NURSES' ENACTMENT OF EQUITY-PROMOTING PRACTICES IN THE EMERGENCY DEPARTMENT: A DISCOURSE ANALYSIS

by

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Abstract

In Canadian emergency departments (EDs), there are significant and persistent inequities in the provision of health care, which both reflect and perpetuate structural inequities. Nurses are the largest group of health care providers in the ED and with the nursing profession recognizing equity as a core value, nurses are ideally positioned to remediate structural inequities and promote equity within this setting. However, this potential is hindered by limited empirical research examining how nurses enact equity-promoting practices within everyday work in direct care settings. This Foucauldian discourse analysis explores how discourse shapes nurses' enactment of equity-promoting practices in the institutional context of the ED. Data were collected through individual interviews (N=33) with nurses, nurse leaders, and other key ED health care providers intersecting with nursing work, as well as nursing professional and institutional texts (N=31) that illuminate how discourse shaped ED nurses' practices. Findings illustrate that discursive power operated within the ED to facilitate nurses' practices that upheld dominant discourses and to constrain nurses' enactment of equity-promoting practices. As such, equity-promoting practices constituted subversive action, with nurses drawing on key contradictory discourses of equity and relational engagement to subvert discursive power. However, persistent tensions between power and equity in the ED institutional context ultimately limited nurses' potential for promoting equity, which was positioned as optional, a matter of knowledge and awareness as opposed to practice, and outside of core ED nursing work. These findings highlight how intersecting dominant discourses constrained nurses' enactment of equity-promoting practices within the ED. Further, despite claims of equity as a central guiding principle within the nursing profession, equity was not institutionally or professional positioned as a nursing practice. To remediate inequities in health and health care, equity must be reframed

as a dominant discourse, enacted practice, and core competency within the nursing profession and across the health care system. Institutional and educational supports may additionally facilitate and guide nurses' enactment of equity-promoting practices in complex contexts in which equity is devalued. Further empirical research is needed that examines nurses' enactment of equity-promoting practices across diverse health care settings and explores institutional strategies for promoting equity.

Lay Summary

Within emergency departments (EDs) in Canada, many patients seeking care experience inequities, or unjust differences in health care delivery. Nurses are well-positioned to reduce these experiences of inequities, particularly as the nursing profession recognizes equity as a core value. However, scant research has examined how ED nurses promote equity through their everyday work. This qualitative study examined ED nurses' equity-promoting practices, or nurses' everyday work promoting equity, and explored how institutional factors, such as health care structures and processes, shaped their practices. Interviews with ED nurses and examination of hospital and nursing professional documents showed that equity promoting practices were not meaningfully supported in the ED setting and that nurses are caught in tensions between efforts to promote equity and the institutional structures and processes that maintain inequities. Interventions and future research are needed that support nurses in the practice of equity, and that integrate equity within health care systems.

Preface

This dissertation is the original, unpublished, and independent work of the author, Allie Slemon. The research described in this dissertation was approved by the UBC Behavioural Research Ethics Board (H19-01027). This research was conducted with support from my supervisor and dissertation committee, who provided guidance in developing this project, data analysis, and review of the written dissertation. I developed the research question and designed the research methodology, as well as conducted all data collection and analysis and wrote the initial draft of this dissertation.

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List of Abbreviations

BC – British Columbia

BCCNM – British Columbia College of Nurses and Midwives

CIHI – Canadian Institute for Health Information

CNA – Canadian Nurses Association

ED – emergency department

EMS – emergency medical services

FDA – Foucauldian discourse analysis

LPN – Licensed Practical Nurse

NNPBC – Nurses and Nurse Practitioners of British Columbia

RN – Registered Nurse

RPN – Registered Psychiatric Nurse

WHO – World Health Organization

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Chapter 1: Introduction

Emergency departments (EDs) are an essential health care service that responds to health care concerns of patients without prior appointment needed, and are typically open 24 hours a day, 365 days a year to provide immediate health care services. The mandate of EDs is to provide health care for all, both as a setting for treatment and as a gateway to the health care system, and is uniquely positioned as a space that anyone can enter to seek health care (Anderson et al., 2016; Nugus et al., 2010). Indeed, this health care space has been described as lower barrier than other settings within the health care system, and as such, plays a key role in ensuring accessible health care for people who experience structural inequities in health and health care[1] (McCallum et al., 2020). However, in Canadian EDs there are significant and persistent inequities in the provision of health care services for people who experience structural inequities, including people of colour, Indigenous people, people who use drugs, people experiencing homelessness, and people with mental health challenges (Browne et al., 2011; Livingston, 2020; Turpel-Lafond, 2020; Varcoe et al., 2022; Wise-Harris et al., 2017). People who experience structural inequities receive disproportionately poor care, including greater likelihood of having symptoms minimized or dismissed, misdiagnosis of health conditions, and withheld assessments and treatments (McLane et al., 2022; Turpel-Lafond, 2020; Wylie & McConkey, 2019). Further, many patients in ED settings have recounted experiences of receiving stigmatizing and

[1] Inequities in health and health care reflect both existence of unjust and unfair differences in health, and also the fundamental structural conditions – such as racism, colonialism, and patriarchy – that systematically affect overall health and access to health care (Braveman & Gruskin, 2003; Browne & Reimer Kirkham, 2015; Reutter & Kushner, 2010). Inequities in health and health care stem from and intersect with structural inequities, for example, in access to the social determinants of health (Public Health Agency of Canada, 2018).

discriminatory comments, not being listened to or believed, or being accused of "drug-seeking", that is, inappropriately using ED services to obtain particular medications (Chan Carusone et al., 2019; Subramani, 2018; Turpel-Lafond, 2020; Varcoe et al., 2022; Wen et al., 2007; Wylie & McConkey, 2019). Further illustrating the crisis of Indigenous-specific racism within health care settings in British Columbia (B.C.), the landmark *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in B.C. Health Care* report describes extensive incidents of racism and discrimination experienced by Indigenous patients across health care settings and within the ED in particular (Turpel-Lafond, 2020). The report details common incorrect stereotyped assumptions made by health care providers that contribute to inequities in health care delivery, including that Indigenous patients are "less worthy" of care, are drug-seeking or intoxicated, and are less capable to take responsibility for health and health care (p. 38). The impacts of such assumptions can be extreme with devastating consequences, such as in the case of an Indigenous man, Brian Sinclair, who died of a medical condition in a Canadian ED in 2008 after waiting for 34 hours without being seen, believed by ED staff to be drunk (Geary, 2017; Provincial Court of Manitoba, 2014). Such instances of discrimination toward people who experience inequities in health and health care occur within individual encounters between patients and health care providers, and yet are shaped by and reflect structural inequities: discriminatory and exclusionary processes that are embedded and normalized within institutions, including in the health care system (Anderson et al., 2009; Turpel-Lafond, 2020).

Nurses are the largest group of health care providers in EDs and are often the initial and most frequent point of contact for patients, from immediate assessment of health concerns upon entry into the ED space (the "triage" process), through treatment and ultimate hospital admission or discharge (National Emergency Nurses Association, 2018). As such, nurses play a key role in

a system that both provides necessary health care to the full spectrum of the population, and can perpetuate inequities in health and health care (Heslop, 1998; Wolf et al., 2016; Wylie & McConkey, 2019). Indeed, nurses have been identified as complicit in harms within the health care system, including failing to provide necessary care and treatment to people who experience structural inequities, perpetuating oppressive and unjust systems that reproduce inequities, and directly making stigmatizing and discriminatory comments to patients seeking care (Canadian Nurses Association [CNA], 2022c; Clarke et al., 2014; Page, 2021; Turpel-Lafond, 2020). However, given nurses' role in providing direct care to all ED patients, nurses have significant potential to remediate such harms, and with a professional and ethical mandate to centre patients' needs and promote patients' safety and dignity, are uniquely positioned to provide competent and compassionate care throughout the entire duration of a patient's health care experience in the ED setting (CNA, 2017; International Council of Nurses, 2021).

Further, equity is explicitly positioned as a core value in the nursing profession, emphasizing that nurses are well-positioned to provide care that responds to and lessens inequities in health and health care (CNA, 2017; Kagan et al., 2010; Thorne, 2015). Equity – and the related concept of social justice – are commonly articulated as a hypothetical or future state in which systemic inequities in health and health care have been eliminated (Braveman & Gruskin, 2003; Browne et al., 2012; Reutter & Kushner, 2010). Within the discipline of nursing, equity is further conceptualized as actions undertaken by nurses that work toward this future state of equity and justice (Thompson, 2014; Varcoe et al., 2015), thus positioning nurses as engaging in practices that aim to promote equity and remediate inequities in health and health care. Indeed, equity is explicitly articulated in nursing professional documents as central to nursing work: the British Columbia College of Nurses and Midwives' (BCCNM) *Professional*

Standards for RNs recognizes "making equitable decisions" (p. 17) as a nursing standard, and the Canadian Nurses' Association's (CNA) (2017) *Code of Ethics for Registered Nurses* states that "ethical nursing practice addresses broad aspects of social justice that are associated with health and well-being" (p. 18). There is additionally a robust body of theoretical literature exploring equity and social justice within the discipline, including analyses of philosophical approaches to conceptualizing equity and examinations of nurses' moral imperative to adopt equity as a professional value (Browne & Reimer Kirkham, 2015; Reutter & Kushner, 2010; Thorne, 2015). Further, equity and social justice are frequently integrated into pre-licensure nursing education, positioning equity as a foundational concept for students as they are socialized into the profession of nursing and learning to provide nursing care for patients who experience structural inequities in health and health care (Beavis et al., 2015; Blanchet Garneau et al., 2021; Mohammed et al., 2014). Given the positioning of equity as a central value for the nursing profession, nurses thus have the potential to lead health systems in engaging in promoting equity through everyday patient care encounters.

This potential for nurses to enhance equity in direct patient care is hindered, however, by a lack of empirical understanding of how equity may be enacted by nurses *as a practice*. Within theoretical literature and professional documents, equity is predominantly articulated as a *value* held by nurses, rather than a guiding principle informing nurses' everyday work with patients in health care settings, or an explicit commitment to action towards remediating structural inequities in health and health care (BCCNM, 2021; Buettner-Schmidt & Lobo, 2012; CNA, 2017; Reutter & Kushner, 2010). In response to this gap in conceptualizations of equity as a

nursing practice, this study utilizes the concept of *equity-promoting practices*[2] to reflect the multiplicity of actions that ED nurses may take to promote equity and remediate inequities in health and health care through patient health care encounters and all associated work, including documentation, coordination and referral across health care providers and services, and all other aspects of everyday nursing practice. Despite emphasis across nursing documents that the value or principle of equity is central to nurses' work, there is a critical absence of guidance for nurses in engaging in equity-promoting practices within direct health care settings (Bekemeier & Butterfield, 2005; Valderama-Wallace, 2017). In particular, despite the key role of the ED in providing health care for people who experience structural inequities, there are substantial gaps in knowledge of how nurses working within this health care setting enact equity-promoting practices within everyday patient encounters. Within this study, nurses' work is understood as occurring within the *institutional context* of the ED (explored further in Chapter 3): the intersection of processes, structures, policies, and norms that constitute the ED as a health care space and shape nurses' – and other health care providers' – provision of health care and engagement with patients. Despite these myriad structures intersecting with and shaping nurses' practices in this health care setting setting, there is a lack of empirical knowledge of how nurses' engagement in equity-promoting practices is variously supported or constrained within the ED institutional context. Without this understanding of the intersections between institutional

[2] Equity-promoting practices builds on Browne et al.'s (2015; 2016) and Varcoe et al.'s (2019) concept of equity-oriented care (EOC) – a model that describes both structures within health services that are informed by equity principles, and staff knowledge, practices, and capacity related to core constructs of culturally safe care, trauma- and violence-informed care, and contextually tailored care, undergirded by inequity-responsive care. To expand EOC to align with this study, the term equity-promoting practices references everyday actions taken by nurses within the broad context of direct patient care that aim to respond to and remediate inequities in health and health care.

context and nurses' enactment of equity-promoting practices, future interventions to promote equity within the health care system and within the nursing profession will be limited and may fail to be responsive to the complex context of the ED and the institutional processes and structures that constitute this health environment. Further, a lack of empirical evidence of how nurses' practices are shaped by the ED institutional context may preclude the development of structural supports for nurses in enhancing capacity for promoting equity within this complex health care setting. Ultimately, gaps in knowledge of nurses' enactment of equity-promoting practices in everyday patient care limit the potential of health services to respond to inequities in health and health care, and may therefore risk perpetuating such inequities.

Study Purpose and Research Question

Situated in Metro Vancouver, B.C., this study aimed to examine how nurses' equity-promoting practices are shaped by discourse within the institutional context of the ED. Discourse is understood in this study as a "common set of assumptions" (Cheek, 2004) that order the social world and fundamentally shape institutions, structures, and practices. This research understands discourse as inherently constituted by power, with power shaping which discourses are dominant within a particular context and which are marginalized or absent (Parker, 1992). Discursive power – the intersection of discourse and power – constructs the structural conditions that produce and reproduce inequities in health and health care; however, discourse can also be employed to challenge dominant discourses and the power structures they uphold (Lupton, 1992; Young, 1990). Within the institutional context of the ED, discursive power is thus understood as creating and perpetuating instiututional processes and structures, which in turn shape nurses' everyday practices. Drawing on such understandings of discourse, power, institutional context, and equity-promoting practices, the research question guiding this study is: *How does discourse*

shape nurses' enactment of equity-promoting practices in the institutional context of the emergency department? To respond to this research question, this study draws on Foucauldian discourse analysis as a methodological approach for examining the complex interrelationships between discursive power and nurses' equity-promoting practices within two ED settings.

In examining how ED nurses' enactment of equity-promoting practices are shaped by discursive power, this research aims to contribute an understanding of how equity can be enhanced through everyday nursing practices in EDs, within implications for direct care settings across the health care system. Given the significant gaps in empirical research exploring how nurses enact equity and what institutional factors may constrain these practices (see Chapter 2 for a full discussion of gaps in current empirical knowledge), this study seeks to build knowledge of how equity-promoting practices are situated within complex health care system power structures that shape nurses' capacity to remediate health and health care inequities through individual patient encounters. Findings from this study may support future research that aims to enhance nurses' capacity for enacting equity-promoting practices and implementing institutional change to address constraining factors hindering nurses' potential to meaningfully remediate inequities in health and health care.

Dissertation Outline

This dissertation is comprised of seven chapters. This first chapter has provided a broad introduction to the research endeavour, including situating this study in the context of structural inequities in health and health care and ED nursing work, and summarizing the study purpose and research question. Chapter 2 presents a literature review related to inequities in health and health care in Canada, structural inequities in the ED context, the context of nursing work in the ED setting, and dominant conceptualizations of equity within the nursing profession. In

summarizing the current state of literature related to these central topics, this chapter identifies key gaps in current knowledge and illustrates the rationale for this study. Chapter 3 outlines the methods guiding this research, including presenting details of this study's theoretical framework and methodological approach of Foucauldian discourse analysis. This chapter additionally describes the study's research settings, procedures related to data collection and analysis, consideration of ethical protections, and rigour. Chapters 4 through 6 present study findings. Chapter 4 examines the central discourses constructing the institutional context of the ED, and how discursive power foundationally shaped nurses' work and constrained equity-promoting practices. Chapter 5 explores how nurses subverted discursive power in the ED context by drawing on key contradictory discourses that supported subversive action. Chapter 6 presents pervasive tensions between discursive power and equity discourses within the institutional context of the ED, with particular attention the consequences of these tensions for nurses' equity-promoting practices. Chapter 7 concludes this document with a discussion situating key study findings within the broader literature and outlining implications and recommendations for the nursing profession and practice, health care systems and structures, nursing education, and future research stemming from this work. This chapter additionally presents an overview of study limitations. Appendices to this document provide study recruitment materials, interview guide, demographic questionnaire used in data collection, and consent form.

Chapter 2: Literature Review

The purpose of this study is to examine nurses' enactment of equity-promoting practices in the institutional context of the emergency department (ED), and how discourse intersects with power to shape these practices. While there is a growing body of literature examining inequities in health and health care and fostering equity promotion, there remains scant empirical research exploring equity as a practice within the profession of nursing, particularly research addressing the clinical contexts in which nurses' work is situated. This chapter presents a review of the literature to examine what is known about health and health care inequities, the ED nursing context, and how equity is situated within nursing. This literature review summarizes and contextualizes this research, and demonstrates key areas where gaps in knowledge remain, thus positioning this study as building on prior literature concerned with equity promotion within nursing practice. This chapter is comprised of four sections. The first section broadly summarizes the literature on structural inequities in health and health care in Canada, providing context for the myriad and intersecting structural inequities experienced by patients who seek health care in the ED, and thus for nurses' work in this setting. The second section examines inequities in the ED context, exploring trends in utilization and accessibility of the ED setting and inequities in ED health care delivery. This section illustrates the extent of inequitable, stigmatizing, and discriminatory care experienced by patients in the ED and demonstrates the need for research that supports nurses in enacting equity-promoting practices to remediate widespread inequities within the health care system, and ED context specifically. The third section explores the context of nursing work in the ED, situating nurses' work in this setting within system-level pressures, including efficiency mandates and a climate of managerialism. This section also positions EDs and ED nurses' work within intersecting social/health crises,

illustrating how these crises were variously impacting the health care system at the time of this research, then concludes with an exploration of research on remediating inequities and promoting equity within the ED context. The final section examines how equity is positioned within the nursing profession, exploring how nursing scholarship and professional documents conceptualize equity and social justice, and demonstrating important gaps in understandings of equity as a practice and empirical research undergirding the theorizing of equity within the nursing profession. This chapter concludes with a summary and discussion of the significance of this research.

Structural Inequities in Health and Health Care

This section summarizes the current state of the literature documenting the widespread existence of inequities in health and health care stemming from inequitable structural conditions that perpetuate oppression and injustice. This study specifically focuses on nurses' enactment of equity-promoting practices within the context of the ED; however, as equity is a response to inequities, this section establishes the considerable inequities in health and health care that necessitate the need for nurses to promote equity within everyday practices in direct health care settings. While it is beyond the scope of this dissertation to explore the myriad structural inequities that construct the landscape of health and health care, this section broadly examines the current state of health and health inequities in Canada to contextualize how inequities are created and perpetuated within the ED context (as explored in greater detail in the following section). This section begins by presenting key literature on structural contributors to health inequities and summarizing population-level research on the health impacts of structural inequities. Following, I examine literature related to inequities in health care, including inequitable health services utilization and accessibility in the Canadian context. This research

illustrates the upstream structural conditions and trends that shape inequities in health and health care, and thus contextualizes structural inequities experienced by patients who seek health care in the ED, inequities in health care created and perpetuated within the ED, and thus ED nurses' experiences providing care for patients who experience structural.

Health Inequities and their Structural Contributors

Health inequities are widely understood as a product of structural inequities (Braveman, 2014; Braveman & Gruskin, 2003; Farmer et al., 2006; Lavizzo-Mourey et al., 2021). As briefly discussed in Chapter 1, structural inequities stem from systematic unjust disparities in social conditions, such as income, employment, and education that disproportionately affect particular population sub-groups (World Health Organization [WHO], 2022a), and are understood as created and perpetuated by socio-political ideology and structures, including neoliberalism, capitalism, racism and colonialism (Bailey, 2013; Browne & Reimer Kirkham, 2015). Such power structures create and perpetuate oppression, which intersects with stigma and discrimination to systematically exclude particular population sub-groups from access to the social determinants of health, including income generation and employment, education, housing and healthy physical environments, and health services (Anderson et al., 2009; Government of Canada, 2020; Raphael, 2015; Veenstra, 2011; Young, 1990). As stated, it is beyond the scope of this literature review to detail the multitude of ways in which structural conditions of oppression produce health inequities, or document the extent of poor health outcomes caused by structural inequities. However, epidemiological evidence from census and other population health data sources provides important insight into how structures of oppression systematically create and perpetuate health inequities and illustrates 'who' experiences structural inequities within the Canadian context. Epidemiological research focused on individual characteristics and identity

demonstrates a multitude of adverse physical and mental health outcomes across population sub-groups who experience structural inequities. For example, people of colour experience increased prevalence of chronic conditions and poorer overall self-rated health compared to white counterparts (Logie et al., 2016; Siddiqi et al., 2017; Veenstra & Patterson, 2016). Indigenous people have disproportionately worse physical and mental health, with projected life expectancy 5-15 years lower than the national average (Gone et al., 2019; Statistics Canada, 2015; Wilson & Cardwell, 2012). New immigrants to Canada also report poorer physical and mental health compared to people born in Canada, and experience declining health after immigration (De Maio & Kemp, 2010; Lebihan et al., 2018). Additionally, inequities in health related to gender include the significantly higher burden of intimate partner violence experienced by women, and women's greater perception of unmet need from the health care system (Burczycka, Conroy & Savage, 2018; Socías, Koehoorn, & Shoveller, 2016). The cis-heteropatriarchy further contributes to health inequities for Two-Spirit, lesbian, gay, bisexual, transgender, and queer (2SLGBTQ+) people, including poorer mental health and greater prevalence of both chronic illnesses and cancer (Barry et al., 2022; Casey, 2019). While such epidemiological approaches are useful in illustrating the existence and extent of health inequities, this research does not consistently frame health outcomes as foundationally grounded in inequitable structural conditions. Rather, health inequities are framed as products of individualized characteristics or demographics (Richman & Zucker, 2019), obscuring the underlying causal factors of systemic racism, colonialism, and stigma and discrimination. As such, the research literature has not comprehensively captured the impact of structural inequities on health outcomes – for example, the impact of colonialism itself (rather than Indigenous identity) (Gone et al., 2019) racism itself (rather than socially constructed notions of 'race') (Datta et al., 2021) on health. Despite these

challenges, population-level research offers valuable evidence demonstrating that structural inequities in health are perpetuated by structures of oppression that restrict access to the social determinants of health.

Beyond examination of inequities related to individualistic characteristics and demographics, such research typically approaches inequities from a lens of relative access or lack of access to 'resources' (i.e., income, housing, etc.) that constitute the social determinants of health. For example, people who are characterized as having "lower socioeconomic status" experience a multitude of disparities in health such as increased risk of chronic illness, cardiovascular disease (Clark et al., 2011; Mondor et al., 2018). Food insecurity – associated with low socioeconomic status and other structural contributors to material deprivation – has been demonstrated to contribute to poor physical and mental health outcomes in adult and children/youth populations (Gundersen & Ziliak, 2015; Jessiman-Perreault & McIntyre, 2017). People experiencing homelessness face considerable barriers to health and well-being, and have been found to experience significantly worse health overall, including increased acute injury and illness, chronic illness, and mental health challenges (Addorisio et al., 2022; Onapa et al., 2022). Further illustrating the numerous health challenges associated with the experience of homelessness, Zhang and colleagues (2018) identified high prevalence of mental health challenges, multiple chronic illnesses, and "self-reported problematic substance use" among a sample of nearly 1200 homeless and vulnerably housed adults in three Canadian cities, including Vancouver. Taken together, this population-level research frequently situates the causes of adverse health outcomes within mid-level structural conditions, such as poverty and homelessness, rather than the underlying power structures – and discourses – that creates such conditions, and thus is limited in its examination of *structural* drivers of health inequities (Baru

& Mohan, 2018; Farmer et al., 2006). However, this body of empirical literature illustrates that, despite a public health care system, there is a complex landscape of health inequities perpetuated by unjust underlying inequitable conditions. As such, individuals' experiences of seeking health care, including in the ED setting, are situated within – and shaped by – this landscape of inequities, as discussed in the following section on health care inequities.

Health Care Inequities: Utilization and Accessibility

Exacerbating inequities in health, inequities related to health care itself are a key component of the landscape of inequities in the Canadian context. The field of research on health services utilization and accessibility aims to examine how the structure of the health care system and people's use of the health care system impact the health of individuals and communities, and within this study, support a contextual understanding of inequities in health care utilization and accessibility, and how empirical research predominantly examines these inequities. Health services utilization describes patterns of health care use by particular population groups, and is related to availability and accessibility of health care services, with availability refering to the supply of health services, including number of health care providers and number and type of specialists (WHO, 2022b). Accessibility, in its most commonly used definition, relates to distribution of health services, for example in urban areas or relative to population size and demographics (WHO, 2022b). Reflecting dominant trends in epidemiological research on health inequities in Canada, empirical research predominantly conceptualizes population-level patterns of health care utilization and accessibility as reflections of individual characteristics, experiences, or practices rather than factors related to structural inequities – for example, focusing on how health care expenditure is distributed across population sub-groups rather than structural barriers to utilization and accessibility (Sporinova et al., 2019; Wiens et al., 2021).

This is seen across empirical research and knowledge synthesis, such as within a recent scoping review of immigrants' utilization of mental health services in Canada, which cites factors such as cultural stigma toward mental illness, male-dominated cultural values, and "aversion to Western treatment" as barriers to health services utilization (Thomson et al., 2015), whereas a structural inequities lens might understand such utilization trends as related to language barriers, prior or anticipated discrimination in health care encounters, and other systemic factors. Similar trends of drawing on individualistic factors to explain disparities in health care utilization and accessibility are seen across this field of research, limiting empirically-driven understandings of how inequities in health and health care are shaped by underlying structural oppression and power structures (Addorisio et al., 2022; Livingston, 2020; Wiens et al., 2021).

Illustrating the limitations of such approaches to understanding health care utilization and accessibility, Allin et al. (2010) argue in their analysis of census data on Canadians' perception of unmet health care needs that measuring accessibility alone is often insufficient as such measures focus largely on personal choices and logistical barriers to access, such as wait times, thus obscuring the "equity implications" of barriers to health care access. Further, in response to traditional constructions of accessibility, Horrill and colleagues (2018) argue that conceptualizing accessibility as a matter of resource distribution fails to take into account how inequities *within* health services, including interpersonal interactions within the health care encounter, shape health services utilization. Applying an equity lens to health care accessibility reframes access as including "the *delivery* of services at the point of care, a significant component of which is the social relationship between the provider and and patient" (Horrill et al., 2018, p. 4). As such, barriers to health care can be reconceptualized as situated within the health care system, including power relations between providers and patients, prior instances of

discrimination or poor treatment, and bureaucratic structures that are out of sync with the realities of people's lives. Conceptualizing utilization and accessibility through an equity lens is crucial for situating this exploration of nurses' enactment of equity-promoting practices in the ED setting, as it expands the notion of health care services as merely a resource that is available or unavailable, used or unused. Rather, it turns our attention to the *experience* of a health care encounter and how inequities in health care delivery impact health care utilization, and thus perpetuate health inequities.

Indeed, a growing body of empirical literature recognizes experiences of discrimination and poor treatment within health care settings, and examines how health care encounters create unsafe and unwelcome environments, with consequences for health care accessibility. As introduced in Chapter 1, the recently released *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in B.C. Health Care* report (Turpel-Lafond, 2020) examines Indigenous people's experiences of health care in B.C., and was commissioned by the provincial Health Minister in response to allegations that emerged within an Indigenous cultural safety training program that ED nurses in a B.C. hospital had engaged in a racist and stigmatizing "Price is Right" game that involved guessing Indigenous patients' blood alcohol levels. While this specific incident was not ultimately substantiated, this report presented findings from an extensive independent review of Indigenous-specific racism across the health care system with the dual purpose of truth-telling and providing recommendations for addressing systemic racism in health care. Presenting survey data from 2,780 Indigenous respondents and qualitative data from key informant interviews to capture the extent and nuance of stigma and discrimination in health care settings, this report demonstrated that up to a third of Indigenous patients experienced incidents of racism, stigma, and discrimination in health care encounters. As a result of such

treatment, Indigenous patients directly experienced adverse health outcomes stemming from inadequate and inappropriate management of health concerns, iatrogenic harms, and avoidable deaths. Further empirical research drawing predominantly on qualitative methods to explore in depth the experiences of racist and colonial health care structures illustrates that Indigenous people experience considerable barriers to accessible health care related to historical and ongoing stigmatizing and discriminatory treatment across health and social services, contributing to lack of trust in health care services and providers (Benoit et al., 2019; Goodman et al., 2017; Nelson & Wilson, 2018; Phillips-Beck et al., 2020). Similarly reflecting structural racism within society and the health care system, people of colour have widely reported experiences of racism in health care, including discriminatory and unequal treatment by health professionals, and incomplete or inappropriate assessment and treatment (Fante-Coleman & Jackson-Best, 2020; Mahabir et al., 2021). Qualitative and quantitative research has further demonstrated the impacts of discriminatory treatment on health care accessibility among 2SLGBTQ+ people (Colpitts & Gahagan, 2016; Steele et al., 2017), people experiencing homelessness (D'Souza & Mirza, 2021; Omerov et al., 2020; Skosireva et al., 2014), people living with chronic illness including HIV (Wagner et al., 2016), people with mental health challenges (Tyerman et al., 2021), and people who use drugs (Chan Carusone et al., 2019; McNeil et al., 2016; Pearce et al., 2020). Taken together, this research illustrates that numerous barriers to health care continue to shape the landscape of health care utilization in Canada, and that issues of accessibility extend beyond distribution of health care services to the experiences of stigmatizing and discriminatory treatment within health care encounters. In the following section, I further explore barriers to truly 'accessible' health care specifically related to the ED setting, which situates nursing work

in a complex health care context that in many instances, serves to perpetuate inequities in health and health care.

Inequities in the ED Context

Utilization and Accessibility

As discussed above, measures of health care utilization and accessibility have been critiqued as obscuring structural inequities that shape health care use, and as failing to account for inequities created and perpetuated within health care encounters. However, it is worthwhile to note key trends in ED utilization and accessibility as they construct and contextualize nurses' work within this health care setting. Overall trends in ED utilization are captured by the Canadian Institute for Health Information (CIHI), which reported that in Canada in 2020-2021, there were approximately 11.7 million ED visits, though only 65% of these were submitted to the National Ambulatory Care Reporting System for statistical analysis of trends (CIHI, 2021d). The median length of stay in Canadian EDs is 3.2 hours, and 90% of patients spend less than 11.4 hours (CIHI, 2021d). Length of stay varies by acuity, with patients scoring I-III on the Canadian Triage and Acuity Scale (CTAS), representing relatively higher acuity (e.g. head injury, severe pain, major trauma) and spending a longer overall period of time in the ED than patients scoring IV-V (e.g. minor trauma, chronic pain, moderate acute pain) (CIHI, 2021d). Nurses are responsible for assigning CTAS scores in the ED setting, and indeed, triage is an essential aspect of ED nurses' practice. Nurses determine CTAS scores based on a standardized system, which includes assessments related to the nature of a patient's primary complaint, alongside other factors such as vital signs and pain level (Bullard et al., 2017). Less than 1% of patients receive a CTAS score of I, with most patients being triaged at III and IV (CIHI 2020), illustrating that the majority of people who seek health care in Canadian EDs do not present with high-acuity health

concerns or needs. Assigned CTAS scores directly impact length of time to initial assessment by a physician and time to treatment, with people assigned lower triage scores waiting longer (CIHI, 2021d). As such, CTAS and the triage process illustrates the key role that nurses hold in shaping a patient's experience of the ED, beginning from initial patient assessment and throughout the entire length of stay.

Reflecting trends across the health care system, analyses of health care system administrative data illustrate that there are persistent disparities in ED utilization in Canada, many of which reflect structural inequities in health and health care described above. Across Canada, having lower income is associated with increased ED use, which researchers theorize is related to structural barriers to accessing primary care in the community (such as inability to take time off work to attend appointments), thus contributing to worsening health conditions and ultimately increasing the need for urgent care (Gentil et al., 2021; Khan et al., 2011). Further, Firestone and colleagues (2014) compared a cohort of Indigenous individuals to population-level health care utilization data and identified that ED visits were higher among Indigenous people, which they theorized as reflecting decreased accessibility of primary health care due to prior incidents of discrimination health care encounters, with consequent need for emergency care as health conditions worsen (see also Kitching et al., 2020; Turpel-Lafond, 2020). People who experience mental health challenges are more likely to access the ED, reflecting community inaccessibility of mental health care and a two-tiered health care system of privatized mental health services that limits accessibility for those without extended health benefits or who cannot pay out-of-pocket (Bartram, 2019; Cheung et al., 2015; Fleury et al., 2019; Gentil et al., 2021). People who use drugs – particularly injection drugs – also have higher overall rates of ED visits (Doupe et al., 2012; Kendall et al., 2017; Penzenstadler et al., 2020), in part attributed to the

toxic drug supply crisis (discussed further below), which has led to significantly higher ED visits related to overdoses (Otterstatter et al., 2018). These increased rates have been further linked to structural inequities among people who use drugs that limit access to primary care (Doupe et al., 2012), increase risk for HIV and other infectious diseases due to lack of access to harm reduction supplies (Fairbairn et al., 2012), and create conditions of unstable housing and homelessness (Gabet et al., 2019; Zhang et al., 2018). Indeed, people experiencing homelessness have been characterized as "frequent users" of the ED (Hwang et al., 2013); for example, one study examining ED use among adults experiencing homelessness in Toronto reported that frequent users (10% of total) accounted for 60% of all visits among the cohort (Chambers et al., 2013).

Thus, as seen across population-level empirical literature, ED utilization is often higher among population sub-groups that experience structural inequities, reflecting underlying inequitable structural conditions and experiences of stigmatizing and discriminatory health care encounters in primary health care and other community settings. Such research therefore contextualizes ED nurses' work in a health care setting that frequently provides health care to people who experience structural inequities, though there is a dearth of empirical literature that examines how nurses' practices may be shaped by these trends, including nurses engagement in equity-promoting practices as a response to structural inequities in health and health care. Further contextualizing ED utilization and thus ED nurses' work, a considerable body of research that aims to explore population-level ED utilization trends and implement interventions to address disparities in ED utilization invokes discourses of 'inappropriate' ED use, constructing ED visits among particular population sub-groups as undesireable and requiring 'diversion' strategies to shift health care utilization away from EDs toward other health care settings, such as primary or urgent health care centres (Kim et al., 2018; Moe et al., 2017; Podolsky et al., 2017). As such,

populations with the highest ED use – and thus the highest need – are positioned as misusing the ED, a framing that underlies and perpetuates oppression and discrimination within the ED setting (McCallum et al., 2020; Vandyk et al., 2018), as described in the following section on inequities in ED health care delivery.

Inequities in ED Health Care Delivery

Augmenting the health care utilization and accessiblility literature exploring trends and disparities in ED use is a growing body of research on inequities within health care delivery, which illustrates that experiences of systemic and interpersonal discrimination within ED settings are widespread among people who experience structural inequities. In particular, the current crisis of racism and colonialism has contributed to significant and ongoing experiences of discrimination in health care encounters among Indigenous patients. The *In Plain Sight* report introduced above (see Health Care Inequities: Utilization and Accessibility) specifically states that the ED was identified by health care providers and Indigenous patients as "the most problematic location" (p. 38) in the health care system for Indigenous-specific racism, and notes that Indigenous respondents seeking health care in the ED were more likely to report feeling "not at all safe" in the ED than in other health care settings. Further illustrating systematic discrimination against Indigenous patients in EDs, McLane and colleagues' (2022) analysis of health system administrative data comparing Indigenous and non-Indigenous patients reported that Indigenous people had consistently lower odds of receiving higher CTAS scores, thereby failing to acknowledge the acuity of their presenting concern and thus ensure faster access to health care, and were ultimately more likely to leave the ED without being seen. Additional qualitative studies have identified Indigenous people's experiences of stigmatizing and discriminatory care in the ED, including being blamed for their health status, having pain

minimized, and not receiving requested or needed medications and treatments (Browne et al., 2011; Wylie & McConkey, 2019).

Further empirical research has aimed to capture patients' experiences of stigmatizing and discriminatory treatment within ED settings, predominantly utilizing qualitative methods and focusing on particular population sub-groups, such as people who use drugs (Gilmer & Buccieri, 2020; Woo et al., 2017), people experiencing homelessness (Nicholas et al., 2016; Wen et al., 2007), people seeking care for mental health challenges (Clarke et al., 2007; Spassiani et al., 2017; Vandyk et al., 2018). Specifically, people who experience structural inequities have reported feelings of unwelcomeness and not being listened to, dismissiveness of articulated health care needs, negative comments regarding frequency of their visits, not receiving needed medications or treatment, and perceptions that they are made to wait longer to receive care (Chan Carusone et al., 2019; Turpel-Lafond, 2020; Wen et al., 2007; Wise-Harris et al., 2017). Discourses of drug-seeking have also been reported by patients seeking health care in the ED, including people who do and do not use drugs, in which health care providers make stereotyped and stigmatizing assumptions that patients are seeking health care for the sole purpose of obtaining particular medications, such as opioids (Gilmer & Buccieri, 2020; McLane et al., 2021). Resulting from such discourses, patients accused of "drug-seeking behaviours" have reported not receiving inadequate pain management, being refused health care, and ultimately leaving without being seen due to insufficient health care provision (Crego et al., 2021; Hawk et al., 2022). Broadly, this body of literature examining inequities in ED health care delivery illustrates that stigma and discrimination contribute to misdiagnosis, withheld and/or inappropriate provision of treatment and medications, patients leaving without being seen due to considerable and inequitable wait times, and ultimately, morbidity and mortality (Brian Sinclair

Working Group, 2017; McLane et al., 2022; Tang et al., 2015; Ti et al., 2015; Wise-Harris et al., 2017).

While crucial for illustrating the nature and extent of stigmatizing and discriminatory care in the ED setting, much of this body of empitical literature explores such incidents through the lens of population sub-groups, examining experiences of stigma and discrimination as related to patients' individual experiences or conditions, such as people experiencing homelessness or people with mental health challenges. This research thus limitedly engages with the complexity of how structural inequities variously shape patients' experiences of receiving health care in the ED, and therefore how nurses' practices are situated within the complexities of inequities in health and health care. A recent study by Varcoe and colleagues (2022) however, directly engages with how patients' experiences of discrimination in the ED are shaped by intersecting structural inequities. Drawing on quantitative data from surveys with ED patients conducted in three EDs in B.C. (N=1692), this study employed latent class analysis using patient sociodemographic factors (i.e., age, housing stability, born in Canada, Indigenous identity) resulting in a six-class solution. One of the six classes was defined as "severely structurally disadvantaged" and was comprised of people who were younger and born in Canada, and had the highest proportion of Indigenous patients. The largest class represented patients with relative privilege: born in Canada, under 65 years old, with stable housing and no shelter use in the past six months. Using the Discrimination in Medical Settings measure, the authors demonstrated that the class identified as severely structurally disadvantaged had significantly higher reports of experiences of discrimination during their ED visit, with 45.6% reporting experiences of discrimination compared to 11.0% to 37.0% among other classes. Thus, rather than examining experiences of discrimination in the ED related to single aspects of a patient's social location,

this study illustrates that discrimination in health care operates in nuanced and complex ways, intersecting with broader societal structural inequities to produce and reproduce inequity within the health care space.

Importantly, I was not able to identify any research that examines how ED nurses' practices are situated within these complexities of discrimination related to intersecting structural inequities, illustrating a considerable gap in knowledge given the magnitude and extent of inequities in ED health care provision captured in the extant literature. Such literature is crucial for exploring the impacts of inequities, discrimination, and stigma within ED settings, including providing preliminary understandings of how particular discourses such as drug-seeking discourses and discourses of "inappropriate" ED use shape the experiences of ED health care provision within particular population sub-groups. However, there are scant empirically-driven understandings of how health care system structures, processes, and discourses that perpetuate inequities may be shaping nurses' everyday work and enactment of equity-promoting practices. This study aims to address this gap by utilizing a discourse analysis approach to examine what discourses are dominant within the ED setting and how these discourses intersect with power to shape nurses' enactment of equity-promoting practices as a response to the considerable inequities in health and health care captured by prior empirical research.

The Context of Nursing Work in the ED

As described in Chapter 1, the ED is a unique and complex setting within the broader health care system and nurses play a key role in operationalizing the institutional processes and structures that constitute the ED, including throughout initial triage, assessment, treatment, and discharge or admission to the hospital. While there is little empirical research that has examined how nurses enact equity-promoting practices in ED settings, prior empirical and theoretical

research has explored key ED processes and structures that shape nursing work, and thus serves to contextualize this study's examination of how discourse shapes nurses' equity-promoting practices in the ED setting. In this section, I firstly examine prior empirical and theoretical literature that has examined particular ED contextual factors and discourses shaping nursing work. I then explore central intersecting social and health crises that were foundationally shaping health and health care in B.C. at the time of this research, and summarize the current research regarding their impact on ED nurses' work. This section concludes with a summary of the current state of empirical literature that aims to remediate inequities and promote equity within the ED context.

ED Contextual Factors Shaping Nursing Work

Since the rise of neoliberalism in the 1980s, health care systems have undergone considerable restructuring, with a reorientation toward an efficiency mandate of prioritizing standardization and reducing 'unnecessary' spending in staffing and patient length of stay (Anderson et al., 2007; Weiss et al., 2002). Predicated on cost reduction and an ideology of individual responsibility for health, efficiency mandates have been positioned as a solution to rising health care costs and high demands on the health care system (Affleck et al., 2013; Weiss et al., 2002). Illustrating the discourse of efficiency shaping ED processes and structures, the Input-Throughput-Output model has been widely adopted across the research literature and health care policies and processes to guide system-wide efforts to reduce pressures on the ED by enhancing system efficiency (Affleck et al., 2013; Asplin et al., 2003; Kamal et al., 2014). This conceptual model describes input as the demand on the ED from movement of patients into this health care space, throughput as the "efficiency and effectiveness" of ED processes that influence patient length of stay, and output as the factors that inhibit movement of patients out of

the ED through admission to hospital or discharge (Asplin et al., 2003). Challenges to efficiency at any of these points within the model are understood to contribute to ED overcrowding, also described as *access block*, in which demand for health care exceeds the ability of an ED to provide timely and efficient care (Affleck et al., 2013; Innes et al., 2019; Savioli et al., 2022). In the Canadian context, national benchmarks for "ED performance" have been established to promote efficiency and reduce access block, which call for time to initial physician assessment as a median of one hour and 90% of patients assessed within three hours. To enforce such benchmarks, British Columbia (B.C.) introduced a pay-for-performance program in 2007 that offered financial incentives for EDs to reduce patient length of stay to under certain time targets (Cheng & Sutherland, 2013). While this program was terminated provincially in 2014, it has been continued within local health authorities and EDs, despite ongoing concerns with the approach, including high rates of return visits (Wang et al., 2019). Current ED wait times greatly exceed targets, with time to initial physician assessment currently at 3.1 hours in B.C. and 90% within 9.5 hours, contributing to ongoing pressures to further enhance efficiency (CIHI, 2021d). Such efficiency mandates – and broader efficiency discourses across the health care system – have contributed to extensive efforts to reduce overcrowding and access block by diverting patients with health care needs that are deemed 'inappropriate' for ED health care provision, particularly for health care concerns considered better addressed by primary care services (Chan et al., 2015; Jeyaraman et al., 2021; Kirkland et al., 2019; Moe et al., 2017). Within a restructured and reformed health care system, efficiency mandates are fundamentally intertwined with a climate of managerialism, which upholds standardization, cost savings, and resource management as core strategies to enhance efficiency and 'quality' of care (Melon et al., 2013; Rankin & Campbell, 2006; Weiss et al., 2002). A managerialist approach to health care services

has been noted within theoretical literature to support the use of measurement tools to "predict and standardize how nurses spend their time in caring for hospitalized patients" (Rankin & Campbell, 2006, p. 24) – an approach that has been taken up within empirical research, such as studies aiming to reducing health care costs by determining the minimum staffing requirements and 'streamlining' nurses' work (Gräff et al., 2016).

Taken together, efficiency and managerialism in health care construct a health care system that fundamentally shapes nurses' practices and experiences of nursing work, as explored through a small body of prior empirical literature. Drawing on findings from an interpretive phenomenological study with critical care nurses, Weiss et al. (2002) describe health care restructuring toward efficiency and productivity aims as fundamentally disrupting "the ecology of good nursing practice" (p. 347), reducing nurses' available time spent in direct patient care and limiting institutional supports that support "good" nursing care. In a qualitative study examining moral distress among ED nurses, Wolf and colleagues (2016) additionally identified that participants experienced "a profound feeling of not being able to provide patient care as they wanted to" (p. 40) in the context of a high-demand environment with insufficient resources. Melon and colleagues (2013) further draw on institutional ethnographic approaches, including field observations and interviews with ED nurses, to examine "ruling discourses" of managerialism and efficiency on nursing work. In particular, they observe that systemic pressures to enhance standardized 'efficient' processes and prioritize measurable outcomes, such as CTAS scoring and wait times, render actual nursing work invisible and "unknowable" within the ED context. Drawing on data from an interpretive ethnographic study, Malone (2000) identifies that the "rapid flow of patients and the brief, episodic nature of contact" (p. 5) in the ED constrain nurses' capacity to engage with patients' vulnerability and fundamental humanity.

Heslop (1998) utilizes discourse analysis to explore the institutional context of ED nursing work, and explores the "categorizing of patients" as shaping how ED nurses' work is enacted, though predominantly focuses on biomedical discourses of acuity and treatment as constructing nursing practices. Heslop further observes that participants experienced "obligation" to rigidly follow protocols and procedures, resulting in the marginalization of nursing practices that engaged with patients' "social and ethical difficulties". While this study is limited by a small sample size (N=3) and a focus on one central biomedical discourse rather than an exploration of multiple intersecting discourses shaping ED nurses' work, this study alongside other qualitative research examining the broader structures and processes of the ED in relation to nursing work, suggests that ED nursing practices are foundationally shaped by context. However, such inquiry has yet to be applied within a framework of equity and inequities, and thus, empirical understandings of nurses' enactment of equity-promoting practices in the institutional and discursive context of the ED remain lacking. In examining how discursive power shapes ED nurses' practices, this study aims to expand current knowledge of how nurses' work is situated within complex institutional contexts, and ultimately illuminate avenues for nursing's role in remediating the myriad inequities in health and health care captured through prior empirical inquiry.

ED Nursing Work Amid Intersecting Social/Health Crises

While health care system factors such as efficiency and managerialism have long been identified as constraining ED nurses' practices, multiple ongoing social and health crises occurring at the time of this research further construct the local geographical, political, and social context of ED nursing work. This section explores the intersecting toxic drug supply crisis, COVID-19 pandemic, ongoing crises of racism and colonialism, and climate crisis, with particular focus on how the ED as a health care space has been shaped by these crises, and how

these crises intersect with nursing work. While this study does not aim to directly examine the impact of these crises on ED nurses' practices, each foundationally impacts the context of the ED and thus nursing work, and may shape how discourses are variously constructed, emphasized, articulated, or minimized.

Toxic Drug Supply Crisis

In Canada and internationally, the unregulated drug supply has been increasingly tainted with highly potent synthetic opioids such as fentanyl and carfentanil (Belzak & Halverson, 2018; Karamouzian et al., 2018; WHO, 2021). The toxic drug supply has contributed to sharply increasing rates of overdoses among people who use drugs, including nearly 25,000 deaths across Canada from January 2016 – June 2020 (Government of Canada, 2021). The number of non-fatal overdoses responded to by emergency medical services (EMS) is approximately five times higher than the mortality rate – a figure that does not include responses to overdose from bystanders and community health care providers, or at supervised consumption sites (Government of Canada, 2021). B.C. has been particularly impacted by the toxic drug supply crisis, with 2,224 deaths from illicit drug toxicity in 2021, representing the highest number ever recorded in a year and a 26% increase over 2020 deaths (BC Coroners Service, 2022). Within the province, EMS responded to over 35,000 calls related to overdoses in 2021, up 31% from 2020 (BC Emergency Health Services, 2022). In response to rising overdose rates and fatalities, the province of B.C. declared a public health emergency in 2016 (Government of British Columbia, 2018). However, responses across Canada have been inconsistent and the response in B.C. has been critiqued as insufficient, failing to meaningfully address calls for a safe regulated drug supply, address underlying structural inequities contributing to harms associated with drug use, and implement effective harm reduction policies and programs across the health care system

(Fischer et al., 2019; Ivsins et al., 2020; Tyndall, 2020). Indeed, the ongoing fatalities and harms stemming from the toxic drug supply crisis, combined with insufficient public health responses to address these harms, has been conceptualized as a "collective trauma" impacting people who use drugs, their families, and peers and health care providers working in harm reduction roles (Brand, 2018).

Unfortunately, despite the magnitude of this crisis, there are considerable gaps in data describing the intersections of this crisis with ED settings. B.C. does not consistently report ED data to CIHI's National Ambulatory Care Reporting System (NACRS), and therefore provincial data was not included on the national report on *Opioid-Related Harms in Canada* (CIHI, 2018). CIHI (2021c) data does illustrate that within EDs in B.C., over 30,000 ED visits were recorded in 2019 for harms related to substance use, not including ten EDs for which data was missing. However, this dataset reports ED visits by the type of drug involved (i.e., opioids, cocaine, other stimulants, etc.); while 5,687 ED visits are recorded as related to opioids specifically, this data does not detail the specific reason for the ED visit and may therefore not directly represent ED visits related to overdoses and other direct harms from the toxic drug supply. A retrospective cohort study by Moe et al. (2021) utilized health system administrative data from the B.C. Provincial Overdose Cohort to identify ED visits for "opioid-related overdose" in the province, and reported records from 3,593 people aged 14–74 with at least one non-fatal overdose-related visit from 2015–2016 alone. Further, the Vancouver Coastal Health Authority inconsistently reports monthly statistics for "overdoses seen at Emergency", with the most recent figure of 331 overdoses across nine EDs in April 2020 (Vancouver Coastal Health, 2020). Despite lack of quality data illustrating the magnitude of ED visits in B.C. specifically, it is clear that ED visits have increased considerably in recent years related to the toxic drug supply crisis (Koh et al.,

2020). While harm reduction initiatives have proliferated in community settings, health care providers and researchers have also recognized the importance of integrating harm reduction into hospital and ED settings (Lennox et al., 2021; Sharma et al., 2017). EDs have responded by implementing programs for initiating opioid agonist therapy (OAT) medications for people who use opioid drugs, increasing availability of take home naloxone kits used to reverse effects of an opioid overdose, and support connections to harm reduction services and supports in the community (Hu et al., 2019; Kaczorowski et al., 2020). One hospital in B.C. has additionally implemented a peer-led overdose prevention site on hospital grounds for use by all hospital patients, including people seeking health care in the ED (Dogherty et al., 2022). Despite these initiatives, research illustrates that nurses experience ongoing challenges in providing care in the context of the opioid crisis and engaging in ED-based harm reduction supports, including experiencing burnout and exhaustion, holding stigmatizing beliefs regarding drug use, and experiencing moral distress related to perceptions that engaging in harm reduction constitutes personal responsibility for "condoning" drug use (Keeler, 2017; Punches et al., 2020; Saunders et al., 2019). This study does not aim to specifically examine how nurses' equity-promoting practices respond to the toxic drug supply crisis, but recognizes this crisis as fundamentally shaping the institutional context of the ED – particularly given higher use of EDs among people who use drugs and who experience overdoses – and thus nurses' work in this setting.

COVID-19 Pandemic

In March 2020, the novel coronavirus (COVID-19) was declared a global pandemic (WHO, 2020). In Canada, there has been a cumulative recorded total of over 3.3 million cases, and over 35,000 deaths (Johns Hopkins Coronavirus Resource Center, 2022), constituting an unprecedented spread of viral illness in the country in the modern era. Public health responses to

the pandemic have foundationally altered everyday life, and have included restrictions on social gatherings, physical distancing, periods of isolation/quarantine for people exposed and/or experiencing COVID-19 symptoms, mask wearing mandates in public spaces, and trends in working from home across many employment sectors (Detsky & Bogoch, 2020; Government of British Columbia, 2022). The impacts of COVID-19 on the health care system have been immense. Comparing pre-pandemic to the pandemic period, there was a considerable drop in ED visits, up to 66% of expected volume (CIHI, 2021b; Lee et al., 2021). This change in volume of visits has been attributed to a decrease in particular injuries and illnesses (i.e., car accidents, other infectious diseases) and a trend of patients not seeking care in the ED for less urgent health concerns due to risk of COVID-19 transmission (CIHI, 2021d; Grunau et al., 2021). Yet, despite lower volumes, the COVID-19 pandemic has introduced complex pressures for health care provision in the ED, including patients presenting with more acute illness, and thus increased mortality (Finkelstein et al., 2021; Lane et al., 2021). Further, the COVID-19 context has exacerbated underlying structural inequities, contributing to worsening health and mental health among people who experience intersecting inequities and further contributing to people presenting with complex health challenges in the ED (Dassieu et al., 2021; Gibson et al., 2021; Jenkins et al., 2021). For example, a large national qualitative study with people who use drugs (N=196) illustrated that accessibility of health and social services – including harm reduction services, primary care, mental health services, shelters, and food banks – has been negatively impacted by the COVID-19 pandemic, with resultant increase in less safe substance use behaviours such as using alone and sharing/re-using supplies (Russell et al., 2021).

The health and mental health of nurses and other health care providers in the context of COVID-19 has been a widely discussed topic throughout research, policy, and the media. Early

pandemic resource and supply chain challenges contributed to global shortages of personal protective equipment (PPE), with resultant re-using of masks and other PPE in ED and hospital settings, contravening safe use guidelines (Brophy et al., 2021; Czubryt et al., 2020; Park et al., 2020). High rates of COVID-19 positive patients combined with limited resources within the ED – such as insufficient isolation spaces – have further contributed to nurses' fears of contracting COVID-19 in the workplace and transmitting the virus to family members (Lapum et al., 2021; Silverberg et al., 2021). Indeed, as of August 2021, almost 100,000 health care providers in Canada had contracted COVID-19 and 43 had died from the virus (CIHI, 2021a); while more recent statistics are not yet available, these figures are likely to be considerably higher in context of the omicron COVID-19 variant. Beyond COVID-19 infection, health care providers have also experienced skin damage from extended PPE use, have reported not attending to basic needs such as food and hydration while on shift, and have experienced fatigue and exhaustion (Casey, 2022; Shaukat et al., 2020). Research has further illustrated considerable mental health impacts of the pandemic among nurses in EDs and other critical care settings, including anxiety, depression, and post-traumatic stress symptoms (Alanazi et al., 2021; Crowe et al., 2021; Havaei et al., 2021). In sum, the pandemic has foundationally shaped the context and everyday realities of ED nurses' work, introducing new pressures and exacerbating prior challenging conditions. However, research has not yet fully accounted for how the COVID-19 pandemic context may be impacting inequities within ED health care provision, and may be shaping nurses' practices of responding to structural inequities. Again, while this study does not focus specifically on COVID-19, the pandemic context is foundationally interwoven with ED nurses' everyday work, and thus must be acknowledged as underlying how ED institutional processes and structures are implemented and operationalized within the ED settings included in this research.

Crises of Racism and Colonialism

Racism against people of colour and Indigenous people in Canada is a long-standing social and health crisis, stemming from historical and ongoing colonial and racist structures, the socio-political landscape, and governmental and institutional policy. Recent events in EDs across the country have illustrated the magnitude of systemic racism across the health care system, and importantly, have been widely reported in mainstream media, drawing much-needed attention to racism in health care. In 2020, Joyce Echaquan, an Indigenous woman living in Quebec, died in an ED after being denied necessary health care, physically restrained, left alone by health care providers, and ridiculed by nurses (Nerestant, 2021; Page, 2021), illustrating the potential consequences of structural racism and discrimination in EDs. The *In Plain Sight* report, as discussed above, details extensive experiences of stigma and discrimination among Indigenous people seeking health care in the ED, including withheld care, leading to adverse health outcomes (Turpel-Lafond, 2020). Further, recent media reports have identified that ED is considered a "last resort" by many Black people with acute health care needs due to anticipated stigma and discrimination (CBC Radio, 2021). Local media in Metro Vancouver also recently covered an incident in which a health care provider made racist comments toward a South Asian patient (Daflos, 2021). Rather than represent isolated incidents, these stories reflect the extent of systemic racism in society and across the health care system, as reflected in empirical research (Dryden & Nnorom, 2021; Phillips-Beck et al., 2020). Further, there is a considerable body of literature illustrating that racialized, immigrant, and Indigenous nurses experience racism in the workplace, including structural inequities such as exclusion from leadership, and incidents of racism and stigma from colleagues, patients, and families (Boateng & Brown, 2022; Jefferies et al., 2018; Nourpanah, 2019).

In response to the multitude of structural inequities and extensive stigma and discrimination experienced by people of colour and Indigenous people, there has been an ongoing and expanding movement in the nursing profession documenting the extent of the crisis and responding to racism and colonialism through calls-to-action, policy, programming, organizational initiatives, and nursing education reforms (Bell, 2021; Browne et al., 2022; Burnett et al., 2020; Cooper Brathwaite et al., 2022; Louie-Poon et al., 2022). However, considerable work remains to shift the discipline and profession of nursing from centring whiteness to actively practicing anti-racism. Initiatives that aim to promote equity can dovetail with and mutually support such efforts, and must ensure direct responsiveness to the crisis of racism and colonialism in society and within health care services. This study's examination of how discourse shapes nurses' enactment of equity-promoting practices has potential to meaningfully inform strategies within the nursing profession and ED settings for remediating inequities in health and health care and promoting equity among patients who experience such inequities. As such, understanding the current crises of racism and colonialism is crucial for ensuring that such strategies are grounded in the experiences of Indigenous people and people of colour, and responsive to structural racism within the health care system.

Climate Crisis

The impacts of climate change on health are immense globally and within Canada. Most recently in B.C., extreme weather events have included a "heat dome" leading to record-breaking high temperatures across the province, unprecendented wildfires fueled by high temperatures and low rainfall, extensive flooding from "atmospheric river" rain events, and winter "cold snaps" with record-breaking low temperatures (Little, 2021; Uguen-Csenge, 2022). Researchers and health officials have emphasized that these events represent dangerous – and increasing – effects

of climate change, and must be considered "public health emergencies" due to the risks they impose on health (Henderson et al., 2021). Indeed, the June 2021 heat dome has been described as "the deadliest weather event in Canadian history", causing 595 deaths (BC Coroners Service, 2021a; Bula, 2021). Such events – including both hot- and cold-weather events, and other climate emergencies – disproportionately impact people who do not have stable or adequate housing, who have low incomes and cannot easily purchase supplies, who have disabilities or other underlying health conditions, and who experience other structural inequities (Bezgrebelna et al., 2021; Klein, 2020; Peters, 2021). In coming years, extreme weather events will undoubtedly lead to increased adverse health outcomes, directly engaging nurses with the impacts of climate change (Dillard-Wright et al., 2020). Beyond the intersections of climate change with direct care nursing in the health system, Kalogirou and colleagues (2020) call for nurses to adopt a planeatry health perspective as a theoretical basis for nursing practice, and to undertake efforts to promote a more climate-resilient health care system. While research has not examined the intersections of the climate crisis with ED nursing specifically, recent events in the province have undoubtedly resulted in related ED visits, suggesting future and potentially increasing intersections of ED nursing and climate change. Within this study, the climiate crisis is understood to intersect with other current social/health crises to shape the broad context of ED nursing work, and thus how discourse may shape nurses' equity-promoting practices.

Remediating Inequities and Promoting Equity Within the ED Context

As illustrated above, the landscape of structural inequities and resultant health outcomes are well-documented in the literature; as such, researchers have increasingly called for a new agenda of remediating – rather than simply measuring – these disparities (Jensen et al., 2022; Marmot & Bell, 2016; Srinivasan & Williams, 2014). Yet despite the articulated support for

equity-promoting initiatives, there is a dearth of literature examining and implementing initiatives to promote equity within health care systems, with health equity initiatives predominantly targeting government policy and large-scale population health reforms (Donkin et al., 2018; Martin et al., 2018; Smith & Weinstock, 2019). In this context, institutional initiatives that explicitly aim to promote equity within the health care system are scarce, and ED-specific equity-promoting initiatives are nearly absent despite the considerable body of literature documenting inequities in accessibility and health care delivery within the ED context. Reflecting broader trends within empirical literature that approach inequities from a lens of particular population sub-groups and individualistic patient characteristics or experiences, research aiming to mitigate stigma and discrimination in the ED context predominantly targets specific sub-groups of patients, for example by implementing interventions to improve care for people who use drugs (Gonzalez et al., 2017; Hawk & D'Onofrio, 2018; Kaczorowski et al., 2020), people experiencing homelessness (Formosa et al., 2021), or people who have experienced violence (Corbin et al., 2011). This research has supported the development of greatly needed interventions to remediate inequities in health and health care and support health care providers in providing care for patients who experience structural inequities. However, such intervention efforts typically do not situate their work within an overall equity framework and do not consistently recognize broader power structures that produce and reproduce structural inequities beyond particular 'groups' of patients, and are therefore limited in their potential for remediating the complex and intersecting structural inequities that stem from systems of oppression in society and health care. Further, such research may in fact perpetuate inequities through advancing aims such as reducing ED visits among patients whose ED utilization is constructed as 'inappropriate' (Podolsky et al., 2017).

A recent research project, the EQUIP Emergency study, aimed to address this gap in equity-promoting research initiatives within the ED by implementing an organizational-level intervention in three EDs within the province of B.C. to improve health care delivery for people who experience structural inequities (Varcoe et al., 2019). This study builds on the research team's prior work developing and testing the EQUIP intervention in primary health care settings, with resultant findings from this health care context illustrating that equity interventions have the potential to "disrupt" the status quo of health services and shift policies, processes, and practices toward enhanced capacity for remediating inequities (Browne et al., 2015, 2018). While findings examining the impacts of the EQUIP Emergency study are not yet published, findings from EQUIP Primary Health Care illustrate the potential for intervention research to promote equity within ED settings, a greatly needed area of research. Other than the EQUIP Emergency study, I have not been able to identify any other research that has aimed to explicitly examine or promote health equity within the ED context, illustrating a considerable gap in the extant literature.

In examining equity-promoting practices among ED nurses – and exploring how these practices are shaped by discourse within the institutional context – this study aims to extend research focus from documenting inequities experienced by particular population sub-groups to examining how ED nurses' practices actively remediate inequities in health and health care. This study's focus on nurses' equity-promoting practices recognizes that such practices may not be captured by empirical research examining inequities within a more specific frame, and may not be meaningfully shifted by interventions focusing on individual patient characteristics or experiences. As such, this study examines nurses' equity-promoting practices as they are situated within complex intersections of discourse and power (as explored further in Chapter 3) with the aim of identifying how the institutional context of the ED variously facilitates and constrains

nurses' equity-promoting practices. This study therefore has potential to inform future intervention research that aims to enhance nurses' capacity for enacting equity-promoting practices that remediate inequities in health and health care in context of the complexity in which structural inequities are produced and reproduced.

Equity and Nursing

This study seeks to examine how discourse shapes nurses' enactment of equity in the institutional context of the ED, with the aim of exploring how equity-promoting practices are variously facilitated and constrained by discursive power. This section explores how discourses of equity within the nursing profession predominantly position equity as a theoretical concept, a value, and a public health endeavor with a focus on high-level advocacy efforts, and resultantly obscure equity as an action or practice. Notably, the nursing literature that takes up the concept of health equity is dominated by discussion papers that aim to theoretically position this concept in the nursing profession and articulate a philosophical orientation to understanding health equity (Browne & Reimer Kirkham, 2015; Kagan et al., 2010; Reimer Kirkham & Browne, 2006), while empirical research examining the conceptualization or enactment of equity among nurses is nearly absent. Such theoretical literature asserts strong claims regarding the centrality and importance of equity and social justice as values for the nursing profession; for example, Thorne (2015) advances the notion that "an aspiration toward social justice has been a dominant normative position for nursing for as long as we have been professionalized" (p. 79), thus positioning nursing as a profession inherently concerned with promoting equity in health and health care. Cowling and colleagues (2000; see also Kagan et al., 2010) developed a *Nursing Manifesto* promoting social justice and nursing, which philosophically and theoretically positions social justice as a value for the nursing profession and calls for nurses to take up social justice as

a shared value: "We believe that nurses are particularly attuned to the needs for social justice throughout the world… While we may have grown silent, our patients believe in us. We must listen. We must speak" (para. 2). Yet, while theoretical literature provides a strong shared vision of equity and social justice as foundational nursing values, theoretical texts have provided little direction for understanding health equity as a nursing action enacted within everyday practice.

As identified in Chapter 1, Canadian nursing professional documents reflect this body of theoretical nursing literature in situating equity and social justice as nursing values, but falling short of articulating equity as a *practice* that nurses are encouraged or guided to enact within health care settings. In the U.S. context, Bekemeier and Butterfield (2005) conducted a critical review of two key American Nursing Association documents (*Code of Ethics* and *Nursing: Scope and Standards of Practice*) and concluded that they advance an "inconsistent, ambiguous, and superficial conceptualization of social justice" (p. 152) that fails to support nurses in enacting social justice and addressing structural inequities. Further, they argue that the use of "weak, noncompulsory language" (p. 156) throughout both documents positions nurses as responsible only for "awareness" of structural inequities impacting health, rather than for action toward remediating inequities. In an updated critical discourse analysis of U.S. nursing professional texts, Valderama-Wallace (2017) noted ongoing inconsistencies in conceptualizations of social justice and argued that this lack of clarity detract from nurses' social justice mandate. While no similar review has been published analyzing Canadian nursing documents, these authors' conclusions regarding U.S. nursing professional documents resonate with central challenges in Canadian texts, which focus predominantly on *awareness* and *endeavours* rather than action and practice. For example, the *Code of Ethics for Registered Nurses* (CNA, 2017) includes a section dedicated to "ethical endeavours related to broad societal

issues" (p. 18), differentiating these endeavours from the *Code's* "primary" nursing values. Futher reinforcing the optional nature of these ethical endeavours, the document consistently utilizes language such as "describes activities nurses *can* undertake to address social inequities" (p. 3, emphasis added), contrasted with the stronger and more direct language used to emphasize that nurses "bear the ethical responsibilities identified under each of the seven primary nursing values" (p. 8). In this way, the *Code* echoes the nursing theoretical literature that predominantly conceptualizes equity as a philosophical concept or shared value, as opposed to a practice undertaken by nurses within health care encounters to remediate the social and health impacts of structural inequities. As such, there remains extremely minimal guidance for nurses – particularly empirically-informed guidance – in enacting equity-promoting practices across diverse health care settings. In constructing the concept of *equity-promoting practices* for this study and examining how nurses enact these practices in the ED, this study aims to begin to build an empirical knowledge base for understanding equity as a practice within the nursing profession, with the ultimate aim of enhancing nurses' capacity for enacting equity-promoting practices to remediate structural inequities.

As described, guidance for nurses in enacting equity-promoting practices is scarce across theoretical nursing literature and nursing professional documents. In particular, there is a dearth of literature examining equity as a nursing practice within hospital, acute/critical care, or ED settings. Indeed, literature examining equity within the nursing profession predominantly conceptualizes equity as enacted within domains of community and public health nursing, advancing the notion that equity and social justice action is predominantly related to population-level inequities and population health initiatives, and thus necessitates high-level responses such as policy reform and advocacy related to broader social causes (Moss & Phillips, 2020; Raphael

& Sayani, 2019; Rudner, 2021). While this body of literature remains almost exlucisvely limited to theoretical literature with a lack of empirical inquiry informing claims and proposed action, the discussion papers and commentaries that constitute this area of literature articulate equity and social justice as enacted values that public health nurses can take up within their work. For example, discussion papers across public health nursing practice and education position social and health inequities as foundationally rooted in upstream structural conditions, and specifically situate public health nurses as ideally positioned to address inequities at the population level through equity-promoting public policy development, advocacy, and political action (Fahrenwald et al., 2007; Pauly et al., 2009; Schim et al., 2007). Further extending these calls-to-action for public health nurses, Drevdahl (2013) argues that individual well-being is predicated on collective well-being and that "ordinary nurses" must therefore engage in social justice advocacy for community-level reforms that can remediate structural inequities and thus ultimately promote individual health. Other nursing scholars similarly argue that nurses engage in advocacy and activism to enhance equity through policy reform within the health care system and at higher governmental levels (Falk-Rafael & Betker, 2012; McGibbon et al., 2014; Scott & Scott, 2021). While this body of literature supports preliminary conceptualization of equity as an enacted practice, the guidance and suggestions offered by nurse scholars often focus on public health nurses alone, with little applicability to nurses working in other health care settings, and by a focus on higher-level advocacy and activism that may obscure aspects of equity that are embedded in everyday practices.

Indeed, while the recognition of upstream causes of inequities is integral to informing theoretical and practice-oriented responses, the predominant focus on nursing responses to inequities as a matter of public health and population-level action has resulted in a common

perspective within theoretical nursing literature that nurses should avoid focusing equity promotion efforts on individual patient encounters, as this reflects a neoliberal framework of placing responsibility for health on the individual (Bekemeier & Butterfield, 2005; Drevdahl et al., 2008; Reutter & Kushner, 2010). For example, in a book chapter exploring "nursing as a force for health equity", Disch (2020) argues that to effectively promote equity, nurses should "strive to fix underlying system issues rather than individual situations" (p. 13), and offers community-level strategies for promoting equity such as creating "healthy neighbourhoods" by advocating for sidewalks and bike lanes. While such perspectives place important emphasis on upstream and structural causes of health inequities, they suggest that nurses' attention to equity within direct care settings (and particularly acute care settings such as the ED) is misguided and threatens conceptualizations of inequities as structural. This study rejects this notion, and rather understands acute care settings as spaces within the health care system where discursive power creates and perpetuates inequities, and thus where meaningful action toward equity promotion can and must occur (Thompson, 2014). As such, this research focuses on the ED setting as a space in which nurses regularly engage with patients who experience structural inequities, and thus have considerable potential to enact equity-promoting practices to remediate inequities in health and health care – though this potential has rarely been taken up in prior theoretical or empirical nursing literature.

While the nursing literature related to health equity is dominated by theoretical perspectives on equity and social justice as well as approaches for promoting equity through population and public health efforts, a small though growing body of nursing literature has explored approaches to enacting health equity in the context of patient care within direct care settings. Pauly and colleagues (2009), in a discussion paper presenting a theoretical examination

of access to care through an equity and justice lens, provide practical examples of an equity orientation to everyday patient care, specifically how nurses can provide care that is more attentive to underlying structural inequities. For example, they suggest routinely assessing patients' access to resources and drawing on their assessments to inform discharge planning, and rejecting language such as "non-compliant" (e.g. with medications or treatment plans) and instead examining underlying factors that impact patients' situations and resources. While these suggestions are not empirically-informed, they are unique among theoretical literature in their focus on "practical action" and the assertion that nurses can enact equity through practice. Similarly, in a book chapter within a the edited collection *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis*, Varcoe and colleagues (2015) additionally emphasize that nursing responses to inequities are not limited to policy reform and advocacy at higher levels, and that nurses can meaningfully "foster social justice in everyday clinical practice through our ways of being and interacting with people/patients and each other" (p. 267). The authors further suggest specific approaches for integrating equity into everyday nursing practice, such as treating all persons with "unconditional positive regard", locating "problems" in health care practices rather than in patients, avoiding language that positions structural inequities as "choices" or "lifestyles", and recognizing capacity and resilience as well as vulnerabilities (p. 272). Moss and Nolan (2020), in a book chapter on integrating the social determinants of health into clinical nursing practice, further suggest specific strategies for inquiring about structural inequities within a health care encounter, such as asking "Do you have money to pay for your medicine?" (p. 125). While these authors offer suggestions of practical strategies for integrating equity into everyday nursing practices, there is a need for evidence-informed guidance that is grounded in how nurses actually experience enacting equity-promoting practices in health care

settings within everyday patient care. In this way, this study has potential to meaningfully situate equity as a practice enacted by nurses in direct health care settings, and contribute empirical knowledge to current theoretical guidance for nurses in enacting equity-promoting practices within patient encounters. Further, by examining the complex health care system contexts in which these equity-promoting practices occur, this study can contribute understandings of how theoretical conceptualizations of equity are currently situated within dominant ED discourses, and thus what further supports may support ED nurses' capacity for enacting equity-promoting practices within everyday nursing work.

There is extremely little empirical research that has explored equity as a practice enacted by nurses within health care settings, and the few studies that have examined this topic are discussed here. Nurse researchers in Iran conducted a qualitative grounded theory study with nurses, nurse managers, and other staff within the health care system (N=27) in Tehran to develop a theory of the concept of equity in nursing practice, and identified that nurses' relative position in the hierarchy of health care combined with a lack of institutional support for equity challenged nurses' ability to enact equity as a practice in hospital settings (Rooddehghan et al., 2017). However, findings centered broader institutional challenges affecting nursing care, such as "nurses being dominated" by physicians, and do not ultimately contribute understandings of how equity is enacted by nurses in everyday practice; this may have been as a result of sampling, which included only nine direct care nurses or the local context in which this research was conducted. Subramani (2018) conducted a grounded theory study in hospital settings in India, specifically examining micro-inequities: "subtle micro-level events and practices that sustain and reproduce unequal relationships in healthcare encounters" (p. 1). Focusing on health care providers' relationships with patients and families, Subramani's findings from observations and

individual interviews with nurses, physicians, and patients (N=63) illustrated that micro-inequities reflect broader power structures in society that perpetuate inequity, and are often unrecognized by health care providers who may enact them. While this study examined inequities perpetuated by health care providers as opposed to equity-promoting practices, this research illuminates how equity-promoting practices may be constrained – and practices perpetuating inequities may be facilitated – by power structures within the institutional context of health care. Beyond these two studies, I have not identified any additional empirical literature that has examined the concept of equity within nurses' practices, illustrating the considerable gap in research literature exploring nurses' enactment of equity-promoting practices in health care settings, and the lack of research examining the ED setting specifically. This study aims to address this gap by contributing to the knowledge base of nurses' enactment of equity-promoting practices in direct health care settings, with specific focus on the ED as a space that holds a key role in providing health care for patients who experience structural inequities.

Summary and Significance of the Research

The review of the extant literature presented in this chapter illustrates that structural inequities foundationally shape health and experiences of health care in Canada, with considerable inequities in ED health care delivery among Indigenous people, people of colour, people who use drugs, people experiencing homelessness, people with mental health concerns, and people who experience various structural inequities. Empirical research documenting these inequities predominantly focuses on particular population sub-groups and as such, does not consistently engage with the complexities of patients' intersecting experiences of inequities and stigmatizing and discriminatory health care in ED settings. Despite extensive empirical knowledge of the existence of inequities in EDs, there is scant research that has examined what

processes and structures create and perpetuate inequities within this unique health care space. However, literature examining inequities in health care delivery as constructed and shaped by broader structural inequities provides important context for understanding nurses' everyday work with patients who experience structural inequities and seek health care in the ED. Empirical research contextualizing nursing work in the ED illustrates complexities of this health care space, in which discourses of efficiency and managerialism constrain nurses' practices and advance nursing work that upholds standardization of care provision and efficiencies that limit nurses' time spent providing patient care. Further, ED nursing work is currently occurring against a backdrop of social/health crises, including the toxic drug supply crisis, the COVID-19 pandemic, crises of racism and colonialism, and the climate crisis, which intersect to affect who seeks health care in the ED and thus the nature of ED nursing practice.

In context of considerable experiences of inequities in ED health care delivery, there have been increasingly calls within the nursing profession and the health care system for research that aims to remediate inequities and thus lessen harms stemming from inequitable care. However, despite these calls, there remains a dearth of empirical research examining equity-promoting initiatives or practices within EDs, with current strategies for remediating inequities in health and health care reflecting predominant trends in epidemiological research that documents inequities, in being largely focused on specific population sub-groups. The nursing profession is ideally positioned to engage in equity-promoting efforts, as equity is positioned within nursing theoretical literature and professional documents as a shared value and guiding principle. However, despite extensive discussion papers and commentaries philosophically and theoretically examining how equity is situated within nursing, there remains scant empirical research examining how nurses enact equity-promoting practices. Such gaps in empirical

examination of equity in nursing have constrained guidance and support for nurses in building capacity for enacting equity-promoting practices across diverse health care settings, particularly hospital settings, and consequently, current practical guidance for nurses in remediating inequities within health care settings is not empirically-informed.

Taken together, the extant empirical literature illustrates that there are considerable inequities in health care delivery within the ED, and that while nurses are well-positioned to remediate structural inequities in health and health care, the lack of empirical understanding of how nurses enact equity-promoting practices is hindering this potential. Further, while some prior qualitative work has examined how institutional factors broadly shape nurses' everyday work, there is a lack of research that has examined the institutional processes and structures that shape nurses' enactment of equity-promoting practices, thus limiting understandings of how nurses' everyday work with patients who experience structural inequities is situated within broader institutional discourses. This research responds to these critical gaps by examining how discourse shapes nurses' enactment of equity-promoting practices within the institutional context of the ED, drawing specifically on Foucauldian discourse analysis to draw attention to intersections of discourse and power in constructing institutional processes and structures that variously facilitate and constrain nurses' practices. In doing so, this study aims to contribute to current gaps in understanding of equity as a nursing *practice*, with a focus on everyday nursing work in the ED, thus extending current theoretical conceptualizations of equity within the nursing profession. Further, this study aims to develop knowledge of how nurses' practices are situated within broader discourses and shaped by power structures, thus illuminating barriers to enactment of equity-promoting practices and contributing to future directions for mitigating such barriers and enhancing nurses' capacity for enacting equity-promoting practices to remediate the

considerable structural inequities perpetuated across the health care system and within EDs settings.

Chapter 3: Methods

This chapter provides an overview of this study's methodological approach, theoretical framework, and methods. Firstly, I describe Iris Marion Young's theory of social justice and power and how this theoretical framework guided this study's conceptualization of equity, inequities, and power. Next, I expand on Foucauldian discourse analysis as the overarching methodological approach facilitating this study's examination of how discourse shapes nurses' enactment of equity-promoting practices within the institutional context of the emergency department (ED). I then provide details of this study's methods, beginning with a description of broad contextual details for each of the two study sites, both located in the province of British Columbia (B.C.). Following a description of this study's sample and recruitment approaches, I then provide details regarding data collection, including individual interviews and institutional and professional texts. Extending from the overarching Foucauldian discourse analysis methodological approach, I illustrate how data analysis was undertaken, guided by Parker's (1992) approach to qualitative discourse analysis. I conclude this chapter with discussions of ethics and rigour.

Theoretical Framework

This study's examination of how nurses enactment of equity-promoting practices is shaped by discourses within the institutional context of the ED is guided by Iris Marion Young's (1990) theory of social justice and power. Within this study, equity-promoting practices is conceptualized as actions undertaken by ED nurses to promote equity across all aspects of their everyday nursing work, and is foundationally understood as shaped by discourse within the institutional contexts in which these practices occur. This study's theoretical framework thus informs an understanding of how discourse produces and reproduces institutional processes and

structures, and thus lays the groundwork for this study's conceptual and methodological understanding of discursive power. Applied to the ED settings in which nurses work, this framework supports an analysis of nurses' practices as foundationally interconnected with the institutional contexts – and power structures – in which they occur, and facilitates analysis of how discursive power constructs particular notions of equity and inequity. Conceptualizing the ED context of nursing work and nurses' engagement in equity-promoting practices within this setting through the theoretical lens of Young's social justice and power thus guides this study's central aims, methodological approach of Foucauldian discourse analysis, and examination of how nurses' enactment of equity-promoting practices is shaped by discursive power within the institutional context of the ED. This section summarizes Young's theory of social justice and power and illustrates the application of this theoretical framework to this research.

Young's theorizing of social justice and power builds on Foucault's (1980) conceptualization of power (described further below), supporting this study's theoretical and methodological alignment of equity and power with Foucauldian discourse analysis. Young (1990) articulates that across disciplinary locations, prior theories of justice have predominantly advanced the distributive paradigm through their examination of unequal and unjust patterns of resource distribution. Such resources are typically understood as materials and goods – including income, access to social and health care services, and education – yet have also been extended to include more abstract 'goods' such as respect, opportunity, and power in society (Rawls, 1971; Young, 1990). Young argues that while theorizing social justice through a distributive lens can be useful for understanding end-state distributive patterns and mapping trends in inequities, this paradigm "tends to ignore the social structure and institutionalized context that often help determine distributive patterns" (p. 15). Young's core theory of social justice thus broadens

beyond a focus on *patterns* to analysis of social and institutional *processes* that produce and reproduce injustice. Specifically, Young's conceptualization of social justice involves the elimination of the institutional structures and processes that create social conditions of oppression and domination (p. 38)[3]. Within this study's examination of nurses' equity-promoting practices, Young's conceptualization of social justice as elimination of oppression and domination is broadened to include actions taken toward the reduction, elimination, and remediation of inequities within the institutional context the ED setting.

Following from Young's process-oriented understanding of social justice, this study acknowledges the unequal distributive patterns that map a profoundly unjust social landscape, but turns the lens upstream from such distributive patterns to the institutional context that produces and reproduces them as well as the efforts taken to disrupt the reproduction of inequities. Young defines institutional context as including "any structures or practices, the rules and norms that guide them, and the language and symbols that mediate social interaction within them" (p. 22). Within this research, institutional context is therefore considered to be the multiple and complex contexts in which nurses work, including social interactions within nursing and interdisciplinary health care teams; the leadership and management context at unit and hospital levels; the numerous policies and documents that shape both the nursing profession and the provision of health care; and the broader social and structural contexts in which the health care system is situated. Actions – or practices, when applied to nursing work – are understood as

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[3] In Young's theory of social justice, oppression and domination are distinct through inter-related concepts. Oppression refers to social and institutional processes that create social conditions that restrict some people's abilities to express themselves and to learn and use skills. Domination refers to institutional structures that create conditions in which some people's actions and decisions are determined by others.

both “a producer and reproducer of structures” (Young, 1990, p. 29). In this way, Young’s conceptualization of power draws on and aligns with Foucault’s capillary power, with *Justice and the Politics of Difference* citing Foucault’s statement that “power exists only in action” (1980, p. 89). In this theory of capillary power, Foucault situates the effects of power in the “extremities” of institutions, and argues that power must be analyzed through its direct and immediate effects “where it installs itself” in institutional structures and social relations. Rather than identifying particular individuals ‘with’ power, Foucault states that power is “never in anybody’s hands” and instead circulates, operating *through* people as the “elements of its articulation” (p. 98). Thus, within this study, the complex intersecting institutional contexts of the ED setting are theorized as foundationally shaping individual nurses’ actions and practices, with individual and collective actions in turn shaping and defining institutional contexts, including how health care is delivered and how the ED nurses’ role is understood and enacted. The study of nurses’ enactment of equity-promoting practices within institutional contexts is therefore the examination of process: both how institutional contexts shape nursing practices and how nursing practices produce and reproduce institutional contexts.

Young’s theory of social justice within the complex institutional contexts in which ED nurses work supports analysis of how nurses enact equity-promoting practices toward the reduction, elimination, and remediation structural inequities in health and health care. However, the study of social justice in ED nursing work is incomplete without an analysis of power. While some conceptualizations of power understand an individual agent as having power *over* another, Young (1990) echoes Foucault in arguing that this dyadic understanding of power reflects the distributive paradigm in positioning power as a ‘thing’ that someone can possess or not possess. Rather, Young conceptualizes power as a *relation*. This power relation that exists between two

agents is theorized as situated within a "larger structure of agents and actions… One agent can have institutionalized power over another only if the actions of many third agents support and execute the will of the powerful" (p. 31). This framework of power is useful for understanding nurses' liminal position of power within the health care system. A dyadic understanding of power, with nurses having power 'over' patients, draws attention to oppression and domination experienced by people seeking health care in complex social and institutional contexts, yet fails to recognize the profession's long history and current experiences of structures of domination within the health care system (Van Herk et al., 2011). Young's conceptualization of power recognizes that power is produced and reproduced through institutional processes and structures outside of this power dyad, yet constructs and shapes how power relations play out within a particular context. Applied to the nurse-patient dyad, the processes and structures shaping power relations may include management structures, policies and procedures at multiple institutional and political levels, social conditions, laws, and toher power structures within the health care system and society more broadly. Young's framing of power thus positions nurses as situated within and having potential to perpetuate institutional power structures, but also suggests possibilities for nurses to grapple with institutional contexts that produce and reproduce power. Through a social justice lens that envisions the elimination of the institutional structures and processes that create inequities, nursing practices are viewed within this study as situated within and reproducing institutional power structures, while simultaneously holding potential for working toward shifting and resisting these very structures. This potential for resistance is conceptualized as *subversion* within this study, and encapsulates nurses' agency in disrupting and challenging power structures within the institutional context of the ED.

Methodological Approach: Foucauldian Discourse Analysis

This qualitative study draws primarily on Foucauldian discourse analysis (FDA) to respond to the research question: *How does discourse shape nurses' enactment of equity-promoting practices in the institutional context of the emergency department?* Broadly, discourse analysis is grounded in an understanding that discourses order the social world in a particular way and form a "common set of assumptions" that are so foundationally embedded that they become nearly invisible (Cheek, 2004). Discourse analysis thus aims to make the invisible visible by examining text as a product of discourse that can illuminate how discourse shapes our systems, institutions, and actions (Powers, 1996). Here, *text* refers simply to that which is said, and invites the questions "Why was this said, and not that? Why these words, and were do the connotations of the words fit with different ways of talking about the world?" (Parker, 1992, p. 4). Thus, text involves not only what is written, but also what is spoken, captured within this study as *talk*, constituting an essential form of discourse in text. While many approaches to discourse analysis – particularly those that adopt a critical theoretical perspective – aim to examine how text reproduces power relations, FDA orients inquiry to the interrelationship between discourse, power, and practices. FDA recognizes discourses as operating unrecognized 'beneath' individuals' practices, actions, and thoughts, with power shaping which discourses are invoked and become dominant within particular contexts (Springer & Clinton, 2015). Powers (1996) explains that an FDA approach recognizes that discourses constitute and are constituted by practices; power operates through discourse to shape how individuals act, and at the same time, individual actions coalesce into social processes that variously "reproduce or challenge the distribution of power as it currently exists" (p. 211). FDA thus extends Young's theory of power as produced and reproduced through institutional processes and structures to an analysis of *how*

discourse shapes the production and reproduction of power within a particular institutional context. This study utilizes FDA to examine how nurses' talk and institutional and professional texts illuminate how nurses' enactment of equity-promoting practices is contextualized by social and institutional discourses, and how the discourses shaping texts and talk within the institutional context of the ED variously facilitate and constrain nurses' actions remediating inequities in health and health care and promoting equity.

Texts provide a window into discourse and through their analysis, allow the researcher to "uncover the unspoken and unstated assumptions implicit within them that have shaped the very form of the text in the first place" (Cheek, 2004, p. 1145). This study takes up FDA as a methodological approach for examining nurses' talk and institutional and professional texts as a means of examining the context of nurses' equity-promoting practices. Nurses' practices are foundationally governed by texts, including institutional policies, professional documents, standardized forms and documentation procedures, and site-specific signage and messaging. An analysis of the discourses that operate within these texts allows for inquiry into the dominant discourses that shape the ED context and variously facilitate and constrain nurses' equity-promoting practices. How nurses describe their own practices – including their experiences of recognizing and remediating inequities, the practices they engage in to promote equity, and the structural contexts for these experiences – inherently draws on discourses. Discourses may reflect the central or dominant discourses of the institution and may also be contradictory discourses that in themselves are a means of subverting discursive power by illuminating alternative emancipatory practices. An FDA approach thus facilitates analysis of how nurses draw on discourse to recount, make sense of, and contextualize their experiences of enacting equity-promoting practices in the ED, including how these practices are facilitated or constrained

by institutional processes and structures. As well as uncover how power shapes how discourses produce and reproduce power, and how contradictory discourses support subversion of power, discourse analysis of can help illuminate "what knowledge we need to create the future we want for the profession" (Springer & Clinton, 2015, p. 91), thus enhancing nurses' capacity to collectively envision and enact equity through everyday practices. Lupton (1992) states that "discourse analysis as a strategy of resistance" (p. 149) in that it reveals not only how power currently shapes discourse, but what discourses – and therefore what practices – are possible. In this way, FDA can have an emancipatory aim of making visible possibilities for action that current power structures may obscure (Powers, 1996). Within this study, FDA therefore supports this study's contribution to identifying strategies to further enhance nurses' capacity to respond to inequities and engage in equity-promoting practices.

This study's examination of how discourse shapes nurses' enactment of equity-promoting practices in the institutional context of the ED is thus broadly guided by Parker's (1992) qualitative discourse analysis approach, augmented with other methodological guidance for FDA. Parker's approach to discourse analysis is particularly appropriate for this research, in that it explicitly differentiates between power and discourse, emphasizing that while discourse reproduces – and therefore illuminates – power relations, contradictory discourses offer a pathway for subversive action through "a refusal of dominant meanings" (p. 18). Additionally, Parker situates discourse analysis as holding potential to illuminate dominant discourses that foundationally construct and uphold institutional and professional processes and structures. Thus, in approaching discourse analysis with the intention of illuminating discourse to examine the intersections of discourse, power, institutions, and subversion, Parker's approach to discourse analysis supports this study's examination of equity-promoting practices as situated within a

complex institutional context that variously facilitates and constrains nurses' practices. Further detail of Parker's approach is provided below, throughout the Methods section.

Research Settings

This study was conducted at two ED sites within the Metro Vancouver area of B.C., Canada. These two sites were selected as they each have a rich and complex history of serving diverse populations that have historically experienced discrimination in society and in health care. The dual-site approach to this discourse analysis supports confidentiality of participants and the sites themselves, while also allowing for rich examination of how central discourses operate across the institutional contexts each ED, thus constructing and informing underlying notions of what an ED 'is' and 'does' within society and within the broader health care system. Further, examination of how nurses' practices are situated within two different ED sites contributes to a nuanced analysis of how discursive constructions of the nursing profession intersect with discourses producing and reproducing power within the ED as a distinct institutional context. Each of the sites are described below to illustrate key contextual features of each ED setting.

One of the ED sites is situated within a hospital located in a large urban centre with a population of over 625,000 people (Statistics Canada, 2017b). The hospital stands on the unceded traditional territory of the Coast Salish peoples, specifically the Squamish, Musqueam, and Tsleil-Waututh First Nations. Originally founded in 1894 by Catholic Sisters, though managed by secular directors since 1969, this hospital continues to be a faith-based health care organization (Providence Health Care, 2007). The health authority's Mandate articulates the institutional aim of "providing compassionate care for everyone in need", and the current Vision states: "Driven by compassion and social justice, we are at the forefront of exceptional care and innovation" (Providence Health Care, 2019a). This hospital has a long history of serving patient

populations who experience inequities in health and health care, including people with AIDS at the beginning of the 1980s crisis. In the context of the current toxic drug supply crisis, nearly 1,800 people in B.C. died from drug overdoses in the first ten months of 2021, with the city where this hospital is located having the highest percentage of any BC city (BC Coroners Service, 2021b). Each month, EDs within the city see hundreds of people experiencing overdoses, approximately three-quarters of whom are seen at this hospital (Vancouver Coastal Health, 2017, 2020). The toxic drug supply crisis has fundamentally shifted this ED's policies and processes, including coordination with the on-site Opioid Overdose Outreach Team to provide supports within the ED, and the recent development of an overdose prevention site on hospital grounds (Dogherty et al., 2022). This ED receives up to 300 patients per day (85,000 annually) and has over 250 staff, including 150 nurses.

The other study site is located in a large city in B.C. that is one of the fastest growing cities in the province with a population of over 500,000 people (Statistics Canada, 2017a). The hospital stands on the unceded traditional territory of the Katzie, Semiahmoo, Kwantlen First Nations and other Coast Salish peoples, and over 13,000 Indigenous people lived in the city as of 2016 (Surrey Urban Indigenous Leadership Committee, 2019). The hospital was originally founded in 1959 with just 100 beds and serving a population of only 50,000. It has since grown to 624 acute care beds. The Vision of the health authority in which this hospital is situated is "Better health. Best in health care", and the institutional Mission reads: "Respect, caring and trust characterize our relationships". This ED is the busiest in the province, receives over 400 patients per day (>157,000 annually) (Fraser Health, 2021a), and has over 300 nurses. In response to the growing numbers of patients seeking health care, the ED was rebuilt in 2013, dividing adult and pediatric EDs and increasing single patient rooms from eight to 100 (Bailey,

2013). As seen across the province, the toxic drug supply crisis has had considerable impact on this hospital, with the city experiencing the second-highest number of drug toxicity deaths in 2021, following the city of Vancouver (BC Coroners Service, 2021b). The most recent available data indicates approximately 350 overdose events per month seen in EDs within the health authority area (Fraser Health, 2018), with overdose deaths in the city increasing since this time (BC Coroners Service, 2021b). Other factors shaping the ED include the high population of Punjabi-speaking residents in the city, with almost a fifth of the total population having Punjabi as a first spoken language and a third of the Punjabi-speaking population not able to conduct a conversation in English (Statistics Canada, 2017a).

Methods

Data Sources

To examine how discourse shapes nurses' equity-promoting practices in the institutional context of the ED, this study draws on three intersecting data sources: i) institutional texts; ii) nursing professional texts; and iii) nurses' talk. The identification of each of these data sources extends from the FDA methodological approach, which is grounded in the notion that "a discourse is realised in texts" (Parker, 1992, p. 6) – that is, discourses are both constructed through texts, and texts make visible the discourses that construct them. Within FDA, selection of data sources thus extends both from the research question and from the core understanding that texts (in their many forms) constitute the object of analysis (Crowe, 2005; Parker, 1992). Each of the data sources for this study were selected as key texts through which discursive power – as it constructs institutional processes and structures and shapes nurses' practices within the ED context – may be made visible. The rationale for utilizing each of the data sources for this study are discussed within this section, and the Data Collection section below further details the

process of selecting specific texts and conducting individual interviews with nurses as a means of capturing nurses' talk.

The examination of institutional texts is common in discourse analysis, as such texts illuminate central discourses that construct and shape institutional processes and structures (Crowe, 2005; Lupton, 1992; Parker, 1992). As this study aims to examine how discursive power intersects with institutional context to shape nurses' practices, the inclusion of institutional texts as a data source was crucial for understanding how discourses produce and reproduce power structures and variously facilitate and constrain nurses' enactment of equity-promoting practices. While the broad category of institutional texts may include any textual objects that are constructed within the institutional context, this study focuses on texts that are created with an aim of guiding nurses' everyday practices, including broad guiding texts such as health authority Mission and Values statements, and specific texts that aim to direct everyday practices within a health care encounter such as policies, guidelines, and protocols.

As the institutional context is shaped by institutional texts, the practice of nursing is guided by dominant nursing professional texts that "claim authority" (Crowe, 2005, p. 59) as documents that aim to regulate, inform, and construct nursing as a profession and a practice within a provincial or national context. Parker's (1992) approach to conducting discourse analysis recognizes that professional regulation texts illuminate central discourses that both construct broad notions of the profession and shape everyday professional practices. Further, methodological guidance on discourse analysis from within the nursing profession asserts that such nursing documents construct a "web" of intertextuality, in which texts are in discursive relationship with other texts and together reflect and construct core meaning, such as the 'meaning' of nursing (Crowe, 2005; Powers, 1996). As such, nursing texts were recognized

within this study as illuminating dominant discourses constructing the profession, and thus making visible how nurses' practices are shaped by core notions of what nurses 'do' and 'ought' to do. Nursing texts were understood as intersecting with institutional texts to form the institutional – and professional – context for nursing work in the ED, and thus inform how nurses enacted equity-promoting practices within this context.

Within this study, nurses' talk was identified as a key data source for informing how nurses' practices were situated within the ED institutional context, and was captured through qualitative interviews with ED nurses (augmented by other health care providers' talk as described further below, in Sample and Recruitment). While some discourse analyses privilege naturalistic data, this study follows Nikander's (2012) understanding of qualitative interviews as "discursive spaces" (p. 403) in which participants' talk reflects, and thus illuminates, the discursive patterns shaping their language, experiences, and actions. Qualitative interviews within an FDA methodological approach support in-depth conversation – and thus, in-depth analysis – of how nurses' practices are situated within complex institutional contexts in the ED, and facilitate examination of the dominant discourses producing and reproducing these contexts. Through conversation and talk, power structures and power relations are illuminated and can be explored through follow-up questions and interviewer requests for stories or examples, the responses to which further illuminate the dominant and competing discourses that participants employ to express their experiences and practices. Taken together with institutional and nursing texts, the use of such talk as a data source for this study was intended to illuminate the discursive context of the ED, and how discourse and power intersected to variously facilitate and constrain particular nursing practices, including equity-promoting practices.

Sample and Recruitment

Initially, this study aimed to interview only Registered Nurses (RNs) who worked in either of the two ED sites in either direct care or leadership roles. This sample was chosen to align with the overall study aim of examining in depth how the discursive context of the ED shaped nurses' enactment of equity-promoting practices, and to explore how such practices were positioned within and reflect discourses shaping the nursing profession. Nurse leaders were included to support in depth analysis of the institutional context of nurses' work, including how discursive power in the ED setting shaped nursing leadership structures, which in turn shaped nurses' direct care practices. However, in discourse analysis, the process of sampling, recruitment, and data collection is often iterative in nature, with new directions emerging from ongoing reflection and analysis of collected data. FDA recognizes texts as inherently interconnected and in relationship with other texts in a particular context (Crowe, 2005; Titscher et al., 2000); thus, the process of capturing texts and talk is both a product of initial study design and aims, and also the growth of inquiry based on the social act of conducting and learning from engaging in data collection activities. Throughout data collection for this study, the sample was intentionally extended from RNs alone to also include Registered Psychiatric Nurses (RPNs), Licensed Practical Nurses (LPNs), social workers, and individuals in leadership positions who did not hold a nursing designation. For example, in early interviews with RNs at each site, nurses' talk illustrated the centrality of social workers, nurses with specialty roles in addictions services, and other health care providers in supporting nurses' work with people who experience structural inequities. Additionally, RNs in direct care and leadership positions identified non-nurse leaders in shaping ED institutional processes and structures, such a co-developing policies or providing specific supports to ED patients. This included, for example, Indigenous peer

liaisons who provided services and supports for Indigenous patients across the hospital, including in the ED, and were identified by direct care and leadership RNs alike as shaping the context of ED nursing practice. As such, the sample for this study included RNs working in either of the two ED sites in full-time, part-time, or casual roles, as well as individuals working in the ED in other health care provider or specialty nursing roles (direct care or leadership) identified through the research as shaping the context of ED nurses' work.

Recruitment activities began at one ED site in February 2021 and concluded May 2021, and at the other site occurred between June and August 2021. As described, study activities occurred in the midst of the COVID-19 pandemic, which has been widely identified as having negative impacts on ED nurses' mental health and well-being (An et al., 2020; Araç & Dönmezdil, 2020; Spoorthy et al., 2020). Recruitment was therefore anticipated to be a challenge among this population, particularly given the curtailment of in-person study activities and the inability of researchers to conduct recruitment on site. Firstly, the research team identified one nurse leader as a site contact for each ED. Following meetings with each site contact and institutional approval to conduct research, site contacts supported all recruitment activities at each respective site. Recruitment was undertaken through four mechanisms: initial recruitment emails; site-specific recruitment strategies initiated by site contacts; further targeted recruitment; and snowball sampling. Firstly, each site contact circulated an email prepared by the research team describing the study to all nurses working at each respective ED. This email included study details, an informational flyer (Appendix A), recruitment poster (Appendix B), and information for how to contact the primary researcher (Allie Slemon) with further questions or to indicate intent to participate. Secondly, site contacts at each ED initiated recruitment activities that fit within existing site-specific processes and structures. This included, for example, hanging

posters in staff areas in the ED and discussing the study at nursing team "huddles". The third recruitment mechanism involved targeted recruitment in response to emerging study directions. This included site contacts facilitating introductions to other nurses, nurse leaders, and health care providers within the department based on the widening study sample. Further recruitment was then conducted via these additional contacts; for example, leaders managing nurses with a specialty role in addictions circulated tailored recruitment emails to their team. In these instances, I often met remotely with team leaders in advance of recruitment activities to provide information about the study and answer questions. Finally, snowball sampling served as a recruitment mechanism, with study participants informally communicating information about the study to colleagues. Participants were never asked to provide information or direct contact to other potential study participants, and all snowball recruitment was undertaken voluntarily and independently by study participants and site contacts. In responding to recruitment efforts, including flyers and emails, participants expressed their decisions to engage with the study as reflecting personal interest and commitment in working with patients who experience structural inequities, and statements such as "this is the population I want to work with" were common. Some individuals further expressed that they experienced challenges in promoting equity within the ED and health care system, and stated that they hoped that research would serve as a means of facilitating institutional change. For others, the research process itself was of interest, and some participants described their own previous research work or identified a desire to engage with research through future graduate degrees and other workplace opportunities.

Data Collection

Data collection consisted of i) individual interviews with nurses and other health care providers at each of the two research sites, and ii) collection of professional and institutional

texts including nursing professional documents, and health authority, hospital, and ED-specific policies and documents. Due to the COVID-19 pandemic, health authorities and university institutional research boards restricted most on-site and in-person data collection activities. To reduce the risk of transmission, all study activities were completed remotely, including meetings with site leadership, recruitment activities, and data collection.

Individual Interviews

Individual interviews were conducted with nurses, nurse leaders, and other health care providers at each research site (as described above in Sample and Recruitment) to explore how the discursive context of the ED shaped nurses' enactment of equity-promoting practices within this setting. The structure of the interview guide (Appendix C) was thus created to elicit nurses' descriptions of their experiences providing patient care in the ED, and how institutional processes and structures shaped their experiences. The intention of the interviews was to facilitate a semi-structured, open conversation that was responsive to participants' talk, and questions were not necessarily asked using the exact language stated in the interview guide, or in the written order. As a window into discussing inequities and equity, the language of "marginalized populations" was used in recruitment materials and the interview guide to spark conversation and orient conversation to the topic of focus. However, throughout conversation with each participant continues, I adapted my own language to reflect each participant's so as to minimally influence how individuals variously drew on different discourses in describing their experiences in the ED context. For example, early interviews at one site illustrated that nurses frequently used the term "vulnerable populations" to capture individuals with specific characteristics or experiences, as reflected in ED documents and policies. I therefore shifted my own language in interviews with this site to reflect this term, when appropriate. Additionally,

conversations within the interview often included direct discussion of language, such as inquiring into what particular terms (such as "vulnerable) mean within the particular ED site context.

Data collection took place between March and September 2021. All individual interviews were conducted by phone or online video conferencing using Zoom hosted by UBC. Interviews were audio recorded with consent, but were not video recorded. Demographic details (see Appendix D for demographic questionnaire) were collected during each interview, after audio recording was stopped. Audio recordings were transcribed by a professional transcriptionist and were checked for accuracy. Each participant received a $30 e-gift card for participating in the study in recognition of their time and contributions.

Professional and Institutional Texts

The examination of nursing professional and institutional texts was a key component of this study's aim to explore how the discursive context of the ED shaped nurses' enactment of equity-promoting practices. As discussed above, FDA understands such texts as making visible discourses that operate beneath individual practices; analyzing these texts therefore allows for an in-depth analysis of how discourse intersects with power to contextualize nurses' practices. Data collection of professional and institutional texts in this study's analysis occurred through three approaches: i) collection of key nursing professional documents; ii) collection of hospital/health authority policies as key institutional texts; and iii) inclusion of texts discussed in individual interviews. Firstly, nursing professional documents at provincial and national levels were examined, with the aim of identifying core documents guiding nurses' practices. As this study's research question focuses on nurses' enactment of equity-promoting practices, only documents pertaining to RN practice were examined, representing the predominant designation of nurses

working in ED settings (Canadian Nurses Association, 2022b). Texts were selected that were developed by central nursing regulatory and professional bodies, and that were articulated as guiding nurses' practices and nursing work. This included documents from the British Columbia College of Nurses & Midwives (BCCNM), the province's regulatory body responsible for "protecting the public through the regulation" of RNs, nurses within other designations, and midwives (2022). To uphold this responsibility, the BCCNM develops and enforces professional standards and competencies for RNs, which shape the practice of nursing within the province. As such, both the *Professional Standards* (2020) and *Entry-Level Competencies* (2021) documents were included in this discourse analysis. At the national level, RN practice is guided by the Canadian Nurses Association (CNA) *Code of Ethics* (2017). This document is described by the CNA as both an "aspirational document designed to inform everyone about the ethical values, subsequent responsibilities and endeavours of nurses" and "a regulatory tool", emphasizing that "nurses are bound to a code of ethics" (2022a). These key professional texts were selected as they specifically aim to shape, guide, inform, or regulate nursing practice, and thus reflect central discourses constructing the nursing profession and nursing practice in B.C. and Canada.

Secondly, the examination of institutional texts included each respective health authority's Mission, Values, and Mandate statements and public descriptions of the health authority, hospital, and ED found on each institution's websites. Additionally, I undertook a data collection process of health authority/hospital policies, guidelines, protocols, and other publicly available documents for each health authority. Policies (used here as an umbrella term to include associated texts listed above) are institutional texts specifically created to guide nurses' and other health care providers' practices and thus provide valuable insight into the institutional context of nurses' work. Many policies are made publicly available online by both health authorities (Fraser

Health, 2021b; Providence Health Care, 2021), and all available policies were screened for relevance to this study's aims. Specifically, policies were included in analysis that both shaped, guided, informed, or applied to nursing practice in the ED (implicitly or explicitly), and addressed issues of equity or aspects of health care delivery for people who experience structural inequities. Additionally, policies were included in which equity/inequity discourses were notably absent within texts addressing care for people who experience structural inequities, or in which intersections of discourse and power were evident. For example, a *Search of Inpatient Rooms and/or Belongings* policy did not explicitly address equity or inequities experienced by patients whose belongings are searched, but invoked discursive power in positioning particular patients as 'dangerous' and a 'risk' to others through their possession of particular items, including alcohol and other drugs. To determine inclusion of policies, all documents were read alphabetically within each respective online database, and were first screened by title, then introductory purpose/aim statement, then by full text if required. Two rounds of this stage of policy data collection were conducted: firstly, in advance of individual interviews to gain a broad understanding of the policy context of each site; and secondly, following individual interviews to capture additional policy documents that did not initially appear relevant but served to further contextualize interview data.

The final approach to data collection of institutional texts was the collection of any texts referenced by participants in individual interviews. In the interview guide for individual interviews (see Appendix C), participants were asked to identify "ways in which the ED has supported you and your fellow nurses" in providing care for patients who experience structural inequities, including through policies or other resources. Any institutional texts named here or at any point throughout the rest of the interview were noted, and participants were not asked to

provide any copies or documentation. If these texts not publicly available through health authority databases, access was negotiated with the site contact at each ED. For example, such texts included a *Resource Guide* document guiding nurses and other health care providers in developing care plans for individuals with high rates of ED visits, and a standardized *Discharge Checklist* for use by ED nurses with patients identified as "vulnerable". All texts obtained through each of these three approaches were included in the dataset for this study, and were analyzed alongside transcripts from individual interviews, as described below.

Data Analysis

All data, including interview transcripts and full text of selected professional and institutional documents, was input into an NVivo 12 ™ (QSR International, 2019) database for analysis. Extending from this study's FDA methodological approach, analysis of all study data was guided by Parker's (1992) approach to qualitative discourse analysis with the aim of examining how discourse shapes nurses' enactment of equity-promoting practices within the institutional context of the ED. As noted above, there is little methodological guidance for conducting discourse analysis, with most methodological texts examining the theoretical foundations and overall aims of discourses analyses as opposed to supporting the analytical process through detailed direction (Cheek, 2004; Lupton, 1992; Springer & Clinton, 2015). Parker's (1992) text *Discourse Dynamics: Critical Analysis for Social and Individual Psychology* however, offers practical guidance for qualitative researchers across the social sciences and health research, providing detailed support for undertaking data analysis through a critical discourse analysis methodological lens while integrating a range of critical theoretical frameworks. Intersecting with Foucault's (1980) theorizing that the analysis of power must begin in the "capillaries" of institutions, Parker's methodological guidance for discourse analysis

supports researchers in distinguishing discourses within texts, with particular attention to discourses that support institutions and reproduce power relations. As such Parker's guidance was used alongside Young's (1990) and Foucault's (1980) theoretical conceptualizations of power to shape approaches to data analysis within this study.

Parker asserts that discourses "both facilitate and limit, enable and constrain what can be said" (p. xiii), and thus articulates the aim of discourse analysis as distinguishing and defining discourses in text so as to identify and deconstruct power. A Foucauldian discourse analysis (FDA), as presented by Parker, invites the researcher to consider both power and discourse, while distinguishing between them in how they operate within institutional structures. While discourses reproduce power, to identify discourses only where power exists is to fail to examine discourses that challenge power and support resistance as a "refusal of dominant meanings" (Parker, 1992, p. 18). Thus, Parker positions discourse analysis as the process of identifying all discourses as they appear in text, including dominant discourses that reproduce and uphold power and oppression, and contradictory discourses that oppose and resist power structures. This study considers the texts – or the products of discourse, where discourses are made visible – to be both participants' talk within individual interviews and professional and institutional texts. To guide this process of identifying discourses in text, Parker identifies ten criteria for distinguishing discourses, which are described in Table 1 below. The first seven criteria are considered central to all discourse analysis processes, regardless of theoretical positioning of the researcher and research study. The final three criteria are described as auxiliary by Parker, to be applied to research that seeks to examine intersections of institutions, power, and ideology, such as through an FDA approach. As such, all ten criteria are considered instrumental to this analysis, which is foundationally concerned with dominant discourses within the institutional

context of the ED, and how discursive power operates through institutional processes and structures to shape nurses' practices.

Table 1

Parker's (1992) Ten Criteria for Distinguishing Discourses, with Summarized Analytic Approaches

Criteria	Analytic Approach
1) A discourse is realized in texts	A preliminary step to FDA; recognize texts as products of discourses and specify which texts will be examined.
2) A discourse is about objects	Identify and describe the 'objects' referred to in text: *what* is being referred to or represented through text?
3) A discourse contains subjects	Identify the 'subjects' or 'types of person' referred to in the text: *who* is being referred to? What can the subjects say and what can't they say? Which subjects are absent from the text?
4) A discourse is a coherent system of meanings	Draw on multiple interpretations and meanings of the text to analyze who the discourse benefits and oppresses. Aim to "map a picture of the world this discourse presents" (p. 12) through examining the text's system of meanings.
5) A discourse refers to other discourses	Identify how discourses intersect, overlap, and contradict one another within and across texts.
6) A discourse reflects on its own way of speaking	Reflect on the term/language used to describe the discourse. Elaborate on the discourse as it appears in text by examining other texts in which the discourse can be observed.
7) A discourse is historically located	Examine how and where particular discourses arose in the current social world and how they have shifted over time (i.e., been made visible or invisible, been replaced by similar or contradictory discourses).
8) Discourses support institutions	Examine how discourses are implicated in the structure of institutions. Identify institutional processes and structures that are reinforced or subverted when a particular discourse is employed.
9) Discourses reproduce power relations	Explore the intersections of power and discourse. Examine who or what benefits from the use of particular discourses, and how power shapes whether a particular discourse is upheld or diminished.
10) Discourses have ideological effects	Illuminate how dominant discourses "allow dominant groups to tell their narratives" (p. 20) and operate to subjugate other discourses. Explore how discourses intersect to perpetuate oppression.

Each of these criteria for distinguishing discourses addresses an aspect of discourse that can be illuminated through the analysis of text, and suggests analytic approaches for making discourses visible in text. While Parker's criteria serve as a guide for the analysis of text, each criteria may not be applied in the same manner for each text. Rather, the criteria reflect possible questions to ask of the data that guide the researcher in thinking analytically and comprehensively about multiple aspects of the text. The intent is not to present findings that replicate 'answers' to each of the ten criteria, but to draw on multiple approaches to interpretation that enrich understandings of how discourses operate in text to shape institutions and practices. Woven through the criteria is explicit attention to how power shapes discourse, which supports this study's critical theoretical perspective in examining how discourse and power intersect to construct institutional processes and structures, which in turn variously facilitate and constrain nurses' practices. Parker further guides researchers to consider discourses and practices as fundamentally reflecting one another, noting that "material practices are always invested with meaning (they have the status of a text)" (p. 15). Thus, both participants' talk and their descriptions of their everyday practices within the institutional context of the ED are analyzed as reflections of discursive power.

In applying Parker's discourse analysis to this study's data, I undertook an iterative process of reading and exploring data from individual interviews at each site and institutional and professional documents. This process of reading and re-reading allowed for identifying, distinguishing, and defining discourses within and across texts. For example, I read interview and institutional texts from each sites separately, then together, to examine how discursive power constructing the ED was reified in institutional processes and structures. Additionally, I examined nurses' interview texts as a distinct subset of the data, then read this data alongside

nursing professional documents and interviews with other health care providers to explore how discursive power shaping nurses' practices were situated in broader contexts of professional discourses and a complex ED setting. For example, nurses' talk expressing violence as "a massive concern" in the ED setting emphasized violence and risk as dominant discourses within this institutional context; side-by-side examination of nurses' talk with institutional texts such as *Violence Prevention* and *Violence Risk Alert* policies facilitated nuanced analysis of how this discourse was constructed, and how the discursive power of risk shaped nurses' practices.

Throughout data analysis and iterative reading of texts, organization of the data was supported by Nvivo 12 ™. The use of this software allowed for in-depth reading of texts in full alongside side-by-side analysis of texts through which particular discursive patterns were apparent. Broad discursive patterns were captured through "codes", or short-hand representations of a discursive pattern identified within and across texts. Three broad codes – *Context*, *Subversion*, and *Tensions* – were further nuanced with sub-codes, such as *Emergency & Lifesaving*, *Acuity & Triage*, *Subverting Institutional Systems & Norms*, and *Equity Deprioritized*. Codes captured dominant discourses distinguished in texts, contradictory discourses, intersections of discourse and power, and impacts of discursive power on institutional processes and structures and on ED nurses' practices.

Ethics

Ethics approval for this study was obtained through the UBC Behavioural Research Ethics Board (BREB), #H19-01027. Additionally, institutional ethics approval was obtained through both the Fraser Health Research Ethics Board and the Providence Health Care Research Institute. All members of the research team have completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – Course of Research Ethics (TCPS2:CORE)

(Government of Canada, 2022), which guides ethical practices for researchers in Canada. In this section, I further reflect on three key ethical principles and considerations, with discussion of how each was navigated within this study: consent, confidentiality, and navigating dual roles.

Consent

In all research involving humans, it is crucial to obtain informed consent from participants, including presenting information about the study, and benefits and risks, in advance of data collection. For all individual interviews, verbal consent was obtained from each participant prior to conducting the interview. The verbal consent process was used in this study as a means of navigating the complexities of entirely remote data collection (i.e., participants' lack of access to scanner technology), and in recognition of the capacity for ED nurses and other health care providers to understand the nature of their involvement in the research and provide verbal consent. Appendix E includes the consent form that was provided to all potential participants in advance of their agreement to participate in an individual interview. Every potential participant received a copy of the consent form a minimum of 48 hours in advance of the scheduled interview to allow sufficient time for review and asking questions of the researcher. Additionally, during each phone call or Zoom video session and before initiating the interview, I reviewed key details of the consent form with participants and invited questions. For example, I outlined the purpose of the study, protections for privacy and confidentiality, and potential risks and benefits of participation. I additionally emphasized that participation was entirely voluntary with no bearing on individuals' employment. Verbal consent was obtained at this point, in advance of beginning audio recording of interviews.

Confidentiality

In addition to addressing challenges of informed consent, ensuring confidentiality is an important ethical consideration in preparing to undertake this research. While high numbers of nurses are employed at each ED site (150 and 300 respectively), the limited potential sample for participant recruitment raises the possibility that individual participants may be recognized by unique characteristics or stories they recount (Kaiser, 2009). Given the interconnectivity between nurses and other health care providers within each ED site, individual interviews also raise issues of internal confidentiality – participants identifying other people through recounting their own experiences (Tolich, 2004). This was anticipated to occur both through participants recounting practices of other health care providers, and through participants sharing stories involving specific patients seeking health care in the ED. Further, as participants are discussing aspects of their work, it was anticipated that some individuals may identify concerns that their comments and reflections raised in an interview may affect their employment. These challenges highlight the importance of thoroughly attending to confidentiality throughout the study, particularly in the presentation of findings.

To attend to these confidentiality concerns, I firstly ensured that transcripts were "cleaned" to remove all identifying characteristics involving the participant themselves, or their colleagues or patients. At this stage, site names and details pertinent to each ED site were retained to ensure accuracy and clarity in data analysis. In the presentation of findings, I omitted all insignificant characteristics of participants, with the intention of referring to participants by their numerical identifier. Following from the work of other nursing research in which confidentiality was identified as a concern (Petrova et al., 2016), this included removing reference to a participant's gender, which was deemed not relevant to this analysis. Broad

individual characteristics to describe a participant were only used in instances in which it was relevant to contextualizing their talk, for example, describing a nurse as "senior" in their role. I additionally omitted key details of other persons described by participants, with the aim of removing as much detail as possible without compromising the central meaning of a recounted event or story. For example, this included using phrases such as "another health care provider" if a person's role was not contextually significant, or retaining only general details of a patient's health condition. Additionally, in the presentation of findings, the specific ED site where each individual participant was employed was not named. This supported the broader study aim of identifying how discourse shapes nursing practices across the broader context of the ED as a distinct health care space. Further, the blinding of participants' respective EDs supported confidentiality for both direct care providers and leaders. To further uphold confidentiality of the sites themselves, research sites are not named and institutional texts are not attributed to a particular study site.

As described above, due to the COVID-19 pandemic, all data collection was conducted remotely. Virtual data collection for qualitative interviews has the potential to enhance confidentiality, as participants are able to engage with researchers from their home or another private space of their choosing (Archibald et al., 2019). However, the use of technology to host individual interviews has been noted to pose challenges to privacy and confidentiality, including the ability to view a participant's home or surroundings through the Zoom video feature, and potential confidentiality and data security breaches stemming from the program's use of the 'cloud' and participants' the visibility of personal data (such as full names) on screen (Gray et al., 2020; Lobe et al., 2020). To mitigate potential confidentiality concerns with the use of the Zoom platform, all participants were informed that conducting interviews by phone was an

alternative option; ultimately, one interview was conducted by phone due to a participant's anticipated technological challenges. The consent form (see Appendix E) additionally noted that participants could choose to sign in using a nickname/substitute name rather than their full name, and that the interview could be conducted with or without video. Participants were reminded at the beginning of each interview (in advance of initiating recording) of these options, and that they could mute the microphone at any time. While most participants chose to have their video on to simulate a face-to-face conversation, some participants did not turn on their video, as they preferred to use the Zoom platform to mimic a phone call. Some participants did mute their audio at times, to speak with others present in their homes, to take an external phone call, or to change locations (for example, moving from the car inside to their home). To further support participants' confidentiality and data security, only local recording was enabled and no data was saved to the 'cloud'; further, only audio recordings (automatically extracted from the video by Zoom) were retained.

Navigating Dual Roles

As a part of my research work, I previously held the role of Site Coordinator for the EQUIP Emergency project, a five-year research intervention project that shares two of their study sites with this research and research team members (Bungay and Varcoe as EQUIP Co-PIs and Blanchet-Garneau as Co-I). My involvement with EQUIP Emergency was in many ways a strength. I was able to gain familiarity with each study site in advance of the COVID-19 pandemic, including the physical space and flow of patients and health care providers between care areas. Additionally, interpersonal connections between this research team and the EQUIP Emergency team supported navigating initial entrée to each ED site, such as facilitating early communications and meetings with nurse leaders at each site. However, it was also imperative

that I was transparent about my respective roles and in articulating this study as a separate research project within study meetings with nurse leaders and throughout recruitment and data collection activities, when appropriate.

My dual researcher role further raises broader questions of my position as insider/outsider more broadly in the ED sites (Sherif, 2001). In earlier scholarship, the concept of the insider-outsider dynamic addresses embodying both nurse and researcher roles, and studying a population *either* in which one is an insider or an outsider (Bonner & Tolhurst, 2002). However, most researchers characterize the insider/outsider dynamic as fluid and shifting throughout the research, with the researcher being simultaneously in insider and outsider positions (Burns et al., 2012). My own insider-outsider status in this research is likewise complex. I am an RN, and as such am recognized as a 'nurse' but not as a Registered Psychiatric Nurse or Licensed Practical Nurse, designations that are both represented in this study's sample. I have never worked in the ED setting, though I have worked in a different unit at one of the two hospital sites in this study. Other complexities in insider/outsider status can occur through research in which the researcher has some degree of prior connection – for example, throughout data collection, I was aware that nurses working in the sites have been my colleagues, peers in my undergraduate and graduate degrees, and former students of mine. Benefits of an insider position can include increased comfort on both the part of the researcher and participants, and potential increased intimacy between research and participants which may produce richer data (Bonner & Tolhurst, 2002). Indeed, I recognized that speaking nurse-to-nurse within individual interviews facilitated an ease in conversation, with no interruptions required for explaining medical terms or procedures. However, my outsider status as *not* and ED nurse led many participants to question whether I was aware of a particular institutional structure, policy, or process. While such questions

"interrupted" conversation and positioned me as 'outsider', they also contributed to the need for participants to explain such structures in their own words, rather than take shared understanding for granted. Indeed, insider status may cause a researcher to fail to recognize routine or normalized patterns and it may be uncomfortable for an insider to present data that critiques particular norms or practices. Burns and colleagues (2012) recognize that in health research, researchers often occupy a complex middle ground between insider/outsider, which characterized my own positionality within the two research sites.

Beyond my professional insider/outsider status, identity factors can shape insider/outsider positionality (Bucerius, 2013). Reflexivity necessarily involves examination of one's social location as an individual and as a researcher in navigating complex ethical considerations throughout the research process, and intersects with critical reflection to incorporates a lens of recognizing power as shaping relational encounters (Daley, 2010). For example, while I am a nurse and many of my participants were nurses, power and privilege may show up in my level of education. This was seen in one interview where a participant appeared unsure at one point in conversation and requested a "definition" of the term "marginalized populations" (as reflected in recruitment and other study materials). Rather than centre my own conceptualization, reflexivity and critical reflection on the underlying assumptions of this study and its methodological approach led me to attempt to recentre this participant's knowledge and expertise, and state: "that's a great question, but do you mind if I ask it back to you?" From this point, our conversation developed into a nuanced examination of what it means to "group people" and how different "barriers" to care may be variously experienced by patients seeking health care in the ED. While capturing just one instance of navigating power relations, this situation illustrates the importance of early and ongoing reflexivity and critical reflection on my own social location and

positionality in conducting this research, and the need to continually assert underlying assumptions in this study that position participants as experts. In this way, McCabe and Holmes (2009) articulate that within critical qualitative research, reflexivity can support emancipatory aims, extending the notion of reflexivity beyond issues of rigour and bias to further centre participants' perspectives and ideas.

Data Security

As this research study was conducted entirely remotely, with data collection occurring by phone or Zoom, all research data from this study is stored electronically. All electronic files, including audio recordings and transcripts, are encrypted and kept on a secure server. The institutional and professional texts included in this study are publicly available documents; however, these texts and documents capturing data analysis are stored in the same manner as interview files for consistency. Only members of the research team (Bungay, Varcoe, Blanchet Garneau, and myself) have access to study data accessible only by members of the research team. All research data will be kept for a minimum of five years, in accordance with University of British Columbia data protocol. After the five-year period, electronic files may be permanently deleted or may continue to be kept securely.

Any information that may identify study participants was removed from transcripts and other study documents. Each participant is identified within transcripts and files only by a numerical identifier (i.e., ID01), with the letter "L" used within identifiers to signify that a participant held a leadership role. To protect confidentiality, numerical identifiers do not include a representation of the ED site where each individual held a position. All demographic information provided by participants is stored in one password-protected document.

Rigour

Within discourse analysis, the intersections of discourse and power within a particular institutional context are recognized as complex and multifaceted, and thus, multiple interpretations of discourse are possible – even encouraged (Crowe, 2005). As such, a rigour framework is needed that both upholds the quality of research and credibility of findings, while also being responsive to the central tenets of critical theory and discourse analysis. This study therefore uses Noble and Smith's (2015) framework for rigour in qualitative research, which redefines the core components of rigour as: truth value, consistency, applicability, and confirmability.

Within Noble and Smith's framework, truth value is not grounded in a positivist view of truth, but rather acknowledges and addresses the multiple truths or realities that a researcher must identify, analyze, and reflect on throughout study activities. In applying the notion of multiple truths to discourse analysis, Parker (1992) asserts that rather than seek 'truth', discourse analysis aims to uncover what Foucault (1980) terms "regimes of truth". Discourse intersects with power to construct a façade of truth, and thus discourse analysis does not aim to uncover truth itself, but to identify how dominant discourses are reified within institutional processes and structures and are 'made real' through the practices that they shape. In this study, a central aim of using discourse analysis as a methodological approach is to explore multiple 'truths' of how ED nurses' practices are shaped by discourse within complex institutional contexts. To ensure that this exploration of multiple truths within complex contexts upholds methodological rigour, Noble and Smith encourage clearly and accurately elucidating and reporting participants' perspectives, while holding space for variations and contradictions. They note that a semi-structured interview approach, as used within this study, supports researchers in "remaining true"

to participants' experiences through allowing self-expression through open conversation. Further, the use of "rich and thick verbatim extracts" (p. 2) in reporting study findings grounds researcher interpretations in participants' own words, upholding the 'truth value' of research findings. Within a discourse analysis approach, language itself is its own form of 'truth' as it reflects and upholds discourse; as such, it was crucial within this study to make visible the interpretation of discourse by directly representing participants' talk as text within the reporting of findings. Lastly, truth value was upheld through side-by-side interpretation and analysis of multiple forms of talk and text across two ED sites. The identification of discursive power within one form of talk or text could be examined within a different context to, for example, confirm interpretations of how a particular discourse operated to shape practices within the institutional context of the ED.

Consistency is described by Noble and Smith (2015) as clarity and transparency of researchers' decision-making throughout the research process. The authors recommend identifying a process for maintaining a "decision-trail" to capture key aspects the research as they shift throughout design, data collection, and analysis. Taking up this recommendation, I kept a running decision-trail document that captured all decision points related to the research process, including in study design, ethical processes, recruitment, data collection, and data analysis. In this document, I reflected on my own decisions as a researcher including moments of reflexivity in approaches to theoretical positioning and the process of identifying discourses in text and talk. I also included decisions made collaboratively with each research site, capturing decisions in study sample and recruitment that led to particular sources of knowledge or inclusion of texts within the study dataset. Lastly, I incorporated decisions made among the research team, including those related to selecting study sites and undertaking recruitment, and

analytic decisions that guided the process of discourse analysis itself. Many such decisions have been reflected in this chapter, as suggested by Noble and Smith, and were continually available to reference throughout the data analysis process and presentation of findings.

Noble and Smith's notion of applicability in rigour refers whether findings apply to other contexts outside the research sites. Among other rationales, the decision to undertake a multi-site study and to analyze data both within and across sites was to enhance applicability of findings. That is, the aim of this analysis is to uncover broader findings about the nature of 'the ED' and to explore how central and shared discourses constructing the ED institutional context across sites in turn shapes notions of 'the ED nurse'. In this way, applicability of findings is woven into this study's analytic approach and presentation of findings. The applicability of this study's findings is further supported by "rich detail of context" (p. 2), which is explored extensively in Chapter 4. Rich descriptions of context situate study conclusions within a clearly defined setting and support future interpretations of applicability to other sites or contexts. In this way, findings related to 'the ED' within the particular socio-geographic context of Metro Vancouver, B.C., and Canada may be thoughtfully applied to other ED contexts within similar settings.

Lastly, confirmability refers to the acknowledgment that findings are "intrinsically linked" (p. 1) to the researcher's methodological approach and theoretical positioning. Thus, findings not only recount participants' experiences and perspectives, but also inherently reflect researchers' subjectivities and interpretations. One aspect of ensuring confirmability is regular engagement with other researchers to reduce bias and reflect on the interpretive analytic process. Indeed, in conducting data analysis and planning for the presentation of findings, I met frequently with my supervisor and dissertation committee to discuss data excerpts, explore and co-develop analytic frameworks including "codes", and to carefully consider how participants'

talk was represented through study findings within a broader researcher-developed methodological approach and theoretical framework. Noble and Smith encourage researchers to challenge assumptions made throughout data analysis – a process which involves both challenging one another within a research team, and engaging in reflexivity to challenge one's own assumptions. Discourse analysis explicitly aims to identify not only where dominant discourses appear, but also which discourses are contradictory and which are absent; as such, challenging assumptions about 'the way things are' is an inherent aspect of a discourse analysis process. As such, the process of undertaking discourse analysis inherently supports researchers in engaging with Noble and Smith's notion of confirmability and invites an iterative process of challenging assumptions both within texts and in our interpretation of texts.

Chapter 4: Findings – Discursive Context of Nursing Practices in the Emergency Department

This chapter is the first of three presenting study findings and focuses on the central discourses that construct the institutional context of the emergency department (ED) and shape nurses' practices within this context. Extending from this study's theoretical framework, findings from this discourse analysis of nurses' talk and institutional texts illustrate how discursive power in the ED institutional context constrains equity-promoting processes and structures and thus perpetuates inequities in health and health care. Discourses, the common set of assumptions that shape our social world, intersect with power to construct institutional processes and structures that reflect and uphold dominant discourses. Discursive power thus shapes nurses' practices within the institutional context of the ED, variously facilitating and constraining particular actions that either uphold or contradict dominant discourses. This study aimed to examine how discourse shapes ED nurses' enactment of equity-promoting practices, and to address this aim, this chapter explicates how discursive power constructs an institutional context of the ED that fundamentally shapes nurses' practices. Further, building on Young's (1990) framing of social justice, this chapter explores how dominant discourses within the institutional context of the ED constrain equity discourses and thus perpetuate inequities in health care. It is important to note that while this study does not explicitly aim to examine the multiple social and public health crises shaping the ED context and ED nurses' work, these findings are necessarily situated within the broader social context of the COVID-19 pandemic, the toxic drug supply crisis, the climate crisis, and the crisis of racism toward Indigenous people and people of colour in society more broadly and within health care specifically. Participants' talk frequently illustrated how

these crises shaped ED institutional processes and structures, and thus nursing work within this setting; such instances are woven throughout the findings chapters.

Firstly in this chapter, the sample is described, including demographic characteristics and professional designations of study participants and details of included institutional and nursing professional texts. Then, this chapter examines the discursive context of the ED through the exploration of two inter-related discursive patterns that shape the institutional context of the ED, and thus variously facilitate and constrain nurses' work. The first pattern examined here is the discursive construction of the ED: how discourse and power intersect to construct what the ED as a distinct health care space 'is' and 'does'. Through the construction of the ED setting, discursive power further constructs particular notions of 'the ED patient' and 'the ED nurse', with discourse revealing and reinforcing normative (i.e., commonly established and expected within a particular context) constructions of 'who' seeks care in the ED and the central work of ED nurses. The second pattern explored in this chapter is the discursive power of resource allocation, reflecting a distributive paradigm in which resources are allocated on the basis of what is deemed 'equal' and 'just' within a particular context. In this section, I explore how discourses of scarcity, preservation/distribution, and equality intersect within a distributive paradigm to direct and constrain nurses' practices in the ED space, ultimately perpetuating inequities for patients who seek health care in the ED.

The overall aim of this chapter is to establish the discursive context of the ED, with subsequent chapters examining how nurses engage in equity-promoting practices as subversive action within this discursive context and how persistent tensions between discursive power and equity impact nurses and patients within this setting. Here, *context* reflects the complex and dynamic nature of a particular environment, recognizing that discourse intersects with power to

construct and perpetuate institutional processes and structures, which in turn facilitate and constrain nurses' practices and actions within this setting. While individual nurses have agency within the ED space, institutional context fundamentally shapes which practices are supported and enabled, and which are constructed as unnecessary, problematic, or optional. How nurses' practices are variously enacted within this institutional context thus impacts how patient care is delivered, illustrating how discursive power operates through nurses' practices to create and perpetuate inequities.

After this chapter's examination of the discursive context of nursing practices in the ED, Chapter 5 explores these complex intersections of context, discourse, power, and equity through an examination of how nurses subverted discursive power to engage in equity-promoting practices within the complex ED context described here. Following, Chapter 6 explores in depth the persistent tensions between the ED discursive context as it shapes institutional processes and nursing practice, and nurses' engagement with the concept of equity and efforts to subvert dominant discourses through equity-promoting practices. This final findings chapter illustrates that despite nurses' enactment of equity-promoting practices as subversive action against discursive power, enduring institutional processes and structures limit and challenge both nurses' subversion efforts and institutional initiatives that aim to promote equity.

Sample

Participants

Thirty-three participants completed individual interviews, including 21 at one site and 12 at the other. Participants' ages ranged from 22 to 62 (M = 39.5, SD = 9.2). A majority of participants identified as white, while 39% identified as Indigenous or were considered racialized (i.e., experienced the attachment of particular constructions of race based on skin colour or

ethnic origins). Almost half of the participants had been working in the ED context for four years or less (see Table 2). Nurses, including Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs), Licensed Practical Nurses (LPNs), and nurses with these designations in leadership roles, represented the majority of participants (n=26, 79%). Years of experience in the nursing profession ranged from less than one to over 40 years. Twenty-one participants (64%) held direct care positions, including 18 nurses (including those with RN, RPN, and LPN designations). Two of these direct care nurses additionally held a specialty role of Addictions Assessment Nurse, a position created within both study sites to support people attending to the ED who have "substance use disorders" or "substance use concerns" (Fraser Health, 2021c; Providence Health Care, 2019b). As described in Chapter 3, nurses' talk within individual interviews illuminated the complex intersections of nurses' work with the everyday practices of ED social workers, particularly related to people who experience structural inequities; therefore, the study sample also included three social workers in direct care positions. Thirteen participants (40%) held leadership positions, which included Director, Manager, Clinical Nurse Leader, Clinical Nurse Educator, and Coordinator roles. Seven of the 13 leadership positions were held by RNs, and many of these nurse leaders also engaged in direct patient care as a part of their role. Most of the participants in this study (n=28, 85%) worked specifically within the ED, and the remaining five participants held positions in other departments within their respective health authority and had frequent engagement with the ED as a part of their work. This included representation from Indigenous Health, Violence Prevention, and Substance Use and Addictions programs. In each case, these programs intersected frequently with the ED, including through co-development of policies and resources, frequent movement of nurses between these programs and the ED, and direct engagement by program staff with ED patients (i.e., peer liaison roles).

Table 2

Demographic characteristics of study participants (N=33)

Characteristic	n(%)
Gender Identity	
Female	25 (76%)
Male	8 (24%)
Race/Ethnicity	
White	20 (61%)
Racialized & Indigenous	13 (39%)
Education	
Diploma/Certificate	3 (9%)
Bachelors	21 (64%)
Masters	9 (27%)
Role	
Registered Nurse	15 (45%)
Registered Psychiatric Nurse	2 (6%)
Licensed Practical Nurse	1 (3%)
Social Worker	3 (9%)
Leadership Position	12 (36%)
Employment Status	
Full-Time	24 (72%)
Part-Time	6 (18%)
Casual	3 (9%)
Time in Current Role	
<1–4 years	14 (42%)
5–9 years	8 (24%)
10+ years	11 (33%)

Among the 23 RNs who participated in this study, six (26%) identified as male, compared to only 10% of RNs in the province of British Columbia (B.C.), as identified by Canadian Institute for Health Information (CIHI) (2021e) health workforce data. The average age of RNs within this sample was 38.6, compared to 43.4 among all RNs in the province. However, 15% of RNs in B.C. are under 30, whereas only 2 participants (9%) in this sample were under 30. While 70% of the RNs within this sample were employed full-time, only 56% of nurses within the province are employed in full-time positions, with the remainder part-time or

casual. As of 2016, only 3% of RNs in the province held graduate (Masters/Doctoral) degrees (CIHI, 2016), compared to 19% of this sample (five participants). However, only one RN in a direct care position had a graduate degree, with the remaining four in leadership positions.

Institutional and Nursing Professional Texts

A total of 31 texts were included in this study's analysis, for a total of 384 pages of text. Five were nursing professional texts from three different nursing organizations: Canadian Nurses Association (CNA), National Emergency Nurses Association (NENA), and the British Columbia College of Nurses and Midwives (BCCNM). Nursing texts ranged in length from 23 to 54 pages. The remaining 26 documents were institutional texts. These included two Mission, Vision, and Values statements, one from each health authority represented by the study sites. Among the 24 institutional documents guiding nurses' practice, 17 were labelled by the institution as policies, three were guidelines, two were protocols, and there was one document and one form. These guiding documents ranged in length from one to 29 pages. As described in Chapter 3, each of these texts were selected for inclusion in this study as they intersected with the aim of this research to examine how nurses' enactment of equity-promoting practices was shaped by discursive power in the ED context.

Nursing professional texts were selected that explicitly aimed to guide nurses' practice in the national and provincial context, including documents presenting competencies, scope, standards, and guidance for ethical practice for RNs. Institutional texts were selected that discursively illuminated the guiding principles of health care provision (Mission, Vision, and Values statements), and those that were created to inform and shape nurses' practices within the hospital or ED setting (i.e., policies, guidelines, etc.). Many of these guiding documents were selected as they were explicitly mentioned by participants within individual interviews, and

others were selected through a comprehensive review of all institutional policies at each site as documents that intersected with equity and inequities in the hospital/ED setting. For example, an *Unsafe Sharps Support Plan* guideline was not explicitly mentioned by participants; however, discourses of risk within nurses' talk intersected with complex discussion of how nurses respond to patients who have drugs on their person in the ED, and thus this guideline was included to further nuance and illuminate institutional discourses that shape nurses' practice with people who use or are in possession drugs within the ED space.

The Discursive Construction of the ED

This section examines how notions of what an ED 'is' and 'does' are foundationally shaped by the intersections of discourse and power. First, I explore the construction of the ED itself as a distinct space within the health care system, in which discursive power creates and perpetuates particular institutional processes and structures. Following, I examine the construction of the ED patient within this space, with the aim of illuminating normative notions of 'who' the ED is 'for', and how patients who experience structural inequities are ultimately positioned as peripheral to the central work of the ED. This sub-section examining the construction of the ED patient concludes with the exemplar of violence prevention within the ED institutional context, which illustrates how dominant risk discourses reproduce inequities and frames particular patients as undeserving of ED care. Next, I examine the construction of the ED nurse, illustrating how discursive power operates through nursing practices to uphold central institutional processes and structures. The exemplar of triage illustrates how discourse and power intersect to shape how nurses' practices are variously facilitated and constrained, thus positioning nursing work as reinforcing power structures within the institutional context of the ED.

Construction of the ED Setting

Participants' talk describing the ED discursively constructs this setting as a distinct and unique space within the health care system. Firstly, the ED was framed as a semi-public space that serves "everybody" and is always open, with one nurse reflecting, "it's not like you can close the emerg!" (ID-L05). Nurses frequently reflected "we see everything" and "anybody can walk through our door", positioning the ED as constantly available and open to anyone who seeks health care: "we're a non-refusal site, which just means that we will be packed to capacity and the nurses will be exhausted but anyone who walks in our doors we can't redirect" (ID-07). As reflected in this language describing the setting, the notion of the ED as an 'open-door' semi-public space informed a central construction of the ED as an intrinsically busy environment. Participants in this study consistently referenced the "very busy" nature of the department, with "a huge volume of people" each day attending to the ED for health care. This continual influx of patients in the ED thus constructed an environment fundamentally concerned with the intersections of volume (the number of patients in the space) and flow (movement of patients through the ED to create space for the incoming patients). Regarding volume, the number of patients seeking care in the ED was not only recognized as considerable, but also as growing over time, reflected in comments such as: "we were running at like 250, 300 people a day. And our average is like 200… But to hit 300 and everybody was sick!" (ID-17). Such increases in volume were often attributed to the COVID-19 pandemic, although other public health crises including the toxic drug supply crisis and recent dangerous heat waves were also identified as playing a role in the rising daily patient numbers. This increasing volume shaped flow of patients through the space, with participants describing an environment of continual movement as patients shifted from initial triage assessment to waiting areas to treatment areas (i.e., beds,

stretchers, and chairs), and then ultimately towards discharge from the ED or admission to another care area of the hospital.

Against the backdrop of the ED as a highly busy space fundamentally shaped by volume and flow, the collective purpose of the ED as a distinct environment within the health care system reflected biomedical discourses, emphasizing the provision of emergency medical care for patients with "acute" physiological concerns. The construction of the ED as providing "medical" care was evident across participants' talk, consistently reflected in the language used to describe the ED, its central aims and activities, and the patient population seeking care in this setting. Nurses consistently discursively positioned patients' physiological needs as the central concern, as reflected in comments such as: "this is an emergency – we deal with acute situations, for example heart attacks, or strokes, and broken bones" (ID-04) and "I feel like emergency is accidents, traumas… we often get a lot of like sepsis type illnesses… a lot of cardiac issues" (ID-03). As seen here, nurses commonly framed patients' reasons for seeking care in the ED as their "presenting illness", or singular most important reason for seeking care, which was almost always identified as a physiological concern. The positioning of patients *as* their "presenting" physiological concern (i.e., 'we deal with heart attacks') further upholds the purpose of the ED as responding to and treating these physiological illnesses and injuries. Illustrating the dominance of intersecting biomedical and emergency discourses in shaping notions of the central work of the ED, participants consistently articulated the purpose of the ED as "saving lives" and providing critical care for the most acute of illnesses and injuries, characterized as "*emergency* emergencies". While participants acknowledged that most patients in the ED were not considered to be experiencing a true "emergency" (i.e., life-threatening condition), the notion of 'saving lives' reified emergency discourses by governing nurses' prioritization of care in a busy

environment: “Well, that’s very easy. It really is a life or death situation. It is life or limb… I don’t know that there’s any other way. And anybody else will have to wait” (ID-L04). The following section explores examines how the discursive construction of the ED – including the notion of emergency as ‘for emergencies’ – shapes how patients are variously constructed in this space.

Construction of the ED Patient

The dominance of biomedical and emergency discourses in this setting constructed the normative ED patient as an individual with physiological concerns requiring urgent medical care. Such individuals were positioned as appropriately utilizing the ED as a health care space, and were noted to therefore receive faster and more responsive care compared to people who do not fit the parameters of a normative ED patient, who may “end up waiting hours and hours” and whose “experience is absolutely horrendous” (ID-03). Troubling this framing of the normative ED patient was the construction of patients positioned as “marginalized” and “vulnerable” (captured as *marginalized/vulnerable* hereafter, to reflect participants’ language). The use of such terms was often quite vague within nurses’ talk, with participants using phrases such as “a pretty marginalized population”, “individuals who are marginalized”, “the vulnerable population”, and “vulnerable folks”. Yet, while explication of ‘who’ constituted a marginalized/vulnerable patient was vague, nurses’ talk revealed core characteristics and experiences that constituted patients as such: experiencing homelessness, living in poverty, using drugs, and experiencing mental health challenges. Often, these constitutive factors were conflated: “homeless… lots of mental health and substance use” (ID-L02) and

> We have people of all walks of life come in, but mostly the marginalized populations. Their needs are very complex – they have issues with basic needs like housing and food and hygiene. But their health issues are also quite complicated, like

> drug use and sepsis… They have a very chaotic sort of lifestyle so it can be really hard to access them and kind of give them care. (ID-18)

Such constructions of marginalized/vulnerable patients are further reflected in institutional text, with *Discharge of Vulnerable Patients* (April 2015; January 2021) policies at both sites defining "vulnerable patients" as including: "mental health/substance issues, homeless" (p. 1). Thus, across nurses' talk and institutional texts, patients with particular experiences were framed as marginalized/vulnerable. Such constructions perpetuated notions of such experiences and characteristics as 'clustered', contributing to very particular (and often stereotyped) ideas about 'who' was considered marginalized/vulnerable within the ED space.

Notably, nurses' talk consistently reinforced work with marginalized/vulnerable populations as a core aspect of the identity of the ED: "[this hospital] is kind of known for dealing with this population" (ID-10), "we have quite a bit of exposure working with the vulnerable population" (ID-04). Indeed, nurses at each site described their ED as "unique" within the geographical region related to this work and emphasized that such populations constituted a considerable portion of patients seeking care in the ED: "a fairly robust marginalized population" (ID-L02) and "I don't know percentage-wise, but I would say maybe two-thirds?" (ID-19). However, this section explores how the centring of this work was contrasted with the discursive positioning of such 'populations' as undeserving of ED care and contradictory to the dominant aims and priorities of ED service provision. Taken together with the positioning of the ED as "full" with patients and "urgent" physiological needs as the central work of the ED, discursive power framed patients constructed as marginalized/vulnerable as peripheral and less deserving of ED care, even as such 'populations' are articulated as constituting a considerable portion of people seeking care in the ED. Such contrasting discursive framings of patients constructed as

marginalized/vulnerable serves to create and perpetuate inequities that legitimize some patients' needs while positioning others as less than. In the following paragraphs, I discuss how such impacts of discursive power in the ED institutional context can be seen in nurses' talk regarding patients with less acute or chronic medical issues, mental health challenges, and social needs, who were consistently discursively positioned as outside of the core work of the ED, and whose needs were challenging – if not impossible or inappropriate – to address in this setting. As stated by one nurse, "In emergency, top priorities are immediate lifesaving… And so some other things can be pushed out to the edges because of that being so important" (ID-01).

Mental health needs were frequently identified as one such 'other thing' that was consistently framed as not constituting an 'emergency' and was therefore often not considered appropriate or possible to address in the ED setting. Nurses' comments often expressed the difficulties associated with caring for patients with mental health concerns in a system that centers acute physiological concerns, such as this nurse's reflection:

> …unless there's an acute psychosis or risk to self-harm or other harm, I don't really feel like I'm super proactive in addressing those mental health needs. I feel like even with medical needs, if we stumble upon a medical need that doesn't relate directly to what they came in for? We don't really address it. We are there to deal with the acute issue. We'll steer back to community support for anything that's not, like, life-threatening. (ID-12)

Here, language of "proactive" and "stumble upon" reveals the discursive power of biomedical and emergency discourses in shaping institutional processes and structures that centre the "acute issue" and position mental health as beyond the constructed norms of ED health care provision. Discourses shaping the ED context thus intersected with inequities (i.e., stigma and discrimination regarding mental illness) to perpetuate power structures that position mental health as a lesser health care need. Nurses' language describing the positioning of mental health

within the ED reflects and perpetuates inequities through suggesting that people with mental health concerns are less deserving of receiving health care in this setting. This relegation of mental health needs to health care services outside of the central structures of the ED is apparent in nurses' reflections on the lack of institutional support for ED nurses in providing mental health care, as seen in the following segment of talk:

> I know for the mental health piece, there are mental health support workers and stuff but I honestly don't really understand all that much, and I think it would be nice. I don't know if this is already in place or if this role is on us but just for somebody who can come around and just make sure that all the rights and stuff are read and to their best ability that they understand why they're certified… I don't think we do a very good job at it at all at [this hospital], the emerg nurses versus the psych nurses who are great at that. And I think it leads to a lot of anger and unnecessary code whites, to be honest. (ID-14)

While this individual describes having the support of psychiatric nurses and mental health support workers in addressing the needs of patients attending to the ED with mental health concerns, they also identify a lack of knowledge of how to communicate legal rights and the certification process and whether such conversations are "on us" as ED nurses. Here, dominant biomedical discourses support the construction of ED nurses as not requiring basic competencies and understanding of mental health care, and perpetuate inequities through positioning patients with mental health concerns as less important within the ED space compared to those with acute physiological needs.

Despite the pervasive claim that 'the emergency department is for emergencies', nurses identified that many individuals who attend to the ED do not fit the construction of the normative patient seeking care for a singular acute physiological issue. Despite the discursive positioning of the ED as a space for providing medical treatment for acute physiological concerns, nurses often recounted instances of people seeking support in the ED for concerns framed as "social":

> There's some people that are here for a medical reason where they're in pain or they're vomiting… But there are some people that come in with a social situation… I have people come in because they're substance users and they just needed a place to crash after they have used some substances. Or some people who are homeless, and even though they would give you a physical reason why they're there, you know that they're there because they just need a place to sleep. (ID-05)

This nurse's description of patients' "social situations" recognizes the potential for legitimate reasons for seeking support in the ED that fall outside of the expected acute physiological needs of the majority of the ED patient population. Yet, the suggestion that some individuals provide an invented physiological concern as a strategy for meeting their actual needs (i.e., temporary shelter or a safe place to rest after using drugs) further constructs the ED as an environment foundationally shaped by biomedical and emergency discourses. Such divisions between physiological and social reasons for visiting the ED serve to legitimize patients with 'true' physiological needs and position individuals with 'other' needs or concerns as undeserving of ED care. Individuals with acute physiological concerns (e.g., accidents, traumas, cardiac issues) were considered by nurses to be the central and priority population to receive care in the ED, and as such, people with social needs were constructed as undeserving of ED care. This discursive pattern was reflected in the following comment from a nurse:

> I feel like sometimes the best place for us to get impact and the best place for us to provide support for these marginalized populations is not in the emergency department. When people are here in the emergency department, they're here seeking emergency care and that should be kind of our first and foremost in providing… If we're talking about like the whole system… if you spend $50 of this kind of care in the emergency department you might have $20, $10 out of it in terms of value. If you are to spend it elsewhere, if you spend it in the community, I think you're gonna get much better response and much better buy back. (ID-11)

As seen in this individual's reflection on the use of ED services, nurses' talk illustrated a broader institutional context in which certain people – those constructed as marginalized/vulnerable – were positioned as not having 'legitimate' concerns and therefore as less deserving of ED care.

Yet, while the construction of ED patients as variously legitimate/illegitimate and deserving/undeserving was commonly reflected in nurses' language, some participants commented on ways in which the institutional context of the ED created and perpetuated inequities, variously impacting patients' access to and experiences of health care. Some nurses spoke of the inequities created and perpetuated within the health care system, recognizing that "not everyone has the same experience of health care" (ID-01) and that "the system sets people up for failure" (ID-19). Additionally, many nurses challenged the notion of the ED as an open, accessible semi-public space, noting that stigma, discrimination, and poor treatment within the health care system more broadly and the ED specifically presented considerable barriers for many individuals in entering the ED space and led to a feeling among some individuals of "'I'd rather die than go'" (ID-L08). The recognition of inequities within the ED space troubled dominant constructions of marginalized/vulnerable patients as inappropriately seeking care and thus less deserving. However, this framing of inequities in the ED was not consistently reflected in nurses' talk, which more often positioned patients identified as marginalized/vulnerable as having needs that are not well-served by the ED – and are thus less legitimate within this institutional context.

Exemplar: Violence Prevention

The institutional structure of violence prevention exemplifies the discursive process through which ED institutional structures perpetuate inequities by positioning particular patients as posing 'risk' and thus being less deserving of care. Nurses' talk consistently emphasized that violence was "a massive concern" in the ED, contributing to fears for personal safety and some individuals' decisions to leave ED nursing work. For example, one nurse described many of their colleagues as "feeling burned out and just being really broken down from the violence we see all

the time" (ID-14) while another identified violence as "a big obstacle to staff retention" (ID-L05). However, discursive power within this institutional context foundationally shaped *who* was positioned as posing risk. Across nurses' talk, language of "behaviour", "risk", and "violence" was frequently invoked in describing patients positioned as marginalized/vulnerable. For example, participants often made comments such as "some of the behaviour of the marginalized population can be a bit labile, can be a bit unpredictable, so we do violence prevention" (ID-04) and "they're living on the street… they're relying on drugs, and very behaviourally challenged" (ID-L06). In this way, patients and 'populations' identified as marginalized/vulnerable were positioned as problematic within the ED through the potential for violence and challenging "behaviours". Indeed, institutional policies related to violence and risk also discursively conflated violence with substance use, with one site's *Violence Prevention* policy's (November 2013) definition of "disrespectful and violent behaviours" including "apparent alcohol and/or drug intoxication" (p. 12). Further, a *Harm Reduction and Managing Substance Use* policy (October 27, 2021) directs staff to "not put themselves at risk by enforcing unit rules… See also: *Violence Prevention in the Workplace*" and emphasizes that "a harm reduction approach does not mean that patients may freely engage in challenging, disruptive or unsafe behaviours… (e.g., verbal or physical violence" (p. 1). As such, both institutional text and nurses' talk constructed the risk of violence as predominantly posed by patients framed as marginalized/vulnerable, especially people who use drugs.

Beyond framing marginalized/vulnerable patients as posing risk for violence, institutional processes and structures constructed to identify and manage violence further created and perpetuate inequities. The Violence Risk Alert/ALERT System at each respective health authority is defined in institutional policies of the same name as "the organizational process of

visually identifying persons at risk for violence" (May 7, 2019, p. 5) and "a communication policy, system and process to designate and flag clients who pose a potential risk of aggression towards workers" (February 2010, p. 1). The Alert involves the placement of physical and electronic symbols and indicators (typically purple, or purple and black) on a patient's electronic record, physical chart, privacy curtains, and bedframe with the intent of informing all health care providers and staff of the risk of violence. The talk of both nurses and leaders working in violence prevention roles reflected that the Violence Risk Alert system, as an institutional process, perpetuated the discursive power of framing particular patients as introducing 'risk' into the ED environment. As described by one individual, "the Violence Risk Alert, the nature of it itself is already biasing" in positioning particular individuals as a "risk" and others as "safe" (ID-L12). Further, nurses recognized inequities in the operationalization of the Violence Risk Alert, with patients situated as marginalized/vulnerable being more likely to be labelled as potentially violent. For example, one nurse illustrated how the discursive power of risk intersected with stigma and racism to variously position patients as "violent" or not. They described having frequently witnessed "young First Nations men upon discharge – the reluctant discharge turns into being dragged out" (ID-16), which was contrasted with a particular incident in which a patient who was "100 times discharged" refused to leave the ED:

> The patient said the most terrible things all day… We could have called the police and had her taken off the property, like we would have any marginalized person… [but] it was two people from our senior leadership who walked this woman out of the department… The patient was white and she was fully clothed in clean clothes… basically, she came from a different place. She got walked out, with her dignity intact. (ID-16)

In this example, and across nurses' talk, patients constructed as marginalized/vulnerable were readily positioned as posing risk for violence, whereas patients with relative privilege were rarely

constructed as a 'risk' regardless of their "behaviours". Notably, nurses recounted that individuals identified as violent were consistently asked to leave the ED, discharged in advance of receiving care, and escorted off the hospital premises: "sometimes we're quick to call security, to escort people out" (ID-12). In this way, health care provision was directly and tangibly impacted by the discursive construction of violence and risk within the institutional context of the ED, disproportionately impacting patients framed as marginalized/vulnerable within this setting.

As seen throughout participants' talk and institutional text, violence and risk was predominantly situated within the individual, with patients constructed as the 'source' of risk in the ED. In contrast to this dominant framing, some participants instead situated the drivers of violence at an institutional level. This was reflected in comments such as "I would usually see it as an unmet need… People are violent for a reason" (ID-L12), "that's a lot of times when violence happens… when they feel like we're discriminating [against] them" (ID-14), or "something triggered them" (ID-L04). However, this construction of violence as systemic was not supported by institutional processes and structures within the ED. Rather, discursive power supported the framing of violence as risk that individual patients bring into the ED space, jeopardizing the safety of health care providers. Through this discursive framing, patients framed as 'violent' are positioned as less deserving of ED care, and immediate removal from the ED space is constructed as appropriate action. Taken in context of the intersections of risk and discrimination, violence prevention thus served as a power structure through which inequities were constructed and perpetuated within the ED.

Construction of the ED Nurse

This section explores how, within the discursive context of the ED, nurses were widely identified as tasked with upholding the central aims of the institution, including upholding dominant biomedical and emergency discourses and their associated power structures through engaging in medical intervention for acute physiological concerns as the core nursing act. In this way, nurses' work further reified discursive power that constructed notions of ED patients as deserving and undeserving. Here, how other health care providers discursively constructed the nursing role provides a window into how nursing was positioned in the broader context of the ED. Participants in allied health roles, including social workers, consistently utilized the language of "the medical team" to reference nurses and physicians, positioning nursing work as reflecting and enacting biomedical discourses in the ED space. One social worker further illustrated the dominance of biomedical discourses in constraining nursing practices that respond to structural inequities: "I see and I work so closely with marginalized populations. *Their* ['the medical team'] mindset is medical. And that's where they're coming from. They don't look at the social part of it right?" (ID-06). Similarly, another social worker echoed, "there's a lot of social work role that actually picks up a lot of gaps and fallen pieces in terms of things that are not medical care" (ID-07). This discursively constructed division of medical versus social care within the ED setting was additionally reflected by nurses in the language used to describe their own practices and responsibilities:

> It is a large aspect of our job, to make sure people don't die, right? And then on top of that, there's all the other social issues and stuff like that. Which is still a huge part, but our priority number one is to make sure that they're surviving, which is the medical stuff. And then after that, once they've stabilized, then you can focus on other stuff. (ID-10)

In positioning the work of lifesaving as "our job", this discursive framing of nursing work perpetuates medical intervention as constituting normative nursing practice and situates "other social issues" as secondary to this aim.

Analysis of nursing professional documents illustrates that this framing of medical intervention as the core of nursing work contrasts with the disciplinary positioning of nursing, illustrating the discursive power of biomedical and emergency discourses in shaping nursing work within the ED setting. For example, the CNA (2015) *Framework for the Practice of RNs in Canada* states that nurses "focus on wholeness, considering the biophysical, psychological, emotional, social, cultural and spiritual dimensions of the client" (p. 6). Here, the positioning of social, cultural, and other dimensions of a patients' 'wholeness' alongside the biophysical is in stark contrast with the framing of these aspects of care as the "other stuff", as articulated by ED nurses. Similarly to the CNA *Framework*, the CNA (2017) *Code of Ethics* states that nurses "recognize the social determinants of health in their assessments, diagnoses, outcomes planning, implementations and evaluations" (p. 10) and "take into account… social and economic circumstances" in patient "treatment and care" (p. 12). While these texts position nursing practice as necessarily integrating medical treatment with the social determinants of health, the constraining of nursing practices to medical intervention within the ED reflects how discursive power foundationally shapes nursing practices within this particular institutional context.

The discursive positioning of ED nurses' work with Indigenous patients exemplifies how nurses' role in promoting equity was discursively articulated as peripheral to nurses' role within this context. Further illustrating discursive power as shaping constructions of 'the ED nurse', comparison of nursing professional documents and nurses' articulation of their practices in the ED illustrates how dominant discourses construct tensions within the ED nursing role and

perpetuate inequities in health care for Indigenous patients. The CNA (2017) *Code of Ethics* articulates that nurses "recognise the unique history of – and the impact of the social determinants of health on – the Indigenous Peoples of Canada" (p. 4) and "take actions with Indigenous people to improve their health services" (p. 19). However, within the ED institutional context, normalized notions of ED nursing work as "medical" intersected with stigma and discrimination to position Indigenous patients' identities and needs as peripheral. This is seen in nurses' discursive framing of the challenges of consulting Indigenous peer liaisons to support patient care in the ED:

> When you have a medical issue, it's easy for us to kind of just hone in on that and just solve that medical issue first cause I think that that's something we're more familiar and more comfortable with dealing with. When [Indigenous patients] are on the acute side [of the ED] and have a presenting medical complaint, the Indigenous side of things kind of gets put on the wayside. (ID-11)

This nurses' use of language to frame Indigenous wellness programming as "extra" and less "familiar" and "comfortable" for ED nurses echoed many participants' talk, and perpetuates the normative construction of the ED nurse as "the medical team" concerned predominantly with medical intervention. Further, discursive power in the ED context reinforced the constraining and subordination of nurses' practices of engaging with Indigenous patients' "social, cultural, and spiritual" (p. 6) needs as articulated in the CNA *Framework*. In this way, ED nursing practice was foundationally shaped by power structures that position equity – including culturally safe care for Indigenous patients – as outside the central practices and responsibilities of the ED nurse role; in turn, nursing practices perpetuated these structural inequities and upheld institutional power structures.

Exemplar: Triage

Within the institutional context of the ED, discursive power shaped which nursing practices were facilitated and which were constrained, positioning nursing work as perpetuating and reinforcing power structures. The triage process serves as an exemplar of how discursive power constructed the role of the ED nurse. Participants described that a certain number of nurses per shift were assigned to the triage role to assess patients entering the ED space, with this role involving identifying their "presenting illness" and following, determining their relative priority for receiving care. In this triage process, nurses use the Canadian Triage & Acuity Scale (CTAS), which is mandated for all EDs in Canada, including the two study sites. As described by participants, CTAS is a five-point scale used for each patient who seeks health care in the ED to determine "the acuity of their illness" using criteria such as a patient's stated symptoms, vital signs, and "risk factors" in their medical history. While one nurse acknowledged that "there's some subjective stuff that goes in", participants consistently emphasized that CTAS directs nurses to consider predominantly objective measures related to the patient's current presenting illness: "It's oftentimes 'what's their breathing?'… It doesn't go into a lot of the other things" (ID-03). Indeed, the use of CTAS was articulated as specifically intended to disregard contextual factors of a person's history (i.e., of chronic illness) or present experience and instead focus on who is "not sick", "sick", and "sickest". Further, the CTAS process was described as intended to strictly apply the standardized assessment across all patients, regardless of the actual present conditions of the ED or how patients may be best served within the space:

> You always triage based on the person sitting in front of you, not based on what resources you have available. So it's tempting to say, "well [one area of the ED] is not busy at all, and the acute side's really busy"… But you're not supposed to triage based on where you can find a space, you triage based on what the person's complaint is sitting in front of you and where they need to be. (ID-18)

In this way, the intersection of biomedical and standardization discourses served to reduce patients to the designation of "sick" and "not sick", and position nurses as responsible for upholding institutional power structures to delineate patients within this constructed division. Further, nurses were directed by CTAS to manage the institutional construct of flow by positioning and treating patients in 'appropriate' care areas within the ED, regardless of the current conditions within the space.

These described practices of maintaining rigid triaging practices within a complex, dynamic environment illustrates how discursive power positioned nurses as responsible for managing and enacting central institutional processes and structures. Further, the triage process reveals the ways in which institutional processes produced power relations between nurses and patients, thus perpetuating inequities within the ED setting. Participants reflected that in the triage process, patients were "supposed to say one word, 'abdominal pain' or whatever – but often they start the story and they're shut down" (ID-17) when trying to tell their stories of illness and injury or describe their concerns in any detail. Reflecting the discursive power of triage, one nurse leader articulated that the "amount of responsibility on that nurse to make decisions about who's in the crowd" shapes triage into a process directed by nurses, which patients "don't understand" and cannot meaningfully contribute to:

> I need you to answer my questions, and I don't have time for whatever else you might want to talk to me about right now. And not because I don't care and not because it's not important but because I've got a very clear function that I need to carry on right now, to make sure that I get you going in whichever way you need to get going and I need to get on to the next person. It's that unintended impact, the triage nurse doesn't even realize that they're having, right? (ID-L08)

The positioning of triage as a "very clear function" of the ED reflects the ways discursive power shaped nursing work as the enactment of institutional power structures. Moreover, the notion that

patients contribute "one word" to the triage process illustrates power relations at play in this environment, constructing a framework for nurse-patient engagement that centres nurses' knowledge, expertise, and decision-making while constraining patients' agency in sharing their own narrative of seeking health care in the ED space.

These power relations further intersected with stigma and discrimination to position nurses as the enforcers of who is considered deserving and undeserving of care in the ED space. A patient's CTAS score was articulated as determining their movement through the ED, including the area of the ED in which they will receive care and how quickly they will move from the waiting room to this care area and be assessed by nurses and physicians. Thus, triage had considerable implications for wait times and duration of stay in the ED. In this way, the institutional process of triage as a power structure enacted by nurses served to disregard and further perpetuate inequities through prioritizing the care of some patients over others and particular aspects of a person's history and experiences over other considerations. The following segment of nurses' talk illustrates how standardization of the triage process perpetuates inequities:

> You're isolating seemingly "looking well" people because you think they have COVID… So you have to put them in an isolation space in their own bed and in their own space. And then you have a 70-year-old First Nations lady who came in and maybe had a fall and has hip pain and you think she has broken hip. She sits in the hallway because that bed is taken. (ID-16)

While this particular example reflects the specific COVID-19 context, nurses' descriptions of triage often reflected similar inequities resulting from the application of CTAS' rigid structure. As noted by many participants, contextual features such as age, ability to wait for extended periods of time in a chair, and history of discrimination and poor treatment in health care settings were not integrated into a CTAS assessment. Within this context of standardization, nurses had

limited avenues for responding to inequities or "justifying why it is that people need a bed versus sending them to a lower acuity area where they don't get a stretcher" (ID-05). As such, while CTAS was constructed as a standardized assessment promoting 'equal' assessment and care delivery for ED patients, triage in fact perpetuated an institutional context in which nursing practices that support power structures are normalized, while alternative decisions and practices that do not align with dominant discourses must be "justified". While many nurses grappled with the inequities inherent in the standardized institutional process of triage, their talk reflected how discursive power constrained nurses' agency in practicing differently: "I was so naïve before, like there's got to be [an available bed] – this is a vulnerable woman! But there aren't" (ID-14). As a whole, triage illustrates how ED nurses were constructed as foundationally responsible for upholding the central institutional processes and structures of the ED. The operationalization of discursive power through nursing practices further served to construct who is deserving of timely and responsive care in the ED, and whose concerns and needs were positioned as less important.

The Discursive Power of Resource Allocation

This section examines the discursive power of resource allocation within the institutional context of the ED, illustrating how the ED space was foundationally shaped by the distributive paradigm, which conceptualizes health care as a collection of 'resources' and shapes how such resources are distributed. Within the ED, the discursive power of resource allocation was upheld through three interconnected discourses, each of which are explored within this section. Firstly, scarcity discourses in nurses' talk advanced the notion that both physical and intangible resources (e.g., both beds and nurses' time) were insufficient to meet the demands of the ED in context of high volumes of patients and acuity of patients' health care needs. Intersecting with notions of scarcity, preservation/distribution discourses positioned nurses as responsible for

upholding institutional aims of conserving and allocating resources 'appropriately'. Finally, this section examines how equality discourses operated within a distributive paradigm in the ED institutional context to construct who was considered deserving and undeserving of scarce resources, illustrating how discursive power upheld equality and thus constrained equity.

Scarcity

Within the ED setting, the discursive power of resource allocation was foundationally shaped by notions of scarcity. Nurses' talk frequently referenced the restricted physical space of the ED environment, describing "super full" waiting rooms and limited chairs, stretchers, and beds relative to the volume of patients. Beds in acute care and assessment areas of the ED were articulated as particularly limited: "I feel like it's always a fight for an acute bed" (ID-05). Beyond the limitations of physical space in the ED, health care providers were likewise discursively positioned as a scarce resource. Nurses described constantly "working short", without sufficient staffing relative to the volume of patients. With high numbers of patients seeking health care in the ED, the availability of health care providers across all designations was limited: "…[not] enough nurses, physicians to look after them. Lab techs, X-ray techs, just not having enough staff… You run out of room after a while" (ID-18). The scarcity of both physical and labour resources was described as considerable at baseline, and further exacerbated by social and public health crises. In the context of the COVID-19 pandemic, already "full" waiting rooms were described as further constrained by physical distancing requirements, which "cut the seats in half" (ID-10). Additionally, infection control protocols for COVID-19 positive patients were described as creating "a revolving door in the isolation rooms" (ID-L04), though extremely high volumes of patients with positive or suspected COVID-19 infection occasionally resulted in the creation of isolation zones in ED hallways. The toxic drug supply crisis was further noted to

intersect with scarcity discourses in the ED: “With the triage hallway, the overdose crisis began and we had too many people, so we would put people in chairs… People need more than chairs. It turned into a care space, which is horrific” (ID-17). Nurses further described recent heat waves as nearly doubling the numbers of patients in the waiting room, which further challenged how nurses “juggled” patients across care spaces. Nurses’ talk related to each of these crises revealed that the ED was discursively positioned as a collection of resources and that underlying notions of scarcity shaped how such crises were experienced within this institutional context.

The framing of ED resources through a scarcity lens reflected not simply the raw numbers of beds and nurses, but rather the availability of such resources relative to the volume and acuity of patients within a variable and complex ED context. As such, resource scarcity discourses served to position patients as the ‘problem’. This was apparent in participants’ use of language, such as describing patients as “taking up a hospital bed” or “taking up our last stretcher”. The positioning of resources such as beds or stretchers being ‘taken up’ by patients rather than ‘used’, ‘occupied’, or ‘needed’ illustrates how discursive power operated to construct space as a resource owned and controlled by the ED. This was further enforced through descriptions of triage nurses as being “protective of *their* beds” (emphasis added). Scarcity of ED resources was thus made attributable to patients as a collective (i.e., high volumes), but also patients as individuals, intersecting with inequity, stigma, and discrimination. Scarcity discourses were frequently employed related to patients whose reason for seeking care in the ED related to their use of drugs, for example. This was reflected in comments such as: “if they’ve had an overdose and they just need more sleep, it’s like… they don’t need to be taking up a hospital bed, right?” (ID-08). Indeed, the discursive framing of people who use drugs as “taking up” – or inappropriately using – hospital resources was common. Another nurse described a frequent

event of patients "who come in at 3 in the morning with, you know, 'stomach pain', and obviously they're just looking for a safe space to sleep", and articulated that the attitude held by many ED nurses was, "'ugh, they're just here taking up a bed and it's thousands of dollars every time there's a person in the emergency department'" (ID-15). This notion of "bed-seeking" was reflected across interviews, positioning particular patients as 'inventing' health care concerns to inappropriately secure a bed in the context of scarce resources. As articulated by one nurse regarding limited space resources in a particular care area of the ED:

> There's only five seats… And that's where a lot of these people end up when they're looking for beds, because they don't have serious concerns. Sometimes it'll be a blister on their toe that they want to see the doctor or a mole that has been there for three years that they want somebody to see… And there's not that many spots available. (ID-10)

Here, and across nurses' talk, language such as "looking for beds" and "don't have serious concerns" illustrates how discursive power of scarcity served to perpetuate inequities within the ED, constructing some patients as less deserving of hospital 'resources'.

Preservation and Distribution

Against the backdrop of scarcity discourses, the discursive power of resource allocation was upheld through nursing practices of preservation and distribution. Illustrating resource preservation as a dominant discourse in the ED, nurses described their own practices as foundationally shaped by a perpetual awareness of managing the continual flow of patients into the ED, in context of the limited resources available: "On a busy day, all of your rooms are full and then you have more [people] coming in the door… you're just trying to get [people] through the process as quickly as you can" (ID-01). This notion that nurses held responsibility for upholding efficiency and preserving resources within an overburdened system was echoed across participants' talk. This was reflected in comments that discharging current patients to preserve

space for incoming patients was crucial for maintaining the flow of patients through the ED: "We have to move the patients quickly so we can get more… Sometimes I think it's too quick, but I can understand. It's emergency, of course you have to work like that" (ID-02). The suggestion that preserving resources with the intention of managing flow can result in moving patients "too quickly" illustrates that the discursive power of resource allocation constructed the ED as a space governed by institutional power structures enacted through nurses, rather than shaped by patients' needs. Further, the discursive power of resource preservation intersected with stigma and discrimination to perpetuate inequities within the institutional context of the ED. This was reflected, for example, in nurses' talk related to patients who need to briefly leave the ED while seeking health care to prevent withdrawal by smoking or using drugs offsite, illustrating how power structures constrained this practice:

> You try the best you can, but flow is flow. And sometimes we'll make promises to patients that change in that next hour, two hours, four hours, as [emergency] departments can be dynamic. And it also depends on the people working – some people are much more hardline to push flow and to see additional patients. And some are, depending on the case of the day, we are maybe a little more lenient… (ID-11)

Here, language of "it's emergency" and "flow is flow" illustrate ways in which resource preservation foundationally intersected with efficiency discourses to shape nursing practices within the ED context. Further, such comments illustrate how discursive power constructed institutional processes and structures that created and perpetuated inequities, upholding institutional priorities over individual patient needs. Depicting people who need to leave the ED to meet their needs as subject to nurses' decisions to take either a "hardline" or "lenient" approach further illustrates how power relations were perpetuated in the ED through constructing patients who use drugs as disruptive to central institutional processes and therefore less

deserving of a consistent commitment to safe care, not dependent on individual nurses' 'leniency'.

In addition to preserving resources, determining the appropriate distribution of resources was articulated as central to nursing work in the ED context. In some cases, this discourse of resource distribution was employed to frame the allocation of physical resources, such as beds and chairs in various care areas across the ED. This was reflected in nurses' talk related to the triage process, which was positioned as supporting nurses in assessing who is "sick enough or unwell enough to warrant a space" (ID-18), with those deemed to not 'warrant' the use of such resources being sent to the waiting room. Further, the waiting room space was also noted to require careful allocation, constructing the entirety of the ED space as a resource carefully managed by nurses: "you want to try to keep the amount of people in the waiting room to the minimum" (ID-10). With beds, stretchers, and ED space positioned as resources requiring 'protection' from unwarranted and inappropriate use, the discursive power of resource allocation was consistently articulated as the pressure to discharge patients whose care was considered – by health care providers – completed. Illustrating this pressure to discharge to uphold institutional processes and structures, the following segment of a nurse's talk describes their thought process while providing patient care:

> I need to be constantly checking, "is their lab work back?" or "is this radiology report back?" and then talking to the physician: "hey can we move this [patient] through?" Because if they are sitting and waiting for no reason then they are taking up a space that another person probably needs. I think as the rooms fill up you get that sense of urgency… (ID-01)

Echoing this 'sense of urgency' to discharge patients, other participants' language similarly reflected efficiency pressures to "open up beds", "send them on their way", or "find them somewhere to go, help with bed congestion". Such pressures, shaped by the discursive power of

resource distribution, further intersected with emergency and lifesaving discourses to construct some patients as less deserving of ED care. Such framing is seen in the following comments from a nurse, who recounted that individuals living in poverty and experiencing homelessness

> will come in – especially like on a rainy night – and they need IV antibiotics, they need wound care done, but they also end up in a bed. And then they get the care that they need and then they don't want to go. And then you're ending up like trying to persuade them or calling security. And I mean that hurts the relationship, but reality is that we're there for emergencies and once things are done, we need to move people along. (ID-12)

In this segment of text, medical interventions of IV antibiotics and wound care are discursively positioned as constituting as appropriate allocation of ED resources (i.e., a bed), which is juxtaposed with the notion that nurses – and not patients themselves – determine the "care that they need" and distribute resources accordingly. Reflecting how discursive power positioned nurses as responsible for upholding institutional processes and structures through decision-making regarding the distribution of resources, another nurse described that in working with patients who have experienced a drug overdose, nurses can elect to be "a nice nurse" or "a meanie who wants to kick them out immediately, which I see all the time" (ID-15). In this way, resource allocation discourses operated to facilitate and enforce nurses' practices of 'immediately' discharging patients in instances when they perceive a bed as being inappropriately utilized by an individual deemed undeserving of this resource, thus perpetuating inequities within the ED institutional context.

Beyond framing physical resources as requiring appropriate distribution to uphold central institutional processes and structures, nurses' time was positioned as an intangible resource within the distributive paradigm of resource allocation:

> Sometimes you really do want to spend the time to get to know the patients. Because some people come in in a mental crisis or a psychological crisis, and honestly

> sometimes all people need is someone to sit and hold their hand and listen to them. And it's difficult because I don't have the time to do that… And it doesn't feel like you ever have enough time to make anyone feel comfortable before you have to move on to the next person. (ID-05)

In this segment of talk, this nurse's articulated personal desire to "get to know the patients" was eclipsed by dominant resource allocation, scarcity, and efficiency discourses that constructed institutional priorities of "moving on to the next person", and by biomedical discourses that position "mental crisis" as constituting a lesser need compared to physiological concerns. Similarly, another nurse reflected that while they "try to not let myself feel too rushed" with patient education, the busy nature of nurses' work in the ED means "you also can't have a 30-minute conversation" (ID-01). Echoing this language, comments such as "nurses don't have the time" and "not a good use of their time" were frequent, reflecting a distributive paradigm that positioned time as a resource that must be appropriately allocated to uphold institutional processes and structures. As such, nurses' practices themselves were thus fundamentally shaped by discursive power, and nurses were constrained in using their time to engage in practices they may identify as responsive to patients' needs for emotional support, education, or building trust and rapport. Rather, nurses' time was constructed as a resource to be managed through the lens of dominant discourses shaping the institutional context of the ED.

Equality

The discursive power of resource allocation further constructed an institutional context in which inequities were reconceptualized as disparities or inequalities; rather than recognizing and responding to structural contributors to inequitable experiences of health and health care, the distributive paradigm positioned the aim of health care as creating 'equal' experiences. As examined above, people who experience inequities in the ED setting often experience inverse

care, as read through the paradigm of resource allocation: receiving the fewest resources despite considerable need for safe and competent care. However, discursive power in the ED constructed *equality* in care as a central aim, while positioning *equity* as impossible within institutional processes and structures. Indeed, equality discourses were frequently invoked through participants' language when describing the allocation of both physical and intangible resources. For example, one participant described the guiding ethical approach of their practice as "do no harm, treat everyone the same – there's that equality bit" (ID-L10). Similarly, another nurse's talk reflected how equality discourses constructed nurses' practices as attempting to "maintain the equality of it", with the stated example of attempting to "treat everyone the same in a waiting room":

> Whether they're someone who you can tell is quite well-to-do and they're wearing nice clothing and then they're sitting beside someone who is not wearing a shirt and they smell, offering both a cup of water, ask them how they're doing, asking a follow-up question for both of them. Just so this is a place where everyone will be treated as a patient who is here to receive care, nothing more. (ID-20)

As seen in this nurse's example, the discursive power of resource allocation constructed equality as the aim of nurses' practices. Consequently, equity was discursively framed as not possible to uphold within the institutional context of the ED. This same nurse whose comments illustrated how discursive power upholds equality within nursing practice further reflected: "So what does equity mean?... Equity would be there'd be more resources, they would end up getting further treatment. But they don't" (ID-20). These competing discourses of equality and equity were similarly echoed the following segment of talk, which illustrates the complexities of grappling with competing discourses of equality/equity in the ED context:

> One of the things about equity is that we're not just treating people all the same. Because I think when I started in emergency department, that's kind of the old school motto, right? "We treat everybody the same"… So I think this concept of equity is

> not always clear, and it's not always clear how to reconcile that with that thought of, you know, as an emergency department in order to prioritize our resources, we can't always achieve equity. (ID-L05)

Here, and as reflected across nurses' talk, discursive power shaped how nurses employed equality and equity discourses within the institutional context of the ED, and what practices were recognized as possible and not possible. While the distributive paradigm facilitated nurses' management of the 'equitable' distribution of resources, equality discourses obscured the recognition of structural inequities beyond potential misallocation of ED resources. This resulted in the construction of an ED context in which nursing practice was not responsive to individual patients, but rather aimed to achieve 'equal' distribution regardless of actual need.

Chapter 5: Findings – Subversion Through Nursing Practice

Chapter 4 examined the dominant discourses that shape institutional processes and structures in the emergency department (ED) institutional context, facilitating particular nursing practices while constraining others, ultimately constituting discursive power that perpetuates inequities. In this chapter, I explore how nurses subverted discursive power through drawing on key contradictory discourses that enabled their subversive action and shaped how these practices were enacted. Subversion is conceptualized here as actions undertaken that aim to disrupt discursive power and the production and reproduction of inequities perpetuated through dominant discourses within the ED institutional context (Young, 1990). Firstly, I describe how nurses subverted power structures in the ED institutional context through employing equity discourses to engage in equity-promoting practices in contrast to the normative nursing practices facilitated by and upholding dominant discourses. Next, I describe how nurses subverted discursive power through relational engagement. In doing so, I examine the positioning of relational engagement as a dominant discourse within the nursing profession, and how this discourse – situated as a contradictory discourse in the ED context – was employed to subvert dominant discourses and to respond to structural inequities. I then demonstrate how the challenges of engaging in subversive action within institutional power structures impacted nurses, including contributing to exhaustion and burnout.

Equity as Subversion

This section examines how nurses employed equity discourses to inform their engagement in equity-promoting practices as subversive action against discursive power in the ED, thus positioning equity as subversion within this institutional context. Firstly, I illustrate how discursive power devalued equity discourses in the ED, demonstrating that nurses'

engagement in equity-promoting practices was not inherently supported by dominant discourses. Next, I describe how nurses drew on equity discourses to subvert discursive power. I conclude this section with the exemplar of social admissions – the practice of permitting some patients to stay in the ED space for 'social' or non-medical reasons – to illustrate key discursive mechanisms through which nurses' equity-promoting practice subverted power structures.

The Discursive Devaluing of Equity

Discourse analysis involves the examination of not only the dominant discourses present in texts, but also the discourses that are contradictory, marginalized, and absent. Within the institutional context of the ED, equity discourses were noted to be largely absent from institutional texts, processes and structures, and inherently devalued within this health care setting. When asked to describe supports within the ED for nurses in "promoting equity" or working with "marginalized populations", participants' responses consistently reflected both a lack of awareness of supports as well as an actual lack of equity-promoting institutional processes and structures. Statements such as "I honestly can't think of anything", "I haven't actually heard of anything", and "I honestly can't think of anything specifically that our leadership has proactively offered" were common, and many participants directly commented that the ED offered "no real extra training" and "nothing formalized, in terms of resources". For example, the following comments from an ED nurse illustrate the 'gaps' in equity-promoting processes and structures:

> In our emergency training we touch briefly on vulnerable populations… It doesn't really cover that social aspect, a vulnerable person's care. That's the gap in the system really. It would be really, really helpful to have some kind of training in that or other resources… There's no formal way to disseminate that information to all the staff. It's kind of like some people have access to that information and some people don't. (ID-03)

While some nurses noted that information related to equity and inequities was "covered somewhat" in orientation, most nurses reported an absence of these conversations, stating "I don't think there was anything". Beyond orientation, nurses' comments similarly reflected a lack of equity-promoting continuing education and professional development, with the absence of such structures noted to be "a lack" and "a gap" in the ongoing education and training provided to ED nurses. Beyond orientation and continuing education, policy was an additional institutional structure in which equity discourses were largely absent. At one of the health authorities represented in this study, there were no identified policies that reflected discourses of equity, social justice, or inequities. Rather, the language of policies often reflects equality discourses, such as the *Sacred Space* policy's direction that the space should be "accessible to all" and "maintain a neutral décor and neutrality in religious detail" (p. 2). While the *Respectful Workplace* policy at this site was named by some participants as helpful in directing nursing work with "marginalized" or "vulnerable" patients in the ED, equality discourses are similarly dominant in the language of this policy, such as the directive to "promote an environment of mutual respect, safety, and inclusiveness" (p. 1) without explication of structural inequities that may jeopardize particular patients' safety in the hospital setting. While one health authority in this study includes "social justice" in the institutional Vision, none of the hospital policies defined this concept or articulated how notions of social justice may translate into nurses' equity-promoting practices. The absence of equity across institutional texts, processes, and structures illustrates the institutional devaluing of equity as a discourse shaping health care providers' practices, and thus the devaluing of these practices themselves.

Further, institutional processes and structures discursively positioned by nurses as equity-promoting often instead reflected dominant risk discourses, illustrating how discursive power

intersected with stigma and discrimination to construct the 'management' of marginalized/vulnerable populations as constituting equity. For example, while nurses emphasized that "there's no real extra training" related to "working with marginalized populations", many participants identified violence prevention, risk management, and "code white" (emergency response to violent incidents) education and training courses as supporting their work with marginalized/vulnerable patients. The construction of violence prevention as equity-promoting reframes 'equity' as behaviour management rather than the provision of care responsive to systemic inequities, and thus served to devalue equity discourses within the ED institutional context. Additionally, policies that articulated aims of supporting nurses in providing care for marginalized/vulnerable patients often reflected risk discourses related to the potential for violence or other "unsafe behaviours". This is exemplified in the *Harm Reduction and Managing Substance Use* policy, which acknowledges that "patients who use substances often report feeling stigmatized in the health-care system" (p. 1) and directs health care providers to "establish a safe environment" (p. 2), thus presenting an opportunity for integrating equity discourses. However, across the text of this policy, risk discourses are dominant, illustrated in directives to "establish and maintain clear and consistent boundaries" regarding "behaviour expectations", with the provided example of a patient "feeling angry" and "yelling" (p. 12). Health care providers are further reminded that "security can always be used for support if needed" (p. 15), constructing harm reduction as behaviour management as opposed to an equity-promoting practice.

While the language of many policies reflects and upholds dominant discourses, one of the two study sites supported two *Philosophy of Care* policies that took up equity discourses: the first *for First Nations, Inuit, and Métis People*, and the second *for Patients and Residents Who*

Use Substances. These policies guide health care providers to "provide a safe environment", "decrease stigma", "foster culturally safe workplace and care provision", and "eliminate systemic racism", directly reflecting equity discourses in acknowledging systemic inequities and the role of health care providers in promoting equity. Yet within the ED institutional context, policies were consistently rejected as a means for supporting equity-promoting practices. For example, comments from nurse leaders included: "I wouldn't think there's any policy out there that really helps them [ED nurses]" (ID-L06) and "I don't think that's the first place nurses go… I'm trying to think of what we would use as a base for policy when it comes to vulnerable folks and I can't really even think what that would be" (ID-L01). Reflecting the broader context in which equity was largely absent and discursively devalued within this institutional context, none of the direct care nurse participants, when explicitly asked within interviews, named a specific policy that addressed equity or inequities or supported nurses in working with marginalized/vulnerable populations, including the *Philosophy of Care* policies; further, only one nurse referenced hospital policy as guiding their equity-promoting practices (discussed below in Subverting Power Structures through Equity Discourses).

Across orientation, continuing education and training, and policy, equity discourses were largely absent and inherently devalued through discursive power. Yet, nurses consistently emphasized that the absence of equity-promoting structures was a gap in the ED institutional context, which left nurses without guidance, direction, or support for responding to inequities in health and health care. Indeed, contradictory discourses positioned the ED as having unique expertise in working with patients constructed as marginalized/vulnerable, yet poorly positioned to respond to inequities or enact equity-promoting practices. This was reflected in nurses' talk

such as: “For an organization that says that they’re the addictions centre for Western Canada, our addictions team goes home at 5pm – I’m sorry, that’s ridiculous” (ID-17) and

> I think sometimes we’re seen as the Centre for Excellence on dealing with mental health… or dealing with substance use in the emergency setting, and yet there are no clear guidelines on what best practice looks like for a lot of that stuff. (ID-L05)

Such contradictions and gaps in equity-promoting structures positioned nurses within an institutional context in which equity discourses were largely absent, and equity-promoting practices were not inherently supported through dominant discourses. The persistent tensions in nurses’ grappling with the devaluing of equity are further explored in Chapter 6.

Subverting Power Structures through Equity Discourses

Within an institutional context in which equity discourses were inherently devalued, equity discourses were employed through nurses’ talk to contradict dominant discourses and support their enactment of equity-promoting practices as subversion. Here, equity discourses included both a recognition of structural inequities as shaping experiences of health and health care, and a value or mandate to respond to and remediate these inequities beyond equality measures of resource allocation. This was reflected, for example, in one nurse leader’s talk, which positioned the ED as a health care space that “needs to be so low barrier for people to access care”, and emphasized: “it’s a huge piece of equity-oriented care is removing those barriers that get in people’s way to try to access care” (ID-L08). In this way, nurses’ talk moved beyond the distributive paradigm of allocating available resources among ED patients, and rather acknowledged broader institutional structures that created underlying inequities. Another nurse reflected that to uphold equity in the ED with marginalized/vulnerable populations: “We have to own up to what we do in the department… How can we provide better care or better services?... As opposed to stating that they’re on the borders, how do we bring them back in?” (ID-11). Here,

and across nurses' talk, equity discourses supported the positioning of responsibility for responding to inequities on the health care system, rather than situating blame among marginalized/vulnerable patients, as advanced by discursive power within the ED. This notion of 'owning up' was echoed in another nurse's reflection on power and the nursing role:

> As nurses, I don't know that we always feel very "powerful". I say that in quotations because we're told what to do by doctors and by management and hospital policy and our hands are tied… But at the same time, we have so much power in the department and we have to be so cognizant of it and gentle with it, right? That cliché saying that "with power comes responsibility". And I think it's important that as nurses we don't wield that power, that we try to lessen it and be more patient-focused. (ID-17)

Here, the notion of responsibility for 'lessening' power suggests a rejection of normative practices enforced by discursive power, and rather a refocusing on patient priorities as opposed to the institutional priorities advanced by overarching dominant discourses. For many nurses, this refocusing on equity – or, as stated by one participant, adopting an "equity lens" – was articulated as a fundamental goal, despite the complexities of reframing equity as a core nursing responsibility within the ED institutional context that constrained such practices.

Drawing on equity discourses, nurses enacted equity-promoting practices that subverted power structures in the ED shaped by dominant discourses. This was seen, for example, in one nurse's (ID-05) talk, through the recounting of a recent event in which an "elderly man" approached the triage window and was "very, very upset" due to difficulties booking an appointment to receive the COVID-19 vaccine. This nurse noted that to book an appointment, an email address or phone that receives text messages is needed, and "if you don't have either, you can't make an appointment – so for this gentleman specifically, that's a barrier to health care", thus illuminating structural inequities in the health care system. Reflecting how dominant discourses shaped normative nursing practice in the ED, this nurse further stated:

> It's technically not really my job description, it's not an emergency… Do I send him away?… I have to choose between that or, you know, holding off on other patients that are coming in with acute problems of being sick, in pain, to deal with this.

Despite the discursive power of biomedical, emergency, efficiency, and resource allocation discourses shaping normative nursing practices, this nurse did work with this individual to set up a vaccine appointment, reflecting that even if a person is not experiencing an 'emergency', "doesn't meant that they don't need help". Illustrating the complexities of discursive power, such talk further perpetuates particular notions of what constitutes *emergency* within the ED, while also contradicting dominant discourses that suggest that only emergencies require nursing intervention. Subversion of discursive power supported by equity discourses was similarly reflected in another nurse's talk, recounting engaging in equity-promoting practices as subversion of the standardized triage process:

> I have had cases where I think, I'm going to give the bed to the person with the overdose versus the person with the appendix because, yes, they need surgery and they're going to get care, but they're also sitting up fine in a chair and they can advocate for themselves and are safe. Whereas this person who came in with an overdose is also, at this point, medically safe after Narcan, but most likely hasn't been treated very well in their life, probably been fighting barriers all their life. And if we can lessen that, if we can honour their dignity a bit more and help them get changed out of their wet, soiled clothes and rest, I feel like that's equity… If you have a line-up of five people needing the bed and they're all of the same kind of acuity, who are you picking and why are you picking? I think sometimes we should be honouring the fact that there are huge inequalities, and we have the opportunity to recognize those inequalities and address them head on, if we can. (ID-17)

As described in Chapter 4, triage is a power structure that ultimately upholds the biomedical paradigm and supports the institutional aim of resource preservation by moving patients efficiently through the ED space. However, as seen in this example of triaging, equity discourses illuminated possibilities of subverting the triage process through equity-promoting practices of reallocating beds to people who have experienced inequities and whose dignity is not honoured

through normative nursing practices. While the standardized CTAS triaging system does not offer explicit opportunities for nurses to respond to structural inequities, this participant's story reflects that nurses do have agency to question "who are you picking?" and make equity-promoting decisions within the constraints of standardized processes and structures.

Most often, equity discourses were employed through nurses' talk to support enactment of equity-promoting practices specifically in working with people who use drugs, who were recognized as experiencing significant inequities in health and health care. Indeed, nurses' talk emphasized that structural inequities among people who use drugs were perpetuated within the ED context through current institutional guidelines and policies, such as those that prohibit both drug use and possession of drugs within the hospital, including the ED. While one participant described this as a "super old school rule", nurses noted that there was "still a sign up in the ED" reinforcing that anyone in possession of drugs will be "kicked out". Despite this overt representation of discursive power shaping institutional processes and perpetuating inequities through text, participants described specific actions they undertook to avoid adhering to these rules and policies: "I'm never in a million years gonna take away someone's drugs, and I'm never gonna kick someone out of the hospital for having drugs on them!" (ID-19). In this way, subversive action was positioned as an intentional choice continually made by nurses within everyday practice – to either uphold dominant discourses or subvert them through practices that differed from normative practices advanced by discursive power. Similarly, another nurse affirmed "I won't tell anybody" if patients are using drugs in the hospital, illustrating that equity-promoting practices can involve *not* acting, and subverting power structures can be achieved through not engaging in normative practices. In a further example of 'not acting' as a meaningful equity-promoting practice in the context of institutional structures prohibiting drug use, another

nurse's talk additionally illustrates that 'looking the other way' combined with intentional practices like "saving" a patient's bed subverted discursive power in the ED:

> I've had patients threaten to leave and I'm just like, "go out and use and come back, I will save your bed and as long as you're more comfortable and you can stay here"… In emergency, if somebody's in the bathroom using, then they're kicked out. I've seen that… Let's just work together on this. You're technically not supposed to but maybe I didn't see anything, that kind of thing. (ID-15)

While many participants described similar practices of saving beds, and not reporting or acting when patients used drugs on site, one nurse's (ID-13) talk in relation to working with people who use drugs in the ED illustrated the challenges of subverting power structures in an environment where nursing practices are constrained by discursive power. They described working in a "float" role (i.e., covering other nurse's patients during breaks) and described a patient who was "having some serious withdrawal", noting that due to his regular fentanyl use, medications available in hospital to address his withdrawal were "not going to be overly successful". They therefore recommended that this patient leave the ED to visit the overdose prevention site to use the drugs of his choice: "then you will be comfortable and we can carry on and do what needs to be done". However, conflict occurred when the primary nurse returned from a break:

> She was like, where are you going? And he's like, "oh I'm going to use". She's like, "no you can't". And I was like, "oh actually, I told him he could, and harm reduction is actually a hospital policy, so he can"… She was obviously not impressed with me at all and she was like, "well if you're not back in 45 minutes I'm giving up your bed"… And he ended up taking an hour and a half but she didn't give up his bed… I have to advocate for these people. Nobody else on our staff is going to, and they're not very good at it – they're advocating for themselves.

In this instance, this nurse not only subverted power structures but also directly challenged the normative practices that are shaped by discursive power in an effort to promote equity within this setting. As illustrated throughout this example and across nurses' enactment of equity-promoting practices, equity was not inherently supported by institutional structures. Rather, equity-

promoting practices were identified as intentional actions of rejecting normative nursing practices and contradicting dominant discourses shaping institutional processes and structures within the ED context. Nurses' equity-promoting practices thus constituted subversive action against the power structures shaping the ED with the intention of remediating inequities created and perpetuated by discursive power in this setting.

Exemplar: Social Admissions

The discourses employed in support of the practice of 'social admissions' to the ED exemplify how nurses enacted equity-promoting practices as subversive action against discursive power in the ED. While dominant discourses position the ED as 'for emergencies' within a biomedical paradigm, participants in this study reflected that the under-resourced health system created structural inequities that led to other urgent needs for people who visit the ED. These needs were normatively positioned through dominant discourses as "social issues" in contrast to "medical issues"; however, many nurses emphasized that these "social issues" stemmed from structural conditions. For example, nurses reflected that a lack community health services and shelter beds often led to patients being discharged from the ED with no health care follow-up or safe place to sleep. In this context, nurses, along with other health care providers, described the equity-promoting practice of social admissions, in which patients are 'permitted' to stay in the ED for longer than their presenting concern may require. Nurses' talk illustrated that social admissions were a discursive strategy that utilized the institutional language of 'admission' to hospital to allow patients to stay in the ED overnight, often in the waiting room or in stretchers, to be able to sleep in a safe place and leave during daylight hours. For example, this discursive strategy is illustrated in one nurse's description of the practice: "There's nowhere else for them to go… so they're just more of a social admit, not acutely ill, and they can potentially manage

without us… Everybody's pretty open to it, so we won't discharge them" (ID-14). Many nurses similarly articulated that this practice of social admissions was endorsed across the health care team, indicating "the doctors know – they're very aware that it's cold out and they don't want to push patients out" (ID-09). However, in other instances, nurses described acting independently to subvert institutional processes by simply not discharging a patient or using strategies such as "seeing my other patients for a while" to afford a patient more time in the ED before discharge. For example, one nurse recounted in working with a young woman who "didn't have a place to go": "It really wasn't in my mind a big favour that I did for her. I just said 'you can stay here, you can just sleep here', and I told everybody to leave her alone" (ID-L04). Though positioned as not "a big favour", enabling social admissions was illustrated to be challenging, often requiring nurses to strongly advocate for patients within an institutional context that prioritized efficiency in patient flow through the ED space.

Although the strategy of social admissions as subversive action was described as quite commonly used by nurses, this equity-promoting practice was also described as constrained by discursive power in the ED context. In one of many such comments illustrating the discursive power of resource allocation shaping the use of ED space for social admissions, one nurse noted that "if there is room in the waiting room, they'll put them in the waiting room instead of putting them in a bed so then the bed is still free" (ID-09). Despite the stated purpose of social admissions as being a safe place to sleep overnight, scarcity and resource allocation discourses perpetuated the withholding of beds for other patients framed as having a 'greater' need. Additionally, the duration of social admissions was described as determined not according to the individual needs of each patient, but by institutional processes such as increases in patient volume and nursing shift change: "the caveat being, okay at six o'clock in the morning I'm

gonna come and you need to leave because it's going to get busy again" (ID-10). Participants who discussed social admissions consistently referenced 5am or 6am as the standard time for discharging patients who were permitted to stay overnight, with the explanation, "they don't want to have these 'carry overs' for the next nurse during the day" (ID-09). The termination of social admissions before nursing shift change further illustrates that while social admissions may have been undertaken collectively among health care providers in certain instances, they remained an individualized equity-promoting practice not supported by institutional power structures. Yet while this equity-promoting practice was constrained by power structures, it was meaningfully contrasted with normative practices that uphold resource allocation discourses and perpetuate inequities:

> I see a lot of overdose patients and some people, as soon as they're awake, they're like "okay, get out". And they lift up their bed so that they can't sleep any longer, make it like super high up and then take off their blankets and kick them out. (ID-15)

As such, despite the institutional constraints on the equity-promoting practice of social admissions, it nevertheless served as an important individual and collective subversive act within a health care system that created and perpetuated inequities, and constrained nursing practices that aimed to remediate these inequities.

Relational Engagement as Subversion

While equity discourses were a key discursive strategy through which nurses subverted discursive power in the ED, equity was not the only discourse that supported subversion of dominant discourses within this institutional setting. Analysis of nurses' talk additionally illustrated relational engagement as a key mechanism of subverting discursive power. A broad concept, relational engagement encompasses numerous aspects of the ways in which nurses engage with patients within the health care encounter, including elements of conveying respect

and empathy, listening and attempting to understand, honouring dignity, and building relationships with a therapeutic intent (DeFrino, 2009; Doane & Varcoe, 2007, 2020). The discourse of relational engagement is invoked through a wide variety of terms used across nursing documents and literature: relational practice, relational inquiry, relational ethics, relational capacity and others. Across these varying concepts, the overarching discourse of relational engagement positions nurses as recognizing and centering patients' humanity and has emerged as a dominant discourse reflecting what nurses 'are' and 'do' within complex health care systems. In this section, I examine how the discourse of relational engagement was employed by nurses to subvert dominant discourses that created and perpetuated power structures in the institutional context of the ED. Firstly, I explore how relational engagement is positioned as a core aspect of nursing within professional documents and institutional policy, and how participants' use of language reflects the centrality of this discourse within the nursing profession and nursing practice. Next, I examine how within the discursive context of the ED, nurses' practices of relational engagement constituted subversive action against dominant biomedical, emergency, efficiency, and resource allocation discourses. Finally, I explore relational engagement as a response to inequities that are created and perpetuated through discursive power in the ED setting.

Positioning Relational Engagement as Dominant Nursing Discourse

Across nurses' talk regarding their work in the ED context, dominant discourses (as described in Chapter 4) were contrasted with the emphasis on relational engagement within participants' talk. Participants frequently utilized language that illustrated the importance of "the relationship" between ED nurses and patients, such as "you really do build a relationship", "we had a great relationship", and "I do try to take the time to establish some kind of relationship".

Further, the use of similar language used to articulate relational engagement across participant interviews and nursing professional documents demonstrates the extent to which relational engagement discourse has permeated nurses' expressions of the profession's identity, core values, and central practices. The text of nursing professional documents consistently reflects the notion of nurses as relationally engaging with patients beyond the biomedical paradigm of medical intervention. Indeed, nurses are positioned through professional texts as fundamentally recognizing and upholding a person's humanity and making efforts to meaningfully connect interpersonally with patients throughout the health care encounter. Specifically, the Canadian Nurses Association (CNA) *Code of Ethics* (2017) identifies "providing safe, compassionate, competent and ethical care" and "honouring dignity" as core "nursing values and ethical responsibilities… central to ethical nursing practice" (p. 3). Within the core ethical responsibility of compassionate care are stated ethical imperatives to: "engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs" and "build trustworthy relationships with persons receiving care as the foundation of meaningful communication, recognizing that building these relationships involves a conscious effort" (p. 8). Further, honouring dignity is articulated as the ethical imperative to "relate to all persons receiving care with respect" (p. 12) and "listen to a person's stories to gain greater clarity about their goals and wishes" (p. 13), positioning patients as determining their own goals of health care rather than reinforcing nurses' 'expertise'. Within this professional text, the framing of upholding dignity, practicing with compassion, and intentionally building relationships as core ethical nursing practice thus reflects the discourse of relational engagement and serves to construct this discourse as dominant within the nursing profession. The British Columbia College of Nurses and Midwives (BCCNM) *Entry-Level Competencies for Registered*

Nurses (2020) similarly identifies providing "compassionate, client-centered" (p. 6) as a core competency for nurses in the clinical setting, while the BCCNM *Professional Standards* include providing care that "preserves and protects client dignity" (p. 17). As seen across these texts, relational engagement is positioned as an ethical value, a nursing competency, and a professional standard, reflecting the dominance of this discourse in framing of what nurses 'are' and 'do'.

At the institutional level, texts from both health authorities represented in this study likewise draw on the discourse of relational engagement to frame health care providers' practices within the clinical setting. One of the health authorities represented in this study (2021) articulates in its institutional Values: "respect, caring and trust characterize our relationships", while the other health authority (2019) similarly identifies "respect" and "integrity" as Values, articulating that "we build our relationships on honesty, justice and fairness". Further, this health authority's Mission includes the provision of "compassionate care", while the Vision describes the institution as "driven by compassion and social justice". Echoing nursing professional documents, the centring of respect, compassion, and care across both health authority Mission, Vision, and Values statements reflects how relational engagement discursively shapes constructions of how health care providers deliver (or ought to deliver) health care within the institution. Indeed, nurses' use of language frequently mirrored how relational engagement discourse was expressed in nursing professional documents and institutional texts, illustrating how discourse shapes nurses' self-representation of their work. For example, phrases such as "honour their dignity", "show compassion", "treat people with respect", "patient-centered care", and "establish that connection of trust" were common in nurses' talk, and illustrate how professional and institutional texts expressing these core nursing values permeated nurses' use of language in expressing this dominant discourse. As such, nurses' talk and institutional and

nursing professional texts reinforce that relational engagement is central to what nurses 'do' in their work with patients in the health care setting.

Across professional and institutional documents as well as nurses' talk, the positioning of respect, compassion, dignity, and relationship-building reflects a dominant discourse of relational engagement that shapes how the nursing profession is constructed within broader health care systems. Notably, despite the dominance of relational engagement in framing nurses and nursing practices more broadly, this discourse was not consistently upheld in the discursive context of the ED. Rather, as explored throughout Chapter 4, nurses' practices enacting relational engagement were consistently constrained, positioned as 'optional' or 'lesser' through discursive power of biomedical, emergency, efficiency, standardization, and distributive resource allocation discourses. The following section explores how nurses subverted discursive power within the ED institutional context by employing the contradictory discourse of relational engagement to guide nursing practice.

Subverting Discursive Power through Relational Engagement

Within the ED, discursive power positioned nurses (alongside other health care providers) as determining the goals and priorities of care, while patients' needs and concerns were devalued in shaping the care provision. This was seen, for example, in a nurse's comment reflecting on a common attitude among ED nurses: "you're here to receive care, you're going to receive care the way we want to deliver it, or you can leave" (ID-13). Yet, in contrast to this approach, many participants employed relational engagement discourses in their talk to justify and inform subversive practices of providing care that engaged with and responded to patients' self-identified needs. This centering of patients' needs was frequently reflected in participants' recounting of their interactions with patients in the ED space, in which the use of phrases such as

"what is your concern today?" and "how can I help?" shifted the approach to care from led by the nurse to guided by the patient's articulated needs. In this way, relational engagement as subversive action was both integrated into everyday nursing practices, and also constituted a fundamental reconceptualization of the ED nursing role in a departure from that constructed by dominant discourses. Nurses' talk conveyed that while discursive power constrained nursing practices that do not uphold institutional processes and structures, nurses can subvert power structures through finding opportunities for relational engagement: "with the small human interaction that we have, there's an opportunity there to help people, guide them towards like services that they might need, or kind of assist them just briefly with something they need" (ID-03). In continually emphasizing "services that *they* might need" and "assist *them*", a relational engagement approach of meaningfully centring patients' needs within the health care encounter is contrasted here with dominant discourses that prioritize the 'needs' of the system over needs of the patient. This reorientation to patients' needs was evident across nurses' descriptions of their practice: "not doing what *you* want to do for the patient, but what *they* want to do" (ID-19) and "providing the care that our population is seeking when they come to visit us" (ID-L08).

Echoing this sentiment of centring patients' needs and expertise in their own care, a segment of talk from one nurse's (ID-13) interview provides a detailed example of how participants frequently employed relational engagement discourses to support their enactment of subversive practices within the ED setting. This individual described a patient who had a medical history of Type I Diabetes, and had "no fixed address, lives on the street", which they identified as creating significant structural challenges for this individual in managing his chronic condition. He was described as presenting to the ED with severe vomiting and reporting to this nurse: "'I know my sugars are high and I've been in DKA [diabetic ketoacidosis] before and I know we're

likely going down that path, so I need some help.'" Throughout this nurse's description, they continually framed this individual as an expert in his own care, identifying that he declined to have an IV catheter inserted as "he has been through this before and he knows how we are going to deal with it… He was like, 'nope, you can just give me an insulin injection and then I'll be fine'". However, the nurse expressed concern about this patient's overall health, noting that his vitals "aren't great" and he was at risk for dehydration from vomiting. They described working with this individual to brainstorm strategies for arranging a consult with the endocrinology team and inserting an IV more comfortably through multiple strategies using a tourniquet, cluster IV insertion and bloodwork to reduce "pokes", and use a warm blanket or a local anaesthetic to minimize pain at the site. Ultimately, the nurse reflected: "We able to get his symptoms sort of under control… He never had an IV, he never got bloodwork done… But in his eyes, we treated him." In an institutional context shaped by discursive power in which the 'success' of treatment is positioned as determined by health care providers alone, this recognition that "in his eyes" this individual received the treatment he needed illustrates how relational engagement discourses can fundamentally reframe the goals and trajectory of a health care encounter. This nurse further reflected on the tensions between health care provider goals and patient needs:

> They want to have some control and we're used to just running around and doing whatever we want… I think it's recognizing that's you have to provide the care that they want, not the care that you want, you know? And sometimes the goals of care are different, like their goal is to not be in pain anymore and your goal is to like figure out what's going on and get some bloodwork. And they're like, nope, that's not a priority. (ID-13)

Throughout this nurse's talk, they described approaching their work with this patient with a fundamental recognition of his expertise in his own health and health care needs – an orientation that was echoed by other nurses' statements such as "meeting someone where they are at" (ID-

19) and “showing an interest in where things are at and what their experiences are” (ID-12). In an institutional context in which discursive power constructs the role of the nurse as “doing whatever we want” to respond to identified physiological needs, prioritizing patients’ goals of care – especially when they are in opposition to nurses’ goals – is a subversive practice supported by relational engagement discourses. As reflected across nurses’ descriptions of their work, discursive power in the ED produced institutional processes and structures that facilitated particular nursing practices – including medical intervention and managing flow of patients through the ED space – and constrained other practices, including relational engagement with patients. Within this context, relational engagement was positioned as a contradictory discourse to dominant discourses shaping the ED institutional context, and thus situated the practice of relational engagement as a subversive action against discursive power.

Relational Engagement as Responsive to Inequities

Within some nurses’ talk, equity discourses were employed to contextualize the importance of relational engagement as an intentional response to structural inequities within the discursive context of the ED. This intersection of equity and relational engagement discourses included recognition of oppressive structures that create health and health care inequities and the positioning of relational engagement as a strategy for remediating inequities. For example, nurses reflected that many patients have experienced a negative “relationship with the health care system”, and “really don’t like going to [the ED] because they’ve had such bad experiences” (ID-20). In response to these structural inequities, nurses described taking opportunities in the ED to engage in “little interactions that helped build that rapport and trust” (ID-03). For example, a nurse explained that people who use drugs often experience stigma and discrimination in the ED and described their practices:

> People come in with a completely unrelated reason, then they have their addiction problems… They don't want any help with their addiction? No problem, let's just help you with what you want help with. I feel like that builds up a better relationship with the health care system. They feel like we're not going to push them, we're not going to try and force them and change them into something they don't want to do… Just try to be as calm, cool, and collected and compassionate as you can. (ID-19)

In this way, relational engagement discourses not only supported nurses in building relationships and honouring patients' dignity and autonomy at an individual level, but also contributed to attempts to build a broader relationship of trust with patients who experience structural inequities and discrimination and the health care system as a whole. Relational engagement as a nursing practice in the ED thus extended beyond the core nursing value to uphold patient dignity and provide compassionate care for *all*, as expressed through professional and institutional texts. Rather, relational engagement was also enacted as a form of equity-promoting practices that aimed to respond to injustices within society, the health care system, and the ED.

As seen through participants' language, nursing practices enacting relational engagement discourses were at times undertaken in recognition of structural inequities experienced by patients. However, most nurses did not conceptualize relational engagement as an equity-promoting practice. Rather, equality discourses were frequently utilized in framing nurses' subversive practices of relational engagement. For example, nurses described their work as grounded in "universal respect" (ID-11) and articulated a shared professional value of "care delivery… that covers every culture, every population, every person" (ID-L01). Further, relational engagement discourses often intersected with resource allocation discourses to position compassion and care as resources to be distributed through nursing practices. Nurses often described taking "extra time" and making "extra effort" for patients who experience inequities in

health and health care. For example, one nurse reflected that they "put in extra effort" with people who use drugs and are experiencing opiate withdrawal in the ED:

> I find that for me to connect best with patients, I try to make them as comfortable as possible. So, frequently offering them medications… "Hey, I got this [medication] ordered for you because I thought this would help." You know, really telling people when you did the extra work for them, even though that's your job. It's my job to do those things, but making them know that I made the effort. Because sometimes they just think, "oh well nobody gives a shit about me when I'm here", right? (ID-16)

Within this nurse's talk, practices of making patients comfortable and offering medications were discursively positioned both as "my job" and as "extra work", illustrating the ways in which resource allocation and relational engagement discourses intersected in complex ways to frame nurses' time as a resource while also framing the allocation of this resource as holding potential for subversive action. While 'appropriate' resource allocation among patients was articulated as a central aspect of the ED nurse role, allocating "extra" time and effort to particular patients is positioned as going above and beyond normative practices within this role, thus constituting subversive action against discursive power. Indeed, relational engagement and resource allocation discourses often intersected in nurses' talk, as reflected in the following example of the distribution of food:

> Speaking of sandwiches, we [nurses] totally take them for granted, but they are miracle workers in our job… So many people come in, they haven't eaten for days… They don't solve anything. I think we rely too heavily on them to solve systemic injustices. But I also do feel like it's a human act to share food. It's a recognition of someone's decency, person-to-person. (ID-17)

While distributing sandwiches was described by this nurse as insufficient to "solve systemic injustices" or "sort out all your problems", this act illustrates how the dominant discourse of resource allocation in the institutional context of the ED makes relational engagement possible, despite such practices being consistently constrained by discursive power within this setting.

Nurses were thus able to subvert the discursive power of resource allocation through positioning relational engagement as a resource that could be distributed among patients who experience inequities, justifying practices of making extra efforts, spending additional time, or allocating tangible resources. Notably, drawing on equality discourses as opposed to equity discourses to inform relational engagement was thus also an effective discursive strategy for supporting meaningful subversive action against discursive power in an environment that does not inherently support nurses in attending to inequities in health and health care experienced by patients.

Impacts of Engaging in Subversion within Institutional Power Structures

While nurses enacted equity-promoting practices and relational engagement as subversive action against dominant discourses in the ED setting, discursive power ultimately constrained such practices. As equity-promoting practices were not inherently facilitated through institutional processes and structures, nurses described adopting such practices individually and intentionally, requiring time, effort, and even conflict with other staff or with institutional policies and norms, as described above. As such, while nurses' talk revealed equity-promoting practices as necessary for meaningfully responding to inequities in health and health care, undertaking such practices was often challenging and ultimately contributed to burnout: "with all those hard moral decisions, it will lead to me burning right out" (ID-15). Nurses further articulated that engaging in subversive action in response to inequities was experienced as an important responsibility, particularly given the consequences of *not* enacting equity-promoting practices. For example, one nurse stated that hearing about patients' "bad experiences" in the ED was "a motivation…what can I do that might give people better experiences?"; however, they describe that making continual efforts to improve patients' experiences led them to feeling

"totally exhausted at the job… you feel like you're not really able to meet this person where they're at, or you weren't helpful" (ID-20). Other nurses' language similarly framed the enactment of equity-promoting practices as a precarious action that could not be consistently maintained: "they're having a bad day and they might just not make that extra effort" (ID-16) and "that's my biggest challenge when I'm exhausted, is it's more difficult for me to be compassionate" (ID-10). The precarity of equity-promoting practices was articulated as having a personal impact on nurses, who articulated burnout as the impact of not being able to continually uphold subversive action. For example, one nurse described the tensions of either engaging in equity-promoting practices and experiencing burnout, or not engaging in such practices and jeopardizing relational engagement with patients: "You're putting up your work cold face – I'm here to work and I'm not feeling and I can't be hurt. But if you're present, you're so vulnerable that it can break you" (ID-17). This responsibility for being fully present while not being supported within the institutional context to do so was felt by many nurses:

> People feel like more and more and more is expected of them with less and less and less… If the person's well is empty, then they really have nothing, not a whole lot extra to offer either, right? And that's the state that we find ourselves, right now. (ID-L05)

In this way, burnout from engaging in equity-promoting practices unsupported within the institutional context not only impacted nurses, but in turn was recognized as affecting the care that nurses were able to "offer" to patients. As such, the constraints placed on nurses' subversive action by discursive power risked reproducing inequities within the ED space. This was seen across nurses' talk, including: "there's a lot of stigma…I'm guilty of also falling into the mindset when I feel really burned out or tired" (ID-03) and "I think it goes back to burned out nurses… and then that causes that stigma" (ID-09). While nurses' identified opportunities for engaging in

subversive action, these practices were ultimately constrained by institutional power structures, resulting in exhaustion and burnout for nurses and the perpetuation of systemic inequities experienced by patients in the ED.

Chapter 6: Findings – Power/Equity Tensions in the Emergency Department

In Chapter 4, I explored how discursive power constructs institutional processes and structures that shape emergency department (ED) nurses' practices to facilitate those that uphold dominant discourses and constrain those that may support nurses in responding to inequities. Chapter 5 then examined how within this institutional context, nurses enacted relational engagement and equity-promoting practices as subversive action against discursive power. In this chapter, I explore the pervasive tensions between discursive power and equity discourses within the institutional context of the ED, with a focus on the consequences of these tensions for how equity is positioned and enacted. Firstly, I examine how competing tensions of dominant discourses and equity discourses position nurses as not responsible for enacting equity-promoting practices. Rather, the conceptualization of equity in the institutional context of the ED was largely constrained to nurses' development of knowledge and awareness, with the *enactment* of equity largely absent from constructions of nursing work. As such, equity is positioned as optional for nurses, and equity-promoting practices – or the 'work' of equity – are regularly described as offloaded to other health care providers. Next, I examine how equity initiatives within the ED setting that articulated an aim of responding to inequities ultimately served to uphold institutional power structures. This section focuses on three exemplars of institutional initiatives in the ED setting: care planning, harm reduction supports, and family visitation. Finally, I discuss the ED as a health care space in tension: how competing purposes of upholding discursive power and enacting equity constructed complex tensions in how ED was conceptualized by participants.

Nurses Discursively Positioned as Not Responsible for Enacting Equity-Promoting Practices

This section explores how persistent tensions between discursive power and equity discourses in the institutional context of the ED positioned nurses as not responsible for enacting equity-promoting practices. Firstly, I explore how discursive power constrained notions of equity to a matter of nurses' knowledge and awareness, rather than the enactment of equity-promoting practices through nursing work. That is, institutional text and participants' talk illustrated an institutional context in which nurses were supported to learn about equity and inequities, but were not inherently supported in taking up actions that aimed to promote equity or remediate inequities within the ED setting. Following, I examine how equity was discursively positioned as optional within the institutional context of the ED, thus reinforcing equity-promoting practices as subversive action – rather than normative practice – within dominant discourses. Finally, I discuss how such discursive framing resulted in equity-promoting practices being "offloaded" from nurses' work to the responsibility of other health care providers.

Equity Framed as Knowledge and Awareness

Across participant interviews, the concept of equity was persistently discursively articulated as an individual nurse's knowledge and awareness of inequities, while discourses framing equity as an action or practice were largely absent. While Chapter 5 illustrates that some nurses drew on equity discourses to inform equity-promoting practices of subversive action, nurses were rarely able to articulate institutional supports for enacting equity as a practice. Rather, nurses' talk illustrated how the dominant discourses that constituted the institutional context of the ED (as described in Chapter 4) positioned the 'work' of equity as gaining knowledge of inequities experienced by various marginalized/vulnerable populations and having

awareness of equity in health and health care as a broad societal aim. This was seen across interviews when, asked to identify institutional supports for nurses in promoting equity or working with marginalized/vulnerable patients, nurses explicitly identified that education in the form of online courses was the predominant formalized process through which equity discourses were integrated into the institutional context of the ED. These courses were described as hosted by health authorities and in the form of asynchronous online modules to be completed at each nurse's individual pace. Reflecting the discursive construction of 'who equity is for' (as discussed in Chapter 4), topics of named courses that were positioned as supporting equity in the ED included "Indigenous cultural safety", "harm reduction", "trauma and resiliency informed practice in emergency", and those on the use of opioid agonist therapy medications. All direct care nurse participants reported taking at least one of these offered courses, yet very few described any other institutional structures and processes that integrated equity discourses or supported nurses in engaging with concepts of equity and inequity. Firstly, the notion of equity as education reflected how discursive power in the ED limited the actualization of equity to nurses' knowledge and awareness, rather than positioning equity as enacted through nurses' action and practices. In addition, despite the topics of the named courses suggesting equity-promoting practices and the potential for translation of equity discourses into nursing action in patient care ("cultural safety"), nurses' talk identified only the courses and continuing education on topics such as opioid agonist therapy as having direct impacts on practice. For example, nurses described such courses as supporting their practices of "giving people Suboxone to take home" (ID-18) and "allowing me to have conversations with people that might show interest in trying to escape that daily hunt for opioids" by initiating opioid agonist therapy (ID-12). Notably, these topics were largely biomedical in nature and presented specific practices and protocols for

the initiation of particular medications, such as "how you do a Suboxone induction". As such, dominant biomedical discourses supported notions of these courses as foundationally supporting nurses' *practices* over and above their *knowledge*. In contrast, nurses' talk in relation to courses addressing topics such as Indigenous cultural safety and trauma-informed practice consistently framed the impacts of these courses using language that suggested the acquisition of knowledge and awareness as the primary outcome. For example, nurses described: "it's opened my eyes", "helped me become a bit more aware", and "helped me always keep it in the back of my head". Notably, biomedical discourses were employed to discursively devalue equity (as seen in Chapter 5), with contrasts in language discursively positioning the outcomes of biomedical courses as supporting integration of new information directly into practice, while framing the impacts of other equity-related courses as predominantly promoting knowledge and awareness.

Participants' talk emphasized that the knowledge and awareness gained through equity-related courses was beneficial for individual nurses, as reflected in statements: "made me aware of my own biases", "helped me kind of see a broader picture", and "made me feel a bit more empowered". However, reducing equity promotion to the development of personal knowledge constructed an institutional context in which nurses were not considered responsible for *enacting* equity. Nurses' use of vague language to articulate the practice of equity suggested that equity as an action was not commonplace within the discursive context of the ED. For example, participants spoke of "that team spirit – our familiarity or consistency in dealing with marginalized populations" (ID-11), "that attitude of compassion" (ID-12), and "this general broad idea like I could voice things" (ID-14). Yet ultimately, when prompted to describe how offered courses shaped their practices, none of the participants identified specific impacts on their provision of nursing care stemming from their learning: "I don't really have any examples

of how I've actually been able to act that out" (ID-01) and "I don't think it changed a whole lot… I don't think it would have changed care" (ID-L03). These statements reflected a broader institutional context in which discursive power devalued equity discourses and positioned nurses as not responsible for enacting equity or meaningfully integrating equity into everyday practices. Rather, equity was positioned as a path for personal growth, leading predominantly to enhanced awareness at the individual level with limited direct linkage to translating this awareness into everyday work with patients in the ED setting. In some instances, a contradictory discursive framing of equity reflected equity as a "competency" (ID-15) and "skills in action that are required" (ID-17). However, this framing was not the norm within nurses' talk, and nurses predominantly positioned the 'work' of equity as constituting the gaining knowledge and awareness, rather than the shifting practices or undertaking action.

Equity as Optional

As previously explored, both nurses' talk and institutional texts consistently reflected an institutional context in which discursive power devalued equity in the ED. Despite nursing professional documents and institutional texts articulating equity and social justice as a value and mandate, nurses' talk emphasized that equity discourses were largely absent from ED institutional processes and structures, and that equity-promoting practices were enacted as subversive action against dominant discourses, rather than normative embedded practices. The tensions between discursive power and equity discourses thus constructed an institutional context in which equity-promoting practices were discursively positioned as optional. In context of a lack of institutional support for nurses in enacting equity-promoting practices, nurses often described gaining knowledge and capacity related to equity and inequities as an independent endeavour, occurring outside of institutional processes and structures. Nurses frequently

commented “I took it upon myself to get more educated” and “you just do a lot of your own research”. Additionally, nurses identified informal means of sharing strategies for promoting equity through patient care in the ED, including “word of mouth in the department” and “knowledge translation passed on from team members”. In addition to independent and informal processes of building capacity for equity, nurses consistently expressed that the online courses they identified as supporting equity in the ED were “optional” and “not mandatory”. This notion of the optional nature of the course was consistently emphasized, as seen in this nurse’s talk:

> Work does provide some support, but I think it is quite a recent thing and it is not mandatory. In the last few months, they have offered an online course… But, like I said, this online course is not mandatory. It’s optional for emergency nurses, if they want to take it. (ID-05)

While continually highlighting the optional nature of these courses – and thus, the optional nature of equity promotion itself – nurses did note that their time completing courses was paid, which was noted to “highly encourage” nurses to engage with these resources. This tension between encouraged and optional was evident throughout nurses’ language:

> No, it’s not mandatory it’s paid though. Where a lot of the other courses are not paid. So they do kind of incentivize it that way, but it’s not – it’s more – it’s not mandatory. Encouraged and with money attached to it, which is a big incentive for a lot of people because on your days off, it’s definitely harder to motivate yourself to do it sometimes, so if you put money behind there… (ID-10)

As seen in this excerpt of participants’ talk, nurses grappled with how to take up the optional but “incentivized” nature of equity-promoting institutional structures within the ED. Some nurses challenged the notion of equity promotion as optional, emphasizing that these courses “should be mandatory for everyone who works in the emergency department” (ID-15). However, nurses predominantly reflected dominant conceptualizations of equity as optional in their language, which reinforced that equity-promoting courses were extraneous to central nursing practices in

the ED: “helpful if you want to… but it’s not something I’m necessarily initiating” (ID-12) and “in the last two to three years, I haven’t done it” (ID-L04).

With equity discursively positioned as optional within the institutional context of the ED, equity-promoting practices were consequently deprioritized in relation to other aspects of nursing practice that dominant discourses facilitated. Nurses’ talk illustrated how the lack of institutional support for equity constructed an ED context in which equity was devalued:

> I feel like the conversation of equity, it happens kind of in theory or maybe in an email that has a picture of like a sunset and a nice phrase, because they’re trying to encourage ‘positivity’ in the workplace emails. When it comes to wound care or ECG [electrocardiogram] reading or whatever, it’s very hands on… But then you get these larger, more complex ideas and those unfortunately get dropped because I think they are just not as tangible… It’s just not first and foremost for a lot of people, including myself. (ID-20)

As seen in this participant’s language, nurses’ talk revealed how the discursive strategy of prioritization operated to centre dominant discourses and position equity as a lesser priority and optional practice. Indeed, several participants used the language of “priority” to justify the devaluing of equity and upholding of institutional aims, for example: “when you’re trying to balance the priorities of a busy emergency department and you’re looking at equity… we just sort of embrace the reality that we can’t meet everyone’s expectations, right?” (ID-L05). Further, beyond deprioritizing equity, nurses’ talk discursively positioned equity as unimportant and unnecessary – both as the work of everyday nursing practice and as a collective institutional aim. Nurses and nurse leaders’ comments that topics related to equity and inequities were not consistently addressed in new nurses’ orientation illustrated the devaluing of equity within the ED institutional context:

> The orientation that new hires get now is really speedy. And that’s not necessarily a good thing but we’re constantly trying to fill vacancies and look at how we can reduce and cut and get people in sooner into lines. So I don’t know if vulnerable

> education needs to be something that they need in order to be hired and brought onto our team. (ID-L01)

As a consequence of the framing of equity as optional and unimportant in the ED, nurses reflected that "a lot of people haven't completed" courses related to equity and inequities in health care, with one nurse leader estimating that only 10% of ED nurses had completed an offered (and paid) Indigenous cultural safety training course (ID-L03). Further, the devaluing of equity was noted to in some instances result in the rejection of equity promotion as a worthy endeavour within the ED: "there's been some criticism among some senior staff that there's a lot of focus on social justice and less focus on rapid medical clinical thinking" (ID-17). Similarly, another nurse recounted colleagues' responses to taking an Indigenous cultural safety course:

> I was working on the coursework at work and people are like "oh you're a goodie-two-shoes for doing that course because no one is really required to do it." I'm not doing it to be a goodie-two-shoes – I'm doing it because it matters. So yeah, I think that is a little discouraging but also sometimes just the stress and the number of competing priorities can make it hard for people to prioritize that. (ID-01)

As seen in this nurse's talk – and across participants' framing of equity – notions that equity "matters" were frequently in tension with discursive power constructing an institutional context of "competing priorities" that devalued equity and upheld dominant discourses described in Chapter 4.

Equity-Promoting Practices 'Offloaded'

Within the institutional context of the ED, nurses were discursively framed as not responsible for enacting equity beyond individual knowledge and awareness, and engagement with the concept of equity (such as through offered courses) was positioned as optional within this setting. However, a central discursive tension throughout nurses' talk was in the intersection of the devaluing of equity discourses alongside the notion that the presence of

marginalized/vulnerable patients was a central aspect of the ED context (as discussed in Chapter 4): "We do have a bit of a reputation for dealing with a particular population… We deal with different slices of the marginalized population pie" (ID-11). The predominant discursive strategy for resolving this tension was the "offloading" of equity-promoting practices from nurses to other health care providers in the department. In particular, social workers, addictions assessment nurses, psychiatric nurses, and Indigenous peer liaisons were positioned as taking up core aspects of health care provision that were framed as outside of ED nurses' knowledge, expertise, and responsibility. One nurse explicitly used this terminology, stating that the responsibility of nurses in working with patients with "any kind of substance use" was to "offload some of the patients" to addictions assessment nurses. However, the language of "referral" was more commonly used to capture this practice. For example, nurses articulated that in working with people who use drugs, "our role is to monitor, give Narcan if needed, and refer to addictions" (ID-18) and "we'll often just refer them" to addictions services within the ED and hospital (ID-16). Nurses likewise described initiating referrals to Indigenous peer liaisons for Indigenous patients and psychiatric nurses for any patient seeking care in the ED "for a mental health reason", illustrating that the discursive strategy of referral/offloading was operationalized across nurses' work with marginalized/vulnerable patients. Nurses further described frequently referring patients to social work in any instance in which they identified "social issues" in addition to a presenting physiological complaint: "it's kind of a joke almost, whenever someone comes to you and they have a mountain of issues… it's like social work consult, social work consult, social work consult" (ID-20).

Undergirding nurses' explanations of involving other health care providers in care was the notion that nurses lacked the knowledge required for engaging in these aspects of care. This

was illustrated, for example, in nurses' statements such as: "Psychiatric assessment nurses are amazing too. They're incredible resources. Because from my background I'm not super well versed in psych care" (ID-10). Similarly, other nurses described "feeling lost" without support from psychiatric nurses, and both ED nurses and other health care providers alike described nurses as lacking knowledge of various illicit drugs and their effects, protocols for initiating opioid agonist therapy, or appropriate doses of medications for use with patients experiencing opiate withdrawal. For example, a nurse identified the addictions assessment nurse role as

> somebody who understands their [people who use drugs] trials and tribulations a little better. For me, this is something I didn't have as much experience with… I don't understand these terminologies patients are using or what these substances really do or what kind of effects they have. (ID-11)

As reflected in this statement, and across participants' talk, the knowledge, understanding, and competencies required for working with people who experience structural inequities were consistently identified as aspects of other health care providers' roles. Notably, such practices of offloading illustrated that despite dominant biomedical discourses upholding nurses' engagement with patients' physiological needs and medical treatment, the institutional discursive devaluing of equity facilitated nurses' offloading of practices that might be considered biomedical, such as understanding medications and dosing. In these instances, the devaluing of equity was not limited to offloading the "social issues" nurses described, but facilitated broader practices of offloading marginalized/vulnerable patients' health care needs to 'other' health care providers, reflecting constructions of patients as undeserving, as examined in Chapter 4.

Consequently, discursive power in the ED constructed an institutional context in which engaging in equity-promoting practices was positioned as *not* nursing work, with various dominant discourses employed to devalue equity. Resource allocation and efficiency discourses

were frequently invoked by nurses and by other health care providers alike to justify practices of offloading equity-promoting practices. For example, an ED nurse articulated:

> Unfortunately, as an emergency nurse who works somewhere that is really, really busy and we are so short-staffed, I don't have much time to spend with [patients]. So the best thing I can do is pass them on to somebody who can better assist them – either a social worker or whatever other support that they need. So if they're a substance user, I can connect them with an addictions nurse. That's honestly the best we can do. (ID-05)

Nurses were often positioned as not having time to engage in equity-promoting practices, which were considered extraneous to the central aspects of nursing work that did justify the use of nursing time, such as providing emergency and lifesaving care or facilitating timely patient discharges. Dominant biomedical discourses were additionally invoked in shaping what was – and what was not – considered central nursing work, with social worker participants in this study identifying nurses as "the medical team" (as discussed in Chapter 4). In contrast, they articulated their own practice as social workers as "working with the whole psychosocial factor of people's lives" (ID-07) and "thinking outside the box, where the medical team is very linear – they're like, we have to save this person's life" (ID-06). Within the nursing discipline, addictions assessment nurses who participated in this study similarly invoked intersecting biomedical and efficiency discourses to position "general" ED nurses as not responsible for engaging with inequities in health and health care in work with people who use drugs:

> Maybe they came in because they have leg cellulitis or whatever, so they're going to get medical care. But then we come in and we say, hey do you need help getting help on your methadone again? Do you, you know, need help finding somewhere to stay tonight?... I think we're kind of like piecing together more holistic care for them I guess?... But I just don't think that [the nurses] are able to, with all the patients that they're caring for medically. They don't have time to worry about what Jimmy's doing later. So that's where we come in. (ID-08)

As seen throughout these statements, participants' talk discursively framed ED nurses as not responsible for "holistic" care, attending to "psychosocial factors", or engagement with patients' challenges and needs beyond lifesaving – and, as such, framed ED nurses as not responsible for equity. The discourses that were invoked to justify nurses' practices of offloading were various and shifting, but were undergirded by the persistent discursive devaluing of equity within nurses' work.

This abdication of responsibility for nurses in undertaking equity-promoting practices in light of the availability of specialized support from health care providers was also reflected in discourses surrounding Indigenous peer liaisons in the ED. Many participants addressed a recent event in the province, in which media widely reported on Indigenous-specific racism in health care following the disclosure of incidents in which ED nurses guessed blood alcohol levels of Indigenous patients who presented for care (discussed in Chapter 2).[4] A small number of participants in this study discursively positioned the responsibility for addressing racism and culturally safe care as held by nurses, articulating "I think we need to have more of a conversation around that" (ID-L03) and "we could at least acknowledge some of these things" (ID-17). However, processes of offloading responsibility for Indigenous-specific racism were reflected across nurses' talk:

> I think it came from something very negative when somebody went to the press saying that they heard them saying racist things, saying that we were betting on the alcohol level, unfortunately. But what really came of that was we now have an Indigenous support worker, where you can just plug in the order [i.e., input the

[4] In response to these claims, the British Columbia Minister of Health commissioned an independent review to investigate incidents of Indigenous-specific racism within the health care system across the province. The findings of the review are summarized in the report *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in B.C. Health Care* (Turpel-Lafond, 2020).

> referral into the institution's electronic charting system] and they'll just show up. (ID-14)

In this example, and across nurses' language, nurses were discursively positioned as both responsible for the specific incident of racism reported in the media, yet *not* broadly responsible for enacting equity-promoting practices in response; rather, this work was offloaded to Indigenous peer liaisons. Yet, the perspectives of Indigenous peer liaisons themselves illustrate the persistent tensions that result from offloading responsibility for Indigenous-specific racism while discursive power situates nurses as responsible for 'other' aspects of patient care:

> Sometimes we show up and it's such a stressful environment and people are focused on the immediate physical needs, addressing appropriately the needs for the patient, that we often will feel like an outsider. We're not always made to feel welcome, I guess is the easiest way to put that… We're constantly reminding people, this is who we are, this is what we do, this is how to refer to us. It gets exhausting sometimes to constantly be doing that. (ID-L13)

Participants' talk consistently illustrated how discursive power positioned ED nurses as required to prioritize practices that align with dominant discourses, as seen above in the language of "immediate physical needs". Resultantly, equity-promoting practices were devalued and framed as not nursing work, and the notion of equity itself was considered beyond the parameters of nursing practice:

> Some people are gravitated more towards the critical care aspect, the resuscitation – "I want to deal with really sick people"… I think people come to show up as an emergency nurse and then they also are expected to be, you know, a social worker sometimes, or an outreach worker, or an addiction specialist… To achieve equity in sort of our specific context, kind of requires a bit of stretching people outside of their scope. (ID-L05)

This notion that to engage with equity was to take up non-nursing responsibilities was reflected across nurses' talk and illustrated how discursive power fundamentally shaped a construct of

nursing practice that did not involve equity discourses, thus supporting nurses' offloading of responsibility for equity to other health care providers in the department.

Equity Initiatives Uphold Institutional Power Structures

While discursive power foundationally shaped the institutional context of the ED and constrained nurses' equity-promoting practices, participants across both sites described institutional initiatives that aimed to respond to inequities in health and health care experienced by some patients who seek health care in the ED. This section presents three exemplars of such initiatives: care planning for "familiar faces" (i.e., people who frequently visit the ED); harm reduction supports within the ED for people who use drugs; and family visitation guidelines for patients positioned as "vulnerable". While each of these initiatives aimed to respond to inequities and drew on equity discourses to support this intention, I explicate how such initiatives were situated within institutional processes and structures shaped by discursive power, and therefore ultimately served to uphold power structures. Resultantly, institutional equity initiatives served to both challenge and perpetuate discursive power, and risked perpetuating the inequities that they aimed to remediate.

Familiar Faces Care Plan

At both sites, the *Familiar Faces Care Plan* was identified as an institutional structure that aimed to respond to patients with high numbers of ED visits within a particular time period: 20 times in one year at one site, and six times in six months at the other site. "Familiar face" is a term intended to reference patients who return frequently to seek health care in the ED and are thus well-known by ED staff and health care providers. Across nurses' talk and policy documents, the *Familiar Faces Care Plan* (hereafter, *Care Plan)* initiative was discursively positioned as an equity-promoting initiative identified as "helping guide care" in the ED for

patients identified as marginalized/vulnerable. For example, the *Familiar Faces Resource Guide* (January, 2018) articulates the overarching aim of this initiative as "improving the care of some of [the health authority's] most vulnerable clients" (p. 3), and participants' talk similarly emphasized that care planning "helps guide care" and supports "consistency" between health care providers. While equity discourses and notions of supporting marginalized/vulnerable patients thus ostensibly guided the broad intention of the *Care Plan* initiative, discursive power shaped how care plans were enacted within the ED, ultimately upholding institutional power structures and perpetuating inequities.

Across the enactment of the *Care Plan* initiative, equity discourses were in tension with dominant discourses of resource allocation and resource scarcity, as seen in the *Resource Guide*, which identifies contradictory goals of the *Care Plan* initiative as "to improve access to health outcomes" and "reducing ED visits and/or admissions to hospital" (p. 3). Indeed, across nurses' talk, care planning was discursively positioned as intended to prevent patients from returning to the ED; resultantly, 'successful' care plans were identified not as those in which excellent care was provided, but those that prevented repeat admissions. This was illustrated in nurses' comments such as: "her total number of yearly visits has gone from over 300 to maybe under 30" (ID-03), "[the care plan] was successful and we hardly ever see her anymore now" (ID-L02), and "there's some direction [in the care plan]… do not give this patient a bed because they're bed-seeking and you know, it's just enabling them" (ID-L04). Another participant's story similarly illustrates how care plans were discursively positioned to uphold institutional power structures despite stated aims of the initiative:

> We had a person who was living in the Downtown Eastside. He had incontinence issues and he had home care that was supposed to come in like two times a day, and change his Depends, but he didn't like the home care worker, he preferred to come to

> the emergency department and have the emergency staff do that for him… We decided to trial refusing to do that kind of care for him when he presented, because obviously that's not emergent care…. And it felt drastic at the time. It felt like a mean thing to do but it actually was really, really successful and he stopped coming because his desires weren't being met. (ID-L09)

In this segment of talk, the use of language such as "preferred", "desires", and "not emergent" reflects how dominant emergency and lifesaving, resource allocation, and efficiency discourses intersected to devalue this patient's reasons for seeking care and position his presence in the ED as inappropriate. As such, the "success" of the care plan was articulated as his ceasing to seek health care in the ED at all. In such instances, discursive power constructed care planning not as improving patient access and care, but as supporting dominant institutional aims of efficiency and 'appropriate' allocation of health care resources. Notably, while biomedical discourses were invoked at times to justify prioritization of 'other' patients' care and minimize health care needs of people identified as "familiar faces", broader patterns of offloading care were operationalized through the *Care Plan* initiative, which constructed notions that some patients ought to seek care 'elsewhere' and limit or eliminate ED visits. As seen in nurses' offloading practices, the offloading of people positioned as "familiar faces" to a vague 'elsewhere' similarly abdicated the ED of responsibility for promoting equity through health care delivery, or even, in some instances, from providing health care. Thus, rather than constituting an equity-promoting institutional structure, care planning thus perpetuated inequities in such instances, further positioning people positioned as marginalized/vulnerable as less deserving of health care in the ED setting.

A further discursive mechanism that positioned marginalized/vulnerable patients as less deserving of care was the predominance of risk discourses shaping the operationalization of the *Care Plan* initiative. Nurses' talk emphasized that care planning in the ED often served as an

intervention for managing "behaviour" exhibited by patients who frequently seek care in this setting. While this "behaviour" was often explicitly articulated as violence, nurses additionally used other language that discursively positioned non-violent behaviours as holding potential for escalation to violence, and thus as unacceptable and requiring care planning intervention. For example, one nurse stated: "if somebody comes in and they're very demanding, you need that care plan in place" (ID-04). Similarly, another nurse leader summarized the *Care Plan* initiative:

> It grew out of patients who were problems when they came to the ED. It was more about managing their behaviour so that they would have a successful visit and no one would get hurt. A lot of times it's about setting up boundaries and expectations in behaviour, and then we will do in turn to assist them through their care. (ID-L02)

This segment of text illustrates a frequently implied understanding of care planning, in which the provision of care in the ED was predicated on – or offered in exchange for – patients' acceptable "behaviour". In this way, care plans addressing violence (and the potential for violence) were discursively positioned as meeting the articulated aims of the *Care Plan* initiative to support health care providers in improving patient care by supporting a "successful visit". Yet, nurses identified that violence was the focus of "the majority" of care plans, suggesting that the enactment of care plans within the ED predominantly served to establish grounds for managing patient behaviour, rather than facilitate equity-promoting health care provision. Reflecting this central tension between discursive power shaping care planning and the equity-promoting intentions of the initiative, one nurse leader reflected on the practice: "I do wonder if they have an unintended impact as well, right? Because people have got a stamp and a label on them before they get care" (ID-L08). This unintended impact of perpetuating stigma was seen across nurses' talk, and contradicted institutional language that framed the *Care Plan* initiative as inherently equity-promoting. Rather, the enactment of care plans often reproduced dominant discourses of

resource allocation, efficiency, and risk to uphold institutional power structures and perpetuate inequities within the ED setting.

The complexities of care planning in purporting to promote equity while perpetuating structural inequities was further seen in participants' descriptions of care plans created in response to frequent visits to the ED related to individuals' substance use. Nurses' talk illustrated that within such care plans, the discursive power of resource allocation further intersected with stigma related to people who use drugs to position such care plans as preventing so-called "drug-seeking" behaviours (i.e., seeking care in the ED with the purpose of obtaining particular medications). The term "drug-seeking" has been widely identified as stigmatizing – and within this study, was described as "a shitty way to call it" (ID-L08) – and was therefore rarely used by participants. Yet, nurses' talk describing the purpose of care planning often reflected this same concept using different language. For example, one participant reflected on why patients labelled as "familiar faces" may be seeking ED care: "some people maybe are coming for a sandwich, other people are coming for like an emotional connection, other people are coming for narcotics" (ID-L09). In another nurse's talk, the language of "legitimate pain for their disease" was contrasted with presentations of "very complicated medical histories or frequent migraines all the time that may or may not be opioid-seeking" (ID-14). In this construction of "legitimate pain", biomedical framing of "their disease" discursively supported the legitimization of patients' experiences, and associated care plans were described as ensuring that some patients positioned as "legitimate" received appropriate doses of analgesic medications. This nurse further described that such care plans responded to "some nurses being uncomfortable giving something like 16mg of hydromorphone in a two-hour frame" – a dose noted to be considerably higher than would be typically prescribed, but appropriate in the context of "legitimate pain".

Conversely, care plans for patients identified as potentially "opioid-seeking" were described as ensuring the *withholding* of medications: "it could clearly say do not give any IV medications" (ID-14), illustrating how stigma and constructions of some patients as not having "legitimate" pain or health care needs intersected with discursive power to result in withheld care. Across descriptions of care planning in the ED, resource allocation discourses further shaped nurses' articulated concerns that opioid and other medications must not be distributed 'inappropriately' and should be used only in 'legitimate' instances. Reflecting the discursive power of the distributive paradigm and intersecting stigma discourses, participants often described the aims of patients' care plans as: "don't prescribe opiates", "no narcotics", or "only Tylenol and Advil". Further, the discourse of the "drug-seeking" patient was employed to illustrate the potential risk of inappropriately allocating other hospital resources, such as nurses' time and beds:

> So this guy who has high levels of anxiety and a severe alcohol use disorder… severe alcohol withdrawal, shaking, and seizure history, is living on the street. His familiar care plan is to try to limit the benzos [benzodiazepine medications]… I think they're trying to reduce the reward of coming to emerg and trying to find another outlet for him, because he's here almost every day. And in a situation like this, where people come in three times a day, every day, to try to curb that kind of reward pathway is challenging, right? You can't refuse care – 90 percent of the time you'd have to do something for them. You can't just send them on their way and be like no, we're not doing anything for you. And I find that kind of challenging too. A lot of the time they don't need medical care. (ID-10)

In this segment, and across nurses' talk, patients who use drugs were discursively positioned as "drug-seeking" and thus the provision of care in the ED was framed as a "reward". As such, discursive power shaped the care of some ED patients as "legitimate" and the care of others as constituting inappropriate use of resources, reifying notions of marginalized/vulnerable patients as undeserving of care within the ED institutional context.

Illustrating how institutional discourses could be variously employed to shape nursing practice, some nurses conversely recounted instances in which care plans were enacted to intentionally counter stigma and drug-seeking discourses. Nurses identified care plans that directed health care providers to ensure appropriate care: "For a very long time, the nurses dismiss it as the person trying to get pain meds, just trying to get opiates… The plan says, this person, within a certain amount of time, they should be getting analgesia" (ID-05) and "The familiar face care plan says this person is… not drug-seeking. We do 2mg of hydromorphone every half an hour until pain is under control" (ID-12). Yet despite these contradictory examples and the articulated intention of the *Care Plan* initiative to support care provision and coordination for people who experience health and health care inequities, the enactment of care plans served to uphold institutional power structures and thus perpetuate stigma and inequities among people who use drugs.

Harm Reduction

Within both of the ED sites included in this study, participants reported that harm reduction initiatives had been recently integrated into institutional processes and structures, and positioned such initiatives as aiming to respond to inequities in health and health care experienced by people who use drugs. Nurses who participated in this study predominantly articulated harm reduction within the ED institutional context as the provision of supplies to support safer drug use – particularly opioid use. For example, participants consistently described ED harm reduction practices as: "we have an actual big box that's full of harm reduction kits" (ID-19) and "we give people Suboxone to take home as well… Narcan kits, we hand out quite a few of those things" (ID-18). Indeed, the discursive positioning of harm reduction *as* the provision of supplies through a resource allocation paradigm suggested that distribution was

itself understood as an equity-promoting practice: "we're bringing in more supplies and resources… we have this cache of supplies here, these are the ways we're kind of trying to break down barriers to people who are receiving certain types of care" (ID-11). This was also reflected in institutional text, with one health authority including in their "who we are and what we do" statement the statistic of "15,244 naloxone kits distributed in a year", though institutional texts do not position harm reduction as an institutional value or collective practice. In this way, notions of harm reduction were also deeply grounded in the context of the toxic drug supply crisis. Nurses' talk and institutional text largely situated harm reduction as a response to overdose from opioid use, with biomedical discourses dominating nurses' perspective on harm reduction as a practice in the institutional context of the ED. This can be seen in the discursive emphasis on medications related to opioid use, including Suboxone and naloxone. Notably, discussion of harm reduction approaches regarding use of other drugs (i.e., stimulants, alcohol, etc.) were absent within nurses' talk.

Gaps and inconsistencies in policies related to harm reduction and substance use constructed an institutional context in which pervasive tensions between discursive power and equity discourses variously shaped nurses' practices. At one of the two hospital sites in this study, there was no policy guiding harm reduction practices or nursing care for people who use drugs. At the other site, a *Philosophy of Care for Patients and Residents Who Use Substances* (May 2020) policy guided practice, which explicitly states that health care providers "have a duty to ensure patients and residents have access to appropriate harm reduction supplies and interventions" (p. 3). However, both policy text and nurses' talk illustrate that challenges to this duty were both anticipated and commonplace. The policy directs health care providers to consult unit leadership or ethics committees if they "have concerns about care provided in relation to this

policy" (p. 3) and participants emphasized that many of their nursing colleagues "aren't really into harm reduction" or "don't agree with it". In this policy context, nurses frequently expressed confusion and lack of awareness of what institutional processes and structures govern their practice in relation to harm reduction: "To be honest, I'm not even sure. But we do give out harm reduction kits… So I'm assuming it was okay. I never really thought about it." (ID-08). This lack of institutional commitment to harm reduction shaped an institutional context in which some nurses enacted harm reduction as an equity-promoting practice and others rejected harm reduction approaches:

> There's some people who are like, "we're gonna go through their stuff and we're not going to let them have [drugs] at the bedside". And then there's other people who are like, "yeah we know they have drugs in their bag but let's just put their bag at the head of the bed – let's just not make a big thing of it and just let them know they can't use at the bedside". They just have a different approach to it. (ID-13)

In this way, some nurses were able to subvert risk discourses that positioned possession of drugs as 'dangerous' by choosing to "not make a big thing" of patients having "drugs in their bag" in the ED setting. Yet, discursive power also operated to enable nurses to search patients' belongings to ensure they were not in possession of drugs. Vague language in the *Search of Inpatient Rooms and/or Belongings* (March 17, 2021) policy further complicates how harm reduction was situated within ED process and structures, identifying that "prohibited property **may** include alcohol… [and] prescription medications that are not pharmaceutical alternatives to illicit substances" (emphasis in original). While illicit drugs are not specifically prohibited in this or other hospital policy documents, most participants in this study reported that hospital policy *did* clearly enable nurses to "kick out" any patient in possession of or using drugs. Indeed, despite a lack of clear policy directives supporting this practice, it was identified as commonplace in the ED setting:

> In emergency I've heard of if somebody's in the bathroom using then they're kicked out. And then I've heard people be, "this patient who has been here for 20 hours is using at the bedside until we told him not to". So not necessarily like, "keep using", but "be safe about it and let's just work together on this". (ID-15)

As such, harm reduction initiatives were undertaken in a complex institutional context in which distribution of harm reduction supplies was encouraged and positioned within institutional texts as a 'duty'. Yet, persistent tensions between ED power structures and institutional texts positioned this duty within a broader discursive context that emphasized drugs as prohibited and empowered nurses to restrict health care provision to patients in possession of drugs.

Within this complex institutional policy context, nurses' talk illustrated that dominant distributive discourses supporting allocation of harm reduction resources were in tension with equity discourses – a tension that shaped the enactment of harm reduction as an institutional practice with the ED. Firstly, nurses' talk illustrates that the availability of harm reduction *resources* was insufficient for ensuring an equity-promoting harm reduction *approach* within ED nurses' practices. Participants described their colleagues as being "confused" by what to do with available harm reduction supplies, and explained that harm reduction initiatives often "just started happening" without explanation or detailed information from ED leadership to support nurses in taking up harm reduction as an orientation to care or as a practice. Further, participants described considerable variation among ED nurses' beliefs and practices related to harm reduction, illustrating how framing harm reduction through a resource allocation lens positioned the distribution of materials as optional:

> We give them a package that includes certain stuff, maybe not what they need. But it's something. It's a step in a direction, I think. But a lot of my peers don't. They think that it's going to bring people into the hospital to get these supplies and that's not the purpose of the emergency department. And they're pretty passionate about that – there's not a place for these harm reduction supplies in our department. (ID-12)

As seen in this nurse's talk, discursive power shaped nurses' understandings of the "purpose" of the ED, thus positioning the distribution of harm reduction supplies as optional and contradictory to ED aims – despite policy mandates – and resulting in inconsistencies in distribution among nurses. While some participants discursively positioned the availability of supplies as enabling nurses' harm reduction practices, noting that patients "can feel safe" asking for supplies, other participants illustrated that resource allocation was insufficient to support conditions of safety for patients in accessing harm reduction materials:

> There's this ongoing stigma of our addiction patients. They just want them in and out. It's the stigma that's attached to them that like, they don't even want to know what Suboxone is or methadone is. Or they think we're giving them more harm than not… And even giving out safe needle kits or pipes and stuff, they think that we're encouraging it and then they're utilizing our hospital more often… I think it's part of just this culture, this stigma culture in the hospital. (ID-09)

In this way, the potential for harm reduction as an equity-promoting practice within the institutional context of the ED was constrained by the intersections of discursive power and stigma, which positioned ED care as a limited resource that is inappropriately allocated to people seeking harm reduction supports or supplies. These tensions between discursive power and equity further illustrated how, despite the dominance of biomedical and resource allocation discourses, the devaluing of equity related to people who use drugs supported nurses' refusal to distribute harm reduction supplies, including lifesaving medications, and enabled conflicting policy as a justification for not engaging in harm reduction practices. Thus, while harm reduction initiatives may have aimed to promote equity at the institutional level, the operationalization of such initiatives reinforced notions of equity-promoting practices as optional for nurses and in some instances, facilitated the perpetuation of stigma toward people who use drugs.

In summary, harm reduction initiatives were described at both ED sites with the articulated aim of supporting people who use drugs in accessing harm reduction supplies while in the ED. However, discursive power constructed an institutional context in which harm reduction was predominantly enacted through resource allocation, positioned as optional, and inconsistently practiced. While some nurses drew on the intersections of harm reduction and equity discourses to engage in equity-promoting practices, other nurses were described as engaging in practices that upheld institutional power structures that perpetuated inequities for people who use drugs within the health care system. As such, harm reduction initiatives did not consistently support the enactment of equity-promoting practices, and rather reflected discursive power in upholding the distributive paradigm as the predominant means of responding to inequities in health and health care within the ED setting.

Family Visitation

Within one of the two ED sites, the exemplar of family visitation during the COVID-19 pandemic illustrates how an initiative that aimed to increase supports for patients positioned as "vulnerable" ultimately served to uphold discursive power and constrain nurses' equity-promoting-practices. Nurses and nurse leaders working at this site described a recent change to the family visitation policy in the context of COVID-19, which led to increased restrictions on which patients in the ED were permitted in-person visitors. The revised *Family Presence Policy – Guideline for Essential Visits in Acute Care* (July 24, 2020) presents a decision-making flowchart for assessing if visitation is "essential and safe" or "NOT essential or NOT safe" (emphasis in original). Essential visitation is stated to be reserved for "compassionate reasons" at end of life or in the instance of critical illness or to meet specific patient needs, including "feeding, mobility, personal care, communication assistance, supported decision making,

emotional support" in instances when "benefits of visit outweigh the risks" (p. 3). In instances in which visitation is deemed not essential or not safe, hospital staff are guided to "ensure needs of vulnerable patients met somehow" and to "demonstrate extra compassion" for those who cannot receive visitors (p. 3).

The guidance to "ensure needs of vulnerable patients met somehow" frames the *Family Presence* policy as upholding equity-promoting aims – albeit through a distributive paradigm – directing health care providers to allocate additional time and support patients positioned as vulnerable. Participants' talk illustrated that a primary mechanism of supporting 'vulnerable' patients in this policy context was to ensure that translation services were made available to facilitate communication with the health care team for patients who are non-English speakers and cannot have family visitors in the ED. Notably, text of the *Family Presence* policy lists "communication assistance" as a reason for permitting family presence, which illustrates the potential of this policy to redress inequities related to non-English speakers in accessing health care. However, participants described the availability of language interpreters and Punjabi-speaking health care providers (the first language of a significant proportion of ED patients) as resulting in such services being provided primarily by hospital staff, and family presence therefore being determined *not* essential. The provision of translation services was thus primarily enacted by hospital interpreters through the technological device of an "interpreter stick":

> It's on an iPad basically… And then that [interpreter] comes on an iPad and then they speak that language… But again, everybody thinks it's an extra hassle time consuming to bring that interpreter stick into the room and try. It's so busy, as I said. Like, suppose I have 4 or 5 patients, and the doctors, they want to do everything quick, quick, quick so they can see the other people… (ID-02)

As seen here, the framing of the interpreter stick as a "hassle" illustrates that while family visitation was denied due to availability of hospital resources, discursive power operated to

deprioritize this work, leaving non-English speakers without adequate translation support. Patients who did not speak English were thus in a catch-22 in which policy restricted family visitation on the grounds of resource availability, yet institutional power structures deprioritized actual availability of such resources, further perpetuating inequities among non-English speakers. Even in instances in which translation services were made available, nurses emphasized that informal interpretive services by family members were of greater benefit to patients than those provided by hospital interpreters via technological devices: "As much as an interpreter and all these resources are helpful, family can often paint the picture of what that patient's been experiencing for the last few months, weeks, hours, prior to coming in" (ID-L01). Yet, dominant efficiency and resource allocation discourses consistently deprioritized communication with family members, with participants emphasizing that nurses "don't have time" to engage with patients or their families beyond minimal requirements of care provision – particularly with non-English speaking patients. As such, policy directive to "demonstrate extra compassion" was further undermined by discursive power in the ED institutional context, illustrating that policy guidance alone is insufficient to support the uptake of institutional initiatives with equity-promoting aims. Rather, initiatives that aim to promote equity may fail to have intended effects – or unintentionally perpetuate inequities – in a setting in which discursive power fundamentally constrains nurses' equity-promoting practices.

The ED in Tension: Competing Power/Equity Purposes

This study has illustrated that within the institutional context of the ED, discursive power constructed institutional processes and structures, which in turn shaped nurses' practices, constraining equity-promoting practices and thus perpetuating inequities (described in Chapter 4). Yet, nurses' talk revealed that contradictory equity discourses enabled equity-promoting

practices as subversive action within institutional power structures, though discursive power constructed equity as optional and outside of nurses' core work in this setting. As such, the ED was illustrated as a space in tension, with competing power/equity discourses variously shaping nurses' conceptualization of the purpose of the ED within the health care system and within society. Across nurses' talk, dominant emergency/lifesaving, biomedical, and resource allocation discourses constructed the ED as a space for medical treatment of urgent physiological concerns, and intersected with the devaluing of equity to commonly position marginalized/vulnerable patients as inappropriately using ED resources, including physical space and nurses' time. Yet, nurses consistently drew on equity discourses to illustrate the foundational tensions within this framing of the purpose of an ED, noting the systemic challenges that perpetuated inequities in health and health care for people who are not currently well-served by EDs and the health system as a whole:

> For people who are homeless, when they come in and they say I need a place to stay, we connect them with a social worker. But to be honest, the only thing that the social worker can do is offer them a list of shelters… This is part of the gap, because the shelters are always full. They can't stay in the hospital unless they're actually acutely sick. There are no shelters for them to go to… I think these concerns – at least in emergency, an emergency situation – they cannot be addressed, simply because we don't have the time to do so. We're not going to ask them, "hey, tell me your life story", you know. (ID-05)

In this segment of talk, the recognition of systemic "gaps" that perpetuate inequities is in tension with the pervasive notion that the ED is not the appropriate space to address such challenges. Indeed, across nurses' talk, the ED was consistently positioned as a space where inequities could not be meaningfully addressed, and the responsibility for promoting equity was situated within the community or a vague sense of "elsewhere". Yet, this was consistently in tension with the understanding that the ED perhaps *was* the space in which systemic inequities and challenges

presented and thus required an equity-promoting response. For example, one nurse recounted their frustrations in allocating time to respond to the "behaviour" of people who use drugs who are "not necessarily medically unstable", and reflected: "Sometimes I wish that there was a designated addictions hospital, you know? Or maybe we are it. But at the same time we have to take care of everybody else" (ID-L04). Similarly, other nurses emphasized that the ED "isn't set up" for supporting management of chronic illnesses or "relatively minor" injuries, yet reflected that the underlying systemic issue is the lack of general practitioners supporting people in the community and that the ED was therefore often the only space to seek care: "you don't have a GP [general practitioner] so you're kind of left in the dark" (ID-19). Additionally, nurses commented that the ED is "almost becoming a shelter" due to high numbers of patients experiencing homelessness and reported hearing colleagues comment "this isn't a hotel"; however, they simultaneously recognized that "the shelters are full" and "there is no housing". Such tensions in language reflect broader tensions in how the ED is conceptualized: both as not responsible for responding to inequities in health and health care, and as uniquely positioned to respond. This central tension is captured by a nurse leader:

> We're basically meeting the basic social determinants of health needs. When you look at the broad system of health care, that's not what the emergency is intended to do. But I often feel that emergency departments are like a little microcosm of society and however things are going is the way it gets played out there. We're trying to fill in some of those gaps of what the system isn't providing them. (ID-L08)

Resulting from these pervasive tensions of discursive power and equity discourses, and the ED as both responsible and not responsible for responding to inequities, ED nurses were themselves situated in a place of tension. While Chapter 5 explored how engaging in subversive action within institutional power structures contribute to burnout among nurses, nurses' talk

further illustrates that foundational tensions of power/equity further constrained nurses' equity-promoting practices, and even positioned nurses as responsible for upholding power structures that perpetuated inequities. Indeed, recognizing inequities but practicing in an environment that did not structurally support responses to inequities was consistently identified as a tension that led to moral distress[5] and burnout among ED nurses. Many nurses recounted instances of forcibly discharging patients from the ED with the knowledge that they lacked a safe place to sleep, necessary health care follow-up, or supportive environments for managing their health, and reflected: "it broke my heart to have to do it" (ID-L04), "you have to send them on their way, and that is a huge challenge for me" (ID-10), and "it makes me feel badly when I say 'you gotta go'… it feels terrible" (ID-14). In this way, nurses were directly implicated in upholding institutional processes and structures, such as facilitating flow and ensuring timely discharge, but recognized these actions as perpetuating inequities, leading to moral distress. The following segment of talk illustrates one nurse's description of how these tensions permeate nurses' thoughts and practices:

> A lot of people really want to be in the hospital but they're forced to leave… On paper, they have supports from the community so they can go. And so it looks simple but then you get people yelling and screaming and crying. It's like you can go now, and you can get these things, we've had this conversation already once, we're not gonna argue about this or negotiate. We do have a plan, and you do need to go because other people need the stretcher. And then it just doesn't happen and then oh crap, and then you have to get security to discharge them. It's really distressing and awful. (ID-20)

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[5] This analysis of nurses' discursive construction of moral distress draws on Varcoe et al.'s (2012) conceptual understanding of moral distress as a phenomenon experienced by individual nurses and occurring within broader structural and institutional contexts in a particular health care setting. This definition intersects with and illuminates study participants' positioning of moral distress as resulting from their recognition of institutional processes and structures operating through nursing work to perpetuate inequities in the ED context.

In this instance, language reveals how discursive power shaped nurses' practices of enforcing discharge; for example, "other people need the stretcher" evokes resource allocation and scarcity discourses and justifies the involvement of security, but leads to "distress" for the nurse tasked with upholding institutional power structures. This tension was similarly expressed across other nurses' talk, with one individual commenting "There's a lot of unsatisfying discharges with marginalized people… It just seems so stupid sometimes when you do so much to help a person" (ID-19). Further illustrating how power structures implicated nurses, one individual reflected:

> Sure, they're – in quotes – "safe for discharge"… but I think it's unethical to discharge them into the street. I also get that there's no alternative, often… I get it's a system thing, I do. And I get that it should be the city or it should be the province or it should be. But it's always somebody else's problem and the reality is that we're the frontline and we're dealing with it. And so to me, that's the human rights/justice piece versus the safety/medical piece. It's like, I need a bed for the next person who's maybe having a heart attack or septic shock from that cellulitis that's not been treated. (ID-17)

This participant's language illustrates that nurses were perpetually caught in tensions between institutional notions of 'appropriate' resource allocation and decisions that may lead to patient harms, whether through unsafe discharges or permitting someone to remain in the hospital at the expense of another patient's care. Such tensions in nursing practice reflect underlying, systemic tensions in notions of what an ED 'is' and 'does', placing nurses in the position of upholding competing purposes: to reinforce institutional power structures and to enact equity-promoting practices to respond to inequities in health and health care experienced by patients who seek care within the ED space.

Chapter 7: Discussion and Conclusions

This chapter discusses the key contributions and implications of this research study, which examined how discourse shaped nurses' enactment of equity-promoting practices in the institutional context of the emergency department (ED). Firstly, I summarize study findings presented in Chapters 4, 5, and 6. I then present a discussion of the central contributions of this research, illustrating how this study extends the extant literature on structural inequities, nursing work, equity-promoting practices, and the institutional context of EDs. Following this discussion, I outline implications and recommendations stemming from this research for the nursing profession and practice, health care systems and structures, nursing education, and future research. I then describe key limitations of this study and provide concluding remarks.

Summary of Findings

This study drew on data from individual interviews with nurses and other health care providers in the ED, as well as institutional texts and professional documents, to examine how discourse shapes nurses' enactment of equity-promoting practices within the institutional context of the ED. Chapter 4 introduced this study's analysis of discursive power and nursing work by examining the dominant discourses that construct the ED context and how these discourses shape nurses' practices in this setting. Study findings identified that nurses' work in the ED context is foundationally shaped by discursive power. Dominant discourses – including emergency/lifesaving, efficiency, biomedical, standardization, risk, and resource scarcity, preservation, and distribution discourses – intersected with power to construct institutional processes and structures that perpetuated the dominance of these discourses and shaped how patients and nurses were positioned in the ED space. Ultimately, these institutional processes and structures, informed and driven by discursive power, perpetuated inequities in health care within

the ED setting, while simultaneously constructing *equality* as a central aim of ED resource allocation and health care provision.

Chapter 5 explored nurses' enactment of equity-promoting practices within the discursive context of the ED examined in Chapter 4. Study findings illustrate that nurses' equity-promoting practices were constrained within an institutional context that discursively devalued equity while upholding other dominant discourses shaping nurses' work, and thus equity-promoting practices were enacted as subversive action against discursive power. Nurses employed equity discourses to inform subversion of power structures in the ED, including recognizing structural inequities in health and health care within the ED and identifying opportunities and strategies to subvert institutional processes and structures that perpetuated inequities. Further, nurses utilized the discourse of relational engagement to shift the enactment of care provision away from upholding institutional aims and toward responding to patients' self-identified health care needs, illuminating other discursive strategies beyond employing equity discourses for meaningfully subverting discursive power and ultimately remediating structural inequities in the ED context. However, findings also illustrate that engaging in subversive action against discursive power was a challenging effort for nurses to enact in everyday work, contributing to exhaustion, moral distress, and burnout.

Study findings presented in Chapter 6 examined the pervasive tensions between discursive power and equity discourses in the ED, as well as the consequences of these tensions for patients, nurses, and the institutional processes and structures that intend to promote equity in the ED context. Despite nurses' capacity to draw on equity discourses to inform subversive action, discursive power advanced a construction of equity as optional and a matter of nurses' personal knowledge and awareness, rather than core institutionally embedded practices that

shaped nursing work in the ED. Through these framings, equity was discursively positioned as a practice that could – and should – be offloaded to other health care providers to preserve nurses' time engaging in practices that upheld dominant discourses. Further, discursive power in the ED contributed to fundamental tensions surrounding institutional initiatives that aimed to promote equity, illustrating that these institutional processes and structures variously challenged and upheld dominant discourses, and often risked perpetuating the inequities that they intended to remediate. Ultimately, study findings illustrated that the ED is a health care space where tensions between discursive power and equity discourses position nurses as responsible for upholding institutional processes and structures that perpetuate inequities and for engaging in subversive action of enacting equity-promoting practices to respond to the inequities in health and health care that they witness within their everyday work.

Discussion

In this section, I present a discussion of this study's unique contributions to empirical understandings of how discourse shapes nurses' enactment of equity-promoting practices in the institutional context of the ED. Here, I focus on three central contributions of this research, situating each in the extant literature on the intersections of nursing, equity and inequities, and ED health care settings. Firstly, I discuss this study's key conclusion that intersecting dominant discourses constrained equity-promoting practices in the ED and illustrate how this central finding extends prior literature exploring institutional contexts of nurses' work. Next, I describe this study's contribution that equity is not discursively positioned as a practice within nursing professional texts or the institutional context of the ED, and examine how this empirical study extends prior theoretical literature on equity and social justice in nursing. I then illustrate how this study further contributes to prior literature on the widespread existence of stigma and

discrimination in health care settings by illuminating how discursive power perpetuates inequities in health and health care within the ED institutional context.

Intersecting Dominant Discourses Constrain Equity-Promoting Practices in the ED

This study illustrates that within the institutional context of the ED, discursive power foundationally shaped nurses' everyday work, with multiple dominant discourses – including efficiency, emergency/lifesaving, resource allocation, biomedical, risk, and standardization discourses – intersecting to construct institutional processes and structures that devalued equity discourses. Discursive power thus operated in complex and contradictory ways, constructing fundamental tensions that constrained nurses' enactment of equity-promoting practices in this health care setting and implicated nurses in upholding dominant discourses and power structures, and thus in ultimately perpetuating inequities in health and health care. As such, this research builds on extensive prior accounts of inequitable experiences of health care from patients (Browne et al., 2011; Chan Carusone et al., 2019; Nicholas et al., 2016; Spassiani et al., 2017; Turpel-Lafond, 2020), further deepening such findings by exploring the institutional conditions that construct these experiences and examining how health care providers' practices are situated within complex health care contexts that shape their capacity to respond to structural inequities. Further, while previous empirical work has explored the impacts of institutional power structures on nurses' practices across various health care settings, including the ED, this study further nuances empirical understandings of the complexities of intersecting dominant discourses, power, and inequities. For example, efficiency mandates – including pressures to reduce health care costs and minimize staffing required to provide patient care – have long been understood as detracting from nurses' capacity to promote equity through patient care (Anderson et al., 2007; Church et al., 2018; Weiss et al., 2002; Wolf et al., 2016). However, there are few studies that

have examined efficiency discourses within the ED context (Heslop, 1998; Melon et al., 2013), and thus the impacts of efficiency on nurses' equity-promoting practices has not been fulsomely addressed through empirical research. Managerialism has also been previously identified as a dominant discourse within the health care system that aims to enhance the performance of health care delivery, and positions nurses as a resource to be efficiently managed, for example, through determining the necessary time allocated per patient and minimum staffing requirements (Gräff et al., 2016; Melon et al., 2013; Rankin & Campbell, 2006; Wright et al., 2021). Within ED settings in particular, a climate of managerialism has been observed to position nurses as striving to "beat the clock" by reducing wait times and length of stay, thus rendering invisible nurses' actual provision of health care and engagement with patients (Melon et al., 2013). Yet, there is a lack of research examining the implications of managerialism on equity and inequities within the ED. Standardization of institutional processes and structures – particularly the triage process – is frequently touted as a means of ensuring *equality* in health care delivery (Bullard et al., 2017; Cotton et al., 2021; Mirhaghi et al., 2015), yet empirical research examining trends in CTAS assignment has illustrated that stigma and discrimination operate through triage, resulting in the assignment of lower triage scores among people who experience structural inequities than a patient with relative privilege may receive (Livingston, 2020; McLane et al., 2022). As I, and others, have previously argued, nurses are tasked with upholding standardization through such processes, creating the illusion of equality in care, but ultimately serving to reify institutional power through driving efficiency, managerialism, and notions of 'quality' (Melon et al., 2013; Slemon, 2018; Thorne, 2021) – though such trends have similarly been rarely examined through empirical inquiry. Further, biomedical discourses in the ED context have been recognized as promoting nurses' engagement in medicalized, task-based, and treatment-oriented work, while

constraining nurses' practices such as addressing ethical challenges or interpersonally connecting with patients (Heslop, 1998; Malone, 1996; Shoqirat, 2014), though such analyses have also not been applied to nurses' equity-promoting practices. Building on prior literature exploring efficiency, managerialism, and standardization, this study aimed to fulsomely examine the complexities and intersections of power, synergistic and overlapping dominant discourses, and inequities within the ED context. The Foucauldian discourse analysis approach to this inquiry, and use of nurses' talk and institutional and professional texts as complementary data sources, enabled a nuanced and in-depth examination of dominant discourses within the ED setting that emphasized the impacts of previously identified institutional discourses and further extended prior research by illuminating complex intersections of discourse and power in shaping nurses' practices. Importantly, this study illustrates that discourses do not operate in isolation to shape ED nurses' work; rather, dominant discourses together constituted discursive power that foundationally constructed institutional processes and structures, and thus also fundamentally shaped nurses' practices.

Stemming from the examination of multiple intersecting discourses in the ED context, this study demonstrated that discursive power positioned nurses in a fundamental tension, facilitating nurses' practices that upheld institutional power structures that often served to perpetuate inequities, and constraining nurses' equity-promoting practices. Equity discourses were fundamentally devalued within this institutional context, constructing a near impossibility for nurses to embed equity-promoting practices in everyday ED work, and thus positioning the enactment of equity as individualized subversive action against discursive power. Nurses' engagement in subversion of power structures across diverse health care settings has been previously explored, including hospital nurses' use of rule-bending to uphold patients' comfort

and autonomy (Hutchinson, 1990), pediatric nurses' engagement in "resistant and transgressive behaviours" to uphold patient safety and care (McMillan & Perron, 2020), nurses' use of "guerrilla tactics" as "responsible subversion" of institutional ideologies (Rodney & Varcoe, 2012), and nursing students' enactment of resistance to normative unsafe and unethical nursing practices in mental health inpatient settings (Slemon et al., 2018). This body of empirical research supports this study's examination of nurses' practices of subversion toward enacting equity-promoting practices and remediating inequities, which further enhances understandings of how nurses are responding to the context of considerable inequities within the health care system. This study illustrates that while the institutional context of the ED fundamentally constrained equity-promoting practices, subversion was a means through which nurses could promote equity in patient care and respond to structural inequities in health and health care. Nurses' subversive practices of "looking the other way", co-opting institutional processes and structures toward equity ends, and making covert concessions that bent ED policies and norms thus constitute what Meyer (1996; see also Peter et al., 2004) refers to as "possible transformations" – instances of small change that can actually be enacted within a particular context. As such, this study demonstrates nurses' capacity for finding the possible within the impossible by identifying avenues for equity-promoting practices through subversive action within an institutional context that constrained and contested this work. Yet, intersecting dominant discourses constructed an environment that emphasized nurses' role in upholding discursive power rather than subverting it, and as such placed nurses' work in a fundamental tension between upholding dominant discourses that devalued equity and perpetuated inequities, and enacting equity-promoting practices through subversive action. Further, the exhaustion, moral distress, and burnout experienced by nurses stemming from working in an institutional

context that constrains equity-promoting practices – and thus necessitates subversive action as a means of promoting equity – illustrate the limits and precarity of subversive action, and detract from subversion as a means of resisting discursive power in the ED institutional context to remediate inequities in health and health care.

Equity Not Discursively Positioned as a Practice

This study further contributes novel empirical evidence that the enactment of equity as a practice is decentred and devalued within both the institutional context of the ED and nursing professional discourses. A considerable body of theoretical literature has articulated equity and social justice as a core value within the nursing profession (Boutain, 2005; Grace & Willis, 2012; Kagan et al., 2010), which is further echoed in the framing of equity as a central nursing value across nursing professional documents (BC Nurses' Union, 2018; British Columbia College of Nurses and Midwives, 2020, 2021; Canadian Association of Schools of Nursing, 2015; Canadian Nurses Association [CNA], 2017; National Emergency Nurses Association, 2018; Nurses and Nurse Practitioners of British Columbia, n.d.-a). Yet, as discussed in Chapter 2, despite these articulated commitments to equity as a value, conceptualizations of equity as a practice are scarce, and there is a considerable need for further empirical literature that examines nurses' engagement in equity-promoting practices across health care settings, and within the ED in particular. This study contributes an empirical examination of how nurses enact equity as a practice within the context of everyday health care encounters with patients, and how the institutional and professional discursive construction of equity shapes this work. Extending from this examination, this research illustrates that across the ED institutional context and nursing professional documents guiding nurses' work, equity is consistently discursively positioned as optional, conceptualized as personal knowledge and awareness rather than an enacted practice in

response to structural inequities, and framed as not nursing work with responsibility for equity offloaded to other health care providers such as social workers. These constructions of equity intersect to demonstrate that institutional and professional rhetoric of equity and social justice as central values for nurses may fail to translate into enactment of equity-promoting practices within health care settings. This research further demonstrates that articulated commitments to equity within institutional texts (such as Mission, Vision, and Values statements) and professional documents did not translate to institutional and professional support for nurses in enacting equity as a practice within patient health care encounters, and consequently, ED nurses identified equity-promoting initiatives (including institutional and educational initiatives) as unhelpful in providing guidance for engaging in equity-promoting practices. Across the nursing literature, there are longstanding and growing calls-to-action for nurses to collectively envision and work toward achieving a more equitable world, within the health care system and beyond (Dillard-Wright & Shields-Haas, 2021; Kagan et al., 2010; McGibbon & Lukeman, 2019). Empirical findings from this study illustrate that current institutional and disciplinary conceptualizations of equity as a value are insufficient in supporting nurses in enacting equity as a practice within EDs, with potential implications across direct health care settings. Indeed, this study demonstrates that conceptualizing equity as a value perpetuates a central tension within health care institutions and within the nursing profession, where equity may be ostensibly centred and promoted as a dominant discourse, but is fundamentally undermined by power structures that constrain nurses' enactment of equity as a practice. Such constructions of equity thus risk perpetuating what McGibbon and Lukeman (2019) describe as moral bystanding within the nursing profession: "intentionally and unintentionally remaining silent when injustice is perpetrated" (p. 6). This study demonstrates that current constructions of equity only as a value

may in fact contribute to the perpetuation of inequities through inaction, and illuminates the need for a reconceptualization of equity within the nursing profession and within health care contexts, as discussed further in the Implications and Recommendations section below.

The ED Perpetuates Inequities in Health and Health Care

Prior literature has extensively reflected that inequities in health and health care are created and perpetuated within the ED, and this study builds on such research to illustrate *how* the discursive context of the ED perpetuates such inequities. This study further extends understandings of the ED as a health care space that does not consistently support remediation of inequities in health and health care experienced by patients (including through nurses' equity-promoting practices), and indeed further perpetuates inequities in health care provision and thus in patients' health and health outcomes. Through the use of discourse analysis to illuminate dominant discourses that intersect with power to construct institutional structures and processes, this study demonstrated that notions of what the ED 'is' and 'does' were constructed through a distributive paradigm, which intersected with emergency/lifesaving and scarcity discourses to discursively position the ED as a space that is predominantly intended to provide urgent health care for "really sick" people with "acute" conditions. Yet, only 1% of patients across Canadian EDs are assigned CTAS 1 triage scores (representing the highest acuity), with 17% of patients assigned CTAS 1/2 compared to 38% assigned CTAS 4/5 (Canadian Institute for Health Information, 2020), illustrating a central tension in the construction of the ED as a health care space designed for "emergencies" yet actually providing health care for a broad spectrum of patient needs and health concerns. This study illustrates how such tensions further intersected with institutional power structures, and dominant institutional and professional discourses, to discursively construct notions of deservingness and undeservingness, which were variously

employed to characterize patients' deservingness of ED health care provision. Such constructions of deservingness and undeservingness reflect a considerable body of literature that documents the discriminatory treatment experienced by people positioned as marginalized/vulnerable within ED settings (Browne et al., 2011; Tang et al., 2015; Vandyk et al., 2018; Wise-Harris et al., 2017). Yet, such prior research documenting inequities in the ED setting – or implementing interventions that respond to such inequities – predominantly explores the experiences of specific populations, such as people who use drugs, people experiencing homelessness, or people with mental health challenges (Clarke et al., 2006; Formosa et al., 2021; Gonzalez et al., 2017). Within this study, deservingness and undeservingness were demonstrated to be complex constructs that operated beyond categorization based on individuals' identities, practices, or experiences alone, echoing Tang et al.'s (2015) examination of the narrative of "underclassism" in EDs, which the authors articulate as the process through which patients are positioned as less legitimate and deserving of care through "the intersecting nature of factors such as discrimination, poverty, stigma, racism, and social exclusion" (p. 700). Similarly in this research, deservingness and undeservingness were constructed through intersecting factors, and did not constitute binary categories into which patients were uniformly positioned, nuancing prior research that aims to identify specific population sub-groups as the focus of ED interventions (Abello et al., 2012; Bodenmann et al., 2017). Further, study findings extend prior literature by illustrating that deservingness and undeservingness were not determined by *patients'* characteristics and behaviours per se, but rather stemmed from fundamental tensions in how discursive power constructed the nature and aims of the ED as a health care space. As such, following Young's (1990) conceptualization of social justice and power, this research acknowledges the distributive patterns of oppression and inequities within the ED setting, but

focuses the lens upstream at the institutional context of discursive power that constructs patterns of deservingness and undeservingness. This upstream approach can shift proposed solutions from a focus on interventions that target specific populations to a more foundational reconstruction of deservingness in health care, as discussed further in Implications and Recommendations for Health Care Systems and Structures below.

Constructions of deservingness and undeservingness further intersected with discursive power and institutional power structures to shape how health care was delivered in the ED and in some instances, whether patients received necessary care or were "kicked out" in advance of completed health care provision. Further reflecting central tensions in what the ED 'is' and 'does', participants at both ED sites discursively reinforced that providing care for marginalized/vulnerable populations was a core aspect of the institutional and moral mandate guiding their everyday work, yet people who experienced structural inequities were frequently positioned as inappropriately using ED resources. Nurses articulated the ED as a "non-refusal site", but also grappled with whether the ED is "the best place" for people who experience structural inequities to seek health care, and indeed, illuminated multiple institutional processes and structures through which patients were effectively refused health care. These tensions in who the ED 'ought' to serve are similarly reflected in the extant literature examining patients' experiences of seeking care in the ED: for example, while people who make frequent visits to the ED are often framed as inappropriately utilizing ED resources with suggestions they should seek care 'elsewhere' (Kim et al., 2018; Malone, 1995; Moe et al., 2017; Podolsky et al., 2017), Doupe et al. (2012) identified that the ED provides a main source of health care among this subset of patients. Additionally, research examining ED experiences of people with mental health challenges emphasizes that many patients view the ED as the only option to address care

needs, despite feeling that their care was not a priority in this setting (Clarke et al., 2007; Vandyk et al., 2018). Indeed, many people do utilize the ED for "non-urgent" health care needs (CIHI, 2020; Penzenstadler et al., 2020), but despite the well-established role of the ED in providing care for people with a broad range of health and health care needs, this study illustrates that discursive power operated to position the ED as not responsible – or not meant to be responsible – for addressing health care needs interconnected with structural inequities. Demonstrating the complexities of intersecting discourses in the ED, the discursive construction of undeservingness was employed even in instances in which patients who experienced structural inequities presented with physiological or more 'urgent' needs. Browne and colleagues (2011) similarly grapple with these central tensions constructing the aims and purpose of the ED as a health care space, noting in their analysis of Indigenous patients' experiences in the ED that "although the ED is not currently designed to respond fully to the complex health and social issues that patients in this study presented with…the ED continues to be used by people whose health is shaped by experiences of social suffering" (p. 341). Such tensions are further seen in the preventable deaths of Brian Sinclair and Joyce Echaquan (discussed in Chapters 1 and 2), in which stigma, discrimination, and undeservingness intersected to withhold medical treatment for urgent physiological health care needs. This study contributes to this growing body of literature by advancing understandings of how competing constructions of the ED as a health care space produce inequities, illustrating central tensions in the discursively constructed notions of who the ED ought to serve. Importantly, such tensions situated nurses in complex and contradictory constructions of what practices constitute ED nursing work, hindered nurses' capacity for enacting equity-promoting practices, and ultimately constructed power structures that perpetuate inequities in health and health care.

Implications and Recommendations

The central contributions that this study makes to the literature on nurses' enactment of equity-promoting practices in the ED illustrate that nurses' work is situated in a complex context in which discursive power foundationally implicated nurses in upholding institutional aims and constrained nurses' practices of remediating inequities through everyday patient care. These challenges point to the need for a multi-pronged approach, with multiple strategies and interventions to shift discursive power, address structural inequities, and promote equity. This section presents key implications and recommendations extending from this research, in four central areas: nursing profession and practice, health care systems and structures, nursing education, and future research. Across each of these areas, I discuss the implications of study findings and offer recommendations for future research and strategies to enhance nurses' capacity for equity-promoting practices and embedding equity discourses across EDs and health care systems.

Nursing Profession and Practice

Findings from this study illustrate that current conceptualizations of equity as a nursing *value* are not effectively supporting nurses working in the ED to enact equity as a *practice*, and indeed, nurses identified extremely little guidance and supports for engaging in equity-promoting practices within patient health care encounters. Echoing Bekemeier and Butterfield's (2005) and Valderama-Wallace's (2017) analysis of U.S. nursing professional documents (described in Chapter 2), this discourse analysis further identified that nursing professional documents in the Canadian context do not meaningfully conceptualize equity as a construct to guide nurses' actions in remediating inequities in health and health care through everyday nursing work. As such, this study demonstrates the need for the nursing profession to grapple with current

conceptualizations and discursive framings of equity and social justice across nursing professional documents, reconceptualize equity as an enacted practice, and reconstruct central nursing documents to guide nurses' work toward this endeavour. Specifically, stronger language is needed within these texts that explicitly positions equity as a practice and positions nurses' actions toward remediating inequities as central nursing practices, competencies, and standards. For example, while the current use of terms such as "endeavour", "awareness", "advocate", and "knowledge" constitute nursing's current equity discourse, the use of language such as "enact", "respond to", "promote", and "engage" may signal and guide nurses' enactment of equity-promoting practices in everyday patient encounters.

Further, professional documents and theoretical literature within the nursing discipline can build on the scarce but highly useful guidance for nurses in enacting equity as a practice within health care settings (Pauly et al., 2009; Varcoe et al., 2015) by offering further practical strategies for nurses in enacting equity-promoting practices within health care settings. As discussed in Chapter 2, preliminary guidance for nurses working in community and public health settings has been advanced within prior literature (Drevdahl, 2013; Fahrenwald et al., 2007; Schim et al., 2007), and nurses working across health care settings are encouraged through research literature and professional documents to engage in activism and advocacy for upstream policy and public health reforms to enhance equity at the population level (CNA, 2017; Falk-Rafael & Betker, 2012; McGibbon et al., 2014). However, there is a dearth of guidance for nurses working in hospital, critical/acute care, or ED settings in enacting equity-promoting practices within and through health care encounters with patients who experience structural inequities. Findings from this study suggest that nurses are caught in fundamental tensions between efforts to promote equity and a lack of guidance and support for enacting equity-

promoting practices, and such guidance can meaningfully support nurses in integrating equity-promoting practices into everyday work and patient care. Indeed, participants in this study illustrated that while guidance for other nursing practices (such as wound care) or was "tangible" and "hands on", any discussion of equity was vague and "in theory". Extending from this study, hands on, practical guidance is needed to support equity-promoting practices in the health care system, and may include listening fully to patients' reasons for seeking health care, grounding nursing health care provision in patients' articulated priorities and needs, and integrating responsiveness to structural inequities into assessment and treatment decision-making.

In absence of professional guidance and institutional support for nurses working in ED settings to engage in equity-promoting practices, subversive action presented an immediate strategy through which nurses in this study enacted equity-promoting practices. Indeed, given the lack of institutional support for equity-promoting practices, study findings suggest that equity-promoting practices are likely to remain individualized subversive actions undertaken by nurses while institutional change that is needed to meaningfully promote equity across the health care system (as discussed below) is ongoing. However, initiatives within the nursing profession, such as hands on guidance and practical strategies supporting nurses' capacity to enact equity, may support nurses in identifying and enacting context-specific strategies for promoting equity – and thus subverting current institutional power structures – within their unique workplaces. Additionally, this study identified that nurses engaged in acts of subversion that they did not articulate as constituting equity-promoting practices but rather identified as upholding relational engagement, thus illuminating opportunities for enacting subversion against institutional power structures through drawing on other dominant discourses within the nursing profession. Nurses within McMillan and Perron's (2020) critical hermeneutic research similarly described

employing nursing discourses to inform practices of resistance and transgression, specifically drawing on patient safety and the therapeutic relationship as dominant nursing discourses shaping practice. Such research, taken together with findings from this study, illustrate that core nursing concepts and values may offer nurses competing discourses to counter discursive power within the institutional setting. For example, nurses may be further supported in engaging in equity-promoting practices by greater support from within the nursing profession in enacting core values in practice, including providing safe care, promoting dignity, and upholding ethical responsibilities.

However, despite the potential of equity and other dominant nursing discourses for supporting nurses' subversion of discursive power and enactment of equity-promoting practices, nurses' efforts to enact relational engagement within an environment that did not foundationally support such practices illustrate the limits of drawing on central nursing discourses that are in contradiction with dominant institutional discourses. While nurses in this study expressed attempts to draw on relational engagement discourses to enact and justify engaging with patients beyond minimum care requirements, such practices ultimately reflected only one aspect of what constitutes the concept of relational engagement in the nursing profession. Doane and Varcoe (2020) outline three interconnected aspects of a relational orientation to nursing practice, which include the interpersonal (engagement between individuals), intrapersonal (each person's experiences and circumstances), and contextual (structures shaping the interpersonal and intrapersonal). They assert that nurses often reduce a relational orientation to the interpersonal alone, which is reflected in this study's findings, as seen in nurses' talk recounting their enactment of relational engagement such as "meeting someone where they are at". The constrained uptake of relational engagement may be understood as a reflection of efficiency

pressures and other aspects of discursive power that limit nurses' relational engagement to more transactional forms of an interpersonal relational orientation. As such, enduring contradictions between nursing discourses and institutional discourses may hinder the effective translation of nursing values to patient care if not also supported institutionally.

Thus, in context of institutional discursive power constraining nurses' enactment of equity-promoting practices as subversion, nursing collectives and community initiatives may extend subversion beyond an individual act. The Nurses and Nurse Practitioners of British Columbia (NNPBC) professional association offers advocacy resources, including workshops, resources, and policy statements that aim to unify nurses in anti-stigma and equity-promoting knowledge building and policy reform, and may support nurses in integrating such resources and initiatives into specific institutional contexts (NNPBC, n.d.b). Further, grassroots initiatives such as Radical Nurses (n.d.) offer an online space for nurses to engage with colleagues on current topics related to inequities and equity in health and health care. Findings from this study illustrated that engaging in continual subversion often involved contravening policies and normative practices, even against explicit push-back from colleagues, and often contributed to moral distress and burnout. As such, identifying and accessing collective nursing spaces where equity is articulated as a dominant discourse for nursing and encouraged as a practice within direct health care settings may support nurses in deriving a sense of collective action and community support for subversive action (Dillard-Wright, 2021). Yet, even collective subversion will remain in tension with power structures and dominant discourses that perpetuate inequities within health care settings and constrain nurses' enactment of equity promoting practices; thus, institutional transformation toward equity is needed across health care systems and structures, as discussed in the following section.

Health Care Systems and Structures

Findings from this study emphasize that the work of remediating structural inequities and meaningfully promoting equity across the health care system cannot be enacted through individual effort – and acts of subversion – alone. Rather, equity must be embedded into institutional processes and structures as a dominant discourse – a process the *In Plain Sight* report (detailed in Chapter 2) refers to as "hard-wiring" (Turpel-Lafond, 2020, p. 125). Within current research literature, interventions to promote equity in the ED typically do not aim to hard-wire equity across institutional processes and structures, and rather address a specific initiative for a particular population, such as embedded case management programs for patients experiencing homelessness (Formosa et al., 2021) or opioid agonist therapy initiation for people who use opioid drugs (Kaczorowski et al., 2020). Within the ED context of this study, specific programs and initiatives were similarly identified as aiming to promote equity among specific groups of patients, including care plans for "familiar faces", harm reduction supports for people who use drugs, and family visitation for patients positioned as "vulnerable". Yet, despite equity-promoting intentions, these initiatives were embedded within institutional power structures and thus served to uphold discursive power and ultimately perpetuate inequity. Such challenges with integrating singular equity-promoting initiatives into institutional contexts that constrain equity further demonstrate the need to transform solutions to inequities from a distributive paradigm to an equity paradigm. An equity orientation to justice rejects distributive 'fixes' such as increasing physical space or directing nurses to devote "more" care or time to particular patients, and rather focuses on institutional reorientation toward recognizing and responding to patients' experiences of inequities in health and health care, and directly and explicitly supporting nurses in enacting equity-promoting practices within everyday work.

Providing an example of strategies for hard-wiring equity, EQUIP Health Care has developed a set of tools, including posters and pocket cards, that aim to support health care organizations in adopting equity-oriented care as an institutional commitment, and embedding equity-oriented practices into health care providers' patient care (EQUIP Health Care, 2017). Further, as described in Chapter 2, the EQUIP research team has developed and implemented the first organizational-level intervention to promote equity within the ED setting. While empirical evidence of the toolkit, EQUIP Emergency intervention, and other institutional approaches to enhancing equity in the ED are not yet available, findings from this study illustrate the unsustainability and impossibility of situating the responsibility for enacting equity among individual nurses alone. Nurses' descriptions of the absences of equity across the ED settings in this research point to where equity may be institutionally embedded, and where the processes and structures are already in place to support the hard-wiring of equity. Explicit integration of equity-promoting practices can be included, for example, in new staff orientation, professional development courses, and institutional policies – all of which were noted by nurses as spaces in which equity was not yet addressed. Other strategies for continually emphasizing equity may involve existing formal and informal communication channels, including nursing "huddles", meetings, and emails and other communications. Use of posters, signage, and other visible communication strategies, such as those developed by EQUIP Health Care or others developed within specific institutional contexts may help foster a collective commitment to equity and convey this commitment to patients and health care providers (Browne et al., 2018; Ford-Gilboe et al., 2018). To further hard-wire and embed equity within health care systems, policies and guidelines can be created to integrate equity-promoting practices into the specific context and nursing work of health care settings, including EDs, to counter institutional dominant discourses

of equity as optional and a matter of knowledge and awareness. Toward this aim, health care settings can meaningfully engage with equity promotion as an institutional commitment by examining and reforming policies and practices that perpetuate inequities, and engaging directly with patients, nurses, and other health care providers to identify and enact meaningful strategies for shifting normative practices toward equity aims. Institutions can also undertake efforts to interconnect equity-promoting initiatives and texts (i.e., policies, guidelines, and institutional Mission and Mandate statements), in what Chin (2021) describes as "a culture of equity in which the whole organization…truly values and buys in to the mission of advancing health equity" (pp. 356-357). For example, at the health authority, hospital, and ED level, this may involve explicitly linking a social justice institutional Mandate – as identified at one of the two sites in this study – to guiding documents, processes, and structures that promote social justice, and emphasizing social justice as a dominant discourse throughout an institutional context through inclusion in staff orientation, ongoing training and professional development, and regular communications. Such approaches may shift constructions of undeservingness within patient care in the ED and emphasize universal deservingness as a dominant discourse and intentional institutional response to structural inequities in health and health care.

In addition to hard-wiring equity as a dominant discourse and institutional commitment within the ED, study findings suggest that a fundamental reconceptualization of the ED as a health care space is needed to meaningfully remediate and prevent harms experienced by people who experience inequities in health and health care. EDs are already providing health care for people who have 'less urgent' concerns, seek care for non-physiological health needs, and experience multiple intersecting structural inequities, and thus EDs as a health care space have the opportunity to discursively embrace rather than marginalize this work and construct patients

as variously deserving and undeserving. While there are many barriers to accessing ED health care among people who experience structural inequities, the ED is lower barrier than many other health care services that require client attachment, have limited open hours, and require appointments. As such, for many, the ED may be more accessible as a health care space, yet findings from this study suggest that this role is not discursively embraced or routinely enacted by health care providers within the ED institutional context. Indeed, this research contributes to prior literature illustrating that a predominant barrier to ED accessibility is stigmatizing and discriminatory treatment (Chan Carusone et al., 2019; Spassiani et al., 2017), suggesting that the ED has considerable potential to increase accessibility and provide care that is more responsive and appropriate for the people who are already seeking health care in this space. The field of social emergency medicine offers some direction for reframing the ED as a space that responds to structural inequities, with its mandate of examining the "dual role" of the ED in providing emergency care and addressing the social conditions that intersect with patients' medical needs (Anderson et al., 2016), and may support a reconceptualization of EDs as having a "social" or equity-promoting mandate. However, this field seeks to specifically address "social factors in the context of acute health care needs" (Shah et al., 2021, p. 1361), discursively reinforcing the ED as a health care setting predominantly responding to emergencies and acute physiological needs, which may additionally have a "social" component. Offering a different framing of "social" needs in the ED, McCallum et al.'s (2020) research examined how people experiencing homelessness understand the role of the ED in their health, with participants' narratives illustrating experiences of discrimination, but also the perception of the ED as a "public, accessible extension of an impenetrable, overwhelming health care system" (p. 1190) and a space where they could "exert agency". Such findings illuminate the potential of the ED as an

accessible, non-refusal health care space that is also designed *for* people who experience structural inequities and perceive the ED as lower barrier.

As stated in Chapter 1, nurses are uniquely positioned to lead and champion the shifting of dominant narratives regarding patients and patient care within the ED setting. Echoing Dillard-Wright and Shields-Haas' (2021) description of nursing as "a dynamic discipline that is, in turns, liberatory and oppressive" (p. 196), this research illustrates the ways in which systemic and institutional processes of domination and oppression reproduce injustice through nursing work, but also illuminates to the potential for nurses to engage in liberatory processes within the ED and across health care settings. Nurses have the potential to collectively leverage shared professional values, including equity and social justice, to lead institutional reforms that reimagine the ED as a health care space that genuinely welcomes people who experience structural inequities and works to remediate inequities in health and health care. However, findings from this study suggest that such work must involve a re-examination of the institutional aims that drive current health care structures and shape nursing practice, and a reconceptualization of who the ED truly serves.

Nursing Education

This study's discourse analysis of nursing professional texts alongside institutional text and ED nurses' talk illustrates that equity is predominantly discursively positioned as a value, and matter of knowledge and awareness of the existence of inequities, rather than as a practice that nurses enact in everyday work. This construction of equity was demonstrated to fall short in meaningfully supporting nurses' enactment of equity-promoting practices, with nurses identifying little institutional and professional guidance, supports, or strategies for responding to and remediating inequities in health and health care experienced by patients who visit the ED.

Offering an alternative conceptualization of equity, some ED nurses reframed equity as "skills in action", or a "competency", which has similarly been suggested by others as a reframing that holds promise for centring equity as a dominant discourse for nursing as a practice-based discipline (Buettner-Schmidt & Lobo, 2012; Edwards & Davison, 2008; Waite & Brooks, 2014). Within the nursing profession, competencies are "statements about the knowledge, skills, attitudes and judgments required to perform safely and ethically within an individual's nursing practice" (BCCNM, 2021, p. 32). Reframing equity as a competency has the potential to extend the concept beyond knowledge and attitudes (elements emphasized through existing documents framing social justice as a nursing value) to include the skills and judgments required of nurses to translate equity into a practice within direct care settings. Indeed, educational approaches and initiatives within pre-licensure nursing programs have aimed to enhance students' capacity for equity-promoting practice by conceptualizing social justice as praxis and integrating social justice education into students' clinical practicums, thus positioning equity as an enacted practice (Boutain, 2008; Furman, 2012; Mohammed et al., 2014; Reimer Kirkham et al., 2005). Yet, despite these efforts, nursing education has also been criticized for delivering "politically 'safe' education" and focusing predominantly on awareness of structural inequities, rather than strategies to remediate injustices (Bell, 2021, p. 3; see also Blanchet Garneau et al., 2021; Canales & Drevdahl, 2015). Further, educational interventions within the health care system have aimed to enhance capacity for equity among health care providers, such as the *San'yas* Indigenous Cultural Safety Training Program – an online, facilitated, interactive program that aims to remediate systemic racism experienced by Indigenous people across health and social services (Browne et al., 2021; San'yas Anti-Racism Indigenous Cultural Safety Education, 2022). Despite considerable uptake of this program across health care and other sectors and

extremely high participant satisfaction and intent to translate gained knowledge into practice (Browne et al., 2021), ED nurses in this study emphasized the non-mandatory nature of the program within their workplaces and expressed challenges integrating course content into their nursing practice beyond awareness of inequities. Study findings illustrate that positioning education related to equity as optional – for either nursing students or nurses in practice settings – perpetuates constructions of equity-promoting practices as optional. As such, this research emphasizes that reconceptualizing equity as a competency and integrating specific and explicit educational initiatives that aim to foster this competency among nurses and nursing students may contribute to recentring of equity as a dominant discourse within the nursing profession and within health care settings, and may better support nurses with practical guidance and strategies for engaging in equity as a practice within health care encounters with patients.

Indeed, despite calls for reconceptualizing equity as a core competency for nursing *practice*, this has not yet been realized within nursing education – including prelicensure education programs and continuing professional education – or guiding professional documents and frameworks that undergird education (Bell, 2021; Dillard-Wright, 2021; Habibzadeh et al., 2021; Thorne, 2022). The construction of equity as knowledge continues to dominate nursing discourse, though findings from this study contribute empirical evidence supporting the limits of awareness of structural inequities in facilitating equity-promoting practices, particularly in institutional contexts where equity is discursively constrained and structural inequities are perpetuated. Echoing this finding, *San'yas* program leaders emphasize that "education alone is insufficient" (Browne et al., 2021, p. 14) and the *In Plain Sight* report notes that leaders within the health care system "questioned whether current training and education programs are making any change at the front line" (Turpel-Lafond, 2020, p. 34). Therefore, findings from this study

suggest that to enhance nurses' capacity for engaging in equity as a practice within diverse health care settings, education related to equity and inequities must be positioned as a key strategy for enhancing nurses' competency in promoting equity-promoting practices, yet insufficient alone for driving action within nursing as a practice-oriented discipline. Nursing scholars and educators have offered promising suggestions for building nurses' and nursing students' capacity for enacting equity through nursing education, including through transformative learning and experiential approaches (Blanchet Garneau et al., 2018; Waite & Brooks, 2014). Such approaches are needed across levels, including prelicensure education and graduate training in preparation for advanced practice roles, as well as through ongoing professional development and training embedded in the health care system. Wylie et al. (2021) emphasize that remediating structural inequities and working toward enacting equity-promoting practices is "a journey not a check box", and across education and health care sectors, nursing can meaningfully embrace this journey by extending aims beyond developing knowledge and awareness of inequities to providing meaningful, context-specific strategies to support nurses' *practice* of equity within everyday work. As discussed above, nursing professional texts can bolster this work by reframing equity as a practice – and equity-promoting practices as a competency – which may support nurses, nurse leaders, and educators in strengthening commitments to equity within the health care system.

Future Research

As emphasized throughout this document, research examining nurses' enactment of equity as a practice within direct health care settings, including the ED, is sparse. Such research efforts have likely been hindered dominant discourses positioning equity as a value rather than a practice, and institutional contexts in which discursive power devalues and constrains nurses'

equity-promoting practices, as illustrated by this study's findings that equity was frequently positioned as unimportant and optional within the ED setting. However, study findings illustrate that nurses are engaging in equity-promoting practices despite challenging and constraining health care environments, and are grappling with tensions between power and equity in the institutional context of the ED. As such, findings from this study support the need for further research that advances empirical knowledge of nurses' enactment of equity-promoting practices across diverse health care settings. Given the dearth of research examining equity as a practice within nursing work, there are myriad directions for future research. Extending from this study's examination of equity, further research may examine how nurses' enactment of equity-promoting practices are variously facilitated and constrained across diverse health care contexts, including hospital inpatient units, various community nursing settings, specialized hospital or community environments such as those related to mental health care or harm reduction supports, etc. Identifying further health care settings where equity is largely devalued and constrained by discursive power may help nuance the challenges nurses experience in engaging in equity-promoting practices, and exploring health care settings where equity is already 'hard-wired' or institutionally embedded may illuminate strategies for enhancing institutional commitments and enactment of equity across other health care environments. Understanding how equity-promoting practices are situated within diverse settings can also contribute further empirical evidence to support broader health system initiatives toward equity promotion, and may contribute evidence-informed guidance and practical strategies for supporting nurses in engaging in equity-promoting practices across divers health care settings.

Further, while discourse analysis supported examination of how nurses' enactment of equity-promoting practices is shaped by dominant discourses within the ED setting, other

qualitative, quantitative, and mixed methods approaches can extend knowledge of nurses' work with patients who experience structural inequities, including how nurses perceive their own competencies in identifying and responding to inequities, and experience enacting equity-promoting practices in complex health care environments. For example, ethnographic approaches may further nuance understandings of how nurses enact equity in everyday practices, and how such practices unfold within complex structural factors. In particular, focused ethnography may be utilized to support enhanced examination of specific institutional processes and structures such as triage and discharge, or interpersonal processes such as 'offloading' of equity described in this study. Additionally, quantitative or mixed methods exploration of nurses' and nursing students' self-reported competencies (knowledge, attitudes, skills, and judgments) related to equity may provide an empirical knowledge base informing the development of future interventions for promoting equity as a practice in diverse health care settings, or enhacing educational initiatives to facilitate students' enactment of equity-promoting practices.

This study's examination of nurses' enactment of equity-promoting practices within the institutional context of the ED additionally illuminates important future research directions specifically related to equities and inequities in the ED as a distinct health care setting. Broadly, future research is needed that engages with equity at the institutional level, empowering nurses and other health care providers to undertake systems-level change. Research endeavours that aim to embed equity within institutions, such as EQUIP Emergency (Varcoe et al., 2019), can support a broader mandate of promoting equity within health care settings, and may more effectively support nurses and other health care providers in collectively engaging in equity-promoting practices and remediating inequities experienced by patients within the ED. Yet, 'hard-wiring' or embedding equity across institutional processes and structures is a considerable endeavour, and

as such, research efforts to further understand and shift specific institutional structures that perpetuate inequities may provide a more immediate avenue for remediating some of the inequities experienced by patients within ED settings. Within this research, nurses identified particular institutional processes and structures as upholding discursive power and perpetuating inequities, such as familiar faces care plans, violence prevention initiatives, time pressures to discharge, and triage processes. Each of these, and the numerous other institutional processes and structures identified in this research, is under-researched, with little empirical examination of how such processes perpetuate inequities or may be re-envisioned to serve as equity-promoting structures. Examining intersections of nursing, leadership, other health care provider, and patient perspectives can further nuance understandings of these institutional structures and inform future directions for embedding equity. For example, nurses identified the triage process as reinforcing prioritization of particular physical concerns and excluding key aspects of individuals' experiences, resulting in triage assessments that minimized patients' needs and produced inequities in the delivery of health care, such as assignment of beds and wait times. Yet, triage was also identified as an institutional process within which subversive action to remediate inequities in health and health care was possible. Future research directions to address these particular challenges can include further examining the triage process from the perspective of both nurses and patients, contributing to the development of strategies to enhance equity through and within ED nurses' use of standardized systems such as CTAS – an area for intervention that has yet to be explored despite documented inequities inherent to the operationalization of these structures within current ED contexts.

This study additionally identified that discursive constructions of deservingness and undeservingness variously shaped nurses' provision of health care for people who experience

structural inequities in health and health care, contributing to instances of withheld and refused care. While such instances are widespread and have been documented within media and research (e.g., Turpel-Lafond, 2020), research has not fulsomely explored the discursive, institutional, and nursing contexts in which withheld care occurs and thus what institutional reforms might prevent these systemic failures. Such research is an important area for future inquiry, particularly given the known potential morbidity and mortality consequences of not providing needed health care, including withheld care stemming from stigma and discrimination. Further, current literature related to undeservingness and withheld care often focuses on a specific population sub-group (McCallum et al., 2020; Vandyk et al., 2018; Wylie & McConkey, 2019), which may limit more nuanced understandings of how notions of undeservingness operate in complex environments to perpetuate inequities and may reduce equity-promoting interventions to a focus on particular populations. To further examine how undeservingness is discursively constructed and intersects with health care provision in the ED, intersectional approaches are needed that illuminate the complexities of stigma, discrimination, and institutional context beyond focus on population sub-groups to inform meaningful interventions that reframe notions of undeservingness and practices of withholding care in the ED setting (Richman & Zucker, 2019; Varcoe et al., 2022). Quantitative approaches, such as Varcoe et al.'s (2022) latent class analysis of experiences of discrimination in ED settings (summarized in Chapter 2), may be helpful in this regard, and qualitative approaches such as interpretive description or grounded theory may also enhance understandings of care withholding in EDs and guide development of approaches to prevent these incidents. While this study illuminates some of the mechanisms through which undeservingness translates into withheld and refused care, methodological approaches such as ethnography (engaging both nurses and patients) may additionally be helpful in supporting a

more nuanced understanding of how undeservingness operates within the everyday context of the ED setting. Guided by such research efforts, interventions are needed that address constructions of undeservingness and related practices of withholding and refusing care, many of which are legitimized and facilitated through dominant discourses and the discursive perpetuation of inequities in the ED context. However, the development and implementation of such interventions are currently hindered by a lack of empirical understanding of such incidents in the ED setting. Broadly, the lack of empirical evidence related to equity-promoting practices and initiatives within the ED setting are detracting from the potential of nurses, the nursing profession, and the health care system in remediating inequities and while this study begins to address this gap, there are numerous research directions that can further support the aim of supporting nurses in promoting equity within direct health care settings.

Study Limitations

While this study has many strengths, including the inclusion of two study sites and the use of multiple sources of data adding nuance and depth to this analysis, there are also important limitations to consider. Firstly, due to the COVID-19 pandemic, all study activities were conducted remotely. Although I had previously visited each ED through prior research activities and thus was aware of its physical layout and general flow of patient care and nursing work, I was not able to be present at either site as a part of this research. This may have limited study recruitment, as all recruitment activities were conducted by study contacts at each ED site. For example, I was not able to conduct traditional and previously intended recruitment strategies such as handing out fliers, circulating among nurses and other health care providers to introduce myself and the study, or holding in-person drop-in sessions within the ED for participants to ask questions and receive further information about the research. The limitation of remote research

may also have reduced opportunities for further data collection, such as direct observation of nurses' work within the ED, which might have expanded understandings of how nurses' everyday practices were shaped by institutional processes and structures. This gap represents an area in which future research may be beneficial to further nuance understandings of how institutional context constrains nurses' equity-promoting practices and to inform institutional initiatives that aim to enhance nurses' capacity to enhance equity within the ED. Additionally, all individual interviews with participants were conducted remotely via Zoom. One challenge of the virtual format was that technological issues occasionally led to short gaps in the audio recording, in which participants' comments were unclear or missed. These were often noted in the moment and when important for understanding, I was able to ask participants to repeat missing words, though this did interrupt the flow of conversation. Additionally, conducting interviews virtually may have hindered rapport between myself and participants and potentially limited the sharing of experiences and perspectives, particularly in phone interviews or Zoom interviews in which the video function was not used. However, Oliffe and colleagues (2021) note that conducting qualitative interviews by Zoom may also have benefits, including supporting participants' involvement in research from the comfort of their homes, and potentially expanding inclusion in the research to those who may not participate under different circumstances. As this study was conducted in a time period where intersecting crises challenged ED nurses' work (see Chapter 2), participating in an interview from home – or in some cases, in their parked cars or while on vacation – may have facilitated recruitment of nurses who otherwise may have experienced barriers to participating. The benefits of Zoom interviews within this research and across many other studies engaging in remote data collection during the COVID-19 context suggest that this may be a viable option for engaging participants even as in-person research activities resume.

There are additional limitations in this study's sample. Nearly half of participants had been working in their current role for four years or less, which may have limited their ability to reflect on broader trends that have shaped the experience of nursing work in the ED over time. However, for many participants, a recent change in role had occurred after a longer period of working in a previous role, such as beginning an ED leadership position following years of direct care nursing within this setting. An additional limitation of this sample is that the majority of participants were white, and that other information on nurses' experiences of structural inequities was not collected as it was deemed invasive and not relevant to the research. While this study focuses on structural inequities experienced by people seeking care in the ED, nurses also experience intersecting inequities, including related to racism, which may not have been fully captured in this research.

An additional limitation is that this research did not include patients' perspectives. This study responds to the myriad reports of discrimination and stigmatizing care experienced by patients in the ED and across the health care system, and was not designed to directly capture these experiences, instead focusing on nurses' enactment of equity-promoting practices within the ED context. Therefore, findings illustrating how discursive power perpetuates inequity within the ED setting are through the lens of nurses recognizing these inequities, rather than patients' direct accounts. It is crucial that future interventions and initiatives that aim to enhance nurses' capacity to promote equity in the ED must be grounded in patients' experiences, particularly those who experience structural inequities and discriminatory care in the ED. Future research can integrate nurses' and patients' perspectives to provide additional nuance and understanding of how discursive power shapes nurses' experiences of enacting equity-promoting practices and patients' experiences of inequities in health and health care within a particular ED context.

Conclusions

This research illustrates that discursive power operated within the institutional context of the ED to constrain nurses' equity-promoting practices, and ultimately perpetuate inequities in health and health care. However, this study also demonstrates that nurses engaged in equity-promoting practices as subversion against the dominant discourses that constrain their practice, illustrating nurses' commitment and efforts to provide equitable care despite considerable systemic pressures, and suggesting future avenues for meaningfully employing central nursing discourses to respond to inequities within direct care settings. Taken together, these findings underscore the need for multiple, intersecting approaches that deconstruct dominant discourses that devalue equity in the ED. There is a need for the nursing profession to strengthen commitments to equity and social justice, including reframing equity as a practice and nursing competency that builds on – but is not reduced to – knowledge and awareness of structural inequities. Within EDs, and across diverse care settings, nurses' equity-promoting practices can be more meaningfully supported by 'hard-wiring' equity in institutional processes and structures, policies, and everyday systems and practices. EDs can further remediate structural inequities perpetuated within the health care system by embracing the role of this setting in providing a wide range of health care services, including specifically for people who experience structural inequities and may experience the ED as lower barrier compared to other health care spaces. There is additionally a need for further research to better understand how nurses' equity-promoting practices can be supported within complex institutional health care contexts, and how institutional interventions can meaningfully position equity as a dominant discourse shaping health care providers' practices and thus patients' experiences in health care settings.

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Appendices

Appendix A: Informational Flyer

Appendix B: Recruitment Poster

UBC School of Nursing
T201-221 Wesbrook Mall
Vancouver, BC V6T 2B5
604-822-7417

THE UNIVERSITY OF BRITISH COLUMBIA

[logo]

SEEKING STUDY PARTICIPANTS

For a UBC study on nurses' work caring for marginalized populations in the emergency department

PRINCIPAL INVESTIGATOR	Dr. Vicky Bungay, PhD, RN, UBC School of Nursing
PRIMARY CONTACT	Allie Slemon, MSN, RN, UBC School of Nursing
[SITE] CO-INVESTIGATOR	Director Clinical Operations (ED)

WE WANT TO HEAR FROM YOU!

What does participation involve?

- Participating in an individual interview with a researcher
- Sharing your experiences working in the ED with marginalized populations
- Interviews will be conducted REMOTELY via Zoom

$ You will receive a $30 honorarium

Participation is completely voluntary and confidential.

If you are interested in participating, please contact:

ALLIE SLEMON

[contact information]

Or scan this code below and enter your email address. Allie will be in touch with you soon.

Appendix C: Interview Guide

1. **Tell me about what it's like working as a nurse in the emergency department.**
    - How long have you worked at this ED?
    - What do you enjoy about your job? About this ED?
    - What are some challenges you encounter in your work?
    - What helps you do your job well? (e.g. resources, supports, leadership?)
    - In what ways do you think working at this ED is similar to working at other EDs? Different?

2. **Can you describe the patient populations that this ED serves?**
    - Are there any patterns in who you see in the ED day-to-day? Differences?
    - Have you noticed any changes to these patterns since you began working here/recently?
    - Do you experience any differences in providing care for various patient populations?
    - What do you think patients feel about coming to this ED?

3. **Can you describe what a typical shift looks like for you?**

    - *For Direct Care Nurses:*
        - How many patients do you see in a day?
        - How do you decide how to divide your time?
        - What types of events or factors might shift a 'typical' day to a *not* typical day?

    - *For Nurse Leaders:*
        - How is your time divided between being 'in the office' and 'on the floor'?
        - When you do have direct contact with patients, can you describe what this looks like?

4. **This study is interested in nurses' experiences of working with 'marginalized populations' in the emergency department…**

    - *For Direct Care Nurses:* **Can you tell me about a recent time you provided care for someone who might be considered 'marginalized'?**
        - Did you encounter any challenges in providing care for this person?
        - What supported you in providing care for this person?
        - What could have supported you further?

    - *For Nurse Leaders:* **Can you tell me about a recent time you supported nurses in providing care to an individual or group that might be considered 'marginalized'?**

i. What do you think supports nurses in this ED in providing care for marginalized populations?
ii. What could support nurses further?

5. **As we discussed, this study focuses on how nurses provide care for marginalized populations. Are there any ways in which this ED has supported you and your fellow nurses in this? For example, changing policies, providing training or resources…?**
    - How do these relate to your day-to-day work (i.e. your practice, direct care with patients)?
    - If the ED has not supported you in this way, what strategies have you developed individually or in your team to support yourself?
    - Do you see any places in which this ED could improve? What other factors could support this ED in providing equitable patient care?

6. **Is there anything that you think I might be missing about your work in the ED and working with marginalized populations? Anything we haven't discussed?**

Appendix D: Demographic Questionnaire

1. What is your role? [Check all that apply]
   - ○ RN
   - ○ RPN
   - ○ LPN
   - ○ Clinical Nurse Leader
   - ○ Clinical Nurse Specialist
   - ○ Nurse Educator
   - ○ Other

2. What is your current employment status?
   - ○ Full-time
   - ○ Part-time
   - ○ Casual

3. How long have you worked *in this emergency department*? _____
   How long have you worked *at this hospital*? _____
   How long have you worked *as a nurse*? _____

2. What is your current level of education?
   - ○ Diploma
   - ○ Bachelor's
   - ○ Master's
   - ○ Other _____

4. What is your gender? _____

5. How do you identify your race/ethnicity? _____

6. How old are you? _____

Appendix E: Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

The University of British Columbia
School of Nursing
T201-2211 Wesbrook Mall
Vancouver, BC Canada V6T 2B5
Phone: 604-822-7417

CONSENT FORM
Promoting health equity in the emergency department: A qualitative inquiry into nursing practices and discourse

Principal Investigator
Dr. Vicky Bungay
Associate Professor
School of Nursing
University of British Columbia (UBC)
[redacted]

Primary Contact
Allie Slemon
PhD Student
School of Nursing
University of British Columbia
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Co-Investigators
Dr. Colleen Varcoe, Professor, School of Nursing, UBC, [redacted]
Dr. Amélie Blanchet Garneau, Associate Professor, Faculty of Nursing, University of Montreal, [redacted], Program Director – Emergency & Access Services, [redacted]
Site Contact
[redacted], Director Clinical Operations (Interim) – Emergency, Pediatric Emergency, Forensic Nursing Services; [redacted] Co-Investigator

This research is being conducted by Allie Slemon for the thesis component of the PhD in Nursing program at UBC. The resulting dissertation will be public document.

STUDY PURPOSE
The purpose of this study is to explore emergency department nurses' perspectives and practices in providing patient care that promotes equity. You are being invited to take part in this research study because you work in an Emergency Department at [redacted].

STUDY PROCEDURES
If you decide to take part in this study, you will participate in an interview conducted by Allie Slemon. This interview is expected to take between 30-60 minutes and will take place remotely via Zoom at a mutually agreed upon time. Participation in this study will occur outside of your work hours in the Emergency Department. You will receive an individual Zoom link from the researcher prior to the interview. You will gain access to the interview through the link, and may log on using a nickname or substitute name. After both you and the researcher have joined the remote meeting, the meeting will be locked. The interview will be either with or without the video and can be used on a computer or cell phone. You are free to turn off your camera if it is not needed, or mute your microphone at any time. With your permission, the interview will be

audio recorded and transcribed. In recognition of your time and contribution to this study, you will be provided with a $30 e-gift card. You will still receive this gift card if you terminate the interview, or later withdraw from the study.

STUDY RESULTS
The results of this study will be reported in a doctoral dissertation, which will be a publicly available document. Additionally, results may also be published in academic journal articles. As a study participant, you may also choose to receive a summary report of the research findings.

POTENTIAL RISKS
There are minimal risks associated with this study. However, some of the questions asked by the researcher in this study may be sensitive in nature may bring up difficult experiences or feelings. You are able to decline to answer any question at any time. Additionally, you may pause the interview (including the audio recording) at any time, and may withdraw from the study during or after the interview. If you choose to withdraw from the study, the audio recording will be permanently deleted; none of your information will be used in data analysis or in writing up the results. Your participation in this study will not impact or influence your employment in any way. If you become distressed following participation in shadowing or the interview, I encourage you to seek support. [redacted]*e services include the Employee & Family Assistance program, which provides critical incident stress management and emotional coaching, and can be reached at* [redacted].

POTENTIAL BENEFITS
If you decide to participate in this study, there will be no direct or immediate benefits. However, your participation in this study will offer you an opportunity to discuss your experiences as a nurse working in the emergency department in a safe, confidential space. This study may also benefit you indirectly, as data collected in this study will expand current understandings of the experiences of nurses promoting equity through emergency department work, and may benefit other nurses and patients through the development of professional development strategies and other interventions to support equity in health services.

CONFIDENTIALITY
To ensure confidentiality, you will be identified by a numerical identifier throughout all study documents including publications. All documents including field notes, audio files, and transcriptions will be identified only by your confidential identifier. Electronic files will be encrypted, password-protected and kept on secure servers, and hard copy documents will be kept in a locked filing cabinet. Only myself and the investigative team will have access to the original files, identified only by your numerical identifier. Information that discloses your identity will not be released without your consent unless required by law. All consent forms, audio recordings, and transcriptions will be destroyed after 5 years.

You are consenting to the use of Zoom to complete the interview. Note that the version of Zoom used for this study is hosted by UBC, with servers located in Canada.

CONTACT INFORMATION

If you have any questions or concerns about the study purpose or procedures, you may contact Dr. Vicky Bungay at [redacted], Allie Slemon at [redacted], or any member of the research team. Names and contact information are listed at the top of this document.

CONTACT FOR COMPLAINTS

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

PARTICIPANT CONSENT

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your employment.

Your signature below signifies that you have read the consent form and received a copy, have been provided with the opportunity to ask questions, understand that you are free to withdraw from the study at any time, and that you agree to take part in this study.

Participant's Name Participant's Signature

Researcher's Name Researcher's Signature

☐ I wish to receive a summary report of research findings once the project has been completed.

This document may be sent to:

Email Address: _____