically ill and/or injured patients in Northern and Central Alberta. In Hospital A, 51% of the patients in April, 1992 were Class 1 and 2 (i.e., non-urgent or should seek medical care within 24 hours), 42% were Class 3 (i.e., urgent or should receive medical care within three hours), and only 6% of the patients seen were Class 5 and 6 (i.e., emergent or must receive medical care immediately) (A. Krauskopf, personal communication, August 26, 1992). These figures remained relatively constant for the months of May and June, 1992. Hospital B's statistics were comparable with 55% of their patients in April, 1992 being Class 1 and 2, 38% being Class 3, and 6% being Class 4 and 5 (Krauskopf, A., 1992). Similarly, their statistics were constant for the months of May and June, 1992. The referral hospital

for Southern Alberta, located in Calgary, reported an average of 4.7% of their patient population as being class 4 and 5 (Krauskopf, A., 1992). The ED Unit Manager from one of these hospitals concurs that there has been a steady increase in the percentage of non-urgent patient visits over the past five to ten years (A. Krauskopf, personal communication, August 26, 1992).

As Roth (1971) predicted, the question as to whether or not a patient should have come to the ED will diminish in importance in the near future. Patients are seeing the ED as a valuable community resource for dealing with their health care needs. The hospital and its personnel must accept the public definition of the ED--a place to get medical care in a hurry.

Nursing research has been scarce in the area of attitudes that influence levels of care in the ED. Attitudes, while difficult to measure, are important factors as they determine the tone and progress of social interaction. It is the nature of the judgements made by nurses about patients which are significant, rather that anything inherent in the patients themselves (Kelly & May, 1982). That is, how "worthy" the patient is to receive optimal health care should not be the issue--rather it is the health care professionals' attitudes towards the patient that need be addressed. The five principles upon which the Canada Health Act (1984) is based include portability, universality, accessibility, comprehensiveness, and public administration (Baumgart & Larsen, 1992). This legislation, which addresses the right of access to care, states that Canadians, regardless of age, race, religion, health status, socioeconomic status, etc. have the right to equal access to our health care system.

The researcher felt it necessary to access emergency nurses to establish how widespread moral evaluation of patients was and to gain insight regarding the practice. A logical first step in changing attitudes considered destructive to nurse-patient interaction is to identify that a problem exists.

Purpose of the Study

The purpose of this study was to explore which patient characteristics emergency nurses use to morally evaluate ED patients, the reasons they attribute to this behavior, and to attempt to identify some factors which contribute to the evaluative behavior.

Increased insight into the importation of the values of society into work and the subsequent evaluating of patients, could result in necessary attitudinal change making it easier to determine patient needs objectively. The ultimate result could be improved levels and quality of nursing care.

Research Questions

This study was guided by the following research questions:

1. Which patient characteristics do emergency nurses use to morally evaluate ED patients or patients requesting emergency care?
2. What reasons do emergency nurses give for morally evaluating ED patients or patients requesting emergency care?
3. Which factors (i.e., individual and/or environmental) influence the degree of moral evaluation carried out?

CHAPTER II

REVIEW OF RELEVANT LITERATURE

The ideal of the health care profession is to have a system free of negative or unhelpful moral values by which individuals are judged unfairly--that is, we will help every patient regardless of his or her socio-economic status and other characteristics. However, empirical evidence suggests that moral evaluation by health care professionals is a regular feature of medical settings and these evaluations directly affect the treatment rendered to the patient (Jeffery, 1979; Roth, 1971, 1972a). Moral evaluation is defined as the appraisal of the goodness or badness of character or disposition. "Moral" is a norm-invoking term which refers to a specific category of human judgement--that is, what is deemed befitting and/or appropriate character and behavior for human beings. Responses can range from admiration to resentment (McInerny, 1987).

All or nearly all societies have established cultural rules or norms resulting in established moral values which influence behavior. That is, we have presumed norms with regard to behavior. Because group functioning depends on the existence of a set of shared social values, there is pressure for responsible behavior in our society and individual members are expected to obey these moral rules (Maccoby, 1980). Indeed, according to Kohlberg, most adolescents and adults are at the "conventional" stage of moral reasoning where the individual understands, accepts, and upholds the existing social rules and expectations (Ketefian, 1987). Those who do not conform are condemned because they have violated their obligation to the social contract to make

and abide by laws for the welfare of all and for the protection of all peoples' rights (Maccoby, 1980).

Moral values are not rules imposed by one person on another, but rather reciprocal agreements that balance the individual's obligations to others against others' obligations to the individual (Maccoby, 1980). Moral values are acquired in a lengthy developmental process and are asserted as basic moral truths as one goes through life. These beliefs develop from many sources including one's family, culture, religion, significant others, traditions, personal experiences, and the statutes of one's society (McInerny, 1987). We judge others according to our moral understanding and correspondingly determine their social worth. Nurses are no different in that they evaluate patients according to how they perceive the patient's moral judgement and subsequent behavior differs or coincides with his/her or the societal norm. Patients may be negatively evaluated if they breach social rules which are merely customs or conventions as well as those that must be followed to prevent others from being hurt (eg., driving a vehicle while under the influence of alcohol).

The Nurse-Patient Relationship

The nature of the nurse-patient relationship in the ED is unique in that the nurse has little or no background knowledge of the patient and thus uses observable characteristics to quickly evaluate the patient (Roth, 1971). In this study, "Emergency Department" will refer to the many different types of

settings available to patients seeking emergency care. These settings range from the large, independent department located in a referral hospital which operates 24 hours a day, seven days a week, and is staffed at all times with a complement of Registered Nurses, emergency physicians, and support staff to the one room set aside in a rural hospital for the purpose of dispensing emergency services/outpatient care as required. In such small locales there may not even be a formally acknowledged ED. The patient must ring the hospital doorbell to announce his/her presence which then results in the nurse leaving his/her other duties to attend to the new arrival's needs. The physician must be called in from the office or home to attend to the patient.

Emergency nursing is the rendering of health care to those patients who present themselves to the ED of the hospital. There exists an unscheduled and unpredictable manner in which the patients arrive. The normal day/night cycle is irrelevant. The environment is unique in that there is a fluctuating volume of patients and variety of patient conditions. It involves a series of brief contacts with previously unknown and anonymous persons. It is a service relationship which is often random and impersonal in that it is unlikely that the nurse will see his/her patient again. There is a limited intensity and duration of nursing contact with the patient. Even if the patient does come back on a regular basis, it is unlikely that he or she will see the same nurse consistently. Although ED clientele is often made up of people living in the area, the staff do not have a long-term perspective and therefore treat each case as an episode

which will be finished when the patient is discharged (Roth, 1971). Consequently nurses may not invest much time and energy into getting to know the person behind the patient or encouraging him/her to return. Also, because there is little or no continuity of care (i.e., several nurses checking in on any one patient), patient care is often fragmented and, at times, compromised (Toohey, 1984).

The Setting

Unlike many service relationships, such as those found in restaurants, hotels, and private law practices, the ED cannot select its clientele. This deprives it of even minimal controls over which clients come and go. There is a lack of control over the number of patients and the patient acuity level. Roth (1971) and Jeffery (1979) found that the power to screen and therefore select one's clientele is a common basis for rating schools, law firms, medical practices, etc. In fact, high selectivity where one "reserves the right to refuse service to anyone" is a common occupational aspiration (Jeffery, 1979; Roth, 1971).

The ED can be a choiceless and hazardous environment in which to work. Although it is difficult to provide statistics which are applicable to all Emergency Departments (EDs), one ED in the United States provides statistics which show that one-third of all patients seen between 2100h and 2400h and two-thirds of those arriving between midnight and 0300h had positive blood alcohol levels (Sheehy, 1992). Rice and Moore (1991) warn that the inherent atmosphere of confusion, rapid

pace, prolonged waiting times, patients with severe illness, patients with psychiatric problems, and an "open door" policy, lends itself to violence.

Emergency Department Usage

It is a well-documented pattern that patient use of EDs has risen steadily over the past few decades (Jones, Yoder, & Jones, 1984; Lewis & Bradbury, 1982; Yoder & Jones, 1981). In fact, the number of ED visits in the United States has more than tripled since 1958 (Sheehy, 1992). Outpatient visits to public hospitals in Canada have increased 61.3% from 1976 to 1987-1988 whereas inpatient equivalent days have increased by only 35.4% (MacLean & Mix, 1991). MacLean and Mix (1991) found that a large increase in ED visits accounted for the majority (58.2%) of the increase in outpatient visits.

Factors involved in the increased usage of the EDs may be classified into four different categories (American Hospital Association, 1972). These include "population factors" such as a growing world population, an aging population with its concomitant increased usage of health care services, an increased prevalence of chronic diseases, an increased accident rate, and an increased geographic mobility of the population which results in people finding themselves without a regular family physician (American Hospital Association, 1972; Andreoli & Musser, 1985; Kluge, Wegryn, & Lemley, 1965). "Physician factors" include a decrease in the number of family practitioners--especially in the inner-city areas, the unavailability of physicians after hours, weekends, and/or holidays, increased physician specialization, and advances in medical technology and science which have reduced the capacity of the

family physician to treat patients optimally in the office (American Hospital Association, 1972; Kluge, Wegryn, & Lemley, 1965; Torrens & Yedvab, 1970). "Institutional factors" involve the fact that the role of the hospital has changed in that physicians have accepted the ED as the preferable place (i.e., over the office) to diagnose and/or treat acutely ill/injured and at times nonurgent patients (American Hospital Association, 1972; Kluge, Wegryn, & Lemley, 1965). Additionally there is increased awareness, expectations, and confidence on behalf of the public, in the hospital as an appropriate, convenient, and accessible place to seek care (American Hospital Association, 1972; Kluge, Wegryn, & Lemley, 1965). Finally "external factors" include a growing tendency for industries, schools, and police to refer patients to the ED, and a growing sophistication of the public's knowledge of symptoms and the immediacy with which they should be treated by a physician (American Hospital Association, 1972; Stratmann & Ullman, 1975). Improved transportation means that patients no longer have to rely on the availability of their nearby family physician when they are ill--they can travel some distance from their home, in a short period of time to get to a hospital (Kluge, Wegryn, & Lemley, 1965). Health care cost escalation and cost-containment measures are manifested in bed closures and cuts in services with a concomitant increase in the number of patients found in the ED (Andreoli & Musser, 1985).

Triage systems began in EDs in the early 1960s when the demand for emergency services began to exceed that which was available. Triage is an effective method of establishing work priorities by separating those who require immediate

medical attention from those who do not. This trend of increased usage of EDs requires that efforts be made to ensure greater predictability and control of clientele so that some semblance of order and expediency is achieved in a safe environment (Davis, 1959; Roth, 1971). Davis' (1959) study of a typology devised by cabdrivers revealed an extensive body of stereotypes which existed to reduce the uncertainty and increase predictability about each fare's behaviour. However, Davis (1959) questioned the accuracy and efficiency of such a typology.

Patient Typology

It appears that within EDs, there is a typology with preferences for and against categories of age, race, ethnic, and socio-economic status with subsequent presumptions of moral behaviour and reputation being made (Hirst, 1983; Kelly & May, 1982; Roth, 1974). In effect, the staff are influenced by the social and moral definitions of the illness as well as its scientific definition (Yoder & Jones, 1981). When the values which the patient exhibits differ from those of the nurse, censorship may occur in the form of moral evaluation (Hirst, 1983). And the more a patient's behaviour, attitude, or attributes differ from those which the nurse approves of, the less interested the nurse becomes in putting time and energy into giving care to that patient (Roth, 1971). It is assumed that nurses will apply the evaluations of social worth common to their culture (Goffman, 1951; Roth, 1972a).

By labelling and morally evaluating patients, nurses can group them into categories thus recognizing individuals as types rather than unique persons. Recognition of expected features enables them to predict how a patient will behave

while in the ED. In addition to making the environment a safer one in which to work, it is felt that such categorization will make the increased numbers of patients more manageable and increase expediency (Jeffery, 1979; Roth, 1971, 1974).

Glaser and Strauss (1964) concluded from their work that as nurses learned more about the social characteristics of a patient, they had the opportunity to change their moral evaluation of that patient. The ED environment is atypical in that one of its goals is to discharge the patient as efficiently as possible. Consequently emergency nurses react mainly to the patients' apparent characteristics because they do not have the opportunity to learn about their other social characteristics (Glaser & Strauss, 1964).

Relevant Work

Although there has been much work done in the area of "good" and "bad" patients, the data reported thus far is weak. Roberts' (1984) study is the most thorough in examining factors which may influence nurses' evaluative behaviour but his self-administered questionnaire is brief and narrowly focused subsequently leaving gaps in the information. Additionally, his sample was comprised of student nurses, not experienced emergency nurses. It is important to note that his study was not limited to the ED. Although his findings differed from others in that there was a low degree of stereotyping behaviour by the students, he concurred that the students were prejudiced towards patients who threatened their self-identity, hindered the flow of routine ward duties, or were not an "interesting" medical case (Roberts, 1984). An important conclusion made by Roberts (1984) is that the more time the student nurse

had at her disposal to converse with patients she disliked, the more likely she was to change her attitudes towards them.

Previous Work In This Area

While we would like to think that our system treats all clients as equally worthy of help, there is no evidence that professional training succeeds in creating a universalistic moral neutrality (Roth, 1971). Whereas nurses are taught to be non-judgemental, unbiased and objective and to overcome any natural or culturally learned reactions to patients, it is apparent that judgements about patients' moral fitness and the appropriateness of their visit to the ED are constantly made and staff action is consequently affected by these judgements (Peternelj-Taylor, 1989; Roth, 1971, 1972a, 1974; Szasz, 1960). Indeed, only an extremely small percentage of nurses studied avoided classifying patients as "good or interesting" or "undesirable" or stated that such classification did not exist (Ritvo, 1963; Roth, 1972a).

Low Boundary Control

The effect of the openness of the ED is that it is an area with little control over the population it serves--it has "low boundary control" (Roth, 1971, 1972a; Yoder & Jones, 1981). Consequently there is great variety in the types of people who utilize its services. Their frustration over this lack of control and inability to refuse to care for some clients makes some emergency staff hostile towards their patients (Roth, 1971). Roth (1971) found that emergency staff generally see the bulk of their patients as undeserving of the services available to them. He concluded that not all patients were treated in a similar manner--that is nurses were selective in how

they chose to deal with the patient (Roth, 1971).

Non-urgent Function of the Emergency Department

While the ED is socially mandated to provide care to the acutely ill and injured, the public has become aware of its non-urgent function resulting in an increasing proportion of patients with non-urgent problems (Jeffery, 1979; Jones, Yoder, & Jones, 1984; Lewis & Bradbury, 1982; Yoder & Jones, 1981). Although the nurses consistently exaggerated that 80-90% of people coming to the ED did not belong there, it was found in one hospital that only 20-25% of the ED patients had no serious illness or trauma (Roth, 1971, 1972a). Roth (1971, 1972a) found similar results in another hospital where only 23% of the 938 patients seen over a two day period were actually illegitimate. He noted that such exaggeration proliferates when categories of patients are discussed amongst staff members who commonly complain about the constant influx of alcoholics, patients with psychiatric complaints, and women with pelvic inflammatory disease. Roth's work (1971, 1972a) revealed that in fact only 6% of the total ED population studied consisted of alcoholics, 2% had gynecological problems, 1% involved venereal diseases, and only 2% had psychiatric problems.

Although Hawley (1992) concluded that "misuse of the ED" by non-urgent patients was one of the two major stressors cited by emergency nurses, it may be more realistic to state that only a minority of ED patients are truly "illegitimate".

Nurses' Response to Non-urgent Patients

Roth (1972a) noted that in situations where the question of urgency is

uncertain (i.e., multiple trauma patients are quickly classified as emergent by all staff whereas abdominal pain is more ambivalent), staff members have more room in which to make a judgement about whether or not the patient's symptoms are sufficiently serious to deserve their care. While outwardly complying with the hospitals' philosophy that no patient will be turned away, staff members resist this non-urgent use of the ED (Lewis & Bradbury, 1982; Jones, Yoder, & Jones, 1984; Yoder & Jones, 1981). Subtle, if not open conflict between staff and patients develops as the staff makes judgements about whether this case is appropriate to and deserving of their service. (Hawley, 1992; Roth, 1971, 1972a, 1972b; Toohey, 1984; Yoder & Jones, 1981).

Findings from previous research showed that emergency nurses' frustration with non-urgent patients did not stem from a personal dislike for the patients but from the frustration of working within the organization of the ED which does not allow for non-urgent conditions or ambivalent diagnostic statuses (Jones, Yoder, & Jones, 1984). That is, the organization of the ED is equipped for medical emergencies which require immediate treatment. Nurses may punish the patient if he or she feels that the patient's illness is not legitimate by making derogatory remarks within the patient's hearing range, avoiding eye contact, completely ignoring the patient, treating the patient abruptly, delaying treatment, using excessive physical force, etc. (Jeffery, 1979; Roth, 1971, 1972a; Yoder & Jones, 1981).

Attempts at Increasing Predictability and Control

The nurse-patient relationship, in the ED, involves a series of brief contacts

with people of whom they have no foreknowledge, and whom they are not likely to encounter again. This creates a high degree of uncertainty and invariably conscious and unconscious attempts are made to fashion means to improve predictability and work towards more control. Because there is little time to learn about patients' other social characteristics, the nurse must rely on clues garnered from his/her mode of arrival, appearance, behavior, the kind of people who accompany him/her and other social characteristics (Glaser & Strauss, 1964). The interpretation of these clues becomes crucial to further treatment (Roth, 1971, 1972a, 1974).

Patient Behavioral Characteristics

Nurses have been found to be biased against patients who are rude, stubborn, angry, complaining, unappreciative, anxious, fearful, withdrawn, depressed, bizarre, outrageous, confused, apathetic, refuse to accept that they are ill and/or the care that is offered, overdependent, demanding, verbally and/or physically abusive, immature, emotional, manipulative, attention seeking, and overly knowledgeable about their condition (Hawley, 1992; Jones, Yoder, & Jones, 1984; Kelly & May, 1982; Papper, 1970; Roth, 1971, 1972a, 1974; Roth & Douglas, 1983). Roth (1971) observed that some patients were allocated to categories according to their mode of arrival (i.e., by police vehicle, ambulance, or referred by another physician or the Workers' Compensation Board) and he concluded that it was their membership in the category rather than the nature of their illness/injury which determined their legitimacy. Toohey (1984) also found that the nurse's initial response to the ill child was influenced by the mode of entry to the ED in that if the child arrived by ambulance

he/she was seen to quickly.

Nature of the Illness/Injury

The nature of the illness/injury that the patient presents with and the subsequent diagnosis can be critical in determining the attitudes of the emergency nurse. Bell (1988) concluded that although the acuity of care in the ED is declining, it is the nurses' critical care role that provides them with strong feelings of satisfaction. Minor or chronic illness/injuries, alcohol or drug related problems, social or psychiatric problems have been noted to be particularly resented (Hawley, 1992; Jeffery, 1979; Jones, Yoder, & Jones, 1984; Kelly & May, 1982; Lewis & Bradbury, 1982; Papper, 1970; Parette, Hourcade, & Parette, 1990; Roberts, 1984; Roth, 1971, 1972a, 1972b, 1974; Roth & Douglas, 1983; Scheff, 1964; Toohey, 1984; Yoder & Jones, 1981).

Patient Physical Characteristics

Patients who were obese, dirty, odorous, scantily clad, or tattooed were frequently seen as not worth bothering about in the emergency setting (Armstrong, 1991; Goffman, 1959; Jeffery, 1979; Kelly & May, 1982; Papper, 1970; Roth, 1971, 1972a, 1972b, 1974; Roth & Douglas, 1983; Yoder & Jones, 1981).

Patient Social Characteristics

Nurses are cognizant of the following social characteristics when they first encounter patients: age, nationality, perceived socioeconomic status, education, morals, family status, and intelligence; occupation, employment status, religion, and social style such as dialect and vocabulary (Glaser & Strauss, 1964; Goffman, 1959;

Kelly & May, 1982; Papper, 1970; Roth, 1971, 1972a, 1972b, 1974; Roth & Douglas, 1983; Yoder & Jones, 1981).

Gender Issues

Gender appears to be an issue only when combined with particular attributes. For instance a scantily clothed woman is perceived negatively by emergency nurses whereas it does not appear to be an issue with male patients (Roth, 1972a). Peternelj-Taylor (1989) found that overweight women were evaluated and treated more negatively than overweight men. A common perception amongst staff members is that most "drunks" are male and that the average "overdose", who does not really wish to die, is female (Jeffery, 1979; Roth, 1972a). Women with tattoos are especially regarded in a negative manner (Armstrong, 1991). Jeffery (1979) and Roberts (1984) concluded that "good" patients were almost entirely described in terms of their medical symptoms, whereas the "undesirable" or "illegitimate" were judged from a moral point of view and described in predominantly social terms with a partial or total disregard for the symptoms he/she presents with.

Methods of Patient Control

In previous studies it has been found that many staff members maintained a stance of moral superiority and controlled patients/visitors through the use of verbal and physical hostility (Jeffery, 1979; Parette et al, 1990; Roth, 1971, 1972a, 1972b; Toohey, 1984). More subtle ways of control included delaying patients' treatment and withholding information. By not making things too convenient and/or by decreasing the overall quality of care, the patients were not encouraged to come back

(Jeffery, 1979; Roth, 1971, 1972b; Toohey, 1984).

Labelling Behavior

The nurse's verbal report is often used as a forum to consciously express personal prejudices and label patients. Reputations may be established for patients in terms of the information passed on either verbally or via the patients' written records (Jeffery, 1979; Roth, 1971, 1972b). This constructed reputation determines to some extent the kind of treatment which a patient will subsequently be given as new personnel are inclined to treat a given patient in accordance with the established reputation before they actually work with him/her (Roth, 1984). Labelling behavior appears to be dependent upon one's life experiences, generalized attitudes to life and work, hospital environment, the degree of professional qualification, work experience, age, sex, racial or ethnic origin, family life, nationality, cioeconomic status, socialization patterns, upbringing, and adoption of reference group values (Armstrong, 1991; Goffman, 1959; Kelly & May, 1982; Lewis & Bradbury, 1982; Parette et al, 1990; Roberts, 1984; Yoder & Jones, 1981). While there does not appear to be any evidence that particular people label more than others, it is noteworthy that variance exists in the manner and degree to which emergency personnel use moral evaluation to determine how they will treat the patient (Roth, 1972a). Additionally, consensus does not have to occur. Nurses with the same information vary in their appraisals of the same patient and in the manner and degree to which they use social worth to determine the quality of their service to the patient (Glaser & Strauss, 1964).

Roberts (1984) and Glaser and Strauss (1964) noted that in environments

where nurses were able to spend time interacting with patients and discovering their less apparent characteristics, they often changed their opinions (and hence labels) of the patients. There has been no evidence of this occurring in the ED. This might be attributed to the fact that the ED, by its very nature, does not facilitate similar quality of interaction with patients. Generally, both parties anticipate their relationship to be an expedited experience.

Contributory Studies

The data reported thus far in the literature can be criticized on empirical grounds. While some of the studies examined contributing factors which may be responsible for evaluative behavior, such as work-related stress, attempts at gaining control, and ED socialization, many did not (Glaser & Strauss, 1964; Hawley, 1992; Jeffery, 1979; Peternelj-Taylor, 1989; Ritvo, 1963; Roth, 1971, 1972a, 1972b, 1974, 1984; Roth & Douglas, 1983).

Jeffery (1979), Roth (1971, 1972a, 1972b) and Roth & Douglas (1983) used a combination of participant observation and interview. Others employed self-administered questionnaires (Hawley,1992; Lewis & Bradbury,1982; Roberts, 1984; Peternelj-Taylor,1989; Yoder & Jones, 1981). The fact that none of these studies mention that self-reporting is subject to bias weakens the data. Although Roberts (1984) acknowledged the self-selection bias inherent in his method and incorporated more of the factors which may be involved in moral evaluation, his survey was brief and left gaps in the information. Unfortunately, his study was not confined to the ED and his sample consisted of student nurses--not experienced emergency nurses.

Because the ED is a unique area of any hospital, Kelly and May (1982) caution investigators against generalizing from studies conducted in different settings and using different members of the health team.

Gaps or Shortcomings in the Work Done to Date

Many of the research findings to date appear to be inconsistent, non-replicatory or non-reliable--and thus lack external validity (Kelly & May, 1982). Some of the difficulty lies in the variety of research instruments used by different researchers. However, even with different instruments, the results should be compatible. No one seems to have compared and replicated the research (Kelly & May, 1982). Careless definition of concepts (i.e., what is meant by a "dirty" patient) and inadequate measuring instruments applied to inappropriate populations result in data which are not meaningful in terms of their internal validity (Kelly & May, 1982). The issue of subjective phenomena being treated as objective fact is not addressed (Kelly & May, 1982). This may account for the variance in research findings. Given these features of the data, it is unlikely that any adequate theoretical constructs have been created (Kelly & May, 1982).

Much of the literature concentrates on staff members' descriptions of patients with the data presented in the form of a listing of patient traits. The staff who ascribe the characteristics in the first place, or why they do so, are ignored. Kelly and May (1982) argue that the research would be more useful if it concentrated on the health care personnel and not on their opinions about patients. Studies to date have not investigated how patients react to their "brusque" or insensitive treatment by staff.

People are usually aware of being liked or disliked and often change their behavior to conform to others' expectations of them. The existing studies appear to presume that all people behave similarly when they enter the hospital as a patient or visitor and adopt a non-reactive stance to however they are treated. There is no perspective on nurse-patient interaction in these studies (Kelly & May, 1982). It is reported that nurses respond to certain patients in a particular way but many questions are left unanswered. We cannot assume that there is a cause and effect relationship rendering patients as passive recipients of nursing behaviors. Indeed, the consequences of labelling are not discussed (Kelly & May, 1982). How variables such as factors external and intrinsic to nurses relate to the issue remain unanswered. The social processes involved here have not yet been studied (Kelly & May, 1982).

This current study replicated with modifications, previous work in the area of moral evaluation of ED patients. It was deemed important by the researcher to determine whether information generated from this study was consistent with or different from previous studies in which emergency nurses received a negative image. It is necessary to establish the accuracy of this reflection of emergency nursing if the information gained is to be useful for nursing education and practice. That is, it must be established that emergency nurses do, in fact, morally evaluate their patients in a negative manner, prior to investigating how the patients react to such treatment, the effects of such treatment, and the direction nursing education must take to affect changes in our nursing practice. Much of the previous work centred on observation of emergency nurses at work and/or brief surveys. The writer wanted to inquire of

emergency nurses, in an anonymous fashion, what characteristics they perceived when caring for patients and whether or not they were cognizant of forming early opinions of their patients.

Conceptual Framework

Exploratory research is conducted with the major purpose being to generate new knowledge about a phenomenon. Until the phenomenon is better developed, a conceptual framework rather than a theoretical framework must be used (Burns & Grove, 1987). Eventually, the findings of this study and similar ones can be developed into theory that is useful for nursing education and practice.

The conceptual framework of this study included the concepts of patient characteristics, moral evaluation, and nursing care. The relationship identified was that patient characteristics evoke either a negative or positive moral evaluation on behalf of the emergency nurse. The resulting nursing care of the ED patient will be determined by the type of moral evaluation he/she receives. That is, moral evaluation has the main effect on the outcome.

The researcher eliminated theories of attribution as a theoretical framework for this study as emergency nurses do not have time to do this. Theories of attribution focus on the cognitive processes involved in forming attributions as well as concentrating on people's explanations of human behavior (Ross & Fletcher, 1985). On the basis of their observations, people form beliefs or theories about what is occurring in an attempt to understand, predict, react, and control events that surround them.

In attribution theory, "moral evaluation" is used as a way to assign and thus interpret and judge moral responsibility for actions. It examines the role of motivation in one's actions. For example, at the level of "intentionality", individuals are held responsible only for the consequences of their actions that they intended to produce--not for any accidents that occur (Ross & Fletcher, 1985). For the purposes of this study, "moral evaluation" is used to express another's judgement of the goodness or badness of the character or disposition of a person--that is a judgement of their moral values.

The nature of the emergency nurse-patient relationship is one of anonymity and singularity. Emergency nurses do not have a long-time perspective of their patients as they know it is unlikely that they will encounter the patient again (Roth, 1971). Thus it is unlikely that they would invest time to ponder the causes of their patients' behaviors and/or characteristics, even if they had the necessary information to do so. In reality, emergency nurses appear to recognize certain characteristics/behaviors of an individual and react without considering the causes of the behaviors.

There is no reason to assume that the nurses would deliberate about the cause of their patient's behavior. They are more likely to evaluate the appropriateness of patients' behavior by comparing it to their own or society's norm than by assessing its causes (Ross & Fletcher, 1985). Not every social judgement is a causal one (Kelly & May, 1982).

CHAPTER III

RESEARCH METHODS

Design of the Study

The research took the form of a descriptive study using a survey with a mailed questionnaire. It was conducted on nurses working in an emergency setting in hospitals throughout the province of Alberta.

Sample Characteristics and Sampling Procedure

A stratified probability sample was selected by computer from the target population. The target population consisted of the Alberta Association of Registered Nurse's (AARN) list of nurses who met the following criteria:

1. hold current registration with the AARN
2. work in direct patient care
3. work in an active treatment hospital, in Alberta, which provides emergency services
4. 50% of sample have identified that they work in EDs in hospitals with 500 or more beds
5. 50% of sample have identified that they work in the emergency setting in hospitals with 150 or fewer beds

The sample was accessed through the AARN who possess a complete listing of all registered nurses currently practicing in Alberta. Consultation with the Office Manager of the AARN revealed that they were able to categorize the list of nurses according to size of hospital in which they work, their capacity in the hospital (i.e.,

direct patient care, education, etc.), and their area of specialty. The investigator obtained the current listing of active treatment hospitals in Canada from the Alberta Healthcare Association and the current list from the Canada Nursing Job Guide which identifies those hospitals across Alberta which provide emergency services. It was from this list of names that the sample of nurses was selected by computer.

Ethical Considerations

By utilizing the services of the AARN, respondents' names, home addresses, and the hospitals in which they work were kept anonymous. This, in addition to respondents mailing in the completed surveys, ensured their anonymity. Completion and return of the questionnaire constituted consent to participate.

Data Collection

Data were collected on emergency nurses' demographic and personal characteristics, personal and prc fessional experiences and behaviors, attitudes towards caring for specific types of patients, and reasons for moral evaluative behavior. Variables measured included:

1. patient characteristics
2. nurse characteristics
3. ED environmental characteristics, such as location, size, type of hospital (i.e., referral, teaching), and hours of operation
4. reasons attributed by nurses for their evaluative behavior
5. nursing behaviors (e.g., giving report, gathering patient data, forming opinions of patients)

Instrument for Data Collection

The instrument used to collect data included a self-administered questionnaire developed by the investigator (see Appendix A). The questionnaire begins with 29 multiple choice and open-ended "fill in" questions involving nurses' personal and professional background and working environment. Then follows eight multiple choice and open-ended questions on nurses' experience as a patient or visitor in an ED. The next section includes 29 Likert Scale items and multiple-choice questions concerning nurses' personal life, such as "How often do you smoke cigarettes?", and their views on some social issues (eg., "Is it too easy to collect Unemployment Insurance?"). The next section includes 42 Likert Scale items discerning how much nurses like or dislike caring for specific patients (eg., "How much do you generally enjoy caring for patients admitted because of intentional overdoses?"). A comment space is provided should they wish to qualify their answers. This portion of the instrument is an adaptation of Roberts' (1984) instrument and was used with permission (see Appendix B). The following section involves 35 open-ended and multiple-choice questions looking at nursing behaviours, such as "Has peer pressure at work ever caused you to act towards a patient differently than you would have normally?", and "Do you usually agree with your colleagues' opinions of a particular patient?". The final section consists of one Likert Scale item investigating responses to evaluative statements concerning emergency nursing (eg., "The ED is a dangerous place to work due to violent patients").

Pilot Test

A pilot test was given to six expert nurses, each with a minimum of ten years experience in emergency nursing to establish the questionnaire's face validity and to determine that it would prove to be relevant to the study sample. All six nurses were currently working in a ED within an urban tertiary care hospital. They were asked to review and critique the research instrument prior to its final draft and implementation to ensure the clarity of questions, effectiveness of instructions, completeness of response sets, time required to complete the questionnaire, and adequacy of data collection techniques. Some minor wording changes were incorporated into the final questionnaire as a result of the pilot study.

Validity

Consultation with an expert in questionnaire design and administration with special expertise in dealing with sensitive topics was sought throughout the development of this instrument to establish its expert validity and thus its content validity (Burns & Grove, 1987). Content validity was further enhanced by incorporating selected content areas from all studies reported to date in addition to questions raised by the researcher who is an experienced emergency nurse. Throughout the questionnaire, the term "moral evaluation" was avoided to prevent subjects from giving "proper" or "socially desirable" responses.

An assumption made in this study is that a questionnaire is a valid instrument to survey the knowledge of a population and that the participants in the survey would complete the questionnaire in an honest manner.

Study

Distribution and Collection of Questionnaires

Once provided with the questionnaire and the introductory letter explaining the study (see Appendix C), the AARN distributed the questionnaire through the mail to the home addresses of the sample. Respondents returned the completed questionnaire to the investigator in an enclosed postage-paid, self-addressed envelope. The AARN discretely numbered each return envelope which enabled the researcher to keep a record of those respondents who had not returned the questionnaire. Six weeks later, the AARN mailed out a follow-up letter, prepared by the investigator, to subjects not responding to the first mail out. The questionnaire was sent to a total of 150 nurses, and of these 83 (55%) questionnaires were completed and returned to the investigator. The response rate for nurses working in hospitals with 150 or fewer beds was identical to that of nurses working in hospitals with 500 or more beds (33%). This study yielded a reasonably high response rate according to the AARN. Their average response rate for mailed questionnaires is usually 25 to 30 percent (J. O'Donnell, personal communication, March 8, 1993).

Data Analysis and Use

Responses to the multiple choice questions and Likert Scale items were summarized with descriptive statistics. Nonparametric statistical analysis was used to determine whether a significant difference at the $p < .05$ level existed between the responses of the subjects. Data analysis of the unstructured data began with content analysis in which answers to each question were separated into mutually exclusive

categories of similar content. Initially all answers to each question were read several times in order to establish a general sense of the implication of the answers. During this process, subcategories of content within each category became apparent. Decisions and then rules were established to guide separation of content. Eventually all data were categorized. The number of responses within each category and subcategory were tabulated and frequencies reported through the use of descriptive statistics. Further analyses included multivariate statistics using analysis of variance techniques.

CHAPTER IV

PRESENTATION OF FINDINGS

Description of Sample

Respondents' Demographic Characteristics

Gender, Age, Marital Status, Children.

The nurses in this study were almost exclusively female (98%) with the youngest member of the sample being 26 years of age and the oldest 59. The mean age was 40 years with a standard deviation (SD) of 8.06. Approximately 77% (64) of the respondents reported being either married or living in a common-law relationship with a small segment (10%) identifying themselves as being either separated or divorced. An equally small proportion (10%) were single. Of the 56 respondents who had children, 50 had children younger than the age of 18 years.

Ethnicity and Religious Affiliation

Eleven percent (9) of the sample reported themselves to be a visible minority according to race and/or colour. Approximately 20% (16) of the respondents replied that they could speak "more than one language". When questioned about religiosity, 18% (15) reported "no religious affiliation". Of those having a religious affiliation, almost 50% (41) belonged to the Protestant faith while 20% (17) adhered to Catholicism. A minority (13%) reported attending their place of worship on a weekly basis with the majority (61%) attending "less than once per month or not at all".

Summary

In summary, the typical respondent was female, Caucasian, middle-aged, and

married with children under the age of 18 years. With the exception of age, the sample profile was congruent with that of the emergency nurse population as provided by the AARN's February 1993 statistics (J. O'Donnell, personal communication, March 8, 1993) in that 96% of the ED nurse population (N = 858) are female with a mean age of 47 years. The ages in this population range from 22 to 68 years. Although the mean age of the study sample was slightly younger (40 years), the study findings should not be affected as both mean ages are generally considered to be "middle-age" (Williamson, Munley, & Evans, 1980). It is important that the mean ages are similar as people usually hold beliefs and values common to the era in which they were reared. We tend to morally evaluate with our reference point being our own beliefs and values system.

It is unknown why there was an over-representation of younger nurses in the sample. Perhaps younger nurses are more inclined to complete and return questionnaires? Regardless, the study was not affected by this over-representation as subsequent data analysis showed that age had little effect in determining attitudes of the nurses.

The AARN does not collect data about the marital status, ethnicity, or religious affiliation of its members. However, the researcher's twelve years experience in emergency nursing validates that the study sample appears to be representative with regard to marital status and ethnicity.

Respondents' Educational, Financial, and Employment Background

Education

On average, the respondents graduated with a Registered Nurse (RN) Diploma 18 years ago (1975). The number of years worked in emergency nursing ranged from one to 20 with the average number of years being approximately 7.5 (SD = 5.1). Eighty-four percent (70) of the nurses in the sample had as their highest qualification an RN Diploma. Only 11% (9) had obtained a BScN. It is of interest to note that although nurses are encouraged to acquire this degree, over half (59%) of the sample had "no intention of returning to college/university to continue their nursing education".

Financial Resources

Concerning their rearing, 50% (41) of the respondents perceived that they came from families who had "average" financial resources when compared to others in their community. While 26 came from "below average" financial backgrounds, 14 came from families who had "above average" financial resources. Twenty percent (16) reported that at least one of their parents had a university degree.

Employment

Roughly one-third (27) of the sample had worked "full-time" in another occupation prior to entering nursing. Such occupations included factory work, bartending, housekeeping, sales, secretarial work, and waiting on tables. Interestingly none of the respondents left highly skilled or qualified work to enter nursing.

Although only 13% (11) of the study sample had collected unemployment

benefits, 65% (54) had friends or family members who had received such assistance. Over three-quarters (63) of the respondents expressed confidence that it was "unlikely to very unlikely" that they would become unemployed within the near future.

Summary

In brief, the sample represented highly experienced emergency nurses who primarily hold an RN Diploma. They have never experienced unemployment or a career change. This sample appeared to be typical of the ED nurse population in which 68% (603) have an RN Diploma as their only qualification and only 10% (90) have earned at least a BScN. Statistics describing the number of years worked specifically in ED nursing are not available for the population but close to 50% of the RNs currently working in Alberta (N = 24,385) have nursed for at least 15 years. Although data are not collected on all aforementioned criteria, it is the researcher's opinion that this study sample was representative of Alberta's ED nursing population.

Respondents' Working Environment

Despite the guarantee of anonymity and confidentiality, many respondents failed to complete all of the questions concerning characteristics of the institutions in which they worked. Twenty-two percent (18) failed to respond to question number 21B which asked respondents to identify their hospital as "community, downtown/core, or neither". Seven percent (8) did not answer question number 21C which dealt with the hospital's function (i.e., teaching/referral hospital). Higher levels of non-response for these two questions suggest that some respondents were concerned about their identity being revealed, may not have understood the questions or simply did not know how to

answer them.

Rotation

At the time of data collection, 54% (45) of the study sample were working between 15 and 37 hours each week. Slightly more than a third (30) indicated that they worked 37.5 hours or more each week. All three shifts were represented in this sample.

Hospital

Approximately 50% (41) of the respondents identified that they were employed in urban hospitals while 40% (33) worked in rural hospitals. The remainder (10%) declined to respond to this item. The number of beds per hospital ranged from 20 to 1200 with the overall average being 438 beds. The average number of beds in hospitals with 150 or fewer beds was 62 and the average number of beds in hospitals with 500 or more beds was 850. Most of the sample (94%) worked in an ED which remained open 24 hours a day.

Summary

In summary, the sample included nurses who worked at least twice a week in a hospital which offered emergency services with 24 hour coverage. All three shifts were represented. The sample was closely divided between urban and rural hospitals. The study sample is similar to the AARN statistics, in that 53% of Alberta's ED nurses are employed within the two large urban areas of Edmonton and Calgary. It is difficult to compare the average number of hours worked each week between this sample and the AARN population. The AARN statistics are not specific to ED nurses

and a different classification of hours (i.e., 16 - 29 hours as opposed to the survey's 15 - 37 hours) is used. However, it is the opinion of the researcher that the sample did not appear to be atypical in any way.

Respondents' Way of Life

The researcher was attempting to discern whether the respondents were amenable to new experiences and whether their lifestyles could be described as "conservative, normal, or adventurous". This could prove to be an important factor in a nurse's tendency to morally evaluate his/her patients. That is, it is reasonable to explore whether a nurse with a conservative lifestyle is more inclined to morally evaluate certain patients in a negative manner.

Although it is difficult to obtain indicators of an individual's way of life through the use of a questionnaire, crude denotations such as willingness to try unusual foods, choice of dress, frequency of cigarette and alcohol consumption, and experience in travel to foreign countries were selected in an attempt to gain such information. It is recognized however that economics and opportunity also influence one's opportunities in life.

Food, Travel, and Dress

The respondents cannot be classified as "adventurous" in their choice of restaurants. Although 96% (80) reported dining at Chinese restaurants, only 18% (15) had tried Arabic foods. However, 40% of the respondents were rural and might not have ease of access to such foods. Similarly they have not taken "adventurous" journeys. Seventy-four percent (61) of the nurses in the sample had never travelled to

an Oriental, African, South American, or Asian country. Only 23% (19) claimed to "dress differently than others". Ten percent (8) of the sample smoked cigarettes on a "regular" basis. Approximately one-third (28) of the nurses reported their alcohol consumption to be limited to once or twice a month and just 2% (2) drank alcohol "every day".

Social Activities

The study sample did not mingle with their ED colleagues on a regular basis. In fact, close to 70% (56) of the respondents indicated that they socialized from "less than once a month to not at all" with their colleagues. Fifteen percent (12) admitted to driving while impaired by the effects of drugs, alcohol, and/or a medical condition in the past year. Only 7% (6) indicated that they never use foul language.

The responses lead the researcher to believe that this sample was characteristic of the emergency nurse population of Alberta. That is they were not highly unusual or adventurous, but probably were not highly conservative.

Interpretation of Data

Characteristics of Emergency Nurses Working in Urban and Rural Hospitals

To facilitate exploration as to whether or not individual factors influenced the degree of moral evaluation carried out, it was necessary to examine the characteristics of emergency nurses working in urban and rural hospitals. The researcher investigated the possibility that the same patient who sought treatment in either an urban or a rural ED would be morally evaluated differently according to the type of nurse who worked in each setting. That is, it is possible that a particular type of

person is attracted to or confined to rural nursing. Conversely, it is possible that there is a "typical" urban nurse. It may be argued that rural nurses are more tolerant because they are generally more sympathetic than their urban colleagues or because they have more time to spend with their patients. Another possibility may be that nurses in urban EDs have "seen it all" and consequently are more tolerant of patients or even oblivious to their lifestyle.

Marital Status, Children, and Religious Affiliation

The results of this study disclosed that nurses who were either married, single, or living in a common-law relationship were evenly distributed between urban and rural hospitals. However, 70% (7) of the nurses who were either estranged from their partner or widowed worked in urban areas (see Table 4.1). While there was equal representation from nurses with children in both urban and rural centres, 71% (15) of the nurses who did not have children worked in urban EDs. Greater than 80% (10) of the RNs who denied any religious affiliation worked in urban areas.

Nursing Experience and Education

Respondents with the least experience in ED nursing and in nursing as a whole were located in urban areas whereas those with the most experience practiced in rural centres. The majority of nurses with a baccalaureate degree (67% or $n = 6$) worked in urban hospitals.

Summary

In summary, in urban EDs there is more likelihood of encountering a divorced, separated, or widowed nurse who has no children and/or religious affiliation than

there is in rural EDs. Urban ED nurses were more highly educated but on the whole had less nursing experience.

The Chi-square analysis suggested that "religious affiliation" and "years in nursing" may be related to the type of hospital in which the RN works. Although other characteristics may also affect the likelihood of an RN choosing to work in an urban or rural hospital, the sample is small which precludes them from being recognized statistically. That is, what appear to be substantial differences may not necessarily be recognized as statistically significant differences.

Table 4.1

Comparison of the Distribution of Characteristics (Marital Status, Highest Qualification, Religiosity, Children, Years of Experience) Between Nurses Working in Urban/Rural Hospitals

Characteristics	Type Of Hospital		
	Urban	Rural	Total
Marital Status			
Married/common-law	55% (29)	45% (24)	100% (53)
Divorced/Sep/Widowed	70% (7)	30% (3)	100% (10)
Single	45% (5)	55% (6)	100% (11)
Any Children			
Yes	49% (26)	51% (27)	100% (53)
No	71% (15)	29% (6)	100% (21)
Highest Qualification			
RN Diploma	54% (34)	46% (29)	100% (63)
BScN	67% (6)	33% (3)	100% (9)
Other	50% (1)	50% (1)	100% (2)
Religious Affiliation			
Yes	50% (30)	50% (30)	100% (60) *
No	83% (10)	17% (2)	100% (12)
Years in Nursing			
1-9	100% (11)	0% (0)	100% (11) *
10-19	56% (18)	44% (14)	100% (32)
20-29	32% (7)	68% (15)	100% (22)
30-39	57% (4)	43% (3)	100% (7)
Years in ED Nursing			
1-5	56% (23)	44% (18)	100% (41)
6-10	77% (10)	23% (3)	100% (13)
11-20	40% (8)	60% (12)	100% (20)

Note. Numbers in parentheses indicate the number of cases per category.

* ($p < .05$; Chi-square test)

Sample Characteristics and Age

In addition to their individual characteristics, the habits emergency nurses have acquired and events which they have experienced throughout their lives may also affect the degree to which they morally evaluate patients. It is plausible to think that nurses who swear, smoke, drink alcohol, drive while impaired, and dress in an unconventional manner themselves would be more tolerant of people who became ill/injured while involved in similar activities as compared to their colleagues who live a more conservative lifestyle. It is often assumed that the younger one is the more inclined one is to partake of and approve of deviant or unconventional behavior. Conversely, as one ages and accumulates more life experiences one may develop greater understanding and tolerance for those who choose to live their lives differently. This may subsequently affect morally evaluating behavior. For these reasons the researcher felt it necessary to explore ways in which the sample lived their lives and whether or not habits were affected by the age of the RN.

Habits

As shown in Table 4.2 data collected revealed that most of the sample (68) were non-smokers. The majority (13% or $n = 3$) of those who smoked "regularly" were between the ages of 26 and 35 years. Although the quantity of alcohol consumed was not determined, it was confirmed that 45% (9) of the nurses who were at least 46 years old consumed alcohol "more than once per week".

Between 75% and 86% of the nurses sampled admitted to using foul language at least "some of the time". Twelve percent of the nurses between 26 and 35 years

"never" used foul language. This age group represented the majority of nurses who did not swear. The majority of the nurses who used profane language on a "regular basis" ($n = 10$) were 46 years of age and older.

Twenty-nine percent (7) of the youngest nurses had driven while impaired by drugs, alcohol and/or a medical condition during the past year. This was close to three times as many nurses compared to the other age groups who admitted to this practice.

Interestingly, the largest percentage of nurses (37%) who dressed in an unconventional manner belonged to the oldest age group. This same age group (i.e., 46 years and older) were also the least likely to attend their place of worship.

While there were differences between groups a Chi-square analysis did not demonstrate a statistically significant relationship.

Experience with Abuse

The researcher deemed it important to explore the incidence of physical/sexual abuse experienced by the sample. It was proffered by Roberts (1984) that emergency nurses stereotyped patients as one method of predicting those patients of whom one should be cautious. It is feasible therefore, that nurses who have been abused may be more inclined to pre-judge patients than those who have not been abused.

Nurses in the study sample had encountered physically and sexually abusive behavior (Table 4.3). Twenty-five percent (6) of the younger nurses and 20% (4) of the oldest nurses had been sexually abused. Exactly where the sexual assaults had occurred or by whom was not delineated. Seventy-nine percent (19) of the nurses in

the youngest age group, 35% (13) of nurses aged 36 to 45 years, and 40% (8) of the oldest nurses had been physically abused by patients and/or visitors while working.

The higher occurrence of physical abuse experienced while at work by the younger nurses may be explained, in part, by the fact that the majority of them work in urban EDs.

Table 4.2

Habits (Cigarette/Alcohol Consumption, Driving While Impaired, Use of Foul Language, Dress, Frequency of Worship) According to Age

	Age (Years)		
Habits	26-35	36-45	46 and older
Smoking Habits			
Never	83% (20)	87% (32)	80% (16)
Occasionally	4% (1)	5% (2)	10% (2)
Regularly	13% (3)	8% (3)	10% (2)
Alcohol Consumption			
Never	17% (4)	5% (2)	15% (3)
Less than once/week	62% (15)	65% (24)	40% (8)
More than once/week	21% (5)	30% (11)	45% (9)
Impaired Driving Past Year			
Yes	29% (7)	8% (3)	10% (2)
No	71% (17)	92% (34)	90% (18)
Use of Foul Language			
Never	12% (3)	3% (1)	10% (2)
Sometimes	75% (18)	86% (32)	75% (15)
Regularly	13% (3)	11% (4)	15% (3)
Unconventional Dress			
Yes	22% (5)	17% (6)	37% (7)
No	78% (18)	83% (30)	63% (12)
Frequency of Worship			
Never	26% (6)	19% (7)	35% (7)
Monthly	57% (13)	64% (23)	45% (9)
Weekly	17% (4)	17% (6)	20% (4)

Note. Numbers in parentheses indicate the number of cases per category.

Chi-square analysis revealed no statistically significant associations.

Table 4.3

Experience of Sexual and Physical Abuse According to Age

Experience	Age (Years)		
	26-35	36-45	46 and older
Sexually Abused			
Yes	25% (6)	11% (4)	20% (4)
No	75% (18)	90% (33)	80% (16)
Physically Abused (in ED)			
Yes	79% (19)	35% (13)	40% (8) *
No	21% (5)	65% (24)	60% (12)
Physically Abused (Not in ED)			
Yes	13% (3)	14% (5)	20% (4)
No	87% (21)	86% (32)	80% (16)

Note. Numbers in parentheses indicate the number of cases per category.

* ($p < .05$; Chi-square test).

Marital Status

Differences in the ways the sample lived their lives existed across the age groups (see Table 4.4). Most of the nurses sampled were either married or living in a common-law relationship. Although 34% (8) of the youngest age group were either separated, divorced, or widowed, none of the oldest nurses reported a similar status. Thirty percent (6) of the oldest nurses were single which was close to four times as many as the other age groups.

Friends/Significant Others With Addiction Problems

The proportion of nurses who had a friend/significant other addicted to drugs/alcohol was approximately the same in the oldest (40%) and the youngest (46%) age groups. The middle age group had the least experience with this situation (30%).

Financial Background

Overall the nurses between the ages of 26 and 35 years came from the most stable financial background as a child. Only 22% (5) perceived that their family was "below average" when compared on a financial basis to others in the community

Employment and Education

The nurses who had encountered the most unemployment (i.e., for one month or longer) were between the ages of 36 and 45 years with almost 16% having been unemployed at one time or another. None of the oldest age group had experienced unemployment. Only one of the nurses from the oldest age group (46 years and older) had earned a BScN. More than four times as many of the youngest age group (21% or $n = 5$) had completed a BScN.

In summary, with the exception of marital status and a past history of being physically abused in the ED, no major differences in the individual characteristics of the emergency nurses emerged according to their ages. It would appear therefore, that nurse's age is not an important variable to consider when examining individual characteristics which may affect the degree of moral evaluation performed.

Table 4.4

Characteristics (Qualifications, Marital Status, Financial Background, Friends/Family With Addiction Problems, Unemployment) According to Age

Characteristic	Age (Years)		
	26-35	36-45	46 and older
Highest Qualification			
RN Diploma	79% (19)	84% (31)	95% (18)
BScN	21% (5)	16% (6)	5% (1)
Total	100% (24)	100% (37)	100% (19)
Marital Status			
Married/common-law	58% (14)	87% (32)	70% (14) *
Divorced/Sep/Widowed	34% (8)	5% (2)	0% (0)
Single	8% (2)	8% (3)	30% (6)
Total	100% (24)	100% (37)	100% (20)
Financial Background			
Below Average	22% (5)	35% (13)	40% (8)
Average	61% (14)	43% (16)	50% (10)
Above Average	17% (4)	22% (8)	10% (2)
Total	100% (23)	100% (37)	100% (20)
Significant others addicted			
Yes	46% (11)	30% (11)	40% (8)
No	54% (13)	70% (26)	60% (12)
Total	100% (24)	100% (37)	100% (20)
Unemployed			
Yes	4% (1)	16% (6)	0% (0)
No	96% (23)	84% (31)	100% (20)
Total	100% (24)	100% (37)	100% (20)

Note. Numbers in parentheses indicate the number of cases per category.

* ($p < .05$; Chi-square test).

Environmental Characteristics and Age of the Nurse

To explore the possibility that certain conditions of employment may bias or influence the degree of moral evaluation conducted by ED nurses it was necessary to examine th characteristics of the sample's work environment. Nurses of a certain personality may choose to work within a particular environment while others leave if the attitude with which certain patients are treated is not congruent with their personal philosophy of nursing. It must be recognized however that some nurses may be forced to work in a particular environment due to circumstances beyond their control. Alternatively the work environment may exert such pressure on an individual nurse to conform to the consensus that a nurse may gradually adapt oneself to his/her peers.

It is important to explore whether or not the age of the nurse is an important variable. If the influence from the environment is significant, the age of the nurse may not affect how he/she treats patients. That is, all nurses who work the night shift or work in a centrally located urban ED would be inclined to morally evaluate patients in a similar vein, regardless of their ages.

Conceivably age, individual habits, and/or life experiences may mitigate the effects of environment with the result that any one work environment may contain different types of nurses. Whether or not a patient is morally evaluated in a negative manner would therefore depend upon the nurse(s) involved in his or her care.

Shift Worked

In the researcher's experience a different mood generally exists in EDs according to the hour of the day. A relaxed mood is more likely to occur during the

night shift. One study determined that 40% of all patients entering the ED in the evening had been drinking alcohol (Freedland, McMicken, & D'Onofrio, 1993). It is the researcher's opinion that such patients are more likely to be morally evaluated in a negative manner than are patients who have not been drinking. Because there are fewer persons of authority around at this hour and intoxicated patients are less able to launch effective complaints, staff behavior proceeds unchecked more on this shift than on any other.

Number of Hours Worked

The employment status of the nurse may also be an important factor to consider. Researchers have found that the frequency with which part-time nurses work may be associated with the degree to which their attitudes differ from their full-time counterparts (Wetzel, Soloshy, & Gallagher, 1990). Nurses who work fewer hours in the ED may be more understanding of and tolerant with patients than nurses who are exposed to them on a more regular basis. Those who work on a part-time basis may have more energy which could result in higher patient tolerance. Part-time employment may be a way for a nurse to cope with stress and burnout while staying in the profession. If one is involved in activities which preclude one from working in the ED on a full-time basis (i.e., family-rearing, volunteer work, pursuit of education, another job,), frustrations encountered while working in the ED may become relatively insignificant. That is, work becomes less central to one's life.

Hospital Location and Size

Data analysis revealed that 80% (16) of the nurses between the ages of 26 and

35 years of age worked in urban hospitals (see Table 4.5). While 67% (12) of the oldest group worked in rural hospitals, the middle age group was evenly divided between rural and urban hospitals. An inverse relationship was noted between the age of the nurse and the size of the hospital in which he or she worked. The smallest hospitals had the largest proportion of the oldest nurses working within them.

Several explanations for this can be entertained. Self-selection may occur as the younger nurses relocate to urban centres initially for their nursing education and then decide to stay either to gain more experience with acutely ill patients or for recreational reasons. That is, they want to experience "big city" social activities. As they age, some may tire of "city life" and choose to move to rural areas. Ultimately the explanation may simply be that there are more opportunities for employment in urban hospitals, forcing newly graduated nurses to remain in the urban hospitals even though they would prefer to work in rural centres.

Rotations and Number of Hours Worked Per Week

As displayed in Table 4.5, the youngest nurses appeared to work the most hours per week whereas the middle age group worked the least hours each week. Few respondents (7%) worked a combination of all three shifts. More of the older nurses (40%) worked a permanent shift (i.e., days, evenings, or nights only) than any other age group. Of those nurses who worked the day/night rotation, the greatest proportion (58%) came from the youngest age group.

In summary, the age of the nurse was statistically significant with regard to conditions of employment. That is, older nurses (46 years and older) tended to work

in smaller, rural hospitals. They were more likely to work a permanent shift than nurses of other age groups and although they did not work as many hours per week as the youngest nurses, they worked more hours per week than nurses 36 to 45 years of age.

Table 4.5

Conditions of Employment (Hospital Location, Hospital Size, Shifts Worked, Number of Hours Worked) According to Age

Condition	Age (Years)		
	26-35	36-45	46 and older
Hospital Location			
Rural	20% (4)	50% (17)	67% (12) *
Urban	80% (16)	50% (17)	33% (6)
Size of Hospital[a]			
0-50	11% (2)	14% (4)	53% (8) *
51-450	22% (4)	46% (13)	20% (3)
451-1200	67% (12)	40% (11)	27% (4)
Hours Worked per Week			
< 15	8% (2)	16% (6)	0% (0)
15-37	33% (8)	62% (23)	60% (12) *
≥ 37.5	59% (14)	22% (8)	40% (8
Shifts worked			
Day, Evening & Night	8% (2)	6% (2)	10% (2) *
Day, Evening, or Night	17% (4)	33% (12)	40% (8)
Day & Evening	17% (4)	28% (10)	45% (9)
Day & Night	58% (14)	33% (12)	5% (1)

Note. Numbers in parentheses indicate the number of cases per category.

[a]Number of beds.

* ($p < .05$; Chi-square test).

Views on Racial Issues, Behaviors and Social Assistance

The general beliefs of the sample regarding issues such as racism, lifestyle choices or behaviors, and social assistance are relevant in that nurses may import their attitudes into the ED and consequently apply them to their patients (Roth, 1971, 1972b). If certain nurses are able to relinquish negative attitudes upon arriving at work, what personal characteristics do they possess which enable them to do so? Alternatively there may be environmental characteristics inherent in some EDs that advocate abandonment of unhelpful attitudes, either voluntarily or not, while at work. Conversely environmental factors may facilitate the importation of personal beliefs to the work place and encourage the nurse in his or her application.

Racial Issues

The sample was asked four questions to assess their general views on certain racial issues. Questions included:

1. Do you have any close friends who are a different skin colour than yourself?
2. Would you like it if a family member became romantically involved in an inter-racial relationship?
3. If single, would you ever become involved with someone from a different racial group?
4. If the opportunity arose, how much would you like to live, travel, and/or work in an Oriental, African, South American and/or Asian country?

Fifty-four percent (45) of the sample had friends who were of a different skin color than themselves. The sample did not have particulary strong feelings about

family members becoming romantically involved in inter-racial relationships and only 32% (26) of them "would not become involved in an inter-racial relationship themselves if single". Descriptive statistics indicated that 65% (54) of the nurses would not "live, travel, and/or work in an Oriental, African, South American and/or Asian country, if the opportunity arose".

Personal Behaviors

The survey incorporated six questions about certain personal behaviors. These included:

1. Do you believe that therapeutic abortion should remain legalized?
2. Do you feel that premarital sex is acceptable?
3. Do you feel that it is acceptable to have multiple sexual partners if you are not married?
4. How much do you agree or disagree with the following statements:
   a. It is unnatural to be anything but heterosexual.
   b. I can be accepting of a person regardless of his/her sexual orientation.
5. Do you approve of people who ride motorbikes?
6. Do you approve of tattoos on others?

A large majority (75%) of the respondents were in favor of therapeutic abortion remaining legalized and 74% responded that premarital sex was an "acceptable" practice . However 80% (66) rejected the idea of multiple sexual partners even if single and 45% (37) did not approve of people riding motorbikes. While just 6% (5) actually approved of people obtaining tattoos, 33% (27) expressed indifference and

responded that "it was not their body so they didn't care".

While 48% (40) of the sample disagreed with the statement that it was "unnatural to be anything but heterosexual", only 11% (9) claimed to be "accepting of anyone despite his/her sexual orientation".

Social Assistance

Judgements are often made about recipients of social assistance. Similarly, this item on the questionnaire drew many comments from the respondents. The most repeated comment involved the mode of transportation to the ED. For example "all people on welfare take a cab to the ED because they don't have to pay for them". Alternatively, the researcher was informed that "welfare recipients take an ambulance to the ED so they don't have to pay for a cab". Nurses' views towards people who receive social assistance were assessed in part through the use of the following statements to which they were asked to indicate their agreement or disagreement:

1. There's no reason to collect unemployment insurance--you can always find work.
2. Many people who get welfare are just too lazy to work.
3. It's too easy to get unemployment insurance.

Forty-seven percent (39) of the respondents agreed with the statement that "many people on social assistance are just too lazy to work". While 45% (37) agreed that "it was too easy to get unemployment benefits", only 23% (19) agreed that "there was no reason to collect employment benefits as one could always find work".

Although one might speculate that beliefs change with age, Chi-square analysis demonstrated no statistically significant association between age and beliefs about

selected racial, sexual, and social issues. Age became important only with regard to legalization of therapeutic abortions with the youngest nurses (26-35 years) being the most opposed to the practice (see Table 4.6).

Table 4.6

Nurses' Beliefs About the Legalization of Therapeutic Abortion According to Age

	Age (Years)		
Belief	26-35	36-45	46 and older
Keep abortions legalized			
Yes	58% (14)	89% (31)	80% (16) *
No	42% (10)	11% (4)	23% (18)

Note. Numbers in parentheses indicate the number of cases per category.

* ($p < .05$; Chi-square test).

Views on Racial Issues, Behaviors and Social Assistance and Age of the Nurse

Although Chi-square analysis displayed a statistically significant relationship only between age and therapeutic abortion, the researcher felt it necessary to investigate whether nurses' opinions were generally affected by their age. That is, does the age of the nurse influence the degree of moral evaluation performed?

Racial Issues

While most of the nurses sampled would not "work, travel or live" in an Oriental, African, South American or Asian country, the youngest group (26 to 35 years) was notable in that 74% (17) indicated that they would not do so given the chance. Nurses between the ages of 36 to 45 years were the most strongly opposed to inter-racial relationships for both themselves and family members. Forty-four percent (14) of them indicated that they would never "marry or become involved" with someone from a different racial group and 39% (14) "would not like it" if family members chose to do so.

Age was not a determinant in the percentage of nurses with friends of a different skin colour. Approximately 55% of the nurses in each age group indicated that they had close friends of a "different colour than themselves".

Personal Behaviors

Although twice as many of the youngest nurses (26 to 35 years) approved of people who ride motorbikes than nurses of other age groups (46%), a disproportionately low number endorsed therapeutic abortions. Only 58% (14) of this same group approved of therapeutic abortions. This compared with 80% of nurses in

the oldest age group (46 to 59 years) and 89% of nurses in the middle age group (36 to 45 years) who endorsed therapeutic abortions.

The oldest nurses (aged 46 to 59 years) were the most likely to agree that it is "unnatural to be anything but heterosexual" (44%). Although the youngest group of nurses was the most inclined to disagree with this same statement (54%), only 4% could "accept people regardless of their sexual orientation".

The youngest group of nurses was the least likely to condone the practice of having "multiple sexual partners if single" (9%). Age was not a factor in the nurses' "disapproval of tattoos on others".

Social Assistance

The oldest group of nurses, none of whom had ever been unemployed, were more likely to support the concept of unemployment benefits whereas the youngest group of nurses were more likely to adhere to the idea that many people who receive welfare are "just too lazy to work" (58%), and that it's "too easy to get unemployment insurance" (50%). Although none of the oldest group agreed that "there is no reason to collect unemployment benefits", 33% (8) of the youngest group agreed with the statement.

In summary, although there were some differences in attitudes according to nurses' age, these did not prove to be statistically significant.

Description of Nurses' Opinions

Nurses' Opinions Towards Specific Types of Patients

It has been proposed that ED staff are influenced by the social and moral

definitions of an illness as well as its scientific definition (Yoder & Jones, 1981). Subsequently, presumptions of moral behavior are made according to the nature of the patient's illness. When the moral behavior which the patient supposedly exhibits differs from that of the nurse, the nurse may engage in negative moral evaluation of the patient (Hirst, 1983).

The researcher investigated whether or not the sample preferred caring for certain patients more than others. Using a Likert Scale, which ranged from a score of 1 ("Not at all") to 5 ("Very much"), the respondents were asked to rate how much they "generally enjoyed caring" for 42 different types of patients. They were given only one characteristic for each patient. These were limited to putative social class, occupation, appearance, age, attitudes, gender, behavior or the apparent illness or injury. Examples included "admitted because of intentional overdose", "patients under 2 years of age", and "patients injured as a result of driving while impaired".

Patient Age Hierarchy

Most nurses sampled did not single out "age" as being a characteristic which influenced their pleasure in caring for a patient (see Table 4.7). Ten percent of the sample disliked caring for patients who were less than two years of age. Comments volunteered on the Likert Scale indicated that it was not the actual age that was an issue but the fact that they were "uncomfortable" or "insecure" with their skills in caring for pediatric patients. This is congruent with Toohey's (1984) work who found that many emergency nurses were "frightened" to care for pediatric patients as they were insecure with their skills and knowledge base in pediatric nursing.

People aged 81 years and older were deemed less desirable as patients. Ten percent of the nurses sampled disliked caring for patients 81 to 90 years of age and 14% disliked nursing patients 91 years of age and older. One respondent considered this last group to be a "waste of critical care beds".

Table 4.7

Patient Age and Nurses' Enjoyment of Caring for Them

Patient Age	Score[a]	SD	Range	Dislike[b]
< 2 years old	3.57	1.0	1-5	10%
2-12 years old	3.80	.96	1-5	6%
13-18 years old	3.77	.85	1-5	2%
19-30 years old	3.86	.78	3-5	0%
31-45 years old	3.87	.79	3-5	0%
46-65 years old	3.87	.76	3-5	0%
66-80 years old	3.77	.82	1-5	1%
81-90 years old	3.60	.95	1-5	10%
≥ 91 years old	3.52	1.09	1-5	14%

Note. N = 83.
[a] Range = 1 - 5 (Likert Scale where "1" = does not enjoy caring for patient at all; "5" = enjoys caring for patient very much). [b]Percentage of responses which included either 1 or 2 on the Likert Scale (i.e., does not enjoy caring for patient).

Patient Characteristic Hierarchy

Undesirable patients.

If the health care profession were truly a system free of moral values, one would expect the sample to have responded with "indifferent" or a score of 3 on the Likert Scale when asked to grade the degree of enjoyment they had in caring for specific types of patients. However, a hierarchy with preference for some patients emerged (see Table 4.8). This was not unlike that cited in the literature (Hawley, 1992; Jeffery, 1979; Kelly & May, 1982; Lewis & Bradbury, 1982; Papper, 1970; Parette et al, 1990; Roberts, 1984; Roth, 1971, 1972a, 1974; Roth & Douglas, 1983; Scheff, 1964; Yoder & Jones, 1981) where patients who could be blamed in part for their poor state were rated unfavorably. That is, those who smoked, drank alcohol, abused drugs, took a drug overdose, were overweight, had multiple sexual partners, acquired a sexually transmitted disease, or became injured while driving in an impaired condition were least desired as patients. Similarly caring for patients who were on the "wrong side of the law", were verbally abusive, suffered chronic pain, spoke little or no English, or had a psychiatric illness were not rated as favorably.

The study sample ranked "undesirable" patients in a similar order. For example, patients who were injured while committing a crime were given a score of 2.45 followed by patients suspected of being addicted to drugs ($\bar{X}$ = 2.36). Those who were considered to be non-urgent received a mean score of 2.30. Patients who had intentionally taken an overdose or had received their injuries as a result of driving

Table 4.8

Patient Characteristics and Nurses' Enjoyment of Caring For Them

Patient Characteristic	Score[a]	SD	Range	Dislike[b]
Trauma victim	4.55	.80	1-5	2%
Surgical problem	4.36	.64	3-5	0%
Medical illness	4.06	.75	2-5	1%
Male	3.61	.78	3-5	0%
Female	3.57	.80	2-5	1%
Accompanied by friends/family	3.54	.79	2-5	7%
Injured while riding a motorbike	3.49	.79	1-5	2%
Low socio-economic origin	3.46	.72	2-5	2%
Familiar with health care system	3.46	.87	1-5	7%
Dressed in a different manner	3.42	.70	2-5	2%
Health care professional	3.40	.91	1-5	7%
Different racial origin than nurse	3.37	.73	1-5	2%
Unemployed	3.25	.66	2-5	5%
High socio-economic origin	3.22	.73	2-5	12%
Has tattoos	3.21	.70	1-5	6%
Speaks little/no English	3.17	.95	1-5	20%
Native Indian	3.05	.83	1-5	17%
On Welfare	3.02	.64	1-5	12%
Smokes	2.95	.82	1-5	18%
Has chronic pain	2.90	.92	1-5	34%
Overweight	2.81	.85	1-5	24%
Has multiple sexual partners	2.80	.73	1-5	26%
Psychiatric illness	2.77	.93	1-5	32%
Has a sexually transmitted disease	2.76	.74	1-5	29%
Escorted by police/guards	2.76	.82	1-5	34%
Has an alcohol problem	2.52	.77	1-4	43%
Injured while committing a crime	2.45	.94	1-5	46%
Addicted to drugs	2.36	.80	1-5	54%
Non-urgent	2.30	.89	1-4	53%
Intentional overdose	2.28	.81	1-5	59%
Injured while driving impaired	2.28	.85	1-5	58%
"Regular" in the ED	2.20	.92	1-5	66%
Swears/uses "foul language"	1.76	.77	1-4	82%

Note. N = 83.

[a] Range = 1 - 5 (Likert Scale where "1" = does not enjoy caring for patient at all; "5" = enjoys caring for patient very much). [b]Percentage of responses which included either 1 or 2 on the Likert Scale (i.e., does not enjoy caring for patient).

while impaired were given a mean score of 2.28. Patients who had come to be considered "regulars" in the ED were assigned the second lowest position in the hierarchy ($\bar{X}$ = 2.20) followed only by those who used "foul language" ($\bar{X}$ = 1.76).

Desirable patients.

In accordance with the literature, the preferred patient to care for was the trauma victim ($\bar{X}$ = 4.55) followed by patients with a problem of a surgical nature ($\bar{X}$ = 4.36). Only 2% of the nurses sampled "disliked" caring for trauma patients and none of the respondents disliked caring for those with surgical problems. Comments about trauma patients included, "Rewarding! This is what ED nursing is all about!" and "These people need nursing expertise!"

Patients injured while riding motorbikes often sustain serious injuries and are classified as "trauma" patients. Indeed the mortality rate per mile on a motorbike is 20 times that of another motor vehicle (Runge, 1993). However, if the trauma patients received their injuries as the result of riding a motorbike, the respondents "enjoyed caring less" for them ($\bar{X}$ = 3.49). This may be attributed to the belief that by riding a motorbike, one voluntarily takes risks and therefore "deserves" to be injured. Alternatively, nurses may apply a stereotypical image of a "biker" to anyone who rides a motorbike. One respondent equated patients with tattoos as having a "low life mentality". Many of the nurses approved of people who rode motorbikes only if they did so in a safe manner and wore a helmet. One comment received was "Make sure they sign their donor cards!"

Respondents' Comments

At the low end of the hierarchy were patients who had come to be considered "regulars" in the ED even though the reasons why they had become regulars were not delineated in the survey. Many patients become regular users of the ED through no fault of their own--that is they have "legitimate" medical conditions such as cardiac or respiratory disease which require frequent medical attention. Regardless, 66% of the study sample did not enjoy caring for them ($\bar{X}$ = 2.20). One respondent referred to these patients as "frequent flyers" while another accused them of being "weak people who depend on the ED for all their needs". A repeated comment was that these patients were "*abusers* [italics added] of the health care system". Several respondents wrote that they get *angry* [italics added] at the bureaucracy of their hospital which does not allow them to turn these patients away.

The category of "non-urgent patient" drew many remarks from the study sample. They were considered to be "inappropriate" types of patients for the ED who "just added to the work load". Patients who used what the nurses considered to be "foul language" were ranked the lowest with 82% of the nurses responding that they "did not enjoy caring for them". This was despite the fact that only 7% (6) of the respondents could claim that they never used foul language themselves. One respondent wrote "I just don't put up with it anymore".

Patients who drew the most cryptic comments were native Indians ($\bar{X}$ = 3.05), those who intentionally took an overdose of drugs ($\bar{X}$ = 2.28), and those receiving social assistance ($\bar{X}$ = 3.02). Remarks concerning overdose patients included, "The

repeat *offenders* [italics added] bother me", "Most aren't serious--just attention-seeking behavior", "They're not really ill", "Chronic overdosers [sic] should learn to do it right", "I like them only if they're quiet and sleep. If they are alert and cooperative the enjoyment level increases. If they're *out to lunch* [italics added] it's not much fun.", and "The first time I care a lot but with repeaters I care less and less [sic]".

Strong opinions regarding native Indians emerged as, "Nearly all overdose or abuse alcohol", "Destructive lifestyles and attitudes", "System abusers", and "It depends on how drunk they are". It was frequently implied that all native Indians seen in the ED are intoxicated and was overtly stated by one respondent as "They're drunk all the time".

Most of the negative comments about patients on welfare centred around their mode of arrival to the ED. Conflicting examples included, "They all come by ambulance so they don't have to pay for a cab" and "They always come by taxi so they don't have to pay for an ambulance". Unemployed patients received a score of 3.25 which was somewhat higher than those patients who are unemployed and receiving welfare ($\bar{X}$ = 3.02). Conceivably then it is acceptable to be unemployed as long as you are not receiving assistance from the government. Indeed one respondent stated that he/she "did not like *freeloaders* [italics added]".

Overweight patients and those injured while driving in an impaired condition also drew derogatory comments from the sample. Statements about overweight patients included "Most have an attitude problem", "I don't mind as long as they can

move", and "They're asking for a lot of medical problems". Interestingly, 46% (38) of the study sample themselves considered themselves to be "minimally overweight" while another 12% (10) reported themselves as being "overweight". With regard to patients injured while driving under the influence of drugs and/or alcohol, one respondent expressed "enjoyment" in caring for them just so that he/she "could *show* [italics added] them the consequences of their actions". Exactly how this was done was not delineated. Another member of the study sample replied that he/she "had little sympathy" for this type of patient.

When considering the results of this hierarchy it is worth emphasizing that respondents were given just one characteristic of the patient. For example when the respondents were asked to rate their enjoyment in caring for patients who had become "regulars" in their ED, it was not implied by the researcher that these patients were obnoxious, abusive, or difficult to care for in any way. The reasons why these patients had come to utilize the ED so frequently also were not given. Why then did 66% of the nurses respond negatively towards this particular patient characteristic? It is possible that a stereotypical picture of a "regular" clouds their perception in such a way that they cannot look beyond the singular fact that this particular patient has made numerous visits to the ED. This may serve to block further communication with the patient. Additionally, any information which the nurse gathers from the patient may be interpreted within the context of the patient being a "regular". That is, the nurse may elucidate and subsequently disregard many of the patient's symptoms by rationalizing that the patient is not ill but simply "abusing" the system.

Ultimately, when the nurse recognizes that the patient is a "regular", he or she may be treated in a dissenting manner regardless of his/her reason for coming to the ED. Patient care will be compromised.

Nurses' Age and Attitudes Towards Patients

When nurses' views on certain issues were studied it became evident that the age of the nurse was of minimal importance in determining the extent to which they would morally evaluate their patients. Indeed age was statistically significant with the study sample only with regard to "therapeutic abortion" with the youngest group of nurses (26-35 years) being the most opposed to the practice.

Interestingly, the nurse's age became important with certain patients--in particular, native Indians and those with a "poor command of the English language" (see Table 4.9). Overall, the youngest nurses (26 to 35 years) were predisposed to negative moral evaluation of natives and non-English speakers, whereas nurses 46 years of age and older were the most benevolent. None of the older nurses reported reluctance towards caring for patients whose first language was not English and only one disliked nursing native Indians.

The older nurses may have exhibited the most benevolence towards patients as a result of attrition. That is, nurses who disliked caring for certain types of patients may have left the ED for other areas of nursing in which there is more control over the types of patients encountered (i.e., high boundary control). Alternatively, older nurses generally have accumulated more life experiences and may have learned, over time, to base their judgements of patients on other characteristics. Or perhaps they

have simply "mellowed out" with time.

Although the age of the nurse and attitudes towards patients who had intentionally taken an overdose of drugs, suffered from psychiatric symptoms, or were overweight were not proven to be statistically significant through Chi-square analysis, a one-way ANOVA found age differences, in reactions to overweight patients, overdose patients, and patients with psychiatric symptoms, to be statistically significant. Again with these groups of patients, the youngest nurses (between the ages of 26 and 35 years) were generally the least tolerant with the exception of overweight patients. Interestingly, with these group of patients, the middle age group of nurses (36-45 years) was more tolerant than the oldest age group.

Nurses' Behaviors and Responses to Caring for Patients

Chi-square analysis did not reveal any statistically significant association between nurses' behaviors (i.e., smoking habits, alcohol consumption, history of driving while impaired, use of foul language, unconventional dress, and frequency of worship) and their responses to caring for the three highest ranking patients on the hierarchy and the three lowest ranking patients.

Table 4.9

Nurses' Age and Enjoyment of Caring for Patients

Patient Characteristic	Age[a]		
	26-35	36-45	≥ 46
Native Indian			
Enjoy	12%(3)	24%(9)	26% (5) *
Indifferent	50%(12)	65%(24)	69%(13)
Dislike	38%(9)	11%(4)	5%(1)
Poor Command of English			
Enjoy	16% (4)	30% (11)	50% (10) *
Indifferent	42% (10)	51% (19)	50% (10)
Dislike	42% (10)	19% (7)	0% (0)
Overweight			
Enjoy	42% (10)	11% (4)	25% (5) **
Indifferent	54% (13)	70% (26)	55% (11)
Dislike	4% (1)	19% (7)	20% (4)
Intentional Overdose			
Enjoy	0% (0)	6% (2)	5% (1) **
Indifferent	25% (6)	50% (18)	30% (6)
Dislike	75% (18)	44% (16)	65% (13)
Psychiatric Illness			
Enjoy	0% (0)	19% (7)	25% (5) **
Indifferent	52% (12)	57% (21)	45% (9)
Dislike	48% (11)	24% (9)	30% (6)

Note. Numbers in parentheses indicate the number of cases per category.

[a]Age of Nurse in Years.

* $p < .05$; Chi-square test. ** $p < .05$; one-way ANOVA.

Hospital Location and Nurses' Responses to Caring for Patients

Responses obtained from urban emergency nurses were significantly different from those of rural emergency nurses (see Tables 4.10 and 4.11). The only illness or injury that evoked statistically significant results however was an intentional overdose. Patient characteristics which were statistically significant included age, socio-economic status, mode of dress, whether or not they were accompanied to the ED by others, familiarity with the health care system, and whether or not they were health care professionals themselves.

Patient Characteristics

Overall, urban nurses were more definite in their opinions whereas respondents from rural hospitals expressed more indifference about patient characteristics. More urban nurses than rural nurses reported that they enjoyed caring for patients with a different dress style. Urban nurses also reported enjoyment in caring for health care professionals and patients who were familiar with the health care system. Seventy-one percent (29) of the urban nurses disliked caring for patients who had intentionally overdosed compared with 44% (14) of the rural nurses. Not one urban nurse, out of a possible 44, responded that he/she enjoyed working with patients who had intentionally overdosed.

Sixty-nine percent (28) of the urban nurses enjoyed caring for patients who were accompanied by friends and/or family whereas only 30% (10) of the rural nurses admitted to the same. While there was no significant difference between hospital location and low socio-economic status patients, 46% (28) of the urban nurses enjoyed

Table 4.10

Hospital Location and Nurses' Response to Caring for Patients

Patient Characteristic	Hospital Location	
	Urban	Rural
Dresses differently		
Enjoy	49% (20)	21% (7) *
Indifferent	49% (20)	79% (26)
Dislike	2% (1)	0% (0)
Familiar with health care system		
Enjoy	54% (22)	22% (7) *
Indifferent	39% (16)	69% (22)
Dislike	7% (3)	9% (3)
Health care professional		
Enjoy	49% (20)	24% (8) *
Indifferent	39% (16)	73% (24)
Dislike	12% (5)	3% (1)
Intentional overdose		
Enjoy	0% (0)	9% (3) *
Indifferent	29% (12)	47% (15)
Dislike	71% (29)	44% (14)
Accompanied by friends/family		
Enjoy	69% (28)	30% (10) *
Indifferent	29% (12)	58% (19)
Dislike	2% (1)	12% (4)
Wealthy		
Enjoy	46% (19)	12% (4) *
Indifferent	42% (17)	79% (26)
Dislike	12% (5)	9% (3)

Note. Numbers in parentheses indicate the number of cases per category.

*$p < .05$; Chi-square test.

caring for well-to-do patients as compared with only 12% (4) of their rural colleagues. Generally, rural nurses were indifferent as to whether or not a patient was "wealthy".

Age of Patient

The majority of respondents expressed either indifference or enjoyment in caring for patients when "age" became the only differentiating characteristic (see Table 4.11). Patients 91 years and over evoked the most negative responses from nurses regardless of their work setting. Nineteen percent (8) of the urban nurses and 9% (3) of the rural nurses disliked caring for them.

Patient Tolerance

More of the rural nurses expressed "indifference" about patient char- -tics than their urban colleagues (Tables 4.10 and 4.11). Their tolerance ma- -m their work environment. The rural setting is often a less intense environment . which to work, allowing nurses more time to interact with patients. Additionally, as the only hospital in the area, the opportunity of seeing the same patients with subsequent visits exists and may facilitate a favorable nurse-patient relationship. In urban hospitals it is difficult to develop a similar type of relationship. Patients may not return to the same hospital each time they seek health care. Additionally, the urban work environment is often fast-paced with little continuity in care as many nurses care for the same patient. Consequently a nurse-patient rapport may never develop. Indeed, patients are often referred to by their "illness/injury" or their bed number instead of their names.

By getting to know their patients better than their urban colleagues, rural nurses may realize the folly of stereotyping patients and consequently express indifference when asked to rate how much they like caring for a patient when given just one characteristic.

Table 4.11

Hospital Location and Nurses' Response to Caring for Patients

Patient Characteristic	Hospital Location	
	Urban	Rural
13-18 years of age		
Enjoy	73% (30)	46% (15) *
Indifferent	22% (9)	54% (18)
Dislike	5% (2)	0% (0)
19-30 years of age		
Enjoy	76% (31)	48% (16) *
Indifferent	24% (10)	52% (17)
Dislike	0% (0)	0% (0)
31-45 years of age		
Enjoy	76% (31)	48% (16) *
Indifferent	24% (10)	52% (17)
Dislike	0% (0)	0% (0)
$\geq$ 91 years of age		
Enjoy	61% (25)	45% (15) *
Indifferent	20% (8)	46% (15)
Dislike	19% (8)	9% (3)

Note. Numbers in parentheses indicate the number of cases per category.

*$p < .05$; Chi-square test.

Researchers to date have not specifically explored whether differences between urban and rural "attitudes" exist. Jeffery (1979) studied three EDs within the same "English City". Roth (1971) reported differences between private and public American hospital EDs. Hawley (1992) used four urban Canadian EDs as her research setting, while Yoder and Jones (1981) drew their sample from three urban hospitals in Northeastern Ohio. Although Lewis and Bradbury (1982) obtained their data from 19 hospitals in the United Kingdom, they did not differentiate between rural and urban EDs. Both Roberts (1987) and Peternelj-Taylor (1989) selected nursing students from urban clinical settings to collect their data. Finally Wetzel, Soloshy, and Gallagher (1990) obtained their sample from three large urban hospitals in Canada.

Description of Nursing Behaviors

Patient Hierarchy

The apparent patient hierarchy implies that the study sample indicated biases towards specific types of patients. That is, after a fleeting assessment of one patient characteristic, the sample decided "how much" they would enjoy caring for that patient. Overall, it did not appear that individual characteristics (i.e., age) or environmental factors (i.e., urban or rural hospital location) exerted much influence on the creation of this hierarchy. However, as this ranking exists, it is of interest to explore whether or not emergency nurses act on their biases and the reasons they give for morally evaluating ED patients.

Forming Opinions of Patients

If individual and environmental characteristics are not major factors in the creation of the hierarchy, which factors if any play a role in moral evaluation of patients? Is it a "fact of life" that everyone morally evaluates people whom they encounter or is this trait specific to emergency nurses? It is unlikely that emergency nurses alone, are afflicted with the need to morally evaluate their patients. It is plausible that environmental characteristics, such as low boundary control (i.e., little if any control over selection of clientele), play a significant role. It is presumable that other occupations/professions with low boundary control also perform moral evaluation on their clients' apparent characteristics. Cab drivers, police officers, servers in restaurants, sales clerks, etc. all have little, if any, foreknowledge of the people they encounter in their line of work and are, on the most part, unable to select their clientele. Similarly, their relationship with the client most likely will be of a short-term and singular nature.

The difference however is that the ED patient, is often vulnerable and dependent upon the ED staff for his/her physical and/or psychosocial well-being. The consequences of a negative moral evaluation are potentially more serious than being treated rudely or even ignored by a sales clerk or server in a restaurant.

A definite hierarchy of patient preferences emerged although 68% (55) of the nurses sampled denied forming opinions about patients before meeting them. Of those who admitted doing so, however, common methods used to "size up" patients included assessing their overall appearance (including hygiene), communication skills,

behaviors/mannerisms, and the clothes that they wore. For some, the patient's "chief complaint" or reason he/she came to the ED in the first place, evoked a preliminary evaluation. One respondent reported that he/she formed opinions on ED patients according to the foods they ate while in the waiting room.

Collegial Influence

Roth (1972a) reported that hospital staff tend to accept, without question, earlier moral evaluations made by their colleagu When asked if they "usually agreed with their colleagues' opinions of a particular patient", only 38% (30) of the study sample answered "no", irrespective of age of the nurse. The effect of moral evaluation can be amplified by peer pressure. Twenty-eight percent (23) of the sample reported that "peer pressure" had caused them to act differently towards a patient than they normally would. Of the 15 nurses who expanded on their answer, 60% (9) indicated that they had prejudged a patient based on their colleague's appraisal of the patient because they respected his/her opinion. Several indicated that this had resulted in negative consequences for all concerned. One respondent revealed that he/she had been coerced into treating patients differently than he/she normally would have because "other nurses wanted me to be as *harsh or cruel* [italics added] to patients as they were for continuity's sake".

Roberts (1984) reported that the amount of socialization one does with colleagues was one of the most important factors in influencing the degree to which a person will adopt reference group values. Interestingly, although there was great homogeneity in the respondents' opinions of patients, only 6% (5) of the study sample

socialized "very much" with their colleagues when not at work.

Environmental Influence

As well as collegial influence, environmental factors facilitate prejudgment of patients. Eighty-three percent (69) of the respondents worked in institutions which have a list of patients who are considered to be "dangerous, abusive, or known drug seekers". Only 4% (3) of the nurses sampled never consult this listing. Fifty-four percent (38) of the nurses referred to it after seeing/interviewing the patient, while 19% (13) looked at it prior to interacting with the patient. This list is generally used to confirm or deny suspicions that the patient is a character of whom they should be wary. Criteria for inclusion in the list and indeed who may place the patient's name on such a list vary from institution to institution. While it is meant to protect and warn the ED staff, it may also serve to "label" the patient after one negative experience in the ED. It is important to recognize that even the "negative tone" of the encounter may be subjectively defined by the nurse involved.

Nurses' Opinions of Patients

Roberts (1984) suggested that the rapid opinions emergency nurses form are not always accurate. In verification of his stance, 90% (74) of the respondents reported that they had "changed their opinion about a patient they initially disliked". Sixty-six percent (39) of the nurses who qualified their answer replied that the change came about after they had interacted with the patient and understood him/her a "little better". Other explanations included "the patient changed" (i.e., sobered up, became more cooperative/agreeable) or the patient's injury/illness turned out to be

"legitimate" (eg., a medical/surgical diagnosis was obtained).

Patient/Visitor Control

The literature contains suggestions that ED staff do not tolerate abuse or "disobedience" from patients and/or visitors. Attempts to control them include verbal and physical hostility leading ultimately to threats of and actual ejection from the ED (Jeffery, 1979; Parette et al, 1990; Roth, 1971, 1972a, 1972b). In confirmation, 61% of the study sample had "ejected" a patient from the ED at least once. Exactly how often this behavior occurred, or how many patients were involved was not obtained from the study.

Patients were commonly ejected because, in the nurses' opinion, they were "disruptive" or "uncooperative" or did not have what the nurse thought was a "legitimate" reason for being in the ED. The subjective nature of these terms must be recognized. What one nurse defines as "legitimate" may differ from his/her colleagues' interpretation of "legitimate". Patients were also turned away if the nurse felt "threatened" by their presence. However, behaviors which threaten one nurse may not necessarily threaten another.

Seventy-seven percent (64) of the respondents had occasion to "eject" a patient's family/friend from the ED. "Disruptive/abusive behavior" towards the patient and/or staff, "interference" with patient care, stealing equipment/supplies, possession of weapons, and "not obeying the nurse" were common reasons for visitor expulsion. One nurse cited "meddling" as a reason for expelling visitors. Exactly what constitutes meddling was not volunteered by this nurse. "Rude" visitors or those

whose presence was not seen as "necessary" by the nurse were also evicted. Generally, visitors were deemed "necessary" if they could assist the nurse either directly or indirectly with the care of the patient. Once again, these terms are of a subjective nature and may be defined differently according to the nurse involved.

Patient Chart

Each time a patient arrives in the ED a "patient chart or record" is created. Although these vary from institution to institution, most provide information about the patient's name, address, marital status, religious affiliation, occupation, health care insurance, chief complaint, and the number of times the patient has visited the ED. The researcher investigated the degree to which the sample utilized this information to facilitate his/her moral evaluation of the patient and complete the patient profile. The nurse may exhibit biases for and against certain information (eg., assume that the patient is of a low socio-economic status based on his/her address, or suppose that the patient is unemployed if no information is provided about an employer).

Patient Address

Forty-six percent (38) of the study sample indicated that they took note of where a patient lived while obtaining a history from them. Seventy-seven percent (30) of the nurses obtained this information directly from the patient's chart. While some respondents did this as an administrative formality (i.e., to ensure that the information was correct), others did it out of interest/curiosity or because they felt it was a necessary component of their nursing care (i.e., useful in discharge planning). Four respondents replied that they used this information to screen patients whom they

suspected were "shopping for drugs". That is, patients were suspect if they were not using the ED closest to their home. One of the respondents referred to this activity as "ER [emergency room] hopping". Yet another respondent used this information to predict patients' "affluence" and whether or not they would be able to pay for orthopedic appliances prescribed by the physician.

Patient Marital Status

When asked if they usually "noted patients' marital status when admitting them", 45% (36) of the sample responded affirmatively. Seventy-nine percent (26) obtained this information from the chart. Many procured these data as it was hospital policy to do so, for purposes of notifying the next of kin that the patient was hospitalized, or to determine the patient's social support system in preparation for discharge. One respondent however, used this information to "rule out a homosexual lifestyle". He/she also suspected certain conditions in relation to one's marital status. That is, he/she indicated that there was a prevalence of depression and breast cancer in "old maids".

Patient Occupation

When asked whether or not they usually "noted patients' occupation when admitting them", only 33% (27) of the nurses sampled reported doing so. Sixty percent (15) of the nurses who acquired this information did so by asking the patient directly. Although the majority extracted this information only if the patient's injury was work-related, some admitted doing so out of "curiosity". Four respondents reported that they predicted the patient's "intelligence" according to what his/her

occupation was and would then adapt their communication style to one which they felt best suited the patient. For example, one respondent reported that he/she was able to "change my level of language to accommodate lawyers or stock boys". This same nurse also noted the patient's occupation so that he/she "could be assured that the patient is contributing to society".

Number of Patient Visits to the Emergency Department

The second least favorite patient in the sample's hierarchy of patients, next to patients who use foul language, was the one who had become a "regular". Only 40% (32) of the nurses sampled reported that they did not note how many times the patient had used their ED in the past. Of the nurses who acquired this information, 47% (21) did so to facilitate detection of patients who were "abusing the system" through what they considered to be "inappropriate" usage of the ED. One of the nurses sampled specified that he/she took note of the number of previous visits the patient had made to their ED to detect whether or not the patient was one of their "frequent flyers". One respondent gave the impression that his/her ED acts as a sentry as the nurses "keep track of *system abusers* [italics added] and contact [the patients'] primary physicians to handle the *problem* [italics added]". In addition they keep records of known narcotic abusers [locally and provincially] and alert staff when these patients appear in the ED. Only 24% (11) of the study sample used the number of patient visits to determine whether or not the hospital had existing records of the patient which could be accessed to facilitate medical/nursing care.

In summary, it appears that many emergency nurses use demographic

information from the patient chart to form opinions of that patient.

Judgements of Patients

Patient Dress

Glaser and Strauss (1964) suggested that nurses relied on clues garnered from the patients' general appearance as a means of increasing predictability of how they would act. When asked if they "usually noticed how the patient is dressed upon his/her arrival to the ED", 74% (60) of the study sample replied affirmatively. The majority of the respondents collected this information as part of their nursing assessment. For example, it was used to determine the mental well-being of the patients (e.g., were they appropriately dressed for the weather?). They also used this knowledge to determine how well patients were able to meet their basic grooming needs. Other explanations (in order of decreasing frequency) included that it was a means of determining a patient's socioeconomic status (the reasons why this was necessary were not indicated), that it was simply unavoidable, or that it was done out of basic curiosity. Three respondents were interested in patients' dress in estimating the patient's personal hygiene to decide "how close they would get to the patient". Two others reported that they could "determine a patient's level of intelligence by the manner in which he/she dressed".

Patient Socioeconomic Status

Although 94% of the nurses sampled felt that they were a "good judge of people" only 36% (29) usually judged what a patient's socioeconomic status might be. When asked what "clues" they used to determine a patient's probable socioeconomic

status, the respondents most often listed (in order of decreasing frequency) the patient's dress, hygiene, communication skills, overall appearance, behavior or mannerisms, employment status, apparent intelligence, and the address at which the patient lived. One respondent supposed the patient's socioeconomic status by way of noticing what his/her "intelligence and racial origin" was. Another simply asked the patient directly what his/her socioeconomic status was.

Patient Personality/Character

Sixty-seven percent (54) of the sample often judged what the patient's personality/character would be. When asked to identify "clues" used to approximate the patient's personality or character, 31% (26) of the respondents reported that they made this judgement only after interacting with the patient. Some judged the patient most often according to his/her communication skills followed by behavior displayed while in the ED. To others however, their first impression of the patient, the degree of eye contact made with the nurse, overall appearance, the people accompanying them to the ED, whether or not they felt that the patient took responsibility for his/her own health, or the patient's general attitude gave important insight into a patient's character. Individual respondents judged a patient by his/her measured blood alcohol level, pain threshold, and the level of education achieved. One respondent summed up his/her comments as, "It depends on what you are looking for--you always find what you are looking for". Two participants in the study indicated that patients were suspect if they demonstrated pleasure at being a patient in the ED. One of the nurses elaborated, "There is also something I call the *positive suitcase sign* [italics added]

which has a strong judgemental component to it. Patient arrives walking--dressed, shaved, parked in long term parking with suitcase packed for admission. Complaining of severe and incapacitating pains of vague origin [sic]. I always check and do a *serum loneliness level* [italics added] assessment . . . ."

Patient Companions

Although Glaser and Strauss (1964) reported that nurses also relied on clues obtained from the people who accompany a patient to the ED, 67% (54) of the respondents reported that they could not judge a patient's character by observing the people who accompanied him/her to the ED.

General Comments

General comments volunteered by the respondents provided further insight into the practice of moral evaluation in the ED. Although some responses were specific to just one respondent, their significance must not be diminished as it is difficult to estimate the influence that one nurse may have on the atmosphere and attitude of the entire ED and ultimately the patients. Eighty-nine percent (74) of the respondents indicated that they were aware that their patients were usually cognizant of being "liked or disliked" by the nursing staff. Apparently even this does not alter the way in which patients are treated.

Enlightening remarks included, "It depends on my sense of humour that particular day . . . how a patient presents . . . how the patient's family acts . . . how I interact or *tolerate* [italics added] patients", "Whether I like a specific patient type or condition is based more on the total patient volume and staffing than on the

specific patients", "I expect people to take control and responsibility for their lives . . . . I *do not tolerate* [italics added] well [sic] those who continue to be fat, smoke, not take their meds, drink and otherwise abuse their bodies", and "Some hospitals have 'blacklisted' many *frequent flyers* [italics added] to their departments [sic]. Ours has not been allowed to do that. Consequently they all come to our ED for treatment (i.e., pain control)". One respondent expounded:

> Emerg [sic] nurses are known for their *hardness* [italics added]. It is very difficult to maintain a bright and sunny attitude when dealing with *inappropriate* [italics added] cases, repeat overdosers, and chronic ED abusers. I wish we had a system of triage where we could send minor cases on to another facility and deal with only the true, real, necessary emergent patients who need us [sic].

Yet another respondent commented:

> This is an age old problem of having a personal philosophy of non-judgemental acceptance of individuals versus the reality that risk takers (motorbikers), hookers, or *noncontributors* [italics added] use a high and disproportionate amount of health care resources--and nursing time. My time, talent, energy, expertise and caring is the most valuable health care resource--and occasionally in ED the scarcest [sic]. This is wasted on abusers of the system (i.e, overdoses) and keeps the *deserving* [italics added] waiting.

It is obvious that many of the study sample possessed strong opinions regarding ED patients. These comments substantiate the existence of the aforementioned patient hierarchy.

While it is unclear whether or not ED nurses are even aware of their prejudicial ways and the detrimental effects these have on their patients, others are well aware of their prejudicial ways. One nurse reported that "At first everything I saw in the ED was facinating [sic]. Now have very little tolerance towards people who abuse the ED, drunks, psych. patients, O.D., people who drink and drive and kill others [sic]". Yet another respondent commented that "It seems staff are allowed to treat patients with disrespect simply because they are frustrated. I also feel that some of the nurses I work with treat all patients with disrespect and should be patients themselves sometimes to see how it feels".

Emergency Nurses' Views on Emergency Nursing

Overall View of Sample

When asked to respond to "If I could, it would be nice to be able to choose my clientele", only 13% (11) of the sample responded affirmatively. This is contrary to Roth's (1971) research which found that a "low boundary control" or lack of control over the population it serves contributes greatly to the frustration and subsequent hostility attributed to ED staff. Indeed, seventy-eight percent (65) of the nurses reported that they liked to have a "mixture" of patients (i.e., both minor and major health problems/injuries).

Findings from previous work (Hawley, 1992; Jeffery, 1979; Lewis & Bradbury, 1982; Roth, 1971, 1972a; Yoder & Jones, 1981) indicated that "misuse of the ED" was a major stressor of emergency nurses. "Non-urgent patients" amongst others were viewed as responsible for this "misuse". Interestingly, only a slight majority

(61%) of the study sample agreed with the statement that "patients with minor ailments should not seek care in the ED".

In examining the rationale behind the negative attitudes of emergency nurses toward certain patient characteristics, it is reasonable to explore whether some nurses feel trapped in a profession which they no longer enjoy, consequently taking their frustrations out on their patients. However, this sample (with an average of 18 years of nursing experience--7.5 of those being in the ED) appeared contented as 92% (76) disagreed with the statement "If I had known what emergency nursing was really like before I got into it, I would never have chosen it". Only 6% (5) of the nurses sampled indicated that they "would like to leave emergency nursing in the next year".

Nurses' Age and View of Emergency Nursing

Age, years of nursing experience, and whether or not the nurses worked in urban or rural hospitals did not appear to be of great importance when examining emergency nurses' views of ED nursing. If any trend appeared it was that nurses, aged between 26 and 35 years of age, appeared to be the least contented. They wanted more control over choosing patients than nurses in the other age groups. Only 12% (3) of this group agreed that patients with minor problems should use the ED.

This may be explained in part, by attrition. That is, older nurses who are discontented with certain characteristics of ED nursing (i.e., low boundary control, working with large numbers of non-urgent patients, etc.) may have left ED nursing. Younger nurses, who have not fully acknowledged their discontentment or may not

have the mobility within today's economic climate to act on their desire to leave ED nursing, remain. Alternatively, older nurses with increased experience may have achieved a balance so that they do not object to the non-urgent patients. That is, they have seen many emergent and urgent patients and are content also with caring for those non-urgent patients. They have a more realistic perception of ED nursing. Perhaps, with time, those nurses in the youngest age group of the sample would express less dissatisfaction with ED nursing.

CHAPTER V

DISCUSSION AND CONCLUSIONS

The focus of this study was to determine which patient characteristics emergency nurses used to morally evaluate ED patients, the reasons they attributed to this behavior, and to identify some factors (i.e., environmental and individual) which contributed to the evaluative behavior. A self-administered questionnaire was distributed to 150 emergency nurses currently working in Alberta.

The study sample was representative of the emergency nurse population in Alberta. Although this very experienced group of nurses generally did not lead a highly unusual or adventurous life, neither did they lead an unusually conservative one. Differences in behaviors (i.e., smoking, alcohol intake, use of foul language, impaired driving occurrences, frequency of worship, etc.), marital status, financial background, and experience with unemployment existed among the sample. There was wide representation of nurses' ages, years of nursing experience, and the location of the hospital in which the sample worked (i.e., urban or rural).

Major Findings

Patient Characteristics and Moral Evaluation

A definite hierarchy emerged from the data validating previous research which found that the nature of the illness and diagnosis in addition to certain patient characteristics are critical in determining emergency nurses' attitudes. Although it is well documented in the research literature that such a hierarchy does indeed exist, few studies have asked the nurses to rate how much or how little they enjoy caring for

certain patients when given just one characteristic for each patient. Yet, this is purported to be a fundamental feature of moral evaluation.

In addition to confirming previous work (eg., emergency nurses dislike caring for patients who are verbally and physically abusive and enjoy caring for patients with traumatic injuries and medical/surgical disorders), the results divulged other patients' positions in the hierarchy. For example, a patient who sustains traumatic injuries while riding a motorbike is ranked lower than one who receives similar injuries as a result of an unknown mechanism of injury. It was also revealed that as patients live beyond 65 years of age, they become less desirable as patients. That is, their berth in the hierarchy decreases as their age increases. Consequently, patients aged 91 years and older occupy the lowest "age" berth on the hierarchy.

Interpretation of the data disclosed that, with the exception of Canada's native Indians, patients' socio-economic and racial characteristics did not appear to be important characteristics for this sample. There is only a small difference between the scores of patients of a "low socio-economic origin" ($\underline{X}$ = 3.46) and those of a "high socio-economic origin" ($\underline{X}$ = 3.22). Although "native Indians" received a score of 3.05 on the Likert Scale (i.e., relatively "indifferent"), the $\underline{SD}$ was .83 which represents variability in the response of the sample. Also of interest is that patients with chronic pain were rated low ($\underline{X}$ = 2.90) with a $\underline{SD}$ of .92.

In summary it appears as though emergency nurses judge a patient positively or negatively according to both visible and invisible characteristics. Roberts (1984) suggested that because of the number of strangers we meet in today's society, we

have to form rapid opinions of others based on previous experience if for no other reason than for personal safety. This, he cautioned, is reasonable, it we are aware that we are thinking in terms of stereotypes, and therefore only generalizations. Roth (1971, 1972a) and Yoder and Jones (1981) allude to rapid opinion formation as a method to cope with occupational stressors inherent in a work environment with low boundary control.

Reasons for Moral Evaluation of Emergency Department Patients

Information gathered suggests that many emergency nurses are unaware of their evaluative actions. For example, none of the respondents volunteered that they morally evaluated their patients in an attempt to increase control in the ED or to protect themselves against unsavoury characters. Indeed, Roberts (1984) suggests that the prejudice in the ED is so widespread that the nurses are often unaware that they are acting prejudicially. As reported earlier, 68% (55) of the nurses sampled denied forming opinions of ED patients. However 90% (74) reported changing their opinions of patients they initially disliked. This indicates that it is more probable that 90% of the sample actually form opinions of their patients.

Similar to Roberts' (1984) findings, respondents in the study sample felt that they were truly gathering information on their patients for nursing assessment and intervention purposes. However, while such information may be beneficial initially for the nurse, it may over time be detrimental to the patient depending upon how that information is used.

When asked if their ED had "a good atmosphere in which to work", 84% (70)

of the respondents indicated that it did. Comments received from the study sample implied that whether or not the environment is perceived as a positive one in which to work depends, in large part, on how much the nurse enjoys working there. Professional satisfaction with high quality patient care received little attention. The overwhelming reason (n =51 or 61%) given for the enjoyment of their particular ED was that there was "good comradeship" amongst the staff. This was followed by explanations that the physical environment (equipment, layout, etc.) was a pleasant one in which to work (n = 9) and that the physicians were "competent" (n = 9). Eight respondents (10%) indicated that they enjoy their work environment because it is "fun" and "kind for patients". Only three of the nurses sampled (4%) indicated that their ED was a good place in which to work because the patients received good medical/nursing care.

Of the 11 (13%) respondents who implied that their ED was not a good atmosphere in which to work, most gave reasons of negative interstaff relationships (eg., lazy co-workers, poor morale, lack of support, etc.). Only one nurse (1.2%) indicated that he/she disliked the work atmosphere because patients were "not treated with respect". Generally then, the emphasis appeared to be on the nurses' personal enjoyment of the ED. High quality patient care or professional self-perception did not appear to be priorities.

When asked if their ED had "a good atmosphere for patients", a lower number of respondents (n = 66 or 80%) replied affirmatively. Only five respondents (6%) indicated that their ED benefited patients because they were "treated with respect".

Twenty-eight respondents (34%) specified that their patients received good medical/nursing care. Twenty respondents (24%) denoted that their ED was good because the staff were "friendly and caring". Eighteen nurses in the sample felt that theirs was a good ED because the patients got "quick *service*" [italics added]. Two respondents (2%) noted that patients in their ED were not treated with any respect. One went on to explain that "some of the staff . . . don't even believe some of the [patients'] complaints". One telling comment received was that the ED was a good one for patients "only if they *cooperated* [italics added] with staff". Another respondent indicated that his/her ED was perceived as being good by patients only because they "don't hear what goes on behind the scenes". Exactly what goes on behind the scenes was not volunteered.

Factors That Influence Moral Evaluation

The researcher explored whether or not individual characteristics of the nurses or environmental characteristics of the hospitals in which they work, influenced the degree of negative moral evaluation performed. This was done to identify predictors for nurses who will morally evaluate patients negatively. That is, are nurses of a certain age more likely to morally evaluate patients negatively than nurses of other ages? Will nurses from large, busy urban hospitals routinely treat patients differently than nurses from rural hospitals? Are nurses who subscribe to a highly conservative way of life more likely to morally evaluate their patients than those who lead a more adventurous way of life?

"Adventurousness" of Nurses' Lives

No dominant pattern emerged from this study to indicate that there is a direct relationship between the nurses' ages, their years of nursing experience, location of hospitals (i.e., urban or rural) in which they work, and their overall way of life. Thus it is not possible to predict which nurses live their lives in a conservative manner and which live their lives in an adventurous manner.

It became evident that emergency nurses' conservatism or lack thereof, did not affect the degree of negative moral evaluation employed by them. That is, nurses who were conservative in their own behavior (i.e., did not smoke cigarettes, drink alcohol, drive while in an impaired condition, or use foul language) were not inclined to act more negatively towards patients who did not adhere to similar values and beliefs. Similarly, nurses who partook in the aforementioned activities did not exhibit tolerance towards patients who followed a similar lifestyle.

Experiences in the nurse's past did not appear to influence his/her behavior towards the patients. Contrary to Roberts' (1984) findings, nurses with friends or significant others with alcohol and/or drug addiction problems, were not predictably different in dealing with patients with similar problems. Similarly, the upbringing of the nurse (i.e., strict, democratic, or lenient) did not predictably affect his/her behavior while carrying out his/her nursing functions.

Age of Nurse, Years of Experience, Hospital Location

The age of the nurse, the number of years in nursing, and the location of hospital (urban or rural) did not prove to be statistically significant in their association

with the practice of moral evaluation. That is, although demographic backgrounds differed, attitudes toward ED patients were similar. Roberts (1984) also found that contrary to expectations, age of the nurse was not a major component in attitudes towards patients. In validation of Roberts' (1984) research, this study also failed to show that prejudice and stereotyping is lower in younger nurses. In fact, a slight trend appeared for the youngest nurses (26-35 years) to exhibit the least tolerance of patients. That is, they were more prone to morally evaluate their patients negatively than were nurses aged 36-45 years and those 46 years of age and older who were, on the whole, the most benevolent.

In summary then, generalized attitudes to life and work on behalf of the nurses, did not appear to affect their moral evaluation of patients. Additionally, their degree of professional qualifications, social class, age, racial or ethnic origin did not appear to be significant predictors of those nurses who would negatively evaluate ED patients according to their more obvious characteristics. It appeared that neither external nor factors innate to the nurses played a significant role in their judgements of patients.

Implications of Findings

Nurse-Patient Relationship

Nursing staff's attitudes to unpopular patients have far reaching effects, not only for patients and their families but also for the morale of the nursing staff involved as caregivers (Roberts, 1984). The majority of the respondents indicated awareness that patients were cognizant of being liked or disliked by the nursing staff. This has implications for the quality of the nurse-patient relationship. If patients are aware of

being disliked by the nurse caring for them, they will not open up to the nurses and reveal everything about their real problems, thus limiting a valuable source of patient data. The nurse-patient communication and ultimately the therapeutic relationship is jeopardized.

Comments received on the questionnaires provided evidence that, in some EDs, nurse-patient relationships are truly in peril. One respondent reported that "Some of the nurses I work with treat all patients with disrespect". Another wrote that he/she interacted differently with patients according to "my sense of humour that day, whether or not the patient is covered by something *malodorous* [italics added], according to whether or not the patient's family is *continually in the way* [italics added]". This same nurse wrote that at times, "intoxicated or mentally ill patients provide *entertainment* [italics added] for the staff". A different respondent indicated that he/she has witnessed "nursing care being delayed for long and occasionally intolerable lengths of time because nursing time was taken up by a person who has self-inflicted--example overdose times three this week [sic]". This implies that the person who has overdosed is not worthy of medical/nursing intervention.

People, including patients, define a situation in which they are involved. They subsequently redefine the situation according to the interaction and modify their actions according to what they think is expected of them (Kelly & May, 1982). That is, their behavior is oriented towards its immediate social context. It is often assumed, perhaps naively, that patients are passive recipients of nursing labels. Obviously, some emergency nurses assume that people become complacent

immediately upon arrival to the ED and that regardless of their behavior towards a patient, he/she will not react. That is, if a patient is evaluated negatively upon his/her arrival to the ED and consequently receives abrupt treatment, it is expected that the patient will tolerate this conduct without complaint or comment. If however, the patient rejects the nurse's attempts to impose his/her definition and consequent behavior on them, the nurse-patient relationship is jeopardized even further, serving to reinforce the negative label placed upon the patient. Why should the patient have the unnecessary stressor of working at "being liked" when he/she is ill and less likely or able to succeed? Just as the nurse deems the nurse-patient relationship as "not worth expending much energy into" because of its temporary, singular status, so might the patient. These considerations have profound implications for behavior and attitudes and should be examined further. That is, to what extent is a patient's behavior dependent upon the nurse's behavior and the ED environment?

Recommendations for Practice and Nursing Education

Ideally, the nurse should understand some of the complex reasons for the patient's behavior and thereby improve nurse-patient behaviors and relationships. The study sample indicated overwhelmingly that they had often changed their opinions of patients after interacting with them. Therefore, nurses should be encouraged not to get caught up in this labelling process until they at least have interacted with the patient. Roberts (1984) proffered that the most frequent reason given for nurses changing their opinions of patients was that they had found the time to talk with them and get to know them. Emergency nurses perpetuate the notion that they never have

time to interact with their patients. Perhaps if nursing education emphasized the mutual significance and benefits of nurse-patient interaction, the time could be found.

In 1959, Davis worried that in professions with a large number and random circulation of clients, informal social control networks would fail. Indeed, it seems as though his concerns are not unfounded. Common social niceties (eg., politeness and kindness) appear to have floundered, resulting in the nurse-patient relationship becoming disreputable, anonymous, and narrowly calculative. This is the antithesis to nursing's promotion of itself as a "caring profession".

Patient Care

A clear recognition by the nurse of the evaluating he/she does and the dangers inherent in this practice, can facilitate the delivery of good nursing care. Nursing needs of the patient can and ought to be determined objectively. Professional requirements of good nursing care can and ought to be fulfilled. Nurses must practice morally, according to the established standards of the profession. Their behaviors must be based on thought and understanding rather than on intuition and self-interest.

Role-Modelling

It is the researcher's experience that students in an area are often influenced more by the seasoned staff than by their instructors. Similarly a nurse's attitude may be influenced to a great extent by those with whom he/she is working as he/she seeks acceptance by new colleagues. By negatively evaluating patients solely on characteristics gathered in part by intuition, observation, selected questioning, or by assumption, expert nurses serve to act as poor examples and unsatisfactory role

models.

Nursing Education

It bears examining how our education curriculum could be altered to increase nurses' understanding of the dynamics of labelling. Wider understanding of human behavior on the part of nurses, is required to improve the nurse-patient relationship as is the emphasis on taking time to interact with their patients prior to labelling them as "good" or "bad" patients.

Continuing education of emergency nurses about the changing nature of ED nursing is also very important. Emergency nurses must change and grow with the changing ED demands which reflect various social forces at work in the community such as an aging population, a decrease in the number of family practitioners, and advances in medical technology which have reduced the ability of the family physician to treat patients optimally in the office. Although the ED patient population has changed over the years, the expectations of emergency nurses have not. This has several implications for continuing education in the ED. For example, the nurse should be helped to more fully understand the dynamics and health care needs of the non-urgent patient and others who rated low in the patient hierarchy. Additionally nurses should be encouraged to express their feelings about these patients who have been identified as contributing to the stressors of ED nursing. By helping the nurse to recognize those characteristics which cause them to react negatively, they will better be able to control their reactions and care objectively for all patients.

There is growing evidence that the phenomenon of stress is particularly severe

and increasing among nursing professionals (Hawley, 1992; Parasuraman & Hansen, 1987). The fact that stressors are a pervasive feature of the nursing role makes it important to examine the strategies or responses evoked by nurses in an attempt to cope with stressful conditions at work (eg., working with patients that they view as undesirable). Maladaptive, non-functional coping mechanisms such as emotional, self-protective behaviors are dysfunctional and serve only to heighten felt stress and job dissatisfaction (Parasuraman & Hansen, 1987).

Psychiatric Patients

Although psychiatric patients received a low score in the hierarchy ($\underline{X}$ = 2.77), the reasons given generally did not focus on the nurses' dislike or fear of them. One respondent reported that he/she has "no patients [sic] with psychiatric patients and try to stay away from them", but others wrote that they felt "inadequate" or did not feel "useful" when trying to care for these patients. They indicated that they had no skill in this area or felt that there were no backup resources for these patients in the community or hospital. Continuing education in the understanding and care of psychiatric patients in the ED is necessary as they are contributing to a large share of the increased use of the ED (Jones, Yoder, & Jones, 1984).

Native Indians

Many respondents had a predominantly negative opinion of Canada's native Indian population (eg., they abuse alcohol on a regular basis or are "system-abusers"). This situation must be addressed as our Indian population is growing and the emergency nurse will be exposed to them on a more frequent basis.

Canada's registered Indian population increased from 224, 164 in 1966 to 490,178 in 1990, which is more than a twofold increase. With the reinstatement of Indians through Bill C-31, this population is expected to reach approximately 623,000 by the year 2001 which represents a 27% increase from 1990 (Indian and Northern Affairs Canada, 1991). Emergency nurses in both urban and rural EDs will be involved increasingly in the care of native Indians as the off-reserve population is growing rapidly. In 1966 80% of registered Indians lived on reserve, but this proportion dropped to 60% in 1990 (Indian and Northern Affairs Canada, 1991). This off-reserve population growth rate is also largely attributed to the reinstatement of Indians under Bill C-31 (Indian and Northern Affairs Canada, 1991). Bill C-31 was passed by Parliament in June 1985 and contained important amendments to the Indian Act. Basically it prevents anyone from gaining or losing status through marriage and also restored Indian status to victims of past discrimination.

Nursing education will be necessary to provide information on cultural nuances particular to Indians in an attempt to change the stereotypical image of the Indian as a drunken, non-contributor to society.

Elderly Patients

Patients older than 81 years of age were not regarded as "highly desirable" patients by the study sample. However, the trend of increased aging of the population will continue to the year 2030 (Andreoli & Musser, 1985) with the most rapid growth of the elderly segment of the population projected to occur between the years 2010 and 2030 when the "baby boomers" reach the age of 65 years. Although sickness is

not inevitable in old age, it is statistically prevalent (Andreoli & Musser, 1985). Emergency nurses will need to readjust their attitudes toward caring for the aged in the ED in order to be truly effective as practitioners.

Non-urgent Patients

The location of the ED is important to health care consumers as they regard it as "a place to get medical aid in a hurry" (Stratmann & Ullman, 1975). Consequently they go to the most and often only accessible and available professional source, which in many communities is the local ED. The ED is a major initial source of patient contact and the hospital's reputation may be determined by the care given in its ED.

ED services must be oriented towards handling all types of patients, including the non-urgent ones. Since non-urgent patients represent the majority of cases seen, the emergency nurses' perspective should change so they will routinely accept non-urgent patients as legitimate. They should receive the same quality of care as the emergent patients (who are really the minority). Little is gained by treating non-urgent patients as intruders into a private domain as illustrated by the respondent who reported feeling "*angry* [italics added] at people who are abusing the health care system".

Limitations to Generalizability

Whereas questionnaires are useful for collecting basic demographic and attitudinal data, when used as a substitute for observing actual behavior they are less convincing. Indeed the questions in the survey may have measured respondents' subjective post hoc rationalizations about putative attitudes and behavior rather than

anything else (Kelly & May, 1982). Additionally, the nurses may have problems with recall of events. A combination of observational and interview methods (i.e., participant observation) would be required to further investigate the research questions. Participant observation is particularly useful in situations in which the researcher needs to verify the information between the informant's reports of behavior with the actual behaviors which occur in the setting (Field & Morse, 1985).

Additionally, the content and format of the questionnaire, in addition to a non-response bias could possibly jeopardize the validity of the instrument. The self-selection of respondents contributes to a sampling bias in that nurses who recognize that they morally evaluate in a negative fashion may have declined to participate in the study--although the data do not suggest this.

Threats to content validity may have included too narrow a focus on specific dimensions, vague wording of items (eg., certain concepts may not have been rigorously defined) which may have confused the respondents, or wording of items that encouraged an acquiescent response bias.

Nevertheless, the questionnaire obtained information on a sensitive topic in an anonymous manner which may have resulted in higher quality of data as evidenced by the many candid comments obtained. The response rate of 55% was considered to be high for the population and is large enough to control for a nonresponse bias (Burns & Grove, 1987).

Content validity of the research instrument was enhanced through consultation with an expert in questionnaire design and administration. It was further advanced by

incorporating selected content areas from previously reported studies and through conducting a pilot test of the instrument.

Recommendations for Future Research

It is necessary to conduct this study in different provinces, nationally and internationally to provide replicability of data which would contribute to the external validity of the data. Externally valid data are the basis of theory building.

It would be of interest to study occupations with the same environmental characteristic of "low boundary control" (eg., police officers, cab drivers, servers in restaurants, etc.) to examine whether they share similar features inherent in ED nursing. That is do they morally evaluate their clients on apparent characteristics, possess similar environmental and/or individual characteristics which contribute to the moral evaluation of clients, and give similar, if any, reasons, for this behavior?

A longitudinal study on emergency nurses would provide further information on the effects of experience on the attitudes of emergency nurses. That is, do they become more tolerant of patients with experience and time? Does the quality of their nurse-patient interactions improve or regress over time?

An investigation into the cause-effect relationship of the nurse and patient would provide valuable insight into patient care. It would be valuable to explore how the patient's behavior is dependent upon or affected by the nurse's behavior and the social processes involved. Does reciprocity between patients and nurses exist? It is possible that the patient's behavior is oriented towards its immediate social context.

It would be interesting to study both the patients and the nurses in the same ED

to examine whether patients agree with nurses who state that their ED is "a good one for patients". That is, do emergency nurses have a true perception of their ED as viewed by their patients? It would be intriguing to explore what reciprocal perceptions the patient has of the nurse and of the ED.

Finally, an inquiry into nursing curricula would be worthwhile to determine the emphasis on the study of nuances common to various cultures, human behavior, communication/interaction skills, and the non-judgemental treatment of all patients. These become increasingly necessary as the trend in nursing education is one in which students spend the majority of their time in the clinical areas with preceptors--not instructors as role-models.

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APPENDICES

APPENDIX A

QUESTIONNAIRE (NURSES' ASSESSMENT OF PATIENT CHARACTERISTICS IN AN EMERGENCY DEPARTMENT)

PLEASE TRY TO ANSWER ALL OF THE QUESTIONS WHICH APPLY TO YOU. MOST OF THEM CAN BE ANSWERED BY CIRCLING THE NUMBER NEXT TO THE ANSWER YOU CHOOSE, OR BY WRITING IN THE BLANK SPACE PROVIDED.

If for any reason you do not want to answer a question, just leave it blank.

THIS SET OF QUESTIONS DEALS WITH YOUR PERSONAL AND PROFESSIONAL BACKGROUND.

1. What year were you born? _____

2. What is your current marital status?

   Married 1

   Living with someone of the opposite sex (but not married) 2

   Single 3

   Separated or divorced 4

   Other (specify) _____ 5

3. Sex: Female 1

   Male 2

4. Do you have any children?

   Yes 1

   No ..... 2 [GO TO QUESTION 6]

5. If yes, how many children are under 18 years of age? _____

6. How often do you attend your place of worship (i.e., church, synagogue, mosque, etc)?

Everyday 1

Several times a week ... 2

Once a week 3

Once or twice a month .. 4

Less than once a month . 5

Never 6

7. Do you have any religious affiliation?

Yes 1

No ..... 2 **[GO TO QUESTION 9]**

8. Please state your religious affiliation.

Roman Catholic 1

Protestant 2

Other (please specify) _____ 3

9. Would you consider yourself to be a visible minority in race or colour?

Yes 1

No 2

10. Do you speak more than one language?

Yes 1

No 2

11. Thinking back, how well-off financially was your family while you were growing up as compared to others in your community? (Circle the number that is closest to your answer).

Below Average Above Average

1 2 3 4 5

12. Do/did you have any parent with a university degree?

Yes 1

No ..... 2 **[GO TO QUESTION 14]**

13. Which parent has/had a university degree?

Mother 1

Father 2

Both 3

14. In general, would you regard your upbringing as:

very strict very permissive

1 2 3 4 5

15. Which is the highest degree or qualification you hold?

Diploma in Nursing 1

Baccalaureate in Nursing 2

Post-basic Baccalaureate in Nursing . 3

Baccalaureate other than nursing .. 4

Master's in Nursing 5

Master's other than nursing 6

Doctorate in Nursing 7

Other (please specify) _____ 8

16. In what year did you graduate from your basic nursing program? _____

17. Have you taken a post-graduate course in emergency nursing?

Yes 1

No 2

18. Do you intend to return to college/university to continue your nursing education?

Yes 1

No 2

19. Please indicate the number of years in which you have worked in emergency nursing. _____

20. Why did you choose to work in emergency nursing?

_____

_____

_____

21. Which of the following categories describes the setting where you currently work? (If you have more than one job, tell me about the one where you work the most hours).

A. Urban hospital (please specify number of beds) ____ 1

Rural hospital (please specify number of beds) ____ 2
[GO TO QUESTION 22]

B. Community hospital 1

Downtown "core" hospital 2

Neither (please specify) _____3

C. Teaching hospital (regularly has medical/nursing students) 1

Referral hospital (regularly receives patients from other hospitals/nursing stations, etc). 2

Neither (please specify) _____3

22. Are you employed to work only in the Emergency Department in your hospital?

Yes ..... 1 [GO TO QUESTION 24]

No 2

23. In what other areas in your hospital do you work?

_____

24. Does your hospital have an Emergency Department that is open and staffed with Registered Nurses 24 hours/day?

Yes 1

No 2

25. Please indicate the rotation that best describes the shift you most frequently work.

Days/Evenings/Nights . . . 1

Days/Evenings 2

Days/Nights 3

Days 4

Evenings 5

Nights 6

26. Please indicate the number of hours/week you work in the Emergency Department. (If you have more than one job, tell me about the one where you work the most hours).

37.5 hours or more 1

15-37 hours 2

less that 15 hours 3

27. How much do you socialize with your emergency colleagues while not working?

Very much	More than once/month	Less than once/month	Not at all
1	2	3	4

28. Have you ever held a full-time job in an occupation other than nursing?

Yes 1

No . . . . . 2 [GO TO QUESTION 30]

29. Please specify the occupation. _____

THE FOLLOWING ARE QUESTIONS ABOUT YOUR EXPERIENCES AS A PATIENT OR VISITOR IN AN EMERGENCY DEPARTMENT.

30. Have you ever been a patient in an Emergency Department (in which you did not work)?

Yes 1

No . . . . . 2 [GO TO QUESTION 33]

31. Were you satisfied with your treatment by the staff?

Yes . . . . . 1 [GO TO QUESTION 33]

No 2

32. Please explain why you were not satisfied with your treatment by the staff.

_____

_____

_____

33. Have you ever accompanied a close friend/family member to an Emergency Department (in which you did not work)?

Yes 1

No . . . . . 2 [GO TO QUESTION 38]

34. Were you satisfied with their treatment by the staff?

Yes . . . . . 1 [GO TO QUESTION 36]

No 2

35. Please explain why you were not satisfied with their treatment by the staff.

_____

_____

_____

36. Were you satisfied with your treatment by the staff (i.e., as a visitor)?

Yes . . . . . 1 [GO TO QUESTION 38]

No 2

37. Please explain why you were not satisfied with your treatment by the staff.

_____

_____

_____

THE FOLLOWING QUESTIONS RELATE TO YOUR PERSONAL LIFE AND YOUR VIEWS ON SOME SOCIAL ISSUES.

I hope you will answer all of these questions. Your answers are completely confidential and I have no access to your name and/or address. However, if for any reason there is a question you do not want to answer, just leave it blank.

38. How often do you smoke cigarettes?

Never 1

Occasionally 2

Regularly 3

39. How often do you drink beer, wine or other alcohol?

Every day 5

Several times a week . . . 4

Once a week 3

Once or twice a month . . 2

Less than once a month . 1

Never 0

40. How often do you swear or use "foul language"?

Never 1

Seldom 2

Sometimes 3

Often 4

Very often 5

41. Do you approve of tattoos on others?

Yes 1

No 2

Indifferent (please explain) _____

_____ 3

42. Do you like to dress differently than others?

Yes 1

No 2

43. How would you describe your weight?

Underweight 1

Normal 2

Minimally overweight 3

Overweight 4

44. Do you have a close friend, significant other, and/or a family member who is/was dependent upon alcohol and/or drugs (prescription, street, or over the counter)?

Yes 1

No 2

45. Have you ever been unemployed for a month or longer other than by choice?

Yes 1

No 2

46. Have you ever collected Unemployment Insurance (not maternity benefits)?

Yes 1

No 2

47. Has a member of your immediate family or a close friend ever been unemployed for a month or longer?

Yes 1

No 2

48. HOW STRONGLY DO YOU DISAGREE OR AGREE WITH EACH OF THE FOLLOWING STATEMENTS ABOUT GOVERNMENT ASSISTANCE?

	Strongly Disagree				Strongly Agree
a. There's no reason to collect unemployment insurance--you can always find work.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
b. Many people who get welfare are just too lazy to work.	1	2	3	4	5
c. It's too easy to get unemployment insurance.	1	2	3	4	5

49. How likely is it that you may one day be unemployed?

Very unlikely 1

Unlikely 2

Likely 3

Very likely 4

50. Do you feel that premarital sex is acceptable?

Yes 1

No 2

51. Do you believe that therapeutic abortion should remain legalized?

Yes 1

No 2

52. Do you feel that it is acceptable to have multiple sexual partners if you are not married?

Yes 1

No 2

53. Do you have any close friends who are a different colour than yourself?

Yes 1

No 2

54. Would you like it if a family member became romantically involved in an inter-racial relationship?

Yes 1

No 2

Indifferent (please explain) _____

_____ 3

55. If single, would you ever marry or become involved with someone from a different racial group?

Yes 1

No 2

56. Have you ever travelled to an Oriental, African, South American or Asian country?

Yes 1

No ..... 2 [GO TO QUESTION 58]

57. Did you gain an appreciation of their culture?

Not at all				Very Much
1	2	3	4	5

58. If the opportunity arose, how much would you like to live, travel, and/or work in an Oriental, African, South American and/or Asian country?

Not at all				Very Much
1	2	3	4	5

59. Which of the following kinds of restaurants do you eat in?

	Yes	No
a. Arabic	1	2
b. Chinese	1	2
c. East Indian	1	2
d. Vietnamese	1	2

60. Has a family member/close friend ever been convicted of a criminal offence?

Yes 1

No 2

61. Have you ever in the past year driven a vehicle when you believed you were legally impaired by alcohol, drugs, and/or a medical condition?

Yes 1

No 2

62. Do you approve of people who ride motorbikes?

Yes 1

No 2

Indifferent (please explain) _____

_____ 3

63. HOW MUCH DO YOU DISAGREE OR AGREE WITH THE FOLLOWING STATEMENTS REGARDING SEXUAL ORIENTATION?

	Strongly Disagree				Strongly Agree
a. It is unnatural to be anything but heterosexual.	1	2	3	4	5
b. I can be accepting of a person regardless of his/her sexual orientation.	1	2	3	4	5

64. Have you ever been sexually abused/assaulted?

Yes 1

No 2

65. Have you ever been physically abused/assaulted while working in the Emergency Department?

Yes 1

No 2

66. Have you ever been <u>physically</u> abused/assaulted while <u>not at work</u>?

Yes 1

No 2

THE FOLLOWING ARE DESCRIPTIONS OF PATIENTS ENCOUNTERED IN EMERGENCY DEPARTMENTS.

67. Please indicate how much you generally <u>enjoy</u> caring for the following people. If you wish to qualify your response, please use the comments space provided below.

		Not at all				Very Much	Comments
i.	Patients admitted because of intentional overdoses.	1	2	3	4	5	
ii.	Patients suspected of having a drinking problem.	1	2	3	4	5	
iii.	Native Indians.	1	2	3	4	5	
iv.	Patients who speak little or no English.	1	2	3	4	5	
v.	Patients suspected of being addicted to drugs.	1	2	3	4	5	
vi.	Patients who belong to the health care profession.	1	2	3	4	5	
vii.	Patients suspected of having a psychiatric illness.	1	2	3	4	5	
viii.	Patients who have become "regulars".	1	2	3	4	5	
ix.	Non-urgent patients--that is they could be seen in their family doctor's office.	1	2	3	4	5	
x.	Patients who have a medical illness (eg.,diabetes).	1	2	3	4	5	
xi.	Patients who have a surgical problem (eg., appendicitis).	1	2	3	4	5	
xii.	Patients having sustained multiple traumatic injuries.	1	2	3	4	5	
xiii.	Patients from a low socio-economic origin.	1	2	3	4	5	
xiv.	Patients from a high socio-economic origin.	1	2	3	4	5	
xv.	Patients who are unemployed.	1	2	3	4	5	
xvi.	Patients accompanied by friends and/or family members.	1	2	3	4	5	
xvii.	Patients familiar with the health care system.	1	2	3	4	5	
xviii.	Patients with tattoos.	1	2	3	4	5	
xix.	Patients who have chronic pain.	1	2	3	4	5	
xx.	Patients injured while committing a crime.	1	2	3	4	5	

		Not at all				Very Much	Comments
xxi.	Patients escorted by police/guards.	1	2	3	4	5	
xxii.	Patients injured as a result of driving while impaired.	1	2	3	4	5	
xxiii.	Patients suspected of having a STD.	1	2	3	4	5	
xxiv.	Patients who are on welfare.	1	2	3	4	5	
xxv.	Overweight patients.	1	2	3	4	5	
xxvi.	Patients from a different racial origin than your own.	1	2	3	4	5	
xxvii.	Patients who smoke.	1	2	3	4	5	
xxviii.	Patients who swear or use "foul" language.	1	2	3	4	5	
xxix.	Patients suspected of having multiple sexual partners.	1	2	3	4	5	
xxx.	Patients injured while riding a motorbike.	1	2	3	4	5	
xxxi.	Patients who are dressed in a different manner.	1	2	3	4	5	
xxxii.	Female patients.	1	2	3	4	5	
xxxiii.	Male patients.	1	2	3	4	5	
xxxiv.	Patients under 2 years of age.	1	2	3	4	5	

		Not at all				Very Much	Comments
xxxv.	Patients 2-12 years of age.	1	2	3	4	5	
xxxvi.	Patients 13-18 years of age.	1	2	3	4	5	
xxxvii.	Patients 19-30 years of age.	1	2	3	4	5	
xxxviii.	Patients 31-45 years of age.	1	2	3	4	5	
xxxix.	Patients 46-65 years of age.	1	2	3	4	5	
xl.	Patients 66-80 years of age.	1	2	3	4	5	
xli.	Patients 81-90 years of age.	1	2	3	4	5	
xlii.	Patients 91 years of age or older.	1	2	3	4	5	

68. Please list any kinds of patients you especially enjoy nursing that <u>were not mentioned</u> in Question 67.

_____

_____

_____

69. Please list any kinds of patients you especially dislike nursing that were not mentioned in Question 67.

_____

_____

_____

THIS SET OF QUESTIONS DEALS WITH YOUR BEHAVIOURS WHILE AT WORK. AS MENTIONED IN MY COVER LETTER YOUR RESPONSES ARE ANONYMOUS AND CONFIDENTIAL.

70. Do you usually form opinions about patients before you meet them?

Yes 1

No ..... 2 **[GO TO QUESTION 72]**

71. How do you form these opinions?

_____

_____

_____

72. Do you usually agree with your colleagues' opinions of a particular patient?

Yes 1

No 2

73. Has "peer pressure" at work ever caused you to act towards a patient differently than you would have normally?

Yes (please explain) _____

_____

_____ 1

No 2

74. Does your Emergency Department have a list of patients who are considered to be dangerous, abusive, or known drug seekers?

Yes 1

No ..... 2 **[GO TO QUESTION 76]**

75. When do you usually consult this listing?

Before seeing the patient 1

After seeing the patient 2

Never 3

Other (please specify) _____

_____ 4

76. Have you ever changed your opinion about a patient you initially disliked?

Yes 1

No ..... 2 **[GO TO QUESTION 78]**

77. Why did this change occur?

_____

_____

_____

78. In general, do you feel that the atmosphere of your emergency room is a good one in which to work?

Yes (please explain) _____

_____

_____ 1

No (please explain) _____

_____

_____ 2

79. In general, do you feel that the atmosphere of your emergency room is a good one for the patients?

Yes (please explain) _____

_____

_____ 1

No (please explain) _____

_____

_____ 2

80. Have you ever ejected a patient from the Emergency Room?

Yes 1

No . . . . . 2 [GO TO QUESTION 82]

81. Why did this occur?

_____

_____

_____

82. Have you ever ejected a patient's family and/or friends from the Emergency Room?

Yes 1

No . . . . . 2 [GO TO QUESTION 84]

83. Why did this occur?

_____

_____

_____

84. Do you usually note where a patient lives when obtaining a history?

Yes 1

No . . . . . 2 [GO TO QUESTION 87]

85. How do you do this?

_____

_____

_____

86. Why do you do this?

_____

_____

_____

87. Do you usually note what the patient's occupation is when admitting him/her?

Yes 1

No . . . . . 2 [GO TO QUESTION 90]

88. How do you do this?

_____

_____

_____

89. Why do you do this?

_____

_____

_____

90. Do you usually note what the patient's marital status is when admitting him/her?

Yes 1

No . . . . . 2 [GO TO QUESTION 93]

91. How do you do this?

_____

_____

_____

92. Why do you do this?

_____

_____

_____

93. Do you usually note how many times the patient has used your Emergency Department?

Yes 1

No . . . . . 2 [GO TO QUESTION 95]

94. Why do you do this?

_____

_____

_____

95. Do you usually notice how the patient is dressed upon his/her arrival to the Emergency Department?

Yes 1

No . . . . . 2 **[GO TO QUESTION 97]**

96. Why do you do this?

_____

_____

_____

97. Do you believe that on the whole, you are a good judge of people?

Yes 1

No 2

98. Do you find usually find yourself judging what a patient's socioeconomic status might be?

Yes 1

No . . . . . 2 **[GO TO QUESTION 100]**

99. What clues do you use to help you make this judgement?

_____

_____

_____

100. Do you usually find yourself judging what a patient's personality/character is like?

Yes 1

No . . . . . 2 **[GO TO QUESTION 102]**

101. What clues do you use to help you make this judgement?

_____

_____

_____

102. Do you feel that you can usually judge a patient's character by observing the people accompanying him/her to the Emergency Department?

Yes 1

No 2

103. Please give an example of a situation in which you were able/were unable to judge a patient's character by observing the people accompanying him/her to the Emergency Department.

_____

_____

_____

104 Do you believe that patients are usually aware of being liked or disliked by nursing staff?

Yes 1

No 2

THIS FINAL SET OF QUESTIONS DEALS WITH YOUR VIEWS ON EMERGENCY NURSING.

105. HOW STRONGLY DO YOU DISAGREE OR AGREE WITH EACH OF THE FOLLOWING STATEMENTS?

	Strongly Disagree				Strongly Agree
a. The Emergency Department is a dangerous place to work due to violent patients.	1	2	3	4	5
b. The Emergency Nurse has a high chance of contacting HIV or hepatitis.	1	2	3	4	5
c. Patients with minor ailments should not seek care in the Emergency Department.	1	2	3	4	5
d. If I could, it would be nice to be able to choose my clientele.	1	2	3	4	5
e. I like to have a mixture of patients (i.e., both minor and major health problems/injuries).	1	2	3	4	5
f. If I had known before what emergency nursing was really like I would never have chosen it.	1	2	3	4	5
g. I would like to leave emergency nursing in the next year.	1	2	3	4	5

THANK YOU VERY MUCH FOR ANSWERING THESE QUESTIONS. PLEASE PUT THIS QUESTIONNAIRE IN THE STAMPED, ADDRESSED ENVELOPE AND MAIL IT BACK TO ME.

C. Lynne Grief
Faculty of Nursing
3-111, Clinical Sciences Building
University of Alberta
Edmonton, Alberta
T6G 2G3

Please use this space for any additional comments that you may wish to add.

APPENDIX B

LETTER OF PERMISSION FROM DAVID ROBERTS

EDITH COWAN UNIVERSITY
PERTH WESTERN AUSTRALIA
CHURCHLANDS CAMPUS

Pearson Street Churchlands
Western Australia 6018
Telephone (09) 383 8333
Facsimile (09) 387 7095

School of Nursing

12th March, 1992

C. Lynne Grief
#35 2115-118 Street
Edmonton
Alberta
T6J 5NI
Canada

Dear Lynne,

Thank you for your letter of 18th Feb. 1992. I would be happy for you to use the assessment tool set out in my chapter contribution "Non-verbal Communication: Popular and Unpopular Patients" in the Recent advances in Nursing: Communication, published by Churchill livingstone (Edinburgh) and edited by Ann Faulkner (1984). I would, of course, expect you to reference those parts of the tool you use according to academic protocol.

I have not pursued this aspect of research for some time. This is not to suggest I don't feel it is important. Prejudice and the consequent potential for discrimination can have far reaching effects in clinical settings such as emergency departments. The work pressures in such settings frequently disallow a comprehensive physical and psycho-social assessment of the clients. By necessity, practitioners are often forced to rely on prejudicial and stereotypical assumptions (both negative and positive) about their client's. Although the characteristics of clients likely to confront prejudice is well established in the research literature, these characteristics differ significantly for one country or one region to another and is still a worthy research exercise.

Two further points you may like to consider. First, my questionnaire refers to "Aboriginal Patients". I understand that your native Indian population also confront prejudicial treatment in some Provinces of Canada. An interesting observation from my study (which I can't recall now if I included in my chapter) was that most respondents expressing positive views towards the Aborigines usually qualified their answer by saying they preferred Aborigines from a "traditional background" ; in Canadian terms. I assume this roughly translates to those spending most of their lives on isolated reserves. That is, the respondents liked them so long as they lived hundreds of miles from urban centres; they did not like fringe dwelling Aborigines (living on the edge of towns, having lost their roots in traditional Aboriginal society, yet rejected by much of white society). Because of the prejudice often confronting Aborigines in some Australian hospitals, I would liked to have pursued this question further. This observations may be redundant since such prejudice towards your indigenous population may not apply in Alberta?

Second, I would liked to have pursued in more depth how any prejudicial or stereotypical attitudes are translated in action. That is, how did it affect their treatment of the clients. Because of the difficulty of measuring such actions, researchers have tended to side-step this most important research issue.

I hope these points are of some use to you.

I wish you well with your study.

Yours sincerely,

David.

David Roberts
Lecturer.

APPENDIX C

LETTER OF INTRODUCTION TO THE STUDY

RESEARCH: NURSES' ASSESSMENT OF PATIENT CHARACTERISTICS IN AN EMERGENCY SETTING

My name is Lynne Grief, R.N., and I am a student in the Masters of Nursing Program at the UNIVERSITY OF ALBERTA. The subject of my Masters' Thesis is to determine how nurses think about patients who come to Emergency. The information obtained will be used to enhance the delivery of patient care. "Emergency" in this study refers to the place in the hospital where patients come in looking for health care. It may be an Emergency Department which has medical and/or nursing staff working 24 hours a day, or a room in the hospital which is opened and staffed only when a patient comes in. In this study, I want to describe those characteristics emergency nurses notice abut their patients and whether nurses have preferences for caring for different types of patients. If you decide to take part, I will be asking you to tell me which characteristics you use to assess patients. I have been given permission by the Faculty of Nursing at the UNIVERSITY OF ALBERTA to do this study. The Alberta Association of Registered Nurses (AARN) has agreed to mail this survey to you, with the researcher paying for administrative and postage costs. Your name has been chosen by their computer and I will never know your name and address or the hospital in which you work. I am asking you to fill out the survey which should take you about 30 minutes. When you are finished, please return it in the stamped, addressed envelope found in this package. All the information I collect will be strictly confidential. You will not be identified or named when I write a report on the results of this study. The results will be presented in

group form and your answers and the hospital in which you work will never be identified.

I will assume that if you fill out and return this survey, you have agreed to take part in this study. If you have any questions or concerns, please phone me at: 484-8811 (ext. 3190) of the supervisor of my study (Dr. M. Ruth Elliott, PhD., R.N.) at 492-6241.

If you are interested in the results of this study, a copy of the completed study will be available at the AARN Library, the John W. Scott Health Sciences Library (University of Alberta), and the Faculty of Nursing, University of Alberta. Upon request, a summary of the study results can be obtained by contacting me

c/o Dr. M. Ruth Elliott, PhD., R.N.

Faculty of Nursing

3-111 Clinical Sciences Building

University of Alberta

Edmonton, Alberta

T6G 2G3

THANK YOU FOR YOUR HELP IN MY RESEARCH.

C. Lynne Grief, R.N., B.Sc.N.