WOMEN'S RESPONSES TO POTENTIAL CARDIAC SYMPTOMS AND EMERGENCY DEPARTMENT CARE: MAINTAINING PERSONAL, SOCIAL, AND PHYSICAL INTEGRITY

by

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ABSTRACT

The purpose of this grounded theory study was to explore how women interpreted and made decisions about their symptoms, and how they subsequently interpreted their experiences of care in the emergency department (ED), in the context of seeking treatment for the symptoms suggestive of cardiac illness. Data were drawn from several sources: 100 hours of naturalistic observation, 17 in depth interviews with 16 women who visited one of two urban EDs between June 2005 and June 2006 for the treatment of symptoms suggestive of cardiac illness, and three interviews with expert ED nurses. The basic social psychological process of maintaining integrity was identified. Three distinct phases were apparent including: “resisting disruption,” which occurred before arrival in an ED; “suspending agency,” which occurred during an ED visit; and “integrating experiences and knowledge,” which occurred after discharge.

Focusing on the outcome of interest – treatment seeking in the context of symptoms suggestive of cardiac illness – health-care professionals and researchers have often attempted to understand the process by which women make decisions about seeking medical advice, through the framework of medical knowledge. In contrast, the women in this study drew on many forms of knowledge to understand both their symptoms and their subsequent diagnoses. Employing the framework of personal context, rather than medical knowledge, the women analyzed their symptoms, decided between competing courses of action, and ultimately came to understand the events that took place before, during, and after their visits to the ED.

The findings of this study suggest that: (1) women’s understandings of their symptoms, and their actions in relation to those symptoms, were strongly influenced by the broader context of their lives as mothers and wives; (2) women’s perceptions of the
ED as a place that is intense, regulated, and besieged played an important role in
decisions about treatment seeking; (3) after discharge from the hospital, women strove to
make sense of new knowledge and experiences in ways that were congruent with their
images of themselves as “good” and “responsible” individuals.
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CHAPTER ONE: INTRODUCTION TO THE STUDY

Within the published research literature, much attention has been directed toward understanding the links between the perceived quality of a health-care encounter and an individual’s future decisions about health care (Becker & Newsom, 2003; Locker & Hunt, 1978; Roter & Hall, 1997; Thorne, Harris, Mahoney, Con, & McGuinness, 2004; Varcoe, Rodney, & McCormick, 2003). The majority of researchers have focused on primary-care encounters, and to a lesser extent, the experiences of those who have specific chronic illnesses such as renal disease or diabetes. Of note, encounters in hospital emergency departments (EDs) are seldom studied in this context, although the setting is a major access point for individuals seeking episodic health care. Each year, one in eight Canadians (Carierre, 2004; Statistics Canada, 2004c) and one in three Americans (Lambe et al., 2002) seek treatment in EDs, and attendance rates are rising annually (Arman et al., 2001; Velianoff, 2002).

Although the published literature confirms that experiences of health care often differ depending on whether an individual is male or female (Good, Sherrod, & Dillon, 2000; O'Brian & Fothergill-Bourbonnais, 2004; Weisman et al., 2000), little attention has been directed toward understanding the experiences of women seeking treatment in EDs. Although at first glance, this gap in the literature may not seem to be pivotal, a closer look, however, illuminates some of the potential consequences that may arise from this gap in our understanding. Nowhere are those consequences more visible than in the population of women who develop symptoms suggestive of cardiac illness. The focus of the present study was to investigate the experiences of women seeking treatment in an ED for symptoms suggestive of cardiac disease.
Background and Problem Statement

In the spring of 2004, I cared for a woman who shall be named Sally, who sought treatment in a local ED. She had been having chest pain, on and off, for 3 days and at the urging of her relatives decided to attend an ED. She travelled in a car, accompanied by her daughter. Sally arrived on a typical day in the ED, which is to say that the average waiting time from arrival to being placed in a stretcher was 4-6 hours; we were short staffed by one nurse and we had two nurses from the medical floor filling ED staff vacant positions. Every stretcher in the department was full. I greeted Sally at the triage desk and carried out a brief assessment, asking about the events leading to her arrival. I explained the situation with regard to the waiting time, ordered an electrocardiogram, asked Sally and her daughter to take a seat where I could see them, and requested that they let me know if Sally’s situation changed in any way.

Over the next 6 hours, Sally and her daughter waited for a vacant stretcher in the ED. Every one half hour or so, Sally or her daughter approached the triage desk to ask for an update on the expected waiting time. They asked if they should travel to another hospital to speed up the process. Throughout the wait, Sally continued to have chest pain. When Sally was placed in a stretcher she was assessed by an ED physician and nurse. She then waited a further 6 hours for various laboratory results before she was referred to a cardiologist for assessment and admitted to the hospital as an inpatient with a diagnosis of an acute coronary syndrome.

Meeting Sally and her daughter, I had cause to reflect on many questions. Why had Sally waited 3 days to seek treatment for her chest pain? What did it mean to Sally to visit an ED? What happened to Sally once she arrived? What expectations did Sally have about the care she would receive? Upon what basis were those expectations formed? What was Sally’s experience of the care she received? How might Sally’s experience that day influence her health behaviour in future situations?

A study examining the experiences of women receiving ED care is important and timely for three reasons. First, health-care encounters and the quality of those encounters likely influence future health-care behaviour. Positive encounters are generally associated with better outcomes for individuals and negative encounters are generally associated with comparatively poorer outcomes (Arora, 2003; Becker & Newsom, 2003; Locker &
Hunt, 1978; Roter & Hall, 1997; Thorne et al., 2004; Varcoe et al., 2003). As well, experiences of health care are sometimes influenced by the gender of the individual seeking treatment (Good et al., 2000; Muecke, 1996; Schooler & Baum, 2000; Watkins & Whaley, 2000; Weisman et al., 2000). An understanding of what contributes to the quality of an ED care experience may help clinicians to influence or shape the quality of those experiences.

Second, patients’ utilization of EDs is changing. Attendance rates, driven by limited access to primary care, an increase in the number of individuals with chronic illnesses, shifting population demographics, a shortage of long-term care facilities, and early hospital discharge mandates, are on the increase in Canada, the United States, and Great Britain (Canadian Association of Emergency Physicians, 2003; Carpenter, 2001; Knickman & Snell, 2002; Larsson, Nilsson, Skovdahl, Palmblad, & Wimo, 2004; O’Brien et al., 1997; Rice & Fineman, 2004). The Canadian population is aging and individuals, in particular women, are living longer (Statistics Canada, 2004b) – long enough to develop significant cardiac disease. These factors may combine to make the quality of ED care a public health issue. In essence, if patients’ experiences of ED care act as a deterrent for future treatment seeking, this has serious implications for the health of many individuals and groups of patients.

Therapies for cardiac disease are often highly time dependent. If women are admitted to an ED and treated within 4 hours (ideally) after the onset of cardiac symptoms, there is a good chance that heart muscle that would otherwise be destroyed can be salvaged. In the United States for example, an estimated 340,000 people die each year before reaching an ED for treatment of a cardiac event (American Heart Association,
Therefore, treatment-seeking delay, in the context of the symptoms of cardiac disease, is an important clinical issue. The process by which individuals make decisions about treatment seeking is a complex phenomenon. Past experiences with health care in general, and with care in EDs in particular, may act as deterrents in future situations. Studying women’s experiences of ED care may illuminate one piece of the complex process that leads to decisions about treatment seeking for the symptoms of cardiac disease.

Cardiac disease is the foremost killer of Canadian women (Statistics Canada, 2004a). In some cases treatment and outcomes for men and women with cardiac disease are not the same, although these data are sometimes difficult to interpret. According to the Heart and Stroke Foundation of Canada (2003), 15% of all hospitalizations for women are for a cardiovascular diagnosis (excluding childbirth and pregnancy), whereas 21% of all hospitalizations for men are for a similar diagnosis. This inequality is not present to the same degree in mortality statistics, which reflect close to an equal rate of death due to cardiovascular causes. As well, men receive coronary artery bypass surgery, in all age groups, more frequently than women, by a ratio of 2.3:1. Similar gender inequalities in relation to invasive procedures are revealed in the context of pacemaker surgery, angioplasty, and valve replacement (Heart and Stroke Foundation of Canada, 2003).

In relation to outcomes, women generally have a poorer prognosis and die more often after a heart attack than do men (Garvin et al., 2003; Greenland, Reicher-Reiss, Goldbourt, Behar, & Israeli, 1991; Lansky et al., 2005; Moser & Dracup, 1993; Woodfield et al., 1997) and risk of death following heart attack is three times higher for
married women than for married men (Young & Kahana, 1993). Given the fact that cardiovascular disease presents in women a decade later than men, this finding is perhaps not surprising, but even after controlling for age, differences in outcomes may persist (Greenland et al., 1991; Kristofferson, Lofmark, & Carlsson, 2003).

Despite sometimes compelling reports of gender disparities, this information must be interpreted with caution. The degree to which gender may influence treatment and outcomes in the setting of cardiovascular disease is increasingly debated within the published literature. For example, Case and Paxson (2004) argued that although women’s self-reported health levels may be lower than those reported by men, this may be attributable to women more accurately reporting their health status. As well, these authors argued that higher rates of hospitalization for cardiovascular disease in men may be a reflection of more severe disease. This interpretation stands in contrast to the commonly advanced hypothesis that fewer women are hospitalized for cardiovascular disease because women are not diagnosed with cardiovascular disease as readily. Clearly debate will continue, however, there is sufficient evidence, albeit conflicting at times, to suggest that the role of gender in cardiovascular disease deserves further investigation. Why do these gender differences in treatment opportunities and outcomes occur? Given that ED care is often the point of first contact for women experiencing an acute cardiac event, what happens there may set the stage for later events.

At a fundamental level, the study undertaken was pragmatic in its development. If experiences of care in an ED sometimes act as a form of ‘aversion therapy,’ they will become a public health issue in the near future. Treatment-seeking behaviour occurs against a backdrop of ED overcrowding and an overloaded system. If, as health-care
professionals, we further develop our understanding of how women negotiate and understand their experiences of ED care, we will be better prepared to positively influence the quality of those encounters. In this way, women who need help may not be discouraged from seeking treatment in a timely fashion.

Research Questions

In this project I set out to explore the ways women interpreted their symptoms, made decisions about those symptoms, and subsequently made sense of their interactions with health-care professionals in the ED. The primary research question for this project shifted as the study unfolded. The original research question was: In the context of the symptoms of cardiac illness, how do women interpret and negotiate their experiences of emergency department care? As the women shared their accounts of events, it became clear that the original research question was too narrow, and thus the question evolved to require a broader focus: In the context of having symptoms suggestive of cardiac illness, what process guides women as they interpret their symptoms, make decisions about their treatment options, and subsequently make sense of their experiences of ED care? The specific questions addressed were:

1. In what ways does “place” influence women’s interpretations of, and decisions about, their symptoms?
2. In what ways do “relationships” influence women’s decisions about treatment options for symptoms suggestive of cardiac illness?
3. In what ways does “gender” play a role in women’s interpretations of their symptoms, their decisions about those treatment options, and their subsequent experiences of ED care?
4. In what ways does the “social context” of the ED influence women’s decisions about treatment seeking and their subsequent experiences of ED care?
Summary

This project arose from a strong interest in outcomes for women who experience symptoms suggestive of cardiac illness and who seek treatment in an ED. As studies about the impact of health-care encounters have traditionally been focused on the primary health-care setting, the ED has been less well researched. Given the possible consequences of experiences of ED care on present and future health, and the troubling persistence of delay in seeking treatment for symptoms suggestive of cardiac illness, knowledge about women’s decisions in relation to their treatment seeking options, including their perceptions of ED care, may be important. The results of this study begin to address this deficit in our knowledge.
CHAPTER TWO: REVIEW OF THE RELEVANT HEALTH-CARE LITERATURE

The following literature review is broad in scope yet attempts to provide some background to this project on women’s experiences of symptoms suggestive of cardiac illness. The literature review is organized according to three themes: the person, the health-care environment (specifically the ED), and society. Although this approach has limitations, in particular a tendency to artificially separate cohesive “layers of reality,” there is benefit to examining these layers separately for the purposes of this review.¹

Thus, I focus on what we know about individual responses to cardiac symptoms, the context of ED care, and Canadian’s ideas about health care.

A search for published literature related to myocardial infarction, treatment-seeking delay, and the context of hospital emergency services was conducted within the Comprehensive Index of Nursing and Allied Health Literature (CINHAL), the Health and Social Science Index, PsychInfo, and Medline. Searches were limited to English manuscripts published in the last 15 years. Search strategies also included hand searches of textbooks and retrieved journals. Key words and phrases searched included: patient satisfaction, patient dissatisfaction, health-care services/psychology, treatment-seeking delay, emergency services, emergency room, emergency department, health-care philosophy, gender and emergency services, stress and coping, stress and coping and

¹There is an ongoing debate, among scientists and researchers, about the ontology of knowledge. This debate is sometimes referred to as the “reductionism versus holism” debate. Researchers who tend toward reductionism would argue that complex phenomena may be best understood by breaking things down to their component pieces and then examining those pieces. In contrast, researchers who tend toward holism argue that not everything can be broken down to its component pieces, and that the whole can be more than the sum of the parts. The statement, “there is benefit to examining these layers separately” appears to situate me firmly on the side of the reductionists, in the ongoing reductionism versus holism debate. In this case, I am using reductionism as a useful tool for explaining the relevant health literature in a coherent fashion.
gender, stress and coping and emergency services, overcrowding, myocardial infarction/psychology, as well as myocardial infarction and gender.

Person/Patient

Mortality and Morbidity Attributed to Cardiac Disease

Cardiovascular disease is the leading cause of death in Canada (Canadian Institute of Health Information, 2006) and the number one killer of Canadian women (Statistics Canada, 2004a). According to the American Heart Association (2004), if all forms of major cardiac illness were eliminated, life expectancy in the United States would rise by 7 years. In contrast, if all forms of cancer were eliminated, life expectancy would rise by 3 years. Cardiovascular disease is pervasive in Canada and the United States. Although the probability that an individual will die from cancer is 22%, the probability that someone will die from a cardiovascular cause is 47% (American Heart Association, 2004). Annually, an estimated 300,000 to 500,000 Canadians present to emergency departments (EDs) with chest pain (Christenson et al., 2004). In the USA, in 2001, visits to EDs that resulted in a primary diagnosis of cardiovascular illness numbered 4,214,000 (American Heart Association, 2004). Approximately 62,000 Canadians are admitted to hospital each year with a diagnosis of acute myocardial infarction (AMI) (Heart and Stroke Foundation of Canada, 2003). An estimated 400,000 to 600,000 Americans die as a result of heart attacks each year in an ED or before reaching a hospital. If a cardiac arrest takes place at home, survival rates are dismal (less than 2%) (Herlitz, Eek, Holmberg, Engdahl, & Holmberg, 2002) and more than three quarters of cardiac arrests occur at home (Pell et al., 2002) making treatment-seeking delay a substantial clinical
issue. The question yet to be answered by researchers is whether these deaths are preventable.

**Treatment-Seeking Delay**

Ho, Eisenberg, Litwin, Schaeffer, and Damon (1989) identified a pronounced shift in the care of individuals who experience AMI – a shift from supportive to interventionist care. The benefits of interventions such as thrombolytic therapy with "clot busting" drugs or coronary angioplasty to directly open the stenosed artery are inversely associated with time-delay because mortality and morbidity related to AMI are directly related to the extent of heart muscle damage. Concurrent with the initial blockage of the coronary artery by ruptured plaque (and subsequent clot formation) is an area of the heart that is deprived of oxygen. This oxygen deprivation results in an expanding area of damage and cell death over time. Therefore, reperfusion therapies are highly time dependent, making treatment-seeking delay (TSD) a phenomenon of significant interest to clinicians. Maximum benefit to rescue therapies results if treatment is received within 4 hours of the onset of symptoms. Increasingly, attention is being directed to a mandate of treatment within 1 hour of symptom onset, given the number of deaths that occur in the first hour (McKinley et al., 2004).

Dracup et al. (2003) confirmed that TSD is an international phenomenon when they studied 913 individuals with a diagnosis of AMI in five countries. The median delay times observed in South Korea, England, Australia, Japan, and the United States ranged between 2.5 to 6.4 hours. Similarly, Goldberg et al. (2002) examined data about TSD from 14 countries and 94 hospitals. With a sample size of 10,582 individuals, the research team reported an average delay of 4.7 hours for a heart attack, 5.6 hours for
unstable angina, and 6.1 hours for non-ST elevation heart attack. One quarter of this sample delayed longer than 6 hours. Of note, Canadians wait an average of 5.6 hours before seeking treatment (CIHI, 2005).

Even though TSD has been studied for the last 2 decades, it is not well-defined in the literature. Zerwic (1999) offered the following definition: “A prolonged interval of time from symptom onset to receipt of therapy. This interval is commonly referred to as delay…” (p. 22). According to Zerwic, TSD is typically divided into patient delay, emergency medical services (EMS) delay, and hospital delay. Patient delay makes up the majority of the delay (Leitch, Birbara, Freedman, Wilcox, & Harris, 1989; Zerwic, 1999). When interpreting this body of research, it is important to remember that some degree of bias is present by virtue of the fact that there are at least 2 groups of individuals who do not participate in studies about TSD: people who do not seek treatment at any point during their experience of symptoms and people who die at home. The absence of these two groups may lead us to believe that, on average, TSD is of a shorter duration than may actually be the case.

The issue of TSD is commonly conceptualized as resulting from individual factors. Researchers investigating TSD generally have focused on understanding the personal, socio-demographic, or social factors that contribute to delay. Personal factors include personal characteristics of the patients such as their medical histories. Findings in this area vary widely. For example, some researchers have found that a history of cardiac disease or angina makes no difference to TSD (Leitch et al., 1989), whereas others have found the reverse to be the case (Ho et al., 1989; Wu, Zhang, Li, Hong, & Huang, 2004). Individuals who smoke or have previously smoked and have symptoms suggestive of
cardiac illness are less likely to delay seeking care (Ashton, 1999). Bunde and Martin (2006) studied the relationship between depression and TSD. They reported that depressive symptoms such as fatigue and sleep disturbance are predictive of TSD. Self treatment also has been studied extensively and there is general agreement in the literature that individuals who take the time to treat themselves are more likely to delay going to an ED (Ashton, 1999; Pattendon, Watt, Lewin, & Stanford, 2003; Rosenfeld, 2004; Ruston, Clayton, & Calnan, 1998).

Social support has been studied with a particular focus on advice seeking after the onset of symptoms suggestive of cardiac illness. On a consistent basis researchers have found that there is an association between seeking advice from a physician and prolonged decision time (e.g., Bowker et al., 2000; Leitch et al., 1989; Zerwic, Ryan, DeVon, & Drell, 2003). Similarly, seeking advice from a relative is typically associated with a delay in seeking treatment (e.g., Rosenfeld, 2004); and living alone is frequently associated with delay (Banks & Dracup, 2006).

Socio-demographic factors also have been closely studied as researchers seek to understand treatment seeking. Commonly, there is a hypothesis that women are more likely to delay than men. Despite more than 2 decades of research, contradictory evidence continues to be reported. Although some researchers have found that being female is associated with greater delay in treatment seeking (Bowker et al., 2000; Finnegan et al., 2000; GISSI, 1995; Goldberg, Gurwitz, & Gore, 1999; Lesneski & Morton, 2000; Walsh, 1993), others have found that gender contributes no unique variance in delay time (e.g., Banks & Dracup, 2006; Moser, McKinley, Dracup, & Chung, 2005; Zerwic et al., 2003), or that being male is associated with greater delay (White & Johnson, 2000).
Finnegan et al. (2000), in a gender analysis of TSD, reported that the women in their study delayed because: (a) they attributed their symptoms to chronic conditions; (b) they had perceptions of low personal risk of AMI; and (c) they experienced higher levels of embarrassment related to false alarms. Of note, greater TSD among women runs counter to the overall tendency of women to access health-care more frequently than do men (Zerwic, 1999).

Based on reports in the health-care literature, gender can be said to be inconsistently related to TSD. When interpreting the results of research on gender and TSD, one must consider carefully the influence of population differences (by region), small sample sizes that provide insufficient power, and an absence of statistical control for confounding factors such as age and co-morbidity. Recall that women are, on average, a decade older than men when they begin to experience symptoms suggestive of cardiac illness (Zerwic, 1999). And, those who do not seek treatment at all are excluded from research about delay. It is unknown whether these numbers differ by gender.

Researchers have also reported a relationship between being “non-Caucasian” and greater TSD (e.g., Banks & Dracup, 2006; Goldberg et al., 1999; Haeok, Bahler, Chung, Alonzo, & Zeller, 2000; Lesneski & Morton, 2000). These studies are extremely difficult to interpret particularly because many results may be confounded by other variables, such as socio-economic status, language ability, and general access to health services.

When considering the body of health-care research about TSD, Clark (2001) noted that most studies about delay focus on understanding the characteristics of the persons who delay, rather than focusing on understanding why individuals delay. This is
an apt observation given that cognitive factors and decision-making processes have received far less attention from researchers, although this is changing. For example, the experiences of one’s symptoms and the attribution of symptoms sometimes referred to in the literature as the “appraisal of symptoms,” have been of interest to several researchers. Individuals have particular expectations about what it might feel like to have an AMI. Zerwic et al. (1998) found that a sample of the lay public had the expectation that the intensity of the pain or chest tightness would be at least 9 on a scale of 1 to 10, leading them to speculate about whether a person would seek treatment if the pain were less severe. Generally, there is agreement that if symptoms are sudden and severe and match the ‘Hollywood version’ of AMI, individuals tend to seek treatment sooner (e.g., Dracup, McKinley, & Moser, 1997; Dracup & Moser, 1997; Finnegan et al., 2000; Horne, James, Petrie, Weinman, & Vincent, 2000; Meischke, Ho, Eisenberg, Schaeffer, & Larsen, 1995; Ruston et al., 1998; Scherck, 1997; Zerwic et al., 2003).

There is debate in the health-care literature about gendered expectations of cardiac symptoms. For example, Lefler and Bondy (2004) reported a persistent belief, held by both genders, that men are more prone to have heart attacks than are women. Arslanian-Engoren (2005) interviewed 10 women who had been hospitalized for a first-time experience of a heart attack. She reported that the reality of having a heart attack was consistently found to be different than expected. Confusion over the cause of the symptoms contributed to delay in seeking treatment. Richards, Reid, and Watt (2002) found that both genders believed that women handle stress more effectively than do men and so the former group was viewed as being protected from heart attacks. As well, there is ongoing debate about the degree to which the two genders share the symptoms of heart
disease (e.g., Moser & Dracup, 1993; Zerwic, 1999). For example, McSweeney et al. (2003) interviewed 515 women with a mean age of 66 years, who had been diagnosed with AMI. They suggested that women’s prodromal symptoms differ from those of men. Women experience fatigue and shortness of breath as major prodromal signs as opposed to the ‘classic’ experience of chest pain or pressure associated with an exacerbation of cardiac disease. This study would have been considerably strengthened, however, by the inclusion of men in the sample.

Pattendon, Watt, Lewin, and Stanford (2003) carried out a qualitative study of the decision-making processes of 20 men and 2 women diagnosed with AMI and found that if individuals experienced prodromal symptoms several days before the acute event, the symptoms were ‘normalized’ and treatment was delayed. Similarly, Clark (2001) interviewed 8 men and 6 women about their decisions to seek treatment 48 hours after admission to hospital with an AMI. The participants in his study also reported ‘normalizing’ prodromal symptoms by carrying out daily activities and using innocuous or nondescriptive language such as “aches” or “listlessness” to explain their symptoms. Not until their chest pain became significant did the participants appreciate that something was awry. Even then, the tendency was to normalize the symptoms and to look for credible yet innocuous explanations of them, such as heartburn from something eaten the night before. The experiences of friends and family members helped the participants to assess what might be causing their symptoms. Only after all of these strategies were exhausted, and their symptoms persisted or worsened, did the participants begin to consider that they might have been experiencing a heart-related problem. This realization was accompanied by a need to seek advice from their family and friends about the best
course of action. Overall, the participants in this study described a need to be certain about the cause of their symptoms before they would seek medical treatment. Clark pointed out that although much work has been done to understand the dynamic interaction of mind and body in the setting of chronic illness, far less research has focused on understanding this relationship in acute illness.

Rosenfeld, Lindauer, and Darney (2005) interviewed 52 women who had been hospitalized for first time myocardial infarction. These researchers focused on understanding the women's experiences of their symptoms, and the decisions they made in relation to seeking treatment. Two groups emerged: a "knowing" group and a "managing" group. The former group knew they needed help and tended to seek treatment promptly. The latter group tended to try self treatment. The authors further identified decision trajectories (e.g., knowing and going to the ED, minimizing the symptoms) and suggested that knowledge about these trajectories might aid health-care professionals in reducing TSD.

Patients who seek treatment for symptoms suggestive of cardiac disease not only consider their symptoms, but also consider many other factors that ultimately shape their actions. For example, researchers have reported that fear and embarrassment play a role in the decision to attend an ED. Individuals are often fearful of being wrong about the cause of their symptoms and so may hesitate or delay seeking treatment (Pattendon et al., 2003; Wyatt, 2001). Many study participants have expressed concerns about wasting health-care resources and not wanting to bother others, both of which influenced their decisions about when to seek treatment. Wyatt (2001) surveyed a random sample of 349 women living in Vancouver, British Columbia. She found that women who had visited an
ED in the past were less likely to indicate that they would seek prompt treatment. As well, 71% of the participants indicated that they did not want to inconvenience others. Of particular relevance to this research is the fact that there was an association between a previous visit to an ED and intention to delay.

When considering the TSD literature, it is important to note three things. First, health-care professionals coined the term TSD in the context of cardiac illness, to signify clinically significant delay. MacLean (1975) pointed out that there is a confident superiority embedded in the use of the term. She argued that the phrase implies self determination and an assumption of precision in both the onset and character of the symptoms, enabling an individual to be certain about their attribution. The concerns raised by MacLean more than 30 years ago have not yet been addressed by researchers, although further theoretical development of the notion of TSD might shift researchers to new areas. An expectation that members of the general public would to be able to distinguish the symptoms of cardiac illness from all other diseases and to seek immediate treatment is perhaps unrealistic in light of our understanding that cognitive representations of health and illness play a critical role in health decisions (Croyle, Sun, & Hart, 1997). Second, it bears repeating that research in the area of TSD confirms that no single factor has primacy in decision making. Instead, a multitude of factors likely play a role in this process (Alonzo & Reynolds, 1998; Pattendon et al., 2003). Finally, a research focus on predominantly demographic variables contributing to TSD may be limiting our ability to see beyond these variables to examine the contributions of other social, cognitive, and emotional factors. For example, previous experience with ED care may play a role. As well, lay understandings about what is involved in undertaking a visit
to the ED, drawn from the media or the personal accounts of friends, may influence treatment-seeking decisions.

Research about TSD is to some extent hampered by a lack of theoretical development of the concept as well as challenges related to its measurement that have yet to be consistently addressed. For example, researchers tend to use medical records to determine the time of onset of symptoms. However, as reported by several researchers, there are typically substantial differences between chart reports of the interval, and patients’ recollections (Fukuoka, Dracup, Ohno, Kobayashi, & Hirayama, 2005; Goldberg et al., 1998; Goldberg et al., 2002). In addition, the measurement of delay often includes that portion attributable to pre-hospital transportation (e.g., paramedic response time), over which an individual may have little control. An additional challenge lies in capturing the data from critically ill patients. Typically only hemodynamically stable patients are included in studies, which may have the effect of over-estimating mean delay time if, in fact, delay is shortened by increased severity of symptoms (e.g., Banks & Dracup, 2006).

Clearly each of these studies confirms that despite our best efforts at public education, TSD remains a significant clinical issue. Of note, although researchers studying ED care have examined patient satisfaction and the factors associated with it, they have not studied how health-care interactions might influence future health-care decisions.

**Gender and Experiences of Emergency Services**

Gender is a cultural construct, arising from the norms with which individuals are inculcated from the moment they are born; sex, in contrast, is a set of physical
characteristics that determine biological sex assignment (Brooks, 2000; Lundberg & Parr, 2000; Watkins & Whaley, 2000). The relationship between gender and health has been extensively explored, particularly in the past 2 decades. Researchers have established that health status may differ according to gender. Women live longer than men (Lundberg & Parr, 2000). Men are more frequently diagnosed with cardiac disorders, whereas women are more often diagnosed with auto-immune or psychological disorders (Schooler & Baum, 2000).

In terms of the social context of health, gender is constructed in particular ways for men and women. According to Davies (2003), “doing masculinity” requires one to be rational, objective, decisive, and physical. In contrast, “doing femininity” requires one to be subjective, empathetic, and nurturing. Although this seems to be an over simplification, there are data to suggest that there are concrete differences between the way men and women view health and healthful lifestyle practices (Saltonstall, 1993). As well, the experiences of men and women differ by socioeconomic status. For example, women classically earn lower wages than do men for comparable work and are more likely to be single parents (Lundberg & Parr, 2000; Schooler & Baum, 2000). Income has been shown to be an important determinant of health status. As well, women tend to work significantly longer hours than do men when unpaid work, such as care-giving or housework, is taken into account (Lundberg & Parr, 2000). Gender and health care also have been extensively studied with researchers finding that, overall, women access health-care services more frequently than do men (Schooler & Baum, 2000; Watkins & Whaley, 2000).
Men and women may also differ in their expectations about health-care professionals. Writing about gender and health care, Watkins and Whaley (2000) pointed out that women value interpersonal competence more highly than do their male counterparts, which is reflected to some extent in the observation that visits with health-care professionals are longer for women than for men (Good et al., 2000; Watkins & Whaley, 2000; Weisman et al., 2000). Women also ask more questions and want more information (Weisman et al., 2000). Weisman et al. (2000) argued that men and women experience basic health care differently and may evaluate health-care services by different factors or weightings of factors.

In Canada, women admitted to the hospital with a new heart attack are significantly more likely to die in the hospital within 30 days, than are men, even after age and co-morbid conditions are taken into account. Thirty-day mortality rates, post heart attack, are reported to be 16% greater for women than for men (Canadian Institute of Health Information, 2006). Woodfield et al. (1997) reported that being female was an independent predictor of 30-day mortality post heart attack. Similarly, Blomkalns et al. (2005) published a review of existing gender disparities in the diagnosis and treatment of ACS. They reviewed national data from 35,875 cases and found that women (41% of the sample) were more likely to die in hospital (5.6 vs. 4.3%) and to reinfarct (4% vs 3.5%). Although confounding factors such as age and severity of disease undoubtedly play a role, we do not yet fully understand the reasons for these persistent differences. For example, the role of biology in outcomes is not yet clearly explicated. Women’s comparatively poorer outcomes post-angiography may be partially attributable to the
smaller relative diameter of female coronary vessels, which make angiography more difficult to perform.

In the context of emergency services, little has been written in relation to gender and health care. However, O'Brian and Fothergill-Bourbonnais (2004) researched the experiences of trauma patients in the ED. They reported that the women in their study derived a sense of comfort from the presence of family and friends. In contrast, the men were less concerned about social support and were worried that their family and friends might “get in the way” of health-care professionals if an emergent situation arose. Similarly, Redley, Beanland, and Botti (2003) reported that female gender, for both patients and family members, is associated with reports of greater anxiety during a visit to an ED (depending on age). And, O'Donnell, Condell, Begley, and Fitzgerald (2005) reported that women experienced greater delays from “triage to medical assessment” than did men (30 minutes compared to 20 minutes) and greater delays in average door to needle time (70 minutes versus 52 minutes). Although this is a single study that took place in 6 major teaching hospitals in Ireland, the findings highlight the possibility that gender may influence outcomes.

The Health-care Environment

In the last 2 decades, several certainties have become apparent in relation to the health-care system in Canada. First, health-care is a program deeply embedded in the Canadian psyche (Lynam et al., 2003). Canadians believe that health care is a right and that socialized health-care is part of the national identity (Lynam et al., 2003; Pauly, 2004). Despite the commitment of Canadians to health care for everyone, the federal government has made significant cuts in transfer payments to the provinces (Lynam et
Second, health-care restructuring, fiscal restraint, rationing of resources, and a focus on efficiency have created a work environment for health-care professionals that is increasingly challenging (Lynam et al., 2003). Health-care restructuring, and a commitment to cost containment, has been driven by discourses of scarcity and efficiency (Anderson, 2000). Unfortunately, because the streamlining of systems is not always accompanied by appropriate transfer of resources (e.g., from hospital to home care), gaps now exist in relation to services and care (Lynam et al., 2003). Instead, the focus is on transferring responsibility from public to private spheres (Anderson, 2000). As a result, nurses are “scrambling to keep up” in every health-care setting.

Rodney and Varcoe (2001) identified that nurses are working with fewer resources and are forced to make increasingly difficult ethical choices in their rationing of time and care for patients. According to Varcoe et al. (2003), the often heard phrase, “we don’t have enough,” is unwittingly extended to “we don’t have enough for this old, or irresponsible, or addicted person.” Decisions about deservedness or entitlement are based on particular biases, which likely become stronger in a climate of resource scarcity, and are often a reflection of the values held by members of society (Woodward, 1999). Generally speaking those who are young (Tsuchiya, Dolan, & Shaw, 2003), cooperate, comply with treatment, adopt the “good patient” role (Holyoake, 1999), have health problems that are not the result of risky behaviour (Olsen, Richardson, & Dolan, 2003), or are facing avoidable death due to accidental injury (McKie & Richardson, 2003; Woodward, 1999) are likely to be viewed as deserving of health-care resources.

The health-care system is perhaps misnamed. Currently, an illness-care system is funded in Canada and the United States. The cornerstone of this system is a biomedical
view of health and illness. According to Armstrong (2000), within a biomedical model, all illness is reduced to a pathological lesion within the confines of the human body. As a result, the social and historical factors that play a role in illness are obscured (Charmaz, 2000).

The Context of Emergency Services

Emergency departments are much more than the nation’s last line of defence for the medically indigent; they are the frontline caregivers to all of us, providing care during our most vulnerable times: emergencies and disasters. (Eastaugh, 2002, p. 11)

EDs are characterized as a “safety net” for communities (Asplin, 2003). EDs provide urgent care when no other access to health care is available. In addition, personnel in EDs provide primary health-care and treat exacerbations of chronic conditions. For the most part, EDs are open 24 hours a day, 7 days a week and, in Canada, all individuals who present are treated regardless of health status or ability to pay. The needs of ED patients are often acute, episodic, and may involve any form of physical or psychological illness or injury. In this fast-paced environment, there is little time to establish the trust upon which a nurse-patient relationship is based (Fitzpatrick, 2000). Indeed, Davies (2003) reported that in the context of an acute-care hospital, during a history and physical examination, it takes an average of only 7 seconds before the health-care professional stops listening to an individual’s account and takes over the communication process.

Varcoe (1997) conducted an ethnographic study of the relationship between the social context of practice in an ED and the ways in which nurses recognize and respond to women who have been abused. She provided an insightful and comprehensive exploration of the ED practice environment and clearly identified that the efficient
processing of patients (within an ideology of scarcity) was routine practice in the ED. Efficient processing requires emotional distancing and maintaining a strong focus on the physiological concerns of patients (Varcoe, 1997).

**Physical Environment**

The physical environment of EDs is almost uniform, characterized by high traffic (both people and equipment) and high noise levels (Sibbald, 2001). In an interesting study, Wears and Perry (2002) examined the ergonomic design of an ED and concluded that the physical environment was a "nightmare." They pointed out that in emergency situations, the staff's expertise and willingness to adapt to the constraints of their physical surroundings lead them to adapt to, rather than change their environment, and to react to, rather than anticipate, provocations. The authors argued that lack of visibility, lack of standardization, and physical constraints create unsafe situations for patients and healthcare professionals. Similarly, Haugh (2004) wrote about the renovations to a large ED, pointing out that the typical physical layout does not take into account the effects of overcrowding and long patient wait times, whether at the triage desk, in the waiting room, in the hallways, or inside the department. Thus, there is no provision for the current situation in EDs across Canada and the United States.

In the past decade, there has been a general reduction in the number of EDs in the country and an increase in the number of visits to EDs (Schafermeyer & Asplin, 2003; Velianoff, 2002). Because of bed closures, hospital and unit downsizing (Blomkalns & Gibler, 2004; Eastnaugh, 2002; Schafermeyer & Asplin, 2003), a shortage of long-term care beds (Canadian Association of Emergency Physicians, 2003), and budget shortfalls, the capacity of the acute-care system is shrinking. At the same time, a variety of factors
including a shortage of nurses and primary health-care providers (Glick, 1997; O'Brien et al., 1997), shifting population demographics as baby boomers reach retirement (Canadian Association of Emergency Physicians, 2003; Knickman & Snell, 2002; Larsson et al., 2004; Rice & Fineman, 2004), and increasing numbers of patients presenting with chronic disease exacerbations (O'Brien et al., 1997; Rice & Fineman, 2004), further contribute to lengthy waiting times almost every urban or community ED in the country. Several researchers have identified that the single most common cause of overcrowding is a department’s inability to transfer patients who have been assessed, treated, and admitted to the hospital (Blomkalns & Gibler, 2004; Fields, 2003).

Overcrowding is defined as waiting to be seen by a physician for more than 60 minutes (Lambe et al., 2002), although there is some variability in the way hospitals and administrators report overcrowding (Kennedy, Rhodes, Walls, & Asplin, 2004). In relation to the initial assessment by a physician, waits of several hours (sometimes more than 8 hours) have become the norm, even for those with symptoms suggestive of cardiac illness. Once admitted to a stretcher in the ED, an individual will likely wait for hours or days for in-hospital admission (e.g., Eastnaugh, 2002; Schafermeyer & Asplin, 2003; Schneider, Gallery, Schafermeyer, & Zwemer, 2003), a phenomenon sometimes termed “inpatient boarding.” Almost inevitably, inpatient boarding results in a reduced ability to mobilize staff to emergency situations because they are caring for admitted patients (Kennedy et al., 2004). Within the current literature, overcrowding is increasingly linked by researchers and clinicians to issues of access to health-care (Kennedy et al., 2004).

Authors condemn governments for failing to address the issue of overcrowding in EDs and professional organizations are promoting practice standards and guidelines for
risk management in the provision of care for patients during long waits (Sibbald, 2001; Wilson & Rosenberg, 2004). The rhetoric of “a crisis in emergency care” is a common theme. Unfortunately the majority of authors focus on the practice of individuals, whether they are triage nurses, bedside ED nurses, or ED physicians. And, all too often, every suggested solution involves additional work for practitioners in the form of subcommittee meetings, documentation, reporting, or completing professional responsibility forms. The main focus is on protecting patients and practitioners, or on identifying and eliminating the attendance of those deemed to be using the ED “inappropriately.” Typically, less attention is given to solving the larger problems of an overflowing system, although this is changing as researchers and policy makers attempt to operationalize and measure overcrowding (Asplin et al., 2003; Canadian Association of Emergency Physicians, 2003).

As a response to the issue of overcrowding, administrators have considered satellite units to hold admitted patients, pending the availability of inpatient beds (Gantt, 2004). Alternatively, administrators have created specialty units for large sub-groups of patients such as those admitted for substance abuse, psychiatric issues, or for cardiac observation (Blomkalns & Gibler, 2004; Gantt, 2004). There is also discussion in the health-care literature about evidence-based practice and the need for practice algorithms to stratify patients by risk and to assign the few remaining beds appropriately (Blomkalns & Gibler, 2004).

As a result of overcrowding, many hospitals engage in the practice of “diversion” or “critical care bypass” during which, for a predetermined period of time, an ED diverts patients arriving by ambulance to other EDs in the geographic area (Lambe et al., 2002).
Although this practice provides time for an ED to ‘decongest,’ it has the adverse effect of taxing the EDs in nearby hospitals, often overcrowding them (Lambe et al., 2002) and resulting in a situation known as “gridlock” in which all EDs in the area are diverting patients (Schull, Lazier, Vermeulen, Mawhinney, & Morrison, 2003). Unfortunately, in addition to delaying definitive care, patients may be transported to a hospital outside of their home community, which can result in significant hardship for their family and friends.

Overcrowding brings into sharp focus the ethics of decisions made about the distribution of scarce resources. Bunch (2002) studied the ethical dilemmas faced by critical care nurses and physicians. She highlighted that, in the current environment of resource scarcity, every decision about bed allocation and patient transfer has serious ethical implications. In effect, you are choosing who is going to get help and who is not, based on reasons that are not always transparent. Unpredictability, scarce resources, and overcrowding mean that patients may be judged in relation to the perceived appropriateness of their decision to seek treatment in an ED. Varcoe (2001) reported that women who sought care in an ED for injuries related to domestic violence were judged as deserving or not deserving based on factors such as their social status, severity of physical injury, or the involvement of alcohol.

Patients in EDs

The vast majority of individuals who present to EDs are self referred and, although the name “emergency department” conjures up images of broken bones, major trauma, and near drownings, in reality, up to 50% of ED visits are non-urgent (Baker & Baker, 1994; Derlet, Kinser, Ray, Hamilton, & McKenzie, 1995). These individuals are
sometimes termed “inappropriate attenders” (Liggins, 1993; Prince & Worth, 1992; Walsh, 1994). Of note, in Great Britain, the name of the ED is “accident and emergency.” This was changed from the original term “casualty” to discourage the casual use of hospital emergency services (Derlet et al., 1995). Yet renaming the ED does not stop people from making strategic choices about ED visits. For example, O’Brian et al. (1997) studied a group of patients presenting to urban EDs and found that patients are well aware of the conveniences of visiting an ED for health care. Open 24 hours a day for 7 days a week, EDs are convenient and care is provided without the need to arrange for childcare or employment leave. Consequently, casual usage is unlikely to cease.

Baker and Baker (1994) estimated that the provision of point of access care in an ED is more expensive than providing the same care in a primary care setting by a ratio of approximately 3:1. The numbers of patients presenting and the cost of treating patients have prompted some EDs to consider the practice of “triaging out.” Triage is the point of first contact for individuals seeking treatment; typically, an individual presents to a triage desk (the entry point for care in most EDs) and is assessed by an experienced registered nurse (RN). The RN makes a judgment about the acuity of the presenting problem, which is informed by a brief history, vital signs, and other objective information such as the patient’s general level of distress. The judgment about the acuity of the problem is used to determine how soon a patient will be admitted to the department for a more detailed nursing and physician assessment. “Triaging out” is the practice of assessing a patient at the triage desk, determining a low level of acuity, and asking the patient to seek treatment at an alternative health centre (usually a clinic or primary-care provider).
Derlet (1995) completed a 5-year study in which they developed guidelines for triaging out. They found that 18% of patients presenting to triage had non-urgent complaints, and argued that any increase in liability was offset by the cost savings generated by not seeing those patients in the ED. This is a solid illustration of institutional practices driven exclusively by resource considerations. Of note, these authors did not write about the possibility of long-term sequelae arising from this practice. Indeed, collectively, studies that research "inappropriate attendance" focus on immediate considerations such as cost savings and do not consider the long-term implications of denying or discouraging access to individuals seeking treatment. Many unanswered questions persist. For example, in the long term, what are the implications of refusing service to members of a community? Will people continue to return when they need to if they or their family members have been refused care? Do the characteristics of those turned away differ from the characteristics of the group treated (e.g., ethnicity, gender, socio-economic or mental health status)?

Green and Dale (1990) pointed out some of the assumptions that underlie the notion of inappropriate attendance in the ED. First, individuals who present to EDs for the treatment of non-urgent conditions often do not have access to primary health-care. Second, there is no consensus among health-care professionals about what constitutes the "appropriate" use of an ED. Third, differences exist between lay and professional definitions of appropriate use. Baker and Baker (1994) claimed that despite potential "savings" that might result from triaging out, EDs have high fixed operating costs, so the realization of real cost savings may not be possible. Grouping people into the category of inappropriate attenders assumes that individuals are able to make accurate judgments
about the severity of their conditions without the input of health-care professionals. This ‘cuts both ways’ as we expect individuals with the symptoms of cardiac disease to obtain an informed opinion (in the form of a visit to the ED) immediately after the onset of symptoms.

**Clinical Practice in EDs**

The culture of EDs is a factor that influences patients’ experiences of hospital emergency services. Eastnaugh (2002) made a compelling argument that individuals who present to EDs are relatively over-treated because ED staff are educated to consider the worst case scenario. Hence every patient becomes classified as “high risk” and a plethora of tests and invasive procedures are ordered. Thus, the duration of ED stays are extended significantly, which contributes to overcrowding and extended waiting periods.

Advances in technology have influenced Canadian EDs. Barnard (1999) argued that society in general, and nursing in particular, equates technology with a utopian existence. That is, it is assumed that technology leads to progress, growth, and development. Indeed, Barnard argued that technology is one of the foundations of western civilization, at least since the onset of the industrial revolution. As such, society tends to embrace technology. Nowhere is the professed value of technology more obvious than in critical-care areas within the health-care system.

In the past, treatments received in an ED were relatively straight-forward. If a particular health concern could not be addressed in the ED setting, individuals were admitted as inpatients and transferred to hospital wards within minutes to an hour at most. Along with the pressures brought about by closures of inpatient beds and the factors previously discussed, additional pressure is on every ED as the scope of
procedures and standards of practice change (Turris & Bell, 2004). For example, 10 years ago, a patient with a Colle’s fracture of the arm would have been sent to the operating room (OR) to have the fracture immobilized. Similarly, if an individual required any painful procedure, that procedure would have been carried out in the OR under anaesthetic. Pharmaceutical companies have provided many new medications that make “conscious sedation” – a twilight state between sleep and wakefulness – possible and consequently, these procedures can now be carried out in EDs. In fact, there are now so many choices that practitioners must choose between agents for conscious sedation, determining which agent will allow patients to be discharged from the ED the most expeditiously (Coll-Vincent et al., 2003). As researchers have uncovered the etiology of such conditions as AMI, health-care professionals are able to intervene much more intensively. For example, a decade ago, if an individual attended an ED with an AMI, there were only one or two medications available for treatment. Now it is commonplace to give seven or eight medications and to expose a patient to invasive procedures for removal of the blood clot.

Health-care Relationships in the ED

Health care in an ED could be described as a “seller’s market” in which individuals in the position of the patient are characterized as supplicants (Roter & Hall, 1997). This puts health-care professionals in a position of power that is supported by their education, experience, and knowledge about health and the health-care system. All of this comes into play during encounters within an ED.

Social, historical, and experiential factors play roles in expectations of care in an ED. Images of health-care relationships in the ED are often drawn from the popular
media. Accordingly, the word “emergency” conjures images of crisis, calamity, and disaster. Television shows such as “ER” glamorize the setting and emphasize the small proportion of individual cases that are emergent. Responses by the staff on television are instantaneous and dramatically life saving. Magazines and newspapers carry editorials about EDs, pointing out overcrowding and, occasionally, profiling accidental deaths. Signs outside of the hospitals are usually red and white and feature the word “emergency” in large letters. Police cars and ambulances are often parked in front of the department, giving a clear message that important matters are being dealt with at any given time of day. To add to the drama, ambulances use lights and sirens and drive speedily on city streets to deliver people to EDs. It is against this backdrop that health-care interactions occur.

Patients and health-care professionals adopt two diverse perspectives when interacting. The former approaches health problems with an illness attitude, focusing on the social, physical, and emotional sequelae arising from the symptoms, and the latter employs a scientific disease model that rests on abstractions from the lived experience (Hartrick, 1996; Mabeck, 1997; Roter & Hall, 1997). In some ways, the two groups are speaking different languages. Nowhere is this more obvious than in an ED.

Patient satisfaction is one way in which the quality of relationships in the ED is examined. Although the concept of patient satisfaction is not well supported by a theoretical base and many authors have debated the merits of primarily survey-based investigations of patient satisfaction (e.g., Strasser, Aharony, & Greenberger, 1992; Turris, 2005; Williams, 1994), the concept remains the most popular way to investigate the care provided, not only in the ED, but in a wide variety of health-care settings. Patient
satisfaction with an ED visit has been shown to depend primarily on two factors: the nurse-patient relationship and the quality of the information provided (e.g., British Columbia Ministry of Health, 2004; Davis, Bush, & Thomas, 1997; Gotlieb, 2002; Knudtson, 2000; Raper, 1996).

In the current health-care context, patient satisfaction is seen to have both practical and political relevance. Practically speaking, long waiting times or unsatisfactory relationships with health-care providers are potential barriers to treatment seeking or to treatment choices. Conversely, researchers have linked satisfaction with patient loyalty (Strasser et al., 1992), treatment adherence (Strasser et al., 1992; Williams, 1994), and positive health outcomes (Kaplan & Ware, 1995). In addition, patient satisfaction is used as a proxy measure of healthcare quality. Politically speaking, attention to patient satisfaction – with an apparent emphasis on the viewpoint of individual patients – is a way to be responsive to the public. The concept of patient satisfaction is often seen by health-care providers as a suitable vehicle for addressing the issues of both ‘people-centred’ service and accountability (e.g., Avis, Bond, & Arthur, 1995; Dougall, Russell, Rubin, & Ling, 2000; Williams, Coyle, & Healy, 1998).

Recently the British Columbia Ministry of Health (2004) reported that 85.2% of individuals who sought ED care between July and September of 2003 rated the care they received as “good, very good, or excellent.” The researchers mailed out 43,131 surveys to randomly selected individuals who received ED care during a 3-month period and received a response rate of 38%. Although at first glance this is favourable, the results of the study must be interpreted cautiously. Although the response rate may be adequate for a mailed survey, a great many people who sought care in an ED did not participate,
introducing the possibility of bias because the people who responded may be a different group than those who did not. In part, this may occur because the survey data are controlled by the researcher, whereas in qualitative interviews, there is room for the patients’ perspectives. In addition, as discussed by Concato and Feinstein (1997), the psychometric approach that is commonly used in patient satisfaction studies seldom gives suitable attention to patients’ values and beliefs related to health care.

Garman, Garcia, and Hargreaves (2004) studied patient satisfaction as a predictor of return to the care provider (in an academic medical centre) in a sample of 1475 people. They found that satisfaction was associated with items addressing perceptions of how well physicians and nurses attended to and provided information for family members and the patients themselves. The unique contribution of this study was that the researchers measured actual return visits over a 2-year period, rather than intention to return. Although this study offers some insights into the relative importance of health-care relationships in shaping patients’ perceptions of their care experiences, these results must be interpreted with caution, given that the American health-care funding model limits individual choice of health-care providers and the survey return rate was 13.2%.

Coping, Stress, Women, and ED Encounters

Women seeking treatment for the symptoms suggestive of an acute cardiac event must experience and cope with stress. Pain, reduced availability of their usual sources of social support, fear, and an unfamiliar environment are a few of the factors that contribute to their experience of stress. Therefore, it is useful to briefly examine the state of knowledge about stress and coping.
Two decades ago, Lazarus and Folkman (1984) wrote about the concepts of stress and coping. In the new millennium, stress is a familiar concept to every member of Western society. The discourse of stress is a phenomenon embedded in our every day lives (Donnelly & Long, 2003); one seldom experiences a day without a conversation about stress levels or coping strategies, whether by the water cooler or in a professional capacity. Although stress and coping theory has given researchers the tools and the language to examine the relationships between stress and disease, there are some well-recognized shortcomings to current conceptualizations of stress and coping. First, stress is seen as an inevitable part of modern living. Second, too much stress is assumed to be harmful. And third, the responsibility for coping with stress rests with the individual. In practice this means that the efficacy of coping is attributed to individuals, without a consideration of access to, and control over, resources and support. Thus, stress has been naturalized, normalized, problematized, and individualized (Donnelly & Long, 2003; Hallman, Thomsson, Burell, Lisspers, & Setterlind, 2003; Kushner & Harrison, 2002).

Within the published literature, coping is regarded as both a trait (part of a person’s character, predisposing that person to react in particular ways across incidents and over time) and as a process (constantly changing cognitive and behavioural efforts to manage specific external and internal demands that are appraised as overwhelming the resources of a person) (Lazarus & Folkman, 1984). Accordingly, coping strategies such as help seeking, venting, or avoidance are employed in response to a stressor. Coping strategies are typically divided into problem-focused or emotion-focused. The former refers to coping aimed at changing a situation, whereas the latter refers to attempts to regulate the emotions caused by a situation (Kristofferson et al., 2003).
A great deal has been written about gender, stress, and coping. Hallman et al. (2003) argued that women, by virtue of entering the workforce and maintaining a home life, expose themselves to increased stress levels and stress-related illnesses. According to these authors, multiple factors contribute to the increased vulnerability of women to stress and stress-related disorders as evidenced by a higher prevalence of such conditions as major depressive disorders and post-traumatic stress disorder (PSTD). Understanding stress and coping and how the experience of stress is influenced by gender is important and deserves more attention. For example, Garvin et al. (2003) studied 410 patients with AMI within 48 hours of admission to a hospital and found that the women expressed greater anxiety than did the men. Other researchers have found that high anxiety levels are correlated with in-hospital complications and cardiac events (Hallman et al., 2003).

Researchers have established that there are physiological differences between male and female bodies related to the actions of hormones such as estrogen and cortisol (Carter-Snell & Hegadoren, 2003; Motzer & Hertig, 2004). Unfortunately, the assessment of stress levels and coping capacity is usually confined to an assessment of individual coping strategies (i.e., emotion focused or problem focused), individual resources (i.e., the availability of a strong social network), and examination of individual responses (i.e., PTSD, depression). Coping in this context is defined as cognitive and behavioural efforts to reduce or tolerate internal or external demands and conflicts and may be both emotion and problem focused. Gender is rarely given attention as an influencing or moderating factor in the research on stress and coping (Banyard & Graham-Bermann, 1993; Hallman et al., 2003), which makes it difficult to apply this body of research to women’s lives and experiences. Banyard and Graham-Bermann (1993) argued that there are gender-based
value judgments about “good” and “bad” coping. Accordingly, scholars of stress and coping are starting to call for research that directs attention to gender systems and power relations, moving away from individualization (Donnelly & Long, 2003; Hallman et al., 2003; Malterud, Hollnagel, & Witt, 2001).

Society

When analyzing the social context of treatment-seeking and women’s experiences of an acute cardiac event, at least three phenomena are important to consider. First, individualism, individual rights, and a value for autonomy and freedom – a libertarian focus – are the bedrock of social systems (Anderson & Kirkham, 1998). However, within health-care, the commitment to individual rights plays out in particular ways. Individuals are viewed as responsible for their health and illness states (Anderson, 2000). As a result, there is a strong tendency (by both health-care professionals and lay people) to blame individuals for their illnesses (Turner, 2000). In the context of women experiencing chest pain, this can be observed when health-care professionals question a woman about tobacco use or cholesterol levels in a way that places blame on the individual. We do not know what effect the assignment of personal responsibility has on future health-care decisions.

Second, globalization and the resulting changes in global market structures have contributed to a market driven ethos in health care. In this environment, cost-saving measures are often fore-grounded in considerations of resource distribution, and best practice and ethical issues are back-grounded (Mohr & Mahon, 1996). In addition, market considerations are at least partially driving the rhetoric about health-care
sustainability in the Canadian context. This means that cost saving measures such as
closing in-patient hospital beds will likely persist, even in the face of ED overcrowding.

Third, within Canada and the United States there is a general expectation that
public services will be available when required. This has extended to health-care services.
Members of the public are dismayed to wait even 1 hour for treatment and 8 hours or
more is deemed unacceptable. What happens when public expectations are not met? Does
the mismatch between expectations and delivery affect decisions about health care?

Summary and Conclusions

Cardiovascular disease remains the number one killer of Canadian women.
“Time is muscle” and any delay in treatment for acute cardiac events substantially
increases the amount of damage done to the myocardium. Decisions about treatment
seeking are complex and no single factor fully predicts who is at risk for harm as a result
of a delay. In this literature review, I have provided evidence that there are significant
gaps in knowledge about the complex phenomenon of TSD. Efforts to date have focused
on searching for relationships between TSD, socio-demographics factors, personal
factors, and social support utilization. This approach has not explained the phenomenon
nor identified solutions, and health-care professionals have so far been unable to address
TSD definitively. In this literature review, I have suggested that we need to question
more broadly and investigate the context of health care and how that context might
influence the decisions women make about seeking treatment. Women’s experiences of
health care in an ED setting, often the point of first contact with the health-care system,
are not well understood. Developing knowledge about the influences of gender on
experiences of ED care might assist in addressing the phenomenon of TSD.
EDs in Canada and the United States are currently in a state of crisis. Messages about that crisis are transmitted frequently to the public through the popular press and print media. We know that positive health-care encounters influence outcomes in a positive way. I have highlighted the evidence that suggests that one’s experience in an ED may act as a deterrent in future situations requiring emergency services. Yet, bodies of literature that might provide guidance for health-care practitioners are under-developed and lack a focus on gender as a potential moderating factor in the experiences of health care in general and ED care in particular. We do not know enough about women’s experiences of ED care, and we do not know about the relationship between the experiences of ED care and intention to seek treatment in future situations.
CHAPTER THREE: METHOD

The method employed for this study was Grounded Theory (GT). GT has a long tradition within health research. Over the past 3 decades, many forms of GT research have been developed. In this study, I employed a Glaserian approach to GT. I selected this approach for two reasons. First, Glaserian GT has a holistic focus. Glaser (1998) suggested that researchers consider entire incidents rather than fragments of data. In the complicated world of health care, a sense of “what is going on here?” with a focus on overall meaning, rather than discrete events, is invaluable for creating theory. Second, the focus of GT is understanding the basic social and/or psychological process that is taking place. I was interested in examining women’s experiences during an episode of symptoms suggestive of cardiac illness and explaining the process by which those women make sense of their experiences prior to, during, and after their visits to an ED.

Theoretical Framework and Theoretical Assumptions

GT is a qualitative research method that has its roots in symbolic interactionism (SI) and is aimed at the generation of theory to explain the basic social psychological process operating in a given situation. SI, a theoretical perspective fathered by Herbert Blumer, emphasizes the study of human group life and conduct. “Meaning,” “language,” and “thought” are the core concepts within this perspective. The first core concept of meaning contains the assumption that humans act toward people and things based upon the meanings that they assign to those people or things. Language, the second core

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2 Blumer’s use of the phrase “core concept” should not be confused with Glaser’s use of the phrase “core category.” The former refers to concepts within a framework for examining human interaction (the tools) whereas the latter refers to the findings (the product) that emerge from systematic investigation of human interaction in a specific context.
concept, gives humans a means by which to negotiate meaning through symbols. It is by engaging in speech acts with others (symbolic interaction) that humans come to identify meaning. The third core concept is that of thought. Thought modifies each individual's interpretation of symbols. Thought, based on language, is a mental conversation or dialogue that requires role taking, or imagining different points of view. People then act on the basis of the meaning they derive (Benzies & Allen, 2001). A focus on meaning, language, thought, and interaction exposes not only the events that are taking place, but also the meaning ascribed to those events.

In adopting SI as a theoretical perspective, I acknowledge that situations may have different meanings for different individuals, but there exist shared, common elements that can be illuminated and used to understand the human condition. Accordingly, research informed by this perspective explores human communication and its consequences (Charmaz & Mitchell, 2000) by focusing attention on both the social process and traditionally, albeit to a lesser extent, the social organization (Benzies & Allen, 2001; Glaser, 1992; Hall, 1987; Lal, 1995). SI guided my analysis by prompting me to explore the meaning of events for participants in this study. Thus, I attended to the quality and form of the interactions between the women and their health-care providers. Throughout the data collection and analysis phases of the research, I sought to understand and explain the basic social psychological process at work during a woman’s experience of symptoms suggestive of cardiac illness.

Although SI offers a focus on process and meaning, in order to perform a comprehensive analysis of the data for this project, I employed a variety of secondary theoretical lenses. Table 1 details the additional lenses that were employed during the
data analysis. Specifically, feminism and critical social theory (CST) lenses were employed. These two perspectives directed my attention to power inequities and power dynamics at work in the ED, as well as to the roles of gender, age, and ethnicity in experiences of ED care. Of note, I am not making a claim that the method in the present project is explicitly feminist or aligned with critical social theory. Instead, I am explaining that feminist and CST perspectives informed my inquiry.

Feminism and feminist philosophies have in common an ideological perspective in which understanding the pervasiveness of gender in everyday experiences is central. In relation to research, feminism offers a counterpoint to scientific rationalism, positing that there are many realities and not a single “truth” (Olesen, 2000). Knowledge is viewed as situated (Haraway, 1991) and researchers are not objective observers, but reflexive participants. Researchers using feminist methods seek to establish non-exploitive and reciprocal encounters with research participants (Creswell, 1998). Similarly, CST encompasses many perspectives. The critical traditions have in common a focus on understanding the relationships that exist between individuals and society. Oppression, domination, equality, and independence are central to everyday experiences and, as is the case with gender, they are pervasive and often undetected (Kincheloe & McLaren, 2000).
Table 1 – Relationship Between the Relevant Theoretical Perspectives and the Research Questions

<table>
<thead>
<tr>
<th>Critical Social Theory and Feminist Theory</th>
<th>Examples of Critical Questions Informing Data Collection and Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Themes: oppression, power relations, gender</td>
<td>What is involved in turning an individual into a “patient?”</td>
</tr>
<tr>
<td></td>
<td>In what ways do individuals embrace or resist the role of patient?</td>
</tr>
<tr>
<td></td>
<td>In what way is agency supported or minimized during a visit to the ED?</td>
</tr>
<tr>
<td></td>
<td>In what ways do women manage their fear and anxiety related to an ED visit?</td>
</tr>
<tr>
<td></td>
<td>In what ways does gender appear to influence the care patients receive?</td>
</tr>
<tr>
<td></td>
<td>What does visiting an ED mean to the women in this study?</td>
</tr>
</tbody>
</table>

Study Overview

I carried out data collection in two EDs over a one-year period in 2005/06, collecting three sources of data. I conducted audio-taped, semi-structured interviews with women 2-6 weeks following their discharge. This provided data regarding the women’s perceptions of their experiences in the course of seeking treatment for symptoms suggestive of cardiac illness. I also interviewed three, expert ED nurses. And, I undertook naturalistic observation to obtain data regarding the context of treatment seeking and the ways in which relationships between women and their health-care providers are constructed in both EDs.

Study Settings

I collected data from two EDs in a western Canadian province, targeting one tertiary care and one community hospital, both with more than 50,000 ED visits each year. Hospital A is a tertiary care referral centre for the province. In contrast, Hospital B
is a community hospital, located in a residential suburb. Hospital B is not designated as a trauma hospital.

The history and culture of the two EDs differ. For example, nurses in their 20s and 30s tend to work and live in the centre of the city, whereas community hospitals tend to attract older nurses with families, who live in the suburbs. As well, referral centres have a different funding envelope compared to community hospitals and thus, nurse-patient ratios often differ. The patients also differ. Hospital A is a metropolitan hospital and, therefore, the staff in the ED often care for patients who live on the street in the downtown core. In contrast, the staff in Hospital B assess and treat a higher proportion of pediatric patients and older adults.

Sample and Recruitment

Sampling for this project was directed at obtaining a rich pool of participants and observations. Initially, the sample was a convenience sample drawn from a group of women who sought ED care for the assessment of symptoms suggestive of an acute cardiac event, were willing to participate, and met the criteria for participation described below. Individuals had to be:

1. Attending either of the two EDs for assessment of symptoms suggestive of an acute cardiac event.
2. Hemodynamically stable.\(^3\)
3. Eighteen years of age or older.
4. Able to speak English.
5. Competent to provide informed consent.

\(^3\) Hemodynamic stability was defined as: systolic blood pressure above 110 mmHg; normal sinus rhythm or atrial fibrillation with a heart rate of less than 120 beats/minute; respiratory rate of less than 24/minute; oxygen saturation of more than .95; and a Glasgow Coma Scale score of 15 (i.e., eyes opened spontaneously and the woman was oriented, conversed, and obeyed directions).
I obtained the accounts of 10 participants as a starting point for this project and completed 80 hours of naturalistic observation. Theoretical sampling was employed to collect further accounts. For example, the initial data analysis highlighted the possible influence of age on decisions about treatment seeking, so I sought participants who were relatively younger to further examine the influence of age on decision-making. Similarly, when the data analysis revealed themes about the form and function of the ED, I interviewed nurses regarding their perspectives about emergency services and the care they provided. At the conclusion of the project, 17 interviews had been completed with 16 participants (one was interviewed twice), and an additional 3 interviews had been completed with nurses. As well, I undertook a further 20 hours of naturalistic observation. Tables 2 provides a summary of the participants’ characteristics. In Chapter Four, I discuss the characteristics of the participants in greater detail.
### Table 2 – Summary of Participants’ Characteristics

<table>
<thead>
<tr>
<th>Age</th>
<th>Ethnicity</th>
<th>Symptom(s)</th>
<th>Marital Status</th>
<th>Time to Arrival</th>
<th>Discharge Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>49 Euro-Canadian</td>
<td>Left arm pain</td>
<td>Divorced</td>
<td>2 hours</td>
<td>Non-cardiac - radial nerve palsy</td>
</tr>
<tr>
<td>2</td>
<td>59 Euro-Canadian</td>
<td>Palpitations and weakness</td>
<td>Single</td>
<td>3 hours</td>
<td>ACS[^iv] – non-ST elevation MI</td>
</tr>
<tr>
<td>3</td>
<td>67 Euro-Canadian (Italy)</td>
<td>Chest pain and difficulty breathing</td>
<td>Widowed</td>
<td>1.5 hours</td>
<td>Non-cardiac - chest wall pain</td>
</tr>
<tr>
<td>4</td>
<td>80 Euro-Canadian</td>
<td>Chest pain and fatigue</td>
<td>Widowed</td>
<td>&gt;48 hours</td>
<td>ACS - heart attack</td>
</tr>
<tr>
<td>5</td>
<td>62 Euro-Canadian</td>
<td>Unconscious collapse</td>
<td>Married</td>
<td>2 hours</td>
<td>ACS - heart attack</td>
</tr>
<tr>
<td>6</td>
<td>84 Euro-Canadian</td>
<td>Palpitations and weakness</td>
<td>Widowed</td>
<td>1 hour</td>
<td>Arrhythmia - atrial fibrillation</td>
</tr>
<tr>
<td>7</td>
<td>89 Euro-Canadian</td>
<td>Chest pain and difficulty breathing</td>
<td>Single</td>
<td>0.5 hours (called 911)</td>
<td>Non-cardiac - chest wall injury</td>
</tr>
<tr>
<td>8</td>
<td>71 Euro-Canadian (First Nations)</td>
<td>Chest pain and anxiety</td>
<td>Single</td>
<td>2 hours</td>
<td>Non-cardiac - stress</td>
</tr>
<tr>
<td>9</td>
<td>29 Euro-Canadian (Ukraine)</td>
<td>Chest pain and anxiety</td>
<td>Divorced</td>
<td>2 hours</td>
<td>Non-cardiac - stress</td>
</tr>
<tr>
<td>10</td>
<td>62 Euro-Canadian</td>
<td>Chest pain</td>
<td>Married</td>
<td>12 hours</td>
<td>Non-cardiac – Gastro-intestinal upset</td>
</tr>
<tr>
<td>11</td>
<td>58 Chinese-Canadian</td>
<td>Chest pain</td>
<td>Single, lives with sister</td>
<td>3 hours (called 911)</td>
<td>Non-cardiac – cause unknown</td>
</tr>
<tr>
<td>12</td>
<td>53 Euro-Canadian</td>
<td>Chest pain</td>
<td>Married</td>
<td>&gt;48 hours</td>
<td>Non-cardiac - stress</td>
</tr>
<tr>
<td>13</td>
<td>70 Euro-Canadian</td>
<td>Chest pain and difficulty breathing</td>
<td>Married</td>
<td>24 hours</td>
<td>Non-cardiac - stress</td>
</tr>
<tr>
<td>14</td>
<td>51 Chinese-Canadian</td>
<td>Chest pain</td>
<td>Married</td>
<td>1 hour</td>
<td>Non-cardiac – cause unknown</td>
</tr>
<tr>
<td>15</td>
<td>48 Filipino-Canadian</td>
<td>Chest pain</td>
<td>Common-law</td>
<td>12 hours</td>
<td>Non-cardiac - stress</td>
</tr>
<tr>
<td>16</td>
<td>76 Euro-Canadian</td>
<td>Chest pain</td>
<td>Widowed</td>
<td>0.5 hours</td>
<td>Non-cardiac – cause unknown</td>
</tr>
</tbody>
</table>

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i The symptoms listed here are paraphrased from the participants’ accounts of the events leading to their admission.

ii This column provides information about whether a participant lived with a partner or family member, but does not provide information about the degree to which this fact contributed to an individual’s experience of social support.

iii Time to arrival is rounded to the nearest half hour, as reported by the participants.

iv ACS is an abbreviation for “acute coronary syndrome.” ACS is a medical diagnosis that encompasses disorders that involve unstable, cardiac ischemia including: unstable angina, non ST-elevation myocardial infarction, and ST-elevation myocardial infarction (Tiemey, McPhee, & Papadakis, 2005).

v Calling 911 connects the caller with a 911 operator who dispatches an ambulance to the caller’s location.
Procedures

The sampling for this study was directed at obtaining a sample of participants and a sample of observations that would provide rich contextual data. I sampled the context through naturalistic observation, seeking experiences on different shifts, at different times of the week, and in different geographical areas of the two EDs. Typically, I arrived in the ED and introduced myself to the nurse-in-charge and the triage nurse(s). I was interested in identifying women who had symptoms suggestive of cardiac illness. The Heart and Stroke Foundation of Canada (2006) provides a comprehensive list of various symptoms that may be warning signals of a "heart attack." If a woman had one or more of these symptoms, or were identified by staff as potential "cardiac" patients, I considered her to be a potential participant for the study. In Hospital A, I used the computerized patient tracking program to locate patients who might meet the inclusion criteria for the study, based on their presenting complaint, as listed in the computer. In Hospital B, the triage nurse or the charge nurse provided information about women already in the department, whether in a stretcher or the waiting room, who might be appropriate to approach about participating in the study.

After obtaining general information about the admitted patients, the patients in the waiting room, the ambulance crews waiting with patients, and other information related to the workload of the department, I positioned myself at the triage desk or at the nursing

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4 Heart attack warning signals are listed as one or more of the following: sudden pain in the chest, jaw, arm, neck, shoulder or back that does not resolve with rest; difficulty breathing; indigestion; vomiting; cool or clammy skin; fear and anxiety (Heart and Stroke Foundation of Canada, 2006).
station to get a sense of what was going on in the department. I also introduced myself to several of the nurses on duty and briefly explained the project:

If a woman in the ED potentially met the inclusion criteria for the study, one of two things took place. In Hospital A, I asked the permission of the nurse looking after the specific patient if I might approach that patient to ask about participation in the study. In Hospital B, I requested that the nurse approach the patient and explain that there was a nurse doing research who was interested in talking to women who had symptoms similar to hers, who would like to speak with her about a study. If assent was given, I introduced the project and myself (see Appendix E), and with the individual’s permission, a conversation ensued lasting between 15 and 45 minutes.

During the course of the project, I had conversations with 28 individuals who sought treatment for symptoms suggestive of cardiac illness in the ED, but either did not meet the inclusion criteria or declined to be interviewed at a later date. The 28 conversations were in addition to the accounts of the 16 women who eventually participated in audio-taped interviews. The data arising from these conversations were dealt with in the following way. During these conversations, I took detailed notes. The accounts shared by the 28 individuals were subsequently documented in the field notes and provided valuable insights related to the context of care. The information drawn from the conversations with the 28 individuals is not specifically reported in the findings, because these individuals did not agree to participate in an audio-taped interview and did not sign consent forms.

At the conclusion of the bedside conversation, if the woman met the inclusion criteria for the study, I requested permission to contact her several days following
discharge, to arrange a convenient time and location for a more formal, audio-taped interview. If the woman was willing to be contacted to arrange an interview, she provided her contact information and I provided an information letter about the study (see Appendix A), including information about how to contact me. During the course of her stay in the ED, I observed the care she received. I typically approached her on two additional occasions to ask, “How are things going?” at which point the woman provided an update on her progress toward discharge or admission. In this way, I was able to observe all of the women during some portion of their stay in the ED.

The women who were interviewed for this project were provided with information about the study and had more than 24 hours to consider whether they wished to participate, prior to being asked to sign a consent form. A minimum of 48 hours after our initial meeting, I made five attempts to contact the potential participants by telephone and, upon contact, we agreed to a mutually convenient date and time for an interview. Twenty-four hours before the scheduled meeting, I telephoned with a reminder. The majority of the interviews took place in the participants’ homes and the balance took place in public venues such as coffee shops. Written consent was obtained (see Appendix B), and a copy of the consent form provided, prior to the tape recorder being activated. As well, prior to being interviewed, the women were reminded that they could choose not to respond to particular interview questions (see Appendix C), or to request that the tape recorder be turned off at any time. In these ways, ongoing informed consent was addressed.

The 3 nurses interviewed for this project were a convenience sample of key informants, chosen on the basis of years of experience and experience with a variety of
roles within health care, such as practice, education, and management. Specifically, one of the participants was employed at an educational institution, one in an ED included in this study, and one in an ED other than those included in the study. These individuals were approached and provided with an information letter (see Appendix A). Within 48 hours they were contacted by telephone and a date and time were chosen for the interview. After obtaining informed consent (see Appendix B) and providing a copy of the consent, audio-taped interviews took place (see Appendix D).

Data Collection and Data Analysis

Naturalistic Observation

In keeping with GT, the data collection and analysis occurred concurrently. In addition to sampling from the accounts of the participants, I sampled information about the context through 100 hours of naturalistic observation. The field notes arising from these observations included details about the location, date, time, and status of the ED in relation to overcrowding and staffing levels, and any other potentially significant factors (such as recent media events). Initially, the periods of observation were relatively brief (e.g., 2 hours) to permit accurate transcription of jottings into field notes. Later, during active recruitment, I remained in the ED for longer periods of time. One hundred hours of observation were necessary to saturate the categories emerging in the data.

Field Notes

In relation to the naturalistic observation, field notes were employed as devices for recording my immediate impressions, which then served as another form of data. The field notes initially consisted of jotted notes, written at the time the observations took place, or immediately following. The field notes were transcribed into a narrative format
within 48 hours of data collection. Field notes were written as a full description based on the work of Emerson, Fretz, and Shaw (1995). Subsequently, the field notes were analyzed and coded. Initial memos arose from the process of coding the field notes. These memos included some discussion related to emerging insights about specific topics or incidents. As the data analysis progressed, the memos became increasingly integrated, in that they addressed specific themes and linked various categories.

An analysis of the field notes allowed me to identify themes, which in turn assisted me in subsequent interviews with the participants, and sensitized me to inquire about issues of possible concern to those being interviewed. For example, many of the 28 individuals with whom I conversed in the ED expressed uncertainty about the cause of their symptoms. This led me to inquire about the issues that may underlie a need to feel certain. The women that were interviewed explained that they felt a sense of frustration about having to go to an ED and possibly waste the time of health-care professionals, if no serious concern about their symptoms could be determined. Accordingly, they preferred to be sure that the cause of their symptoms warranted the use of health-care resources.

The Audio-taped Interviews

The interviews, conducted 5-41 days after leaving the ED, took between 30 and 90 minutes to complete and were audio-taped, transcribed, and checked for accuracy. All identifying material was removed from the interview transcripts (e.g., names of physicians or place names). To obtain data that best represented the women's experiences of their ED care, the majority of the interviews took place within 2 weeks of the ED visit
(mean 16 days). All of the interviews took place within 6 weeks of the visit to the ED. In one case, when I required clarification in relation to the emerging theory, and the participant was a particularly thoughtful informant, I conducted a follow-up interview.

Coding

The heart of GT is a coding process that consists of open, selective, and theoretical coding. Each level of coding moves the data analysis toward increasing levels of abstraction. Open coding, a form of substantive coding, was the first step in the theoretical analysis, and required that I “start with a conceptual nothing” and ask “what is going on here?” with a focus on examining the process (Glaser, 1992). Incidents were compared to other incidents, and similarities and differences were sought, compared with other concepts, and subsequently grouped to form categories. This process is termed “constant comparative analysis.” I began open coding in the margins of the transcripts and field notes, and made notes about the incidents and compared those incidents to other incidents. I then coded each incident into as many in vivo codes as possible. Initially, labels for the initial categories were drawn from the interviews directly. As the analysis proceeded, the labels became increasingly explanatory.

Gradually, I grouped the information according to various relationships and interactions; important concepts began to become apparent in successive accounts. These concepts informed the development of the categories, which explained what was going on in the women’s accounts and my observations. Categories possessed two essential features: they were both analytic and sensitizing. The former refers to the quality of being

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5 Two of the women were interviewed 41 days following their visit to the ED.
6 In vivo codes arise directly from the data and are often labelled in terms used by the study participants.
sufficiently abstract and the latter refers to the ability of a code to generate a meaningful picture (Glaser & Strauss, 1999). Regular meetings with my research supervisor (bi-weekly), and supervisory committee members (approximately every 3 months) assisted me in the process of data analysis; the discussions guided me to ask questions and to explore the relationships within and between the accounts of the participants, as I developed the categories.

Initially, my categories were general and broad; they became more specific and better developed as new data were constantly compared with that obtained in earlier interviews. Eventually, these categories were analyzed to examine the existing connections and, as some of the categories were collapsed and subsumed within others, I sought evidence of a core category. According to Glaser (1978), a GT study always has a core category that explains what is occurring in the data. That core category may or may not be a basic social process\(^7\) (a process with phases that unfold over time). I ended open coding when a category was developed such that no new related concepts emerged.

After open coding, I began select\(\text{ive}\) coding. Selective coding was delimited to the data that were related to the core category that emerged (Glaser, 1992). The goal was to develop a core category that accounted for "most of the variation seen in a pattern" (Glaser, p. 75). The core category developed as I coded the data at increasing levels of abstraction. The focus was on specifying a category in terms of the conditions that gave rise to it and on systematically integrating the relationships between the categories (Polit

\(^7\) According to Glaser (1978), a basic social process may take one of two forms: a basic social psychological process or a basic social structural process. In this study, a basic social psychological process (BSPP) was identified.
Selective coding guided the next phases of data collection and analysis.

Memoing

I employed memos as a tool to assist in the process of increasing the level of abstraction during the data analysis. The memos formed an ‘audit trail,’ clearly documenting decisions and insights in relation to the emerging theory (Morse & Field, 1995). I used analytic memos and process memos as tools to facilitate the coding. The former were vehicles to explore the possible relationships between various incidents. I used process memos as vehicles to support reflection on the process of data collection and to shape future interviews and naturalistic observation experiences.

Finally, greater integration of the findings occurred. This took place through the process of theoretical coding – the process of returning to the data (or to the field) and using additional sampling to close the gaps in the data (Charmaz & Mitchell, 2000). As such, I conducted additional interviews and naturalistic observations. For example, the data analysis revealed what I termed the “discourse of deservedness” – that is, the notion that some individuals seeking care might be thought of as more deserving of the limited available resources than are others, based upon unwritten and unspoken criteria. To further explore this idea, I obtained the accounts of three nurses with expertise in emergency care.

Data Saturation

Approaching or achieving theoretical saturation is not simply about collecting data until no one is “saying anything new.” Instead, theoretical saturation is reached when categories are saturated. For example, I established “surveillance” (i.e., of the
participants by their health-care professionals) as a category and I coded and compared
the many incidents of surveillance (i.e., examples of both positive and negative reactions)
found within the data set until the relationship between the surveillance category and
other categories could be well delineated. Surveillance was eventually coded as one
aspect of "being repackaged." The goal of theoretical saturation guided me to continue
collecting data until the categories were well developed and a basic social psychological
process was identified.

**Theoretical Sensitivity**

Theoretical sensitivity is described by Glaser (1992) as the knowledge,
understanding, and skill of a researcher that fosters the generation of categories and
properties, in the development of hypotheses and further integration of the emerging
theory. In the present study, I honed my theoretical sensitivity through the use of neutral
questions to further understand the data and through the use of comparisons between and
among incidents. Cultivating theoretical sensitivity in this study required that I use a
variety of strategies. I read widely, including, for example, the literature related to
situational awareness in the military literature, architecture, and geography. I discussed
the project and the findings with colleagues, nurses, and other health-care providers. Not
infrequently, casual conversations with hospital staff triggered further insights.

**Ethical Considerations**

This project was undertaken with the approval of the university Behavioural
Research Ethics Board as well as the relevant hospitals' boards. Fontana and Frey (2003)
emphasized that in qualitative research, because the "objects" of inquiry are human
beings, scrupulous attention must be paid to ensure their safety. Specifically, the
participants in this research had a right to privacy, protection from harm, and a right to free and informed consent. Confidentiality was ensured to the greatest extent possible. The transcripts were password protected and any identifying data were removed. Only members of the research team had access to the transcripts. Challenges in relation to the ethical conduct of the study are discussed in Chapter Seven.
CHAPTER FOUR: RESISTING DISRUPTION

Over the course of this project, 16 women who had experienced symptoms suggestive of cardiac illness talked to me about their experiences, explained their fears, and explored their outstanding concerns. This study was about the women's experiences of ED care, but the women could not begin their stories with those accounts. Instead, without exception, the women began by talking about where they were when they first noticed their symptoms and how they experienced their symptoms. As their stories unfolded, the multitude of factors influencing the decisions they made in relation to seeking treatment became apparent. Common to all of the participants was an initial period of confusion about their symptoms, followed by a reasoned consideration of possible courses of action in relation to treatment seeking. In every case, the women sought to balance the needs of others against their own needs as potentially unwell individuals. The women strove most often to resist any disruption to the rhythm and routine of their daily lives. In doing so they were able to keep intact their images of themselves as capable, responsible, reliable, and healthy people.

Nurses, paramedics, and physicians at two busy hospitals allowed me to observe their practice and to learn, from them, about the structure of ED care. These observations, and three interviews with nurses, provided important contextual information about factors that influenced the women's experiences of care in the ED. The accounts of the women and their health-care professionals illuminated the extent to which the primary focus of health-care professionals and the women differed and illustrated the impact of structural factors on the women's experiences of care.
The age of the participants ranged from 29 to 89 years. Slightly less than one half were employed at the time of the interview. Roughly one quarter of the participants were married at the time of the interview and all but four of the women had been married at one time. One half of the women had children. None of the participants resided in care homes or had live-in assistance with the activities of daily living. The majority of the women experienced the onset of symptoms while at home. Seven of the participants reported that family members were present in the home when the symptoms began. The amount of time that elapsed between the onset of the symptoms and arrival at the ED ranged from approximately 30 minutes to more than 48 hours. Five of the participants were transported to the ED by ambulance and roughly one half were transported in a private vehicle. Four of these women received a cardiac diagnosis prior to discharge from the hospital.

In reporting the findings, I use the terms “prompt,” “delayed,” and “extensively delayed,” defined as follows. Given the 3-4 hour window after which the risks of cardiac rescue therapies begin to outweigh the benefits, prompt treatment is defined as presentation to an ED within 4 hours after the onset of symptoms. Delayed treatment signifies that treatment was not sought until 4-12 hours after the onset of symptoms, and extensively delayed refers to treatment sought more than 12 hours after the onset of symptoms. Applying these criteria, the 11 of the participants arrived in the ED less than 4 hours after the onset of their symptoms, 2 of the women arrived within 12 hours, and 3 women were extensively delayed in seeking treatment.

In the following discussion, I first provide an overview of the basic social psychological process (BSPP) and then a more detailed description of the first phase.
Quotations are employed for two purposes: (1) to provide illustrations with regard to specific aspects of the theory and (2) to illuminate the voices of the participants. In writing up the findings, I used ellipses to signify the removal of any part of the speaker's comments that were extraneous to the discussion. The quotations were used verbatim, with the exception of the removal of words such as, “Um,” and “Uh,” and “Er,” also signified by the use of ellipses. My rationale, drawn from the work of Corden and Sainsbury (2006) on the use of quotations in reports of qualitative research, was as follows: these terms add no value to the quotations, are tedious to read and therefore may distract the reader from the content, and may make it difficult for the reader to take the speaker seriously.

Maintaining Personal, Social, and Physical Integrity: An Overview

The symptoms the women experienced represented a threat to their physical and emotional well-being, as well as a barrier to their ability to carry on with their daily lives. The threat represented by the symptoms was multi-dimensional and included threats to their sense of selves (e.g., as healthy, capable, reliable, and caring people); threats to the integrity of their social relationships (e.g., as family “helpers”), threats to their ability to meet their social role obligations (e.g., as chauffeurs and cooks), and threats to their physical intactness (e.g., faced the possibility of a heart attack and death). Maintaining integrity, a basic social psychological process, explained the women’s actions in relation to their symptoms prior to, during, and after a visit to the ED.

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8 For example, when a narrative addressed two separate points, I spliced the quotation and used ellipses to denote the removal of the material.
Maintaining integrity refers to the process that the women used to keep intact their sense of selves and to continue functioning in the context of their daily lives, despite the threat represented by the symptoms of heart disease. The women’s integrity had several dimensions including the personal, the social, and the physical. Personal integrity encompassed the women’s images of themselves as capable, responsible, and worthy individuals. Social integrity was closely intertwined and captured the importance women attached to their role responsibilities, such as those related to being a wife, mother, daughter, or employee. In contrast, physical integrity encompassed the women’s biological well-being and was concerned with the women’s images of themselves as healthy.

Before arrival in the ED, the participants’ efforts to maintain their integrity, while they engaged in decision-making processes about seeking medical attention for their symptoms, were focused on resisting any disruption to their daily lives. After arrival in the ED, the women focused on maintaining their physical integrity, accepting the care of the ED staff. Following discharge from the hospital, the women attempted to make sense of the recent events; and, in some cases, to address the lifestyle factors that placed them at risk for cardiovascular disease, such as tobacco use and lack of exercise. Although none of the women talked about reducing stress, many of the participants spoke about managing stress more effectively. In this way, the women were able to incorporate new information while maintaining images of themselves as healthy and socially worthy individuals.

The main concern of the participants was “carrying on as usual.” Carrying on as usual was inextricably linked to their social roles and to the social expectations associated
with those roles. Before their admission to the hospital, the women viewed their symptoms as an unwelcome distraction to the business of everyday life. For them, maintaining their personal and social integrity concerned addressing the expectations of others and preserving, intact, their images of themselves as capable, strong, and healthy. For the participants, an ability to carry on with their daily routines was closely linked to their personal identity.

The women in this study generally defined themselves in relation to — that is, they defined themselves according to their responsibilities to significant others in their lives. When their images of themselves and their role responsibilities were threatened, the threat was often elemental. For example, one participant stated, “When the doctor told me ‘nothing’s wrong,’ no blood clots, nothing serious, so I was happy to hear that because I’m still able to work and help my family.” Another woman shared that she felt, “Useless, not useful in my life, to my family” when she was receiving care in the ED.

The data from this study revealed that the participants moved through three phases as they strove to maintain their personal, social, and physical integrity, including: resisting disruption (pre-hospital), suspending agency (in-hospital), and integrating new knowledge and experiences (after discharge). Table 3 provides a summary of the findings.
Table 3. Basic Social Psychological Process: Maintaining Personal, Social, and Physical Integrity

| Core Category: Maintaining Integrity | Context                      | Phases                      | Stages                                      | Influencing Factors
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<td>Pre-hospital (home and work)</td>
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<td>Ways of knowing:</td>
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The first phase took place before the visit to the ED. The women assessed the symptoms they were experiencing and employed the knowledge and resources at their disposal to resist any disruption of their personal or social routines. "Symptom analysis" and "managing the situation" were stages of resisting disruption. In the first phase, the women were agents of their own destinies – determining cause and effect and making
decisions about alternative courses of action. For example, “managing the situation,” one of the stages of resisting disruption included minimizing the symptoms (e.g., labelling the symptoms as having a gastrointestinal origin) and watching and waiting to see whether the symptoms resolved spontaneously. Both of these strategies were aimed at maintaining integrity in relation to their role responsibilities and images of themselves as healthy. When these strategies (and others) failed to resolve the symptoms, or the symptoms worsened to the extent that the women were physically unable to continue (e.g., driving, working), they made a decision to seek treatment. In making this decision, the women continued to resist any disruption of their daily lives by attempting to manage the situation, sometimes rather creatively (e.g., suggesting that a spouse continue to work rather than waiting at the ED or getting children to school before going to the ED).

The women commonly went to the ED because they were no longer able to perform their role functions due to ongoing and often worsening symptoms, and were therefore forced by circumstances to attend to their physical integrity. This inability resulted in a threat to the integrity of their physical well-being. Suspending agency was the second stage of maintaining integrity. The women went to the ED to seek an answer to the question, “What is wrong with me?” To maintain their physical integrity, they sought expert advice. At this time, the women stopped trying to meet their social expectations and stopped acting autonomously. In this stage of maintaining integrity, the women let others direct them and take action on their behalf. Structure to some extent replaced the women’s agency as the primary force in shaping their experiences of illness and care. The interplay between agency and structural conditions was such that generally the latter was supported and the former was suppressed. In response to structural
conditions, the women mounted acts of resistance (e.g., questioning the actions of their health-care providers with regard to the need for particular procedures or tests). However, far more commonly, the women’s exercise of their agency functioned to reinforce the structural features of the ED such that the woman-environment interactions reinforced passivity.

All active symptom-solving strategies were now directed by the health-care staff who defined the problem, undertook surveillance to gather information, and then arrived at a diagnosis. The women worked at maintaining their integrity by adopting a passive stance, allowing the health-care professionals to act on their behalf. The women experienced being repackaged as a cardiac case and, ultimately, being judged with regard to the appropriateness of their decisions to seek treatment, as well as their risk behaviour in relation to cardiac illness. “Becoming dependent,” “being repackaged,” and “being judged” were three stages associated with suspending agency. Suspending agency was about the women adopting passivity, taking on the role of a patient, and delaying or deferring permanent disruptions to their sense of selves or their ability to meet the responsibilities associated with their social roles.

In the third phase, integrating knowledge and experiences, the women made sense of the new information they acquired and used that information to make choices about their future. During this stage, the women synthesized three sources of information to make sense of their recent events as a whole, and then integrated the understanding gained into the context of their lives. First, the women had a tentative diagnosis upon their discharge from the hospital (e.g., cardiac or non-cardiac symptoms). As well, the women drew on new information about their individual risk behaviour in relation to the
development of heart disease (e.g., alcohol consumption, exercise, stress, diet) gleaned from their interactions with their health-care professionals. Finally, the women drew on their experiences of care in the ED to position recent events within the context of their lives and to synthesize all of the knowledge and experiences they had gained in order that they might make decisions in future situations. “Taking the blame” for risk behaviour and “making choices” about future health behaviour were phases of synthesizing their knowledge and experiences. In this stage, the women strove to preserve their images of themselves as healthy (e.g., making decisions to change risk behaviour) and socially worthy (e.g., not wasting health-care resources).

Ideas about “goodness” and social and familial roles ultimately shaped and constrained the women’s actions so that the most attractive course of action often involved adopting an approach of watching and waiting, hoping that the symptoms would resolve spontaneously. The women in this study sought to maintain their personal and social integrity by avoiding the consequences they perceived would be associated with failing to carry on with their daily lives. Maintaining their personal and social integrity by attending to important role responsibilities effectively took precedence over attending to the symptoms. In other words, the important aspects of daily life commonly crowded out the urgent requirement for action mandated by symptoms suggestive of cardiac illness.

The First Phase: Resisting Disruption

Resisting disruption, the first phase of maintaining integrity, explained much of what had occurred before the women visited the ED. Resisting disruption described the women’s efforts to avoid any alterations to their daily routines (or those of their family members) and their efforts to preserve their physical well-being. One feature of resisting
disruption was the ways in which the women understood and managed the symptoms they were experiencing. In this phase, the women strove to maintain their integrity by carrying on with their daily activities, in spite of the symptoms including chest pain and difficulty breathing. Resisting disruption had two stages: symptom analysis and managing the situation.

**Symptom Analysis.** The first stage of maintaining integrity was an analysis of the symptoms. The accounts of most, if not all, of the participants began with the development of awareness. Awareness involved taking notice that something out of the ordinary was occurring in their bodies. Sometimes this awareness took the form of recognizing a particular sensation, such as pain or dizziness. At other times, awareness that something was wrong arose from the inability to carry out normal tasks or routines such as showering or preparing a meal. This awareness resulted in ongoing self monitoring, to track the duration and quality of these sensations. Whereas one might expect momentary twinges of pain or temporary bouts of weakness, when a symptom persisted for longer than a few minutes, their awareness and continued monitoring led to an acknowledgement that there was a threat to their physical integrity.

*Problem identification* followed awareness and self monitoring, and occurred when the physical sensation or inability to perform a task was judged to be more than a momentary aberration. At this time, the women began to interrogate their symptoms. Perception (awareness and problem identification) moved forward to comprehension (understanding). *Assessing their general and personal risk* for heart disease and *looking for explanations* occurred concurrently. In each of their accounts of the events, the participants considered possible explanations for their symptoms, while simultaneously
carrying out an assessment of their general and personal risk. Considerations about demographic factors such as their age and gender were often prominent as were their personal risk factors such as smoking, past medical history, family history, and stress level.

*Looking for explanations*, another aspect of symptom analysis, involved the consideration of a limited number of possible (usually three or fewer) explanations for the symptoms. The women hypothesized various causes of their symptoms and from these came a preliminary determination about the potential root cause. This determination served as a platform for later decisions about self treatment and other actions to be taken in the course of managing the situation.

Three explanations were common in the accounts of the participants and explained the symptoms in a way that allowed the women to carry on with their typical daily activities, thus maintaining their personal and social integrity. First, the women almost always believed, at least initially, that their symptoms were caused by dietary misadventures whether in the form of food poisoning or over-indulgence. This was without question the most common explanation, even when the same food was consumed by another person without ill effect. Stress was another common reason identified by the women as the root cause of their symptom(s). Stress was normalized and pervasive, serving as a ready explanation for the women’s experiences of symptoms. Labelling symptoms as “stress” gave the women an explanation that did not involve cardiac disease. Many of the women did consider, however, that their symptom(s) might have had a cardiac cause.
Situational awareness, a final aspect of symptom analysis, was essentially about projections into the future and the prediction of outcomes. During symptom analysis, the participants defined their symptom(s) as a threat to their personal, social, and physical integrity. If a woman chose (or avoided) a particular course of action, what were the possible outcomes? These outcomes were explicitly or implicitly ranked in relation to their desirability.

I really didn’t think it was anything...I was hoping it wasn’t. It was just that I thought I had to check it out. I just thought...all I could see was that if I went to work and something happened because there really was something...it would be my fault and I would be remiss and, you know, I didn’t want to deal with that so...

Managing the situation. Managing the situation was the second stage of resisting disruption. Managing the situation involved not merely the actions the women took to address their symptoms, but also the management of the people and responsibilities of their daily lives. The women undertook to manage their situation in ways that allowed them to continue to address their role responsibilities and thus preserve their images of themselves as healthy, strong, and capable. Specifically, this stage included making decisions about how to respond to the symptoms as well as how to manage the role(s) that others might play, depending on the course of action chosen. While actively managing the situation, the women were able to preserve their personal and social integrity, addressing the needs of others even while taking action to definitively address their symptoms.

One aspect of managing the situation was a framing of the symptoms, which involved choosing from among competing explanations and using that choice to explain the symptoms to other people. Framing gave the women a way to describe their
experiences and provided a way to allay their fears (and the fears of others) that the symptoms might have arisen from a cardiac cause. If a woman framed her symptoms as having a cardiac cause, this provided a way to rapidly mobilize resources to seek immediate treatment in an ED. Framing the symptoms was a double-edged sword, however. On the one hand, framing the symptoms as having a non-acute cause reduced the women's fear; on the other hand, the women felt like impostors when they presented to the ED stating that their symptoms were caused by, for example, gastrointestinal upset.

*Taking action*, another aspect of managing the situation, involved a myriad of decisions and the subsequent initiation of a wide variety of strategies to manage the symptoms. Consulting others, including family members, co-workers, family physicians, friends, or the ambulance service was a common strategy used to gain an additional opinion about the possible causes of the symptoms, but more importantly to obtain advice about the best course(s) of action to take. There was often a gap between the symptom analysis and the action taken. Several participants expressed a reluctance “to worry” their family or friends. As well, if the symptoms did not affect the women’s ability to continue their daily activities, they were even more reluctant to seek advice.

*Self treatment* was a popular course of action. Self treatment was based on the women’s symptom analysis and often consisted of trying medications, such as nitroglycerine (by those that had a previous history of heart disease or had access to this medication) or over-the-counter remedies such as antacids. An attempt to treat oneself often delayed a visit to the hospital because the women waited to see whether their interventions were effective.
Watching and waiting was another popular approach as the women often chose to simply monitor their situations. This (in)action was motivated by a hope that their symptoms would resolve without intervention. The women spoke about their fears in relation to seeking medical treatment. First, there might be nothing wrong and they would be embarrassed about seeking treatment for a false alarm, not to mention disrupting their lives. Or, there might be something wrong (something serious) in which case they were potentially very ill. When “choosing” between embarrassment and illness, watching and waiting was seen as a strategy to avoid both alternatives. According to the accounts of the participants, avoiding embarrassment was viewed as an important consideration.

Addressing the needs of others frequently preceded the visit to the ED and involved meal preparation, transportation to school, or work obligations. The women did not want their loved ones, such as family members or friends, to face long waiting periods in the hospital. Accordingly, the women often travelled to the hospital alone by car, having sent their partners to work for the day. As well, addressing the needs of others often translated into a time delay in getting to the ED. For example, one participant explained that although she had pain all night, she wanted to wait until the morning to seek medical attention because her partner worked 12-14 hour days and he needed his rest.

He didn’t park. I think he...he has to be at work at 5:30, so I think he dropped me off and I probably said, “It’s fine and I’ll let you know. I can phone and get you at (work), don’t worry about it.” Because it’s such a process. Like, he just sits around and waits anyway and they let him in after the fact, which could be an hour later or something. So no, he went to work and said phone him if...I just went in on my own.
Re-evaluating was also an aspect of managing the situation. New developments such as additional symptoms, the passage of time (i.e., symptoms throughout the night and into the morning), or the failure of self-treatment interventions caused the women to “take stock” and re-evaluate what was occurring. Re-evaluation always resulted in an assessment of how significant the symptoms might be, causing the women to consider relatively more serious explanations for their symptoms. The only exception to this was if their symptoms resolved, and even in this case, if their symptoms recurred over several days.

I don’t know whether that was it or what caused the indigestion. It just stayed with me. It was like a band around my middle, all into my back. My back hurt; it was almost as if I was having gallbladder attack because I remember how severe that was but I don’t have a gallbladder. It was a band around my stomach and it just stayed. It was sort of from the mid-chest down, not low and I thought, “Okay.” And I’d spent the whole night...I had taken Rolaids®, I had taken Tums®, then I had tried the Pepsi®, and that was it.

The women in this study resisted disruption of their personal, social, and physical integrity. In the course of doing so, they drew upon several different types of knowledge.

Conditions Influencing Resisting Disruption

Resisting disruption of their personal, social, and physical integrity was a dynamic process influenced by particular ways of knowing. The women used these ways of knowing to understand and interpret “the facts” of their symptoms within a larger personal and social context. In effect, their ways of knowing involved a marriage of “the facts” with a consideration of the context. Ways of knowing captured the types of information the women employed in understanding both their experience of their symptoms, and the sequelae that might arise from their symptoms. The understandings
gleaned from particular ways of knowing provided the women with information about specific threats to their personal, social, and physical integrity.

**Ways of Knowing**

The women’s decisions about seeking medical attention were influenced by four ways of knowing including: *embodied* knowing, *temporal* knowing, *rational* knowing, and *relational* knowing. Their ways of knowing served to weave the context of the women’s lives into their interpretations of, and decisions about, their symptoms. The different ways of knowing discussed in the following section are presented in a particular order, to reflect the women’s experiences of becoming aware of their symptoms (e.g., embodied knowing) before attributing meaning to those symptoms (e.g., rational and relational knowing). Of note, for each way of knowing, there was a key feature that captured the critical point at which the information obtained was adopted and used to support the women’s decisions to visit the ED.

A useful way to understand embodied, temporal, rational, and relational knowing is to consider a radio dial. Before one adjusts the dial, the sound emitted is full of static. Then one uses the radio dial to move between stations. Each time the dial is adjusted, a station comes through clearly – the signal is strong. Similarly, the women in this study moved between ways of knowing, sometimes “tuning in” and sometimes “tuning out.” Understandings gained from particular forms of knowing were used to analyze their symptoms and ultimately influenced the women’s decisions about how to address those symptoms.

**Embodied knowing.** In assessing the threat to their physical integrity caused by their symptoms, the women drew on the knowledge and understanding gleaned from their
personal experiences. Embodied knowing captured information about the symptoms in relation to their quality and intensity, and influenced the subsequent conclusions about the cause of those symptoms. The visceral experience of the symptoms was prominent in each account of the participants.

I didn’t feel any stress, I wasn’t tense at all. At one point I started feeling chest pain...chest tightness more than chest pain... At that point I remember that I was a little bit short of breath and my head was pounding and I noticed that my hands were shaking.

Important features of embodied knowing included the number of symptoms experienced, the intensity of those symptoms, the development of any new symptoms, and evaluation of the symptoms based on past experiences, as well as the degree to which the symptoms interfered with the women’s normal daily activities. The latter proved to have a substantial influence on the women’s behaviour in relation to their treatment seeking. With rare exceptions, the understanding gained from their embodied knowing delayed their treatment seeking. That is, in an effort to avoid disruptions, the women tended to minimize their symptoms, attaching little importance to any understanding gained from their embodied knowing and often delaying a visit to the ED.

Minimization of their symptoms was a recurring theme in the women’s accounts. They had assumptions about what constituted an “emergency.” The criteria for an emergency included visibility. The illness or injury had to be readily apparent to others and not simply an internal experience. For example, when presented with a scenario in which a fall occurred and resulted in a fracture of the ankle, the women expressed no hesitation about visiting an ED. In contrast, because their symptoms were an internal experience, for the most part, and not always obvious to bystanders or family members, the women frequently delayed seeking treatment.
If it's not so significant that people are turning around on the street looking as I go past, I could wait... until I've got a day off, or I'll find something is open on a Saturday, but it will wait... it will definitely wait. It's not that bad and I think people tend to feel the same way about themselves. And I think maybe, you know, if I had a compound fracture I don't think I'd hesitate to bother somebody but I think things like whatever was the matter with me that isn't completely debilitating, you can still go to the store, you can still, I guess in many people's cases, look after your husband, your children or your dog, you know we can certainly wait until tomorrow. "I'm not going to bother anybody with this today."

Ideas about gender were sometimes used to downgrade the level of threat attached to the symptoms. For example, the participants frequently mentioned the belief that women have "a higher pain tolerance" than men and accordingly the experience of pain was often dismissed or rated as unimportant. The pain itself did not constitute legitimate grounds for seeking health care. Dealing with the pain without outside intervention, such as that provided by health-care professionals, was seen as a reasonable course of action even when there was a strong suspicion that the pain might be cardiac in origin.

I think if I had been given half a chance, by about 9:30 or 10:00 that morning I might have come home and just lie down and decided if I'll just see if it doesn't go away on its own and I'll feel a lot better but I kind of got into this... I was railroaded so... I don't know. I think women are more stoic than men and I think it would... you know, when a man is going (mimics heavy breathing)... I think women just think, "Oh! I'll take an aspirin or put some Vaseline on and it will be fine."

Although the women's embodied knowledge generally delayed their treatment seeking, there were two important exceptions. First, the development of new symptoms usually prompted the participants to reconsider their initial evaluation of the significance of their condition, which often resulted in a prompt visit to the ED. Second, if the symptoms interfered with the women's ability to work, drive, or take care of their families, then the interference, rather than the actual intensity of the symptoms, constituted appropriate grounds for seeking treatment; embodied knowledge was taken up
and used to support a decision to visit the ED. In this situation, maintaining their physical integrity was judged to be more important than their efforts to maintain their personal and social integrity. Thus, the development of new symptoms, or symptoms interfering with their activities of daily living, influenced the women’s decisions.

Whereas, you know, I’m a little bit short of breath, well, you know, that’s not going to stop me making dinner or putting the clothes in the dryer; it’s not going to stop me feeding the cat. You know, I’ll just sit more often or...I think it depends entirely how debilitating and what’s happening to you. If you can ignore it, I think generally speaking, unless it fits the criteria to the letter and you go, “Oh, this is what they’re talking about,” I think people tend to just...women particularly, “It will just go away.”

Embodied knowing, then, was a form of knowledge that allowed the women to identify threats to their physical integrity, and to assess the threat level represented by their symptoms. In general, if the women were able to carry on with their usual activities and meet their role responsibilities, the threat to physical integrity was not (at least initially) judged to be serious.

**Temporal knowing.** Resisting disruption was also affected by the women’s temporal knowing. This is a form of knowledge that captured the contributions of time in relation to the women’s symptom analysis and management of the situation. Temporal knowing was, for the most part, a way of resisting disruption to their daily routines and images of themselves as healthy. The women did not measure time in minutes and hours. Instead, time was divided into sections based on social conventions (e.g., meal times) and were sometimes pivotal in the women’s decisions about seeking treatment. Moving from one time segment to another was significant. Their symptoms could be minimized during the night – that is, a woman might say to herself, “I’ll go to the hospital in the morning if I still have the pain.” Accordingly, symptoms that were judged not to be significant at
night were reassessed in the light of the day. Similarly, symptoms that started before
breakfast were judged to be serious only after additional meals had passed. These time
segments were often seen as milestones. Thus, apportioning the day into discrete sections
delayed the women's treatment seeking. Most of the women expressed a desire to "wait
and see" whether the symptoms resolved spontaneously. For example, as one of the
participants reported, "I just thought, 'Well, it will go away in a couple of minutes.' But it
didn't go away in a couple of minutes. It lasted quite some time until I was able to fall
asleep."

Several women spoke about interpreting their recent event in light of a past
cardiac event, in order to estimate their threat level. One participant nicely illustrated this
point.

I think one of my big problems now is that I feel so...my assessment skills before
were very on until this whole issue came up and then all of a sudden this...it just
means that all the ways I looked at discomfort and all the ways I looked at pain
and handled them in no nonsense ways and everything and this just makes you
sort of second guess it, you know. So, because it was discomforting and I thought
I had no chest pain...I had no 'anything' else but before I had very weird things,
too. So, you know, I thought I was going to call somebody but I knew that
anybody that I would call would say to me, "Go to ER and get it checked out."

The use of a past event to evaluate the current threat was time limited – with the passage
of time the past event became less significant. If a prior cardiac event had occurred
relatively recently, the participants were very likely to associate the new event with that
event and to promptly seek medical attention. However, if the original event was in the
distant past, the participants were more likely to delay, while considering many other
potential causes of their symptoms.

Temporal knowing allowed the women to identify threats to their personal
integrity. At risk were their images of themselves as intelligent individuals who could
distinguish between a “false alarm” and a real emergency, based on past experience. As well, this form of knowing allowed the women to resist disruption to their daily lives, by providing them with a way to avoid a visit to the ED. The women used the passage of time, to a great extent, as a way of delaying decisions about treatment seeking.

**Rational knowing.** Rational knowing was another form of knowledge used by the women. Rational knowing captured the knowledge gleaned from the media, reported statistics, and general information about women and heart disease. For the participants, rational knowing affected their ability to resist disruption, and exerted an influence on their symptom analysis and management of the situation. Although prominent in every account and powerful in terms of the meaning the women assigned to their symptoms, rational knowing did not generally exert a profound influence on their decision making.

Whereas the knowledge gleaned from their embodied ways of knowing seemed to exert an influence primarily during their symptom analysis, rational knowing was a more pervasive form of knowledge. For example, in considering the possible causes of their symptoms, the women drew on their formal knowledge about heart disease and reported reflecting on statistics about cardiovascular illness gleaned from the media and healthcare professionals. Rational ways of knowing were embedded in the development of their situational awareness when the women considered the benefits and drawbacks attached to particular courses of action, and when analyzing the results of a particular course of action.

Almost without exception, the participants stated that “women have different symptoms of a heart attack than men.” An assessment of their personal risk for heart disease, drawing on their knowledge of their family history and personal health history,
was also prominent in their accounts. Yet even when the participants expressed concern about their level of risk (i.e., strong family history of premature heart disease), a prompt visit to an ED did not always occur. Instead, knowledge and understanding drawn from other ways of knowing guided their decision making and delayed their treatment seeking. For example, one of the participants reported that although she had read signs on bus advertisements that described the symptoms of a heart attack or stroke, she held the belief that she had to have all or most of the symptoms listed. As she had only one or two of the symptoms, she chose not to take immediate action.

In terms of their rational knowledge, the women had particular expectations about the ED. For example, the women uniformly expressed an expectation that the wait for treatment in an ED would be long and onerous. These images were drawn from the media and from their own experiences of ED care in the past, whether in the context of care for themselves or their family members. Knowledge about long waiting times generally served as a deterrent to treatment seeking.

The only time that rational knowledge was prominent in reducing their treatment delay was when such knowledge was taken up by the women’s family members. Family members used this knowledge to force action upon the participants. Commonly, the primary reason the participants presented to the ED for treatment was because a daughter or other family member had insisted on that particular course of action. In this situation, the women were not able to resist disruption and had to visit an ED, however reluctantly. As one of the participants reported, “...then, the next morning I got up with the same thing, I wasn’t feeling well. And I just was drained...just not well at all so my daughter come and said, ‘Okay, Mom! You’re off to the hospital.’”
Rational knowing was employed by the women to assess threats to their physical integrity. However, unless their experience of symptoms matched their expectations (e.g., in terms of the number of symptoms, or the disabling effect of those symptoms), the effect of rational knowing was generally to delay treatment seeking.

**Relational knowing.** Resisting disruption was to a great extent influenced by the women's relational ways of knowing. Relational knowing captured the knowledge that arises from being part of a social world composed of relationships and interactions that shape behaviour and meaning. Drawing on this form of knowledge supported the participants in their decisions to delay treatment, and ultimately to resist disruption. Important features of relational knowing included perceptions about the social consequences of seeking or delaying medical treatment, an evaluation of the impact of treatment seeking on one's customary social roles within the family, the impact of illness on caring for families and work responsibilities, and an acknowledgment of the richness of a life lived. Relational knowing was pivotal in influencing the women's treatment-seeking decisions typically by delaying them.

The participants discussed *the dangers* associated with not seeking treatment and carrying on with the normal activities of their daily lives. Considerations about the dangers of driving (e.g., colliding with another car in the process of driving oneself to the ED) and the risk to others if one collapsed at work and accidentally injured someone else in the process were concerns expressed by the participants.

I wasn't doing very much so it wasn't like it was a big stressful deal, but you know, when you're running out the door to go to work and everything like this and you've got to think about it and you don't want to be...you don't want to collapse at work and have somebody say, “You know, you shouldn't have come to work...” As it is at work, they're always saying to me, “I always worry about
you driving yourself to the hospital,” and I’m thinking, “Oh my god!” I said, “I keep to the outside lane... I’m not going to call...”

Similarly, one woman explained that she could not call 911 because she had her grand daughter in the house. The year before she had experienced a sudden onset of chest pain and dizziness and had been rushed to the hospital for surgery. At that time her mentally challenged grand daughter had been left alone in the house and was still talking about her fear that she would be abandoned once again.

The impact of treatment-seeking decisions on the social roles held by the women within their families was often a critical influence on their ultimate decisions. In the example below, a participant described the social costs to her if she acted on her experience of symptoms.

Well... my family demographics... the whole thing... the boys always rule. (Laughter) That seems to be sort of how things go and even though... this is just family politics... my dad had a xxx company, my brother ended up with it. My brother has... sons. I’ve been divorced... before... You sort of feel a bit like the family black sheep and yet I’m still the one they all phone. But you just don’t want to give them any more... anything else that makes you feel like a flake. And that’s sort of how you feel sometimes. And I can hear my brother with a snide comment or something like that, which is nothing I would ever do to him because my brother is an alcoholic who falls off the wagon...

Other women emphasized that their responsibilities at home, particularly in relation to young children, influenced their decisions about seeking treatment. One woman explained that she had not told anyone at all about the chest pain, partly because she believed her family physician to be incompetent and also because she did not want to bother anyone. As well, she had children and no one to call on to stay with the children. She reported that she was unwilling to have her children wake and find her not at home. She also refused to call a friend and take that person away from her own children.
Stress discourse underpinned the women’s relational knowledge. Stress discourse refers to the belief pervasive in the Western world that individuals have power over the effects of stress in their lives, whether by adoption of a positive mental attitude or by making prudent lifestyle choices (Pollack, 1988). Stress is viewed as a barrier to a happy, healthy life and stress is to a great extent decontextualized – located in the individual and their unique experiences and reactions, rather than in the larger social context. Although not prompted by questioning, stress discourse was pervasive within the interviews. A common fear held by the women was that their symptoms might be explained by stress and that such manifestations of stress represented a personal failure.

Part of it you feel like a fraud. You feel like you’re afraid people are going to think, “Why don’t you just go to your doctor?” Another part of it is being embarrassed that you can’t handle stress better than you do, that it is stress.

A self-diagnosis of stress was congruent with the women’s attempts to maintain their integrity; in particular, this explanation was consistent with their perceptions of themselves as being physically healthy. Stress provided a somewhat reassuring explanation of the events, implying that if a woman could avoid stress in the future, she would not experience a recurrence of her symptoms. A notable exception to the belief came in the form of the accounts of the two women who identified themselves as having immigrated from Hong Kong. Both of these participants expressed incredulity that anyone would take a chance with their health and delay seeking treatment. In particular, they expressed surprise that “people wouldn’t know better.”

Before a visit to the hospital, the women juxtaposed their experiences of stress against the possibility of heart disease and the former was judged to be far more likely. If a cardiac diagnosis was subsequently confirmed, the women had larger concerns than
whether they had sought treatment for a “false alarm.” As one of the participants
explained, “I don’t want to go because...if there’s nothing wrong and I’ve taken their
time, you know. No, I don’t want to go [to the ED] unless I really feel as though I need to
go.” The women who delayed seeking treatment explained that underlying the decision to
“wait and see” was a desire to balance, on the one hand, the reality that something might
be wrong, and on the other hand, the reality that if nothing was medically wrong, social
embarrassment and wasted health-care resources would be the consequences.

I kept thinking, with me, that it will...it will go away on its own and particularly
having been into emergency Monday morning, you just looked around and you
thought, you know, “These people have just so much to do, there aren’t enough of
them, they’re overwhelmed, I don’t want to bother these people with this little
whatever it is I’ve got because I’m not bleeding, I’m not throwing [up].” And you
look around and the place is just jumping. You do feel a bit like, “Oh, wow! What
am I doing here? Don’t bother them.” That probably says it quite well. “Wow!
There’s sick people here. What am I doing here? Cause I feel better than I did.”
Yeah, ‘bother’ people is quite a good...I mean you’ve been there, you’ve seen
what it’s like. “Man! They haven’t got time for me.”

With relational knowledge, the women’s past experiences with health-care
professionals exerted an often profound influence on their decision making. If, in the
past, a woman had received clear messages that she was doing “the right thing” by
coming to an ED, she did not hesitate to call 911 or to go to the ED within a short time
after the onset of symptoms. As one of the participants stated, “They’ve always told me,
‘You did the right thing calling the emergency.’” Similarly, a participant with a
background in emergency nursing, reported:

I’ve worked in Emergency before. A lot of times they are busy and they’re kind of
abrupt and stuff like this. This lady was just lovely, just totally lovely. The nurse
was fine...but no...your first contact is with, you know...and I was saying, “I
didn’t think I should be here but I didn’t know what to do.” And she... “You did
the right thing...you should be here...you have every right to be...a good thing
you came.” And I went and told her right after...when I left, how much I
appreciated her because it was so...it does...it makes such a big difference...that
first person. Because you feel awkward and unsure and everything like this and she was just excellent so I must say and I hope that gets passed along because it makes a big difference, at least it did to me.

Relational knowledge prompted the women to consider not only the cause of their symptoms, but to interpret those symptoms within the context of the quality of their lives. For the participants, relational knowledge was a way of knowing about one’s symptoms that was achieved by placing the symptoms within a personal context.

I would prefer to go...if I’m going to pop off someday, that I pop off with something that’s final; that I don’t get rescued to be a ‘case,’ you know. As a matter of fact I read something in the paper the other day that they’re hearing more and more from people that they don’t really want to be a ‘case,’ including some of the people who now are. Maybe I should have stayed home sort of thing, but I’m not ready to go yet; I’ve got things to do.

In contrast to the above account, several participants shared their experiences of multiple losses such as children, partners, and close friends, as well as being concerned about their growing dependence on their family members. They reported that given their age, and these losses, they were not unhappy at the thought of experiencing a cardiac event that might result in death. Several of the women provided examples of “perfect days” that they had had, and in this context spoke about death and expressed an acceptance that “it may be my time” and “I have lived a good life.” One participant stated, “If it is god’s will, he will take you home. It is in his hands. I have had a good life and I am ready.” Another reported that, “I thought that the good lord wanted me. At my age I could go tomorrow and I really wouldn’t mind.” For these women, the onset of symptoms was, if not welcome, then timely. The participants spoke about viewing death as an opportunity to rejoin loved ones. Not surprisingly, this group of women did not tend to seek treatment in a timely fashion, but rather delayed – often for days – until a family member forced intervention.
If I can do it myself, I'd rather do it myself than to ask somebody to do it for me. And there are times in... both my husband and I... we won't say anything because we know they'll offer to help and so we tell them after it's done. I think, for our age, I think we're doing very well. He's 83 and I'm 79. And we don't really want to ask too much of them because we'd rather do it ourselves.

Relational knowing allowed the women to identify and evaluate threats to their personal and social integrity. Because the women defined themselves in relation to others, this form of knowing exerted a powerful influence on treatment-seeking behaviour. At stake, were the women's images of themselves as independent, reliable, and responsible mothers, wives, daughters, and employees.

Summary

Resisting disruption was the first phase of the BSPP of maintaining personal, social, and physical integrity. This phase captured the variations in the data during the time between the onset of symptoms and arrival in the ED. The women in this study carried out an analysis of their symptoms and managed the situation, acting as agents and actively problem solving in an effort to resist disruptions, frequently choosing the path of avoidance and making decisions to delay. Their goal, in every action taken, was to resist any disruption to the rhythm of their daily lives or to their images of themselves as healthy and capable of continuing to be good mothers, good wives, and good employees.

If a disruption was inevitable, due to the nature of the developing symptoms, the women worked to minimize that disruption by dictating the role of others close to them (e.g., driving a woman to the hospital). Of note was the role of particular forms of knowledge, characterized as “ways of knowing” in the decisions made by the women. The findings confirm that attending to their role responsibilities as wives, mothers, and employees, as well as maintaining their images of themselves as independent, intelligent,
and responsible, were important to the women. Accordingly, attending to their symptoms
was often assigned a much lower priority. The role of “caregiver” was given greater
importance than the role of someone needing care.
CHAPTER FIVE: SUSPENDING AGENCY

The women, having been unable to resolve their symptoms at home, mobilized the resources of the health-care system and sought care in the ED. At this point they suspended their individual agency, adopted the patient role, and supported the efforts of their health-care providers in their assessment of the symptoms to determine diagnoses. In the present chapter, I provide an interpretation of the findings related to the women's experiences of ED care. The analysis presented here is shaped by the data arising from both naturalistic observation and the interviews, with particular regard to the structural features of the ED as a place. Accordingly, I begin by providing an overview of "suspending agency," the second phase of maintaining integrity, followed by a detailed discussion of the 3 stages involved. As background, I provide an analysis of the structural features shaping the women's experiences of ED care.

Suspending Agency: An Overview

Suspending agency is a conceptual label that addresses the women's actions and decisions in relation to maintaining their personal, social, and physical integrity during a visit to the ED. Agency here refers to human agency, or the capacity of individuals to act independently and to make free choices, as the term is used in the sociological literature. Agency, so prominent in the women's accounts of the period before their arrival to the hospital, was suspended during their visits to the ED.

During this phase, the women temporarily stopped trying to address their role responsibilities related to their employment or their roles as wives or mothers. They stopped trying to manage their symptoms and the actions of the people close to them. The
participants stopped their attempts to minimize disruptions to their daily lives. The "patient role" was adopted, involving passivity, cooperation, and patience.

The suspension of agency served several purposes. Specifically, suspending agency was one way to ensure their continued physical integrity. Temporarily setting aside the responsibilities and commitments of daily life was viewed as a trade off—a loss of agentic capacity in return for a diagnosis and the resolution of the symptoms. Suspending agency was also a way for the women to manage their fear and anxiety by turning over the responsibility for a solution to others (i.e., the health-care professionals). Having reassessed the threat level and determined that something serious might be causing their symptoms, the women reported great emotional distress. Suspending agency and ceding the responsibility for solutions to the health-care team, for the most part, reassured the women. Experts were monitoring their symptoms and help was nearby at all times. Finally, suspending agency was a strategy used by the women to support the health-care professionals' ability to intervene. Therefore, docility, compliance, and cooperation were important features of this phase.

The unique structural conditions within the ED supported, and indeed mandated, the women's adoption of the patient role. The interplay between agency and structure was complex and the influence of structural conditions was multifaceted. Consider that before the ED visit, the experience of their symptoms was woman-centred (e.g., the problem was defined by the woman, located in the woman's experience of the symptoms, and she was the problem solver). Once in the ED, however, a pronounced shift occurred such that the problem became defined by the health-care professionals, the problem to be addressed was relocated in the individual case, and the problem solver(s) became the
members of the health-care team. The women entered the health-care system as “women,” but moved through it as “patients.” Maintaining the women’s physical integrity became the purview of the health-care professionals as they assumed the primary responsibility for identifying the cause of the symptoms and responding to them. In the context of the ED visit, the staff chose when, and when not, to act. Only occasionally did the women advocate for themselves, questioning treatment decisions, and requesting information. Far more commonly, the participants chose not to act, putting themselves in the hands of their health-care providers.

Within the interactions between the patients and their health-care providers, the powerful influence of the ED as a special place was apparent. It is important to understand the ways in which the context of treatment seeking – the qualities of the ED as a place – shaped the women’s efforts to maintain their personal, social, and physical integrity.

Structural Conditions of Suspending Agency – The ED as a Place

The ED as a special place exerted a powerful influence on the women’s exercise of their agency. Place is here defined as a bounded setting in which the constitution of social relationships and identity occurs (Gilmour, 2006). Places are viewed not only as physical spaces or locations, but also as the complex inter-relationships of human practices and physical settings that make places social, cultural, and symbolic phenomena as well as sites for personal attachment and meaning (Andrews, Holmes, Poland, Lehoux, Miller, Pringle, et al., 2005).

The women and the health-care professionals in this study thought about the ED in particular ways. Specifically, characterizations of the ED as “intense,” “regulated,” and
“besieged” predominated, shaping both expectations about ED care and the care provided. The intensity of the ED as a place arose from many sources including: the acuity of the illnesses being treated, the emotions that arose in the course of critical illness, and the vulnerability experienced by both patients and the staff. Characterizations of the ED as a regulated place arose within the dynamic of the visit, during which the women were treated in particular ways in order that they might receive expeditious diagnoses and treatment. Images of the ED as a besieged place arose, in part, from ongoing public debates about access to emergency health-care and current conditions within emergency departments.

**The ED as an Intense Place**

“I won’t go to the emergency unless it is really, really bad.”

“It must be serious if they want to send me here.”

Vulnerability, unpredictability, and a sense of urgency were pervasive in participant accounts of their experiences and contributed to constructions of the ED as an intense place. Although the ED was often a point of first contact for securing health-care services, it was usually a court of last resort for the women who had tried “watching and waiting” and active self-treatment without any resolution of their symptoms. As a result, when the women presented to the ED they were often emotional and agitated. They frequently used the words, “scared,” “terrified,” and “frightened” to describe their state of mind. In part, this vulnerability arose from their fear of the unknown. For example, the women did not know the cause of their symptoms. Many feared a cardiac cause and, as identified by one woman, “the heart is special.” For the people providing care for the participants, vulnerability was linked to uncertainty. One nurse stated:
The first thing that’s unique about it is the context in which we carry out professional nursing, right. We work in an environment where we have no idea who’s coming through the door next, what they’re coming through with. You know…I start my day and I have no idea what it’s going to look like at the end. I have no idea what it’s going to look like in an hour. It can look like one thing in an hour; it can look like a completely different thing in the next half-hour, right? You just have no idea; you’re working with all uncertain…it’s the uncertainty, it’s the unknown, and you’re working under time constraints, so maybe that broader category is really environment. It's the environment that we...the context that we carry on nursing care and the uncertainty, it’s ambiguous, we don’t know what people are coming in with; we don’t know what their history is...you know...all that kind of stuff.

The women in this study commonly thought of the ED as a place where one goes for treatment of injuries resulting from emergencies, crises, or catastrophes. This belief was widely shared by the nurses. As one nurse stated:

I think when they need to get fast care, they still feel reassured that they are going to get it if that’s...if they go [to the ED] and they state their sense of urgency and the sense of urgency is there, they’re going to get the care that they need in an emergency.

Accordingly, a sense of urgency was evident within the ED, reflected in the characteristics and organization of the physical space, the behaviour of the health-care staff, and the expectations of the patients. For example, the signs outside of both EDs stated, “EMERGENCY” in large red letters. There were usually ambulances parked outside the department, and often the sound of sirens was heard in the distance. When individuals entered the ED, typically many people were pacing or seated in the waiting room. Not infrequently there were people moaning, crying, or yelling. There may have been blood visible on bandages or dripping from wounds that had not yet been dressed. The staff were usually walking quickly and speaking rapidly. There was a steady stream of people entering through the sliding doors, seeking care. There was a general perception by the women that the patients in the ED had acute conditions. As one
participant summarized, “Every minute is precious. You could die. The faster you get there, the faster they can heal you.” Another stated:

I guess it was a lot better when you were actually sick. When there was something really wrong with you that they could identify and then they could get to work in fixing it. Whereas it’s this sort of hurry up and wait, while they’re deciding, “Well, we’ll x-ray you and we’ll take blood.” It would be nice to have somebody there with you. It’s a daunting place.

Although the positive impact of a sense of urgency was obvious (e.g., structuring the physical space to support staff responding to life and death situations was an efficient way to manage emergencies), there were also unintended negative effects. Both the women and their health-care providers ascribed to the “tyranny of the urgent.” That is, the urgent almost always trumped the important. Specifically, urgency functioned to discourage the women from seeking prompt treatment, or supported the development of a sense of guilt and embarrassment about having gone to an ED. For example, one participant stated, “I feel like I am taking up space, because there is nothing wrong.”

Similarly, the health-care staff tended to believe that anything less than an emergent situation did not warrant their concern or full attention. As an illustration, the nurse in the following quotation made it clear that the person wanting a place to park was not worthy of the full range of resources available at the nurse’s discretion. “If you came here with an emergency, like you were having a heart attack, then we would put a sign on your car. Otherwise you take your chances.”

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9 This phrase is drawn from two sources: (1) a lecture by Heather Mass, the Chief Nursing Officer for BC Women’s and Children’s Hospital, on acute rather than community-based health care spending and (2) an episode of the television program West Wing in which the actors discussed “the urgent crowding out the important.”

10 The reference here to a “sign on your car” refers to the practice of leaving a note on the dashboard, confirming an emergency situation, so that a patient’s automobile does not get ticketed or towed if the parking time limit is exceeded.
In relation to acuity, the perception of the health-care staff was that the ED was a place for *episodic care* of urgent and emergent health problems. Chronic illnesses were viewed as the business of family practice physicians or specialists. Accordingly, there was a bias toward treating physical and visible illnesses or injuries. In one striking example, a nurse summarized his stance. "There is a 10-hour wait, but whatever. How long you wait will depend on what is wrong with you – if you are bleeding, we can find some space.” Similarly, another nurse reported her perceptions about acuity and ED care:

... what most emergency physicians tell the patient is, “You had this problem for awhile, go get it dealt with.” And if the care in the community doesn’t... if their care provider cannot attend to that problem because they can’t get a visit with their family doctor, or maybe their ultrasound is booked for three months down the road and they perceive it to be an urgent problem, then they come to us for that answer...But most of the emergency physicians will say...more so the younger ones...they’ll say, “You know, you’ve had this problem, go back and see your family doctor. I deal with emergencies, this is not an emergency.”

If and when an individual had a presenting complaint judged not to be urgent (whether by virtue of physiology or “non-compliance” with treatment regimens), informal sanctions were applied. For example, on one occasion, a patient experiencing chronic pain was triaged. The individual had been assessed several times in the ED and upon discharge had not followed through with treatment recommendations. The triage nurse expressed an intention to extend the time until placement in a stretcher, due to the nature of the complaint, with specific reference to the fact that the individual lying on the stretcher had been “non-compliant” with recommended treatment.

Finally, the “tyranny of the urgent” justified organizing the environment and adopting routines that sometimes resulted in treating people in disrespectful ways. In one example, the ED waiting room was crowded and there were several patients waiting in front of the triage desk for placement. One of those patients was a woman, aged
approximately 25 years, seated in a wheelchair. Her head was hanging, as though she were having trouble staying awake. She had been given charcoal and her lips and mucous membranes were black. At one point she tried to rise to a standing position and the nurse yelled at her, “You might as well sit down because you are NOT going home.” Everyone in the waiting room stopped talking for a moment and looked over at the patient. A few minutes later, another patient walked to the triage desk, eating from a bag of chips. The nurse yelled, “WHAT are you doing?!?” “I am eating,” he replied. “Well, don’t – absolutely nothing by mouth! LIE DOWN, NOW, SIT!” She laughed out loud and everyone in the waiting room could hear her comments. “He had a grand mal seizure and we don’t know what is going on! He can’t just get up and walk around.” In this example, the health-care provider attempted to justify her actions by citing patient safety and potential acuity as issues.

The women, presenting to the ED with acute and potentially lethal symptoms, enjoyed a position of relative privilege in terms of their diagnoses. In the existing patient hierarchy, having an acute condition (or visible symptoms of an acute condition) is a virtual guarantee for relatively prompt nursing and medical attention.

**The ED as a Regulated Place**

The ED as a place operated in some ways like an industry or more specifically, a factory. Particular goods were brought to the factory floor (individuals with illnesses or injuries), the goods were standardized prior to production (routine assessment and the data collection), technology and human resources were applied (cardiac monitoring, diagnostic tests, and nursing/medical care), and a product was the result (a diagnosis of disease). The production of a diagnosis required, just as is the case in industry, tight
control of the environment, the application of industry-specific knowledge, and uniformity of the goods produced. And, just as is the case in industry, standardized procedures and information were required to make the system run smoothly. As a place where disease is "produced," both the environment and nursing practice were organized and regulated in ways that supported the staff in exerting an extraordinary amount of control over the individuals presenting as patients.

The physical organization of the ED is conducive to controlling the flow and the behaviour of the individuals within, and outside of, the department. For example, both ED waiting rooms contained vending machines (for soft drinks and one for snack food). Posted right beside the vending machines were signs that read, "Do not eat or drink before you are seen by a physician." The walls of the waiting room and triage area were covered with a multitude of additional instructions for patients and their family members. At one of the hospitals, there were more than 18 signs with messages such as, "one visitor per patient," "all patients please wait here for the nurse to call you," "we will not tolerate violence or abusive behaviour toward staff," and "restricted access." The signage inside and outside of the EDs was a form of communication that exerted an observable effect on people's behaviour. For example, on one occasion I observed a woman of about 30 years of age. She climbed out of a car and limped toward the entrance to the ED. She was obviously reluctant to put weight on her left foot. She was wincing when her left foot touched the ground. She arrived at the doors, which opened automatically, and read the sign stating that the particular entrance was for ambulance patients only. She put her head down and hobbled 25 feet to the next set of doors – the entrance for walk-in patients and other members of the public.
Various additional strategies were employed to restrict access to different sections of the department: keypad coded access, signs stating "authorized personnel only," and doors separating one area from another. Upon entering the ED, the participants were required to approach the triage desk. The triage desks at the two EDs were different. In Hospital A, the triage desk was encased in plastic and there was a microphone facing members of the public approaching the desk. In Hospital B, the triage desk was separated from the waiting room by a gate with a red stop sign. Depending on the time of day, there might have been a volunteer standing near the desk directing members of the public about where to stand while waiting in the line. Approaching the triage desk was often a slow process – a person might stand in line for up to 45 minutes before being addressed by a nurse.

Returning to the simile of the ED as a factory, individuals presenting to an ED for treatment move through an "assembly line," undergoing routine, standardized procedures in a highly regulated fashion. The following section provides a brief description of the events that typically comprise an ED visit for the assessment of symptoms suggestive of cardiac illness, including triage, placement, testing, diagnosis, and disposition.

The women entered the ED, often waited in the triage line up, and then were directed, by signage or a volunteer, to approach the main desk. One of the participants explained:

And so we went in and there was no-one...there's usually a receptionist sitting...there was no-one there. So he was standing there, sort of tapping his fingers and...like we could see a nurse interviewing somebody there and after...you know, in those circumstances, every second seems like an hour. So he got her attention and when she...oh, I guess the person she was interviewing was just leaving and she took me right away.
At the triage desk there was a nurse designated “triage nurse.” Triage is the process of sorting patients according to most immediate need and relative to those already in the ED or incoming. There is a constant process of reassessment at the triage desk, with the most acute patient getting the available resources. For example, on one occasion, I observed a triage nurse walking a patient with chest pain to the last available stretcher when another triage nurse called out, “Stop!” The last available stretcher was reassigned to the newest patient to arrive, who had had a seizure.

The triage nurse, at times dressed in a nursing uniform and occasionally wearing hospital identification, greeted every patient who entered the ED. Typically, the triage interview took place (in both hospitals) with a triage nurse standing behind a desk (waist height), sometimes through a microphone embedded in a glass wall, often with the nurse sitting in an elevated office chair, and always with the patients standing. The exception to this physical set-up occurred when patients arrived accompanied by paramedics, in which case they would be lying on a stretcher and would not typically be interviewed by the triage nurse. Instead, information about their symptoms would be provided by the paramedics.

The first question asked by a triage nurse was usually a variation of, “What brings you to the hospital today?” For the women in this study, interacting with the triage nurse involved responding rapidly to a series of approximately 15, closed-ended questions. Other than a request for her name, the questions addressed the woman’s general health status and the nature of her presenting symptoms.

I thought she dealt with what she needed to know and nothing else. Because of what...that I thought it was you know, that it was heart pains and that had the possibility of being a heart attack, I felt that she was moving me along as quickly as possible.
In the course of questioning the patient, the triage nurse carried out a brief assessment related to the reason the person was seeking medical advice, began the paperwork involved in registering someone to be assessed and treated, made a decision or series of decisions about placement and in the process of triage, an acuity level known as the “CTAS score”\textsuperscript{11} was assigned. The acuity levels were assigned according to the level of urgency of the presenting symptoms. For example, an individual who was not breathing independently and required ventilatory support would be assigned a level 1, signifying that he or she needed immediate attention from both a nurse and a physician. Thus, the assignment of relative need, in the form of the CTAS score, is linked to resource allocation. The assignment of a level of urgency in the previous situation is clear – death would have resulted within minutes if medical attention were not received, a situation that demanded immediate action. In contrast, an individual who presents for an uncomplicated suture removal is assigned a level 5 (the lowest level of acuity possible), signifying that he or she could safely wait indefinitely for both nursing and medical attention. The participants in this study were typically assigned CTAS scores of 2 or 3, depending on their physical presentation and history of presenting illness.

During this interaction, the triage nurse uses targeted strategies to guide the individual’s contributions. For example, if a woman did not respond to a certain question, did not answer quickly, or responded to a question other than the one posed, the triage

\textsuperscript{11} CTAS is the “Canadian Triage Acuity Scale.” Upon arrival in an ED, after a brief (but comprehensive) assessment by the triage nurse, every patient is assigned a CTAS score of 1, 2, 3, 4, or 5. One signifies the most immediate need or the sickest patients, and 5 the least acute. This scale sets the national standard for “time to see nurse” and “time to see physician” and is used in both of the EDs at which this study took place. The CTAS score represents a snapshot of patient status, obtained during the 3-5 minutes of interaction between the triage nurse and the patient.
nurse used strategies such as speaking over the woman, interrupting through the use of touch or a hand gesture, repetition, or moving on to the next question in the series. In this way, the interview proceeded more quickly than a typical conversation between two people. The entire interview took 2-3 minutes unless complicated by a language barrier, with the accompanying need for translation.

At the conclusion of the triage interview, the participants were generally provided with the following information: “Take a seat in the waiting room; your name will be called so that you can register; then, when there is space, we will take you to a stretcher inside the department.” After an indeterminate wait (depending on the volume of people in the ED), the women were interviewed by an admitting clerk. The focus of this interview was on personal identification (e.g., home address, health-care insurance). Then followed (usually) a wait for an available stretcher. During this time blood samples, a chest x-ray, and an electrocardiogram were typically obtained.

Minutes or hours after arrival, the woman heard her name called by a nurse and was escorted (usually walking) out of the waiting room and into the stretcher area – an area of restricted access. Family members were discouraged, at times forbidden, to accompany the woman and were asked to wait in the waiting room. Upon arrival at the bedside, the participant was asked to undress and put on a hospital gown. A nurse arrived at the bedside, typically within 3-5 minutes, introduced herself and repeated the same questions asked by the triage nurse, as well as further questions about the woman’s general health status. At the same time, the nurse carried out a physical assessment, attached the woman to a cardiac monitor, and commenced oxygen therapy. In addition, intravenous access was established. Of note, during an ED visit, a woman might be cared
for by several different nurses as required by staff breaks, emergencies in other parts of the department or the hospital, end of shift, or staffing shortages.

Following these events there was a period of waiting for assessment by a physician. When a physician arrived (distinguishable from the nurses by virtue of wearing a white laboratory coat), he or she repeated the questions asked by the triage nurse and the bedside nurse. As well, he or she usually briefly discussed a clinical impression (e.g., "I don’t think it is your heart" or "We will have to do some tests; I think you might be having a heart attack").

Tests were performed over the next hours by a series of individuals in uniform who introduced themselves by name and department and carried out blood sampling, electrocardiograms (ECGs), and chest x-rays (if not already completed during the waiting period for placement in a stretcher). A period of 2 hours of waiting for the test results typically followed, at which time the physician returned to the bedside, shared information about the test results, and provided the woman with a provisional diagnosis. Depending on the diagnosis and whether the blood tests needed to be repeated, an additional wait of several hours would ensue, after which a definitive diagnosis would be proffered and the woman would either be admitted or discharged with follow-up instructions. If admitted, a wait ensued for a bed assignment on an inpatient unit. This wait lasted several hours to several days.

This regimen – triage, testing, placement, diagnosis, and disposition – occurred for each of the women in this study. Both the content and substance of each interaction between the participants and their health-care providers were determined by this regimen. Attempts by the women to make decisions about what to include (e.g., relevant
information during the triage interview) were discouraged. Instead, the staff determined the content of each interaction according to those practices required so that patients might move through the department as efficiently as possible.

Maintaining the ED as a regulated place requires a coherent effort by each staff member of the health-care team. In many ways, this works in the best interests of the patients. For example, the women’s safety was ensured (to some extent) through the use of protocols about blood work and electrocardiograms. In other ways, the staff’s efforts to maintain the integrity of the ED as a place, did not serve the best interests of the patients. This was particularly true when the staff “enforced place,” attempting to not simply manage situations and individuals, but to control them. For instance, in the course of maintaining the ED as a regulated place (e.g., controlling each step of the “production process”), the staff sometimes attempt to restrict access to health-care services. Although the ED is ostensibly open to all, in fact the health-care staff frequently attempt to exert control over who receives care and who does not. These conversations typically take place during the triage process and set the tone for what remains of the ED visit. The excerpts below provide examples of typical conversations during which the triage nurse suggested that an individual’s decision to seek treatment in an ED (or in a particular ED) was inappropriate.

“I come here all the time as I live nearby.” The triage nurse responds, “You shouldn’t come to the department because you live nearby!”

Man: “Hi, I was told to come and get checked out. I was electrocuted this morning.”
Triage nurse: “Where did this happen?”
Man: “I was at work in... [a suburb].”
Triage nurse: “What are you doing here?”
Man: “[The staff at the local hospital were] really busy and I live ... [here].”
Triage nurse asks about the spelling of his name, his date of birth, and directs him to take a seat in the waiting room.

A patient presented to the triage desk with a request for suture removal. The first triage nurse to interact with him suggested a clinic. The patient (who had limited English) declined and said he wanted to have the stitches removed in the ED (where they had been put in place). She entered his name into the computer. When his chart arrived, the other triage nurse said, “The only way to get those stitches out is to go to a clinic.” She gave him a list and kept repeating (five or six times) that he had to go to a clinic, speaking loudly and pointing toward the exit of the ED.

Even if access in the form of registration is granted, other issues sometimes arise. For example, because of the extended waits for placement in an ED stretcher, which were often several hours long, individuals requesting treatment frequently asked whether they could leave and return in several hours to resume their place in the queue. This request was always refused and individuals were made aware, explicitly, of the consequences associated with leaving the department. On one occasion, I observed a man of about 20 years of age approach the triage desk and state that he was going outside to have a cigarette. The triage nurse laughed and said, “Just so you know, they will call your name three times and then your chart gets thrown out. If you return after that you get to start all over.” He said, “Thank you,” and walked out of the sliding doors. I commented that I was surprised he was leaving since he might lose his place in line. The nurse responded, “Do we really care? I mean, really?” On another day, a man of about 50 years of age approached the triage desk and asked when his mother would be seen. It unfolded that he found his parents sitting in the cafeteria and had brought them back to the waiting room. The triage nurse turned around and looked angry. She raised her voice and said, “You can’t leave! We are so busy!” Her tone said they are stupid and should know better. “The nurse will call her name again – just wait in the waiting room.”
Returning briefly to the simile of the ED as an industry, ED staff efforts to control the movement of individuals awaiting assessment and treatment ensured that a supply of raw materials (e.g., patients) was readily available for processing at the convenience of the health-care team. This was to some extent positive as individuals were in the waiting room and close to help should their conditions suddenly worsen. However, an unintended effect was apparent when individuals, frustrated about indefinite and lengthy waits, chose to sign themselves out “against medical advice” or left without being seen by a nurse or a physician.

Attempts to control the movement of patients seeking treatment also extended to their family and friends, again with both intended and unintended effects. For example, the health-care staff consistently assessed individuals without the presence of family members or friends and this resulted in the women, on the one hand being able to speak freely about abusive home situations (for example), and on the other hand being separated from their available support system. At times the practice of separating family members from patients was not related to assessment, and was enforced nevertheless. For example, on one occasion, I observed a nurse walk by and comment to another nurse, “I told them two visitors at a time and now there are five people there. I just want you to know, I did not do that!” The second nurse responded, “I don’t argue with them. Get security to walk by and ask them to leave.”

If a woman spoke limited English, the practice of enforced separation from her social support presented particular challenges, as illustrated when a 54-year-old woman presented to the triage desk accompanied by her son. He explained that his mother had severe right, flank pain. The triage nurse did an assessment, using the son to translate and
then said to me, "I am just going to take this woman inside – she has renal colic." She
instructed the man to talk to the admitting clerk and then to have a seat in the waiting
room for half an hour, while his mother was assessed by the nurse. I followed the woman
inside and observed. The bedside nurse arrived, obtained a set of vital signs and, finding
she could not communicate with the patient, left (perhaps to find a translator). A few
minutes later the ED physician arrived and attempted to obtain a history, unable to do so
as he did not speak her language.

The data from this project were insufficient to confirm what might have underlain
the actions taken by staff, although a need to control a frequently unpredictable
environment likely plays a role, as was suggested by the nurses interviewed. Of note, the
women experiencing symptoms suggestive of cardiac illness were never turned away
(e.g., "triaged out"), nor was it implied that they should not have sought treatment.
Nevertheless, the majority of the women who participated in this study had prior
experience with seeking treatment in an ED, whether for themselves or family members,
and were well aware of the negative aspects of receiving care in this setting. This
knowledge, as illustrated in the following section, ultimately shaped the women’s
decisions about their health care.

The ED as a Besieged Place

In keeping with images from the popular media found in television shows such as
“ER,” the ED is consistently constructed as a place under siege and overburdened. The
women in this study commonly held a perception that EDs were “insanely” busy and
overcrowded. Media accounts and personal experiences were cited as sources of this
knowledge. This perception frequently played a role in delaying the women’s arrival to
the ED in one of two ways. Either the women did not want to “bother” the staff with non-critical health concerns, or the women did not want to wait for hours in the ED waiting rooms. “They are just so busy. I just sit and see I am not so bad; others are worse” and “The doctor was just harassed to death and they had somebody die on them and it was really bad. They were trying to save his life and you know it was really hard.” Another participant summarized the impact of perceptions of the ED as a place besieged:

It could be that if I walked into Emergency and they looked swamped I might have turned around and walked out again. I don’t know. But the fact that I could get up there right away made a difference. They dealt with me right then. I mean it’s not that I didn’t have to go and sit in the waiting room for awhile but I’ve seen Emergency there…it’s lined up, you know, and I probably would have gone home...

As one nurse explained:

Emergency departments are busy nowadays. People know if they go to the Emergency department, they’re going to be sitting in the waiting room with lots of other sick people and lots of unpleasant things happening and they’re not going to be seen right away. So, I think that’s a discouraging factor. People know that they’re going to have to wait and it’s not going to be timely. It’s not like going to the take-out window at McDonald’s, right? You’re going to have to sit and wait your turn.

The participants, without exception, had particular expectations about their care. Specifically, they expected to be treated impersonally, to be uncomfortable, and to experience long waiting periods. As one participant stated succinctly, “It’s so impersonal that… you know, they’re busy, they deal with the problem and you move on.” The participants were well aware of the overcrowding problems occurring in EDs, drawing on knowledge about this issue gained from media representations and from past visits to the ED, whether for themselves or family members. One woman with a rapid heart rate recalled:
When I went to the doctor for the follow-up visit yesterday, she said ... "You know, if you can get yourself to Emergency, when it was happening," and I mean...I did laugh out loud...and I said, "Uh-uh" and, you know, by the time anybody would see me, what do you think the chances of my heart rate still being at that, you know, and if it is, I'm probably dead so...you know...it wasn't a logical suggestion and she said my heart rate was 130 when I got to the ED and it was no where near that when somebody finally saw me.

The rules inside the ED are different from the rules of society in specific ways and the only way to learn about the rules is to experience them. For example, in wider society when you seek service, you are taken care of on a “first come, first-served basis.” Participants in this study learned that in the ED, individuals are taken care of on a “worst-come, first-served basis.” Expectations that one would have to wait in the ED were so prevalent that when a wait was not required, surprise resulted.

Well, because they got onto everything real quick. I mean they came in right away, I came in, I wasn’t waiting long ... the doctor saw me almost immediately; it wasn’t more...I don’t think it was more, maybe 20 minutes or so before...and they called for all the blood work and to have things looked at. However, I think it was a lot to do with they weren’t that busy at that particular time.

Not only were waits expected, but certain negative experiences were anticipated and when those negative experiences did not occur, several of the participants again expressed surprise.

Actually both times ER were very good compared to what my expectations would have been. I was quite impressed both times. [This surprised me] just based on experience. I mean ER isn’t always the most welcoming place... let’s face it. I mean, you know, there’s often disease, often overworked (staff) and it’s often, you know, “Okay, what’s going on here?” and now on to the next, that sort of thing. But, I found that people were very welcoming...not welcoming... very amiable, I guess, to a point, you know and not just professional.

But in the hospital they were very, very nice. Oh...they take me right away and I was surprised...to me...they treat me nice, everybody.

It was really good. I have no complaint. And it was much cleaner than when I was in the last time. Because when I was in with the pneumonia the bed I had...I was
lying in bed and wished I had a toothbrush so I could have cleaned the bed...the railing on the bed. You wonder why you get the super bug!

A perception of constant busyness in the ED not only shaped the women’s decisions about treatment seeking, but also shaped health-care practices in particular ways. For example, the women in this study who presented to the ED with symptoms suggestive of cardiac illness (such as chest pain or shortness of breath) required an ECG. This diagnostic test necessitated that the chest of an individual be completely exposed for a period of approximately 5 minutes. Ideally then, an ECG should be performed in a space that provides some privacy. However, a nurse described the compromise the staff reached as a way of balancing situational constraints with medical necessity when she explained that privacy is not taken into account as a necessity. “It takes at least 10 minutes to organize a private spot and the test only takes 5 minutes. I know we shouldn’t, but I just get it done in the hall.” Unfortunately, practices taken up in the context of overcrowding were seldom, if ever, altered when the ED was not overcrowded or busy.

Overcrowding and busyness were frequently discussed in the context of resource scarcity. Acknowledgment that there were insufficient resources (e.g., stretchers, staff) to meet the needs of patients highlighted specific values and beliefs embedded in health-care practices in the ED. For example, the women with symptoms suggestive of cardiac illness were sometimes disadvantaged by their age. One triage nurse shared her perspective that triage was about sorting out who was going to benefit the most from the limited resources available. She explained that if a 45-year-old man walked up to the triage desk and said that he was having chest pain and shortness of breath, he would be assigned the last stretcher, rather than a 74-year-old woman with the same symptoms. Similarly, another nurse stated:
You know...if you think of life in the emergency department as life and death in general, we always go to the younger population as being more acute because when someone older comes in, they’re sick, it seems more natural to expect that they are going to have health problems...they’re going to be sick and possibly you know, they might even die and it’s not the end of the world for us because it’s an older person, not a child...

Constructions of the ED as a besieged place influenced both health-care practices and the attitudes of the health-care professionals, ultimately affecting the nurse-patient relationship in profound ways. Nursing care that in the past might have been considered basic and unremarkable (such as offering a blanket or oral fluids) was now described as atypical. One nurse explained:

They’re lucky when they get into a bed. And I think what it does is, it taxes the staff to the point that they do not feel they have anything left to offer the patient...and that, to me, is the saddest thing. That we don’t have the thing...the energy left, to care for people. We’re so busy, doing what you just said, allocating our resources in the department; we can’t care for people. Heaven forbid you should ring your call-light and want a warm blanket.

On one shift, the staff had been caring for a woman diagnosed with a heart attack. Subsequently, during angiographic studies, it was discovered that this diagnosis was incorrect. I returned to the ED and told the nurses about the diagnosis and their response is an illustration of the disconnection between the patients and those providing health care. When I returned to the ED, I commented to the staff that the woman did not have an AMI. They shrugged and said, “Oh, we don’t care. She is out of the department now.”

During the time this project was conducted, media attention was directed to EDs in the local area. Norwalk virus epidemics necessitated the closure of hospital units and a public announcement requesting that people refrain from visiting those hospitals unless absolutely required was issued, and continued overcrowding in the EDs created well-publicized conflicts between ED physician groups, hospital administrators, and the
government. Ongoing human resources issues create challenges for the health-care staff and patients in the ED. Debates and disputes regarding funding, access, and utilization are common topics in both professional journals and the popular media. For example, the headline on April 27, 2006 of the *Vancouver Sun* read, “We Warned of ER Deaths: MDs,” with an accompanying story about deaths in ED waiting rooms during periods of overcrowding. The ED was therefore to some extent a disputed place – with various groups taking positions in opposition to one another. Concerns about patient safety and fiscal restraint were used to defend opposing perspectives. In one hospital, the ED physicians had published a letter regarding unsafe practice conditions. The ED physicians at another nearby hospital had published a similar letter and the resulting furor prompted the government to earmark $7 million to address physicians’ concerns. The ongoing issue of overcrowding, and the specific sequelae arising from overcrowded conditions, are used as a political platform to support demands for additional resources and is a source of tremendous frustration for health-care professionals.

In summary, the ED is a place commonly constructed as intense, highly regulated, and besieged. These characterizations function to influence both the decisions of patients in relation to their treatment seeking, and the practices of health-care professionals. In both cases, the influences exerted are at times negative, resulting in treatment-seeking delay and oppressive health-care practices. Images of the ED as a compassionate place, as a welcoming place, or as a health-promoting place were notably absent from the accounts of the women in this study and of their health-care professionals. As one participant stated, “It has all the warmth and ambience of a bus depot.” Uncertainty, conflict, and competition for resources were major themes within the data. An
explanation of the ED as a place sets the stage for the following discussion about the
women's experiences of care in the ED, with a particular focus on the interplay between
the context of treatment seeking and the women's agency.

The Second Phase: Suspending Agency

Suspending agency was the second phase of the women's process of maintaining
their personal, social, and physical integrity in the face of cardiac symptoms. Moving
through the system necessitated that the women shift from an active, problem solving
approach, to a less active problem solving approach that involved accommodation, and
sometimes assimilation of, the values, attitudes, and beliefs that were embedded in the
practices of the ED. The participants and their health-care providers were in a
relationship. The former acted, the latter reacted, repeatedly, in a continuous feedback
loop. Specifically, the staff "took control" and the women experienced "becoming
dependent;" the staff engaged in "constructing a cardiac case" and the women
experienced "being repackaged;" and the staff "made judgments" about deservedness and
the women experienced "being judged."

Becoming Dependent

Urgency and a bias toward the treatment of high acuity illnesses were embedded
within the organization of space in the ED (in terms of layout, physical area, and patient
flow), as well as the attitudes and practices of the health-care staff. Thus, the efficient
movement of patients within the department, as well as the expeditious management of
emergency situations, were supported. Through their actions, the health-care
professionals created the conditions necessary for dependence to develop and thrive.
Dependence served the interests of the health-care professionals, creating docile bodies upon which to act.

The staff acted to "take control" from the moment the women presented to the ED. Oriented toward the treatment of acute illness, the staff used their expert knowledge to project the worst possible situation that might arise, given a particular set of symptoms, and then took pre-emptive action to address that possible outcome. Working on the assumption that the worst case scenario would occur, and defining all situations as potential emergencies, the health-care staff adopted particular practices to gain rapid access to information about a woman's health history and physical condition. In this way, the staff members were well-positioned to intervene, if needed.

**Taking control.** Becoming dependent occurred in response to the health-care professionals "taking control" and involved both disclosure and socialization to the ED culture. Although the label of "taking control" captures the essence of the relationship between the women and their health-care providers, in some ways it is not fully accurate. A more accurate description might be that the women, by virtue of choosing to go to an ED, disclosing their symptoms, and remaining in the ED for treatment, provided the health-care professionals with favourable conditions under which to pursue their diagnoses and treatments. The staff, drawing upon their expert knowledge, shaped the events that occurred during the women's visits to the ED.

Disclosure, on the part of the women, was not typically a well-constructed narrative that explained the events leading to a decision to visit the ED, or that described the symptoms in vivid and explicit detail. Rather disclosure was driven by fear, having tried everything they could think of without effect, the women were driven to visit the
ED. Disclosure to the triage nurse often began with one of two statements. First, the women might have stated that they were sure they did not need to be in the ED, it was just indigestion or another gastrointestinal complaint. Alternatively, the women responded to the triage nurse’s question, “What brings you to the hospital today?” by saying, “I don’t know.” What inevitably followed was a series of probing, direct, closed questions about the symptoms, and the woman’s past medical history. These probing questions comprised the triage interview. At no time was a narrative solicited. Only particular types of information were accepted.

With the act of disclosing their symptoms, the participants surrendered the responsibility of solving the problem and the health-care professionals took on the responsibility. With the women in a dependent role, the ED staff could more easily take action and respond to the women’s symptoms in a pre-determined way using predetermined strategies. The creation of dependence continued as the women became socialized to the ED culture. Socialization, in essence, was about learning the rules of behaviour in the ED and learning how to be a “good patient.” Specifically, such socialization involved three things: drawing upon past experience, learning about the current ED environment and the rules by which the ED functioned, and cultivating qualities associated with being a “good patient.”

The women described themselves as emotional and scared at the time of their arrival to the ED. In contrast, after being admitted to the ED, assessed, and treated, the women commonly reported a sense of safety and security. As stated by one participant, “I didn’t know what was happening, but I was in the right place.” Another summarized her perspective, exclaiming, “No, I am safe, I am in the hospital! It is their promise!”
*Becoming dependent* was about the position of the women relative to the health-care professionals. Becoming dependent began at the triage desk and was reinforced for the duration of the visit. A lack of information and knowledge, an unsettled emotional state, a relative lack of social support, interactions with health-care professionals, and an unfamiliar environment all contributed to establishing and sustaining dependence. Dependency began with waiting for access to the triage nurse and was strengthened by the triage interview, waiting for placement in a stretcher, and having to get undressed to put on a patient gown. In contrast, the health-care professionals were independent and depended upon, holding relevant information about cardiac illness (e.g., when to be concerned and when not to be concerned), having expertise in the form of clinical knowledge (e.g., how to treat cardiac disease) and practice experience (e.g., knowing when someone’s condition is unstable), having a shared language and common symbols (e.g., “The second set of trops are negative,” translated as no cardiac injury has occurred), and the power to control access to both people and resources (e.g., separating patients from families during the first 30 minutes of an ED visit). In addition, the staff has a systematic approach to the assessment of cardiac symptoms and therefore know what to expect.

Not only did the women lack specific knowledge about cardiac illness (e.g., information about the time limited efficacy of rescue therapies), but the somewhat interrupted nature of the nurse-patient relationship in the ED created a lack of access to consistent staff. Due to staff shortages and shifting acuity within the department, nurses were frequently reassigned to different areas. Between staff reassignments, coffee and meal breaks, and staff turnover at shift change the women in this study might have been
cared for by upward to six nurses during their stay. In fact, the majority of the participants had difficulty identifying the individuals involved in their care.

Undoubtedly an inability to recognize the various members of the health-care team was at least, in part, due to the fact that there were no consistent uniforms and identification badges. The single exception to this was the paramedics. Frequently street clothes were worn by the nurses, paired with scrub pants, making identification even more challenging. Interactions in the ED were typically initiated by the people in uniforms. People seeking treatment wait to be addressed by those wearing uniforms. The people in uniforms wear plastic name tags and were mostly dressed in scrubs. Admitting staff were not in uniforms, but lab coats were worn over their street clothes. It was not obvious who was a nurse. During the hours I observed in both departments, only on one occasion did I witness a nurse introducing herself to a patient (name and title). In contrast, the ECG technicians, laboratory technicians, physicians, and radiology staff all introduced themselves on a more or less consistent basis.

The women in this study did not have access to information and resources about cardiac illness; nor did they have access to a consistent source of information about their condition given shifting staff assignments. This created a vacuum for the women that had the indirect effect of reinforcing the professionals' power, of causing persistent fear and anxiety for the participants, and of creating dependence on the health-care professionals. This dependence served the interests of the health-care professionals, ensuring that important health information was accessed expeditiously.
Being Repackaged

Repackaging transformed the women from unique individuals with particular histories, to members of a group of women with possible cardiac disease. Repackaging required the application of a professional body of knowledge about cardiac disease, as well as the generation of a substantial amount of the data related to the symptoms of cardiac disease. The women heard themselves being referred to as “the heart attack in bed six,” “the chest pain NYD,” or “the woman with the elevated trops in bed eight.” Repackaging allowed the health-care professionals to act in standardized ways, to address the diagnosis and treatment of the women. The participants experienced a flurry of activity, as their health-care providers took action, often without offering accompanying information:

I was still getting the same symptoms so they gave me an ECG and there was something wrong with the ECG and that’s when it triggered to treat me for a heart attack. So right away they put me on oxygen, IV, and all the blood samples, nitroglycerin and aspirin. Wow! So many things all at once... So they put me on everything all at once. But I didn’t know what it was and like I said, I just knew that I wasn’t well, there was something wrong.

Later on during her interview, the same woman shared her state of mind in relation to the above events:

It got me a little bit nervous when all these doctors came around. Yeah...really thinking that I was getting a heart attack. But I think I overheard one conversation saying that getting something ready could be for...if I did get a heart attack...they were getting something ready. I can’t remember exactly what the doctor said but I remember he sort of alerted all the nurses around.

To reach a diagnosis about the cause of the women’s symptoms, the health-care staff generated several hypotheses and then considered each possibility in turn. In the

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12 “NYD” is an abbreviation for “not yet diagnosed.”
course of arriving at a diagnosis, the staff "constructed a cardiac case" and the women experienced being repackaged. Constructing a cardiac case captured the approach health-care professionals take in the assessment, care, and treatment of people with symptoms suggestive of cardiac illness. In this context, repackaging signified paying attention to certain types of information. For the health-care professionals, information about the specifics of their patients' symptoms, past medical history, and medications were examples of important information. Family structure, employment, and social responsibilities were examples of information not solicited. These bits of information were used to assign provisional diagnostic labels; which, in turn, determined the selection of diagnostic tests and interventions.

Surveillance and standardization were important aspects of being repackaged. Building a cardiac case required the availability of particular forms of knowledge. This information had to be obtained from each of the participants and served to assist the staff in standardizing the information they exchanged. In this way, the women could be compared, based on specific criteria such as the degree of elevation of their cardiac enzymes, the degree of derangement of their cardiac rhythms, the amount of pain they were experiencing, or the number of symptoms they expressed. For the women, this translated into the experience of constant observation or "surveillance."

Surveillance and standardization, in the form of cardiac monitoring, direct observation, and diagnostic tests were the main methods used to collect information to create a cardiac case. Alternatively, if the data could not be re-assembled to fit the hallmarks of cardiac illness, they were used to dismiss the symptoms. The need for surveillance data to support the creation of a cardiac case created several challenges for
the women, particularly in relation to their experiences of the care provided, and ultimately, the outcomes of that care. Breaches of confidentiality, objectification, and unwarranted treatments were three obvious consequences.

Surveillance required that the physical environment be organized in particular ways. First, the women were visible at all times, whether in the waiting room, or lying on a first aid or acute care stretcher. The entrances to both of the EDs were glass, so that patients and people approaching the ED were visible and if someone collapsed in the parking lot, they would be observed. The stretchers and chairs were clearly arranged for maximal viewing of patients in the department.

The arrangement of the stretchers meant that the women were sometimes face to face with strangers, strangers who might be vomiting, confused, restrained, attempting to climb out of bed, or disrobed. Although the participants might have requested that the bedside curtains be drawn or partially closed, the request was usually denied. Safety was cited as a rationale for keeping the curtains open. Curtains used to separate stretchers blocked vision, but not sound. As a result of this, and the arrangement of the stretchers, many if not most conversations were audible to those in the nearby nursing station.

The proper names of the patients were treated as public information – the admitting staff stood at the desk and called out the full names of patients so that they could take a seat at the admitting desk and be registered, and nurses and physicians stood at the nursing station and spoke into the phone, giving reports to other health-care professionals. As well, health conditions were not held in close confidence. Anyone attending to a conversation at the nursing station would be aware of the diagnoses and symptoms of the patients in nearby stretchers.
For several of the participants, a lack of privacy and exposure to sometimes unpleasant images were not problematic and in fact constituted a welcomed distraction, whereas others expressed a desire to have more privacy. For one participant, concerns about privacy and confidentiality influenced her decision to seek treatment – delaying her visit to the ED. For another, privacy was not a concern:

After you’ve had a baby, that part doesn’t bother me. It really doesn’t. I’m just another number! I mean there’s lots of people, like my daughter-in-law, she was here and she had cancer of the cervix, and the men around the operating table and she just felt terrible. I said, “I couldn’t care less.” I’m getting old and senile!

The data collected through various methods of surveillance had to be tracked, usually in the form of patient charts and a unit census. This created privacy issues. For example, in one of the hospitals a 4-foot by 6-foot, white board recorded the names of all patients in the department, and this information was accordingly visible to many of the individuals in the department at any given time. As well, vital signs were typically recorded each hour, at a minimum. This resulted in nurses walking up to stretchers, holding a clipboard, and staring at the cardiac monitor screen to record the previous vital signs readings. No direct contact with the patient was required and frequently none was sought. When a patient was attached to the cardiac monitor, the staff gained the ability to monitor vital signs, often an indicator of overall health status, through the use of technology, but they sometimes stopped attending to the women as individuals as a result.

When attached to a cardiac monitor, as all of the participants in this study were, the women were unable to move about the department without asking for permission and assistance. A trip to the bathroom was an ordeal. Such a trip required that a nurse respond to a call light, which often took up to 30 minutes. Sometimes the nurse who responded
was unfamiliar with the woman’s condition and did not know whether ambulation was permitted. Finally, assistance was required to detach the woman from the cardiac monitor so that she could go to the bathroom, and then be reattached to the monitor upon her return to the stretcher. This was particularly challenging when a woman was older and required more frequent trips to the bathroom. On several occasions women caught my eye some minutes after returning from the bathroom and requested that I re-connect them to the cardiac monitor, expressing some anxiety that they were not being monitored for a period of time.

Although these aspects of surveillance were apparent to the women in this study, other forms of data collection were not. For example, each patient presenting to an ED had a PharmaNet search performed. A PharmaNet search described all prescriptions filled by an individual in the past several years. In addition, in one of the hospitals, a separate records search, termed a “master patient index,” was performed detailing all contacts with health care in that region, in the past 5 years. Past medical records, detailing past visits to an ED, were also requisitioned when the women arrived. This information was sometimes invaluable for the health-care professionals in forming a clinical picture, especially for situations in which patients might be unable to provide information about prescription medications. However, this information was also sometimes used to form impressions about individuals that were not clinical in nature. For example, a woman who had accessed ED care on more than two or three occasions in a single year might be labelled, “a frequent flyer,” a pejorative term used to signify that a particular individual has visited an ED for treatment so often that his or her case history is known to all the staff. Similarly, accessing the care of a psychiatrist might trigger a belief that a mental
health disorder was underlying the physical complaint. Essentially, in the ED, the need for surveillance (i.e., interpreted as access to any and all information that might have clinical relevance) was in conflict with confidentiality and the former was always the more powerful influence on health-care practices.

**Constructing a cardiac case.** The experience of cardiac symptoms is personal and frightening. For health-care professionals, the women’s experiences were to be analyzed, measured, and categorized in order that an accurate diagnosis might be reached. The women learnt that their symptoms were being constructed and understood not in a personal context (e.g., a particular individual’s social, emotional, and physical world), but in the context of the accumulated biomedical knowledge about illness in general, and cardiac illness in particular. Interpreting symptoms in light of this knowledge required standardized approaches to care. In the process, for the duration of their visit to the ED, the women underwent a repackaging and became recognized as cases rather than as individuals.

For the health-care professionals, constructing the women as cardiac cases meant that the women’s symptoms required re-interpretation beyond that carried out by the women themselves. The staff, in the course of extracting information from the women, compared a particular woman’s clinical presentation with classical cases of cardiac illness. Images of classical presentations were drawn from past experience and expert knowledge. The staff discussed previous patients, for whom they had provided care, focusing on similarities and diagnoses. The application of knowledge about classic cases resulted in the women being questioned about their symptoms in standardized ways.
Descriptions of the location, onset, duration, and the quality of the symptoms were examples of the types of information sought.

The cardiac pictures or cases generated by the staff served the interests of the women and their health-care professionals because the cases could be used as a form of shorthand communication. Clinical pictures also were used by the ED nurses in gatekeeping and advocacy functions, and ultimately, to make management and resource allocation decisions. For example, if there was a single stretcher available and several patients in need of placement, two triage nurses would discuss each patient, pointing out atypical diagnostic findings and deciding which of the patients was most in need.

ED staff members were acknowledged by the women in this study as having expertise and “knowing what to do.” For some of the participants, the “experts” were seen as all-knowing and powerful. One patient characterized her ED experience in this way: “It went really well. They just took over!” A belief in the professional’s expertise was so strong that one participant expressed dismay when she was consulted by a cardiologist.

When he said, “Do you have any more questions [you think] I should ask you?” that was the most stupid thing! My specialty is not cardiology, but you know, that was the most stupid question anybody’s ever asked me... but he might have been nervous. I don’t think so. No... you’ve asked me everything... You’re the one! You’re asking the questions. What haven’t I told you?

The benefits of the application of expert knowledge were clear; however, there were unintended adverse effects. For example, although knowledge of classical cases functioned to alert the staff about the need for swift action, if a particular woman’s clinical presentation was atypical and did not fit the classical picture, cardiac causes might not be considered. For example, a 29-year-old-woman presented to the ED with
chest pain and ECG changes indicative of cardiac ischemia. In the excerpt below, she described her experience of having her complaints dismissed by a nurse. “The nurses... the triage nurse, from my history, took it seriously. The other nurse, she came around and said, “You’re too young to have chest pains.”

Despite the participants awareness that the risk of heart disease for men and women after menopause is equivalent, a bias against women was a theme in many of the health-care professionals’ accounts. On one occasion, a nurse told me about a woman who presented to the ED with epigastric pain. The nurse recalled that the woman’s vital signs were fine and her story seemed vague. Because there was no room in the acute area, the patient was triaged to the treatment area (e.g., “walking wounded,” non-acute). The nurse explained that 1 hour later the patient went into cardiac arrest, caused by a massive heart attack. One of the other nurses commented that women with epigastric pain should not be assigned to the non-acute area of the department, regardless of how busy the department might be, to which the first nurse replied, “I know, I know, but she looked fine.” This situation was by no means uncommon. On another occasion, the staff members were eager to share the story of a 48-year-old woman who presented with left scapular pain. She was triaged to first aid and later found to have the signs of an AMI. The staff were shocked, especially when the woman was subsequently found to have blockages to multiple coronary arteries.

For repackaging to take place smoothly, the participants had to be positioned as passive objects of investigation, rather than participants in that investigation.

And then we had a parade. I looked up and lo and behold! I was completely surrounded. The young cardiologist who had been accompanied by a fellow doctor from China, on one of these visits, now came back with her and a Dr. G., who said he was the boss and four or five others who all just had a really good
listen to me and poked at me and discussed me, almost but not quite, as if I wasn’t there.

To collect the data required to establish a cardiac case, the woman had to be in a stretcher, lying down, undressed, and not moving about the department. She also had to be willing to undergo various, sometimes painful, procedures – often without explanation or discussion. And, if discussion did take place, it was often not reassuring. She also had to be willing to let people “practice” on her body, whether this was in the form of medical rounds or an intravenous start by a new paramedic. And, she had to cooperate while being treated as a model or an object, rather than as a person. Nudity, exposure, pain, and lack of privacy were all features of the ED experience.

The paramedic is poking me with a sharp instrument while he’s asking me all these questions so that was a little distracting but his questions... if I had to think of one word, looking back, I found him annoying... you know, he was just doing his job. But he could have either waited ‘til the guy stopped poking at me; it would have been more, I don’t know, tactful or something if he’d have just backed off for a few minutes until they finished what they were doing. So, that was a little hard to answer his questions while that was going on.

**Being Judged**

The ED staff judged the women regarding the appropriateness of their decision to seek treatment. They also made judgments about the women’s health behaviour and about their actions in relation to their symptoms. The view that individuals are responsible for their health status was commonly held by both the staff and the participants themselves. “Healthism” was apparent in the ways that the women spoke

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13 One might argue that all patients have the right to refuse to be cared for by students (and that some individuals do refuse). Such an argument assumes that the person has been informed that a student will be providing the care (which was not the case in this situation) and that the individual lying on the stretcher is in fact fully capable of refusing consent. Pain, fear, stress, an unfamiliar environment, and relative dependence on the goodwill of their health-care professionals are several factors that may combine to limit the patient's ability to decline to be the subject of someone else's learning.
about their risk factors, including obesity, smoking, diet, family history, compliance with physician advice, prescription regimens, and lack of exercise. For the staff, these factors were front and centre when caring for their patients. On one occasion, for example, one of the staff nurses approached me to talk about her frustration that people wanted to smoke when she felt that they should be lying in their beds, recovering. She speculated that people cannot be really ill if they are well enough to leave the department for a cigarette. Her expression and tone were of distress and disgust. She acknowledged that of course smokers would want a cigarette, but questioned whether smoking was an appropriate behaviour when one was ill.

The women were aware of the judgments made by the staff, and indeed they judged themselves in relation to their risk behaviour, as illustrated when one of the participants, when speaking about her health history to a nurse, raised her hands in the air and stated emphatically, “OK, OK, I haven’t been taking my pills. I forget sometimes. Don’t judge me!” or when another participant confided, “I don’t walk. I’m a bad girl!”

One participant, who had in the past been employed as a nurse in an ED, was surprised not to be chastised about having sought treatment in the ED, certain that she would be judged to have sought care inappropriately.

He didn’t reproof [sic] me or anything like that and he felt sure that it was this radial nerve palsy and was good enough to do the blood work and listen to me. You know, it didn’t show up before without testing...without looking at the enzymes or whatever, so he did run that and, other than that, it was very, you know...there wasn’t much attention but I didn’t need any attention.

On other occasions, I witnessed the staff questioning women who had waited for extended periods of time before seeking treatment. Commonly, patients were asked rhetorical questions such as, “You have had this chest pain for a week and you haven’t
seen anybody about it?” At times the judgments were more overt. For example, on one
shift, a 29-year-old woman arrived in the ED requesting treatment for her chest pain. She
was a nurse and experienced chest pain at work. She obtained an ECG and took
Nitroglycerine. When the medication had no effect, she sought care in the ED. During her
stay in the ED, she asked the physician about the need for laboratory tests to rule out a
cardiac cause for her chest pain. The physician replied, “You don’t need any,” and went
on to say, “You can get it done, but I am not going to read the results!” as he walked
away from the stretcher. The ED nurse providing care for the woman commented, “You
don’t want to judge, but really we all have aches and pains at work. But to diagnose
yourself and get an ECG and give yourself Nitroglycerine! The physician is really saying,
if she can get her own ECG, she can get her own blood work.”

The Interplay Between Agency and Structure

The ED was held, by both the participants and their health-care professionals, to
be a place one frequented when experiencing an emergency. Accordingly, the ED, as a
place, was organized in both environment and practice to enable the staff to deal
effectively with emergencies. The staff were focused, one might say, on maintaining the
integrity of the ED (e.g., in relation to patient flow, “appropriate” use of resources, and
patient outcomes). For example, on one occasion I observed a woman brought to the ED
by ambulance. The paramedic reported that the police had just visited the woman’s home
and discovered a marijuana growing operation. Upon the arrival of the police, she had
begun hyperventilating and collapsed to the floor. He commented that she was likely
trying to avoid being arrested by feigning the symptoms of a heart attack. The ED nurse
responded to this information, stating, “So, not really cardiac.”
Their efforts were sometimes in conflict with the needs of the women, who were striving to maintain their personal, social, and physical integrity. For example, in the course of providing care, the health-care staff frequently acted to “enforce place.” Separating patients from their family members, restricting access, and regulating behaviour were but a few of the practices employed by the staff in the context of overcrowding and scarce resources. Standardized health-care practices were employed to access information and to move patients through the department expeditiously.

In response to these acts of enforcement and standardized health-care practices, the women occasionally resisted the structural conditions, questioning some of the practices and advocating for themselves. In doing so, the participants’ actions were congruent with their images of themselves as capable, intelligent women. In taking such action and resisting the expectations of the health-care professionals, the women were, in effect, striving to maintain their integrity.

Resistance was most visible when the women’s expectations of care were in conflict with the staff’s expectations about appropriate patient behaviour. For example, the staff held an expectation that, given the busyness of the department and overall resource scarcity, the women should wait patiently and without complaint for placement and examination. In contrast, several of the participants expressed fear that they would be forgotten, their chart misplaced, and accordingly they wanted to “check in” with the triage nurse. For example, one participant stated:

You do get the feeling that, how can they keep track of anybody in this…chaos isn’t the right word cause it’s kind of organized chaos but…and you think, “I wonder what if they forget me and I just sit here and sit here…forever?” Well, maybe I’ll just dehydrate and turn to dust and blow away.
The triage staff fielded inquiries about the wait reluctantly, commonly expressing frustration and sometimes anger. Inquiries about waiting times were not interpreted as an exercise of agency, but rather as an imposition. The stereotypes of patients as passive, compliant, and dependent people did not include an expectation that the women would advocate for themselves to obtain information or to expedite their care.

Consistent with the images of “good patients,” the women in this study were expected to cooperate with the treatments and procedures when little information about the rationale for either was provided. In this situation, acts of resistance by the women often involved rejecting or questioning the health-care providers’ authority, whether in the form of asking for information or questioning the need for medical procedures.

I heard one nurse say to another nurse, her blood work is fine, she can go home... so I got changed and then I said to the nurse, “So, I can go home now?” She said, “Can you?” She talked to somebody else; then they came back and I said, “So... it is that radial nerve palsy?” She said, “Is it?” I said, “Well, didn’t he write it down?” And she said, “Well, no,” or something like that. So I guess he was in his break...having a break or was in another room so she went and checked with him and he came out in the hall and said, “I told her.”

On this topic, one of the participants summarized that, “I think they just have a routine but they don’t take the individual into consideration; they just have to do it.”

On a rare occasion, a participant would have sufficient knowledge to advocate for herself and to shape the care she received, but this was the exception rather than the rule. In the example described below, I observed the interaction between an ED physician and a participant who was sure that her symptoms had a cardiac cause, although the physician was not. She volunteered a key piece of information that altered the physician’s plan of care. He stated that he thought she likely had a muscle strain. The patient then mentioned that the only way they knew she had a heart attack previously was that her cardiac
enzymes were elevated. This information got the attention of the physician who was walking away. He returned to the bedside and asked some more questions; in the end, he ordered additional blood tests to rule out cardiac involvement.

Summary

In seeking to maintain personal, social, and physical integrity, the women suspended agency and sought the assistance of experts. Entering the ED, the women experienced transitions, becoming an object instead of a subject, becoming a case instead of an individual, and being classified according to particular norms, which were defined by the health-care professionals, albeit shared, to some degree, by the participants. The interplay between the staff's actions, the environmental structures, and the women's experiences of, and perceptions about, their ED care reflected the actively reinforcing nature of the relationship between agency and structure. Specifically, agency was for the most part suppressed, and structure reinforced – in some cases by the women's participation in (or uptake of) professional values.
CHAPTER SIX: INTEGRATING NEW KNOWLEDGE AND EXPERIENCES

The third phase of the basic social psychological process of maintaining integrity was integrating new knowledge and experiences. This phase involved making sense of the recent events. As argued by Sherwin (1998), the self is not fixed or static, but is constantly evolving and accordingly, the women in this study strove to integrate new information, while preserving their images of themselves as healthy. Once they had returned to their home environments, the women reflected on their symptoms and the ED care they had received. The women attempted to integrate their new-found information while maintaining their personal, social, and physical integrity. There were limited data to describe this final stage because the focus of the study was on understanding women's treatment-seeking decisions and their experiences of ED care. However, several themes were apparent in the women's accounts.

The Third Phase: Integrating New Knowledge and Experiences

The experiences of care were not simply about the character of the women's interactions with the health-care system during their visit to the ED, but also about the ways in which they constructed the meaning of those experiences. For the women who received a cardiac diagnosis, making sense of their diagnoses was about both "taking the blame" and "making choices." The former refers to acknowledging the perspectives of the health-care professionals and assuming the blame for their recent symptoms. In assuming the blame, the women took responsibility for their symptoms and attempted to "do something about it." Behaviour identified as risk factors by nurses and physicians (e.g., smoking, excessive use of alcohol, dietary decisions, or a sedentary lifestyle) were verbally acknowledged by the participants to be part of the reason that a cardiac event
had occurred. Making choices refers to women’s efforts to incorporate the advice of the health-care professionals, in relation to life style changes. In each case, if a woman was diagnosed with a cardiac event, she made significant alterations in her daily habits. For 12 women who did not receive a cardiac diagnosis, taking the blame and making choices were equally prominent, but in different ways.

In the third phase of maintaining their integrity, the women integrated knowledge and experiences to make sense of the recent events and, sometimes, to take action with regard to their health. In this phase, the public and the private spheres blended as the women struggled to reconcile their individual perspectives and values with those of their health-care providers. Reconciling new information with their images of themselves as healthy and capable was sometimes challenging, particularly if a woman had received a cardiac diagnosis. Nevertheless, these women were able to maintain their personal, social, and physical integrity by balancing their new diagnoses with a commitment to change their health behaviour. Conversely, if a non-cardiac diagnosis was received, the women reported no intention to alter their present or future health behaviour.

Taking the Blame and Making Choices

The participants were aware of the judgments that the health-care professionals had made about their lifestyles. The women who were diagnosed with a cardiac problem seemed to accept those judgments. For example, one woman who had smoked for decades spoke about her decision to stop, after she was “warned” by the experience of her heart attack:

But it’s my own decision. Then again, maybe he [the general practitioner] happened to mention, “Did I smoke,” and I said “Yeah.” Maybe somewhere in my...in the back of my mind, I’m thinking, “Hey, this is a good warning...time to wake up and smell the roses.”
Another participant described her hope that exercise, dietary change, and abstinence from alcohol consumption might balance the effects of smoking over the past decades. "I’ve never [had any risk factors] but the smoking… so that’s got to be in my favour.” Having been diagnosed with a cardiac event resulted in the women re-evaluating their personal risk and risk behaviour. A threat to their integrity and fear of death were motivators for behaviour change. As one of the women stated, “That scared me. I don’t want to be in that place again.” As well, the reactions of family members served as a motivation for behaviour change. As the same participant exclaimed, “All my family… they came out of the woodwork. You don’t see them for years and all of a sudden, “Jesus! I am dying!”

The women that received cardiac diagnoses took aggressive action directed at maintaining their physical integrity. One participant altered her diet to include food high in fibre and low in fat:

I’ve been trying to look at the labels to get check-mark things that say healthy which means [healthy heart]… or whatever and cereal I’ve tried to change sort of gradually. I bought some like Kashi® cereal instead of just Shreddies® and Rice Krispies® and stuff. I use only Splenda®. I haven’t used sugar; I don’t smoke anymore, I don’t drink coffee, I don’t drink alcohol so I figure all those things are probably in my favour as not necessarily just to do with food. Exercise too… that was the other thing. I started out mostly once a day, but only 5 or 6 blocks, and lately I haven’t done that much. I do like to swim but my pool is closed down until next Monday so I’m going to start back on that. But I think, all things considered, I’ve taken a lot of… when I look at the whole picture I’ve probably done a lot to adjust [after my heart attack].

Another woman started exercising after the instructions of her physician. “The doctor told me when I go home to walk like for 10 minutes a day for the first week or so.” After being diagnosed with a heart attack, this woman stopped drinking alcohol, which had been a health issue for her. “I haven’t had anything. Absolutely, I don’t want nothing! I
don’t want any alcohol, I don’t want nothing. The only thing I’m having a hard time with is quitting smoking. That’s tough.” Yet another woman started attending a cardiac rehabilitation program on a weekly basis after receiving a cardiac diagnosis.

The responses of the women who had not received a cardiac diagnosis differed substantially. For these women, making sense of the problem also involved reflection on the events that had occurred. However, rather than planning to alter their lifestyles, these women chose to maintain the status quo. For example, without exception, when asked what they would do if their symptoms recurred, this group of women stated that their behaviour would remain unchanged. The participants who “watched and waited” said that they would choose the same course of action (or inaction) if their symptoms recurred. Similarly, if a participant sought treatment immediately, she reported that she would do so again. Their experiences of ED care appeared to make no difference to their intention to return, if necessary. Instead, social concerns about embarrassment and wasting resources, as well as prior knowledge about the ED were the major factors influencing decisions about treatment seeking in the future, for a recurrence of their symptoms. For those who did not receive a cardiac diagnosis, taking the blame involved self-castigation for “wasting people’s time,” acknowledging feelings of intense embarrassment about the “false alarm,” and expressing the intention to choose a similar course of action in the event of future health problems.

The women who did not receive cardiac diagnoses upon discharge from the ED typically expressed beliefs that the root cause of their symptoms was stress and they acknowledged a sense of personal failure at not having been able “to cope” with daily
life. They uniformly expressed a belief that the management of stress was within their control, and therefore they need not experience a recurrence of their symptoms.

Summary

The few participants in this study, who had been diagnosed with a cardiac event at any time during the preceding 6 months, were highly motivated to alter their behaviour in relation to the risk factors for cardiac disease. Although prior to having a heart attack, the women had information about the risks associated with, for example, smoking, they did not take action. In contrast, after being diagnosed, the women in this study attended to that information and used their knowledge to alter their lifestyles, illustrating the power of their interactions with health-care professionals in the context of an acute cardiac event. This group of women had received a cardiac diagnosis and they acted on this knowledge, undertaking changes to their lifestyles. In this case, rational knowledge was personalized, which resulted in the uptake of information and, ultimately, behaviour change. It is not known whether this behaviour change was sustained. In contrast, for those who did not receive a cardiac diagnosis, there appeared to be no impetus for altering their present or future health behaviour.
CHAPTER SEVEN: DISCUSSION AND IMPLICATIONS

Treatment seeking, in the context of symptoms suggestive of cardiac illness, is a complex phenomenon. Health-care professionals and researchers have often attempted to understand the process by which women make decisions about seeking medical advice through the framework of medical knowledge. In contrast, the women in this study drew on many forms of knowledge to understand both their symptoms and their subsequent diagnoses. Employing the framework of personal context, the women analyzed their symptoms, decided between competing courses of action, and ultimately came to understand the events that took place before, during, and after their visits to the ED. The BSPP of maintaining personal, social, and physical integrity shaped both the women’s actions, and their understanding of events, from the onset of their symptoms, to their subsequent discharge from the hospital. The goals of the women and their health-care professionals, although overlapping, are not identical.

For the women, an experience of symptoms suggestive of cardiac illness represented a significant threat to their physical and emotional well-being, as well as a barrier to their ability to carry on with their daily lives. From the onset of their symptoms, the women strove to maintain their personal, social, and physical integrity. They engaged in the process of maintaining integrity to keep intact their sense of selves and to continue functioning in the context of their daily lives. The women continually strove to meet the expectations associated with their social roles as wives, mothers, and employees. Striving to meet their own expectations, and those of others, commonly meant carrying on with their daily routines. This necessitated that they minimize their concerns about their physical well-being by adopting a “best case scenario,” attributing their symptoms to
non-cardiac causes. Of secondary concern for the participants, unless and until the symptoms worsened to such an extent that carrying on with the tasks and responsibilities of their daily lives became impossible, was maintaining their physical selves.

The women's efforts to maintain their personal, social, and physical integrity were to a great extent “situated.” That is, maintaining integrity was both enabled and constrained by the place in which the events unfolded. In their home and work environments, the women were free to evaluate their situations and to take independent action to address their symptoms. In contrast, in the ED setting, the women suspended their agency and sought the advice of experts. Suspending agency was a strategy employed by the women, in order to access the help they needed and to meet the expectations of others. They accepted the role of the “good patient,” and in the process supported their images of themselves as good and socially worthy individuals. They maintained personal, social, and physical integrity by deferring to the experts and accommodating the structural features of the ED.

In the ED, the health-care staff found their attention divided between the needs of individual women and the needs of the organization within which they provided care. In the course of attending to the women’s health concerns, the staff were generally engaged in routines and practices that functioned to maintain the integrity of the department. Accordingly, the physical environment was structured in ways that encouraged the women to accept the role of the “good patient,” that is, complying with directions, waiting patiently, and not asking too many questions.

The ED as a place was a powerful force in shaping the meaning that these women ascribed to their symptoms. Accordingly, structure ultimately shaped not only the
women's perceptions of their symptoms, but also their judgments about the appropriateness of their decisions to seek care in an ED. After discharge from the hospital, the women sought to reconcile their new information and experiences with their images of themselves as healthy and capable individuals.

The primary research question for this project was: In the context of experiencing symptoms suggestive of cardiac illness, what process guides women in interpreting their symptoms, making decisions about treatment seeking, and subsequently making sense of their experiences of ED care? The specific objectives of this project were to investigate: the ways "place" influenced the women's interpretations of, and decisions about, their symptoms; the ways "gender" played a role in the women's interpretations of their symptoms, their decisions about those symptoms, and their subsequent experiences of care; the ways "relationships" influenced their decisions; and the ways that the "social context" of the ED influenced their decisions about treatment seeking. These questions were addressed by the development of the theory of "maintaining integrity." Based on the data obtained, the women strove to maintain their personal, social, and physical integrity in the face of a perceived threat to their lives.

A consideration of the research findings in relation to the larger body of health literature is an important part of any project. In considering the findings of this project, several themes emerge. The health-care literature about treatment-seeking behaviour, the influence of "place" on the health of individuals and on health-care practices, and the literature about "good patients," are useful in interpreting the results of this study. Finally, all knowledge is influenced, and to some extent constrained, by a number of
factors. A critique of the methodology used in this study is therefore both timely and relevant.

Decision Making and Treatment Seeking

Although the results of this study are in accordance with the findings of other researchers who reported that rational knowledge\(^\text{14}\) – that is, knowledge about the risk of heart disease or the symptoms of a heart attack – plays a small role in treatment-seeking decisions (e.g., Dempsey, Dracup, & Moser, 1995), the extent to which such information was used by family members to urge action was surprising. In fact, the results of this study are in conflict with reports that consultation with family members increases delay (e.g., Hartford, Sjolin, & Herlitz, 1993; Rosenfeld, 2004). The participants that consulted their family members for advice typically proceeded to the ED immediately, a visit that may not have taken place without such consultation. The results of this study suggest that the relationship between decisions about treatment seeking and advice from others should be re-examined. A study in which the participants are asked not only about whether they consulted a relative or friend for advice, but also about the degree to which that advice affected their subsequent actions would be useful in further illuminating the role of family members in treatment-seeking decisions.

Although there are consistent reports of women underestimating their risk of heart disease, as compared with men (e.g., Oliver-McNeil & Artinian, 2002), the participants in

\(^{14}\) I have theorized that women making decisions about treatment seeking draw upon particular forms of knowledge, here characterized as "ways of knowing." In nursing and the social sciences, this terminology is not uncommon. Belenky, Clinchy, Goldberger, and Tarule (1986) used the term to describe women's epistemology. My use of the phrase is in line with Carper's (1978) ways of knowing in nursing practice (e.g., empirical, ethical, aesthetic, and personal) or Benner's (1984) case, patient, and person knowledge, which is employed by expert nurses.
this study, without exception, were well aware that women are at equal risk and that women's symptoms might differ from those of men in a similar situation.\(^{15}\) In addition, it is noteworthy that none of the participants in this study had knowledge about medications or medical procedures that might reduce damage to the heart muscle during a heart attack. Therefore, it may be important to consider that particular types of information may be more effective than others in relation to reducing TSD. For example, several researchers reported that although education about the symptoms of a heart attack does not make a difference, knowledge about thrombolytic therapy and angioplasty does (Dracup et al., 1997; Moser et al., 2006). Moser et al. (2005) suggested that individual messages to those at highest risk may prove to be more effective than massive public education campaigns. Such messages might be provided by general practitioners, nurses, staff members in healthy heart programs, endocrinologists, and cardiologists. Over-reliance on any form of intervention, including public education, may eclipse other possible approaches.

Relational knowledge played a pivotal role in decisions related to treatment seeking. As Moser et al. (2006) pointed out, we live in a world of social commitments. Researchers investigating TSD have reported that women's expressed concerns about their role responsibilities and social considerations, such as fear of embarrassment in the case of a "false alarm," play a role in treatment-seeking decisions (e.g., Finnegan et al., 2000; Pattendon et al., 2003). The results of the present study extend this work by

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\(^{15}\) Whether the symptoms of heart disease differ according to biology (e.g., female or male sex) and gender (e.g., socialization as a man or woman) continues to be debated. According to the Canadian Heart and Stroke Foundation of Canada (2006), men and women may experience similar typical and atypical warning signs, however women may report those symptoms differently. Chest pain remains the most common reported symptom for both groups.
providing a model of the types of knowledge that women employ when making decisions about treatment.

Advancing age is sometimes reported to be associated with longer delays (e.g., Moser et al., 2006). A basic assumption of this study was that reducing TSD is a worthwhile endeavour because such a reduction addresses the clinical problem of premature death from a heart attack. However, the women in this study who were more than 80 years of age reported that when deciding whether to seek treatment, they paused to reflect on their lives and expressed a sense of acceptance that the symptoms they were experiencing might be timely given their situations in relation to their age, marital status, and life satisfaction. Keeping in mind that the sample for this study is too small to make claims in this area, the effect of age in relation to decisions about treatment seeking may be an issue deserving of attention in future research projects.

Access to care was an issue for the women of this study in several ways. The participants commonly expressed a reluctance to call 911 when experiencing symptoms suggestive of cardiac illness. The financial cost\textsuperscript{16} of having an ambulance dispatched was a factor cited as a deterrent for several of the participants. The women also spoke about the social costs of activating 911. The health-care literature confirms that calling 911, the most appropriate action in these situations, is far more likely to be the exceptional course of action, rather than the rule (Lozzi, Carstensen, Rasmussen, & Nelson, 2005). It is

\textsuperscript{16} According to the participants in this study, calling 911 and having an ambulance dispatched for transportation to the ED results in an invoice for $45. Individuals who call 911 are not informed about the user fee, until the invoice arrives. The participants in this study had advance knowledge about the fee, drawn from one of 2 sources: personal experience, or word of mouth via friends, family, and acquaintances.
possible that user fees may be acting as a deterrent to the timely activation of an emergency response.

Conflicting reports in the health-care literature regarding the association between past medical history (e.g., previous heart attack) and decisions about treatment seeking have persisted for the past 2 decades (e.g., Ho et al., 1989; Leitch et al., 1989; Wu et al., 2004). An intriguing issue in this study arose in the stories of the women who had a recent history of a cardiac event. Although this subgroup is too small a sample upon which to base conclusions, the women talked about a tendency, which faded over time, to interpret every ache and pain in light of the recent, serious diagnosis (e.g., a heart attack). Further exploration of this relationship might be useful.

The interactions between the women and their health-care providers had an important influence on the women's treatment-seeking behaviour. Specifically, the women who did not wait more than 1 hour, following the onset of their symptoms, before visiting the ED reported that they had been told in the past that they should always seek treatment promptly, rather than adopting a "wait and see" approach. This finding is not reported in the published health literature and suggests that a brief interaction undertaken by ED nurses, paramedics, or physicians could influence future treatment-seeking decisions.

I was able to locate only one grounded theory, pre-hospital study that examined the decisions of women who were subsequently diagnosed with a heart attack. Dempsey et al. (1995) interviewed 16 women about their decision-making process, prior to seeking treatment for the symptoms of cardiac illness. They reported two core categories: maintaining control and relinquishing control. There are some parallels between their
results and the findings reported here. For example, the women in the current study
exercised agency prior to an ED visit, but this was much less the case after arrival and
admission to an ED. What the present study adds to the work of Dempsey et al. is
additional information about the types of knowledge that the women drew upon to make
decisions about seeking medical care as well as a theory about the basic social
psychological process underlying the women’s behaviour.

In summary, the findings of this study suggest that making decisions about
treatment seeking is to some extent a social phenomenon, and not, as currently portrayed
in the health-care literature, solely a product of individual factors. Theory about treatment
seeking currently focuses on the proximal causes of delay, ignoring, for the most part, the
larger social context of treatment seeking. Understanding treatment seeking as a social
phenomenon may widen the focus of the research. Wu et al. (2004) pointed out that a
model including gender, age, past medical history, co-morbidities, education, the
presence of family members, and symptom presentation, explained only 41% of the
variance in decision times, leading to speculation that many other factors exist, as yet
undiscovered. Specifically, the findings of this study in relation to treatment seeking,
suggest that the following may be useful in advancing knowledge about, and ability to
influence, treatment seeking:

1. A re-examination of the relationship between family consultation and
decisions about treatment seeking.
2. A focus on public education in relation to medical therapies for heart attack,
and their time dependent nature.
3. The continued development of theory that explains decision making, with a
particular focus on the types of knowledge that women (and men) use to make
decisions regarding treatment.
4. A re-examination of the relationship between age and decisions about
treatment seeking.
5. A critical examination of the relationship between user fees and decision
making in the context of symptoms suggestive of cardiac illness.
6. An examination of the contribution of past medical history in decisions about
treatment seeking and associated research in relation to ways of exploiting this
relationship.
7. A study examining the effect of a brief intervention in which health-care staff
affirm the appropriateness of individual decisions to seek treatment in an ED,
with return for timely treatment as the outcome of interest.

The ED as a Place

The ED occupies a peculiar cultural niche. It is a bastion of defence against
finitude and vulnerability, and the place where these are revealed most
graphically. There is no other community institution so focused on the task of
heroically helping. (Malone, 2000, p. 2)

No emergency will ever be effectively addressed by a democratic process.
(McEwan, 1997)

The Concept of “Place”

Until recently, little has been written about place within the health-care literature
in general, and the nursing literature in particular. Investigations about the influence of
place on health have previously been confined to the work of medical geographers.
Epidemiological studies, for example, delineate health outcomes for populations,
according to geographic distributions. More recently, place, space, location, and other
related concepts are being taken up by health-care researchers as relevant to
investigations about the relationships between physical location, social context, and
health. Fusco (2006) pointed out that increasingly researchers are paying attention to
health, health care, and the material conditions of place. As well, the work of the health-
care professionals who “maintain geographies of health-care settings” has been receiving
attention (p. 209). It has become clear that the ED, as a place, has not been well theorized
to date and that such knowledge might assist health-care professionals in understanding
the dynamics of an ED visit.
Throughout this discussion, I use the word place to signal not a physical location, but a type of "thing," within which social context, human relationships, and space interact, or as Gilmour (2006) more eloquently described, a bounded setting in which the constitution of social relationships and identity occurs. In the present study, the concept of place is useful in examining the interactions between the social context of treatment seeking in an ED, (from the perspective of both the participants and their health-care providers), the structural features of the ED, and the characteristics of the relationships that form between patients and their health-care professionals.

**The Social Context of Treatment Seeking in the ED**

The results of the following studies provide us with some understanding of the social context of providing care in an ED. Heslop (1998) interviewed three nurses, using a post-structuralist, theoretical approach, and asked the participants to describe their perspectives on ED nursing practice. She reported that a variety of discourses informed the nurses in providing ED care. Each discourse informed, shaped, and constituted the practice of the nurse and, in turn, the ways in which the patient came to be known and understood. Specifically, Heslop argued that ED nursing care takes place in the context of a primarily biomedical discourse that dominates, or tends to dominate, the work of the emergency setting. This is consistent with the findings of this study, in which a biomedical discourse was embedded in the ED, in relation to both the organization of the physical environment and the practices of the health-care staff.

Varcoe (1997) carried out an ethnographic study researching the social context of help seeking in the ED in the context of women who had experienced inter-personal violence. She found that the predominant practice pattern in the ED was that of
processing patients efficiently. In the process, the needs of the women who had experienced inter-personal violence were neglected. Thus, the efficient processing of patients was an overriding concern for the health-care staff, and shaped each interaction between the women and their health-care providers.

Malone (1998, 2000) examined the context of ED care in two papers. In the first paper, an ethnography study, she examined the social history of the ED. She characterized it as an "almshouse" in which individuals used the ED as a social safety net. She pointed out that the current economic reality creates a tendency to problematize behaviour such as repeated use of an ED for non-urgent problems. In the context of the present study, similar findings were reported. As well, drawing on ethnographic data from group interviews with 40 emergency clinicians, Malone (2000) examined nurses' experiences of caring for patients who presented to one of two EDs more than four times a year (termed "frequent flyers"). She characterized the ED as a "zone of protection" and found that interactions in the ED environment were often characterized by vulnerability, helplessness, and tragedy.

The present study extends the work of Malone (1998, 2000) and Heslop (1998) by providing a patient-focused perspective, shedding light on the influence of place on the women's experiences of care. Specific information about what happened to, and for, the women when they presented to the ED for the assessment of symptoms suggestive of cardiac illness adds to the health-care literature. This study confirms Varcoe's findings and suggests that processing or repackaging of individuals who present to EDs deserves further attention by researchers. Such knowledge may be used to positively influence experiences of ED care. For example, a key finding of this study was the tremendous
impact of a simple reassurance by health-care professionals that a decision to seek treatment was a correct and appropriate decision. Such interventions are virtually "free" and yet may be important factors in influencing future treatment seeking decisions.

According to Carolan, Andrews, and Hodnett (2006), place, as discussed within the nursing literature, consists of three elements, including: setting, locus, and situatedness. Setting refers to the relationship between place and disease prevalence, onset, and duration; whereas, locus refers to the social environment of care. The last element of place, situatedness, is of particular interest in relation to this project. Situatedness here refers to the significance and meaning individuals accord to certain places.

The ED is an intense, regulated, and contested space. The "tyranny of the urgent" was very much in evidence. McKie and Richardson (2003) wrote an interesting paper entitled, The Rule of Rescue, in which they argued that as a society17 we feel a moral imperative to rescue individuals facing death that is avoidable, illustrating a preference for lifesaving over non-lifesaving measures. A focus on the needs of particular individuals, rather than populations that require care, as well as a lack of concern with regard to cost-effectiveness, characterize this imperative. Accordingly, health-care professionals tend to focus their attentions on situations of some urgency, in which death is possible, likely, or imminent. In the present study, the participants, presenting to the ED experiencing symptoms suggestive of cardiac illness, were viewed as "legitimate" visitors to the ED.

17 "Society" is used here in the context of Western society.
The meaning and significance the participants, their family members, and their health-care providers accorded to the ED as a place influenced the women’s behaviour in specific ways. As previously discussed, for the most part, the women and their health-care providers shared beliefs about what constituted an “emergency.” Ideas about the ED as a place one visits only if an injury or illness is life threatening were predominant and influenced the women’s treatment-seeking decisions. Only when their symptoms worsened or persisted over hours or days, did the women alter their assessments of the situation as non-emergent, and their images of themselves as “healthy.” Thus, the ED became an appropriate place to seek help. Once in the ED, structural conditions shaped each woman’s experience of care.

**Structural Features of the ED as a Place**

As argued above, place is not simply about the location where interaction between human beings occurs. Instead, place is socially constituted and both shapes, and is shaped by, the relationships that form. The results of the present study indicate that particular structural features of the ED as a place directly influenced women’s experiences of ED care. For example, uncertainty and vulnerability contributed to an intense experience of care; rules and procedures in the ED enforced a set of norms that guided behaviour; and resource issues created conflicts about patient safety in the context of overcrowding.

The ED is a professional space in which the private becomes public as the staff—mandated to manage emergency situations – scrutinize bodies and behaviour. Accordingly, an important feature of the ED as a place was the organization of the space and health-care practices to support the application of expert knowledge. Lepofsky, Nash, Kaserman, and Gesler (2006) carried out a critical analysis of the television show *ER.*
The authors argued that the television program can be read as an account of the ways in which order may be achieved and maintained in a crisis through the use of “technologies of ordering,” with the goal of fixing crises. In this study, technology was used not only to “fix” a crisis, but also to support the application of expert knowledge to a given situation in order that patients might be moved through the department as efficiently as possible. Diagnosis and speedy disposition were some of the goals of the health-care staff in this study.

One of the ways in which power was exercised within the ED was through the employment of “technologies of normalization.” Technologies of normalization – in the form of rules, procedures, structured and standardized provider-patient interactions, and the organization of physical space – combined to provide a set of norms for the regulation of behaviour during an ED visit. The use of technologies of normalization created docile bodies upon which health-care professionals might take action. In this study, taking action always involved the application of expertise by health-care professionals. This expertise, in the form of knowledge about cardiac disease as well as knowledge drawn from their particular clinical examinations, surveillance, and interviewing, was used to construct images of classical patient presentations and then to compare those images with the account of the particular woman. Expert knowledge about heart disease was then used to create and enforce norms – for both physical and social behaviour.

Foucault in *Madness and Civilization* (1978) directed attention to the questions: who is defining the norms, who draws the boundaries, and who gets included and excluded? Although Foucault focused on madness and sanity, his questions are relevant to this project because they direct us to more deeply interrogate accumulated cardiac
knowledge. In the context of cardiac illness, who is defining the norms? Who constructs cardiac illness and in what ways? For example, is cardiac illness a matter of genetic inheritance (biological determinism), behaviour (morality and risk), or some other factor or combination of factors? More importantly, how do the ways that cardiac illness is constructed influence health-care practices?

Ceci (2006) argued that according to Foucault, truth functions constitutively, producing rather than reflecting reality. Consider, for example, resource allocation within the health-care system. No one has yet provided definitive evidence that long-term outcomes (greater than 3 years) differ (post-heart attack) according to whether an individual diagnosed with ACS is treated with thrombolytic therapy, coronary bypass surgery, or angioplasty. Yet defining a heart attack as an “emergency” demands immediate action. Accordingly, angioplasty is definitive care and governments spend hundreds of millions of dollars establishing angioplasty suites across the continent. What is not being paid for when we devote such intensive attention to rescue therapies? How might a focus on the downstream sequelae of cardiovascular disease be limiting the ability to address the upstream and preventable causes?

In this study, expert knowledge was frequently used to produce new identities for the women as “cardiac,” “good,” and “compliant.” As Foucault (1980) pointed out, it is not possible for power to be exercised without knowledge or for knowledge to be exercised, without engendering power. In the case of cardiac illness, the application of

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18 Although there are studies that confirm reduced mortality, as well as lower rates of reinfarction and stroke at 30 days, long-term outcomes have not yet been firmly established due to issues related to sample size, recruitment, and the use of expert clinical sites (Dalby, Bouzamondo, Lechat, & Montalescot, 2003).
knowledge is helpful because it expedites care in the case of a heart attack. However, Gilbert (2003) pointed out that “institutions into which expertise is invested are coercive... their influence lies in a moral authority that rests in their capacity to define the problems experienced by individuals and to propose a solution based upon these definitions” (p. 39). Professional knowledge can become oppressive. In this study, the health-care professionals, in the course of applying their expert knowledge, assessed and defined the risk related to heart disease and in the process moved toward moral judgment of the individual’s, physical bodies, as well as to moral judgment about their social bodies. Helmon (2000) described a social body as an essential part of one’s body image, for it provides people with a framework for both perceiving and interpreting physical and psychological experiences, which in society exert powerful control over body size, shape, and health practices. Thus, power and expertise are enmeshed.

Cardiac health has been a focus of research for decades. Enormous social and economic resources have been devoted to addressing heart disease, the leading cause of mortality and morbidity for Canadians and Americans. As a result of this focus, the health-care system is increasingly well organized to address the challenges associated with cardiac illness. Cardiologists, paramedics, and nurses are trained to use advanced cardiac life support protocols, clot-busting medications, angioplasty, and cardiac rehabilitation programs as part of the arsenal used by health-care professionals to address cardiac illness. Individuals’ treatment-seeking behaviour is ostensibly outside of the control of health-care professionals, yet critical to their desired outcomes.

Foucault conceptualized power as localized, dispersed, diffused, and pervasive throughout social practices and relationships (cited in Gilbert, 2003). Power is viewed as
operating through social systems in everyday practices. Foucault’s work offers substantial contributions to understanding of the current study’s findings. For example, Foucault (1980) directed attention to the notion that *individuals are vehicles of power* and not merely points of application. Power is viewed as relational and forms a distributed network (cited in Gilbert, 2003). Hierarchical surveillance, technologies of normalization, and clinical examinations are features of disciplinary power present within the findings of this project. As Holmes and Gastaldo (2002) pointed out, “Nurses constitute and make feasible the institution and systems that they believe are the source of their oppression” (p. 558). In the same way, the women in this study, when asked to wait in the waiting room during an experience of having symptoms suggestive of cardiac illness, or waiting without a stretcher, and without information, did so patiently and without challenging the direction to wait. Structural features, as well as the social context of treatment seeking in the ED, combined to support women in adopting the patient role, and a passive stance toward their interactions with health-care professionals.

In summary, the findings of this study suggest that:

1. Structural conditions of the provision of care in the ED mandate treating people in particular ways not always congruent with and respect for dignity and autonomy.
2. Structural conditions are self-reinforcing. The participants cooperated with, and at times adopted, the professionals’ values.
3. The current context of the ED as a place that is besieged, intense, and regulated served as a deterrent to treatment seeking for symptoms suggestive of cardiac illness.

**Social Discourse and the ED as a Place**

Foucault and feminist writers view the body as a site of power and view discourse as a way of producing and sustaining power (e.g., Foucault, 1994; Mitchinson, 1998; Morgan, 1998). Similarly, Parker et al. (1999) argued that discourses are always focused
on power relations. In this study, multiple discourses shaped the women's efforts to maintain their integrity and influenced their experiences of ED care. The discourse of resource scarcity was apparent in the statements of the women who were reluctant to seek treatment for fear of "bothering" health-care professionals, perceived to be both busy and overworked. As well, the discourse of scarcity was present in the efforts of the nurses who sought to control access to the ED when potential patients' presenting complaints were judged to be non-urgent.

The discourse of acuity was obvious in the belief that an illness or injury warranting a visit to the ED should be visible to any bystander, a belief that influenced treatment-seeking decisions. As Irving (2002) pointed out, in order for a phenomenon to come into the realm of debate, it must first be problematized. In a future project, it may be useful to interrogate the particular practices that arise from the assumption that everyone experiencing a particular set of symptoms is having a heart attack, and to investigate the outcomes of those practices. By establishing a person as an "emergency," that person may be disqualified from the usual rights to dignity and respect while receiving treatment. Because only a small proportion of individuals who present to an ED have emergent health concerns, such an interrogation might be useful, and may entail asking about the sequelae of these approaches and considering alternatives.

The discourse of deservedness was apparent in the common statement that others were more in need of care and in the attitude of self-blame adopted by the women who had risk factors associated with the development of heart disease, such as smoking or a lack of exercise.
As discussed earlier, the women in this study also experienced the influence of the discourse of biomedicine. As identified by Malone (1998), in the ED "a kind of legitimacy thus inheres to conditions that can be rapidly and definitively treated" (p. 810). In other words, ED staff view complaints that can be resolved quickly and efficiently as appropriate for treatment in this setting. Assessing and treating patients quickly and efficiently is expedited if patients are cooperative and compliant. Thus, the discourse of the good patient was also operating to shape the behaviour of women and staff, during a visit to the ED. Within the literature about “good patients” there is a focus on the behaviour of patients, both in relation to their risk behaviour (e.g., use of tobacco, lack of exercise) and their interactions with health-care professionals. For example, “good patients” do not interfere with, and indeed cooperate to address the agendas of their health-care providers.

Cowley, Mitcheson, and Houston (2004) posited that nurses have a particular agenda with regard to the collection of health information and that agenda is their priority. Patients who respond to health questions directly, accurately, and concisely are rewarded. Those who respond to questions by raising issues beyond the scope of the questions are redirected. “Good patients” use health services “appropriately,” are polite

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19 Biomedical discourse arises from the medical model – the dominant approach to disease and illness treatment in Western society. This approach has made possible improvement in the human lifespan and the health of individuals. However, the discourse of biomedicine has been noted to have the following characteristics: a tendency to focus on deficits as opposed to capacity; the reduction of the experience of disease and illness to its physical components, ignoring both personal and social aspects of the experience of illness; a focus on individual situations that sometimes obscures the social determinants of health and wellness; a paternalistic approach to treatment; and a tendency toward reductionism, at the expense of a more holistic approach to health and wellness (Gabe, Bury, & Elston, 2004). Hyde et al. (2005) identified that biomedicine has been criticized on the one hand for being reductionistic and on the other hand for the medicalization of human life by extending their role beyond the biological into the social and psychological realms.
when dealing with health-care staff, and follow medical advice (Stokes, Dixon-Woods, Windridge, & McKinley, 2003). "Good patients" respond to treatment in expected ways (Lacal, 2006); do not complain about pain or discomfort and are not demanding of the attentions of the health-care staff (Salmon & Manyande, 1996). They recognize that other patients are in greater need of attention, willingly "step aside," and do not complain about the health-care staff, but instead assign blame elsewhere (e.g., politicians) (Nystrom, Nyden, & Petersson, 2003).

Hyde et al. (2006) studied 45 sets of nursing documentation, drawn from four different hospitals, seeking to understand the structural and social processes operating within the texts. Not surprisingly, they found that nurses had particular expectations in relation to patient behaviour, and that in making judgments about patient behaviour the nurses used normative standards within which moral positions were embedded. For example, the notion that "good patients" are individuals that follow medical directions and adhere to treatment regimens was important. "Non-compliance" might be excused if a patient was judged to be genuinely incapacitated by illness or injury. Inability, whether due to biological or psychosocial illness, was an acceptable reason for non-compliance, whereas unwillingness was judged to be much less acceptable. If a patient was not compliant, he or she would be subject to "subtle attempts to regulate aberrations" (p. 739).

In relation to the current study, the biomedical discourse and ideas about "good patients" shaped both the environment and the women's experiences of care. The biomedical discourse was present in every aspect of the ED, from the organization of the department to the practices of the health-care staff. In contrast to the espoused role of
nursing – the care of individuals – the role of nurses, more commonly was co-opted by the institution; nursing practice was transformed into a tool to achieve institutional goals (e.g., the efficient treatment, diagnosis, and disposition of patients). Ideas about “good patients” were used to evaluate the women’s risk behaviour and to make judgments about their worth as individuals.

Finally, an alarming finding of this study was the ubiquity of the stress discourse. Every participant raised the effects of stress (and an implied failure to cope) as a partial or complete explanation for her symptoms. In essence, the women in this study berated themselves for a perceived inability to cope with stress, which they speculated might be the root cause of their symptoms. “Stress” was not viewed as a legitimate explanation for the symptoms, but rather a cause for self castigation. A perceived failure to cope was viewed, by the participants, as a moral failure. Stress as an explanation for their symptoms, on some level, reassured the women that in the future, if they managed to cope more effectively, the symptoms would not recur. On the other hand, this meant that the sole responsibility for managing stress lay with the individual woman. Notable was the absence of a consideration of the social and organizational factors that might create milieus in which stress is embedded. This is consistent with recent findings by researchers who note that women view stress primarily as an individual experience rather than a characteristic of the culture of a particular place (Harkness et al., 2005). Although several of the women touched on social explanations for stress, such as the work environment, they expressed a perception that notwithstanding these challenges, they should (as individuals) be able to cope (e.g., manage stress effectively and so not
experience physical illness as a manifestation of that stress). Five of the women in this study were told by their caregivers that stress was the cause of their symptoms.

The application of professional knowledge to women’s bodies has undoubtedly positive effects on the health and wellness of women. However, when this knowledge is extended and applied to judgments about deservedness, the impact is not positive. For example, risk avoidance as a moral exercise was a theme in this study, the women were well aware that the health-care professionals judged them in relation to their risk behaviour. The ED is a place where the private becomes public. An obligation to remain healthy is a moral dimension of citizenship; health and health care are not neutral or apolitical.

**Gender and the ED**

It is sometimes difficult to separate the influence of female gender from the influence of female sex. In the assessment of symptoms suggestive of cardiac illness, the results of this study indicate that both gender and sex affect ED care and the outcomes of that care. In terms of female gender, for example, ED nurses expressed surprise when a young woman received a cardiac diagnosis. The stereotype of men with heart attacks prevailed. In addition, the fact that women are usually a decade older than their male counterparts when they develop symptoms suggestive of cardiac illness, may disadvantage them if they are “competing” against a man 10 years younger, for the only available stretcher. As well, according to the Heart and Stroke Foundation of Canada (2006), the *symptoms* of cardiac illness are not thought to differ by gender, however, the *report* of those symptoms may differ. Female biological sex may also play a role in outcomes for women because their coronary blood vessels often have a smaller diameter.
than is the case in their male counterparts, which may result in an increased incidence of re-occlusion following angioplasty (Cantor et al., 2002).

Critique of Methodology

In the course of any research, methodological challenges arise. This study was no exception and indeed, particular challenges arose in relation to sampling and ethical conduct. In general, I discovered that concepts such as confidentiality are not as straightforward as they seem, when applied to specific situations.

Sampling Challenges

The recruitment of the participants presented several challenges, including potential bias, failure to participate after initial verbal consent was given, and the inclusivity and diversity of the sample. Bias is arguably present in any research project, to a greater or lesser extent, by virtue of a researcher recording and interpreting the data. Nevertheless, the goal is to minimize bias and to interrogate situations that may introduce systematic bias. Early in the study, I interviewed a participant and when I asked her what she found most memorable about her ED visit, she replied that she found her contact with me to be the most memorable. She went on to say that she had told “everyone about me” and felt very much that I was present “just for her.” Learning from this situation, I cultivated a more detached presence during my naturalistic observation. Although this stance may have resulted in the next few participants booking interview times and then failing to appear, no subsequent participants reported contact with the researcher as an important influence on their experiences of ED care. In the end, data collection for this project required a balance between connection and detachment, which I addressed by taking the time to listen to the women’s stories after briefly introducing the project and
then visiting the bedside on two or three occasions during their stay in the ED. Otherwise my involvement was at a distance only.

Eight of the women I recruited expressed a willingness to be interviewed following their discharge from the hospital, but were not subsequently interviewed. A failure to participate after verbal consent had been given could be attributed to one of several reasons. A few of the participants in this study received a diagnosis of “heart attack,” however recruitment of members of this subgroup proved to be challenging. Although expressing a willingness to participate in the study when seen in the ED, following discharge their commitment faltered. The women explained that profound and persistent fatigue, combined with a heavy schedule of diagnostic tests and specialist appointments, made participation difficult. In an effort to address this feedback, I widened the acceptable interval between the ED visit and the interview, but this made no difference. After engaging in a maximum of five follow-up contacts, I acknowledged that the women were not interested in participating, thanked them for their time and removed them from the call list. On three occasions I was unable to complete five contacts before the women’s family members called and asked me to remove their mother or grandmother from the study.

Failure to appear for a scheduled interview was another reason for failure to be interviewed. On three occasions, an interview was scheduled, a reminder phone call was made 24 hours prior to the interview date, and the woman did not keep the appointment time. On these occasions, three phone calls were made during the following week to re-

\[\text{20 In pursuing an acceptable date for an interview, I left the interval as indefinite.}\]
establish contact. In each case, I did not receive a response to my phone messages. And, on one occasion, a woman agreed to be interviewed, but when I attempted to contact her, the telephone had been disconnected. On another occasion, no reason was provided.

**Ethical Challenges**

Confidentiality, particularly in qualitative research, is vital because so many potentially identifying personal details about individuals become pieces of the data. Many challenges exist in relation to ensuring confidentiality, such that I have had cause to reconsider the wisdom of “guaranteeing” confidentiality. Instead, the consent forms for this study should have qualified the guarantee, stating clearly the exceptions that might arise, such as unsafe nursing practice, which must be reported. Nevertheless, according to the *Uniform Requirements for Manuscripts Submitted to Biomedical Journals* (2006), the findings reported meet the standard for ensuring the privacy and confidentiality of the participants.

In relation to the ethical conduct of this study, *taking advantage* arose as a potential issue. In this study, the participants were women. There is a longstanding debate in the literature about the relationships that arise between the people doing the research and the people participating in the research. Specifically, feminist scholars have raised issues about the ethics of various interview styles with women (Cotterhill, 1992; Finch, 1993; Oakley, 1981). Finch (1993) argued that adopting an approach to interviewing that encourages friendship raises moral issues because this sort of relationship has a strong potential to be exploitive. She argued that some women may be particularly vulnerable during interviews. At the same time, if there is too much distance between an interviewer and a participant, the latter is unlikely to wish to continue in a project. Similarly, Oakley
(1981) argued that women are particularly vulnerable during an interview due to the fact that some women are relatively socially isolated and yet enjoy social contact. Many of the participants in this study found ways to extend our time together and treated the interview as a social event.

In the course of completing this study, my status as an insider created challenges. The provision of care, that is, the degree to which I participated or was asked to participate in providing care was an issue. After the first few interviews, I realized that the comfort measures I might naturally offer, such as providing blankets or a telephone, were making a difference in the women's experiences of the ED care they received. I discussed this issue with my dissertation advisory committee members, having decided not to undertake interventions of this type unless human dignity was at risk (e.g., covering an unconscious patient who had been left naked on a stretcher). The committee members confirmed that caution was required because such comfort interventions could be interpreted as manipulative or coercive if an individual later participated in the study.

With this clarification, I attempted to make decisions that were in keeping with preserving human dignity and compassion, such as the provision of information. I encountered a male patient who was told he had “atrial flutter,” a condition with which he was unfamiliar. He expressed deep concern about this diagnosis. Because this man was not going to be recruited as a participant, I took the time to share information with him about the pathogenesis of atrial flutter. I used this situation to further interrogate the issues that arise for women during a visit to the ED, combing through the data for references to a similar experience of fear arising from a lack of information.
On one occasion, I observed the staff caring for a man experiencing an evolving heart attack. He had arrived within the first 3 hours after the onset of symptoms, and consequently, active treatment to limit the amount of damage to the heart muscle was still possible and desirable. The treatment required multiple sites of IV access and despite the attempts of several nurses, no IV access had been established.

Staff are trying to start a second and third IV (required when giving thrombolytics) and have made six unsuccessful attempts. The paramedic turns to the bedside nurse and myself and says, “You know, Sheila is famous for being able to start IVs when no one else is able to. You should get her to do it.” I explain that I am not an employee of this health region and so can’t provide care and the nurse responds, “We won’t tell.” Fortunately, the 4th RN manages to start the lines they require. The nurse responsible goes ahead and gives the thrombolytic.

After discussion with my dissertation advisory committee members, I contacted the CRNBC and spoke to a practice consultant about this situation. This was not an easy discussion. The first question from the practice consultant was, “Where was the physician?” Further discussion illustrated that she had little understanding of the scope of practice of nurses and physicians in the ED. However, in the end, the position of the practice consultant was that this was primarily an issue of liability and that the University of British Columbia (UBC) insurance should cover any actions undertaken on the behalf of patients while on site in a student researcher role. The ethical aspects of acting, or failing to act, were not highlighted. In summary, reflexivity and ethical conduct in this study were defined not solely as properties of the researcher or of the project, but as a practice and process concerned with power, responsibility, accountability, and positioning (Skeggs cited in Aranda, 2006).
Rigor

In qualitative research, as with all research, rigor is of central importance; therefore, each step of the research project requires attention. The specific criteria for rigor in a GT study includes “fit,” “work,” “relevance,” and “modifiability” (Bonner & Tolhurst, 2001; Glaser, 1992). In addition, general criteria for qualitative approaches are important. In order to attend to rigor, I employed several ongoing strategies, including maintaining a clear audit trail through the extensive use of memos.

In commencing the project, I ensured that the initial research questions were clear and that the design of the study was appropriate for the research goals. The data for this study were collected from multiple sources (e.g., naturalistic observations, in-depth conversations, semi-structured interviews). I used sampling strategies appropriate to the method to ensure that a variety of data about the women’s experiences and the context of ED care were available for analysis. For example, the context of ED care was examined through the accounts of the women, the accounts of the nurses, and the data from naturalistic observation. As well, each successive interview with a participant allowed me to confirm (or obtain a contrasting account) and to further develop themes from earlier accounts. In these ways, I ensured that the emerging theory fit the data. Fit is described as the extent to which a theory fits or describes the situations in the social area under study. Glaser and Strauss (1999) pointed out that a lack of fit results in the need to force and distort the data to fit the core category emerging. To avoid a lack of fit, every concept has to ‘earn’ its way into the analysis (Charmaz, 2000).

Over the course of the project, the research question shifted to more accurately reflect the data I was analyzing. Data collection and analysis continued until the
categories were well developed, ensuring that there were sufficient data to support the emerging theory. When writing about the findings of this project, several drafts were reviewed and in the process, inconsistencies were identified and addressed by returning to the data and carrying out further analysis.

I ensured that the data were collected systematically and analyzed appropriately. In this undertaking, biweekly meetings with my supervisor provided opportunities to discuss issues related to the data collection and analysis. Regular dissertation advisory committee meetings assisted me in employing GT faithfully, as my committee members coached me to explore the method in greater and greater detail. As well, explaining the early findings to an audience assisted me in identifying gaps in the data analysis and pushed me to develop an integrated theory.

Relevance, in the context of GT, addresses the idea that the theory produced should be relevant to action in the area it purports to explain (Lomberg & Kirkevold, 2003). This implies that the theory generated is considered to be useful in everyday practice. One might ask, to what extent does the theory generated explain actual problems and basic social psychological processes in the research setting (Charmaz, 2000)? I addressed the issue of relevance in the following ways. As I collected the data, I checked emerging themes with the participants, as well as with a group of colleagues, asking about the explanatory power of the theory. As well, I asked emergency nurses to read my accounts of the ED and to provide feedback about the fit between my explanation of what goes on in the ED and their experiences. In my own practice as an ED nurse, the theory generated assisted me in understanding the decisions made by women who are experiencing symptoms suggestive of cardiac illness.
Finally, with regard to the rigor to this project, the issue of modifiability must be considered. Modifiability is a quality of the theory produced (Glaser, 1992; Hewitt-Taylor, 2002). A theory should be able to evolve and encompass new information. For example, a rigorous GT about women’s experiences of ED care might be useful as a starting point for researching the experiences of men in EDs. Modifiability should not be confused with generalizability. For example, one is not seeking simply to take a theory and apply that theory to a new group, setting, or time. Rather, one might seek to employ an existing GT and further develop that theory, in a new setting, at a new time, or with a different group using that theory as a starting point. The degree to which the theory described in the following chapters is rigorous in relation to these criteria must be evaluated in future projects.

**Insider Status.** As an ED nurse with 15 years of experience in both clinical and educational positions, I am an insider. In the present project, this position allowed me to carry out the research in an ED and, more importantly, added to the findings of the project by improving my access to the data (in the form of both observations and the accounts of potential participants). For example, I knew where in the department I was most likely to find participants for the project. I knew the reporting structure in the ED and who to approach with information about my role, when I arrived on each shift. As an ED nurse, I was familiar with the language used by health-care professionals and could judge if an overheard conversation or an unfolding situation was relevant or not. And, practical challenges, such as knowing where to stand during a crisis situation, were eliminated.
However, insider status also created challenges to rigor. The challenges associated with bringing an insider perspective to this project related to the rigor of the results for several reasons. First, an insider has a pre-existing understanding of the context in which a particular study takes place (Coglin & Casey, 2001). This prior understanding can lead to the assumption that one understands the reasons for particular actions or statements in the clinical setting, reducing the richness of the data (Bonner & Tolhurst, 2001; Kanuha, 2000). Ceci (2000) argued that "what we see and what counts for us as a valid observation depends on where and how we are positioned" (p. 68). Holding the position of an insider (as a working ED nurse) and a clinical expert placed me in a particular relationship to the data. I acknowledge that research findings are likely influenced by the researcher in a multitude of ways ranging from the very questions being investigated to the collection and analysis of the data. Thus, the results of this project provide an account, rather than the account.

Nurses doing research in their own settings often experience role confusion. Torn between the roles of 'staff nurse' and 'researcher,' it may be challenging to remain in the latter role and refrain from participation in the work of the unit (Bonner & Tolhurst, 2001; Coglin & Casey, 2001; Hewitt-Taylor, 2002). In an effort to build trust and rapport, the insider may be drawn to over-participation (Hewitt-Taylor, 2002), altering the quality of the data. Kanuha (2000) raised the important issue that we are each situated in social, political, and historical contexts that reinforce inequity and power differentials. This is a particular issue for nurses who hold positions as educators or administrators and choose to do research in their own settings of practice, such as myself. To what degree will the staff behave "as usual" in the presence of someone who has more actual or perceived
power than they do? In the context of this study, the degree to which the staff behaved “as usual” could not be assessed with certainty, however, I witnessed behaviour that bordered on unprofessional, suggesting that staff were not necessarily “on their best behaviour” when I was present.

Although being an insider may improve access and participation, Thomas et al. (2000) identified that this can ‘backfire’ because the staff may be reluctant to provide honest responses. In the situation where the researcher is known to the participants, confidentiality and anonymity are to some extent sacrificed. Again, this may compromise the rigor of the findings.

Distraction may also be an issue for researchers in the position of an insider (Hewitt-Taylor, 2002; Kanuha, 2000). For example, Hewitt-Taylor (2002) explained that insiders may find it challenging to listen actively to participants’ accounts when they are simultaneously processing their own responses to the events. And, there is always the risk of introducing bias to the interpretation of the data. As a member of a group being studied, an insider may be influenced unconsciously to interpret the findings in a more favourable light, out of a sense of camaraderie or loyalty (Thomas et al., 2000).

To address the issue of role confusion, I did not wear a uniform when on site nor did I provide nursing care for the patients. I had neither taught nor been employed at either of the EDs, although I was known as a teacher in both settings. The issue of insider bias in the data analysis process was addressed in regular meetings with my supervisor and the dissertation advisory committee. On the one hand, I brought to the data analysis an ability to grasp the processes and procedures of an ED (such as the ways in which acuity is rated), allowing me to extend the analysis deeper than might otherwise have
been possible without a great deal of additional field research. In essence, I was able to move more easily beyond a simple description of the events to an explanation of them. For example, rather than simply describing triage observations, I theorized more easily about the relationship between triage practices, women’s exercise of agency, and the exercise of power in the ED.

My position as an expert and insider likely introduced the potential for bias in the analysis of the results. After all, my interest in the research questions arose from practice and the humanistic values that I hold inevitably shaped the inquiry (e.g., nursing is a human endeavour; individuals in the position of patient deserve excellent care). How I framed the findings was undoubtedly affected by my background. For example, I struggled with how to talk about less than optimal practices that I observed. In striving to move beyond description to explanations about what I observed, the data analysis moved in the direction of understanding such practices as arising from structural factors in the work environment when other explanations might be equally valid.

Insider status may have contributed to the introduction of bias during both data collection and analysis, although actions were undertaken to reveal and minimize the effect of insider status. And, the results of this study are not generalizable in the common usage of the term. That is, the results cannot be applied to other disorders or conditions, or to other groups (e.g., a group of men). Generalizability is a complex phenomenon. The focus of grounded theory as a research method is to reveal the basic social

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21 Stephens (1982) contrasted horizontal generalizability, a claim that if a study were to be replicated the results would be the same (the most common usage of the term), with vertical generalizability, the integration of aspects of a situation are being linked to existing theories and bodies of work. The latter is directed toward theory building, whereas the former is oriented toward replication and wider applicability (Johnson, 1997).
psychological process at work. A BSPP is context-bound. Findings are therefore ideographic (e.g., focused on understanding and explaining individual situations or events) rather than nomothetic (e.g., universal laws governing actions). Thus generalizability to another group is not a goal. Nor is the focus on testing a theory or trialing a solution to the clinical problem of TSD, although the findings inform such efforts. Rather, the goal was to generate theory that informed practice and research. Accordingly, this work informs theory development in relation to treatment seeking in the ED, making a contribution to existing theory and research. In particular, the results of this study highlight the notion that treatment seeking is a social, rather than individual phenomenon.

**Reflexivity.** Reflexivity involved the interrogation of the relationship between the knower (the researcher) and the knowledge produced. As Ceci (2000) pointed out, “We read other positions through our own” (p. 60). She further suggested that the most important intervention to address this relationship was interrogating the certainty of our own world views. In this project, cultivating reflexivity about the potential sources of bias required a critical examination of the process used by individuals when they make decisions about seeking treatment, not merely as a clinical phenomenon (e.g., treatment-seeking delay), but also as an idea constructed and adopted by health-care professionals.

Throughout this study, I employed the following strategies, drawn from the literature, to minimize the bias that might have been introduced (Asselin, 2003; Bonner & Tolhurst, 2001; Kanuha, 2000; Thomas et al., 2000). To address my prior beliefs, I attempted to adopt the perspective of a “naïve visitor” to the ED. Attempting to take the point of view of someone who has never visited an ED required me to consider how I
might go about orienting a stranger to the culture of an ED. I also kept a reflective journal as a means of examining my pre-conceptions and shared my insights with my supervisory committee for their consideration.

**Use of Quotations.** When explaining the findings, the challenge was where and when to use various quotations. As stated by Corden and Sainsbury (2006), there exists no theoretical basis for making decisions about the use of quotations, although the practice of including quotations when reporting qualitative research is widespread. In part, the authors argue, this phenomenon has arisen because use of quotations is one way to "prove" the quality of a study, illustrating how the conclusions were derived.

In exploring the issue of the use of quotations, I reviewed published GT studies in order to gain an appreciation for the standards expected in a variety of scholarly publications. In reviewing the majority of the studies, I found that the authors generally illustrated each point of a theory with a single, well chosen quotation. However, I also found several manuscripts that used few or no quotations. In other words, there was great variation. I also reviewed a paper by Corden and Sainsbury (2006), in which they reported the findings of a research project aimed at discerning upon what basis social researchers, who employ qualitative methods, make decisions about the selection and inclusion of quotations within their publications. At the end of their report, they summarized the thoughts of the participants, identifying that studies were less satisfying when quotations were over-used, particularly if the over-use of the quotations was a substitute for comprehensive analysis.

The quotations for this project were drawn from the computer folders I generated during the data analysis. As the categories emerged in the data, I created a computer
folder that contained excerpts from the accounts of the participants, in relation to the properties of that particular category. As the study progressed, the categories collapsed and became fewer in number. When I began writing about the emerging theory, I returned again and again to these folders (now full of excerpts from the interviews) and culled the quotations that addressed the specific points I wished to substantiate. Initially, I provided my dissertation committee members with a great many quotations, embedded in the drafts they reviewed, as one way to substantiate the emerging theory, and as a way of sharing the voices of the participants. Gradually, I was encouraged to be more selective about my use of the quotations, with a view to selecting those most specific and providing the most effective exemplars to illustrate the main points of the theory.

Employing the terminology provided by Corden and Sainsbury (2006), I moved from using the quotations as evidence, to using the quotations as illustrations and accordingly, the number of quotations were substantially reduced.

Caveats

When interpreting the results of this study, there are several limitations to be considered, particularly in relation to the design of the study. Several groups of women were not represented. Only women who presented to an ED for assessment of symptoms suggestive of cardiac disease were recruited. The accounts and experiences of women who did not attend an ED for treatment (whether because they died at home or because they never sought treatment) were not included. It is possible, and indeed probable, that decision making differs for this group in comparison to the sample for this study. I did not recruit critically ill women for participation in this study, due to concerns about hemodynamic instability. Had they been included, their accounts may have altered the
theory generated. As well, the voices of women for whom English is not a spoken language are entirely absent from this account. And, the accounts of the women who visit an ED, but leave without being seen by a physician, are not considered in this study. Finally, it is important to bear in mind that this is a single study. As such, the results add to understanding about treatment seeking and experiences of ED care, but are an insufficient basis upon which to recommend policy or practice changes.

Conclusions

In conclusion, decisions about treatment seeking, in the context of symptoms suggestive of cardiac illness, remains a phenomenon of interest to clinicians, given the time dependent nature of available therapies. The results of this study, investigating prehospital decision making and experiences of ED care, highlight several interesting observations. The women drew on particular forms of knowledge, here termed “ways of knowing,” to understand, and make decisions about, their symptoms. Employing ways of knowing allowed the women to interpret their symptoms in the context of their daily lives. Family responsibilities, employment roles, and social roles were generally judged to be of a greater priority than an experience of potentially life-threatening symptoms. The theory of maintaining integrity explains the women’s actions in relation to their symptoms and provides us with more information about the forces shaping decisions about treatment seeking.

Framing treatment-seeking decisions as an individual phenomenon limits the ability to address the problem, as this approach problematizes individual behaviour and ignores both the social context of health behaviour and the inadequacy of system responses. Framing treatment-seeking decisions as a system phenomenon, and
understanding those decisions as related to the women's efforts to maintain their personal, social, and physical integrity, may result in interventions that will address the issues related to treatment-seeking behaviour. The results of this study hint at the possible benefits of re-conceptualizing such behaviour as more than an issue of individual decision making. Such development might support researchers in moving away from the exploration of purely individual factors and toward examining the spectrum of care and health-care structures, with a focus on understanding how that care might be influencing women's decisions about treatment seeking.
REFERENCES


patients with acute coronary disease (the GRACE registry). *American Journal of Cardiology, 89*, 791-796.


women in quality measurement. *Journal of Women's Health and Gender Based Medicine, 9*, 657-665.


APPENDIX A – INFORMATION LETTERS
Information Letter for Health Care Professionals

Sheila A. Tunis
School of Nursing
University of British Columbia
T201-2211 Wesbrook Mall
Vancouver, BC
V6T 2B5

Women with Chest Pain: Negotiating Experiences of Emergency Department Care

Thank you for taking the time to read this information letter. My name is Sheila Tunis. I am a registered nurse and a doctoral student at the University of British Columbia.

For my thesis I am interested in learning about the experiences of women who visit Emergency Departments (ED) because they are having chest pain. In particular, I want to learn about the events that led them to decide to come to an ED, the events that took place while they were in the ED, and how women participated in those events. I hope that this study will provide health-care professionals with information that will assist them in caring for women who present to EDs with cardiac signs and symptoms.

In order to carry out this research about the experiences of women with chest pain, I need to spend some time in your department, learning about the routines, the physical layout and the overall functioning of the unit. As well, I want to observe study participants during their stay in the ED. I will therefore be walking around the department observing how it all works. When I have a sense of the overall functioning of the unit, I will begin recruitment for the project.

I am interested in talking to women who come to your ED with a complaint of chest pain. If women are willing to share their experiences with me, I will spend some time at the bedside during their ED admission. After women are discharged, I will contact them to set up a face to face interview at their convenience. The interviews will last 45-60 minutes and there is a possibility of a second interview lasting the same amount of time. I will be asking questions about women’s experiences, perceptions and feelings about being a patient in the ED.
If you would like further information about this study please contact me directly at 604.XXX.XXXX or . Thank you for your attention to this matter.

Sincerely,

Sheila Turris, RN
Thank you for taking the time to read this information letter. My name is Sheila Tunis. I am a Registered Nurse and a student in the doctoral program in the School of Nursing at the University of British Columbia. For my thesis research, I am interested in learning about the experiences of women who visit Emergency Departments (ED) because they are having chest pain. In particular, I want to learn about the events that led you to decide to come to an ED and the events that took place while you were in the ED. I hope that this study will provide health-care professionals with information that will assist them in caring for women who present to EDs with cardiac signs and symptoms.

I am inviting women who have visited an ED for chest pain, to tell me about this experience. If you are willing to be interviewed about your experiences as a patient in the ED, I would talk to you at a location that is convenient to you, after you are discharged from the hospital. You can contact me at 604.XXX.XXXX if you wish to participate. The interview would last approximately 45-60 minutes. In some cases, I might ask for a second interview at a later date, which might also last 45-60 minutes. In order to collect accurate information for analysis, I would ask that you allow your interview to be audio-tape recorded. If you feel uncomfortable with what is on the tape, I will erase the tape, or portions of the tape, in front of you. I might also observe you during your visit to the ED, and may be present during your assessment by the nurse or physician.
Confidentiality will be strictly maintained and only myself and the three members of my thesis committee will have access to the tapes. No actual names will be used in the study.

The decision to participate is entirely your own. You would be under no obligation to continue to participate once the interview has begun and can withdraw at any time. If you decline to participate at any point, there will be no consequences, nor will anyone know about your decision.

I hope that your participation will be useful to you in thinking about your own experiences. I anticipate that other patients, and health-care professionals, will benefit from the findings of this study. I hope you will consider this study worthwhile and will consider participating.

If you are interested in being interviewed or have any questions, you may contact me at 604.XXX.XXXX or my committee chair, Dr. Joy Johnson at 604.XXX.XXXX.

Sincerely,

Sheila Turris, RN
March 5, 2005

CONSENT FORM: Interview (Women)

Title of Study: Women with Chest Pain: Negotiating Experiences of Emergency Department Care

Principal Investigator:
Joy L. Johnson, Professor, School of Nursing, University of British Columbia

Co-Investigator:
Sheila A. Turris, Doctoral Student, School of Nursing, University of British Columbia

Introduction
You have been invited to take part in this research study because you have some knowledge about the experience of health care in an Emergency Department (ED).

Chest pain is sometimes a symptom of heart disease, so getting to a hospital in a timely fashion is important. Women often delay coming to the hospital, for lots of reasons. For example, they don’t want to bother anyone or, they have been to an ED before and do not wish to return. In this study I want to understand what happens for women when they come to an ED, in order to improve the care we provide.

Participation
Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits and risks.
If you wish to participate, you will be asked to sign this form. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision. If you do not wish to participate, you do not have to provide any reason for your decision.

**What the Study Involves**

If you decide to participate, we will arrange a time and place to meet for an interview.

- The interview will take place at a location convenient to you. This interview will be audio-taped and will last 45-60 minutes. If, at any time during the interview you feel uncomfortable with what is on the tape, I will erase that part of the tape in your presence. In some cases I may ask if you if you would be willing to be interviewed a second time.
- Following the interview the tape will be transcribed into written form (without identifying names or places). The tape will not be shared with anyone other than the three members of my thesis committee. The tapes will be destroyed five years after completion of the study.
- In some cases, a second interview may be requested. This interview will last 30-60 minutes and will also be audio-taped.

**Study Risks and Benefits**

No injury is anticipated as a result of participation in this study and no compensation is offered. No one knows whether or not you will benefit from participating in this study. There may or may not be direct benefits to you from taking part in this study. We hope that the information learned from this study can be used in the future to benefit other women seeking care in Emergency Departments.

**Costs For Treatment and Compensation for Injury**

There will be no costs to you for participating in this study. You do not waive your legal rights by signing this form.

**After the Study is Complete**

The study will be completed in April of 2007. If you wish, I will provide a copy of the findings of this project at that time.

**Confidentiality**

Participants in this study will not be identified by name in any reports of the completed study. All documents related to this study will contain no identifying names. Audiotapes will be kept in secure storage at the university and destroyed five years after the completion of this project. Tapes will be reviewed by Sheila Turris and the three members of her thesis committee.
For More Information
If you have any questions or desire further information about this study before or during participation, you can contact Sheila Turris at 604.XXX.XXXX. If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, contact the “Research Subject Information Line in the University of British Columbia Office of Research Services” as 604.XXX.XXXX.

Consent
- I have read and understand the information given above.
- I have had sufficient time to consider the information provided and to ask for advice if necessary.
- I have had the opportunity to ask questions and have had satisfactory responses to my questions.
- I have been informed that all of the information collected will be kept confidential and that the result will only by used for scientific objectives.
- I know that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time without changing in any way the quality of care that I receive.
- I am not waiving any of my legal rights as a result of signing this consent form.
- I know that there is no guarantee that this study will provide any benefits to me.
- I have read this form and freely consent to participate in this study.
- I have received a dated and signed copy of this form:

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CONSENT FORM: Interview (Health-Care Professionals)

Title of Study
Women with Cardiac Symptoms: Negotiating Experiences of Emergency Department Care

Principal Investigator
Joy L. Johnson, Professor, School of Nursing, University of British Columbia

Co-Investigator
Sheila A. Turris, Doctoral Student, School of Nursing, University of British Columbia

Introduction
You have been invited to take part in this research study because you have some knowledge about the experience of health care in an Emergency Department (ED).

Chest pain is sometimes a symptom of heart disease, so getting to a hospital in a timely fashion is important. Women often delay coming to the hospital, for lots of reasons. For example, they don’t want to bother anyone or, they have been to an ED before and do not wish to return. In this study I want to understand what happens for women when they come to an ED, in order to improve the care we provide.

Participation
Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits and risks.

If you wish to participate, you will be asked to sign this form. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision. If you do not wish to participate, you do not have to provide any reason for your decision.
What the Study Involves
If you decide to participate, we will arrange a time and place to meet for an interview.

- The interview will take place at a location convenient to you. This interview will be audio-taped and will last 45-60 minutes. If, at any time during the interview you feel uncomfortable with what is on the tape, I will erase that part of the tape in your presence. As well, you can choose not to respond to a specific question, at any time.
- Following the interview the tape will be transcribed into written form (without identifying names or places). The tape will not be shared with anyone other than the three members of my thesis committee. The tapes will be destroyed five years after completion of the study.

Study Risks and Benefits
No injury is anticipated as a result of participation in this study and no compensation is offered. We hope that the information learned from this study can be used in the future to benefit other women seeking care in Emergency Departments.

There will be no costs to you for participating in this study. You do not waive your legal rights by signing this form. The study will be completed by April of 2007. If you wish, I will provide a copy of the findings of this project at that time.

Confidentiality
Participants in this study will not be identified by name in any reports of the completed study. All documents related to this study will contain no identifying names. Audiotapes will be kept in secure storage at the university and destroyed five years after the completion of this project. Tapes will be reviewed by Sheila Turris and the three members of her thesis committee.

For More Information
If you have any questions or desire further information about this study before or during participation, you can contact Sheila Turris at 604.XXX.XXXX. If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, contact Dr. A. Belzberg and Dr. M.R. Foulkes at 604.XXX.XXXX.

- I have read and understand the information given above.
- I have had sufficient time to consider the information provided and to ask for advice if necessary.
- I have had the opportunity to ask questions and have had satisfactory responses to my questions.
- I have been informed that all of the information collected will be kept confidential and that the result will only be used for scientific objectives.
- I know that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time without changing in any way the quality of care that I receive.
- I am not waiving any of my legal rights as a result of signing this consent form.
- I know that there is no guarantee that this study will provide any benefits to me.
- I have read this form and freely consent to participate in this study.
- I have received a dated and signed copy of this form.

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APPENDIX C – INTERVIEW QUESTIONS (WOMEN WITH SYMPTOMS SUGGESTIVE OF CARDIAC ILLNESS)
Date of Interview
Interview # ___________________________ Code Name ___________________________

Main Research Question:

In the context of signs and symptoms indicative of cardiac illness, how do women interpret and negotiate their experiences of care in an Emergency Department?

Brief background (experience with health care, health history, prior visits to EDs):

1. You know that I am interested in hearing about your visit to the Emergency Department. Before we talk about your visit, can you tell me what prompted you to come to the ED? (Prompts: Obtain details related to temporality, social support, self management, state of mind, etc).

2. Please tell me, step by step, everything that happened after you arrived in the ED. (Prompts: What was the most memorable thing about your visit to the ED? What, if anything, was the most disturbing or upsetting thing about your visit to the ED? What did you do to cope while in the ED)?

3. Drawing on your own experiences, can you tell me what is expected of you in the ED? (Prompts: Who was in charge? Were you involved in decision making? In what ways, if any, do you think being a woman influenced your care?)

4. If you think about what you were expecting when you arrived in the Emergency Department, what, if anything, surprised you? (Prompts: What did you notice the most about the environment? Please say more... What did you notice the most about the staff, the other patients?)

5. If you had the same experience of chest pain next month, what would you do?

Would you like:
* a summary of my thesis findings
* a copy of the transcript of this interview

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APPENDIX D - INTERVIEW QUESTIONS (NURSES)
Main Research Question:

In the context of signs and symptoms indicative of cardiac illness, how do women negotiate their experiences of care in an Emergency Department?

1. Please tell me about your background as a nurse.

2. Please take a moment now and think about the variety of people who present to the ED seeking treatment. Drawing on your nursing experience, what kinds of patient presentations do health-care staff in the ED particularly pay attention to? Pay less attention to? A couple of examples would be great.

3. From your perspective as an expert ED nurse, what would discourage individuals (or encourage them) from visiting an ED for treatment?

4. Imagine, for a moment, that you are writing a chapter for an ED nursing textbook. You wish to illuminate for the readers unique aspects of the ED as a work environment. What would you write about?

Would you like:
*a summary of my thesis findings
*a copy of the transcript of this interview
APPENDIX E – DIALOGUE WITH POTENTIAL PARTICIPANTS

Having obtained assent, I approached potential participants, employing the following script:

"My name is Sheila Turris. I am a registered nurse and I am currently studying for a PhD at the University of British Columbia. I am interested in speaking to women experiencing symptoms similar to your own. With your permission, I would like to sit with you and learn about what brought you to the ED today."

If the woman assented to further conversation, I positioned a chair at the bedside and asked if I could take notes as we spoke. I began by saying: "Tell me what brought you here today." During the conversation, I said as little as possible, using nods, "Um-hmm," and "Yes" to encourage as much detail as possible. At particular points during the conversation, I asked about demographic information (e.g., age, marital status) and the history of the presenting complaint. For example, if this information was not volunteered, I frequently asked about an individual's decision to seek treatment, by asking, "How did you make the decision to come to the emergency department and when did you arrive?"

Data from these conversations were subsequently recorded in the field notes.

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22 No one I approached, declined to converse.