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An Uneasy Subjection: The Emergency Room Encounters of Health Professionals and
Women with Cardiac Symptoms

by

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Abstract

These are troubling times for health care. The sustainability of our current health care system appears bleak in the face of an aging population with growing health concerns and global economic uncertainty. Heart disease, as a leading cause of death in North America, imposes a particularly onerous burden both on the individual and society. Health care institutions have focused on improving efficiencies in the institutional delivery of health care, while individual management of health in the context of their private lives has received much less attention. This study examines the accomplishments of a health care encounter for both the recipient and provider. Holstein and Gubrium's (2005) analytic interpretive approach to discourse analysis was used to examine the practices and understandings of health professionals and women with cardiac symptoms by discursively exploring the Emergency Room encounter. Field observation and interviews of health professionals as well as women seeking care for heart symptoms in an Emergency department were used to gather the data.

The biomedical view of health and healthcare, and the institutional imperative of economics and efficiency were found to be the privileged discourses. Precariousness inherent in the emergency room as well as the lives of women with cardiac disease, contributed to an ethical tension for both parties. Their narratives revealed both resistance and alignment with these privileged discourses, and the understanding and management of these women's health issues was constrained. Understandings generated from this research could support the privileging of new discourses in health care encounters that orient to the individual management of health, and that encourage a new ethos within these encounters.

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Dedication

I would like to dedicate this to the memory of my parents, Harry and Margaret Friesen.

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Chapter 1

Introduction

The emergency room encounter is for most, a moment that is both terrifying and compelling. The very nature of a health emergency is that it is an unplanned event, with potentially profound life altering consequences. The emergency room (ER) epitomizes the very best life saving treatment that science and medicine have to offer. It is a place that represents so clearly the fine line between life and death. The ER is at once chaotic and yet reassuring. It is a place to which few choose freely to come, yet a place that most depend on being there when their very greatest need arises. It is a place where the most fundamental of all human impulses reveals itself, and that is the will to live. This is perhaps most clearly understood by people who have experienced life-threatening circumstances such as those inherent to living with heart disease. These life threatening circumstances that arise in the everyday activities of health professionals practicing in the ER as well the everyday activities of people living with heart disease, contributes to a precarious and high stakes milieu within which their everyday existences must be negotiated.

This relatively small space of the hospital is a revered place where human lives are recurrently lost and saved, where tears of relief and grief flow in equal abundance. This is one of the many prevailing characteristics of this place that allow for the power of certain ways of thinking, knowing, and acting in reference to health issues to emerge and reign. In this space reside the discourses that dynamically and invisibly influence the communication between health care recipient and the health care provider, allowing experiences and self-understandings to emerge in a certain way for both those seeking and giving care. It is in

this space where in the context of potentially life threatening situations, identities are performed and constructed, and where certain aspects of social order are reified.

Heart disease continues to be a leading cause of death for men and women in Canada, and so remains a very significant health issue (Public Health Agency of Canada, 2009). The onset of cardiac symptoms heralds the undeniable implication that a life might be in jeopardy. When the heavy glass doors of the ER slide open as a person with cardiac symptoms enters to access care, a very powerful moment is about to unfold. This threshold represents a significant demarcation of disparate realities. It is in this place that people's private health issues become a public spectacle, where their most fervent passions that normally take precedence in influencing how they conduct their lives now fall into the background as they present with symptoms that might be forecasting the end of their lives. It is in this place that they bring themselves and their private lives, their understandings, their bodies, and their very lives to health professionals.

Of great significance too, is the context in which these performances unfold. It is indeed the *emergency* room where context becomes of paramount importance. The ER is to a large extent the gatekeeper to acute care in the Canadian health care system. The ER is frequently the first access point to health care, and almost always the first access point to critical life saving health care. People seeking acute health care must pass through this initial portal to the health care system in order to achieve the potentially life saving treatment that they seek. With its overflowing waiting room full of people waiting for care, with its never ending traffic of patients on their way to diagnostics and surgery and hospital admission, with its overall goal of rapid diagnosis, treatment, and patient *flow*, the ER is in effect a

caricature of our health care system, and offers an exaggerated glimpse of how health care has evolved and how health has come to be understood.

It is through the heavy glass doors of the ER that I first entered to begin my research. Of great significance is the fact that I started my nursing practice in 1977 in the ER in which I conducted the field observations for this project. Although I spent only a few months there as a student, and then as a newly graduated nurse, memories from this time are etched clearly in my memory. This was the time I fell deeply in love with nursing. In particular, I felt honored to be given the privilege of helping people in their very profound moments of need. Over the next twenty three years, as I continued to work as a bedside nurse in emergency and then critical cardiovascular care, I experienced the many rewards as well as the tensions that accompany the work of health professionals dealing with patients with life threatening illnesses.

For the past fourteen years I have been the facilitator of a support group for women with heart disease. Through my experiences with this group, I have heard countless instances of women offering their support and wisdom to someone newly diagnosed. I have heard and felt the anguish inherent in their daily existences, as they struggle to maintain their everyday lives amidst the terrifying possibility thrust upon them with their diagnosis of heart disease, and that is the ever present and real possibility of losing their lives. The stories of women's experiences with heart disease that I have been privileged to hear have almost universally included a description of the moment when they needed to access emergency care. Their ER encounters were a time when they saw their life as depending on their ability to assess and act on their symptoms, and on the availability and the unimpeded

access to health care knowledge and expertise. Perhaps most significantly, through my experiences as a nurse, as well as a facilitator for a support group for women with heart disease, I have had a unique opportunity to view the inherent tensions in the everyday practices of these women as well as those in the everyday practices of health professionals working with clients who have life threatening illness. It is not surprising that I have now arrived at this point, where my own passions as well as my tensions have led me to examine the emergency encounters of women with cardiac symptoms.

My own identity, self-understandings, and practices have emerged in a certain way because of influencing discourses that I have embraced and resisted throughout my life and career. I attempted to keep these understandings at the forefront of my thinking as I began my field observation in a large, incredibly busy emergency room. These understandings would form part of the context with which I would view the emergency room encounters of women with cardiac symptoms. This reflexive approach was critical to engaging in discourse analysis as I began my research.

ER encounters are significant and pivotal for women with heart disease, and is one that few women with heart disease manage to avoid. The ER is a site where women not only present their bodies to health professionals for care, they present to health professionals a glimpse of their understandings and practices regarding their diagnosed or potential heart disease from within the context of their lives. ER encounters have the capacity to powerfully shape women's understandings and practices as cardiac clients, and to influence the way in which their care unfolds. The identities and practices of health professionals working in the ER are similarly influenced within ER encounters. An examination of the

construction of the identities and practices of both offers the possibility of revealing limitations in the understanding and management of women with cardiac symptoms.

I completed a hermeneutic study for the requirements of my Masters program entitled “Women’s Quest for Treatment of Their Cardiac Symptoms: Exploring a Neglected Risk Factor” (Russell, 2003). My findings suggested that women’s experiences with seeking care were complex. These experiences were characterized by women’s tenuous understandings of their symptoms, and uncertainty in accessing and negotiating care in family physician’s offices as well as emergency departments. Care seeking encounters between women and health care professionals were influenced by perceptions of each party. For example, women’s reporting of anxiety in relation to their heart symptoms seemed to reduce the credibility of their stories for health professionals. As well, women’s perception of health professionals’ limited time affected their willingness to access health professionals for care. Impeded care seeking endeavors increased the risk to women’s health by delaying the diagnosis and treatment of their cardiac disease (Russell, 2003).

This project extends these understandings of the experience of women in seeking treatment, to explore how identities, understandings and practices are discursively constructed in ER encounters for both health professionals and women seeking care for cardiac symptoms. The primary underlying theoretical perspective for this project is a social constructionist view, using the method of Holstein and Gubrium’s *Analytcs of Interpretive Practice* (2005).

For the ordinary person, outside of philosophical and theoretical discussions, reality is something that is taken for granted. Everyday life presents itself as “solid and real” as we

go about our business and interact in the world (Phillips & Hardy, 2002, p. 2). It is what we know to be real as we engage in our everyday lives that is the focus of “the social construction of reality” (Berger & Luckmann, 1967, p. 15). It is this social construction of reality that is the focus of my chosen research method. It is through discourses that social reality, including our identities and everyday practices, are produced and sustained (Berger & Luckmann, 1967; Holstein & Gubrium, 2000). Beliefs and practices regarding health and illness are constructed and reinforced repeatedly through discourse, which includes the way we talk about health and illness, as well as in the way we act out our beliefs regarding health and illness (Gwyn, 2002). Holstein & Gubrium (2005) describe discursive practice as the “patterns of talk and interaction that constitute everyday life” and discourses in practice as “regimens/regimes or lived patterns of action that broadly (historically and institutionally) ,discipline’ or encompass their adherent’s lives” (p. 491). Together these two practices refer to the “doing or ongoing accomplishment of the social world” (Holstein & Gubrium, 2005, p. 491). Holstein and Gubrium (2005) describe this as the ,what’ (discursive practice) and the ,how’ (discourse-in-practice) to describe how social realities and subjects are constructed. In this project it was the discourses taken up by women seeking emergency care as well as those of health care professionals working there, that served to accomplish or construct their identities and practices.

From this perspective, a fundamental understanding for this project is that health care institutions are social institutions, where certain practices, functions, and systems of knowledge serve to shape the character of the society in which we live, where power is exercised, and where a certain social control is achieved (Turner, 2008). In particular for

this project, the underlying social constructionist perspective is that healthcare encounters have an important role to play in fabricating individual experience and identity, both for those seeking and giving health care. Institutions such as hospitals in this way provide “resources” for the ongoing construction of identity (Holstein & Gubrium, 2000, p. 167).

In institutions such as hospitals, personal narratives are elicited through mechanisms such as examinations and history taking. It is here where stories are screened, focussed, and streamlined to align with certain institutional imperatives such as efficient use of scarce resources or the strictly biomedical imperative. It is in institutional settings such as these where certain aspects of personal narratives are highlighted, valorized, and deemed relevant or irrelevant through the application of these institutional narrative frameworks. It is in institutions such as the ER that personal narratives are disciplined, where “constructions of the self are conditioned by working senses of what we should be at particular times and places” (Holstein & Gubrium, 2000, p. 3). These narratives take on meaning when individuals are incited to provide an explanation of their experiences from within institutional narrative frameworks, assembled into a coherent account, by a willing individual. It is the self that is constructed through narrative, disciplined by “ubiquitous narrative technologies” operating in institutions such as the ER (Gubrium & Holstein, 1998, p. 164). The personal narratives elicited are the words selected by individuals themselves to provide a coherent account that is in alignment with privileged ways of knowing and acting in a given context, so the power exercised becomes an outcome of *self-subjection* to certain discourses. The self that is constructed through this subjection is one which is sustained in everyday activities through a continued orientation to these

discourses, where the personal self becomes connected to the institutional self. Daily existences with the frightening symptoms of heart disease for example, become an ongoing opportunity for this kind of powerful interpretive work to be done, and this “person-building activity” is done within the messiness and complexity of everyday life (Gubrium & Holstein, 2001, p. 11). I offer a cautionary note regarding my use of the term “self-subjection”, in that this use of the term does not necessarily imply a conscious choice. Indeed it is the *invisibility* of certain mechanisms of power that invite people toward certain action where the real power resides, and this too is at the crux of the significance of this project.

Within people’s accounts, certain items or understandings are incorporated, and these comprise the „what’ or the context, institutional conditions or other resources and discourses that contribute to interpretively mediating interactions (Holstein & Gubrium, 2005). The way particular vocabulary is incorporated in storytelling to align with and orient to the rules and conventions of a particular context, comprise the „how’ of this perspective.

The initial research questions for this project were as follows:

- How does the ER encounter serve to construct the identity, understandings and practices for women with symptoms of heart disease as well as health professionals?
- In what ways are the articulated understandings and practices of women with symptoms of heart disease divergent from those of health professionals?

As my research project unfolded, certain things rose to the forefront during my field observations in the ER, in my interviews with women who had sought care for cardiac

symptoms, and in my interviews with health professionals. In this analysis of ER encounters, the supremacy of the biomedical view of health and health care, as well as the institutional imperative of economics and efficiency were the privileged discourses. The precariousness inherent in the context of the ER as well as in the lives of women with cardiac disease, contributed to an ethical tension for both parties, and their narratives regarding their everyday practices revealed both a resistance and an alignment with these discourses. The orientation of health care professionals to efficiency, flow and scientific rationality, limited the possibilities for understanding the health issues of those who sought care in the ER. For health professionals, an orientation to these discourses eclipsed the very thing that drew them to ER practice in the first place, and that was the passion they had for their work in which they had the daily opportunity to make a profound difference in the lives of those who sought care. For both the ER health professionals and the women who had sought care for cardiac symptoms, orientation to these discourses served to eclipse the experiential wisdom of the women with cardiac symptoms, it eclipsed the acknowledgement of the anxiety ridden complexity of women's lives within which they needed to manage their health issues, and the possibilities for the understanding and management of women themselves and their health was constrained.

The context of a health care environment with severely limited resources was a reality created by government healthcare policies, and now has become a taken-for-granted reality. The orientation of health care providers' practice to efficiency and economics in this analysis of ER encounters served to reify this context, and eroded their professional and ethical practice. The findings of this research relates most significantly to larger health

policies, but also to the need for a reorientation within the healthcare encounter toward the individual context of health management.

The research questions that emerged in the final analysis of this research became:

- In what way are the articulated practices and understandings of those seeking care in the ER divergent from health professionals’?
- What are the consequences of privileging the discourses of economics and efficiency in the practice of ER health professionals?

The following chapters will offer a review of the literature related to the relevant substantive and theoretical issues for this project, as well as a review of the methodological approach used. An analysis of the data obtained through field observations in the ER, as well as data from interviews with ER health professionals and women who sought care in the ER will be presented in the following three chapters. A discussion section will be included at the end of each of these chapters. The discussion chapter will offer perspectives on the significance of the findings as well as possibilities for practice that have emerged from this project.

Chapter 2 Literature Review

Significance of Heart Disease Among Women

Heart disease continues to be the major causes of disability and death for Canadians. Ischemic heart disease, acute myocardial infarction and heart failure accounted for 24.35 % of all deaths among women, and 29.31% of deaths among men in 2004 (Public Health Agency of Canada, 2009). The magnitude of the problem of heart disease among women has been overlooked in the past, and this is related in part to the under-representation of women in clinical trials prior to 1985 (Steingart et al., 1996; Wenger, Speroff, & Packard, 1993). There has been substantially less information about preventive strategies, diagnostic testing, and responses to therapies for women in comparison to men. Over the past twenty years, much attention has been directed toward a better appreciation of the influence of gender on cardiovascular risk and management (Blum & Blum, 2009; Chandra et al., 1998; Giles, Anda, Casper, Escobedo, & Taylor, 1995; Foody et al. 2009; Giardina et al. 2011; Green & Ruffin, 1993; Heston & Lewis, 1992; Hochman et al., 1999; Lehmann, Wehner, Lehmann, & Savory, 1996; Marrugat et al., 1998; McFarlane, Symes, Frazier, McGlory, Henderson-Everhardus, Watson, & Liu, 2010; McGovern et al., 2001; Mosca et al., 2004; Schwartz et al., 1997; Steingart et al., 1991; Steingart et al., 1996; Tobin et al., 1987; Wong, Rodwell, Dawkins, Livesey, & Simpson, 2001). Despite this, there remain some concerning issues regarding women and heart disease.

Gender Bias in the Care of Women with Heart Disease

Today, studies continue to show gender bias in the treatment of women with coronary artery disease, as well as rates of mortality and morbidity that are significantly higher than men following an acute myocardial infarction (Chou et al., 2007; Dudley et al., 2002; Grace et al., 2003; Kattainen et al., 2005; Pezzin, Keyl, & Green, 2007; Public Health Agency of Canada, 2009). Women are significantly less likely to be treated by a cardiac specialist, or to be referred for angioplasty, coronary artery bypass grafting, or cardiac rehabilitation following a heart attack (Public Health Agency of Canada, 2009; Kattainen et al., 2005; Kattainen et al., 2006). Women with established cardiovascular disease have also been shown to be less likely to be on aspirin and statin therapy, both of which are standard therapies for the prevention of future cardiovascular events (Cho, Hoogwerf, Huang, Brennan, & Hazen, 2007). Women also have been shown to be less likely to undergo heart transplants (Young, 2007), despite higher rates of heart failure as well as mortality related to heart failure for women as compared to men (Public Health Agency of Canada, 2009).

A study conducted in Ireland, used a one year prospective census to look at male and female patients who were admitted with myocardial infarction in six major teaching hospitals (O'Donnell, Condell, Begley & Fitzgerald, 2005). A total of 277 women and 613 men with confirmed myocardial infarctions were included in the study. Their findings were that women experienced significant delays as compared to men, from emergency room triage to the first assessment by a physician. The median „door to needle time’, meaning the time from when they entered the doors of the emergency room to the time when the needle was inserted for angioplasty, was 70 minutes for women compared to 52 minutes for men.

Men received aspirin significantly sooner than women, and also received bed in the coronary care unit significantly sooner than women. This same study found that women also experienced a significant delay between their initial symptom onset as well as intense symptom onset and their arrival in the emergency room (O'Donnell, Condell, Begley, & Fitzgerald, 2006). This finding suggests that gender differences exist from the moment a woman decides to seek care for cardiac symptoms.

There is evidence that demonstrates significant improvement in outcomes for men and women with heart disease over the past several years (Ford et al., 2007; Public Health Agency of Canada, 2009; Trovato & Lalu, 2007), however the decline in death rates for men with heart disease has been much more significant than for women in the years between 1971 and 2004. This has been a major contributor to the narrowing gap between men's and women's life expectancies (Public Health Agency of Canada, 2009; Trovato & Lalu, 2007).

The strong evidence that women continue to experience gender bias in the treatment of their cardiovascular disease, remains very concerning, particularly in light of the significant research that has been done to explore this issue over the past twenty years. Issues related to gender were not examined as such in this study, however further analysis of the data generated from this research would certainly warrant this kind of an examination.

Delayed Presentation for Treatment

One factor that could influence better outcomes for both men and women with CAD is a reduction in the time from the onset of symptoms of an acute myocardial infarction to seeking medical intervention. In the case of an impending heart attack, cardiac clients experience a range of warning symptoms (DeVon, Penckofer, & Zerwic, 2005; Ryan et al., 2007). It is imperative that someone experiencing symptoms of a heart attack seek immediate medical attention so that if they have a blocked coronary artery, it can be immediately opened with thrombolytics or angioplasty, and thereby preventing or reducing myocardial damage as well as subsequent disability and mortality (Moser et al., 2005; Moser et al., 2006). The optimal time frame for revascularization in an impending MI has been shown to be ninety minutes from the onset of symptoms (McGovern et al., 2001; Schweiger et al., 2001; Zijlstra et al., 2002a; Zijlstra et al., 2002b).

Despite the enormous evidence of the benefit of early revascularization in an impending heart attack, studies continue to demonstrate that a majority of people with acute myocardial symptoms continue to delay seeking treatment for several hours (Banks & Dracup, 2006; Gibler et al., 2002; Goff et al., 1999; Hwang, Ryan, & Zerwic, 2006; Kaul et al., 2011; Moser et al., 2006). Gibler et al. (2002) examined delay times for patients with heart attacks in two large multinational randomized trials of fibrinolytic therapy, Global Utilization of Streptokinase and Tissue Plasminogen Activator for Occluded Coronary Arteries (GUSTO-I) and Global Use of Strategies to Open Occluded Coronary Arteries (GUSTO-III). Comparison studies of 27, 849 patients with AMI enrolled in GUSTO-I or GUSTO-III demonstrated that in hospital delays to treatment (either thrombolytics or

angioplasty) decreased from 66 minutes to 48 minutes, but that time to arrival at the hospital had not changed in the seven years between these two trials (Gibler et al., 2002). This would suggest that a major limiting factor in the successful treatment of a patient with an impending heart attack is the rapidity with which they present themselves to emergency services.

There is strong evidence that women with an impending heart attack delay seeking treatment significantly longer than men, which may negatively affect their outcomes (Gibler et al., 2002; Kaul et al., 2011; Malacrida et al., 1998; Moser, McKinley, Dracup, & Chung, 2005; O'Donnell et al., 2006; Rosenfeld, 2001; Rosenfeld, 2004; Sheifer et al., 2000). Although many studies document this delay among women, there remains a lack of understanding as to why this may be occurring. There is evidence that women may perceive themselves to be at lower risk for a heart attack which could contribute to their delay in seeking treatment for their symptoms (Legato, Padus, & Slaughter, 1997; MacInnes, 2006). Other factors associated with delay in seeking treatment include knowledge of symptoms, age, socioeconomic status, and social support (Hwang et al., 2006; McKinley et al., 2004; Moser et al., 2005; Rosenfeld, Lindauer, & Darney, 2005). These findings are concerning, particularly in light of the poorer outcomes for women with AMI as compared to men. This significant issue points to the importance of attending to women's understandings and practices regarding their heart disease in the context of their private lives.

Women's Unique Issues with Heart Disease

There is evidence in the literature to suggest that women's symptom experience is unique as compared to men's. Several studies have shown that women experience different symptoms of CAD than men (Canto et. al., 2007; DeVon & Zerwic, 2003; DeVon & Zerwic, 2004; Løvlien, Schei, & Gjengedal, 2006; McSweeney, Cody, & Crane, 2001). The difference in women's cardiac symptoms has been linked to their delayed treatment seeking behaviour (Lockyer, 2005; MacInnes, 2006), as well as their delayed diagnosis when they do present for treatment (McSweeney, Lefler, & Crowder, 2005).

Women who believe their symptoms are cardiac in origin have been shown to seek emergency care more quickly (Arslanian-Engoren, 2005). The influence of gender is also evident in the way cardiac symptoms are described in the literature. Women's cardiac symptoms are often described as being more atypical as compared to men's (Devon & Zerwic, 2004). The labeling of women's symptoms as outside of the norm may marginalize women in ER encounters and may have an influence on one's understandings and practices with regard to heart disease. The labeling of women's cardiac symptoms as frequently atypical could also contribute to women's perceived legitimacy of their symptoms. There is also evidence that women who are knowledgeable and concerned about their heart health, hbmay be more motivated to modify their cardiovascular risk factors (Galbraith, Mehta, Veledar, Vaccarino & Wenger, 2011). This evidence suggests that not only are women's symptoms different from those of men's, their perceptions and understandings have a strong influence on the management of their real or potential heart disease. The way in

which women come to these understandings, or how they are taken up, contested or legitimized in health care encounters has not been examined.

There is a plethora of qualitative research regarding women's experiences with heart disease that provide us with insights into many other issues that are unique to women. The important influence of the socially constructed role of 'mothering' among women has been shown to be influential regarding the health of women (Varcoe & Doane, 2007). In particular, risks to women's health have been linked to issues of poverty, violence against women, and workload (Varcoe & Doane, 2007). Women's roles, women's unique symptom experiences, women's everyday experiences, women's treatment seeking, relationships with health professionals, as well as women's recuperation following a cardiac event have all been addressed in the literature (Emslie, 2005). These studies depict the unique issues and experiences of women with heart disease and have contributed to our ability to provide more thoughtful health care. It is important to note that although many studies have addressed issues specific to women, the gendered nature of women's experiences or their cardiac care has received little attention in the literature (Emslie, 2005).

Although the influence of gender norms in ER encounters has not been examined specifically, there is evidence that points to the influence of these norms on women's health care experiences. For example, Birdwell (1993) found that physicians were much more likely to attribute cardiac symptoms to coronary artery disease in women with a businesslike portrayal of their symptoms versus patients with a histrionic portrayal. As well, women in my previous study described the need to "speak more like a man", "just stick to the facts", and "leave the emotion out of it" in order to be taken seriously in their

care seeking encounters for cardiac symptoms (Russell, 2003, p. 119). What counts as appropriate presentation in the ER, may be a more stereotypical „male’ presentation, and this in itself could be putting women at a disadvantage in ER encounters.

Emergency Room Encounters

There is growing evidence related to the significant factors within the ER encounter itself that influence how health care proceeds. Using a qualitative approach, Andersson, Omberg, & Svedlund, (2006) used field observation and interviews of nurses in an ER to explore factors that triage nurses used in making decisions. Factors including patients’ conditions and history formed the basis for their decisions, but other factors such as personal capacity and skills, as well as external factors such as high workload and practical arrangements in the department affected the way in which decisions were made (Andersson, Omberg, & Svedlund, 2006).

Varcoe (2001) conducted an ethnographic study in two hospital emergency units employing field observation and interviews of health care providers as well as clients seeking care for physical abuse in the emergency unit. Findings of this study revealed that stereotypical thinking, rapid processing, and a focus on physical problems by health care providers masked women’s history of abuse in ER encounters, and this served to influence nurses’ practice. Results from this study point to the significance of ER nurses’ assessments.

In an analysis of their three ethnographic studies, Varcoe, Rodney and McCormick (2003) found that rapid assessments and limited engagement of health care providers with clients in ERs led to decreased interpersonal trust between them. This seemed to contribute

to an increase in the use of coercive power by health care provider. Rapid decision making required of nurses in this setting led to nurses' use of hasty stereotypical judgments of how deserving of care a client was, rather than judgments based on more thorough and time consuming engagement with their clients. Nursing practice in these emergency units was dominated by efficient patient processing, driven by the notions of scarcity that pervade the health care system. Nurses used a variety of discourses to enact a number of written and unwritten rules and practices that created and organized the framework for their practice. For example, compliant clients were seen to receive better care than those seen as non-compliant. The ethnographic approach used in these studies offered important insights into the culture within health care settings that influenced practice, as well insights into the discourses that may be at play in constructing health professionals' practices. Provision of services in the ER for women seeking care for their heart symptoms may be based on presentation that conforms to institutionally constructed discourses. The institutional discourse of being service worthy, as described by Varcoe, Rodney & McCormick (2003), may influence the care as well as the constructed identity and practices of women with heart disease.

In a discourse analytic study, Spencer (2001) described the need for those seeking homeless assistance to present themselves as worthy of service by conforming to certain standards of morality, conforming to institutional rules and processing, and being sensitive to the limitation of resources. Spencer found that clients presented "institutional selves" which they saw as being worthy of the requested services (2001, p. 162). This finding was echoed in my previous research looking at the care seeking experiences of women with

cardiac symptoms (Russell, 2003). In this study, female participants felt the need to learn to communicate and interact in care seeking encounters in a way that was acceptable to health care providers. For example, participants learned to mask their anxiety when presenting themselves to physicians as their anxious presentation was thought to erode the credibility of their stories and confuse their diagnosis.

One of the most significant research studies related to the findings of this project, is a grounded theory study conducted by Turris and Johnson (2008), who examined women's experiences with treatment seeking, their symptom appraisal, their decision making about seeking treatment, and their experiences in the ER. Data was derived from 100 hours of naturalistic observation in the emergency room, interviews with sixteen women who had visited an emergency room, and three interviews with nurses. These authors found that women seeking care for cardiac symptoms were primarily seeking to preserve their sense of self as well as their capacity to fulfill their role responsibilities, including family, employment, and social roles. These findings suggest that women's delay in seeking treatment of their cardiac symptoms may be connected to protecting the context of their private lives. Of great significance for this project too, is that part of women's reluctance to seek emergency care was their orientation to the discourse of "resource scarcity" (p. 1473). They were reluctant to "bother" health professionals because of their perception of how busy and overworked health professionals were. They also expressed an orientation to the "discourse of acuity", where women felt that their symptoms were not blatantly visible, and this diminished their deservedness to seek emergent care which contributed to their delayed treatment seeking (p. 1473). An orientation to the "discourse of deservedness" was also

revealed for women who had risk factors related to the development of cardiovascular disease such as smoking or lack of exercise (p. 1473). The role of stress on women's experiences was also found to be significant for women, who not only viewed this as evidence of their inability to cope, the experience of stress served to confound their symptom analysis. The experience of stress was viewed by women as a moral failing, which if managed might mitigate their future symptom experience. The findings of this study underscore the importance of understanding the perspectives of women seeking treatment in the emergency department. This study provides insights related to the emergency room encounters of women with cardiac symptoms, and that is an understanding of the influence of the interpretive work that is undertaken when women make the decision to seek care in the ER. The interpretive work done by women in this study prior to seeking emergent care in this study, was related to their everyday existences including their roles and responsibilities in their private lives. The meaning they attached to their heart disease and their private management of symptoms influenced their emergent care seeking encounters. The ER encounters themselves thus were constructed to a large extent by interpretive work done by women in their everyday existences with heart disease.

Another study related to the current project, is an ethnographic study that used discourse analysis to examine ER communication between clinicians and patients (Dunston et al., 2008). Patients entering an ER were observed and their communications were audiotaped from the time they entered the ER, to the moment a decision was made to either admit them, or discharge them from the department. Semi-structured interviews were also conducted with patients and hospital staff to capture their understandings and insights

regarding communication in the ER. ER health records were also examined to collect clinical information related to the patients stay in ER. An analysis of policies and procedures affecting communication in the ER was also conducted. Their findings characterized patients in the emergency department as “outsiders” in communication and practices in the ER. The experience of time was also significant, including time spent waiting for care and further communication with hospital staff. Patients and hospital staff were found to express differing goals within communication, and concerns of the patient were overlooked. There was a disjuncture between professional knowledge and questioning, and the concerns patients had regarding their private lives, revealing a significant difference in the goals of instances of communication for patients and hospital staff. The dominance of physicians during their assessments, resulted in submission of patients within interactions. Communication of physicians oriented most strongly to the illness, while nurses’ communication was oriented to the interpersonal relationship with the patient, revealing the orientation to diagnosis and treatment for physicians, and care of the patient for nurses. Experiences of illness such as pain for example, were constructed as subjective and personal for patients, and objective and diagnostic for physicians, revealing a difference again in their orientation within instances of communication. The principal finding of this study was the valorization of “medical tasks over the experiences and sensibilities of people involved” (p. 292). Nurses were found to attempt to bridge this gap through their communication. This study confirmed the importance of communication within the emergency room encounter.

Although many aspects of women's experiences with heart disease have been examined empirically, there is little research that has examined their ER encounters specifically. The evidence presented however, suggests that for those seeking care, the practices of health professionals within the ER have significant consequences that warrant further exploration.

Lay versus Professional Discourses

The literature explores differences between lay and professional understandings of health and illness, and suggests that these differences also could be influencing the care of women with heart disease. For example, the notion of cardiovascular risk management has been understood and enacted in very different ways between lay persons and health professionals. The first published article regarding cardiovascular risk factors was published in the *Annals of Internal Medicine* in 1961, and was entitled *Factors of risk in the development of coronary heart disease- Six year follow-up experience, the Framingham study* (Kannel, Dawber, Kagan, Revotskie & Stokes, 1961). Much of the care that cardiac health care professionals deliver today is based on this discourse of cardiovascular risk management. The risk factors identified fall almost exclusively into the biological domain: that is, the management of risk factors such as smoking, hypertension, hypercholesterolemia, diabetes, and obesity. Cardiovascular risk factor management is one of many "risk" discourses in health care that has become ubiquitous and powerful. For example discourses related to prevention of cancer or sexually transmitted infections, and much of the care and assessment of patients with potential cardiac disease is based on this discourse. The premise of this discourse is that everyone should be aware of, accept responsibility for, and manage the risk factors that could affect one's cardiovascular health.

From this scientific biomedical perspective, rational behavior should be oriented to the detailed objective knowledge that has been produced through careful scientific means such as the Framingham study or randomized clinical trials. The discourse of cardiovascular risk factor management has become ubiquitous and taken for granted among health care professionals and the public, and therefore requires our critical attention.

Other ways of viewing cardiovascular risk were brought to light in an ethnographic study in South Wales (Davison, Frankel & Smith, 1992). The findings of this study suggested that participants had extensive knowledge of risk factors associated with heart disease. This knowledge however was not reflected in their personal lifestyle choices such as smoking and consumption of fatty meats. These lifestyle choices were not understood by the participants as being irrational, but rather as a reflection of adhering to what the authors termed „lay epidemiology’. Notions of luck and fate predominated everyday discourse to explain health status, along with a belief that God controlled one’s ultimate destiny. Participants believed that heredity, social conditions and the environment had a larger impact on health than did lifestyle choices. Health care initiatives instituted in this area were found to be “out of step with popular culture” (Davison, Frankel & Smith, 1992, p. 683).

Another example of this was offered in a study by Lupton and Chapman (2005) who studied the responses of the lay public to media coverage of dietary advice to reduce the incidence of cardiovascular disease. The participants displayed a high degree of cynicism regarding media coverage of this health issue, particularly when medical controversies were

discussed. Participants frequently responded that “you must trust in yourself, and that it comes down in the end to using one’s own commonsense and experiences” (p. 490).

Health care providers may be doomed to failure in attempts to optimize clients’ health without an appreciation of the potential differences between the lay and professional perspectives on health and illness. This gap in understanding may be limiting both to the health professional and to women themselves. There may be a need for reciprocal learning which could enhance the practices of the professional as well as the client. An understanding of the gap in the discourses between health professionals and cardiovascular clients could assist health professionals to provide more meaningful care, and could assist clients to perhaps enact their own health practices in a more effective way. In light of women’s poorer outcomes following a heart attack, as well as their continued reluctance to seek emergency care in the event of a heart attack, an understanding of this gap would seem to be imperative, and the possibility of change which could improve these outcomes is compelling.

The literature reviewed in this chapter bears upon the topic that has garnered my interest. My own previous research regarding the experiences of women seeking treatment for cardiac symptoms, my experiences with a women’s cardiac support group, as well as my experiences caring for women with heart disease, have also led me to this research. The following chapters will outline the research method, explain and explore the analysis of discourse in ER encounters, and discuss the significance of the findings for this project.

Chapter 3

Research Method

Theoretical Perspective

Holstein and Gubrium's (2005) *Analytics of Interpretive Practice* offers a discursive analytic approach which helped to provide insights related to the proposed research questions. Holstein and Gubrium developed this method out of the ethnomethodological tradition where the focus of inquiry is on how members engage in their everyday lives through accounting for their actions (Holstein & Gubrium, 2005, p. 486). Where traditional ethnography inquired into the shared rules, conventions and meanings that provide "exogenous" accounting for members' actions, ethnomethodology inquires into the way in which members account for their actions through their orientation to these rules and conventions, that is the "hows" of reality construction. Holstein and Gubrium's analytics of interpretive practice, incorporating a Foucauldian perspective, was developed out of the ethnomethodological tradition to include not only the "hows" entailed in constructing everyday reality, but also the "whats". The "whats" are described by Holstein and Gubrium as the "institutional conditions, resources and related discourses that substantially nourish and interpretatively mediate interaction" (2005, p. 493). It is the interplay between the "hows" and the "whats" of reality construction that is the focus of this method. Analysis requires what Holstein and Gubrium (2005) describe as "analytic bracketing" in which the focus of analysis alternates.

As analysis proceeds, the observer intermittently orients to everyday realities as both the products of members reality constructing procedures and as resources from which realities are constituted.

At one moment, the analyst may be indifferent to the structures of everyday life in order to document their production through discursive practice. In the next analytic move, discursive practice is bracketed in order to assess the local availability, distribution, and/or regulation of resources for reality construction.....in Foulcauldian terms, it leads to alternating considerations of discourses-in-practice, on one hand, and the locally fine-grained documentation of related discursive practices , on the other (Holstein & Gubrium, 2005, p. 496).

According to Holstein and Gubrium, this form of analysis allows for a “contextually scenic and contextually constructive picture of every day language in use” (2005, p. 496). This method allows for insights into the way in which members creatively construct their everyday realities.

Holstein and Gubrium’s (2005) *Analytics of Interpretive Practice* offers a way of analyzing discourse that also provides the basis for looking at the „why’ questions enabling explanations of “why certain discursive actions unfold in specific directions or why they have particular consequences” (Holstein & Gubrium, 2005, p. 499). This method provides the possibility to understand new ways of approaching practice as health care providers as well as health care clients, because “action can be organized toward preferred possibilities” (Holstein & Gubrium, 2005, p. 500).

This method resonates with my own understandings of the way in which women construct their everyday realities in relation to their heart disease and the various contexts in which they are involved. My experiences as a staff nurse in an emergency department, a coronary intensive care unit, a cardiovascular surgical intensive care unit as well as from

my experiences in facilitating a women's cardiac support group, have allowed me the opportunity to see firsthand the way in which women creatively construct their everyday realities in relation to the various contexts and resources that are available to them. This method of inquiry offers a way of recognizing the contingent nature of discursive practice. The way in which discursive practice is influenced by the contexts in which they occur is revealed with this method, along with the interpersonal and personal consequences of doing so.

In the end it is the 'so what' about how identities are performed or constructed.

What became clear to me as I stewed with my data, the literature, and the philosophical underpinnings of my research method, is that ER encounters have significance beyond the self-evident. On the surface it appears that in ER encounters, what is asked of the health professional is to present themselves as experts whose mandate is to identify those who need their care, to identify the urgency with which that care is to be delivered, and then to deliver that care. The woman seeking care presents an account of herself that should result in the appropriate care being given to her. The significance of this encounter comes into a more consequential view when the lens of Holstein and Gubrium's (2005) *Analytics of Interpretive Practice* is applied. The Foucauldian perspective offers a glimpse into the historical shadows from which the complex nexus of knowledge, power and discourse interact to allow for experiences to emerge in a certain way, including the performance of identity. The ethnomethodologic perspective of the performance of identity allows for a recognition of the dynamic way in which local constructs of social order are reified out of resources at hand, in ways that are recognizable. According to Holstein and Gubrium

(2005), this approach to the empirical data gathered, results in „analytics’ versus traditional theoretical frameworks. The Foucauldian and ethnomethodologic perspective looks to answer “how it is that individual experience comes to be understood in particular terms such as these” (Holstein & Gubrium, 2005; p. 491), as opposed to the *why* concerns of traditional theoretical frameworks. These two perspectives align in Holstein and Gubrium’s (2005) common goal of articulating the bases of the practical accomplishments of daily life. ER encounters, this “narrative-in progress” (Palumbo-Liu, 2000), this double sided performance of identity, offers a glimpse into each party’s assumptions and understandings whose origins are *of* consequence, and the performance of which *have* consequences. This analysis of ER encounters revealed that an instance of communication is not merely a reflection of reality for those engaged in this encounter, it is a process of generating social order, practices, and self understanding.

Attention to everyday practice.

A key to understanding ER encounters using the perspective of Holstein and Gubrium (2005) is an appreciation that this encounter must also be understood in terms of things that happen outside the physical walls of the ER. Much of the attention in the interviews I conducted with nurses, physicians and women with cardiac symptoms was directed at activating their narratives regarding their everyday practices (Holstein & Gubrium, 2009). The double-sided performance of identity for those seeking care as well as those offering care in ER encounters is the result of understandings and practices that have been generated and sustained in the day to day existence of both parties.

The questions for this study are:

- How does the ER encounter serve to construct the identity, understandings and practices for women with symptoms of heart disease as well as health professionals?
- In what ways are the articulated understandings and practices of women with symptoms of heart disease divergent from those of health professionals?

The research questions, therefore, required the exploration of those day-to-day “going concerns” (Holstein & Gubrium, 2005, p. 493), where these understandings and practices are not only generated, but also revealed and reified. It is from this perspective within ER encounters, that we are incited to “hear the distant roar of battle” (Foucault, 1995), where a certain version of social reality emerges as the one that counts. Attention to the distant roar in everyday struggles is an essential view, in that it is here that mechanisms of power operate to privilege certain interpretations of social reality.

The very construction of the self therefore can be seen as the effect of power to invisibly construct and assign meaning to the world for the individual who becomes complicit in reifying this version of reality. Persons orient their interactions in the world to these dominant “systems of knowledge” or “truth games” that emerge as seemingly objective ways of making the world and the individual knowable (Foucault, 1988b). This self-subjection is at the very crux of the significance for viewing this encounter from Holstein and Gubrium’s perspective (2005).

The ethnomethodologic perspective allows for the revelation of the practical ways in which people orient their language and everyday practices to the rules, conventions and these dominant systems of knowledge in any given social world. From this perspective,

through the act of self-subjection to certain rules, conventions, or discourses, the “social facts” of a given social world are not only made visible, they are reinforced and reified (Garfinkel, 2002, p. 251). This self-subjection that serves to constitute the social world and the identity of that person are revealed in their language as well as their everyday practices. The ethnomethodologic perspective of self subjection in this way aligns with the Foucauldian view to offer a discerning analysis of discourse.

Self-subjection to discourses: Ethics of the self.

The Foucauldian lens of Holstein and Gubrium’s (2005) *Analytics of Interpretive Practice* offers a useful theoretical lens with which to further examine issues related to the construction of identity or subjectivity. Foucault ascribes two different but interconnected meanings to the term subject. First humans become subjects by being *made subject to* others by control and dependence. Secondly, humans are *made subjects* in the sense that their subjective identity, that is who or what they understand themselves to be is constructed by being tied to a specific identity through a “conscience or self knowledge” (Foucault, 1982, p. 212).

Subjectivity, for Foucault, is produced through social and institutional norms and practices which are produced and reproduced in discourse (Foucault, 1990). The self is produced through self-subjection to these discourses, and this self-subjection is made possible through each person’s relationship with oneself. This relationship each has with themselves is what Foucault described as *ethics*, and it was this that he saw as determining how an individual would act in order to constitute himself as a moral subject. He described ethics as the:

process in which the individual delimits that part of himself that will form the part of his moral practice, defines his position relative to the precept he will follow, and decides on a certain mode of being that will serve as his moral goal. And this requires him to act upon himself, to monitor, test, improve and transform himself (Foucault, 1985, p. 28).

The first aspect of Foucault's relationship with oneself, or ethics, was the identification of an ethical substance. He described this as the aspect of oneself that is concerned with moral conduct, for example sexuality (Foucault, 1984 p. 352). The second aspect of Foucault's notion of subjectivity is "the mode of subjection, (*mode d'assujettissement*), that is, the way in which people are invited or incited to recognize their moral obligations" (p. 352). He gives the example of divine law that has been inscribed in text, natural law or universal laws in which rational beings are incited to act in a certain way as a product of being members of the human community.

The third aspect of Foucault's ethical framework is "the means by which we can change ourselves in order to become ethical subjects" (Foucault, 1984, p. 352). In Foucault's analysis of sexuality for example, he suggests that moderation of behavior, or attempts to understand the self, or attempts to eliminate desires, or to use sexual desire as a means to having children, are all examples of ways of behaving ethically in relation to sexual desire.

The fourth consideration in Foucault's framework regarding the relationship one has with oneself, is in the acknowledgement of the kind of person one aspires to be through moral behavior: "For instance, shall we become pure, or immortal, or free, or masters of ourselves, and so on?" (Foucault, 1984, p. 355). So in his conception of morals, he includes the effective behavior of individuals, codes of conduct, and this relationship to oneself with

these four characteristics. This understanding of ethics as a mode of self-constitution through moral conduct is central to this project.

Health, and more accurately perhaps, the universal desire for the potential of life itself, has become the “ethical substance” that is shaped through the moral activity inherent in health care encounters and in the practices of those seeking to achieve health. The uneasy self-subjection of the individuals in this study was made possible through their recognition of a moral obligation within the health care encounter, and that was to align their behavior with certain privileged discourses regarding health and health care.

Construction of the Ethical Self.

The significance of the Foucauldian perspective inherent in this method is that it allows for invisible mechanisms of power to be revealed, and it opens up the possibility for the construction of what Foucault referred to as the ethical self (Foucault, 1985). The ethical self is one who can resist the mechanisms of power inherent in places such as the ER in the construction of their identities and practices. The possibility of the assemblage of this ethical self, who can reflect and take a position with respect to relations of power, who can choose to construct their identity in a certain way, who can choose how to engage in everyday life, is a self that emerges out of the resources at hand in their every day existence. An understanding of the consequences of certain mechanisms of power inherent in health care encounters could serve as a resource in the construction of the identities and practices of health professionals as well as those seeking care.

All my analyses are against the idea of universal necessities in human existence. They show the arbitrariness of institutions and show which space of freedom we can still enjoy and how many changes can still be made (Foucault, 1988, p. 11).

Examining the generative nature of the encounter.

Examination of instances of communication in the ER, including the context in which they occur, allows for insights into the generative nature of this encounter. Analysis of interviews with ER health professionals as well as with women who sought care in the ER, allows for insights regarding the construction of their identities and practices in their everyday activities, including their experiences in ER encounters.

These analyses will reveal the interplay, the resistance, and the taking up of discourses that operate at both a macro level (societal, institutional) and micro level (individual practices or self understanding) to *accomplish* something. This “something” that is accomplished in the end is the understanding of self, the production of identity or subjectivity with resulting practices, and ultimately the composition or “anatomy of the body” itself (Foucault, 1995). The perception of the body then moves from being objective, inert, and constant, to being subjective, conditional and possessing a social identity responsive to prevailing discourses. Central to the understanding of the production of subjectivity in this project is the understanding that the discourse of health is a resource for the construction of self. The body itself becomes a product of discourses such as this, and the self is constituted by relations of power operating through these same discourses. The body thus becomes a vehicle that allows power to circulate through everyday practices, these practices themselves made possible by knowledge generated and reified through power relations in everyday life. Power is thus exercised in everyday activities such as ER encounters through the dissemination and operation of knowledge, which produce and sustain these everyday practices (Foucault, 1980). Self-subjection to certain discourses is

revealed in the way behavior and language are oriented to certain privileged discourses regarding health and health care, and this in itself becomes a mechanism of power and a form of constraint. In the end it is the very constitution of the self that is accomplished through power relations, which operate through the mechanism of “multiple forms of constraint” in everyday practices (Foucault, 1980, p. 131).

This ‘so what’ forms the basis of this project. It is not the discovery of truth that I sought in this project, but a revelation of the mechanisms of power operating in everyday practices which serve to construct the subject.

Analytic Aims

Central to the analytic aims of this research is that understandings, beliefs and practices regarding health and illness must be viewed within the social context in which they are to be found. In the case of this research project, it is the social world of a woman with heart disease as well as health professionals working in the ER, and the practices and accomplishments of the discourses they take up and engage with that can accomplish certain things. This project explores the way in which understandings and identities are constructed, replicated and legitimized through talk as well as practice in ER encounters. Field observation was conducted in order to have a fuller apprehension of the context in which health professionals worked, and the context within which women presented themselves for care when having cardiac symptoms. Contextualization is critical to apprehending the ways in which people orient their language as well as their behavior to reveal the practical meaning inherent in a given situation. In this analysis, contradictions within the discourses were found for both women seeking care and health professionals working in the emergency department. In some instances, certain things were emphasized,

downplayed, or missing completely in the narratives, as well as within the practices I observed. In the final analysis, the privileged discourses that were revealed for both the health professional and women seeking care were both embraced and resisted in their everyday existences.

Research Method

Recruitment.

Sampling for this study was purposive, in that I was interested in participants who had sought care for heart symptoms in an ER, or health professionals who had cared for women seeking treatment for heart symptoms. I posted and distributed invitations to participate for health professionals to be shadowed as well as interviewed while I was doing field observations (see Appendix B). Over the course of 96 hours of field observations, I obtained the consents of 38 nurses and physicians to shadow them in their practice in the ER. Several nurses stepped forward very quickly to volunteer to be interviewed, and some of these nurses subsequently recruited other nurses as well. Recruitment for nursing interviews was complete within a few days. I gave invitations to participate in interviews to physicians I was shadowing over the course of the five months of field observation, and only three of them volunteered. I was able to interview eight nurses and three physicians in total. There were several physicians who had indicated that they would be interested in being interviewed, but after two follow up e-mails with no response, I did not pursue them.

I interviewed eight women who had sought care for cardiac symptoms in an ER. I planned on offering an invitation to participate in an interview (see Appendix A) to women coming in with cardiac symptoms during my field observations. I found myself being very

uncomfortable with this because of the level of anxiety that these women were experiencing at the time, and I did not want to add to this. In total I offered approximately 10 invitations to participate in an interview to women in the ER, and these invitations were offered by the nurses caring for them. None of these women contacted me to arrange for an interview. Invitations to participate in an interview were distributed to members of the Woman-to-Woman cardiac support group that I facilitate, and these women contacted me either directly at the meeting, or by phone to confirm their participation. I was able to obtain the consents from eight women within a month of this offer. All of the interviews with women were recruited through this support group.

Data Generation

Field observation

Field observation was done in a large urban hospital emergency department that was chosen because of its specialization in cardiac care. I used an unstructured observational method described by Pretzlik (1994). Pretzlik describes this method as being useful in looking at complex social organizations where the researcher can use pencil and paper to record conversations and practices within a loose structure. Events were recorded in a notebook as they occurred, and I was able to jot down observations, personal interpretations, and actual conversations when possible. Many details of my observations were recorded immediately after a given interaction. I also spent thirty minutes or so after each period of observation filling in details I may have missed. Although the unstructured method was very time consuming, this method allowed me some flexibility in the way in which I collected the data. A total of 96 hours of field observation was conducted over six

months beginning in September of 2008. The observation periods were at various times of the day between 0700 and 2300, and on various days of the week. Most observation periods were three to four hours in length, and the majority of the observation was done between the months of September and December of 2008.

After obtaining the approval of the department manager, the Medical director of research, the Faculty of Nursing, as well as approval from the Office of Medical Bioethics, University of Calgary and Alberta Health Services, I was able to post information regarding the study prior to the beginning of my field observations (see Appendix B). The manager offered to connect me with a nurse who had expressed interest in this study, and my first two days of field observation were done with her. I spent a great deal of time in these initial few days conversing with nurses and physicians about this study. These initial days were spent observing everything that I could, and I tried to make the most detailed field notes that I could in order to produce a rich description of the setting and the participants in it, and their interactions with health care providers (Seale, Gobo, Gubrium, & Silverman, 2004). Reflection and expansion on the field notes was done as soon as possible after the observation period. Beginning interpretive writing was done after each period of observation as well.

After the initial two days, I began to spend time observing in the triage area exclusively. I avoided shift change, and tried to arrive about an hour into a given shift. I would always give a brief explanation for my presence to the nurses, and then would obtain the consents to be shadowed from all of the triage nurses when I arrived (see Appendix E). I initially thought I would be shadowing one nurse or one physician at a time, and I began to realize

that I would need to obtain everyone's consent working in a given area since there were so many back and forth conversations between nurses and physicians, and any given patient would have interactions with several nurses and physicians. As my days observing in the department progressed, the nurses became familiar with me and with the project, and obtaining consents became quite routine and fluid. When patients arrived in the triage area, the nurse would briefly solicit their verbal assent by introducing me and the purpose of my presence. This was usually done with a statement such as "This is Heather. She is a nurse doing research about the emergency room. Would it be OK if she listens and makes notes about our discussions?" I was initially quite concerned about how this would interfere with the triage assessments, but this brief introduction usually took only seconds. During all of my field observations, not one person refused or even hesitated to give their verbal assent. When I was observing in the triage area, I would sit just off to the side of the triage window. In this way I could observe and hear all of the nurses in this area, and not be in the way of the interactions themselves.

After several days observing only in the triage area, I began to first go back to the monitored treatment area to see if any women with cardiac symptoms had been admitted there. Interestingly, many times there would be only men in this area with cardiac symptoms. Not once did I arrive when the monitored area had only female cardiac patients. If no women were present there, I would proceed back to the triage area to observe. If there was a woman present, I would obtain the consent of the nurses and physicians working in this area so that if they had an interaction with her, I could observe. I also would have the nurses obtain a verbal assent from the patient prior to my observation. If a woman arrived

at the triage area with cardiac symptoms, I would follow her back to the treatment area, and obtain consents from the nurses and physicians there to observe their interactions. The nurses or physicians would then obtain a verbal assent from the patient to have their interaction with her observed. Frequently women with cardiac symptoms were sent to the waiting room and did not proceed to the treatment area during the time I was observing and so I was not able to observe their subsequent interactions. I purposefully engaged nurses and physicians in a follow-up reflection of encounters that I had observed when this was possible. This was done to establish rapport and trust, and to look for further insights regarding the interactions themselves so that I might offer a fuller representation of the interactions in my writing. I frequently showed both nurses and physicians the notes I had been taking about the interactions, which often prompted discussions about the encounter.

I spent several three or four hour sessions shadowing physicians in their practice. I asked the nurses about who might be amenable to being shadowed, and they would first approach the physician. If they were agreeable, I would make arrangements to shadow them on that particular day, or a subsequent day. I was told by one physician that having a junior resident with him usually meant that his practice was significantly slowed down, and for him this meant that he would make significantly less money when he had someone like this with him. I learned that it was important to articulate that I did not want to interfere with the way they usually practiced, and that they did not have to offer me explanations of their thinking or their decisions during any period of observation.

Although I was quite apprehensive about my presence being intrusive in the department, my field observations proceeded very easily. I initially tried very earnestly to be aware of

how my presence was being received, but I found that as I relaxed about being there, the nurses and physicians did as well. I was able to perfect a short script that summarized my research when soliciting consents for the shadowing of nurses and physicians. I would make sure to tell nurses and physicians that I would not be offended at all if they asked me not to follow them into any given situation, or to let me know if they were growing weary of being observed. This never actually happened during all of my observations. I found that I was the one who would become quite exhausted after only four hours of observation. I had initially planned on spending eight hours observing at a time, and I found that this was just not possible. I made it clear to nurses and physicians that I did not want to be included in any given interaction, and that I just wanted to observe in order to minimize the impact of my presence on the interaction. There was the odd occasion when I needed to offer some assistance to the nurses or physicians, for example grabbing a gauze or oxygen tubing if it was needed in a hurry. A few occasions in the monitored area, I had to call the nurses' attention to an arrhythmia I had observed on a patient's monitor, but for the vast majority of the time I spent observing, I did not offer any assistance or comments at all.

I believe my observation of nurses and physicians proceeded as smoothly as it did because I began my shadowing with a nurse who was very positive about my presence, and eager to participate. She was obviously respected in the department, and she spent much of those first two days introducing me and my research to nurses and physicians in the department. The manager would also seek me out at various times in the department to see how things were proceeding. This manager was very well liked and respected by both the nurses and physicians in the department, and I think this was a distinct advantage for me.

She would engage me in conversation about the research in the department, and I think this too had a powerful impact on how my presence was received. The manager would often make a point of saying that I had worked in critical care for many years, in order to establish my credibility. I think it was also helpful that I bought pizza for the whole department on four different occasions. I also frequently brought in other goodies that I would leave in the staff room in order to demonstrate my appreciation for their continued participation.

Interviews.

Nineteen interviews in total were conducted for this project. Eight were with women who had sought care in an emergency room for cardiac symptoms, eight were with ER nurses, and three were with ER physicians. I completed all but one of the interviews with women in the second and third month of my field observations. Interviews with nurses and physicians were conducted in the fourth and fifth month of my field observations.

Consent forms were signed just prior to the commencement of each interview (see Appendix D). Participant confidentiality was again assured prior to the commencement of each interview, and the participants were reminded that at any time they could withdraw their consent for their interview to be included in my research. I made a point of watching for signs of fatigue, in particular for the women with cardiac symptoms, and if they appeared to be tired, I would ask them if it was reasonable to proceed. A few times I suggested that the interview be stopped because of this, and only once did the participant agree to stop the interview. No interviews were longer than two hours, with the average interview being one and a half hours in length. Interviews with ER health professionals as

well as women who had sought emergency care for cardiac symptoms were conducted on an ongoing basis during the time I was doing field observation. The field observations I had conducted initially informed my interviews with health professionals as well as women who had sought emergent care for their cardiac symptoms. The interviews I conducted with women similarly informed my subsequent interviews with health professionals.

Questions posed were open ended, and leading or restrictive questions were avoided in order for the participants to have the opportunity to provide the fullest account (Wood & Kroger, 2000). On occasion, a particular issue arose more than once during the interview, with different contexts, which allowed for the emergence of variability in accounts. I would actively construct follow up questions in response to participants' reflections. Holstein and Gubrium (1995) describe this as an important aspect of the *active interview* in which the focus is to reveal how responses are constructed in the interaction while attending to the meaning-making that is being presented.

All interviews were digitally audiotaped, and then downloaded onto a password protected confidential web space. The audio-tapes were then transcribed by a transcriptionist and reviewed by me. The transcriptionist was given the password to this space in order to access the interviews. After conducting the interviews, I made field notes in order to capture data that might not have been apparent on the audio-tape, such as non-verbal communication, participant appearance, and my perception of the content of the interview. Beginning interpretive notes were made at this time as well.

Interviews with Women.

The eight women I interviewed had each had an emergency room encounter for cardiac symptoms that resulted in a heart attack or an urgent angioplasty within the previous 3 years. All of the women had sought care in the emergency room for cardiac symptoms at least twice, and once within the previous year. Most of these women had multiple ER encounters for their cardiac symptoms. These women ranged in age from 46 to 68 at the time of their event, with three of them being in their 40's, two in their 50's, and three in their 60's. All of the interviews with women who had sought emergent care for their cardiac symptoms took place in the participants' homes.

I began each interview with a description of the purpose of my research, but ended this introduction with a statement such as "I want you to talk to me about what stands out for you in your experiences in getting emergency care for your cardiac symptoms. I don't want you to try to figure out what it is I want to hear, I just want you to tell me what was significant about this for you." Each of the women I interviewed had experienced either an acute myocardial infarction or an emergency angioplasty. I asked them to begin thinking about their experiences by thinking back to the months leading up to this event. What I heard during these interviews was surprising and revealing. The interviews revealed much of the complexity behind their decision to seek emergency care, but also revealed much about their self-understandings of themselves that were shaped, mediated and constrained by the resources they elicited to tell their story.

In conducting the interviews, I drew on Holstein and Gubrium's (1998) description of "narrative practice", a term they use to describe the act of storytelling while attending to

resources used to tell that story, as well as the contexts in which they occur. This practice considers the “hows” and the “whats” of narration as previously described. This way of viewing the narrative in the interviews, allowed for insight into how participants actively constructed their personal accounts, but also how their accounts themselves and ultimately their experiences and self understanding are constrained by certain ways of knowing or “conceptual limits” (Holstein & Gubrium, 1998), for example those set by institutional settings such as the hospital.

The context in which these interviews took place with women who had sought emergency care for their cardiac symptoms is important to consider in their analysis. All of the participants were acquainted with me as the nurse facilitator in the Woman-to-Woman Cardiac Support Group. Each of the participants was aware of my interest in women’s heart health, and of my fourteen year history of facilitating this group. These women were all comfortable speaking with me, as they had all done so on numerous occasions in our monthly meetings as well as other times they might have phoned me for information or reassurance.

They all spoke to me knowing I was a health care professional, and yet my relationship with them could not help but make this encounter much different from a typical encounter they might have with a less familiar health care professional. This potential conflict is resolved by using the active interview in this research method, as previously described (Holstein and Gubrium, 1995). This interviewing process is active and dynamic as meaningful stories are created collaboratively between the interviewer and the respondent, where both are involved in the interpretive process. The familiarity the participants and I

had with each other in this sense did not take away from the authenticity of the stories, as might be understood from a more positivist perspective. My relationship with them could be seen as allowing me to invite and assist the participants in their narrative production in ways that might not otherwise be possible.

Representativeness of the participants from this viewpoint is not the primary concern. According to Holstein and Gubrium (1995), attempting to select participants that might be representative of a population is not necessary from this perspective, as people can each bring their individual perspectives which are all equally worthy and richly multifarious, which can provide insightful interpretations of experience.

Interviews with Health Professionals.

Like the interviews with women who had sought emergent care for their cardiac symptoms, all of the interviews I conducted with nurses were in their own homes. Of the three physician interviews I conducted, one was done in hospital, and two were conducted in their offices. I had originally contemplated trying to do some interviews before or after my observation times in the ER, but time constraints on these professionals made it almost impossible to do so.

In the interviews with health professionals I was attempting to activate their narratives regarding their everyday practices, including their practice in the care of women with cardiac symptoms (Gubrium & Holstein, 2009). All of the nurses and physicians were familiar with me from the time I had spent observing their practice, as I had shadowed almost all of them at some point. I previously had conversations with all of them regarding my research, so all were somewhat acquainted with the premise of my research. I began

each interview with the question regarding why they had been drawn to emergency care, in order to open up the dialogue regarding how they saw their practice in this environment.

The narratives I elicited in the interviews with both health professionals and women with cardiac symptoms were mostly performed in the physical context of their private lives, and yet much of the narrative was about their institutional experiences. Holstein and Gubrium (1995) suggest that interviewees do not merely report their knowledge in an interview, that their knowledge is constructed from a diverse fund of knowledge, which is selected according to resources available to them and according to the context in which the storytelling occurs. The interviewee actively makes sense of their experience in their narrative, and they “activate” different facets of their knowledge and often shift their position during the course of an interview (Holstein & Gubrium, 2009). During my interviews with the participants, they would sometimes tell their stories from shifting points of view related to their various life roles. For example women often referred to their roles as wives, mothers, or health care recipients. The fact that I was speaking to them in their homes about their largely institutional experiences again is completely in keeping with Holstein and Gubrium’s notion of the active interview (1995). Indeed one of the goals of this kind of interview is to encourage the respondent to shift positions and explore alternative perspectives of a given experience. As the respondent constructs versions of experience within the context of an interview, they are not just describing something, they are accomplishing something, which is indeed at the crux in understanding the analysis of the active interview. In this project, it was the resources that the participants drew on to

depict themselves and their stories, and the way their narratives were mediated and constrained, that I wished to illuminate.

Data Analysis

No standard approach to discourse analysis exists, in that analysis is “data-driven” (Tonkiss, 1998, p. 250). Similar to other types of qualitative methods, the focus of the research, as well as the analysis evolved out of the data itself. Discourse analysis as such is “a fluid, interpretive process which relies on close analysis of specific texts, and which therefore does not lend itself to setting up hard-and-fast rules of analysis” (Tonkiss, 1998, p. 254). This type of research does not look for answers to a specific question, but it looks at the way meanings are constructed. The overall goal of the analysis was to explain what was being accomplished in a given instance of communication, how this was done, and what resources were drawn upon to accomplish this. Thus, the meaning-making process is actively documented by the discursive analyst. The goal was also to show how what was being said by the participants related to their experiences and their lives (Holstein & Gubrium, 1995). Analysis was directed at examining the way in which talk was used to present different pictures of reality, and not so much about examining the content of the discourse, or making claims about the ‘truth’ of the reality presented (Tonkiss, 1998). As well, analysis was not aimed at finding a “representative overview” of discourses in ER encounters for women with heart symptoms. Analysis was directed at examining how language was used to construct a certain version of events, and to demonstrate how particular attitudes were shaped, reproduced and legitimized within their narratives (Tonkiss, 1998, p. 253). Contradictions, varying frameworks, the way in which larger

discourses were taken up, contested, and resisted, as well as the way in which certain things were emphasized, downplayed or missing completely, were examined in the specific instances of communication offered in the data.

Interpretive context was considered in examining the texts. For example, the dominant position of the health professional in ER encounters offered an opportunity to examine power relations implied by the participants' speaking position. Small scale contexts were also considered, for example the ER surroundings in which the discourse took place, the nature of the relationship between speakers, the type of interaction, and the immediate goals of the speaker (Tonkiss, 1998). These contexts would be described by Holstein and Gubrium as the 'hows' of discourse analysis (1995). The final analysis interpreted the data in a way that brought to light the way in which the identity, understandings and practices both for women with heart symptoms, and health professionals were constructed.

The units of analysis in this study were the texts and audiotapes generated in audiotaped interviews, and field notes made from direct observation. Analysis of the data began with interpretations done during field observations, with the reading and rereading of field notes, and with the generation of interpretive writings done after field observation. Data from interviews was initially analyzed with the listening and re-listening to the audiotaped interviews, and then with the reading and rereading of the transcribed interviews and field notes in order to become immersed in and very familiar with the data (Wood & Kroger, 2000) The aim of this initial reading was to identify specific areas of focus and sections for analysis (Wood & Kroger, 2000). Data was first organized into preliminary categories using HyperRESEARCH software. Analysis began with the recognition of obvious

categories. Variability as well as what was missing was considered in analyzing data. Multiple functions of discourses are common, so any segment of text revealed that it fell into several categories as analysis proceeded. A *strategy of reversal* was used in which segments of text being analyzed were examined if they stood out or presented a problem (Wood & Kroger, 2000). As analysis proceeded, areas for analytic focus were refined. All data relevant to a particular topic or concern was brought together so further analysis could begin. The large amount of interview data that was gathered for this project made the use of the Hyper RESEARCH software invaluable, as it was possible to pull up all of the excerpts relating to a given category in a report. A great deal of time during analysis was spent linking the interpretations of the data to theoretical considerations, in order to ensure the analysis consistently aligned with the theoretical underpinnings of the method, and to look for new ways of theorizing about the data (ten Have, 2004, p. 11). I maintained a constant dialogue between the data and theory as suggested by ten Have (2004), and it was this moving back and forth between the theoretical and the empirical that took up the vast majority of time spent in analysis. The analysis not only alternated between interpretation of the „hows’ and the „whats’ in the data (Holstein & Gubrium, 2005), it alternated between the theoretical and empirical, and this process required a great deal of time and vigilance.

The following is a summary of the approach to analysis that was used as described by Tonkiss (1998, p. 257-258):

- *Using key words and themes* – data was organized into key categories of interests, themes and terms using hyperRESEARCH software. Analysis then became a process of sifting, comparing and contrasting the different ways in which the themes

emerged within the data. The text was read to determine if certain ideas or representations clustered around them, to look for associations being established, or for particular meanings being mobilized.

- *Looking for variation in the text* – Differences within an account pointed to work that was being done to reconcile conflicting ideas, to cope with contradictions or uncertainty, or to counter alternatives.
- *Reading for emphasis and detail* – Patterns of emphasis within a discourse were looked for, as well as the use of taken-for-granted notions.
- *Attending to silences* – Discourse analysis requires the reader to read *against* the grain of the text, so silences or gaps were attended to in order to make conjectures about alternative accounts that are excluded by omission, as well as those that were countered outright.

Rigour.

Numerous frameworks exist for assessing the rigour of qualitative research and many authors stress the importance of using terms and criteria to describe and assess rigour that are consistent with the often subjective, creative and interpretive nature of qualitative inquiry (Creswell & Miller, 2000; Emden & Sandelowksi, 1998; Emden & Sandelowski, 1999; Meyrick, 2006; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Wood & Kroger, 2000). Central to the application of any criteria for rigour, and in particular for this research, is the awareness that practices and understandings in health care may be influenced by the research findings. The “goodness” of the research is therefore paramount (Emden & Sandelowski, 1998).

The following is a list of strategies I adapted from a framework developed by Morse, Barret, Mayamn, Olson & Spiers (2002) and Creswell (1998) to establish rigour by shaping and directing this research:

- *Methodological coherence*: Is the research method congruent with the question? In this project, I would make frequent checks to ensure that there was coherence between the question, the theoretical perspective of the method, as well as data analysis strategies as previously described.
- *Appropriate sampling*: Participants who had knowledge regarding the research topic were chosen purposefully, as previously described, in order to best address the research topic. Cases which did not fit the developing interpretations were included in order to represent alternative views. Sampling continued until sufficient data was gathered as previously described.
- *Prolonged engagement and persistent observation*: Field observation occurred over a period of six months, with a total of 96 hours of field observation. This prolonged engagement allowed the researcher to develop the trust of the participants and understand the context in which the observed discourses took place. Interpretive writing was done with reference to the field notes after each session of observation in order to capture beginning interpretations.
- *Peer Review*: Ongoing analysis was periodically reviewed with the research supervisor. Written accounts were made of these review sessions.
- *Congruence between data and analysis*: Data was collected and analyzed concurrently. Ideas that come out of the emerging interpretations were compared to

existing text, and this “checking and rechecking” through theoretical thinking about findings, contributed to reliability (Morse et al., 2002, p. 13). This is important in discourse analysis because interpretations and arguments are developed from close attention to the text itself. In this project, research claims were supported by a very thorough reading and rereading of the data. Audiofiles of the interviews were reviewed many times over during the period of data analysis while reading the written transcripts and making hand written notes in the margins. I repeatedly listened to the audiofiles as I coded the data using the HyperRESEARCH software. Theoretical written memoing was done on an ongoing basis to capture emerging interpretations.

- *Researcher responsiveness*: A reflexive approach to discourse analysis was implemented, where I remained open to other critical insights, questions and assumptions. I also maintained a critical examination of the effect of the research process itself. For example, I tried to maintain an awareness of the potential effect of my presence in field observation. I tried to include reflections regarding my own assumptions and understandings as analysis proceeded. I also attempted to maintain an orientation to the theoretical framework during data gathering and analysis.

Reflective written memoing was used to capture these insights.

I also used criteria developed by Wood & Kroger (2000) to establish standards for rigour in outcomes of this study:

- *Coherence*: Analysis proceeded in a way that would give the reader a sense of how the discourse fits together and how discursive structure produced effects and functions.
- *Plausibility*: Claims made in the analysis were examined to determine if they seemed acceptable and persuasive or “seemingly true”. The claims were examined to determine if they made sense in relation to other knowledge, for example other studies that had examined the emergency room encounter, as well as studies that had used discourse analysis to examine health care encounters.
- *Fruitfulness*: The research was examined to ensure it had scholarly merit and meaningful implications. This has been addressed in the literature review, the discussion chapter, as well as the chapter regarding implications for practice.

Memoing was an important strategy used in developing an “audit trail” for developing interpretations (Emden & Sandelowski, 1998). I kept a written journal with me to record developing ideas and interpretations that occurred to me on an ongoing basis as I proceed with this research. I made ongoing notes after meetings with my supervisor and supervisory committee members as well.

Ethical Issues

I initially met with the manager of the Emergency department, introduced myself as well as the proposed research, and was able to get tentative approval to do field observations in this department. A copy of the *Application for Scientific, Administrative and Ethical Review of Clinical Trials/Health Research* form (Office of Medical Bioethics, University of Calgary and Alberta Health Services, 2007) was then forwarded for approval to the

Research Coordinator for the Emergency department. I then met with the medical research director of this department, as well as the research coordinator to explain the nature of this project. I submitted a copy of my proposal as well as my ethics application to the manager, the medical research director, as well as the research coordinator for department approval. After obtaining this departmental approval, the application was reviewed by the *Conjoint Health Research Ethics Board of the University of Calgary* and found to be ethically acceptable.

Protection from Harm.

During field observations, I remained very sensitive to avoid obstruction or interference with the care of anyone seeking treatment. In order to represent observed instances of interactions in my findings without the blaming or shaming of the health professionals, I purposefully engaged the health professionals in discussions about the interactions I observed, both in informal discussion following the interaction when it was possible, and during my formal interviews with them later.

No participants became emotionally distressed during an interview, but I did have contact information for a local counseling service that could provide emergent drop-in counseling if necessary.

Informed Consent.

Written informed consents were obtained from all participants who were interviewed (see Appendix C and D). Written consent was obtained from all the health professionals I shadowed in the Emergency Room (see Appendix E). Verbal assent was obtained from clients and health professionals who had been observed in the ER, and about whose

encounter I wished to make field notes. Field notes were not made for observations of patients or health professional until verbal assent had been obtained, or after the written consent for shadowing had been obtained. Participation was completely voluntary, and all participants were advised that they could withdraw from the study at any time without penalty. Periodic „check-ins’ were done to ensure ongoing consent from participants who were observed and interviewed (Cutcliffe & Ramcharan, 2002).

Right to Privacy.

To ensure anonymity, participants were assigned a code number or pseudonym for any written data and interpretive materials. A code book with participants’ names and pseudonyms remained in a locked filing cabinet. No names were recorded on tape or on typed transcriptions of the interviews. Data from interviews, in the form of excerpts, was used in presentation of findings and for teaching purposes, but anonymity was protected.

All hard data was kept in a locked file cabinet to which only the researcher and her supervisor had access. Computer files containing data were also secured with a password. Audio-recordings will be erased at the completion of the study. Transcriptions of the interviews will be stored in a locked file cabinet and will be kept for five years after termination of the study. A summary of the results will be sent to all participants who request a copy. This provision for requesting a copy was included in the consent form.

Limitations of the Study

Several limitations need to be considered before interpreting the results of this study. Participants in this study included women who had sought help in a formal self-help group who may share some unique beliefs or practices that distinguish them from other women

who experience heart disease and do not seek this kind of support, and this might be seen as a limitation of this study. It may have been beneficial to interview women whose care seeking experiences I had witnessed during my field observations, but as mentioned previously, this was not possible.

Another limitation of this study is the limited number of physicians I was able to recruit for interviews. The hesitation of physicians to volunteer for an interview was something I had not anticipated. However, as previously explained, representative-ness of participants is not a primary concern with this method (Holstein & Gubrium, 1995).

This study may have benefited from audio recordings of actual instances of communication in the emergency room, similar to the study that was conducted by Dunston et al. (2008). Detailed field notes were made, but there was much rich data that was not captured as might have been with audio-recordings of real time interactions. The fact that there were no texts from my field observations to include in the analysis made it more challenging to make claims about the instances of communication I had witnessed.

I believe that this study would also have benefited from the analysis of the documentation done by nurses and physicians in the ER. I realized very quickly into my field observations that I was not capturing the nurses' and physicians' interpretation of a given instance of communication. Analysis of nurses' and physicians' documentation could have also have helped to reveal what information they had chosen from the narratives of those seeking care, that is what "counted" as significant in this environment. I was able to access this indirectly from discussions held between health professionals as well as those

between patients and health professionals, but analysis would have benefited from this additional data.

The potential for insider bias may have been present during my field observations as well as my interviews given my previous experience working in this department as well as my many years working in this hospital as a nurse. However, I believe my previous experience served to establish credibility with the nurses and physicians in this ER, as they readily allowed me to shadow them in their practice.

The potential for bias also exists in my relationship with the women who participated in interviews, as they were well acquainted with me as the facilitator of their cardiac support group. However, the trusting relationship I had with these women served to strengthen rather than limit the credibility of the findings, as opportunities for discussing difficult topics was enhanced. Knowing the participants over a prolonged period of time also enhanced my understanding of the context of their private lives, and this provided the opportunity for stronger interpretation that adequately described their narratives.

The research process described here allowed me the opportunity to gather a great deal of data related to ER encounters of health professionals and women with cardiac symptoms. My prolonged immersion in the data allowed for certain insights to emerge. The following three chapters will provide a summary of the analysis of the field observations, interviews with women, as well as interviews with health professionals working in the ER.

Chapter 4

Looking Through the Slit in the Triage Window

The field observations for this study were conducted in the ER of a large urban tertiary care hospital over a period of six months, with a total of 96 hours of observation. The following interpretations emerged from rough field notes, then more refined field notes made following periods of observations, and also from interpretive writing that was done after most observation sessions. This summary includes some of the most compelling situations I witnessed over this time period that contributed to my reflection on the research questions. Many of the more mundane aspects of the ER are included to provide a fuller contextual view. Many of the anecdotes provided do not relate to women with cardiac symptoms as such, but offer some broad insights into the context of care seeking in the ER in general. My own reflections are also interspersed throughout to offer the reader a glimpse into the reflexive analysis used for this project. Beginning theoretical interpretations are also included with the empirical data presented here, and these interpretations are discussed again in the final chapter. Certain discourses revealed themselves in linguistic as well as non-linguistic ways in the context of the ER as will be subsequently shown. The opportunity to conduct these field observations first proved to be invaluable as I entered into interviews with health professionals later, as I had shadowed many of them during this time.

Performance of Identity that ‘fits’ Through the Slit in the Triage Window

After entering through the heavy glass doors at the entrance, those seeking care are first required to line up waiting to be triaged by a nurse, who will make a decision regarding

how urgently they need to be seen. The treatment area of the emergency room lies behind the triage window, and this area can only be accessed by the public through emergency room staff working behind this window. It is behind this window that potentially life saving treatment looms agonizingly nearby.

In order to be assessed and triaged, patients and their families are required to line up behind a red line some ten feet or so from the triage window. They are only allowed to proceed to the window when they are called or waved in by the triage nurse. Instead of bringing everyone in to the triage area immediately through the sliding glass doors, patients have an initial short exchange with the triage nurse regarding their reason for seeking care. This brief exchange at the window is observed quite closely by the other people waiting in line. They are required to speak through the slit in the glass window, which is there for the protection of the nurses, and very often the triage nurse needs to turn her head so her ear is in line with the slit in order to clearly hear patients' voices. This gives the evocative appearance of whispering a secret, or of whispering a confession to a priest leaning into the window of a confessional. For many whom I observed, it seems this was indeed a moment of confession: for not taking care of themselves or managing their risks, for doing something risky or foolish, for not having the capacity or resources to handle their situations themselves, or for being without a family physician to follow them.

The many apologies I heard during my field observations hinted at a kind of perceptual or cognitive dissonance experienced by many seeking care. Statements such as: "I waited as long as I could to see if it would go away", or "I really wasn't sure what else to do", or "my doctor insisted that I come here", or "I know I'm not as sick as some of these people", were

repeated over and over during my observations at the triage desk. These apologies seemed to reveal the tensions and even anguish behind their decisions to seek treatment in this hallowed place. It made me question whether they understood what was expected of them to be good custodians of their own health and good custodians of scarce healthcare resources, thus good and moral healthcare citizens who were worthy of getting treatment.

After the initial exchange at the triage window, patients seeking care would then be directed to enter the triage station through sliding glass doors that were opened from the inside by the triage nurse. Families were also allowed into the triage area as well at this time. Once admitted into the triage area, the patient, or the family member, depending on the condition or English proficiency of the patient, would then begin to tell their stories. Family members were always very eager to be present at the triage assessment. Their participation ranged from quiet observation to total presentation of the history. Many patients had difficulty with English and a family member would serve as the interpreter. Sometimes elderly patients were confused or had difficulty with memory and a family member would serve as the primary historian. I sensed that family members wanted to be there to advocate for their family member. Comments such as “she’s not a complainer usually so I know this is bad” or “I’ve never seen him like this” were often offered to the triage nurse taking this initial history.

The triage nurses were very proficient at summarizing their stories, although the patients would be frequently interrupted if they began to talk about things that were considered extraneous to the description of their presenting symptoms. If the nurse interrupted with a summary statement such as “So the first time you had this pain was....”, the patients and

their families sometimes corrected the nurse, but these kinds of corrections were rare. The exchange was usually very respectful on both sides. I was genuinely surprised at how few patients and families asked how long it would be until they would be seen by a physician at this point, perhaps because of the waiting room full of obviously ill patients who had been waiting a long time. I wondered if they felt that good or respectful behavior might get them seen sooner.

Many Urgent and Dangerous Issues Hung in the Balance

Three senior nurses were usually assigned to the triage area. Generally one nurse was responsible for the patients lining up at the window, that is, walk in patients waiting to be assessed. The second nurse was responsible for talking to ambulance drivers bringing in patients to assess their patients' acuity. The third nurse generally kept busy reassessing patients who were waiting in the waiting room. The nurses were exceptionally diplomatic in their interactions. They were calm and matter-of-fact for the most part and did not get drawn into arguments with anyone during my observations. The nurses were amazingly nonplussed at all of this drama going on around them. Again and again they calmly asked people to wait their turn behind the red line if they approached the triage window before they were called forward by the nurse who was at the window. They often gave each other knowing looks after a particularly difficult situation, but perhaps because all of their actions were being very closely monitored by the people waiting in line, they seldom went further than that. I often felt overwhelmed with how the triage nurses continued to deal with the never-ending flow of patients. I often felt a swell of pride for these fellow nurses as I watched them deal with these almost desperate situations with such dignity and composure.

The nurses seemed to have perfected a sort of veneer in order to deal with such an impossibly busy unit. Triage nursing, I was told repeatedly by nurses, was so stressful that few could perform this duty for more than four hours at a time.

I really was impressed with the constraint and control that the nurses and the people seeking care showed in this initial assessment in triage, almost as if they both realized that this situation was outside of their control, and the high stakes context of the situation demanded that neither should do anything to make the situation worse. Or perhaps it was that patients and their families understood the importance of this moment, and that this audience they were given with a health care professional was not to be squandered. This initial assessment felt strangely like a job interview, where patients were trying to present themselves as deserving candidates, hoping they would be short listed in order to get the treatment.

The beds reserved for psychiatric patients were just off to the side of the triage area, and these beds were almost always being monitored by security officers in case of any dangerous behavior. Paramedics bringing in patients via ambulance were required to report to one of the triage nurses before a decision was made regarding whether the patient needed immediate treatment, or whether they could wait, which most of them did after this initial reporting, in the hallway just outside of the treatment area. Many times this long hallway had as many as ten to fifteen paramedics attending to their patients until a bed in the treatment area became available. These paramedics could frequently be seen taking their patients to the washroom or offering them something to drink. They did not seem to get any preferential treatment in getting their patients into the department to be seen so they could

leave. The paramedics were required to give a regular report to the triage nurses as to the condition of their patients, so there was an almost constant stream of paramedics waiting to speak to the triage nurses. The noise, the movement of bodies and equipment, and the security features built into the triage area, were a constant reminder to health professionals as well as patients and their families, of how busy the department was, of how many urgent and even dangerous issues hung in the balance.

Emergency as a Place of Last Resort

Many patients were sent here from the cancer centre day care if they needed to be admitted but no beds were available for them to be admitted to in the cancer centre. Patients would also arrive from out of town hospitals or physicians offices because of the need for admission for specialized care. Often the nurses would have received no communication that these patients were arriving even if the specialist had been notified. Rarely were these patients able to be admitted directly to the hospital because of lack of beds, so they would need to be taken care of in ER until a bed became available. Many patients coming in said they had no family physician. On one occasion, a young woman being assessed in the triage area had been brought in by her supervisor with episodes of dizziness and numbness in her arm. Her face was so flushed that her color was almost a purple hue. Her blood pressure was very high. She had been trying to get a family physician for several weeks for these symptoms, and had been to this ER in the past week as well. "Don't bother giving me that list, I got one last week and none of them are taking new patients anyway" she said to the triage nurse who handed her this standard list of physicians' names who were taking new patients. She was sent to the waiting room to wait

as well. I was quickly beginning to see that the ER was not only the portal to the health care system, it was the place where patients gathered when they needed care and had nowhere else to go.

Precariousness Obscured, Accepted, or Revealed?

The line of people waiting to get to the triage window was relentless. Until these people in this initial line had been assessed by a triage nurse, they were still sort of on their own, and according to the triage nurses, until this initial assessment took place, the hospital did not have any legal obligations to them. This really did add another dimension to the context of ER encounters. One of the things that struck me was that this line up from the entrance door formed parallel to the waiting room of people who had already been assessed in triage and were waiting to get into the department for further assessment. This constant visual of the flow of people seeking care was seen not only by the nurses in the triage area, but by the waiting patients as well. From my perspective, this constant visual of people lining up for care could serve to accomplish certain things. For the people waiting in the waiting room, it might have been a reminder again of how busy the department was, of how many people were seeking the same care that they were. It could also provide an opportunity for waiting patients to size up their competition for getting into the department. The entrance of every patient who appeared more critical than they were could mean they would be spending more time in the waiting room. I heard many comments from patients and their families acknowledging their awareness of how sick many people in the waiting room were.

These people in the lineup were physically quite close to one another. They must have overheard conversations between patients and their friends or families as they tried to manage their symptoms or pain while they waited. Most of them maintained a very earnest and constant gaze toward the triage window. I developed the strategy of placing myself behind a pillar beside the window so as to be outside of the eyesight of people in the line. I found looking at the lineup to be quite disconcerting for me. I found myself trying to guess at what brought them here, and doing a distance assessment of them. A few times I actually walked past this line up to have a closer look, on the pretense that I was heading to the staff room. My clinical experience had taught me how quickly life-threatening situations could occur, and I had a hard time looking away. I could not resist making a closer inspection. It was easier to keep them out of my sight from behind the pillar. One of the nurses told me that most of them took the back way to the staff room just to be able to avoid the waiting room. It occurred to me that I was developing a strategy to deal with the professional dissonance I was experiencing, much the same as the staff nurses had, and that I would need to explore this in the interviews I would have later with physicians and nurses.

On one occasion a cardiovascular surgeon came to the department looking for a patient who had undergone coronary artery bypass surgery 10 days before, and had been sent to the ER at his request because this patient had been found to be in serious heart failure by his family physician. He had not been able to find this patient in the department, and came to the triage area to try and locate him. He was told that this patient was in the waiting room, and that there was absolutely nowhere to put him in the department to be assessed and treated. He proceeded to assess this patient in one of the two private assessment rooms just

off of the waiting room that had been constructed after a woman had miscarried in the waiting room of a local hospital, a room constructed to hide the messier more disturbing and situations from public view. A few minutes later he came back to the triage area to complete his orders for treatment and admission. To this he replied that he had never in his several decades of practice as a cardiovascular surgeon been required to assess and admit a patient from the waiting room. The nurses later told me that they felt it was good that he had experienced this, so others in the hospital would have a glimpse at what they were dealing with.

In two four hour periods of observation, the following patients with potentially very serious issues presented themselves and were required to wait for treatment:

- A woman in her 40's arrived with severe chest tightness. She arrived accompanied by her very distraught husband. She was receiving chemotherapy for breast cancer and was obviously very ill. She had no hair and appeared to be very weak. She had no cardiac history and was sent to the waiting room. Her husband came back a short time later to express his concern that this might be a heart attack. She was admitted to the department for treatment 90 minutes after her arrival.
- The husband of a woman in the line-up came forward ahead of others in the line to say that his wife had an angioplasty two months ago, and was now having severe chest heaviness. He was told to get back in line to wait his turn. The line-up of patients for the triage desk at this point was about fifteen people deep. Four of these patients in the line up were in wheelchairs.

- A young man in his 20's arrived with chest heaviness and aching, with radiation of the pain down his left arm. He had been profoundly fatigued for the past two days. He'd had the chest pain for three and a half hours at this point. His vital signs were normal. He was sent to the waiting room. At this point more than 20 patients were waiting in the waiting room. The triage nurse called a physician to start assessing patients in the waiting room.
- A middle aged woman with abdominal pain, nausea, and vomiting, came up to the triage desk several times asking when she would be getting into the department to be seen. Her pain was increasing, she was very pale and obviously in distress. She was frequently gagging into a basin that had been given to her when she was assessed in triage. She had been here since before I arrived several hours before. She was told it should not be too much longer. The triage nurses were unable to give her anything for her pain and nausea besides Tylenol, as the waiting room nursing role had not yet been introduced during this period of observation.
- A man arrived by ambulance with atypical back pain that started while he was exercising in a cardiac rehabilitation facility. He had suffered a heart attack a few months before. He had taken two Nitroglycerines and his pain had been relieved. He too was sent to the hallway to wait with the paramedic.
- An extremely obese woman arrived with advanced cellulitis of her abdomen. Her oxygen saturations were low, and she was having difficulty staying awake as she gave her history. No beds were available, and she was sent to the waiting room. She

was asked to sit in a chair just opposite the triage window so the nurses could keep an eye on her.

- A 45 year-old woman arrived with a history of hypertension and diabetes. She arrived with facial drooping and she was unable to blink her right eye. Her blood pressure was normal at this point, and she had no other obvious neurological symptoms, so she was sent to the waiting room.
- A 60 year-old man came in with a previous history of transient ischemic attacks and atrial fibrillation. He had double vision, a headache, and was short of breath. He told his story with amazing calm. His oxygen saturations were normal, his pulse was regular, and he was sent to the waiting room.

By 1445 on one particular day when I arrived to observe, there were 24 patients in the waiting room waiting to be taken into the department. Twenty-two of the 56 beds in the treatment area were occupied by patients waiting for hospital admission. There were at least fifteen patients in the line up to the triage window waiting to be assessed; five of them were in wheelchairs because they were unable to stand. One nurse whom I had shadowed in the past looked at me as I arrived and said, “There are five chest pains in the waiting room”, as if she needed to acknowledge this as quickly as possible. I often felt that the nurses were eager for me to really see the kinds of things they were dealing with. This nurse later told me that she often felt ethical distress during times like this, and that she suspected this came across as anger to patients, and that “patients don’t see what we are dealing with”.

No beds had come available in the hospital, but a nurse from outside the Emergency department whose responsibility it was to find beds, was frantically working to decide

which of the patients in the ER was most in need of the few beds that were to become available. It was not unusual to have 40 of the 50 treatment beds in the ER occupied by patients waiting for a bed in the hospital. Several times during my observations, there were only five or six beds in the department that were not occupied by patients waiting for admission. The number of patients waiting for hospital admission was discussed frequently by nurses and physicians, and often this was offered to patients in the triage area as a reason for the long wait.

I had the strong sense that the nurses and physicians wanted the public to know about the limited resources they were dealing with. This was almost a sort of lobbying for their case, an act of politics. I wondered as well if these discussions helped to assuage the nurses' and physicians' sense of culpability for the incredible wait times patients had to endure before getting treatment. This was a sort of constant orientation to the limited resources they were being asked to practice within, and they seemed to be soliciting the patients' support with these repeated discussions. I wondered if this constant orientation to limited resources was changing the nature of their practice, if this was turning their attention away from the patients themselves. I wondered what the effect these discussions were having on the patients themselves. I wondered what effect this was having on the construction of their understanding of their health or themselves, or on the health care encounter itself.

Enduring Professional Dissonance: Surrendering to the Peril

During the course of any period of observation, I would hear the stories of so many patients with concerning symptoms. I had a very difficult time letting many patients out of

my sight whose history I had heard in triage. My experience with critically ill patients had taught me that many of these patients' conditions could deteriorate into life threatening situations in a very short period of time. The triage nurses would try valiantly to continue to do reassessments of the people waiting for care in the waiting room on a regular basis. During my observations however, the time between reassessments was often several hours. I did not feel comfortable leaving these patients in the waiting room to essentially monitor themselves until a bed was ready in the treatment area. I continued to be amazed at how few patients or their families complained about the extensive waits before a treatment bed was available. During my observations, I would pass by the waiting room at times just to view how patients were coping. For the most part, patients would be just quietly and submissively waiting. Some would be lying down, some would have basins or bags to vomit into. Volunteers, when they were available, would make rounds in the waiting room to offer warm blankets and on occasion something to eat or drink. On occasion a volunteer might come to the triage desk to tell the nurses about a patient they were concerned about. The volunteers would also do a check of people waiting in line to see the triage nurse. Wheelchairs would be offered to those who had difficulty standing up, and on occasion a nurse would be called to check on a patient in line. I was told on more than one occasion that the volunteers or the staff in the admission department who sat just adjacent to the waiting room were very good at letting them know if someone needed help in the waiting room. My unease continued to grow.

The strain on the nurses at the triage desk was often very evident. I could see the nurses' posture changing as the unit became busier, a sort of stiffening of their posture, as they

would brace themselves for the overwhelming barrage of patients. I could see them straining to concentrate on one patient's story after another amid the cacophony of phones ringing, the multitude of conversations between staff, and the many overhead pages. The overhead pages were constant: "mop to 17" ; "housekeeping to 32"; "ambulance avoidance will be in place for the next hour", "Dr....to bed 45"; "nurse to bed 22". A bank of phones in the triage area was reserved exclusively for urgent communication with incoming ambulances and STARS air ambulance. With this advance communication, the appropriate team could be notified to be ready for the arrival of a critical patient (eg stroke team, cardiology team, trauma team etc). Paramedics could consult with physicians via these phones, so physicians would frequently be paged into the triage area to speak with these paramedics. In the case of patients with cardiac issues for example, electrocardiograms could be sent from the field to the ER for a physician to read, who could then order the appropriate therapy. If the ECG showed an impending MI, arrangements for these patients could be made for them to go directly to the angiography lab for emergent angioplasty immediately on their arrival to the hospital. It was possible for someone having a massive heart attack to be in the lab having their coronary artery opened within minutes of dialing 911, and potentially averting death or any permanent damage to their heart (Bogaty et al., 2004).

`Door to needle` time was one of the things that the computer kept tracked, meaning the time that the patient arrived through the doors of the ER to the time a needle was inserted for angioplasty. These phones had a very harsh loud ring, out of necessity, which only added to the urgency of the atmosphere. The ringing of these phones would frequently

require the immediate attention of one of the triage nurses. With each ring was the reminder that sophisticated life saving treatment was in their hands, and was one professional assessment away from making it to these patients in time. The work of these professionals was not just any busy day at the office; it was indeed about offering these patients life itself, and all the while the computer system quietly kept vigil on how efficiently they were working.

During the course of any period of observation, I could see nurses slipping into a sort of familiar, tired resignation, almost a surrendering to the craziness as the shift wore on. This all felt very familiar from my days working in critical care, when things would often start to get out of control, when I could do nothing but ride the wave of craziness, knowing that my practice was slipping into perilous territory where I had little control, knowing that people's lives could quite literally hang in the balance. Raw humanity was being displayed in such a public spectacle. I felt truly overwhelmed at times.

I was teased several times by nurses in the earlier part of my field observation for wearing a white uniform in such a messy place. All of the nurses wore a standard dark blue uniform, a color chosen to disguise the occasional splash of bodily fluids. I did in fact feel a little virginal, and not just because of the color of my white uniform. I was very used to dealing with critically ill patients, but in a much more controlled environment. I shopped for some darker colored scrubs shortly after starting my field observations. I felt as though I was quickly losing my innocence as I spent more time in this department where I had in fact started my nursing career. I realized that much of my reaction to what I was observing was related to the difference in practice I was witnessing, as compared to what I had

experienced as a staff nurse here more than thirty years ago. The incredible wait times the patients were made to endure before getting treatment was very significant for me. I felt an overwhelming sense of peril in the way patients were being managed because of the astonishing delays in treatment that patients endured as a result of the bed shortage in the treatment area. The stress I felt as I continued my observations in the triage area was unbearable at times, and I wondered how the nurses managed to maintain their composure. As patient after patient was sent to the waiting room by the triage nurses, it began to feel like a game of Russian Roulette. I felt sure that at any given moment, a catastrophic event would occur to one of the patients waiting for care in the waiting room.

I noticed that as the unit became busier, the triage nurses would give more detailed explanation to people as they were sent into the waiting room regarding the kind of symptoms to report to them. If a patient was not able to come up to the triage window on their own, they were directed to have their family members, or someone else in the waiting room to notify them of worsening symptoms. Each patient was given a brochure that clearly indicated the rules of engagement in the emergency department. This brochure indicated that patients with more serious health issues would be seen first, and that the potential wait for treatment could be significant. There was a description of what patients could do to make their encounter more efficient, and a space was provided at the front of the brochure for patients to be able to clearly articulate what their reason was for seeking emergency care. Patients and their families in this way were being conscripted to not only take responsibility for their status until they could be seen in the treatment area, but to learn how best to present themselves to promote efficient flow in the department. In this way

patients were conscripted to present themselves in a way that aligned with the biomedical perspective, as well as the institutional imperative of efficiency. Their first interaction with a health professional revealed another mechanism of power in the form of this brochure. Patients' self subjection to the discourses of biomedicine and efficient use of scarce resources was reinforced through this simple yet powerful mechanism.

Constant Threat of Impending Chaos

Patients had multiple points of entry into the triage nurses' domain: they could come in through the front door, they could arrive through the side doors from the ambulance bay outside the department, their arrival could be heralded by a phone call from STARS air ambulance or paramedics in the field through the bank of phones behind them, and of course they could become critical in the waiting room, where the nurses previously had no choice but to send them.

A video monitor of the waiting room was mounted above the triage desk, and the nurses glimpsed at it occasionally if there was someone in the waiting room they were particularly concerned about. The two computers at the triage desk kept a constant vigil on the status of the unit. Patients in the waiting room, patients in the treatment area, and patients who had been admitted to the hospital but were still awaiting a bed, were all displayed on a graphic representation of the unit. This computer monitor was almost constantly being referred to as the triage nurses worked to find appropriate places to treat patients. Discussions regarding the status of patients in the treatment areas as well as the waiting room, were unceasing, sort of a constant reassurance between health professionals that they were handling things appropriately. So too were the unending discussions about bed availability,

both in the department and in the hospital itself. I felt a constant sense that although any given shift was quite busy, it could get much, much worse. The threat of impending chaos, the potential needs of critically ill patients who had not yet presented themselves for care, always seemed to hang in the air. I felt and heard the ethical distress that these nurses and physicians were experiencing as they struggled to treat, and to delay the treatment of patients that they knew were ill and needed care. I knew I would need to talk to them about this in more depth in the interviews I would conduct later. More than once I heard nurses making statements like “I feel my license is on the line here”, suggesting that they were thoroughly aware of the high risk of an error in judgment or action that could jeopardize patient safety.

There was a constant flow of family members coming to the window to be allowed in through the security doors and into the treatment area where their family members were receiving care. Family members would be given a laminated green card during the triage assessment, which they would hold up for the triage nurse at the window to indicate that they wanted to enter the treatment area. Many times I saw family members submissively hanging back for several minutes, holding this green card in their hands, waiting for a moment when they could catch the eye of the triage nurse. The triage nurse would frequently need to press the security button to unlock the doors to the back for these family members, or other health professionals wanting to enter, as she was taking a history from a new patient. A loud buzzing sound would be heard with each entry as the large glass sliding doors would open. With each buzz, the nurses would often instinctively look up from what they were attending to in that moment. Waiting patients sometimes came to the window to

ask if they could have something for nausea or pain, to ask if they could eat or drink, or to ask how much longer it might be before they were going to be seen, but this was surprisingly infrequent. Families and patients watched all of this coming and going with a sort of quiet and submissive respect. Although you could see the anxiety in their faces, families and patients rarely interrupted the work of the nurses and physicians with questions or requests. I noticed that pleasantries often became abbreviated during this interaction when the department was very busy. The collegial patter that was sometimes evident in the unit between nurses, physicians and patients fell way off when the unit became busy. The interactions often became very business-like, and I observed that when the pleasantries were dropped, that this had a silencing effect on patients in the interaction. Patients and their families sort of backed off when the nurse was all business. Conversations would become minimal and efficient, both with patients and between health professionals.

The ongoing arrival of patients with serious health issues was never ending, and I felt my resistance weakening as time went on, a sort of surrendering to the reality that most would need to wait. Situations that had initially made me extremely anxious, began to look much less frightening. I could feel myself becoming lulled into a sort of numbed complacency as I let go of my need to be sure these patients were not in imminent life threatening danger. The triage nurses quite literally had no alternative but to delay treatment for most of the patients coming in for care, and this for me was becoming more and more acceptable.

I remembered my first few shifts doing field observations. My first reaction was that this kind of overwhelming precariousness must be somewhat of an aberration, but as my days observing wore on, I realized that this situation was the norm. My need to understand everything that was going on with critical patients in my care had been finely honed over more than two decades of practice in critical care, and this was not easy to relinquish. I had made a decision prior to commencing my field observations that ethically I would need to step in to say something if I observed something being missed in the care of patients, that there might be times where I could not be a silent observer. I let go of this notion very quickly. I witnessed so many patients being sent to the waiting room who had potentially very serious health issues that I quickly realized it would be futile to step in. It had been thirty years since I had worked in this department, and my practice in this place had been nothing like this. The acuity of the patients, the wait times before treatment, the lack of space to treat patients was monumentally different from what I had experienced. So many of the patients coming in for care were in peril because there was literally no place to assess and treat them. This was not safe practice, and I sensed that the nurses and physicians understood this only too well. The professional dissonance I felt was agonizing, and I would need to speak to these physicians and nurses about this later in my interviews. The atmosphere of this place required no linguistic explanation, as it revealed itself clearly in this high stakes environment.

CTAS Scoring as Safe Practice or Dividing Practice?

As my days observing in the triage area continued, I began to see how often the CTAS scores were referenced. CTAS¹ scores were assigned to each patient looking for care, scores that had been established as standards of practice from their professional bodies as time frames in which patients should be safely treated. These nurses in the course of a shift would steadfastly assign these scores to each patient seeking care, knowing full well that

¹ The Canadian Triage & Acuity Scale (CTAS) is a tool that enables Emergency Departments (ED) to:

- Prioritize patient care requirements

The CTAS allows ED nurses and physicians to:

- Triage patients according the type and severity of their presenting signs and symptoms
- Ensure that the sickest patients are seen first when ED capacity has been exceeded due to visit rates or reduced access to other services
- Ensure that a patient's need for care is reassessed while in the ED

The CTAS allows ED managers to:

- Measure the case mix (volume and acuity) of patients who visit the ED
- Determine whether the ED has an operational plan and the resources to meet patient needs
- Assess the ED's role within the hospital and health care region Examine patient care processes, workload, and resource requirements relative to case mix and community needs
- Examine patient care processes, workload, and resource requirements relative to case mix and community needs

The triage level assigned using the CTAS criteria is a mandatory data element to be used in all Canadian Hospital Emergency Departments for reporting to the [Canadian Institute for Health Information](#). (Canadian Association of Emergency Physicians' Website)

there was no way these patients would receive care in the time frame outlined by these guidelines. At many points in my observations the nurses informed me that there were several CTAS 2 or 3 patients in the waiting room that had been waiting for several hours to be seen, and these were patients who should be seen in fifteen or thirty minutes respectively. They would of course keep a closer eye on these patients, but the fact remained that they were not being treated in the time frame established by their professional bodies, and the computer system would ensure that this would not go unnoticed.

It occurred to me that CTAS scoring could be seen as what Foucault described as a dividing practice, that is practices that evaluate, judge, and categorize, therefore giving rise to normative notion. CTAS scoring could be seen as being similar to the 'examination' described by Foucault in *Discipline and Punish* (1995). The CTAS score, although not shared with the patient, directed the health care professionals to look at each individual in a particular way, that being how life threatening their situation was, according to strict biomedical criteria. Of course this made intuitive sense, because this was the mandate of the ER. However, I wondered what else was being accomplished with this standard way of assessing patients. It appeared as if their practice and their gaze were being disciplined to align with strict biomedical criteria. The assessments made of the health of clients were almost exclusively from within a very narrow biomedical perspective. With every assessment, with every CTAS score specified by the nurses, was an orientation and reorientation to this biomedical perspective through their assessments and again through their written documentation. Each patient during their stay would be referred to in terms of

their CTAS score, so the identity of the patients became to a large extent, a product of this scoring technique. In this way nurses were being constantly conscripted to assess and describe the health of those seeking care in terms of the biomedical perspective.

The CTAS score also provided a reference point as to how soon a patient should be seen, and so efficiency was being tracked by the computer using the CTAS score as an indicator of the acuity of patients seeking care. Both nurses and physicians referred to patient's CTAS scores on an ongoing basis in order to make decisions about who would be seen or treated next, or how quickly a bed needed to be made available for those requiring more immediate attention. The self-subjection of nurses and physicians to the discourses of biomedicine and the institutional imperative of efficiency were clearly evident here, and a mechanism of power revealed itself in the CTAS scoring.

I wondered about all of the criteria that could be added to this initial assessment to make it more inclusive of all of the determinants of health, that would include patients' unique life circumstances and ability to manage their health, that would support the promotion of health, and perhaps reduce their future need to seek care in this place. And my eyes again took in the line of people waiting for care in the triage lineup, and again I was reminded of the context in which this encounter took place, and the circumstances in which these health professionals were asked to practice.

Computer Technology: A Mechanism of Power, A Form of Constraint?

The position of the triage nurse at the window during the interaction was also interesting. She would either stand or sit on a high chair while entering the patient's history on the computer. The patients would sit on a regular chair, so the position of the nurse was

always above the patient. As the triage nurses' brisk assessments and history taking were entered into the computer system, her gaze most often directed at the computer screen. Very often, the patients gaze also rested on the computer screen, so the computer itself appeared to be the mediator in this initial exchange. Each patient, including the patients waiting in the waiting room would have this brief history and assessment show up in a small box when the mouse was held over their name for the remainder of their emergency room stay. Decisions regarding how soon someone would be given a bed, or be seen by a physician were made based on this one or two line assessment.

The triage nurses took great care in making this one or two line summary succinct and accurate. Impossibly complex stories were distilled into this brief summary. The presenting complaint was always the focus of this assessment. Questions such as "What is the emergency that brought you in today?", or "What is it about today that made you want to come here?" were asked that focused attention on „the' presenting complaint. The nurses I observed were quite remarkable in their ability to flesh out the biomedical history that appeared to be salient to the presenting complaint. I was amazed at the triage nurses' ability to focus on this interaction with all of the craziness going on around them.

Once the patient had been "entered into the computer", there would be a detailed tracking of patients, including their time to treatment, time in the waiting room, discharge time, time from admission to hospital orders until the time they actually were admitted to a hospital bed. The acuity of the patients in the department was also tracked through REDIS (Regional Emergency Department Information System) according to the CTAS scores patients had been assigned by the triage nurse during the initial assessment. This system

connected all of the Emergency departments in the city, as well as all of the paramedics. This system would discern whether a given emergency department had reached its capacity to handle any more patients based on patient numbers and acuity, and staff available. An *avoidance* would be issued by the system to all of the paramedics so all ambulance pick ups would be directed to other emergency departments until the system discerned that the department could handle more patients. The ever vigilant computer system was in this way always there, safely detached from the human and emotional elements of this place, steadfastly keeping track of not only the acuity of the department, but its efficiencies as well.

After this initial triage assessment and history taking, the nurses would direct the patients and their families to go to the admitting area where they would be entered into the hospital computer system and get a hospital card. I was told many times over that patients could not be treated until they had been entered into the computer system, unless they were extremely critical. The patients were consistently warned at the end of this triage assessment that it might be several hours before they were seen. The nurses often suggested that they should go to get something to eat, or to make sure that the patient kept drinking while they were waiting. I wondered about the situations that might have prompted this regular warning. This truly was beginning to feel like a public spectacle of the strained nature of our health care system. No real explanation was necessary as to why the wait was so long as that was pretty evident from the many patients waiting to be seen in the waiting room. Very brief explanations were occasionally offered by the nurses.

Moments of Resistance

One elderly patient who came in with her daughter was particularly memorable. She had macular degeneration, diabetes, congestive heart failure, and had fallen a few times in the past few days in her apartment where she lived independently. Her doctor had suggested they come to the hospital to have her assessed for placement in long term care. The daughter was giving the history, which the nurse was dutifully entering into the computer. The daughter's voice cracked at one point and she said "this is really heart breaking to see her like this". She was referring to her mother who was just sitting there silently with her face in her hands. This moment for her mother was very significant. Her mother had just recently lost the last little bit of her sight and was about to lose her independence. When the daughter's voice cracked the nurse did look up, and I was able to see her recognition of what this all meant for the elderly woman. The nurse pulled away for a moment from the computer to see the humanity of the situation and her interaction with the two of them really softened.

It was moments like this that really made the nature of this encounter stand out for me. The daughter's voice cracking was in effect a moment of resistance to the institutional discourse of efficiency and the biomedical perspective. For the nurse looking up from her task at the computer, this was also a moment of resistance. For one brief moment, the meaning this encounter had for the individual and her life took precedence. For one brief moment the institutional discourses of efficiency, economics, and 'flow' were disturbed. Also disturbed was the biomedical discourse of obtaining an accurate history of symptoms in order to best treat this woman. For one brief moment, the constitution of this elderly

woman's identity was understood not only in terms of the prevailing discourses that existed in this powerful environment. For one brief moment, the meaning this moment held for this elderly woman was viewed in the context of her private life. I longed for more moments such as this as I spent more time observing.

I had the luxury of being an observer in this frenzied environment, a luxury I had never experienced as a practicing nurse. I was able to take time to reflect in the moment, to look beyond the tasks and responsibilities of these nurses. In my own practice, most often these kinds of reflections could only really take place in the lunch room, over coffee, or at home with my husband. I really did understand the pressures these nurses faced to maintain some sort of control in this chaotic environment, although looking at it as an observer with little ability to help them put me in a strange dimension that was extremely uncomfortable. More than once I felt embarrassed to be sitting there just observing when things became out of control. I felt shame at my position, but more poignantly, I could sense the shame that these nurses felt at having their practice so closely observed when they knew they were not practicing to standards they knew to be safe. Often in the lunch room after a period of observation, or in a rare quiet moment in the triage area, nurses would do a sort of debrief with me regarding things that I had observed. They were able to share the thinking behind their decision-making, frustrations they felt at how care unfolded for the patients, and many times it was an admission of fear for things that could and had gone wrong.

Moving scenarios would continue to unfold in my time observing. Many times patients and their families would see that I was moved and concerned by their stories, even though I did my best to remain a neutral observer. Very often they would continue to tell their

stories to me, and I would have to redirect them to speak to the triage nurse. The unrelenting flow of these stories continued to touch and disturb me. The discomfort I felt as I witnessed these encounters was profound. Many, many times I felt the ethical tension between speaking up regarding my concern with a particular patient, and remaining a silent and unobtrusive bystander who did not interrupt the *flow* of patients as I had promised the manager and medical director when I gained approval to do my field observations here. I felt the interplay between competing discourses, as well as my resistance, much like the participants in this emergency encounter. My practice for so many years had been directed by institutional rules and conventions, and I could sense my constant awareness, if not quite submission to the institutional rules of engagement for the nurses, such as the need to optimize patient flow. I would also need to pursue this in my interviews later on.

At one point I saw a young man waiting in line who was extremely pale, he was obviously short of breath, and frequently closed his eyes as if he was in great distress or dizzy. Again I was reluctant to say anything to the triage nurses as I was to be an observer of their patient assessments. When this patient did come into the triage area to be assessed, we found out he had been in an all-terrain vehicle accident and the vehicle had rolled over him. He had a large abrasion on his back and left side and he was having sharp pains in his chest. He said he felt like his abdomen was filling up and he could not catch his breath. I could not help but think that this young man very likely had a traumatic pneumothorax and ruptured spleen, and that we had let him stand in line for ten to fifteen minutes before being assessed. The nurses in the triage area immediately recognized how serious his injuries might be. He was taken by wheelchair into the department without delay after this initial

assessment. His heart rate was very high, and his blood oxygen levels were significantly low as well. I was surprised that he had not said anything while waiting in line, or that even other patients had not seen his distress and had him move to the front of the line. He looked to be about 20 years old and he appeared to be by himself. I could not help thinking that if this had been my son that I certainly would not have waited in line. I also could not help thinking that my son on his own would probably have waited his turn as well. This young man was trying very hard to be stoic, but when I quietly told him not to worry and that we would take care of him, he immediately broke down crying. I was reminded of how often in my career I had seen similar reactions to small acts of caring in critical situations. I had developed a habit of leaning in to a patient's bedside during life threatening situations, to whisper just a couple of words of reassurance into their ears. I had learned how easily I could be completely swept up in critical moments, and how easy it was to lose sight of the person themselves in my eagerness to offer life saving treatment. The moment this young man broke down in tears felt so authentic. I wondered if he had been trying very hard to present a certain version of himself in the triage area, perhaps one that he felt was appropriate or respectful. His suppression of fear and pain as he stood submissively in line waiting his turn for care was most certainly influenced by his understandings of how to behave as a health care recipient. His reaction to my reassuring words was immediate, as if he had been waiting for someone to recognize what was truly going on for him. This moment was touching, and yet disturbingly familiar.

Close Attention to How Presentations were Received

I began to see the attention patients seemed to pay to the nurses' reaction to their stories.

The following examples depicted this for me:

- A 30 year old man arrived who had several open lesions visible on his face and arms, as well as a large bandage on his leg. He said he was MRSA positive², and had recently been discharged from hospital after receiving treatment for his skin lesions. He said he had just been kicked out by his roommate and now had no where to go.
- A young man came in with abdominal pain and diarrhea. He had seen a physician two days prior, and was given a prescription for an antibiotic that he could not afford to fill and was now severely dehydrated. "Look at me, I'm a mess" is what he said.
- A man in his 30's came in who had discharged himself from hospital against medical advice three days ago, after having been admitted with three fractured vertebrae secondary to a fall he sustained while intoxicated. Some of the things he said were "I need a room, I want to quit drinking, I'm a bachelor, I'm having trouble taking care of myself".

² MRSA refers to a strain of staphylococcal bacteria that are resistant to the commonly used antibiotic, methicillin, and so these infections are very difficult to treat.

- A man in his 40's arrived with a severely infected tooth. "Dentists won't have nothing to do with me because of my credit" is what this man said. He had not been to see a doctor because he could not afford the antibiotics until he got paid on Monday. Now the pain was excruciating, he was having chills, fever and dizzy spells. The nurse had to ask many questions of him before he confessed to his financial issues.

All of these men were certainly in need of care, but more poignantly, all seemed very concerned about how their stories would be received. They seemed ashamed of their financial and personal circumstances that they now finally had to reveal when they desperately needed care. I continued to be aware of patients' need to present a certain version of themselves, or their need to perhaps gauge how their stories were being heard as they were speaking. Their submissive posturing, the often downcast eyes as they told their stories, the vigilant attention to the nurses' words, the respectful demeanors that these men showed, seemed to almost get in the way of addressing their health issues.

The presentations of these men seemed to be a reflection of their understanding of what was acceptable in this environment. The stories that these men presented demonstrated how they had failed to align themselves with health care advice they had been offered, and now their submissive posturing and presentations, revealed their awareness of this breach of conduct in the unwritten health care seeking code. These men seemed to be hesitant in asking for care, an acknowledgement perhaps of their deficient deservedness for care. This moment of presentation in the ER, had no doubt been considered before they had made a decision to seek care here. I was struck with the fact that I saw very few women coming in

on their own as these men had with these kinds of desperate situations. I was reminded that I was observing patients who had made it into the ER, and that we needed to be aware of all of those who could not bring themselves to reveal their circumstances in order to get care. I wondered how many people continued to manage their serious health issues at home because of their reluctance to reveal their „breaches’ in this unwritten contract between health care provider and recipient. The powerful nature of this place could only serve to augment these potential tensions for those seeking care. It was the daunting atmosphere of this place that seemed to „speak’ volumes to those seeking care.

Confessions at the Triage Window

This brief initial exchange between the nurse and the patient in the triage area was emerging as a moment of great significance as I spent more days observing. For this reason, I spent many more days observing in the triage area than I had originally planned. I felt this was a significant moment for both the nurse and the patients seeking care as they both presented a certain version of themselves, and both seemed completely engaged in this encounter. The focus and the intensity from both parties in this moment of communication really demonstrated for me that this was a high stakes encounter, and yet I began to suspect that just as significant was what was not being said by either party.

For those seeking care, I began to wonder if this moment of *confession* at the triage window was for issues that were largely invisible, unrecognized, or perhaps just unacknowledged in this environment, even to the patients themselves, and yet may have been monumentally significant in how they arrived here. Confessions were offered for being poor, for being uneducated, for being old, for struggling with the English language,

for being at the margins of society for whatever reason. These types of confessions were rarely articulated by patients in my observations, but were often given away by their physical appearance, their clothes, and their manner of speaking and presenting themselves. These issues most certainly had contributed to put them in this place and circumstance in the first place and would surely serve to bring them back to *the window* another time. Many of these issues did not seem to make it through the slit in the triage window and into the nurses' ears however, at least they were never brought up by the nurses during my observations. These issues seemed to be missing in the discourse at the window and would become invisible in the two or three sentence assessment that was entered into the computer system on the patient's arrival.

I was aware of the smell of certain patients and their families as they entered the triage area. This was something I did not remember being so obvious in the hospital units I had worked on in the past. There were often cooking smells from their homes that still lingered on their clothing, or the scent of cigarette smoke. They often arrived with greasy hair and dirty or worn clothing, often with fur from their pets still clinging to their clothes. It was often obvious that they had not had time to make themselves presentable in such a public place, as might be expected in a typical health care visit. It was often very apparent that they had been torn unexpectedly from their private domestic lives. They still had the scent of their messy human lives on them that stood out in this clinical environment, scents of another reality that had not yet been cleansed off of them. They had not had the opportunity to disguise their realities before coming to this sacrosanct space that held the keys to life itself. I heard many apologies from patients and their families regarding their appearance,

as if they felt that their appearance was disrespectful, or perhaps that their appearance might negatively affect how they would be treated.

It occurred to me that in a sense their determinants of health were a little closer to the surface in this environment. The context of their lives in which they managed their health was a little more visible and this may be something that deserved our attention. The very fact that they had to seek emergent health care made this encounter somewhat more authentic and revealing, and less cloaked in the traditional rules of engagement in a health care setting such as dressing up. They had not had time to make themselves presentable. I remembered that the Chinese symbol for crisis was a combination of the symbol for danger as well as the symbol for opportunity. Perhaps these moments of health crises were indeed a moment of opportunity where health could be considered in a broader context.

In a sense, both the people seeking care and the health care system itself were exposing their vulnerable and fragile selves in this interaction. Each portrayed themselves as somewhat in control within the interaction through their careful and respectful demeanors. Each was influenced by larger discourses, resources, and contexts influencing their 'lives'. These influences were revealing themselves in varying ways. For the health care system: the scarcity of resources such as nurses, physicians, beds and the need to accommodate the never ending line of people coming in, the need to support patient flow was evident in the way the operations of the department were managed. It was patients' manner of dress and presentation that partially revealed their own resources or lack thereof. It revealed many of the determinants in their lives that influenced how they got here in the first place and would determine how their health and their lives would subsequently be affected and managed.

All of this complexity was reduced to a two line description while they waited....and waitedto be „seen’.

Patients at the Margins of Health Professionals’ Gaze

I spent several days observing in the monitored treatment area as well. If a woman with cardiac issues came through the triage area I would try to follow her back to the treatment area to observe the interactions. The patients’ beds in the monitored cardiac area were arranged in a circle around the central desk with everyone’s curtains opened most of the time unless a physical exam was being carried out. The patients and their families could see all of this movement of beds so they had a great visual of how busy the unit was. None of the patients in this area had their call bells next to them. I was told that because of all of the noise of monitor alarms and overhead pages, that they had decided to take away the call bells to eliminate one more ring to which the nurses would need to attend. I was told that patients or their family could call out if they needed anything. Most of the families sat quietly at the bedsides and rarely approached a nurse or physician for anything unless they came to the bedside.

The unit was very busy one particular night. Four patients came in all at once with a tranycypromine overdose, two of whom were unconscious and needed mechanical ventilation. Within fifteen minutes of these patients arriving, a man arrived with a complete amputation of his hand from a baler. At one point an “avoidance” was announced, which meant that the department would accept no more ambulances for the next hour, they would all have to be diverted to another hospital. This was an indication of how busy the department was.

A great deal of discussion occurred between nurses and physicians regarding who was on their way in and who was in a monitored bed that could be moved. There was constant negotiation with triage regarding the juggling of beds to accommodate new patients. Two of my nurse's patients were transferred to another area of the department to accommodate new urgent patients. There was a constant movement of beds, either patients going to diagnostics or moving to another area of the department. There was little communication with the patients regarding any of these moves, but this might have been because of the nature of my nurse's clients on this particular evening. It was as if this was just a given, that all of this movement was very natural. In my subsequent days observing in the treatment area, I realized that this constant movement of beds was the norm, as was the constant negotiation between nurses, physicians, and the triage desk regarding placement of patients in the treatment area, particularly those very precious monitored beds. Much of the communication between nurses and between physicians and nurses was held over a computer screen, with both of them checking the status of the department or individual patients' diagnostic results. This required that they have their backs to the patients themselves during these discussions, or when they were making notes on the paper chart or the computer. In the critical care areas I had worked in, I had been used to having my patients in front of me as I charted, or even as I discussed my concerns with physicians, so this felt significant to me. Again, it seemed as if the computer was the mediator in communications, now between health professionals in the treatment area. Attention again was being given to the computer, which not only kept track of patients waiting for care and results of diagnostics, it kept track of bed availability, which seemed to occupy so much of

the nurses' and physicians' attention. The direction of their gaze was revealing of what was capturing their attention, and this was viewed very closely by the patients and their families in the treatment beds surrounding this central station that housed the computers. This struck me as a sort of reverse panopticon as described by Foucault (1995), where physicians and nurses very clearly demonstrated what caught their attention and their gaze. These patients and their families appeared to be on the perimeter of the "going concerns" of this treatment area, and I wondered what this was accomplishing for the patients as well as the health professionals (Holstein and Gubrium, 1995, p. 493). This was also something I would need to pursue in my subsequent interviews.

Catching a Glimpse of my Own Constructed Identity

During an evening of observation in the triage area, a 70 year old woman was brought in by ambulance after a syncopal episode. According to the paramedic's report, she had had a ventricular fibrillation cardiac arrest in early August and had subsequently had a permanent intracardiac pacemaker/defibrillator installed. She had a large contusion on her forehead. This woman was brought into the department within a few minutes of her arrival at the triage desk, and I followed her into the treatment area. I had already obtained a shadowing consent from the nurse taking care of her in the monitored area so I was able to watch this initial nursing assessment after she obtained the patient's verbal assent. She deftly took down her fairly complex history while doing the physical assessment. Her assessment, like many others I had observed in this treatment area, included an assessment of the biological risk factors for heart disease, including smoking, hypertension, family history of heart disease, diabetes and so on. She questioned this woman regarding the details of the

symptom history that brought her here, as she was conducting a physical assessment, all of which was very typical of how an assessment proceeded once a patient was in the treatment area. Two other nurses were initiating an intravenous, drawing bloodwork, and connecting her to a cardiac monitor. Most of the care they were initiating was done with very minimal verbal communication with the patient, as was typical of the care I had observed here in any urgent situation. A technician had been called to do an electrocardiogram. Having several nurses attending to the patients in this way while this initial interview was being conducted was pretty typical nursing practice from my own experience as well as the practice that I had observed during my field observations. The admitting nurse gave this woman information about what the course of events would most likely be in her stay here. This 70-year old woman and her husband, like the vast majority of patients I have cared for, and like those whom I had observed in this environment, respectfully allowed all of these nurses and technicians to initiate this flurry of treatment with no comments, questions, or resistance.

I could see that this woman and her husband who accompanied her were clearly anxious, which was very understandable given her history. Both she and her husband were not only very compliant, they were very pleasant and appreciative in their comments. The primary nurse taking the history and doing the physical assessment was clearly a confident and experienced nurse. This nurse was extremely skillful, caring, and knowledgeable in her interaction. The caring demeanor demonstrated by the nurses had resulted in an encounter that felt urgent, yet compassionate, and this woman and her husband had responded by thanking the nurses for their care. I left this bedside feeling very good about the practice

and the encounter I had just observed, even though to someone not used to the pace of this environment, this might have seemed somewhat frantic. I understood that a patient with a potentially life threatening issue needed to have all of this care initiated as soon as possible, that this was not just about efficiency, it was literally about potentially preserving a life. The care offered by the nurses in this interaction reflected the importance of compassion in this encounter, but also of the essential importance of the skill and knowledge that these nurses were demonstrating. The respectful and appreciative reaction of this woman and her husband to the flurry of activity by the nurses, suggested an awareness of the significant technical expertise that these nurses were representing in their care.

I spoke briefly to the physician who was to care for this woman and also obtained his consent to shadow him in his interactions. The physician began with a physical assessment. He began questioning her about her history, wanting to have absolute clarity about her symptom history. He was very abrupt in his conversation with her, frequently interrupting her in an agitated manner. He said more than once in a loud and condescending tone “Listen to me!” Very soon both she and her husband were near tears and she was physically shaking. When he asked her to point to where her discomfort had been today, she started by pointing to her left chest and said “well the first time it was more over here”. The physician literally took her hands and very abruptly pulled them down to her side and said very loudly “I am talking about today!”. Her husband apologized several times saying that they both had some trouble with memory. He often held a shaky hand up to his forehead trying to articulate something that was asked of him. When the husband offered some information at one point, the physician abruptly held up his hand to him while continuing to speak to his

wife. At one point the patient turned to her husband and said “I really don’t feel as if I can live”. Her husband was very upset with this, and said that he had never heard her speak in that way, saying, “she’s usually such a fighter”. The physician realized how upset the patient was and did in the end try to comfort her, which I was very relieved to see. I exited the bedside with the physician, and two of the nurses that I had just been observing, were at the desk and had obviously heard this exchange. I can only describe their expression as one of shame. I did not have the courage to speak to any of them about this episode, and I never did. Much later in my field observations I learned that the encounter I witnessed was very typical of this particular physician’s interactions with patients.

I was quite honestly shaken by this encounter. This physician’s behavior was very much an aberration from the caring interactions I subsequently observed with other physicians. This was the first physician I had followed “behind the curtain” during my field observations, and I almost felt partially to blame for his behavior, thinking that my watching him had made him more agitated, or perhaps sort of grandiose in his interaction with her. We had a short discussion afterward and he very calmly spoke about how frightened she had seemed and wondered if the contusion she had on her head had created some foggiess in her thinking. He seemed to have absolutely no insight into how incredibly rude and abrupt he had been with this terrified woman, and the effect this had had on her.

I initially did not know what to do with this observation, as it was so disturbing for me. This was remarkable in particular because when I had talked to this physician initially about getting his consent to be shadowed, I had explained that I was interested in the

„interaction’, and that this encounter held a great deal of significance for women seeking care. I was tempted to leave this interaction out of my field notes, and then again, to leave it out of my final writing. On further reflection, however, this interaction felt significant to me, and I was compelled to include it. It was the difference in the two encounters this woman and her husband had had, first with nurses and then with this physician that was most noteworthy for me. This woman had very nearly lost her life just over two months prior, and both the nurses and this physician were very clearly aware of this as they began this encounter. I could not help but imagine how this very agitated and frightening encounter with this physician would subsequently affect how this couple sought care in the future. Perhaps the most poignant moment for me was when this woman said to her husband that she did not think that she could live, after being berated by the physician. I could not help but imagine how this couple was affected by this interaction, particularly as they continued to face a life threatening health issue that they would surely need to seek care for again.

I could not help but reflect on how this encounter could have proceeded in a very different way that might have left them feeling genuinely cared for and validated. This encounter truly distressed me, and I regretted not bringing this to the attention of administrators in the emergency department, or to even speak up in the moment. The most profound thing for me upon further reflection was my own silence. I myself was guilty of being complicit in this interaction by not speaking up. This interaction had left me with a hauntingly familiar sense of shame, not unlike the shame I saw in the faces of the nurses as I exited this woman’s bedside with the physician. I had caught a glimpse of my own

constructed identity as a nurse that was disturbing for me, and still not entirely surprising. The power relations in that moment were agonizingly revealed to me through my silence. This moment had harshly reminded me of whose interpretation of things, whose voice in this encounter really counted in the end. Although this encounter was an aberration from the usual caring encounters I had witnessed in my career and in my field observations, it served as a powerful revelation of the power relations that were most often hidden from view in health care encounters. I had been distressed by this observation, but like the nurses at the desk who overheard this exchange, I had not been entirely surprised.

I had been transported to countless similar moments in my career, which were now revealed in my silence and in my shame. The shame I felt was not only for the physician's behavior, it was for my own behavior. I was reminded of those moments when one of my young children had revealed an embarrassing truth about our family life in public. The construction of my identity as a nurse, the construction of my own practice, had been shaped in the countless everyday interactions I had had with physicians, many of which had elicited the same response I was now feeling. I was now orienting my behavior to align with the rules of engagement I had learned through my practice. The physician's voice held such sway that none of the nurses in this moment dared to challenge this situation. The "distant roar of the battle" had revealed itself in my silence (Foucault, 1995). I would need to reflect on this as I continued with this project.

Later this evening, a woman in her 50's arrived with chest pain and unstable angina. This woman had had 8 angioplasties over the course of the last 20 years, the first one at age 38. According to her husband, she had never suffered any myocardial damage with any of

these events, which was truly remarkable. This nurse was not as fluid in her interaction and was obviously less experienced as the nurse I had just observed. The patient however, was very adept at giving a history however. She was able to say how long the pain had lasted, where exactly it was and how it felt, how many Nitro sprays she used to control it over the past few days, and exactly what she had been doing at the time. She was very confident and fluid in describing her situation, as well as her previous medical history. She had an incredibly vigilant husband who was able to add great detail to her description of her history and presenting symptoms. I could not help but feel that he had something to do with her success in getting treatment in the past. She had had a few bouts of angina a couple of days earlier while on holiday in Manitoba and had taken it upon herself to drive back to Alberta with her sister so that she could be seen by her own cardiologist, as if she knew that she might not be heard in the same way by an unfamiliar physician. This woman was admitted to the coronary intensive care unit without cardiology first seeing her, because her cardiologist knew her very well and he had said over the phone “If she can’t control her chest pain I know it’s serious. We’ll just admit her”. He had been following her for these past 20 years. I was very impressed with this level of recognition he gave to her experiential wisdom, something that I quite honestly had not witnessed very often in my career.

On reflection, these two encounters I witnessed could not have been more different, even though both women were presenting with a serious cardiac history, and now very concerning symptoms. The older woman only had a two month history of heart disease, and was therefore new at presenting her history and making assessments of herself. Her

symptoms obviously terrified her. She and her husband were understandably very anxious about her situation, whereas the younger woman and her husband seemed to be confident that this would be addressed. These two women were side by side in the department, but had very different encounters even though they were probably equally critical. In a large part, I think the difference was because of the difference in their own resources and personal history, for example their knowledge, support, age, experience, confidence perhaps, as well as the difference in their ability to engage with the physicians and nurses. The resources which each of these women brought to the encounter seemed to be of paramount importance in terms of how their stories, and their voices, „counted’. All of the resources mentioned created conditions of possibility for not only their very different identities as cardiac clients to emerge, but for their voices to be heard as well in this environment. These two encounters that happened with literally only minutes between them, had monumentally different outcomes, and so much of this difference appeared to be in the way their self-presentations emerged.

Visibility of only Certain Emergencies

The nurse I was shadowing on one particular evening had three beds in the monitored area for which she was responsible. The first patient was a man in his late 70’s. It was 1900 in the evening when we first met him. He and his elderly wife had been in the ER since 1200. He had been having classic cardiac symptoms: dizziness, chest pain, and diaphoresis. He had been significantly bradycardic on arrival. His wife’s cane rested beside her chair, and she had spread out all of his medications on the bedside table. The first questions the nurse asked this patient were around cardiac physical assessment, that is, do you have any

pain, trouble breathing, nausea, and so on. His response to all of these was “no” and then, “I feel like I should go home”. Again later after the nurse had completed the physical exam he asked, “is there a chance to go home?” His wife became quite worried when the nurse suggested there might be a possibility for discharge, to which his wife replied “We’ll probably be back in the morning then”.

During the course of the evening the unit became very busy, so the nurse had little time to go back to this patient other than to glance at his monitor. At one point the wife asked the nurse if she should give him his 2100 medications. The nurse looked at the bubble pack with all of his medications and told her she had to check with the physician, to which the wife replied “can I give this over to you then?” I wondered if by spreading out his medications on the bedside table she was giving the nurses and physicians a visual communication regarding the complexity of his situation, and perhaps a glimpse into the onerous responsibility she felt with all of this. She may have been hoping someone would “take this over”. Around 2130 the nurse offered the patient a sandwich and soup. I had not seen his wife leave the bedside except for a few steps that were quite difficult for her. She had a significant limp and seemed to have problems with balance. I asked her if she had eaten anything, and she said she had not eaten since breakfast. She immediately changed the subject and began getting the food ready for her husband, so I did not pursue this.

The decision was made by a physician to admit this man. This particular scene I found very fascinating. The physician had actually spent quite some time asking them questions about family, their living arrangements, what family lived nearby, and generally what kind of support they had. From the conversation she had with them, she had discovered that the

wife was feeling overwhelmed. When this physician came out to tell the nurse that he was going to be admitted, the way she put it to her was “I can’t really find anything definitively cardiac on his ECG or bloodwork, but the symptoms are convincing and given his history I think he should be admitted to be watched”. There was nothing in the discussion about problems with coping at home. The nurse seemed relieved, although she too had never outwardly discussed concerns about this couple’s ability to cope at home. The conversation was completely from within biomedical terminology, although I strongly sensed that they had a mutual understanding of what the real issues were.

A short time later the wife went to leave. She was having a great deal of difficulty walking, perhaps because she had by this time been sitting in the same position for nearly 12 hours. I approached her and asked how she was getting home. She said she was driving herself and what she usually did was to steal a wheelchair to walk behind so she could steady herself more. I was very moved by this. We had easily spent several hundreds of dollars on diagnostics for her husband, admitted him to a very expensive bed for a somewhat vague diagnosis, and we were now sending her out in this vulnerable state without even the blink of an eye. How could this not have been addressed? How could we turn our eyes from this woman hobbling out with her most painful and unstable gait? This was an incredibly powerful metaphor for me. Here she was invisibly barely hobbling out of the department amid the hustle and bustle, barely keeping herself in balance, completely on her own, and all of this unfolding in a state of the art health care facility. Their life together was very possibly one slip, one hip fracture away from being completely dismantled, and then coming totally under the responsibility of the health care system. This woman did not

seem to capture the attention of health professionals in this environment, and yet in her world, she was on the very brink of a serious crisis in her life. The ability of this woman and her husband to cope in their private domestic world was in serious jeopardy, in a large part because of their diminishing health as a resource in sustaining their way of life. Where was the CTAS score that would capture this kind of a health crisis, a score that would allow it to become visible in their weekly report?

The CTAS score that each patient was assigned on arrival to the triage area was in fact a score of how impending their actual death might be, an indicator of their potential time left in the presence of a life threatening situation. The CTAS score was a measure developed to not only capture statistics related to emergency room use, it was used to launch our most sophisticated and aggressive biomedical expertise against an immediately life threatening situation without delay. Indeed this could be described as the very mandate of the ER. And yet this elderly couple's situation was not imminently life threatening, nor were the vast majority of patients who sought care here. However, it was easy to see that they were on the very cusp of an emergency in their own lives.

Constitution of Subjectivity through Subjugation: for both Health Care Provider and Recipient

My mind wandered to a scene not unlike that of a cardiac arrest, where all of the appropriate health professionals gathered around this woman and her husband to urgently assist them in handling their health issues within the context of their lives before she was allowed to go home, or even before he would need to be admitted to a very expensive acute care bed. Calls would be made, resources would be made available, because everyone

recognized how serious their situation was, how urgently they needed our help and expertise before their situation turned critical.

It seemed that it was not so much that health professionals in this environment did not care about this couple's circumstances or their needs, it seemed as though their gaze and attention had been captured by other more pressing concerns. I wondered if the constant attention paid to the computer and bed availability, with the backs of the nurses and physicians facing the patients for whom they were caring, the relentless arrival of critical patients who needed urgent and even life saving care, the astounding lack of space to actually treat people, served to cast a cloak of invisibility over this woman as she limped out of the department. Perhaps these things contributed to the woman herself wanting to remain invisible. This couple's situation at home, and ultimately their optimal health, did not really fall under the mandate of the ER. I wondered if the invisibility of "emergencies" like this again pointed to the way in which health and health care had come to be viewed.

I wondered if the physicians' and nurses' gaze had been disciplined to turn away from situations such as this in order to accommodate institutional goals such as efficiency and patient flow. I wondered if patients themselves also were being disciplined to behave in a submissive way in the emergency room. The removal of the call bells from patients' bedsides stood out strongly for me as a mechanism of power, where communication with nurses was controlled and patients' voices were silenced. The nurses' and physicians' rapt attention to the computer signaled the orientation of their concerns, their self-subjection to biomedicine and efficiency. These health professionals' practice and the way they demonstrated their understanding of who they were in their practice was being influenced

by their necessary and constant attention to the computer screen. Certainly, none of this had been deliberately contrived, but appeared to have emerged as a product of health professionals' self-subjection to the institutional discourse of efficiency, and this most certainly influenced the way health and health care had come to be understood in this environment. Most certainly these things would have implications for what was being achieved in the health care encounter itself.

The Context of the ER: Conditions of Possibilities for the Construction of Identity

The very nature of the ER itself made this health care encounter revealing of the resources that allowed health care to unfold in a certain way. It occurred to me that the ER was a site for the perfect storm. Limitations in the ability of individuals, as well as the health care system to manage health issues, revealed themselves a little more obviously in this site as compared to other health care encounters. On one front was the lack of resources: physicians, nurses, beds, access to diagnostics, and paramedics being taken away from their work to care for patients in the hallways. On another front were the patients arriving who had already fallen through the cracks of our health care system. In the lineup to the triage window were patients who had been discharged from hospital too soon, before they or their families were ready and were now returning through the ER for further care. In the lineup were patients with few resources and little support for their health issues, patients without family physicians, or other health professionals to follow them or to deal with health issues when they arose and before they became urgent. In the lineup were patients whose health had been viewed and addressed through the narrow lens of the biomedical perspective, while other significant issues affecting their health, or their ability to manage

their illness, had not been addressed, and they were now presenting themselves only after an urgent illness had arisen that they could not manage on their own. All of these fronts developed outside of this public view, outside of the mandate of the ER, but all came together in a very public spectacle here in the ER.

This public spectacle could not help but have consequences for the way in which people would seek help again in this place. This daily drama in the ER was frightening and intimidating for me, let alone for the people awaiting health care assistance. Not only were they required to stoically endure their symptoms while waiting for extended periods of time, they were required to do so in very public way, and in a very uncomfortable environment. This public spectacle almost demanded that patients include as part of the „discourse’ in ER encounters, a justification for being there to begin with. They seemed prepared to give evidence that they were entitled to care, thus the many apologies, the submissive posturing of most patients presenting their stories, the vigilant attention that seemed to be paid to what the nurses wanted to hear, and the incredible wait times that were endured with relatively infrequent complaints.

I could not help but reflect on the notion of morality that was beginning to enter my thinking about these encounters. For example, except for the most critical patients, the moment of confession in the triage area was always followed by the wait. What truly startled me in my observations was the submission to the process of waiting. They had made their confessions regarding their health, and now seemed accepting of their penance. For penance, they must now wait to gain access to care. They must gaze upon the others who also may have committed a transgression against their health. They must gaze upon

others with health issues perhaps much more serious than their own, of others perhaps more deserving of care. They must sit and wait and consider their circumstances. They must wait and consider the circumstances of others who are also waiting for care from a system that is so obviously overstretched. They must wait to be called. They must wait to be seen. Time spent waiting becomes a mechanism of power where bodies become „docile bodies’ under this disciplinary regime (Foucault, 1995). Waiting became an act of politics and economics: a regime of power made possible in part because of how health has come to be understood, perhaps in terms of morality, perhaps in terms of economics.

It struck me that what I might be witnessing could be the result of conflicting discourses that were called upon as resources in the production of identity and practices for both the patients and the health professionals. Scientific rationality and the biomedical perspective were clearly the prevailing discourses for health professionals in the emergency room as evidenced by nurses’ and physicians pursuit of an accurate history, an accurate diagnosis, and the initiation of appropriate treatment. Their reliance on the scientific biomedical view revealed itself clearly in that very first exchange in the triage area, where patients were first categorized according to the CTAS score. For patients, their stories of illness began to be reconstructed as a biomedical issue in this initial exchange. In that very first moment of contact with a health professional, the meaning of their illnesses began the process of separation from their private and domestic lives, to become an institutional dilemma requiring austere management that might only be rationally resolved through the efficient application of biomedicine, where their experiences of illness were disciplined to become a presenting complaint.

Self reflection and self regulation however, would seem to require the consideration of all of one's life circumstances in order to enact the practices of cardiovascular risk factor management within the context of one's complex private life. However, this broader, more holistic, more subjective and less clearly defined view of health would seem to be antithetical to the scientific biomedical perspective inherent in the discourse of cardiovascular risk factor management that health professionals relied on so heavily in their assessments of patients admitted with potential cardiac symptoms. Most certainly this broader, unscientific, untidy and unwieldy view of health would not fit well within the institutional discourse of efficiency and flow in the ER.

Rational behavior for the health care professional, from the scientific biomedical perspective, would require that they assess and offer treatments or counseling that would demonstrate an orientation to the discourse of cardiovascular risk factor management. Power is thus exercised in everyday activities in ER encounters through the dissemination and operation of this knowledge, which would serve to produce and sustain these everyday practices.

The institutional discourse of economics and efficiency also predominated in this environment. The valorization of only certain scientific evidence as well as the institutional imperative of efficiency was so clearly depicted in the nurses' and physicians' rapt attention to the computer screen which provided a constant update of the flow of the unit, as well as continuous access to diagnostic results as they became available. All of this attention was given to the computer screen while their backs most often remained turned to

the patients themselves. The content of nurses' and physicians' communication as previously described, also pointed to what counted as important in this environment.

An orientation to the significance of this encounter for the patient and their families seemed to be missing. For patients and their families, in particular patients with cardiac symptoms, coming to this place reflected that they were acknowledging the significance of their symptoms. This was clearly not an easy place to come to and, it was clearly not an easy place to continue to endure symptoms. The very fact that patients and their families were here indicated that they had surrendered to the possibility that they may need to access potentially life saving treatment. The forbearance demonstrated by patients and their families as they waited for care, in part, pointed to their submission to the significance of this encounter. Those waiting become "docile bodies" as described by Foucault (1995), which can be seen to arise as a product of disciplinary coercion, however invisible it might seem on the surface.

In this ER environment, health care professionals unconsciously left patients on their own to negotiate the divide between scientific rationality and the messy complexities of their private lives. Patients' descriptions of their life circumstances rarely entered into the dialogue in the emergency room. These inconvenient truths were left behind at the slit in the triage window. Complexities and the messiness of everyday life such as responsibilities inherent in their roles as wife, mother, or family caregiver, the presence or lack of financial resources, the unquestionable anxiety that their symptoms would generate in their day to day existence were missing in the discourse here. The complexity of all of the determinants of health which most certainly influenced women's health or their ability to maintain their

health, were not only resources in the production of identity for women seeking care for their cardiac symptoms, they were the invisible conditions of possibility which allowed these women's identities and practices as health care recipients to emerge in a certain way. This complexity was also what each surely would be returning to when they returned home.

The very fact that women needed to seek emergent care for their cardiac symptoms in this place meant that they recognized that their ability to sustain their private lives might be in peril, perhaps that their very lives might soon end. This too becomes a condition of possibility for mechanisms of power inherent in the everyday practices of health professionals in the ER to reign. The bodies of women with cardiac symptoms, more significantly their very lives, become a vehicle through which power is circulated in the everyday going concerns of the ER. I questioned whether health professionals in the ER ought to be obligated to attend to these concerns. Women seeking treatment for cardiac symptoms in the emergency room, along with others with a multitude of illnesses, were indeed waiting to be "seen". I looked forward to pursuing this in my interviews with women who had sought care for their cardiac symptoms, as well as the nurses and physicians who worked in this emergency department.

Chapter 5

Women Who Had Waited to be Seen

I had begun to see how significant the context of the ER was as I spent time observing instances of communication in this context. I had been overwhelmed with some of my observations in the ER, and I was anxious to hear women's descriptions of their experiences there. I was also anxious to hear nurses' and physicians' descriptions of their practice.

I entered into these initial interviews with the expectation that I would be hearing detailed stories about these women's experiences in the ER, with some examples of instances of communication with health care providers, perhaps with a description of how their understandings of themselves or their heart disease had changed as a result of this encounter. What I would hear in the coming interviews was a narrative that would help to illuminate the social construction of their identities and practices as cardiac clients, chiefly through the description of the complexities inherent in their everyday lives.

The Women Who Had Sought Care for Cardiac Symptoms

The following is a brief introduction to three of the eight women I interviewed who had sought care for their cardiac symptoms. All of the participants have been given pseudonyms to protect their privacy. Not all of these women's stories have been depicted in detail here, but all of their stories contributed to the overall analysis and the understandings produced in this project.

Each of the women I interviewed had experienced significant coronary ischemia at some point, and all but one suffered a heart attack as a result. Each of them had several

experiences in seeking care in the ER for cardiac symptoms, and all of them had been to the ER for cardiac symptoms within the previous year. Most often their interviews began with a description of the symptoms they had been having. The description of the events leading to their ER encounters always included a detailed description of things that were happening in their private domestic lives. Each of the women I interviewed consistently wove in descriptions regarding their concerns and responsibilities they had with their family, with a description of how they had managed their cardiac symptoms. Every one of the interviews with women who had sought care for emergent cardiac symptoms included a description of their resistance and even terror at assuming the new identity of someone with cardiac disease.

Sharon's Story.

Sharon is a 55 year old woman who was first diagnosed with coronary artery disease (CAD) after suffering a heart attack in March of 2002. At the time of her heart attack, she was 49 years old and was working full time as a social worker. She was married, and was the mother to two teenage daughters. Up until that point, she had had no serious health issues. She was admitted to hospital immediately after presenting to the ER via ambulance, and underwent a coronary angioplasty within hours of her presentation to the hospital. Within hours of her angioplasty³, she developed a serious retroperitoneal bleed⁴, and

³ A coronary angioplasty is a procedure where a catheter is inserted into the radial or femoral artery, and fed up into the coronary arteries, where a blockage can be opened through the inflation of a balloon at the tip of the catheter.

nearly lost her life. She had emergency surgery to repair a tear in the femoral artery that had been accessed during her angioplasty. Sharon spent several days in a critical care unit while she recovered from this experience that nearly took her life. She developed a major infection four days after being discharged from this initial event, followed by re-hospitalization for antibiotic therapy, and weeks of homecare to manage the wound. She would return to the ER within a few months with recurrent chest pain, and would subsequently have coronary artery bypass surgery.

The following is an excerpt from my interview with Sharon, when I had asked her about the circumstances around her heart attack:

I'd been exercising. I was a little tired but I attributed to the fact that I was working full time, the kids were teenagers I was running around getting ready for Katie's birthday that was coming up, Mike was out of town, which was the usual hectic life that everybody has so I didn't think anything of it so, but this was on about a Wednesday so I called the doctor and made an appointment for Monday to go see my family doctor to check this out. Well, low and behold Saturday, and as I say, the day before I had the day off, so I, it was a little more relaxed but I was shopping for my daughter's birthday at Chinook and then I had a perfectly reasonable night and I woke up the next morning at 8:30 and Mike was out for breakfast with a friend and I, as soon as I got up I started, I didn't feel well. I felt flu-ish

Sharon was able to call her husband just before she lost consciousness. Her husband arrived home within a few minutes to find his wife losing consciousness.

⁴ A retroperitoneal bleed is a potentially fatal consequence of femoral artery access in percutaneous angioplasty, where bleeding occurs from the femoral artery puncture site into the retroperitoneal space. (Farouque et. Al., 2005)

I think it was like a minute maybe (that I lost consciousness), I don't know because of course I was out of it and my daughter ran across the street and got our firefighter neighbour, who had just gotten off duty to come over because he has, so does Katie, they have basic EMT training so he took my pulse. I woke up and I remember lying there and Katie was going to clean up the mess, which I felt terrible about. Our dog knew to stay away, he kind of backed off and kind of had a feeling that something was going on. I woke up and Ryan, our neighbour, was taking my pulse and I heard him say something about, "it's very, very, low, it's extremely low." And they called the ambulance, they got there fairly quickly. ...So they came in and Katie called my daughter, who was at a sleep over and, my other daughter Claire, and she came tearing over and the next thing I knew I come to and I felt better because I, I think I had thrown up, I was losing the bowel control, threw up a bit. It was almost, you know like when you throw up a bit and it was almost like, you know, when you throw up you feel better. So I thought, oh well, it's the flu, it'll be fine. I don't know why I'm going to the hospital. But anyway, I'm on this gurney and they're taking me out, it was quite cold, it was March. I remember it was a snowy day like it is today and my daughter was standing there, my other daughter, watching me be carried out of the house on this stretcher and all the neighbours were there, all these people looking at me. And I, I was kind of stunned and I felt in shock and I they way I deal with that is I talk a lot, so I was blabbering on when I got in the ambulance about how my daughter wanted to be a paramedic.

In this previous excerpt, Sharon is describing her experience largely from the perspective of herself as a mother. Even as she is making sense of the symptoms she experienced in a near death experience, she is demonstrating a concern and awareness of where her family is in all of this. In presenting a story that was personally coherent for her, her orientation to her identity as a mother seemed to be equally important as her description of her symptoms. The description of her symptoms almost seemed to be secondary in her description of these events.

Much of her memory of this event seems to include descriptions of the reactions of others as they witnessed this event. In this interview, she presented her identity as a healthy

middle-aged woman who was preoccupied with concerns of her family and work, who suddenly had this new menacing identity thrust upon her. She was now a woman with a potentially life threatening illness, and this moment of revelation was being presented to her in a very public circumstance in front of her family and neighbors. Her description of this moment reveals her shame, as does the description of how she “blabbered on” in the ambulance. She talked about her busy life with her family with pride, but being someone with a life threatening illness was presented as a shocking embarrassment, and her resistance to taking up this new identity is revealed in the following excerpt.

***Sharon:** Yeah, that's all I could think about, that she wanted to be a paramedic and she could talk to them afterwards.and they were working on me and one was a student and I think they just wanted to tell this woman to shut up because they were trying to save my life. I mean it was my main artery, I found out afterwards, was 97% closed and they were giving me aspirin, they were doing an ECG, which they sent to the hospital and they had a, I think they had a nitro patch on me too or they gave me nitro, one of the two I'm not sure. My husband rode in the front and a neighbour of ours took the kids to the hospital. And we were tearing along and I was in the back and I thought, this is ridiculous, I'm fine, I'm in good shape, I can't believe this is happening.....Still in total disbelief, because I was good shape, I hadn't had anything more wrong with me than a cold or flu and um, never had a problem with my health and at 49, I was 49 years old, I just could not believe this was happening to me. It was just a huge shock and, of course, Mike was totally, he was so upset and so confused and traumatized but he went into take charge mode and he did that for the whole time I was in the hospital..... But I felt so bad for my 15 year old that she saw me coming out on the stretcher and I didn't even know she was there, I didn't even see her. She was standing there with a friend of hers, her friend was crying her eyes out and, this is the friend that's going to be the bride's maid in her wedding in January. And she was crying and Claire was just standing there in shock and I didn't even get a chance to say, you know, I love you or anything. But not realizing the seriousness of this that I could have died on the way to the hospital. So, I don't know it was just huge.*

Her own identity, as well as the identity her family had of her, had been dismantled in that moment, but her biggest concern in this description seems to centre around her

inability to fulfill her role as a mother, even guilt at having subjected her family to this trauma. This narrative demonstrates the lack of coherence regarding who she understood herself to be. Her own personal narrative had been abruptly rewritten for her, and she was left trying to make sense of the situation by *first* analyzing the impact this had on her family. It seemed as though in this moment her role as wife and mother trumped her need to assess the implications for herself.

Within this narrative, Sharon is also clearly linking her story to her past identity as a normal, healthy woman, whose concerns had not centred on herself. Her portrayal of herself as a healthy person who had this unusual circumstance happen to her may be reflective of her own struggle to accept the identity of someone with cardiac disease. Her description of the events around her heart attack, events that nearly took her life, is full of statements justifying that she had indeed done her best to take care of her own health. “I was in good shape” and “I just could not believe this was happening to me” and “It was just a huge shock and, of course” were examples of how she inserted her previous identity as a healthy woman. She describes those moments when she first began having symptoms:

1. **Sharon:** *Sometime that week, I don't recall because it was sporadic, it was once when I brought the groceries in and once when I was in exercise class. I remember those two times. It could have been other times but those were the two times I was aware and it was just a slight panging in my chest*
2. **Researcher:** *So at that time did it enter your mind that it might be your heart?*
3. **Sharon:** *Not at all.Because I was in such good shape, that's why.....So that masked me from maybe being aware of my body and thinking that it can happen to me. I hadn't smoked, you know, I wasn't over weight at the time, no cholesterol problems, always got a check up and always exercised since I was in my mid to late twenties ...*

4. **Sharon:** *But nothing, no, I always cooked really healthy for them. I wasn't always consistent and I ate as well because we had healthy food in the house*
5. **Researcher:** *So, in your mind, the way that you're making sense of this is the decision making, so you're listing off, you're thinking about the cardiovascular risks....*
6. **Sharon:** *I was aware of that, ... I'm the kind of person I'm very conscious about my health and I want to be the best I can be for my husband, for my kids, for me and now it's in a different order. I want to be good for me (laughter), and then for my kids, and then for my husband..... because I know they need me, right? As a mother, boy, you've got to be there for them so I was always aware of that and wanting to be in good shape and even though I hated to run to my exercise class at noon sometimes, I did it anyway. So,And my age...I was thinking this is for old men this is not for a 49 year old women.And also probably the fear, now that I think about it. You know when you reflect back you always think about other things, you're in denial often because of the fear. Like if I had realized at that point that it was very, very serious, I couldn't have coped. I was, all I can remember was lying on the floor and them getting me on the gurney was you, you get into coping mode, it's survival mode and it's where you have to block out everything else and you just have to, So I had to, I had to say to myself it's not that serious or else I wouldn't have been able to handle it and even now I think I do that ...It's very hard to put it as my identity because my identity was also being the healthiest person in the office at that point. I'm telling you, everybody else was out there smoking on their breaks, nobody was going to exercise, lots of over weight people and not coping well with stress and I always prided myself in being, my identity was caught up in me being very healthy and I prided myself in that So this was just out of my realm. I feel like God threw me a real zinger*
7. **Researcher:** *So to make that true in your head was to negate everything you believed about yourself?*
8. **Sharon:** *Yeah, yes,*

This excerpt reveals the tension that this participant feels in having to surrender her previous identity as a healthy woman. In excerpts 1-6, she described how she had difficulty assessing symptoms, even though she demonstrates that she understood that they might indeed be cardiac. As she is describing the way she reflected on the symptoms, it is

apparent that denying that these symptoms were indeed cardiac was more personally coherent with her identity as a healthy person. She continues to portray herself as a healthy person, and the justification for this aligns very closely with the traditional discourse of cardiovascular risk factor management. She ate well, she exercised, she was not overweight, she was only 49 years old, and she took pride in being “the healthiest person in the office”. Her narrative includes a description of various risks she knows to be related to heart health such as smoking, obesity, and sedentary lifestyle (excerpt 3). In my response to her I have recognized this and have encouraged her to expand on this by naming this as her recognition of cardiovascular risks (excerpt 5). She then responds by elaborating on her alignment with the discourse of cardiovascular risk factor management (excerpt 6), and frames this as a moral imperative as a good wife and mother.

Her description includes a great deal of detail regarding her healthy lifestyle, so she seems to be framing her story first with a description of her healthy behaviour which sets up how I will hear the rest of her experience. She seemingly presents herself as a good and competent health care citizen who did not deserve this. This experience may be linked to notions of morality when she declares that “God threw me a real zinger”, and so her new identity as someone with heart disease is presented as an ethical tension for her in the words she chooses. Further to this notion of morality, she also presents herself as a good mother who did everything a competent mother should do to stay healthy for her family. Being healthy is presented in this way as being a moral imperative related to her role as mother. She clearly presents how this new identity as someone with heart disease is not personally coherent with how she views herself, nor how she wants others to view her. She

prided herself in being seen as healthy, and her resistance to accepting this new identity as a person with cardiac disease is very evident.

The experience of having a heart attack now not only took away her identity as healthy woman and eclipsed her normal day to day concerns that centered on her family, it put her squarely face to face with her own mortality. She accounts for her denial in excerpt 6 as being related to fear, that her denial in fact was her way of coping with the experience. Her description is filled with concerns about her family's concern. In this interview she frequently gave great detail regarding her thinking behind her actions including this initial experience when she experienced life threatening cardiac symptoms and needed to present herself to the ER. Throughout her interview, again and again, she would construct her story around the impact this experience had on her family. Her presentation provides insights into her alternating orientation to her identity as a healthy woman whose primary concern is for her family, and her new identity with this life-threatening illness that requires a new orientation to the biomedical imperative of seeking immediate ER treatment. The following excerpt is regarding her initial experience in emergency when she was continuing to have chest pain, and she was being prepared to undergo emergency angioplasty:

1. **Sharon:** *Yeah, and the thing that scared me, the only problem that I was trying to think back on what bothered me is when my family was out of the room, probably talking to the professionals, and I was alone and I had this pain still and I guess at that point I probably had an inkling there was something to do with heart, yeah, I did. I know I did because I remember saying to the girls 'I am so sorry, you've got history now.'*
2. **Researcher:** *To your daughters.*
3. **Sharon:** *Yeah, because they now have history of, you know, was it in your family? Yes, my mother had a heart attack at 49. I was so, I don't know, about you Heather, but I am so protective of my kids*

4. **Researcher:** *I am too. So that's when you allowed yourself to be realistic about what was happening to you was when you understood the consequences potentially for your family*
5. **Sharon:** *For the kids*
6. **Researcher:** *So because of them possibly, you were having to face that reality, for their sake?*
7. **Sharon:** *Yeah, right, right. I did, I realized because I said to them "I'm really sorry" because you're are going to have to be more aware of your heart, which isn't a bad thing*
8. **Researcher:** *And you were saying that while you were having chest pain? (Laughter)*
9. **Sharon:** *..... I thought right away for the girls' sake it's going to be very difficult for them long term because it could mean that they would have early heart disease, I mean who knows? I just really felt that that was a big concern for them and for me and, again thinking about everybody else and not myself at that point, and also thinking about Mike and the trauma that this was causing him and the stress and then thinking about work, you know, and oh my gosh, I'm not going to be able to go back to work next week and have all things I had going on at work. And you know how you think of everything but what's important which is my heart*

In the previous excerpt, the words Sharon chooses still reflect her resistance to assuming this new identity. For example she describes having “an inkling” in excerpt 1. She provides this very minimal acknowledgment after having undergone a total loss of consciousness when her symptoms first appeared. She had been given a very hasty ride to the hospital via ambulance, many urgent diagnostics had been initiated, and she had received many medications to treat this obviously emergent situation. In this narrative, it seems to be the potential impact this will have on her daughters that compels her to reluctantly take in the significance of what has happened to her. In excerpt 4 I have pointed to the significance of her description in which she apologized to her daughters for giving them a cardiac history.

She then responded by elaborating on the supremacy of her role as a mother in interpreting the meaning this diagnosis had for her.

Sharon would go on to have a very difficult course in her subsequent stay in hospital. She did undergo a successful emergency angioplasty that night, but developed a life threatening hemorrhage from her femoral artery where the angioplasty catheter had been inserted. She very nearly lost her life that night. She would spend an entire week unconscious and on a ventilator in the intensive care unit. She went home three weeks after her initial admission to the ER. She had been devastated by this turn of events, but her reaction to the care that she had received now had turned to anger as evidenced in the following excerpt:

1. **Sharon:** *And then I went back to work in June, this happened in March and my manager said to me you shouldn't be here. And so I thought oh yeah I guess she's right. I needed someone to tell me that, I couldn't comprehend that this had happened.*
2. **Researcher:** *Do you remember the moment when it really sunk in, that you were now a cardiac patient?*
3. **Sharon:** *At Cardiac Wellness. I went and started in July. I went back to work on June 10th and realized I shouldn't be there so I stayed off. In July I was referred to Cardiac Wellness, went in there and the doctor said to me, you have heart disease. I said, I don't have heart disease, what are you talking about? I don't have heart disease. Because I still didn't believe I had heart disease so after,But I was arguing away so finally after I had seen all the professionals at Cardiac Wellness I started to accept it.And I started seeing this psychologist through Cardiac Wellness and she helped me come to terms with it too because it wasn't just heart disease it was the anger of the adverse event, it was that my life had been totally screwed up by this, I felt like I was a victim of the --- Hospital and whenever people ask me now I say it was an accident. They all say were you in a car accident or something because I lost so much blood, and I say no I was in an accident at the --- Hospital. And that's how I see it. I see, I was a victim of the ----- Hospital and sure they saved my life but they also screwed it up. They did both.*

She is still clearly presenting herself as being reluctant to accept this diagnosis in excerpt 1. In excerpt 2 I have encouraged her exploration of assuming this new identity as a person with heart disease. Perhaps the trauma of all of the other events around that initial heart attack served to confound this for her, but she is now presenting herself as a victim who has lost trust in the kind of care that she might receive, and whose life has been profoundly changed. By presenting herself as a victim, she may be mitigating the ethical tension she feels with this new identity. In the following excerpt, Sharon is still describing how she is trying to come to terms with this diagnosis, and still maintain her sense of personal coherence as a person who has been diligent in managing her health:

Sharon: *I knew I had done nothing to contribute to this...what I was thinking though is, I got, and again it was the anger, I was being accused. People, when you have heart disease, I find a lot of the professionals, it was at Cardiac Wellness and the hospital they are very accusatory and blaming.....They're blaming the patient because you got yourself into thisMost, percentage of cardiac patients have gotten themselves into this because of their lifestyle and I wasn't one of those and..... I'm very sensitive to that and I wanted everyone to know that there was nothing I had done to cause this, but I had done everything to prevent it, and because of that I made it through and I'm as good as I am today because I had taken care of myself. So I tell people that with the Woman's Heart Initiative. I said you can't prevent everything in your life and I really believe that God was giving me a message here that, you know, he's in charge and I'm not. And I think that we have to realize that not everybody's in control of everything that's going on but I said you'll have a much better chance of surviving a trauma whether it's heart or a car accident if you're in good shape. So I said get in good shape and do whatever you can*

In this previous excerpt she is describing her recognition of the blaming inherent in the discourse of cardiovascular risk factor management that health professionals used in the hospital as well as the cardiac rehabilitation program that she attended. She is resistant to accepting blame, and continues to strongly advocate for herself as a good custodian of her

own health. She describes being angry at this insinuation inherent in the way they spoke of cardiac risk management. In presenting herself in this way she is reinforcing her identity as a good custodian of her own health. She links her positive health outcomes to this identity as well in this excerpt, positioning herself as significant in her ultimate recovery.

Sharon ends the interview with a description of what she now sees lacking in the current health care system:

1. **Sharon:** *Hospitals are not necessarily optimal healing environments and they need to look at everything from the color scheme to signage to staff having values around the patient and family are key components of the medical team. Like it needs to be a complete atmosphere of healing, concern, care, openness, you know, welcoming of the patient and family into the scenario and they aren't doing that as much as they need to. It's a whole culture change*
2. **Researcher:** *So how does it feel for you when you walk in?*
3. **Sharon:** *It's very institutional, very scary, you don't feel understood, you don't feel that you're important. It's just a very, it's void of feelings and concern and care and healing. I just find it a really difficult place to be and I did before all this happened but even more so now because you just don't, you don't, are people really paying attention to what's going on? Are details being taken care of, they're not listening to the family necessarily.....Because they're busy, they don't care, they're burnt out, they don't, they're the experts, they don't see the patient and family as being expert. The patient and family know themselves better than anybody, and if you only looked at it as a team effort where you have all the knowledge and expertise of all the nurses and doctors combined with the patient/family perspective, knowledge, intuition, that feeling - whatever you want to call it, we have that. Mike and I knew what was going on. If Mike had stayed around that night (of her first angioplasty when the hemorrhage occurred) I think he would have said something's going on here, you need to get a second opinion*

Sharon is now presenting her distrust in health care as being linked to the lack of collaboration she has experienced with health care professionals. In excerpt 2 I encourage her to elaborate on her presentation of hospitals as not being optimal healing environments.

She presents health care institutions as frightening and untrustworthy not only because of their lack of collaboration with the patient and the family, but because of the pressures of just being so busy. She presents the health care she has received as being „institutional’ and not caring or even diligent (excerpt 3). In framing it this way, she is presenting herself as being an outsider to her own health care which is presented as being frightening, not therapeutic, and even dangerous. The use of the word “institutional” depicts health care as being focused on institutional imperatives, rather than concerns for the patient themselves where “you don’t feel understood” and “you don’t feel important”.

She has linked her narrative to the potential for safety issues in patient care, as well as her recognition of the need for more caring and inclusiveness in health care encounters. Her self-subjection to the discourse of cardiovascular risk factor management appears again and again in her narrative, however she is also presenting herself as resisting this discourse. Her resistance to accepting the diagnosis of heart disease appears to be linked to the dissonance she feels. She presents herself as having diligently worked to maintain her health and has oriented her behavior to the discourse of cardiovascular risk factor management, and now finds herself in the position of assuming the identity of a heart patient, along with the implication that she may not have managed her risks appropriately. She presents her reaction to this as well as the adverse event she experienced in the hospital as anger as well as a deep distrust of the hospital care. Through her experiences with health care encounters, Sharon’s identity has been constructed as a person whose experiential wisdom is irrelevant, along with the personal meaning this diagnosis holds for

her and her family. She summarizes this in her opening statement in this excerpt where she says “Hospitals are not necessarily optimal healing environments.”

In describing her story in this way, Sharon has presented herself as being triply marginalized in her health care experience. First she fails to get credit for her positive healthy behaviors that may have contributed to her final outcome, then she feels marginalized through health professionals’ lack of collaboration and acknowledgement for her and her family’s knowledge and intuition, and finally she feels marginalized by the lack of concern and care demonstrated by health professionals.

Nickie’s Story.

Nickie is a woman who required emergency coronary angioplasty to correct an occluded coronary artery at the age of 46, just a few months prior to the interview. Nickie’s angioplasty averted any damage to her heart. Nickie had been experiencing symptoms of angina and fatigue for several months prior to this hospitalization, and had previous health issues with fibromyalgia and endometriosis. Nickie is a wife and mother of a 12 year old boy at the time of the interview, and had been working full time prior to this cardiac event, although she was not working at the time of the interview.

The following is an excerpt from the interview with Nickie where she describes first getting the potential diagnosis of heart disease first in her family physician’s office, and then at a stress test:

1. ***Nickie:** From now on I remember all the dates of everything and I am a date person... So that was on April 20th, it was on a Monday and that’s when she told me you should be going onAnd you know, I was upset with that. I thought well geez, you know, I’m 46 years old I got high blood pressure like, well it’s manageable I’m going to be on meds and if that’s the worst thing that happens okay whatever, trying to get my head around it. On that date I*

also told her about this chest pain that I was having so she asked about my family history....., and I told her that my dad had had a heart attack at 43 and a stroke, She said hopefully they'll call you and you'll get in (for a consultation at a diagnostic centre) and I don't know what they'll want to do..... So this was about 8:30, 9 o'clock in the morning and I, during my consultation I told them while I was running here I did feel that chest pain so they decided they wanted me to do the stress test but they couldn't do it right away they said can you come back in an hour.It was about six or seven minutes and I got that burning chest pain and they noticed there was an abnormality so they pulled me off and he's sitting across from me just like you or I and he said okay your stress test shows that you have some form of heart disease, I don't know what it is, I'm going to get in touch with cardiology and someone should be calling you within the next two weeks to set up further testing and investigating, I'm going to put you on a bunch of meds that's going to stop anything in it's tracks and I'm sitting there thinking, are you talking to the old fart behind me? Because you can't possibly be talking to me.... Yeah, I'm just sitting there and I'm in shock, in disbelief, in denial, you know, the whole ram of feelings. You're by yourself, you're not expecting this. Like, otherwise I would have brought my husband with me if I'd of known I was going to get some kind of news like that So I had a ton of questions but yet I was frozen.....Regardless, it went from zero meds to like four meds in a week and it's for my heart so I'm calling my husband from Shopper's Drug Mart and I'm crying and I'm like this is what's going on and he's like in shock and I just came home and just. So I waited, that was on a Monday, I waited for that phone call ... and I thought well I can't sit here, like I can't sit and wait.so all's I could do is think well I've got this heart disease and now I'm going to go in a room full of, the wedding was a Mexican wedding..... so I don't want to miss the wedding but I'm torn because if I go and get the flu am I going to die?I didn't want to tell them because I didn't want to upset them and in the mean time a neighbor who had moved back from Ontario had come out for the wedding..... ..and I'm not talking to anybody like I haven't told anybody, I don't really know what to tell anybody besides my husband at that point. Like I hadn't talked to my mom, I didn't tell my neighbors because, you know, we're all looking forward to this wedding, we're all going to have fun and party

2. **Researcher:** And your son, you wouldn't have, how old was your son at that time?
3. **Nickie:** He would have just turned 12. So yeah, I'm not telling him until I know what we're dealing with. So yeah, not that it was a big secret but you know bad timing for everything, happy occasion going on in our neighborhood and now granted with my other neighbor having the heart attack it kind of set it up that I could have just snuck in there and said oh by

the way, move over (laughter). ...I did phone [cardiac diagnostics] back and said I haven't heard back from them and they said.....and they said it can take anywhere up to whatever and part of me is like do I just go to emergency? Why am I messing with this? It's not my arm, it's not my leg, it's my heartI refused to exert myself to that extent anymore because I was scared..... What if I have a heart attack and die..... Something was in me where I wasn't ready to face up to it or, I can't tell you why I decided that that wasn't a good time to go....then on the Sunday my neighbors were having a little party for one of the neighbors birthdays or whatever, so we went over to that and I came home and I bent down for something and I felt a sharp pain and I thought, and it's the worst time because I thought, I'm going to take Scott to school on Monday morning and I'm going to go to emerge and I'll have all day, I'll probably get out in time to pick him up. That's how us mom's think, right?.....So well, yeah, I'll just go to the hospital while Scott's at school and so that was in my head. I'm not going to mess around with this, I'm not going to wait for them to call, I need to know what's going on then on that Sunday night..... and it's the worst timing because I think it was 9 or 9:30 on Sunday night, Scott's just getting ready to go to bed, it's a school night. We leave him alone but not usually to go to emergency at 9:30 at night and be gone for eight, ten, twelve hours.... I just said to my husband, I said it's bad timing but we need to go because this is what's just happened and I know it's bad timing but it's just, I'm scared. So we put Scott in the car and we were trying to get in touch with his parents... he ended up dropping me off and he didn't want to leave me but I said I don't want Scott in here, he doesn't need to see all that. Anyway, so he ended up getting in touch with his parents and dropping him off and he ended up coming back. Now, gosh, this is starting to be a blur..... did they hook me up right away? They put the oxygen thing on you right away no matter what you've got, right?

In this narrative Nickie, much like Sharon, is depicting herself as a competent health care recipient, by referring to her decision making process as these events unfold. She describes how she has carefully monitored her symptoms, diligently sought care for those symptoms, and then followed the advice of her family physician, as well as the cardiologist at the cardiac diagnostic clinic. However, in this narrative she is presenting her story very significantly in terms of the emotional impact this experience is having on her, and the dissonance this diagnosis has created for her identity. In this excerpt, Nickie is clearly

depicting her story in terms of the life changing, and life-threatening implications embedded in this new diagnosis. She is clearly articulating the emotional impact that this experience has on her, and the potential impact it could have on her friends and family. I encourage her to explore this reference to her family and friends by making reference to her 12 year old son in excerpt 2. In describing her story to me, she is intent on my understanding the larger significance this has on her life and the lives of those she cares about, as well as the complexity within which she has to manage this new diagnosis. She presents her story with frequent references to the fear and anxiety that this diagnosis has created for her. She too has framed her decision making in terms of the implications her care seeking would have for her family as well as herself. She seems to be presenting this as an ethical tension, where she is orienting her decision making toward minimizing the implications for her family while also attending to a potentially life-threatening situation by following her physician's advice.

In the following excerpt, Nickie, described a situation where she had just been admitted after seeking emergency room treatment for her recurring chest pain:

1. ***Nickie:** So I sent my husband to work,..... Well no sooner that I sent him away did they came to get me and they said we're taking you down for an angiogram and I mean that's the one I don't want because everything I ever read about it, because I read up on it when my dad had it.....But anyways I was scared, I mean you read that you can die from them, I mean you can have a stroke or heart attack or what and it's scary, it's your heart..... And you're by yourself now. I've sent my husband off to work, haven't seen my kid since the night before and I'm sitting there thinking what if I die, what if I die so, I know that you're sedated, that you can be heavily sedated but I know that you can't be knocked out but I'm like you gotta knock me out as much as you possibly can (laughter). And they did because it gets to the point, you know, where you start to watch them, right, when you can watch them there's no way you can do that without being knocked out. So I mean they were very good at settling me down, I mean I was beside myself, like if*

there was a roof top I probably would have ran and jumped off. I mean I was scared..... Anyways, they went in there and they said there is a problem, there is blockage here and to fix it we're going to put a stent in, and I'm still not, I mean you're sedated.....Whatever, do what you gotta do (laughter) but honestly I got wheeled up to that room and the sedatives not really wearing off because they knock you out pretty good but I'm just sitting there, I'm in shock. I mean this was on May 4th, so on April 20th I got high blood pressure diagnosis, April 27th I have some sort of heart disease, this is May 4th I've had an angioplasty..... Like I'm just getting passed that I have high blood pressure, let me get my head around that.....So I phoned my husband and said they just took me down for an angiogram and I had an angioplasty and I had a stent put in. And he said what?... They didn't even say that they were going to do that test for two days and now they've already had it and you've got a stent? LikeSo, because the one was blocked the 90% but it's not a main one which is good butI've asked if this were to block would I have a heart attack? I mean how small of one is it? Or how, you know, they said you would have a heart attack. It probably wouldn't kill you.....But you would have a heart attack. Okay, I'm not sure why I wanted that question answered (laughter) Why did I want to know that? Well I guess I asked that with that happening to me the second time, right

2. **Researcher:** *So how long were you in the hospital after that?*
3. **Nickie:** *Over night..... So that, they did that I don't know about noon-ish and I was out the next day. So it's like here's your big pamphlet of information, have any questions? See ya. And your going yeah, what the um just happened to me? You know, like your head is still spinning.....*
4. **Researcher:** *Did they spend much time talking with you about the medications? No?*
5. **Nickie:** *No*
6. **Researcher:** *Or your diagnosis?*
7. **Nickie:** *(shook head)*
8. **Researcher:** *Did you get a referral for Cardiac Wellness at that time?*
9. **Nickie:** *I did*
10. **Researcher:** *And you got, and you went to see your cardiologist probably in 6 weeks*
11. **Nickie:** *6 weeks, there's a story. I never did get a 6 week follow up, I got a 6 month another angioplasty with him..... But I never did get a 6 week follow up but I had my 6 week follow up from the last one already though.....He*

couldn't get me in....., I don't know why and I was quite persistent. I remember probably phoning once a month and saying what's going on here? I mean I have questions and I'm 46 years old and I've got a heart problem and I have a few questions now that I've got my head wrapped around it a little bit, like you know...

12. **Researcher:** *Had you been seeing your family physician after you were discharged?*
13. **Nickie:** *I probably saw her, I went and followed up with her shortly after the procedure and I was probably seeing her with other things because there's always something going on with me so, plus I was going through Cardiac Wellness so that was on May 4th that I had the procedure. My first stress test so that I could go work out was on June 9th, which came back abnormal so then you start going well last time I had an abnormal one I had a blockage so what does this one mean? So they sent me for a Thallium test, that is as normal as it can be for women, they are not*
14. **Researcher:** *Completely conclusive*
15. **Nickie:** *But from what they can tell it was okay so I did the exercise program, still no follow up. Got out of the exercise program in September, had my stress test, end of exercise program stress test on September 11th*
16. **Researcher:** *You remember all these dates?*
17. **Nickie:** *Yeah, and abnormal*
18. **Researcher:** *And how frustrating, hey?*
19. **Nickie:** *Well it's scary because you're going around and you're thinking much time do I have? Am I just going to just drop dead? Why is it abnormal? Finally I did see, I think I saw a cardiologist, I think I saw a cardiologist a few times at Cardiac Wellness. Cardiac Wellness, if I didn't have that I don't know what I would have done, I don't know what I would have done without Cardiac Wellness honestly. I mean I might wait to see a cardiologist, I don't know I've never gone in to see a cardiologist but if I had to I'm confident that I could get an appointment within the next week or two. They, they have been wonderful and they reassured me that sometimes women have abnormal readings and not to worry but it's like.....but then how did we know that the first one.... The first one was a bad abnormal and what your telling me is not to worry about these, these could be normal abnormalities?*

In this previous excerpt, Nickie, a 46 wife and mother of a 12 year old son, is representing herself as a previously healthy young woman who is now face to face with a

life threatening illness. She presents this narrative with reference to the significance for her family, and wanting to protect her family, and even her neighbors, from the stress of learning about her diagnosis. The other thing that clearly comes through in the way she presents her story is the lack of coherence this has created in her personal life. She too describes how her ability to fulfill her role as mother, daughter, and even friend is now put in jeopardy with this diagnosis. She describes needing to come to terms with the complex ramifications of this diagnosis on her own, not the least of which is her potential death (excerpt 27). Her story is also filled with descriptions of her uncertainty regarding how her care will unfold, and the significant anxiety that this causes her. She describes the rapid processing she underwent in the hospital when she receives her first official diagnosis of heart disease by means of an angiogram and then angioplasty, and then when she is discharged within 2 days after seeking treatment in emergency for her chest pain. In excerpt 1, she is minimizing the significance of her angioplasty in her description by saying that health professionals told her that another blockage would “probably not kill her”. This minimal accounting of the significance of another heart attack does not ring true with me, and in excerpt 2, 4, 6, 8 and 10, I am trying to explore how the significance of this was explained to her by health professionals.

Nickie presents this story in a way that shows how much of this she is left to process on her own. She repeatedly uses the phrase “I’m thinking....” to show how she is left to make sense of things, for example when she first received her confirmed diagnosis of heart disease during the angiogram and angioplasty. She presents this story in a way that

demonstrates how much of the responsibility for her well being is left in her hands, in particular when she is unable to get a follow-up appointment with her cardiologist.

She makes a detailed description of how she has managed her care and how she has understood the significance of her diagnostic tests, including a meticulous attention to dates. She is in this way representing that she has done her due diligence in managing her heart disease as a reasonable health care recipient, but she has not received the support that she anticipated with an event of this significance, even to the point of having to repeatedly advocate for herself in order to get the care she needs. She clearly presents that this is a potentially life threatening event for her. Nickie's description of the conflicting advice she receives regarding her abnormal stress test results, as well as the lack of fulfillment of a promise for a cardiologist to follow her after her initial angioplasty, demonstrates a significant lack of coherence for her with respect to the way she anticipated being "cared for" by health professionals.

Six months after her initial angioplasty, Nickie began having chest discomfort, which she described as indigestion. She still had not yet had a follow-up with a cardiologist at this point, and so she had made an appointment with her family physician. Her family physician was able to contact her cardiologist, who immediately booked her for a repeat angiogram the following week, which Nickie initially strongly resisted. The following is a description of this series of events:

***Nickie:** And all of a sudden I've got this procedure booked.And I said well why am I having an angiogram and she said well have you not talked to your family doctor?So again I'm balling my eyes out thinking what the hell is happening now? I phoned my doctor back and she said sorry I meant to get to you before they did so that I can tell you that I talked to Dr.---- and this is what he's recommendingShe is an excellent physician and she's*

my age so I think..... I think she looks at it like this could be me and I've also been going to her for 25 years so we grew up together so she's trying to calm me down saying, listen I talked to him, you are having these kinds of symptoms and that's not a good sign. She said, you know, you can try this other medication but we all, we have to start with you have a heart condition so we have to rule out that it's not coming from your heart and I'm still believing that this is an acid reflux issue because I'm a doctor now myself and anyway she calmed me downBut in the back of my mind like now I'm having anxiety over it because I had a fear of the angiogram before, before I knew what it was and now that I know what it is I don't know which fear is worse because now you know how yucky it is..... I had such anxiety that I felt that I couldn't breathe properly. I was here by myself it was about twenty to three, I was supposed to go pick up my kid from school and I'm thinking I can't breathe... and I start thinking about this person that just passed away from this funeral and she was at home by herself and so all these things, kooky things, are running through my mind and my doctor had told me don't mess around. If you feel you've got something going on, you have a heart condition you call 911..... And that's flashing in my head and I'm like. So I phoned my husband at work and I said I'm thinking about calling 911 and he said well why are you thinking about it? Hang up and do it....I hung up and I phoned 911 because I thought I don't know what's happening to me. I just felt funny and it turned out it was probably just an anxiety attack.....Because they came. ECG's normal, well of course it is, they always are. My blood pressure was up a little bit and understandably so but all my vitals are good. So they were like, what do you want us to do? Do you want us to take you to emerge and have totally checked out? He said I can tell you right now that Foothills is running at a, is it a red?.....which is you're going to wait and especially if your vitals are all good. Even though you have a heart condition you're going to wait because all your vitals are good. So I'm like oh my God, I don't feel like going there and I did feel better just having these paramedics there and was like can't you just have coffee with me? (laughter). They said you know we could maybe take you to the ----centre. You know, they don't have cardiologists or whatever there butThey could do ECG's, they could do ultrasound, they could do, you know, chest x-rays, they could do CAT scans. You know, they could do quite a bit of things or if you really do need something they could transfer you over. So they phones the ----- centre and they said yeah come because it's hardly a wait at all.g I think I got there about 4 o'clock and I was home by 8:30 but that doctor was very good because I just felt like I needed someone to listen to me about, I really didn't feel like it was coming from my heart and I believe that we know our bodies better then a doctor goes by what are percentages

The way in which Nickie depicts this course of events is again as someone who feels she is ultimately in charge of how things proceed, although she depicts herself as desperately needing reassurance. In this account, she is still presenting herself as a normal healthy woman, but she is needing to link this story with the incredible anxiety that underlies her day to day existence with the new diagnosis of heart disease. She depicts her understanding of the scientific rationality for her need to have a repeat angiogram, or later the need to dial 911 to address her potentially urgent symptoms, both of which she understands as the rational thing to do. Her narrative depicts how she is caught between conflicting discourses: scientific rationality and the complex, confusing, anxious and even guilt ridden reality within which needs to manage her illness. On one hand she articulates how she has been a diligent health care recipient who has carefully tried to follow the advice of her physicians. At the same time she articulates the reality of someone who needs to deal with the overwhelming anxiety that accompanies her acknowledgement that she is trying to manage a potentially life threatening situation, all the while trying to manage and maintain her roles as mother, wife and daughter. She is demonstrating how she has aligned herself with the scientific biomedical perspective by attempting to follow the advice she has been given by health professionals. Now however, she is resisting the self subjection to the discourse of biomedicine by presenting herself as the authority regarding her own body, despite her clear understanding of the potential implications of not seeking medical attention.

In this account as well, she demonstrates a mistrust in how her care might unfold, or how it is being managed. She describes the potential need for a long wait should she dial 911 and be taken to a large hospital, as well as the potential long wait if her vital signs

should be normal. Her description of the conflicting and minimal advice she has received from health professionals since her angioplasty depicts her as needing to rely on her own judgment in the end. She describes having been discharged from hospital following her initial diagnosis of heart disease and angioplasty, with very little information or time spent with her to help her assume this new identity, and yet she now describes how she is ultimately the one who is making life and death decisions about her symptoms. When she says “I’m a doctor now”, she is making this comment tongue-in-cheek, however she is making reference to the kind of responsibility she is compelled to take on.

She also describes the vagueness of the symptoms, and the similarity they have with other less lethal diagnoses such as acid reflux. She depicts how this too makes it very difficult to behave in a way that aligns with the scientific rationality of the advice she has received from her family physician as well as her cardiologist. She is demonstrating that she is being asked to assess and act on her confusing symptoms in a way that aligns with the scientific biomedical perspective, despite the fact that the care she has received in hospital and from her cardiologist, or that she anticipates receiving in the ER, does itself not align with that kind of rationality. For example, with her first abnormal stress test, she was immediately referred to a cardiologist and she ultimately had an angioplasty to open an occluded vessel. With another abnormal stress test at the cardiac rehabilitation program, she was merely reassured that women often have abnormal stress tests, and was allowed to continue exercising after seeing a cardiologist there. After her first angioplasty, she is told how important it is to seek emergent help for her symptoms because the vessel could re-occlude, and that she needs to have a follow up appointment with her cardiologist as well

because of this. Yet she is not able to make an appointment with her cardiologist to reassess and reassure her, despite monthly phone calls to her cardiologist's office.

She describes her reluctance to go to the ER in this last excerpt. In this narrative she orients her behavior to previous experiences in the emergency when she has been required to wait, and her knowledge that the people who are "dying" will be seen first, thereby again presenting her behavior as a rational, justifiable, and ethically sound in that she is considering the difficult circumstances in the ER, as well as the potentially life threatening situations of others seeking care. She includes in her narrative a description of the paramedics referral to the code red status at the ----- hospital, where all ambulances will be diverted to other hospitals, and referral to this comment supports her thinking and her behavior as rational and morally conscious when she decides to seek care at the less busy --- Centre. She may also be presenting this as another example of how these life and death decisions have been put back into her hands again.

This account reflects how Nickie tries again and again to behave as a rational health care recipient, when her predominant concern is the potential end of her life. She seems to be depicting herself as being reluctantly in charge of her precarious situation, and wanting the reassurance of someone to steer the ship for her, to reassure her that she has been managing her situation in an appropriate way, and possibly most importantly for her, to acknowledge the incredible fear she is experiencing as she tries to manage her symptoms. Again and again she presents herself as the rational, deserving, and moral health care recipient who is left to negotiate the overwhelming anxiety associated with her lethal symptoms on her own. Her frequent referral to the emotional component of her experience speaks to the

significance of this meaning she attributes to her symptoms, although she does not describe articulating this clearly to those from whom she is seeking care.

The following excerpt resulted from my questioning around how she would subsequently seek emergent care, and what it would take for her to call 911 for assistance in the future. She had been extremely reluctant to proceed with her second angioplasty that had been booked for her as previously described, and in this excerpt I am trying to understand this as well as her willingness to seek emergent care in the future.

1. **Nickie:** *It was, it is a rough road when you have an illness and I feel bad for my son. I'd like to be in his head for a day to know what he really, really thinks and, you know, he's going to be 13 next month. I don't know what he thinks. I don't know if he's terrified of his mother dying or if he even thinks about that. I don't know.....and then there's that fine line of I don't want to scare him too, but it has to be like, you know. I don't want to scare him like it's just me, but, you know, if you see dad or anybody passed out on the floor, you know what to do right? So I've made it into a generalization, not just me to scare him that this could happen just to me now or whatever. It definitely puts a strain on relationships, I think... you find out who your friends are who you can count on for emotional support..... it's very clear now that not every friend can be there for you for this and I get pissed off about that. Like, it's taken me, it's still taken me a long time to get over that*
2. **Researcher:** *So you feel like you have to hold back?..... Hold back the emotional piece with some people?*
3. **Nickie:** *Absolutely, absolutely. Or you say to someone oh sorry I'm just having an emotional day today. What's wrong? Well you know, this was maybe a week after my second angioplasty, well I'm just having a bad day, why did something else happen? And I just thought, something else? Do I need something else to happen? Like it makes me mad and I just want to go, what do you mean something else? What's happened to you this year?..... Something else? I need something else to be emotional? Two angioplasties in five months doesn't do it for you? Not to mention the other crap going on....*
4. **Researcher:** *Even with your husband probably hey?*
5. **Nickie:** *Yeah, because a lot of times he doesn't get it either. He doesn't get it. You know, his attitude is you had this, you're fixed, let's move on. Of*

course, he's an engineer, he's an engineer, so they are lets fix the problem, what's wrong with you? My son gave me this for (referring to a heart shaped pendant around her neck).....So obviously it affects him, right.....And, you know, for him to see me go through emerge again in Windsor through Christmas, I don't know, I don't know what the poor guy thinks

6. **Researcher:** But that wouldn't, would that hold you back from calling? Or from seeking help, wanting to protect him?
7. **Nickie:** Probably Even when you phone 911, this better be like almost death, like you don't want to disturb someone to come and get you to have someone else die coming to get you and there's nothing wrong you. And get the neighbors all talking, oh did you see the ambulance outside Nickie's today? You do, you think like that, well because when I had them here, my next door neighbor was like Nickie are you alright? And I'm like I'm good. (laughter) and you feel stupid it's almost like something damn well better be wrong with me and now that's a great attitude
8. **Researcher:** Even after having two stents you still feel that way?
9. **Nickie:** I guess so..... I guess I feel like it's serious but I didn't have a heart attack, supposedly this isn't going to kill me if I do. I mean, okay this is sounding like I'm naïve to it and I'm not I'm really on the other side where I'm paranoid as hell that I will drop dead from it. But on the other side of it is, yeah I have two stents but it's in an artery that's not a major one and supposedly it's fixed and I don't know. Should I be more scared?
10. **Researcher:** No, no I'm not saying that. One of the things that I'm really, really trying to understand is women's reluctance to seek care
11. **Nickie:** I don't feel like I'm in that category.... I don't think so. Anyone that's been in emerge three times in four days, I don't think that you can say that about me (laughter). Persistence, right
12. **Researcher:** Yes you have been tenacious about being seen, and assertive, yes you have beenThe anxiety, that's really a difficult one and I don't think we give enough credit to how uncomfortable that whole anxiety piece is for, and I'm not sure if it's women in particular or if women are just more sensitive to it, but I've heard this over and over and over again that the anxiety around this whole experience is almost worse then the symptoms themselves....
13. **Nickie:** Well and it's over everything, it's over life's little things....Like flying, what if something happens to my heart while I'm on the plane? Is there a doctor?

14. **Researcher:** *So it's almost like trying to avoid....going back to the angiogram thing again (laughter)*
15. **Nickie:** *See? I knew you wouldn't leave it alone*
16. **Researcher:** *Wanting to avoid that was also trying to save yourself from that anxiety that you felt around that. Is that fair?*
17. **Nickie:** *Probably, yeah. And like I said the fear of now I know. So on one hand it's now I know what that angiogram is and I know I didn't like it and I remember that.... And it's uncomfortable that when they put that dye in you feel that warmth, that gives me anxiety. ...I just freak right out, I don't like the warm stuff in me. That just freaks me right out, so it's that. It's nothing painful, I've had a lot of pain in my life.... It's not the anxiety from the pain, it's the..... the anxiety of what if they take a wrong turn? What if it does kill me this time? What if, what if, what if*
18. **Researcher:** *And the biggest anxiety around that, is it around your family?*
19. **Nickie:** *Well my kid*
20. **Nickie:** *No, I mean if someone can tell me if something happened you'd go to heaven and you'd be able to see Scott and you could still see him get married and still be able to touch him and he'll know that you're there and all that then I'd be okay. But you don't know. Mothers feel like that but I mean that, as a mother, I think that's your biggest fear in life is when they're this young is to not see them grow up. And you definitely think about it (crying)..... Well, I could die and I don't have a problem if it was just me. Oh well, I got friends up there, aunts and uncles, and I've lost a few friends, I don't have a problem with that. But to leave him and not see him the rest of his life and for the rest of mine or just being able to see him through a glass? No, no, not good enough*
21. **Researcher:** *Yeah, I get that*
22. **Nickie:** *Well yeah, you're a mom of course you do*

In this previous excerpt, Nickie is presenting to me how difficult it is to manage her fragile health. She presents her story as someone who is reluctantly compelled to engage friends and family in her health issues to some extent. In excerpt 1, she describes how she has felt guilty about imposing this stressful situation on her son. She feels reluctantly required to speak to him about how to manage a situation where she might lose

consciousness and be completely reliant on his judgement. She is uneasily subjecting her behaviour to align with the rational biomedical perspective. Her uneasiness is related to the implications that seeking care might have for her family, balanced against the implications the end of her life might have for them as well.

In this previous excerpt, I have encouraged her to explore the implications that her desire to protect her family and friends might have on her future emergent care seeking. I bring up the issue of anxiety that other women had expressed in excerpt 12, because my intuition is again that she is trying to minimize the implications that this diagnosis has for her. I proceeded with this questioning because I have sensed that she is avoiding this discussion, as she does for example by using humour in excerpt 7. She has introduced the possibility that she is “paranoid as hell that I will drop dead from it” in excerpt 9, and then invited me to talk about the anxiety by saying “should I be more scared?” in excerpt 9. I am reluctant to tell her how she should feel, and so I frame my answer by speaking to the anxiety that other women have expressed, and in doing so I invite her response to this perspective.

Nickie describes herself as having to manage the anxiety related to her heart disease in everyday activities, where she constantly has to be vigilant in making assessments of what might potentially trigger heart symptoms, and therefore what she might need to avoid, or what kind of help may be available to her should she need it. She presents this narrative in a way that represents her as being constantly “on duty”, and left to endure this emotionally draining way of being, where she is quite literally constantly rehearsing how to manage the potential end of her life. In excerpts 1-3, Nickie describes her reluctance to frighten her son

and her friends, her reluctance to burden them with her anxiety, and then her dismay and even anger at having to hide that part of her everyday existence from the very people she is emotionally closest to. In excerpt 5, she refers to a silver heart shaped pendant she is wearing which her son gave her after her heart attack, which she is representing as being a constant reminder to her of not only her son, but his concern for her. Again, Nickie presents herself as having to manage this very difficult aspect of her illness in a relatively emotionally isolated way.

Toward the end of the interview (excerpts 18), I broach the subject of her potential death and what frightens her most about that prospect, which I have been reluctant to directly address with her thus far. She clearly depicts herself as being primarily concerned about her son's welfare should she die, which I had heard from her in our previous conversations, and which I was surprised she had not brought up in this interview until I persuaded her to do so. She refers to her potential death as her inability to do the things she sees as most important in her mothering role, even helping him come to terms with her own death (excerpt 20). Her resistance to discussing this, points to how difficult this possibility is for her. Her tears that come immediately as she reveals this very poignant truth about her new existence with heart disease, demonstrates this very painful meaning that she associates with her symptoms and her diagnosis. She links our identities as mothers in the last excerpt (22), to help me to understand the profound meaning this has for her, to solicit me in recognizing this excruciating truth that another mother could surely understand.

Of great significance, is the excerpt 7 where she is presenting herself as being reluctant to dial 911 should she have further cardiac symptoms. She clearly depicts herself as being

aware of the potential lethal significance of the symptoms, but she also links this decision to how others might receive this, including her neighbours, her son, and personnel in the ER. She presents this decision to seek emergency services as having consequences for others as well as herself, which she is balancing in making decisions about her treatment seeking behaviour. She links this description immediately after this excerpt, to a description of how she might be willing to take a chance that even if her symptoms are cardiac, that they might not be lethal since she has survived two cardiac events which resulted in angioplasty, and she had no damage done to her heart (excerpt 9).

Nickie resists my suggestion that she might be reluctant to seek care (excerpt 11), saying “I don’t fall into that category”. She then goes on to describe how she was very persistent in seeking emergent care for severe abdominal pain over the previous Christmas holiday. This pain was found to be as a result of an anal fissure she had developed secondary to severe constipation. This pain had been agonizing, and Nickie was now pointing to how she had demonstrated the ability to endure agonizing pain with little help that health professionals could provide to her, and yet she continued to persist in seeking help in the ER. In this excerpt she is demonstrating herself as a competent health care recipient who feels entitled to care, and is not reluctant to seek treatment.

In excerpt 17 she is presenting her reasons for being fearful of seeking emergent treatment in the future for cardiac symptoms. “The fear of now I know” presents her as now being fully aware of the terrifying road she might be compelled to take should she seek treatment, for example undergoing an angiogram or angioplasty. She presents herself as now having to not only deal with life threatening symptoms, but potentially an invasive

procedure she might be compelled to undergo, which is itself is not only “gross”, but possibly life threatening in and of itself.

Earlier in the interview, she had referred to the fact that now that she had the diagnosis of cardiac disease, all physicians could see was “heart”, that her identity was now completely tied up in that diagnosis. “The fear of now I know” may demonstrate how reluctant she is to step foot in the emergency department, perhaps because she worries that her presentation to the ER might be the catalyst to being wrenched into the powerful and terrifying biomedical black hole from which she might be powerless to escape.

In Nickie’s case, her diagnosis of heart disease had been constructed for her through her interactions with health care providers, as a scientifically diagnosable and treatable condition that was amenable to control, and whose very inception was amenable to control through adherence to the scientific discourse of cardiovascular risk factor management. According to this discourse, for this biomedical management to be successful, Nickie would be required to manage her risk factors, adhere to medical treatment regimes, and seek immediate care for her cardiac symptoms when they appeared, all of which Nickie had diligently done. This had been the great promise that indirectly had been pledged to her through the discourse of biomedicine in her interactions with health care providers, including her encounters in the ER. This promise however, had been thwarted by the reality within which health care providers were asked to practice. Health professionals who Nickie encountered had left this promise woefully unfulfilled as their practice was constrained in the context of having to ration scarce healthcare resources. She was given very little time or counselling following her first angioplasty regarding how to manage

herself with this new diagnosis, and she had been unable to get an appointment with a cardiologist following this event. On one occasion when she did dial 911, she had been asked by the paramedics to make the decision regarding where to go for treatment, based on the potential wait she might incur and the overstretched resources of a larger ER.

Seeking care for cardiac symptoms that were clearly identifiable as reflective of an urgent cardiac event requiring immediate, expensive, and invasive treatment was something that had been offered to her with intimidating aggressiveness and breathtaking skill in the past, however inconsistently. She had twice been given angioplasties which had quite literally potentially offered her life itself in response to her cardiac symptoms.

Once she had been conferred this aggressive medical management, that is the angiogram and angioplasty, she had been released immediately on her own recognizance, left to manage her precarious cardiac affairs in the context of her complex private life, virtually on her own. She was given the menacing reminder that she needed to continue to present herself appropriately for future symptoms, with the unspoken qualifier: “if you want your life to be saved”. The repercussions of not aligning herself with this biomedical view of her health were obvious and terrifying for her as evidenced in her narrative. Biomedicine clearly had the trump card when it came to whose view of things counted because of the potential to offer life saving treatment. The personal meaning the diagnosis of heart disease held for her had been left unacknowledged for the most part, the biomedical promise to ‘manage’ her heart disease had been largely unfulfilled, and Nickie was left to contend with this double betrayal.

Perhaps her inability to remember events that actually happened to her once she entered the ER, as previously described, also speaks to this; perhaps as being an outsider in the going concerns of the ER who has no need to think or make decisions once she has crossed that threshold. Of significance too, is the way in which she describes “this is starting to become a blur” when she enters the ER, when she no longer is responsible for making decisions about her heart symptoms.

Nickie’s story, like Sharon’s, was filled with descriptions of the profound uncertainty she felt in not only living with and managing her heart disease, but in those moments when she surrendered to the need to access health care. The tension she presents in her narrative appears to be an ethical one. She is at once protecting her family from the disruption and anxiety her care seeking might produce, and yet she is painfully aware of the lethal implications of not seeking care, and the more onerous implications this might have for herself and her family. Other interviews with women who had sought care for their cardiac symptoms would continue to reveal this somewhat paradoxical view.

Anne’s Story.

Anne is a woman who suffered a massive heart attack at the age of 48, in June of 2008. She is married and a mother of three children, two of whom were in their twenties and living independently, and one of whom was in her teens still attending school and living at home at the time of her heart attack. She was working full time at the time of her heart attack. She had no health issues prior to this heart attack. She underwent an angioplasty,

and required an intra-aortic balloon pump⁵ following due to the severity of her heart attack. She was discharged within 10 days following this initial event. She would have another admission to the hospital for recurrent angina that required further angioplasty just a few weeks later to reopen an occluded coronary vessel. At the time of the interview, she continued to have concerning symptoms including chest pain, facial numbness, and overwhelming anxiety.

Anne begins the interview with immediately discussing how she had been discounted by her family physician just prior to her heart attack:

1. ***Anne:** So the week of my heart attack, I should say two years prior to this I had mono. I was home for four months with mono and I was very lethargic very tired obviously with the mono, and I never seemed to recover fully from it so often times now in the last two years being back at work I would have situations where I felt really, really tired like that again and I often wondered if it was mono. I did not have a great family physician at the time, mine had retired. This was a new person to me and they just kind of really didn't even think I had mono. I had to force them to do a blood test so anything that came after that they sort of didn't really listen to me. I didn't know what was wrong with me but I knew I never felt good since I had the mono. So the week of my heart attack, the well prior to my heart attack, I started to get really tired, lifeless, not feeling good. And I was just thinking possibly a flu maybe or something, I always had to talk myself into something else because no one in the medical field seemed to listen to what I was concerned aboutAnyway, on the Tuesday I really started to feel like maybe a flu or something so worked through the week, and you know, kind of lifeless but on the Friday morning is when my heart attack first happened about 9:45 in the morning. I just felt like somebody had flicked me with their finger in the centre of my chest. So a quick flick, you know, like a thud*

⁵ An intra-aortic balloon pump is a form of circulatory support in which a large catheter is fed into the femoral artery and into the proximal aorta where a balloon is inflated and deflated by an external pump which synchronizes with the patients own heart to optimize cardiac output.

feeling in the centre of my chest..... Just like a thud, just like that with your hand on your, you flick your finger into your hand. You could feel it but it didn't, it wasn't extreme pain..... But as soon as that happened to me, which I thought was odd, I remember feeling that taste in your mouth and then kind of like oh my God I'm going to get sick because from Tuesday forward I felt crummy anyway.....So I thought oh I'm probably going to get the flu, whatever so I continued to work at my desk for the next five minutes and then somebody required my assistance so I got up to go to assist with them and I noticed that my face started to go numb from the jaw, in the jaw area, no pain just kind of numb tingling feeling. I continued to go help someone and felt my shoulders start to ache on the right side. Came back, got a little concerned, I mean I certainly had heard some of the stories about what heart attacks were, having had some friends, male, who had had some problems and then I decided of course I was a smoker so I would go outside and get some fresh air, I wanted air, I needed air so off I went with a friend to go outside and have a cigarette and fresh air seemed to help, obviously I was getting more oxygen. ..In about an hour and a half after that the same kind of feelings came back again, the numbness in the face, the arm aching, and went back outside again because the air seemed to really help, well this time it didn't help as much. When I came back in another friend was going downstairs to go out for a cigarette and she said you don't look good, I said I don't feel good and she said you go to your desk, I'll be right there. However I looked to her she went to her computer immediately and she looked up stroke and heart attack, I just looked that way to her apparently. She came to my desk and said you know what I think this is what's happening, we better go, I need to take you and so I argued with her. I said take me to my doctor, I don't want to go to the hospital, I mean blah, blah, blah, so she took me to my doctor. And my doctor, I told him, I think I've had a couple heart attacks or something at work at they still made me sit there like a walk in wait patient. And then I started to feel like I was having another one so again it was about another hour or something later

2. **Researcher:** That you were sitting in your doctor's office?
3. **Anne:** Yeah, and then so I went up to the counter and I said I think something's happening right now, can I please see the doctor
4. **Researcher:** So, from the time you first had the symptoms to this point was how long?
5. **Anne:** Well 10:45 and then it was probably around an hour and a half later so 11:30 and then it was 1 o'clock, so it was almost like two and a half hours. So at about one o'clock, just after one, I'm telling them please this doesn't feel right so they did kind of scoop me in to the doctor and I'm telling her and they took my blood pressure and they listened to my heart and she

said there's nothing wrong, you probably have indigestion, here Nexium, go home and take some Nexium and I said are you sure there's nothing wrong with my heart? Why is this happening? And she said well if it gets way worse then go to the hospital. So I went home, took the Nexium waiting. I had another heart attack at home, phoned my husband, my daughter was here actually, sleeping, she had come picked me up and phoned my husband, he came home and then I had a massive heart attack when he got home and he phoned the ambulance and they came and took me

In this narrative, Anne begins her story with a description of her previous experiences in seeking care for profound fatigue in the past, which was eventually found to be mononucleosis. What she seems to be presenting here, is an image of herself as being invalidated by physicians in the past, that she has had experience in not being heard, and also her mistrust of those in the medical field in general (excerpt 1). She is presenting herself as being a somewhat reluctant and wary health care recipient prior to launching into her description of the events around her heart attack. This is perhaps to frame how she wants me to hear the remainder of her story. She is thus linking her experiences with care seeking for her cardiac symptoms to a previous significant health care seeking encounter. She is in effect setting up her own personal context in how she managed this event.

As she begins to recount her initial symptom experience, she is quite precise about the sequence of events as they unfolded and the symptoms themselves as they occurred. She includes descriptions of what she was thinking to represent that she is being accountable and competent. In excerpt 9, she describes how she is considering how her initial symptoms might be cardiac, and despite this consideration, she describes going outside for a cigarette with a friend “to get more oxygen”. She refers to “needing to get air” in the remainder of the interview on a couple of occasions, and she represents this as a way of managing her anxiety, and perhaps to account for doing something that she now knows would be a risk to

her heart health. This again might point to her need to first manage her anxiety despite her knowledge that the symptoms might be related to her heart.

Her account of first seeking treatment at her physician's office included a detailed description of how her co-workers had urged her to seek treatment (excerpt 1). Then later, after she had been sent home from her physician's office when her symptoms persisted, she describes how it was her husband who sought emergency treatment for her by dialling 911. In this narrative, she introduces her story about care seeking for her cardiac symptoms by demonstrating how her own knowledge about her body had been invalidated in previous care seeking for her mononucleosis in the past. She then links her narrative about her care seeking endeavours for her heart symptoms to the encouragement and actions of others. In doing so she is presenting herself as somewhat resistant, perhaps cautious or reluctant, about seeking care because of her previous experiences.

In excerpts 2 and 4, I am compelled to explore the timeline of events with her, such as the time spent waiting in her doctor's office because of the lethal implications of this delay in diagnosis and treatment. I understood going into this interview how very serious her heart attack had been, and this portion of her story was very significant for me. I am encouraging her to explore this by pointing to the time frame of the events she is describing. My own biomedical perspective is showing itself in this way, as I am asking her to frame her story in terms of time, much as I had done in my experience as a critical care nurse.

She then goes on to describe what happened after her husband came home at her daughter's request:

1. *Anne: Well the pain was extreme and I just shot off the couch as fast and I think that was my realization, I couldn't deny anymore that this was something major, this was not heart burn, and I just took off running. When he caught me we were in the garage and he called and the ambulance people came, I was conscious the whole time..... I just ran there, I ran to get away.... I just wanted air, it seemed like I always wanted air when these were happening. Maybe I was short of breath but that's not what I was thinking, I just needed oxygen, it was real obvious. Anyway, the ambulance came, I was conscious when they came and they, you know, right away they figured it was a heart attack or whatever. He told me I was not in good shape, he started shooting me with nitro and he said, I mean if I'm to be candid and tell the truth, I just said to him don't f-ing let me die, I'm not dying, I'm staying here, I got three kids and a husband, I'm only fifty, I'm not dying. Don't you dare let me die, you do what you got to do but don't you let me die. And then he put all the stuff on me, they put me in the ambulance, I felt like I was in a B rated movie because he was so, he was sort of red neck, a great guy. He got me and he understood where I was coming from, he worked very well with me, he was able to keep me going and probably more calm then a calmer person would have been because he bantered with me but it was like stuff falling off the shelves and he's telling the guy just drive don't stop. Like we can't stop, I was in bad shape I guess and the kept saying where's your pain, where's your pain? And of course my pain, I kept saying, I don't know, I don't know 4 or 5 and he couldn't believe it and he kept saying you're only at a 4 or 5? So what ever was going on was very seriouswhatever he was doing was very, very, serious and he couldn't believe that my tolerance or pain level did not acknowledge.... He kept shooting me with nitro and yelling at the driver just go, just go, just go and we got there and we got to the hospital whatever and he, the trauma team had apparently left for the evening, I don't know procedure at hospital but that, I remember him saying that they're on their way back. And he stayed with me, he was incredible, he was, like I say, a bit of a red-neck but perfect personality for me. He understood me, he worked with me and then he, he obviously noticed what was going on and then I knew when he put the big patches on me I was in trouble because that was like okay he's going to zap me now because this is not good and just as he put those big patches on me I said a prayer and he's rubbing my head and he said to me, he said I'm not letting you go, don't you dare die on me he said..... They told me there was papers I needed to sign, so no sense reading them because if I didn't sign them there was no point, like I had to do this. They were very good, they made me very relaxed, it was Dr. M. He was very kind, he explained very quickly as much information as he could be he said honey, you know, just sign the papers, okay. Like we don't got time for anything, let's just do this. And he did the angiogram, said there was a three way blockage, all over 90%, on the front of my heart.....Up the front of my heart and he said*

your heart attack has done some damage to the muscle but he said, we need to get these unblocked so we need to put a stent in here to open this up for you so they did angioplasty, put a stent in. And then he told me that the front of my heart had, because I had heart attacks all day long, the muscle was damaged. He said it's very hard to tell with these muscles how long they'll stay damaged, sometimes they do recover, sometimes they don't recover, sometimes they recover better than we think. But he said he would like to put a pump in there to help to generate the muscle to be working again. It was not working in the front of my heart..... I had a massive heart attack

2. **Researcher:** *You had an intra-aortic balloon pump*
3. **Anne:** *I had a pump put in*
4. **Researcher:** *Wow*
5. **Anne:** *So he put the pump in and I remember him grabbing my arm, because I didn't know procedure in the hospital, I've not even been through that before. And grabbed me arm and he said to me, if you can keep this thing in for 24 hours or 48, even better, the better chance we have, no guarantee's, the better chance we have. And he just smiled at me as if to say you battle upstairs when you get there to keep this in. So my determination was I was not taking this thing out until I had to and the nursing staff I had upstairs were great people, Venus and Matt, they sat, one of them sat beside me 24/7 while that pump was in me, watching the computer and monitoring what the pump was doing but in the morning they wanted to take it out. The physician that was attending came around and he was going to take the pump out and I said no, I don't want it out and he said well I think we need to take it out and I said no, I don't want it out, you talk to Dr. M and he said keep it in, I'm not talking it out so they had a consultation and I managed to keep it in for 40 hours..... I stayed tied to that bed and I didn't move for 40 hours and I believe that that's why my heart started to regenerate and it started to work again because three days after the initial surgery they did an ultra sound after the pump came out and the heart was starting to pump again..... So I strongly believe that that's the reason why, I hope that's the reason why because I believed in him and he convinced me I could do it and so I did that. They said I recovered amazingly from the massive heart attack.*

By the time Anne arrived at the hospital by ambulance, she had suffered a massive heart attack. The moment she could no longer deny what was happening was presented as being the moment when the pain became unbearably intense (excerpt 1), demonstrating that she had indeed been considering the seriousness of this situation. She links her story again to

the profound anxiety she was experiencing, even to the point of feeling she wanted to run away. The way in which she presents her story leaves no doubt that she was aware of the potential lethal consequences of this situation. I have supported this recognition in excerpt 2 and 4 by reiterating her description of the intra-aortic balloon pump insertion, and then offering the exclamatory “wow”. In doing this, I have encouraged her to continue presenting her story as being very important and significant.

She has described this experience thus far, as someone who has acted responsibly in seeking help from her physician, and then taking the medication she prescribed. Although she is describing in detail how she followed the advice of her physician, her story is filled with suggestions as to her mistrust of the advice she was given, for example the way in which she introduces her story in the initial part of her interview.

Anne’s description of the very technical intervention that she underwent, that is the angioplasty and intra-aortic balloon pump insertion, contains many references to her participation in her care and how she felt she was being asked to participate in her care. She first describes signing the consent for this procedure with little explanation, because the cardiologist had made the strong suggestion that time was too limited to do more than this. She presents this part of her story as clearly understanding how life threatening her situation was. In excerpt 5, she makes a point of noting how the physician had grabbed her arm, to indicate how important it was that she understood what needed to happen, that is the need for her to have the intra-aortic balloon pump for “24 hours or 48, even better”. She depicts this in a way that she is again being asked to be a partner in her care, that her participation in her care is critical. She describes this with a sense of pride, and even offers

her interpretation of this as being the physician's way of demonstrating his reliance on her participation, and also his concern for her. In these first two excerpts from her interview, she has now twice referred to the compassion demonstrated by health professionals. Her inclusion of a description of how a paramedic had bantered with her in a way that made her feel understood and comfortable in the ambulance on the way to the hospital, and again when he had said to her "don't you die on me", was presented as a significant part of her narrative, and again pointed to her recognition that this health professional cared about what happened to her as a person. In this last excerpt, the small but significant encounter with her cardiologist when he had grabbed her arm as he talked to her after her angioplasty, also was presented as her recognition of his attention to her as a person, and not merely about accomplishing an intervention on her body. She describes both of these two scenarios in a way that links these two health professionals' personal connection to her as significant in the positive outcome of her care. She also describes these two scenarios in a way that links her own participation as a positive influence, and that this participation was invoked through their concerned communication with her. This way she is orienting her narrative to the personal significance and meaning of these encounters. Her interpretation of these encounters reveals what she sees as important to her in the end, and that was the caring demonstrated by these health professionals, as well as their acknowledgement of her as a person within these encounters.

The following excerpt in her interview reveals a very different experience in her health care journey. The following excerpt is a description of events a month and a half after her initial heart attack and angioplasty

1. *Anne: You know like I knew something was wrong but didn't know what it was, just did not feel the way I had been feeling. It had gone on for three, four, five days and it didn't get any better. Wasn't anything major but I just knew something wasn't right.....Yeah, tired short of breath all the time when I walked and I had been and just, you don't feel good I don't know how else to explain it, just not right. And so I went in and of course all my tests showed that everything was great and I was fine and my heart was doing good and blood pressure and all that was fine but the cardiologist, Dr. -- that dealt with me in the ER, she listened to me and understood that I was saying that my symptoms were getting worse. I was getting more numb face, I was getting more of this and I couldn't relieve it. So she said you know, I just don't like that it's getting worse so we're going to keep you and admit you.... they really wanted to take another look to see if I had a problem because I was off Plavix, if I didn't clot again or something... Well, what scared me was here I was with Dr. M, who did my original surgery, and that's who I thought my cardiologist was. H..... was looking after me, attending physician, so he was the physician who came to speak to me the second time now when I was in the hospital in August. He told me they were going to do another angioplasty, they felt they needed, or the angiogram and possibly a plasty if it need be. They assured me that that's what they would do. Well, I assumed that he was the one doing itAnd so, yeah I was nervous I didn't really want to have another done again but if it had to be done I guess I had to do this. So when they came, and this was all rushed, the nurse came in and she said they'll just fit you in and I said okay. So she came in and she said, you know, get ready, you need to go and shave, you need to get this ready and they're going to take you and they're going to do this right away so I was very panicked and I couldn't move very well because they had me on so many blood thinners and I was dizzy and light headed. Nobody assisted me, I was kind of panicked like, hurry up, you gotta go. Got myself ready and they took me down on the bed to like I don't remember being dark tunnels, it was like the dark tunnel, it was like scary, it was like where am I going? Whatever, so I get there and they just leave me in this hallway on this bed and it's dark in there and I have no clue what's going on and finally a nurse comes out to speak to me.....And I said don't know if I want to do this, I'm scared. And she said well I'll get a doctor to come and explain the techniques so Dr. W came out, he was a really nice man, came out and he spoke to me. He said you know you don't have to do this, no one will be mad at you if you don't go ahead with this, there's other ways to find things out it just will take longer and this is just faster and safer for you and if there's a problem we're here and we can do it now, whatever, but it's alright if you don't want to do this. He was very kind as so I sort of relaxed a little bit and out then came these other two people..... and this one guy reminded me of a Lebanese fellow and he said to me don't worry, we'll get you real good drugs, coke or heroine whatever you want. And I'm like*

okay he's trying to be funny I don't think this is funny in my mind and I said no I'll stick to Valium thank you, I know I'm not allergic to anything like that or whatever and he just persisted and then the nurse, she took me in there and I said where's Dr. H? Oh well, he's not doing it and I said how do you guys even know what's going on with me? How do you know my history? Like I've had S, I've had H and now who's going to touch me now, like who's in there? What doctor? Like, do you guys have my file? What's going on with me? And I didn't, oh yeah we know what's going on. I didn't get any reassurance, I sort of got the brush off treatment so I was a little nervous, they were wheeling me in there and then again this guy comes at me again and oh okay, she said give me Percocet and I said no I don't want Percocet, I don't know what that is, I've had Valium, give me Valium. I know I don't have any reaction to that and he said oh no, let's give her some coke or heroine and know I'm like upset because I don't know how this doctor is and it wasn't M.. it was someone named R and R is like nobody to me. I don't know this person and I got another Lebanese guy telling me he's going to give me coke or heroin and then they're talking about two babies and one of them is bye-bye, gone, no more and it's like they're laughing about it and I'm like, I thought I was in some kind of freak show. I had no clue what was going to happen to me. I was scared to death to begin with. I wanted out of there now but I was too scared to say I'm not doing this because now I thought I needed it so, I didn't feel they were competent and I got scared to death. The fear started from there and it's never stopped

2. **Researcher:** *So at that point, compare that fear that you're feeling then to your original experience*
3. **Anne:** *Night and day. I was totally calm and trusted everybody the first time (crying). And I had no idea what to expect the second time I was scared to death, I thought they were going to kill me (crying)...*
4. **Researcher:** *Is that right? Take a minute, its okay (:)*
5. **Anne:** *I'm usually a very strong person and I'm not really sure some days, even now, why I've reacted this way to some of these things because I realize that they work in an environment where they deal with people dying all the time and so they have to be a bit cold and turned off from it because it would be pretty hard to live with all the time. If you were sensitive and emotional to everyone coming through there but I thought they already understood that I was already afraid, so to make light of it in my face like that, I couldn't control the fear. It just created this fear in me that these people were, this is my life and they're dealing with me and they're not taking things seriously and it's like they don't care about me and I'm in here by myself no family even knew I was in here at that point because*

6. **Researcher:** *They had taken you at the last minute*
7. **Anne:** *Yeah, I was kind of ripped out of my room and told you're going and I thought I was getting my cardiologist, I got someone I didn't know and left in a hallway and it was just too freaky. Everything was just so unprofessional that it just compounded the fear each step I took to go fix this problem seemed like oh my God they're going to kill me, like nobody seems to know what's going on, they don't care, they're not recognizing that I need support here, I'm afraid....*

Anne had begun this interview with the suggestion that she had not been acknowledged in previous care seeking endeavors, such as when she developed mononucleosis. She also included in her description of the initial events around her heart attack, a description of how her concerns about her symptoms had not been taken seriously by her own family physician, and linked this to her delay in getting emergent care for her cardiac symptoms. She is presenting herself as having acted rationally and appropriately from her perspective. She then presented her connection to health care professionals' caring manner when she described events around her initial heart attack, and she presents this as an important part of the success of her treatment after she did seek emergent care.

In this last excerpt, Anne is describing the events around her second angioplasty, when she was not in the midst of having a heart attack as she was with her first angioplasty. This situation was much less life threatening for her, and yet had caused her incredible anxiety, to the point that she felt they were going to "kill her" (excerpt 7). In excerpt 1 she makes a point of mentioning the ER physician who had listened to her, understood her, and validated the seriousness of her symptoms. In presenting this, she is pointing to the importance of her own experiential wisdom that had been previously discounted. She has again clearly described the importance of feeling validated and having a connection to the people who were caring for her. When she required this second angioplasty, she describes

not knowing who was going to be doing the procedure, and most importantly, not knowing if she could trust the health professionals in charge of her angioplasty, because of their uncaring and unprofessional manner. She is describing the events around this second angioplasty as if she were now the outsider in a very serious procedure that previously had literally spared her life. The apparent rush to perform the procedure is presented as making this all seem dangerous for her. All of the people involved in her care are now new to her, and she is left wondering if they really understand the complexity and risk inherent in her case and therefore the meaning that this event holds for her. She describes being terrified, and yet does not challenge these health professionals. It is their uncaring and unprofessional manner that is presented as being most disturbing for her, to the point that she wonders if they care whether she lives or dies. She is clearly presenting that these health professionals do not seem to be aware of the significance this moment has for her. The apparent lack of caring or concern of these health professionals is linked to her subsequent mistrust of health care professionals in general, and a profound anxiety about her condition which she is subsequently unable to shake. In my brief comments throughout this previous excerpt, I have validated her description of the anxiety and thus encouraged her to present this aspect of her experience.

In this next excerpt Anne is describing how she is managing the anxiety and fear that she continues to experience daily since this last angioplasty:

1. ***Anne:** If I'm strong and feeling good about myself and my confidence is there, three weeks I've been doing the same thing and functioning again in my life, I'm fine with it. I can get the cold cloth or go have a shower, take a walk, just you know find a diversion that will take me away from it. But when I have a new heart incident being, you know, a situation where I can't fix it, then those things, again start to scare me. Are they real, aren't they real? Am*

I in denial, you know, so I really struggle to find a balance of where can I trust myself, who can I trust, if I go there are they going to do the right thing? Are they going to get, the information that I'm giving them, are they going to get it interpreted right and do the right thing? You know, like I really mistrustful of my own feelings of how they react to what I say of how, what are they going to do with me? You know, I just, I've lost that confidence (:).

2. *I remember my doctor growing up, Dr. ---, he was mine from a baby and delivered all three of my kids. He was the kind of guy, he was a teaching doctor at the Foothills Hospital, very well respected man. You could walk into his office and tell him something and he was like your father and he would say, well this is what's wrong, this is what you have to do to fix it...I guess that's what I was spoiled with. That is what I had all of my life and when I lost him, when he passed away, I've never gained the confidence of anyone. I went in there really sick to this new doctor and they're telling me they're going to do this with my thyroid and this with my this and this with my that and I said you know what, I'm not a doctor I just want to sleep all the time and I never sleep all the time. Could I have mono even at my age? No, you can't have mono. Well we're going to test your thyroid, we're going to do this, we're going to do that and well since we're testing all this stuff and doing all the blood work, could you just tick off mono? What's it going to hurt? Let's just test and see if I do have mono? I mean I had to convince them to test me for mono, guess what? I had mono! I don't know how I knew that, I just knew I was tired all the time where I could fall asleep at my desk at 10 o'clock in the morning, which is not me and I've never done that before in my life and I knew people with mono couldn't stay awake so maybe I had it and sure enough I had it*
3. **Researcher:** *So that's when your confidence maybe started to slip, probably hey?*
4. **Anne:** *Yeah, yeah, and then she's the one who sent me home to have a heart attack and you know, I just don't know. I gained confidence with Dr. __, his staff that night in trauma were awesome and then came home and then the second problem happened the way I was treated, I just lost everything*
5. **Researcher:** *So do you feel a little betrayed?*
6. **Anne:** *I don't feel like I have anybody who's looking out for my best interest right now. Like I don't have a family doctor and the cardiologists are very hard to get a hold of and they're very, you know, you get passed around. You get one that operates on you and then you get one who attends you and then you get one who discharges you and then you go to [cardiac rehabilitation] and there's different ones there and who's got all my information in one*

place? Like, who is taking care of me?...Who's got control of this? Because I don't...I need to have a sense of somebody knows what's going on not just me, someone to help me (crying).....Someone's who's going to give you that direction, you know. Like we've done this, this and this. I go see the cardiologist next Friday, Dr. ____, I've never met him. How do I know she's got everything about me? Like Dr. ____ has stuff, Dr. ____ has stuff, Dr. ____ has stuff, like who has all my stuff?

7. **Researcher:** *And you've probably been somebody who's very much in control, I get that sense*
8. **Anne:** *Absolutely. I round up all the ducks in this house and mange everything, multi task major, yeah that's me. So it's really hard to, it's not getting over control because I think I can get over control when I have to, but I also have to have the confidence of who I'm giving it to has my best interest at heart and I don't feel that. I don't feel there's anybody out there for me and I don't feel like I'm capable of knowing all this And I refuse to be an internet doctor and search myself and question everything that the medical profession is doing to me because they obviously know more than me so I need to have that confidence in them but I don't know who that person is. Who is that one person that I can say helped me? [crying]*

In this past excerpt, Anne is extending her previous description of losing trust in health professionals, to now including herself as being untrustworthy. The incredible anxiety she describes in this and the previous excerpt, is now linked to all of her day to day experiences, including the management of symptoms, as well as her care seeking. She is presenting herself as being untrustworthy, because the physical effects she is feeling as a result of the anxiety feel much like the cardiac symptoms she was previously having, and she feels she might be inclined to deny the seriousness of those symptoms (excerpt 1). She is also presenting herself as being reluctant to make decisions on her own, that she needs someone there to reassure her. In excerpt 1 she presents herself as having no where to turn with any confidence in dealing with her illness, including herself. In excerpt 2, she links her current mistrust of herself and the health care system to the confidence she had in her old family physician, who really „knew’ her, from the time she was a baby. This link was

perhaps encouraged when I offered the possibility of her losing confidence in her care (excerpt 3), and then offering the possibility that she might feel betrayed (excerpt 5).

She now links her anxiety to the fragmented way in which her care has unfolded, for example with having several cardiologists being involved in her care, through several health care sites. She, like Nickie, is now presenting herself as being very reluctantly in charge of her health, and not at all confident in the care she might receive should she need emergent care. In excerpt 8 she describes how her experiences with getting care for her heart disease have left her feeling perplexed, frustrated, frightened, and left wondering who has *her* “best interests at heart”. Articulating her concerns in this way points to her need for more than just technically sound health care interventions, she wants to have herself and her overall well being as the centre of concern in her interactions with health care providers. In saying that she wants to be “helped” with this, she is demonstrating the kind of onerous responsibility she feels. This passage suggests that perhaps that she does not feel connected in the care she has received for her heart disease, and that her heart disease is something for which she has felt largely responsible. The need to trust and feel cared for by health professionals was something that came through very clearly in my other interviews with women.

Looking Back at Women’s Interviews

Resistance to their diagnosis.

Every woman I interviewed resisted their initial diagnosis of heart disease. For some, like Sharon, it was presented as being a surprise because of the way in which they had managed their health by aligning themselves with the discourse of cardiovascular risk

factor management in their daily lives. For some, even those who recognized that they had considerable risk for developing heart disease such as smoking, or a strong family history of heart disease, the diagnosis was still presented as being an unwelcome surprise to them which they continued to resist. The diagnosis was presented in this way as something that was not personally coherent for them. Some overtly acknowledged the blaming implications inherent in the discourse of cardiovascular risk factor management. Others indirectly referred to the blaming inherent in their communication with health professionals who communicated with them about their heart disease by framing it around this discourse.

I was struck with how the discourse of cardiovascular risk factor not only exercises power to produce practices and subjectivities among health care professionals who orient their practice to align with this discourse in the ER, it produces practices and subjectivities among those seeking care. This discourse produces an expectation of “rational behavior” such as the personal management of cardiovascular risk factors, and maladaptive behavior and lack of knowledge are seen to be the major culprits in the development of cardiovascular disease. The implication in their care seeking seemed to be that a moral health care “citizen” would align themselves with this discourse, and the very fact that they had developed heart disease could be seen as a moral failing.

Part of the resistance to accepting the diagnosis of heart disease, was a resistance to the blaming implications of the discourse of cardiovascular risk factor management, as well as a resistance to the insinuation that they were now categorized as someone who did not manage risks related to their heart. It seemed to be an ethical tension that these women

were experiencing in how they viewed themselves, and how they were viewed in health care encounters.

Despite this resistance to the blaming inherent in the biomedical discourse of cardiovascular risk factor management, much of women's narratives regarding their experiences were in alignment with the biomedical perspective. For example, they presented a detailed tracking of when symptoms started and how long they lasted, the nature of their symptoms, and what they had done to relieve those symptoms. They frequently wove in descriptions as to how they had or had not aligned themselves with the discourse of cardiovascular risk factor management in their everyday lives, revealing their ongoing self-subjection to this discourse. In this way, their identities as cardiac clients were constructed by them through their self-subjection to the discourse of biomedicine and cardiovascular risk factor management.

The resistance to accepting the diagnosis of heart disease that women presented in their narratives was also linked to the implications this had for their families and friends. Sharon presented this as her recognition that with her diagnosis her daughters now had acquired awareness of their own additional risk of heart disease by having a family history. For most, like the stories presented here, the diagnosis of heart disease meant that their family and friends were now subjected to the added stress that this serious diagnosis conferred. Nickie was also acutely aware that she may not live to see her son grow up, and for her this was the most distressing thing. Most women spoke of their potential death, and the implications this would have for their friends and families. The ongoing surveillance they conducted on themselves for symptoms of heart disease, forced them to be continually

orienting to the possibility of their own demise. The onset of each episode of cardiac symptoms, was a stark reminder that their very existence was at stake, and perhaps largely dependent on their ability to follow the advice that had been offered by health professionals in the past, including their immediate presentation for, and submission to, treatment. Within the going concerns of their daily lives, was this ever present possibility lurking in the shadows. Accompanying every submission to seeking emergent care, was their uneasy submission to this possibility. When cardiac symptoms appeared for these women, it was a harsh reminder of these implications, and they were then compelled to reluctantly orient their behavior and way of thinking to align with the biomedical imperative of seeking immediate help. Where normally their everyday activities would be oriented to other important aspects of their lives such as their families, friends and work, they were now obliged to reorient themselves and their activities to the very real possibility that their lives might be at risk. They were thus uneasily compelled to subject themselves to the discourse of biomedicine because of the life threatening implications that their new diagnosis conferred.

Orientation to Time: Invoking the Discourse of Biomedicine and Efficiency

In reviewing my interviews of the women who sought care in an ER, I became aware of how often time is mentioned or referenced. This was also very definitely the case in my observations of nurses and physicians work in the ER. Time was valorized by both myself and the women in their interviews. In many instances, my orientation to the timing of events in their narratives led them to also account for themselves in relation to time, and so I was complicit in streamlining their accounts to align with this biomedical perspective.

I am left wondering about the origin of the discourse that is driving this need to frame patients' experiences in terms of time. My 23 years of critical care bedside nursing are again showing through in my own questioning. I have learned to legitimize, quantify, and think about the experiences of the patients I cared for by framing them this way. I have learned to elicit patients account from within this scientific perspective knowing that I will need to document their stories in a way that "makes sense" to other health care professionals. This discourse that is being invoked is the biomedical perspective, where symptoms need to be "clear" in order to be understood and acted upon.

In the ER, nurses' practice is constantly being oriented toward time. The time of the initial assessment is documented at triage when the patient first enters the computer system. This time becomes part of the information used to decide who has precedence in receiving care. From this point, there is a continuous and permanent computerized accounting of things such as patient wait times, time between physician orders and their execution, time of nursing assessments and reassessments, time spent waiting for results of diagnostics, and time spent waiting for a hospital bed. In this way, time becomes a way to quantify quality of care as well as efficiency of patient processing, of patient flow.

One of the first comments made to me by the nursing manager of the department was that my research could in no way interfere with patient flow. Flow of course is the measure of volume over a given period of time. Because of the computerized charting system, which is accessible to everyone, there is a constant awareness on the part of ER health professionals on how well the department is doing in terms of patient flow.

Health professionals' work has come to be measured and accounted for in terms of time.

It seems as though time is particularly part of the discourse in nurses' practice. Nurses are called upon to put a time entry each time they document, which is not always required of other health professionals. Nurses are pressured to give patients medications at a specified time, even if at times these institutional schedules do not necessarily align with the patients home medication schedule. Current computerized charting forces nurses to consistently document within a time framework. Physicians' orders are documented by time, and their execution by nurses is documented by time, although there is much less requirement of physicians to keep track of the time of their assessments and interventions.

The relentless marking of time in health care becomes not only a way of disciplining and accounting for health professionals' practice, it becomes a frame which is applied also to those seeking health care. In cardiovascular care in particular, time is of utmost importance. "Time is muscle" is an adage that health professionals are all familiar with, that is in the case of a myocardial infarction due to an occluded coronary artery, the longer it takes for that occlusion to be opened with thrombolytics or angioplasty, the more cardiac muscle becomes damaged or necrotic. This is true to the point that after a certain amount of time, it is no longer beneficial for these revascularization techniques to be initiated because very little to no cardiac muscle can be salvaged. So the concept of time is invoked when eliciting a description of symptoms for instance: "When did your symptoms start? How long did they last? How often have you had these symptoms in the past week, month, year? How long has it been since your heart attack?"

I remember during the interview with Anne, that I was almost unable to think about what Anne were describing to me until I had temporally framed her experiences. In one

instance Anne had just finished a very emotional accounting of an experience, and I responded with, "So this was the end of October?" I remember in that moment I felt very moved by the story, and yet what came out of my mouth was this very callous question. I remember being conscious of this during the interviews, and then again when I reviewed the interviews, and yet I would find myself repeatedly asking questions about time.

So I am left with, "What is being accomplished with this kind of communication?" From my observations in the Emergency department, as well as from my interviews, I can see that patients are constantly called upon to clarify their stories in terms of time. In asking how long a patient has had a given symptom, we are engaging them in a dialogue in which they have to give an account of their practices as competent and deserving health care recipients. In their presentations they validate their actions by presenting themselves as having sought care in a 'timely' manner, and thus present themselves as having a competent identity. Although I have observed that there is an underlying assumption by health care professionals that the competent patient would have tried to manage their symptoms to a certain extent before seeking emergent care, so there is often a fine line that the patients need to negotiate. Patients' orientation to time becomes part of their acknowledgement of the rules of engagement in a health care setting. Time then, becomes the panopticon for health professionals as well as patients (Foucault, 1995). Orientation to time becomes a regime of power in which each participates. Health professionals' as well as health care recipients' practice becomes oriented to time in the way they are conscripted to account for their own practices, and thus each become complicit in reifying this aspect of social order in the health care encounter.

Women waiting to be seen.

Perhaps what stood out most strongly for me in all of the interviews with women, was their need to articulate the complexities within which they were required to live with heart disease. All of the women interviewed wove in descriptions regarding their family, their work, and day-to-day roles and responsibilities into their narratives regarding living with heart disease. This not only revealed the supremacy of family, friends, and work implications in terms of how they normally conducted their lives, it suggested that they needed to be understood as being multidimensional and complex, and not merely as people with heart disease. Nickie articulated this as the physicians only seeing *heart* when she sought health care, as if this diagnosis was so powerful that it took precedence over everything else. Like Sharon and Anne, others also described that health professionals caring for them had not demonstrated an understanding of the personal significance that their cardiac symptoms held for them, and this contributed to their anxiety and resistance to seeking care again.

Women consistently wove in descriptions of their families' reactions to instances where they were required to seek emergent care. These narratives suggested that interpreting and acting on their symptoms was not just an interpretation of themselves and symptoms of their illness, it was a concurrent interpretation of the potential implications for other aspects of their lives. Most concerning was that every one of the interviews I conducted with women revealed instances when they had resisted seeking help when they knew their symptoms were probably cardiac in origin. Although they did not directly link their lack of seeking treatment to their concerns with other aspects of their life, they presented their

narratives in a way that wove in their thinking regarding these personal matters as part of their decision making when they avoided emergent care. Their narratives presented both the taking up and resistance of the biomedical advice they had been given. Their uneasy subjection to the biomedical imperative of seeking emergent care for their cardiac symptoms was in part the result of implications for other aspects of their life which were seldom acknowledged in their care seeking encounters.

Outsiders in their health care experiences.

Women's narratives regarding their emergent care seeking was always very detailed regarding their thinking and actions leading up to this event. The women who had called for an ambulance most often remembered conversations they had had with paramedics, but their memories of the events seemed to fade after entering the doors of the ER, except for times when they were admitted for angioplasty or to the coronary care unit. I found this frustrating at first, as I was trying to capture some of their experiences in the ER, but their stories were presented as if once they entered the doors of the ER, they were no longer in charge of how things proceeded, and they had no need to carefully think about their course of action. I asked about instances of communication within the ER as well, and again these descriptions were most times vague, even including moments when they were given results of diagnostics. They presented their narratives as outsiders to events in the emergency room, and in the end I realized that this was quite significant.

The one moment that all women remembered very clearly in their narratives was when they were taken into the angiography lab for angioplasty. This moment was presented as universally terrifying for them. That moment was not only presented as being terrifying for

them in terms of the invasive nature of the intervention, it was the moment when they were given irrefutable evidence of their continuing issues with heart disease. The angiography and angioplasty left no room for speculation about their heart disease, and this was presented as a moment of clarity regarding the life threatening nature of their disease, and perhaps their ongoing need for very technical interventions such as this that might have life saving potential. The time in the angiography lab was clearly the moment where biomedicine emerged as a powerful and intimidating necessity for the potential continuation of their lives. This too was a moment of uneasy subjection for them that always potentially lay in wait for them with each care seeking encounter.

Moved by acts of caring

Almost universally, women's narratives did include praise for the nurses and physicians who cared for them in the ER, and several of them spoke of brief moments when a physician or nurse had demonstrated an act of caring. Anne's description of the moment when the cardiologist grabbed her arm as he was explaining the significance of the next 48 hours for her after her emergency angioplasty was presented as a moment of caring and connection. Other descriptions included things like being offered a warm blanket by a nurse, or being given a hug for comfort, or being asked about their families. Anne made a point of describing the ER physician who had validated and understood her concerns regarding her symptoms prior to her second emergent angioplasty. Many of their descriptions of these small acts of caring brought them to tears in their narratives, as if this was very significant for them. I found this to be very telling, as acts of caring like this from my perspective should be seen as a natural occurrence in a health care encounter. Few of

them directly articulated a concern that their care in the ER had been anything but professional and appropriate. Their narratives positioned them as being in continual tension between appreciating the care they had received, while resenting and resisting the necessity for it at the same time. Women's tearful descriptions of those moments of caring they experienced somehow demonstrated to them that they had been acknowledged as people caught up in this frightening encounter, and this was very meaningful for them.

Losing trust in health care.

Throughout women's narratives, they presented an awareness of their bodies, and their ability to interpret their symptoms. Many times, the anxiety that they experienced in conjunction with their cardiac symptoms served to confound their interpretations, and this was presented as losing trust in their ability to assess themselves. Many women reported being discounted in health care encounters before and during their experiences with seeking care for heart symptoms, and this was presented as a moment of confusion as well as resentment which perhaps contributed to their mistrust of themselves. Most women did not report challenging health professionals in health care encounters, but their detailed explanation of those moments when they were discounted pointed to this resentment.

Women's stories of their everyday lives brought to light the way in which they tried valiantly to follow the advice of health professionals regarding the biomedical management of their heart health. They were diligent in getting the required diagnostics completed such as lab work, exercise tests, and other cardiac diagnostics. They carefully monitored their symptoms, took their medications, and made the required follow up visits with their physicians. Women's narratives however, revealed many moments when they had

experienced conflicting advice regarding the management of their heart disease. What really stood out in their narratives was the inability of health professionals to live up to the advice they themselves had given, and this resulted in a loss of trust for women. Nickie for example, had been told that she needed to monitor herself closely for the first six weeks after her initial angioplasty, and that she would need to follow up with her cardiologist at six weeks as well. She was unable to get an appointment with her cardiologist however, and this left her with great anxiety, in particular because she was having ongoing cardiac symptoms. Sharon, as depicted earlier, was left with deep distrust of health care professionals after her very serious adverse event following her angioplasty which she was told was medically necessary. Her experiences in being discounted within her health care encounters in the hospital also contributed to a resentment and distrust of health care professionals. Anne had been left feeling as if no one had her best interests at heart after her second angioplasty where she felt the care she received was unprofessional and uncaring. Women's loss of trust was linked to a lack of acknowledgement for their experiential wisdom in previous health care encounters, and for a lack of acknowledgement for the personal meaning of their care seeking. Most women presented feeling a loss of trust in the health care system as a result of failings such as this, as well as a lack of support that they anticipated receiving after an event of the magnitude that they all experienced.

Women understood the limited resources that health professionals were asked to practice within, including their limited time available for individual patients. Their narratives often included an orientation to this discourse of limited resources with comments such as “this *better* be a heart attack”, or “I don't want someone dying out there

while the paramedics are picking me up” when speaking of circumstances around seeking emergent care for cardiac symptoms. They frequently made references to wait times in the ER as a consideration for them in their decisions to seek care, not only in terms of their own potential wait, but also as a consideration of the health needs of others waiting for care. It was also their orientation to the discourse of limited resources that made them question health care professionals’ ability to offer the care they needed, while still attending to others in need of emergent care. It was their loss of trust in health care that also contributed to their uneasy subjection to the biomedical advice that had been offered them regarding their heart disease.

These women’s narratives, although not about ER encounters as such for the most part, offered insights into their understandings and practices regarding their heart disease. It was the ongoing interpretive work in which they had engaged within the messiness and complexity of everyday life that had contributed to the construction of their identities and practices. The meaning they attached to their symptom experience and management in their everyday lives contributed to the way their emergent care seeking unfolded, and much of their narratives were about these day-to-day activities. Their ER encounters had contributed to their constructed identities and practices, but more importantly, it was their constructed identities and practices that influenced how their everyday activities proceeded, including their emergent care seeking.

Chapter 6

Health Professionals: First Seeking to Make a Difference

The interviews I conducted with nurses and physicians working in the ER were commenced after I had spent four months doing field observations in this ER. This proved to be a very valuable platform from which to begin discussing their everyday activities in the ER, as I had shadowed most of them at some point in these field observations. I had discussions with most of them about my research during my field observations, and I had the sense that many of them had given considerable thought to their practice prior to these interviews. The nurses in particular were very eager to discuss their practice with me. I had been honored to be allowed to follow them in their practice in the ER, and so many times during my observations I had been moved by their incredible skill and ability to manage the most devastating life threatening situations. I was inspired by these health professionals during my observations, and now their willingness to engage in interviews pointed to the significance we both understood regarding the nature of the work that they engaged in on a daily basis. The following is a summary of some of the insights that were produced through an analysis of their interviews. I interviewed both male and female nurses, but for the purposes of confidentiality, I will be referring to all of the nurses as “she”, and physicians as “he”.

Surviving and Thriving in the ER

In the interviews, health professionals consistently began their narratives with a description of the pride they had in their practice. For most, part of that pride was the very fact that they were required to practice in a very chaotic, unpredictable and high stakes

environment. Their stories were filled with descriptions of the pressures they felt in their practice, not the least of which was the lack of resources they had to deal with, in particular the lack of beds in which to assess and treat their patients. One of things that emerged as I analyzed the transcripts was health professionals' description of how they loved their practice in the ER, despite, and even because of the inherent challenges. As one physician put it:

1. **Physician 1:** *I think a lot of us in emergency medicine who are really academically driven and involved who probably would be surgeons if we really liked the technical component of it, like the idea of having the control, like the operating room, like that practicing medicine in an austere environment to some degree, and like having the capability of making decisions and changing course, courses of clinical pathways significantly like a surgeon does.... I really, really do like the unexpected, hence doing STARS too, like I sit here at the base waiting for crashes and disasters to happen because I really like that idea that somebody's going to call me and ask me for help and I know I've got the knowledge and skills to help*
2. **Physician 2:** *I think that's what draws a lot of us to emergency medicine in the first place is that we are trained to look after critically ill individuals and I think we do a pretty good job of it....I think that's what really what attracts me to emergency medicine the most, is knowing that there's a good chance on both shifts that I will look after sick people.*
3. **Physician 3:** *I just enjoy it. I mean it's, a lot of it's, well canned answers but really genuinely the team atmosphere and working as a team and just the medicine, you never know what's coming in the door and some people don't like that and others thrive on it and I'm just the kind of person that thrives on not knowing what's around the corner and a little bit of adrenaline is always healthy and it's satisfying because you get immediate or close to immediate answers to the questions you're asking.*

In these previous excerpts, the physicians are presenting their view of practice as being primarily about offering life saving treatment his work. Many similar comments were

offered by nurses in their interviews. For example, these comments came from 5 different nurses regarding their practice:

1. ***Nurse 1:** Well there's, I think there's a certain persona that's drawn to this environment, you know, the highly driven person that wants to be out and make the biggest impact on someone's health and I think that emerge, it really draws, as do other areas of specialization, I think it really draws the cream of the crop. And there's a certain camaraderie that comes from that.... I think, you know I don't want to speak for other nurses, but I think to our staff it's not just a job, it's not just a paycheck. You know, there's something at the end of the day to be, I mean not that other areas of specialty have any less reason to be, but I think that there's a common kind of goal of the staff that work here. And it kind of creates, for a lot of people, for a lot of our staff, and because of what we see everyday, and because you're in the trenches side by side everyday there's a camaraderie and you, the staff here are almost like a second family to each other and I think that's where that tightness and that bond comes from*
2. ***Nurse 3:** I think I really like the way that the nurses in emergency are part of the diagnosis process, you know, like they really are able to start a lot of stuff off before the doctor sees that patient and if we are calling a doctor to the bed side emergently they know that something's going on and there's a level of trust between us and the physicians that I don't you get when your a floor nurse and its not, I mean floor nurses they do a lot of great assessments and they communicate back and forth with the doctors but its more like the doctor gives you the order and you carry out the order rather than you're suggesting other ideas about what the patient could be presenting with and you're collaboratively figuring out how you're going to treat that person so I just like the integration better. I like that we get a lot of time to think for ourselves and a lot of the physicians will say well what do you think? Do you think this would be appropriate for this patient? Do you think this patient can go home? You know, and they're very interested in our opinion being at the bedside all the time and I really liked that.*
3. ***Nurse 4:** I got hooked on the trauma, like I loved the adrenalin rush of the trauma patients.... Now that I'm older I don't really need that adrenalin rush (laughter) but I still like the ever changing pattern in emergency and I feel like sometimes now it's so hectic and it's so busy that we aren't giving the kind of care that we should be giving to patients but at the same time I'm still there because, you know, because I feel like you're trying to do what you can to make a difference and when I'm there and it's absolutely crazy and there's forty admits laying there and what not, you want to feel like you're making some difference and I think as long as you can still feel that, you know, then you get some gratification from the job some satisfaction*

4. **Nurse 5:** *It's the change of, it's the puzzle, it's the not knowing, it's the change. You go into work and every time something's different, it's the team work between staff.*
5. **Nurse 7:** *I'm sure you've heard from everybody, the variety, right. So you are able to keep your knowledge up in all areas and it doesn't slack off in any of the disciplines so that's what's good. Now, when I listen to the younger nurses a lot of them are here for the adrenaline rush And, I probably was here for that as well, at the beginning, that's certainly not what motivates me now....So I know with the younger nurses I hear that almost every single day, oh I'm looking for a good code, oh I'm looking for this or that, so it's not my motivating factor any more so what kept me in emerge I think it was the variety and the fact that I'm able to keep my knowledge up in all aspects of medicine.*

What seemed to be consistent in nurses' and physicians' descriptions of their practice was not only a description of the pride they had in their work, but a sense that they were making a profound difference in the lives of those who sought care in the ER. Their work was consistently described in terms of its high intensity, complexity, and excitement. They frequently described a sense of solidarity and trust that came from working in very difficult situations together.

Nurse 1's use of the military terms such as "camaraderie" and being "in the trenches side by side", depicts ER practice as being perilous, difficult, high stakes, and even self sacrificing, in that staff 'choose' to practice in this difficult circumstance. He depicts the ER as drawing highly driven and highly competent professionals who willingly put themselves in this high stakes circumstance in order to make the biggest difference for those seeking care. In these previous excerpts, it is interesting how these health professionals introduced me to their practice in terms of how they saw their role in providing treatment, most significantly in terms of providing treatment in life threatening situations and really making a difference. The interviews, including these cited excerpts,

clearly demonstrate that one of the compelling features of practice in the ER is the unpredictable and even dangerous nature of this environment. In all of the interviews I conducted with nurses and physicians, it was clear that they were passionate about their practice.

Strong Orientation to Biomedical Perspective and Transitory Nature of the ER

During all of the interviews with health professionals, I attempted to elicit a sort of day to day description of their practice, including a description of how they went about attending to patients with potential cardiac disease. Not surprisingly, the biomedical perspective was very dominant in their narratives. Many comments were offered regarding the temporary and transitory nature of the ER as well. Frequent comments were made that the ER as a place of provisional health care where life threatening issues were attended to, and then appropriate follow up initiated. The following excerpts illustrate this:

1. **Physician 1:** *Well coming out of the five years of training, the mandate I have, I guess, and the skills and what I'm able to provide is when I'm in the emergency department and there isn't a single thing that can't come through the front door that I can't manage at least for 15 to 30 minutes without any concern and I feel very confident about that and that's a beautiful thing to walk into the department, really walk in there and just be like bring it on. I don't care who you are or what happened or what's sticking out of you, I guarantee you I am as trained, or probably the best trained in the department to manage you if the first 15 minutes, 30 minutes of your what ever that is, whether it's a pediatric patient to a trauma patient to a pregnant woman.*
2. **Nurse 2:** *So, we're the first ones to see the patient that ever comes into the hospital and from there they make a decision whether that person needs to be consulted to something and then, or if the person comes right into trauma we're the one's to keep you alive long enough before you go to OR to get whatever needs to be fixed if you have gun shot wounds or multiple traumas from accidents. We're the ones, we don't do a fancy job, we're the ones that keep it together and good enough, long enough and at least temporarily until you get to where you need to get to. Or we can sometimes fix a little bit but*

we can't finish it. I guess you could say ER never finishes, well no, there is times we can send people home and we can consult you out to other programs that are set up now because the hospital can't always, cardiac surgeons or cardiac doctors can't come down all the time for every heart attack and sometimes it doesn't show any troponins rising or ECG changes so they might contract you out to a cardiac service that will be fast within a week or two weeks and make sure you're doing okay.

In these previous two excerpts, these health professionals are presenting their practice as being primarily oriented to offering immediate life saving care in the presence of critical health issues. They present this part of their practice with a significant amount of pride. Their practice is presented as being about keeping patients alive until more specialized care can be initiated, or until follow up consultations can be arranged. The nurse presents ER practice as not „finishing’, demonstrating her understanding of ER practice as being temporary only.

Physician 2:*And what attracted me to the emergency department was a couple of things, one was the fact that you were still exposed to a wide variety of pathology so any evening you could see people with heart attacks and trauma patients all the way to more simple things such as ankle sprains that I found it quite challenging to have to be, to be up to date on the current management of all these topics. The other thing that actually becomes more important now that I have a family is the absence of a pagerSo the idea that you come in and that you work hard and once your shift is over you leave and you sign your patients over to somebody else, actually really helps me to switch off at the end of a shift and allows me to focus on family or other non-clinical commitments*

In this previous excerpt, this physician presents another temporary aspect of his practice that is quite different from other physicians’ practice, and that is the ability to go home at the end of a shift and not have any further responsibility for the care of patients he has seen. This really does add another dimension regarding the transitory nature of ER care, and this

is presented as being a very compelling aspect of his practice that allows him to “switch off” at the end of a shift.

In all of the interviews with health professionals, I asked them what they saw as the mandate for the ER.

1. **Researcher:** ...*What do you see as the mandate for emergency medicine?*
2. **Nurse 7:** *Unfortunately I see, from a physician's perspective, what I see is to treat the presenting complaint. Get the patient out of the department as quickly as possible.There's, I'm just trying to think of interactions of physicians with patients, I think very seldom are they tending to look at the big picture. I think the only time they look at the big picture is if our patient crashes and then they have to look, like oh, why is this happening? And it has nothing to do with the presenting complaint. I think a lot of times that's happening that we're not getting really, truly to the bottom of all of this.*

In this previous excerpt, this nurse describes the predominant focus of care in the ER, that being a focus on the presenting complaint. This is presented as being linked to the need for improving efficiency and patient flow, as there is not enough time to address every health issue the patient may have. I was reminded of my field observations, when triage nurses would frequently ask the patients “What is the emergency that brought you in today” as a way of framing the patient’s interviews, and perhaps reminding each patient about the nature of the environment in which they were seeking care. Very often the question would be asked, “What is it about today that prompted you to come into the emergency department?” In this way, an orientation to only the presenting complaint limited the health issue to a very narrow window of time. In the ER environment there is little time or ability to review and interpret past medical histories, nor is there the mandate to be responsible for future care. Health issues in the ER are viewed within a very narrow time frame by health professionals, and this is presented by this nurse as not looking “at the big picture”.

In each of the interviews I conducted with nurses and physicians, I asked about their practice when people presented with potential cardiac symptoms. Almost exclusively, their answers were framed with an orientation to the biomedical perspective of the discourse of cardiovascular risk factor management as previously discussed. The following are excerpts that demonstrate this:

***Physician 1:** Okay, well a lot of it is past medical history. That's the huge component because risk stratification and cardiac disease for one is somewhat allusive at lot of the time in the sense of how are they going to present in such varying ways, I don't think I need to tell you all this stuff so I re-stratify them just based on past medical history alone and I usually can do that from the triage note to say, you know, what are they here with before? And then as far as if they're coming in with chest pains, it's the classic questions, you know, the character of the chest pain, when did it start? And so the thing that we really like to know that are really important is how it is different then normal chest pain you've had? Like so what makes this different? And why did you come to the emergency today with this kind of chest pain? So really getting to try to understand what the patient's interpretation of their chest is. There's lots of women and men with stable angina that have angina everyday so common questions I have is, you know, do you have nitro spray? Do you use it? How often do you use it? When do you use it? What's the usual response to it? So see patients sometimes that a family member has decided to bring them to the emergency department because they've chosen to use their nitro spray today, lets say they're visiting from out of town, but it's something they do every single day and so it's a quick re-stratification to go she has cardiac disease, it's stable, there's no difference to it today. So a classic question that I would ask even my residents that are presenting to me is why did this patient come today? What was the issue today? And then from the chest pain point of view is the classic questions, where is it? Where does it go? How does it feel what makes it worse? And it's always a beautiful thing, you know, like if they say I was weight lifting yesterday, you know, those real ones that you can go, oh okay, not a 100% but there's a good story that this is MSK related or, in women it's always in the back of our minds and I have yet to be burned but I'm sure I will be, but having a pulmonary embolism presenting with chest pain and I admit and me missing it and so that's when I always have on my radar is what other mimics of chest pain does this patient possibly have? And then everyone, the one embarrassing thing that people have, is do they have herpes zoster on their chest that you're going to miss because you didn't do a proper physical exam. So that, so I always ask about a rash*

This physician's description of his practice is clearly presented as having a strong orientation to the biomedical perspective. He presents the medical imperative of making an accurate diagnosis as his primary concern. Again the question is asked, "Why did you come to the emergency today?" By framing his practice in this way, he is presenting his understanding of his practice as being oriented to potential critical and acute health issues versus chronic ones that would not necessarily fall under the mandate of the ER. His description of his practice is almost entirely framed from the perspective of what he is required to do, versus an orientation to the circumstances of, or implications for the patient. His description of "I have yet to be burned" or the implication that he would be embarrassed at a misdiagnosis of cardiac chest pain versus herpes zoster, reflects his primary orientation to his own practice. In framing his narrative in this way, he is situating himself and his practice as primary in health care encounters in the ER.

This physician describes the thinking behind his decision-making in terms of risk stratification. This orientation is from a population health perspective, and so individual health concerns are reframed from being an issue affecting individuals in the context of their private lives, to being an issue to be rationally analyzed with regard to their relative risk according to population health statistics.

This physician's presentation of his practice illuminates his rational and economically efficient approach to offering care.

Other physicians had very similar comments regarding their practice:

Physician 2: *I think that the perfect patient that comes in with lets say middle of the spectrum chest pains, got some risk factors but you're not sure what's going on is able to describe what their symptoms are, is able to have knowledge of their past medical history, and is able to tell me what their risk*

factors are, has knowledge to understand the tests I'm doing, so that's a, well there's a good example of how I'd, what I'd do. The knowledge of a troponin test, right, to say I'm going to hold you here ma'am or sir for another eight hours when I'm going to re-do another blood test to help me understand what's going on with your heart, that's frequently not understood and they stare at you like what are you doing? You need to poke me again? Whereas if somebody has some medical knowledge or knowledge of chemical assay or understands the idea that troponin levels will rise over time and we can't measure that right now, that makes it a lot easier and I think patients have a lot more buy in when they understand what's going on. I bet they, I may be inferring but I get the sense that in eight hours when I say you've been here for eight hours, I've repeated the troponin your chest symptoms haven't changed, now I'm a lot more confident or I'm able to rule out ischemic disease with a lot more, a lot more precision and you get the sense that they're a lot more reassured with what's going on, whereas someone who doesn't understand that test kind of goes you kept me here for eight hours and now your sending me home and you still don't know what's going on. I think that's where some education, knowledge of the medical system, knowledge of kind of pathophysiological processes does make a difference in follow up and their care as well.

In this last excerpt, I have just asked the physician about what an optimal cardiac presentation might look like from his perspective. In this narrative he describes the importance of patients' understanding of the significance of the medical care they are receiving, and the importance of them „buying in'. He presents the importance of their understanding of the biomedical view as being linked to more precision in his diagnosis as well as better outcomes. So in this view, he presents the patient's role as being one of understanding, complying with, and therefore optimizing his medical practice. An orientation to the patients themselves or the optimization of their health appears to be eclipsed by the biomedical imperative offered here.

In the interviews with nurses as well, I asked them about their typical kind of practice with patients with potential cardiac disease. The following comments from a very experienced nurse, typifies the kind of responses I received to this question:

1. ***Nurse 4:** Occasionally I ask them if they're smokers, I can't say I do that always, always, but I do sometimes. I don't ask them about diet. Sometimes high cholesterol will come up in their medications or whatever, or things like that. High blood pressure often, yeah I ask about that, so some things I guess. I think by the time you've asked your first three or four questions, you've got a pretty good clue of whether they're going to be cardiac or not*
2. ***Researcher:** So tell me about that, tell me how you arrive at that? And I know a lot of it is hard to articulate*
3. ***Nurse 4:** It is but, well first of all I ask them about the pain, where is it? Any symptoms associated with it? You know, so I'm kind of looking for the classic cardiac story and if they're falling in that group I probably know in the first couple of questions. If they're not then I'm asking if there's family history and I'm asking a bit more about possible conditions like diabetes and things like that sort of thing, are you on medications? Do you have high blood pressure? Things like that, so I'm looking for some risks if the first few questions don't give me the picture, kind of thing and sometimes people are extremely vague, like you're, like you're really trying to pull some history out of them and they're just really, really vague and it's very difficult, you know, so sometimes those ones are the ones that get flagged just because they are so vague and you can't pin point what's going on*

Like the previous excerpts from physicians, this nurse presents her practice as being linked to the way in which patient's stories align with the biomedical perspective. Her assessments clearly align with the biomedical view of heart disease and the discourse of cardiovascular risk management. Patients who are unable to clearly articulate their stories from the biomedical perspective are characterized as difficult and vague, who may require more attentive assessments. In this way, this nurse situates patients whose story does not conform to the biomedical perspective as being difficult, somewhat frustrating, and time consuming.

Many nurses and physicians suggested that women's presentation was particularly vague and difficult to interpret as compared to men's. In the following excerpt, I am attempting to elicit a narrative regarding this:

1. **Researcher:** *Do you find that there's a difference in the way that women present their stories?*
2. **Nurse 7:** *They often will down play it and say that they don't belong there, often down play it and say that they don't belong and then their troponin comes back positive*
3. **Researcher:** *And so how do they down play it? So tell me*
4. **Nurse 7:** *By saying oh I shouldn't be here, I'm just taking up time that belongs to sicker patients than me, or it's just a little heart burn that's all it is, I've had it before, oh this is nothing, it's just that I was talking to my friend and she insisted that I come, yeah I've had this before, yeah I've had this off and on for probably about six months now, and what are you usually doing when it happens? Oh, running up the stairs. So, no, I don't my questions are different for, for genders*

In this previous excerpt, this nurse links the vagueness in women's presentation to their awareness of the health of others seeking care in the ER, perhaps their reluctance to be there. Many other nurses and physicians described similar insights regarding women's presentations:

1. **Researcher:** *One of the things that some of the other nurses have said, and they've said this without even me bringing it up, is that women tend to minimize their symptoms. Have you had that experience?*
2. **Nurse 5:** *Yeah, I would think so, I'd tend to agree that women minimize a little bit more than men but then again it might be more minimized because it actually is minimized because their vagueness, the vagueness of their symptoms, they don't really, they know something's wrong but they just don't know what it is*
3. **Researcher:** *So it's not necessarily that they're trying to play down what they're feeling?*
4. **Nurse 5:** *No, and maybe too like most of the women have probably gone through child birth, right, so pain (laughter) it's true*

5. **Researcher:** *So ten out of ten pain is much different for them*
6. **Nurse 5:** *Yeah, so this, this, ache it's wrong, they know it's wrong but it's not like the excruciating pain of giving birth whereas men, they're not used to having any pain so to have this, you know, constant ache in their chest is just horrendous for them, you know. So maybe that's it*

In this previous excerpt, this nurse also describes the vagueness in women's presentation, but this time it is linked to their possible higher pain tolerance, or perhaps the possibility that women's symptoms are in fact more difficult to describe.

The following is a response from a physician to my question regarding any potential differences in the way that women presented in the ER:

Physician 1: *Oh, I would be generalizing a lot if I, ... my gestalt is that women who present with cardiac symptoms are similar to what the research tells us, they're stories are some what more vague in the sense that it takes a lot more questions to kind of figure out is it pleuritic? What are the aggravating, alleviating symptoms? To answer all those questions I just said I tend I have to ask more questions and the answers I'm receiving aren't quite as direct. Like if I asked a man tell me about your chest pain. Well my chest pain is in the center of my chest, it's worse when I take a deep breath in and out, and it feels like a big heavy thing on my chest whereas I find a lot of times when a woman says I have chest pain, can you tell me about it? Yeah, it's in my chest. What do you mean? Well it's right here, I'll even give them some adjectives, is it sharp? Is it dull? You know, what's going on? And oh well it's more of a dull pain then a sharp pain so I have to lead them a little bit. In general, I find I'm leading them a little bit more*

This physician also describes women's presentation as vague and difficult to diagnose. This physician describes needing to *lead* women in their presentations, so that their stories align with the biomedical perspective. This might suggest that women's stories do not align well with nurses' and physicians' biomedical perspective in trying to obtain an 'accurate' diagnosis, let alone their imperative to be efficient. This representation situates women as being difficult to assess.

Describing Good Practice in Terms of Efficiency and Multitasking

The most common subject that was brought up again and again in my interviews with nurses and physicians was the lack of beds in the ER in which to initiate treatment, and the resulting long wait times for patients. I asked each professional what they saw as „good’ practice, and for nurses, many responses centered around the institutional imperative of efficiency and the ability to multi-task in this environment.

The following nurses describe what they saw as imperative in the practice of ER nurses:

1. *Nurse 5: Well definitely being able to prioritize and multi task, oh my gosh, some nurses that come down, I mean we get a lot of nurses that want to try emerge, they come down and can't handle it and I think that's probably the biggest reason because we're always multi-tasking like eight different things at once. I know that I'm waiting for this consult to call me back, I know that I'm waiting for this blood work to come back, I know that I'm waiting for the psych team to assess that patient, I know that a family member is going to be here in about half an hour and I needed to talk to them before hand, I know that this patient's going to go home and so I need to pull out his IV, I know I need to get antibiotics, you know, there's so many multi tasking all at once and because, because of the change right, because of that changing environment,or you're waiting for critical labs to come back, you're waiting for blood products to be sent up, you're waiting for, you know, like things are on a, maybe a higher stakes kind of thing because they are, sometimes at that unstable stage...*
2. *Nurse 2: Well, I mean I think a good emergency nurse has to be able to multi task indefinitely, like you have to be able to juggle, you have to be very flexible, you have to be willing to try all these band aid solutions, you know, you have to be willing to do anything that you can that will facilitate things. You have to be very proactive, I think if you're not proactive you don't make things happen, and you don't improve the flow, and you don't get things happening for your patient*

The previous excerpts both provide examples of nurses’ strong orientation to the discourse of efficiency and patient flow. Nurses’ practice in the first excerpt is primarily a description of the way in which nurses are required to juggle tasks. Nurse 2’s description of being proactive and getting things happening for your patient, provides an insight regarding

nurses' orientation in their practice to the institutional imperative of efficiency. The nurses' orientation to the transitory nature of the environment requires nurses to constantly orient their engagement with patients in terms of where they are in the trajectory of ER flow. Part of the nurses' assessment of patients in this way becomes an assessment of how efficiently the patient is moving through this trajectory. Nurses' and physicians' practice is thus disciplined to align with the discourse of efficiency.

Nurses described being required to constantly monitor their own practice to look for inefficiencies along with serious or life threatening things in caring for patients. They clearly depicted a link between a lack of resources and the need for efficiency in their practice.

1. ***Nurse 1:** In this department specifically we have a 54 bed department and most recently we were holding at least 30 admitted patients at any one time so that gives us, in effect, 24 active beds instead of having 54, what should be 54 active beds. The biggest reason for that, and I don't know the exact numbers but in Calgary alone the region is holding upwards of 200 long term care patients in acute care beds which influences the flow through, through the emergency department. So if you can't move patients in and up to the floor then you end up with a back log in emergency, which is where you see the capacity crunch come to a head*
2. ***Researcher:** So how would things be different for the nurses and for the physicians if, how would our care be different?*
3. ***Nurse 1:** If we didn't have the capacity issue? I think it was, a perfect example as evidenced over the recent Christmas period when it slowed the OR's down for a period of about 4 days and so they weren't doing the non-urgent cases which freed up somewhere in the ranges of 50 beds per day. We still saw the same number of patients per day but because we weren't fighting for those beds with the operating rooms we were able to create that flow through the department and the biggest impact you see is more timely care, shorter waiting room times, shorter triage to physician times and the emergency department can function the way that it is designed to function to provide that rapid treatment and assessment.... Yeah, I think that, I think that in order to function as an ER nurse you have to be as efficient as possible because it's important to provide skill and adequate care to the*

patient your looking after who's right in front of you, you also have to think about anything, any interaction that you can do to expedite that patient's stay in the department. It might be that, you know drawing the lab work as soon as it's ordered or discharging them out of the system as quickly as possible once they're dispositioned to the floor or discharged home or expediting that process so that they're, you know, you won't see too often patients waiting in a bed for half an hour until the husband comes to pick them up because we need that space for the next patient to come in so often times it's a matter of creating those efficiencies. It also would have been unheard of ten years ago to send someone to the waiting room to wait for a ride, it's now common place.

The nurse in this previous excerpt begins by presenting the larger issues in the health care system that have resulted in fewer beds available for hospital admission, resulting in a back up of admitted patients occupying emergency beds. She describes the difference in practice that occurred over Christmas when more hospital beds were available because of fewer booked surgeries. In presenting her narrative in this way, she situates the inefficiencies in the system as the culprit in the lack of expedient care in the ER. In excerpt 3 she describes how efficiency was much improved when more beds were available, therefore the nurses and physicians are presented as not being to blame for the wait times patients are experiencing. Her description is filled with references to care as a process to be efficiently managed, such as the “disposition” of the patient to the floor, “expediting that process”, and “discharging them out of the system” (excerpt 3). These references reveal her orientation to the discourse of efficiency and flow as previously described. The language she uses is more in keeping with a business model, than one of health care where the patient becomes the centre of concern. She presents her description of care as being driven by efficiencies monitored by this computer system. In describing the efficient care of “the patient who is right in front of you”, she is indirectly making reference to all of the patients

who have not made it to this point, and are also waiting for care. She links this reference to multitasking such as drawing blood and discharging patients as soon as possible. In this way she is presenting how the discourse of efficiency is prominent in her thinking as she is caring for any given patient as she is engaging with them.

She goes on to describe a new initiative to improve flow: the initiation of treatment in the waiting room:

Nurse 1: I'd say capacity is the biggest impingement. We have tried to develop strategies to improve triage to physician time or triage to disposition Time and one of those examples in the fact that we are now providing care in the waiting room. We have nurses who are allocated to waiting room care just in order to facilitate diagnostics being started so at least while they may not be in what is traditionally defined as the treatment space that at least you are moving towards having some data that gives you an idea of the severity of their condition or what treatment might be needed

Again her language is filled with descriptions of time intervals as they are reported from the computer system report: REDIS. In framing her comments in relation to the weekly REDIS reports, she is revealing her orientation to this constant monitoring of efficiencies in the ER by this computer system. In this way the nurse is presenting the need for nurses to monitor their own practice for efficiency, as the computer system will ultimately reveal how efficient their practice has been in any given time period, according to the time intervals measured.

She describes facilitating diagnostics in order to have the *data* to initiate treatment, again revealing her orientation towards efficiency in processing patients, rather than an orientation to the patients themselves. By presenting her practice in this way, she reveals an objectification of patients seeking care by orienting her view of the care of patients with

health issues as a process to be efficiently managed. Her previous description of emergency nursing as being compelling because of the opportunity to make a difference stands in contrast to this institutionally driven orientation. The mechanism of power revealed in this excerpt is the weekly REDIS report, which arises from the institutional imperative of efficiency and flow. An orientation to this report serves to change this nurse's orientation in practice from "making a difference" which she referred to at the beginning of the interview, to being "as efficient as possible". The passion that drew her to the ER is now eclipsed by this new orientation.

Continually Asked to Reflect and Justify Their Way of Practicing

Health care professionals, in particular nurses, are asked repeatedly to justify their way of practicing. They justify their practice and decisions to themselves, to patients, to each other, and to the computer system. In this way they are repeatedly rehearsing and analyzing how their practice aligns with not only the discourse of biomedicine, but with the institutional discourse of efficiency and flow. Nurses' and physicians' practice is disciplined on a day to day basis in the way they are required to document their thinking, their actions, and the response of the patient to their interventions. Their practice is constructed in part from the understanding that they will need to justify their practice in writing, as well as verbal communication with each other and their clients in their everyday interactions. This creates a constant awareness among them as to the appropriateness of their practice, an ongoing reflexivity in their everyday activities that is typical of many professions (Gubrium & Holstein, 2009).

One nurse described how ER nurses, and in particular triage nurses, are required as part of their practice, to answer for the incredible delays in treatment in the ER:

1. **Nurse 1:** the current state in our health care system comes to a head at triage That is, that is where it is felt most by the patient and by the nursing staff Well, it comes to a head there, I mean, because people are waiting prolonged periods of time for often urgent situations and the patient's are frustrated. Often times they've been sent in to see an emergency physician or specialist by their family doctor who thinks they need to come in urgently and so if their family doctor has sent them in there's a, and often times the patient is set up with expectations that my family doctor thinks this is urgent so therefore I should be seen right away and in an ideal world they're right they should be but because of the capacity issues that we're dealing with that's often not the case. So they come in with expectations of getting in quickly and then they're not and that creates stress for them which they often express upon the triage nurse so it can become, not can, it is a very stressful situation for the triage nurses
2. **Researcher:** It's almost, what I've observed, it's almost a visual of the nurses sort of as the line up gets bigger to come to the triage window and as things become tighter you can almost see them steeling themselves, you can almost see a physical stiffening of their posture because they know what's coming, what coming through the
3. **Nurse 1:** It's certainly, I think it's probably the most difficult role in the health care system and it's important to have highly skilled, not just nursing wise but people who deal well with conflict in triage. And it doesn't mean that every when I say conflict maybe confrontation is a better word but I think at the end of the day it's important for the nurses to remember that for, while it's frustrating for them, they need to try not to express that frustration to the patient and I think it's important to remain, for lack of a better word, human and express that, you know, validate the patient's frustration to say that, you know, I understand that you're frustrated and you have good reason to be, I'd like to get you. And it's okay to say to a patient that, you know, I really would like to get you in right away but unfortunately I don't have the space. So I think at the end of the day patients just want to feel heard, they just want to have a voice and that doesn't mean fixing everything or creating that space but I think it's okay for the patients to see that, that the nurses and physicians are doing the best they can in the given situation It's a system problem and if anyone's at fault it's the system..... So it's pretty hard to be held personally accountable for someone having a long wait when you had no but to, if you have no treatment space then so long as, so long as you work that you do personally is up to the standards of the

profession, you know, and meets the requirements laid out by the health region then they should have nothing to fear but it doesn't stop the anxiety

4. ***Nurse 1:** I think though that, I often view my, I almost always view the patients as my employer, you know, at the end of the day we're working to serve them. And I think as patients and as tax payers who are contributing to our health care system, they have every right to know how busy we are ...Because the only way change will come is from public pressure so it, and you know knowledge is kind of power too. I think they, I guess there's the other side of the argument, if they come here and they see that it's really busy, then the next time they have a chest pain they may not come. That's an interesting challenge, what they should and shouldn't be allowed to know but I personally feel that the more information the better and you can kind of probably mediate their reaction to the busyness by being genuinely interested in every interaction that you have*

In this previous excerpt, Nurse 1 presents her narrative regarding triage nursing as having to deal with the negative impact of lack of resources in the health care system itself. She describes the triage area as the place where the current state of the health care system comes to a head. In presenting it this way, she is presenting the ER health professionals as well as those requiring emergent care as being victimized by the short comings of other parts of the health care system. The triage nurse in particular in this narrative is presented as being required to include in their interactions with patients, a recognition of patients' frustration and desire to be heard (excerpt 3). She describes the importance for triage nurses to acknowledge that their care is significantly delayed because of the lack of resources, and in this way she presents triage nurses' work as including a justification for the way they are compelled to practice. Her comment that it is "OK" for patients and their families to see "that the nurses and physicians are doing the best they can in the given situation", is also reflective of this need to justify practice (excerpt 3). She identifies the possibility that nurses might feel, or unknowingly convey to patients, a personal responsibility for the delay, unless this understanding is included in their communication with patients. In this

way, she describes the emergency room encounter as including for both the health professionals and those seeking care, a mutual acknowledgement of the difficult circumstances they are each required to practice within. Perhaps in framing it in this way, it serves to mitigate the ethical and professional dissonance that is felt by health professionals, while mitigating the dissonance that patients seeking care are experiencing when presenting with potentially very serious symptoms. Her description however, underscores the anxiety that the lack of resources produces for both the health professionals and those seeking care, despite this acknowledgement.

In the last excerpt (excerpt 4), she reaffirms the need for the open disclosure of the limited resources within which health professionals are working. She presents the argument that health professionals are working *for* those seeking care, and from this perspective, those seeking care should be aware of their employee's situation in delivering care. Framing it from this political perspective again positions health professionals as blameless, but also as responsible workers who keep their employer informed. By presenting her practice in this way, she is enlisting the support of the public as she comes to terms with the very difficult circumstances in the ER. She acknowledges the potential outcome of soliciting patients to recognize the limited resources, in that they might be reluctant to seek care in the future. She presents this source of professional or ethical dissonance as a "challenge". Throughout this previous narrative, the presentation of her practice shifts between acknowledging the difficult circumstances health professionals are asked to practice within, and her acknowledgement of the difficult circumstances for those seeking care. She is clearly attempting to frame this very serious situation in a balanced and

positive way, perhaps in order to mitigate the professional and ethical tension to which she alludes.

The ethical tension that she has articulated serves to change the very nature of her engagement with patients. Patients seeking care are in this way solicited to orient themselves to the discourse of lack of resources in their care seeking encounters. The lack of resources itself, the need to wait for care, becomes a mechanism of power which changes the very nature of this care seeking encounter. This source of professional dissonance was also clear to me in my field observations as previously described. Her final comment suggests another attempt to resolve this dissonance by “being genuinely interested in every interaction that you have” (excerpt 4). Her attempt to resolve this dissonance in this way is reflective of his uneasy subjection to the discourse of limited resources and efficiency, and her desire to focus on the patients themselves.

Acknowledging the Peril

The field observations I conducted, as well as the interviews with health professionals, pointed to the constant sense of precariousness they felt in their practice. This was related to the sense that they might not be providing treatment in time for those seeking care, and that patients might be in life-threatening danger as a result. This was most clearly described by both nurses and physicians as being the result of the lack of space to assess and treat patients who come in for care, and this for them was a constant source of professional and ethical tension. The narratives of nurses and physicians repeatedly pointed to their acknowledgement of their inability to optimally manage people with potentially life threatening situations. This was presented as a constant source of professional and ethical

tension, particularly in light of the fact that the opportunity to offer their biomedical expertise to those in life threatening situations was what had drawn them to ER practice to begin with. Their assessments and continued surveillance of patients in their care were primarily oriented to looking for, and managing life threatening issues, and so there was a constant awareness and rehearsal of this mandate in their practice. Their inability to optimally fulfill this biomedical imperative to which they were constantly orienting, produced an ongoing sense of professional dissonance. Much as women in their interviews were orienting to their own demise through their constant surveillance of themselves for potentially lethal cardiac symptoms, health care professionals' practice was also constantly oriented to the possibility of death through their own surveillance of their practice. In this way, the possibility of death resided everywhere in the everyday lives of women with heart disease, as well as in the everyday practices of ER health professionals. The constant attention demanded by the supremacy of the ever-looming possibility of death, serves to construct the everyday practices of women with cardiac symptoms, as well as the practices of health professionals in the ER as precarious.

Of all of the interviews with nurses, it was the three interviews with nurses who had over 30 years of experience that most clearly described this sense of peril they felt in their practice. This next excerpt is from an interview with a nurse with over thirty years of experience, twenty of which were in this ER. I had shadowed her in her practice a couple of times over the previous five months, and during that time we had several opportunities to talk about my research as well as her experiences in practicing in this department. She lived a fair distance outside of Calgary, and on the day of her interview she drove through a

very bad snowstorm to be interviewed in my office. I remember her arriving for the interview, and feeling quite guilty about her having to drive in such difficult conditions. She was very eager to be interviewed for my research, and in fact had prepared several pages of notes for herself to remind her of some of the significant issues she wanted to bring up. Her earnestness was touching, and now looking back on the transcripts of this interview, her words hold a great deal of significance for me. I was interested in hearing about the difference she had seen in her practice over the previous twenty years.

1. **Nurse 8:** *Well, I think over time you're asking yourself about the changes. We're a lot more, we're working on the edge much more then we ever did, you know, like we're working on the edge of safety much more then we ever did with the pressures that we're under, right. Both in terms of what we will discharge and say, okay you're on your own recognizance until you get back into care with somebody if you need it and, you know, assuming responsibility for people who are really not in our care in the waiting room, you know. Like we're working much more on the edge of safety then we ever did*
2. **Researcher:** *Is there, is there an awareness? Is that something that nurses discuss, is that something that wears on them, do you think? Or physicians?*
3. **Nurse 8:** *I'm not sure about the physicians, it is amongst some of the nurses, the older nurses.... Some of the older nurses and I won't say it's not for some of the younger nurses, you know. But the younger, I've noticed a few years ago, people who have some through their whole residency and everything else in this more pressured system, there's much more of an acceptance of what's safe to be out there than there was before.*
4. **Researcher:** *So they've got a higher threshold to be anxious about what can potentially happen*
5. **Nurse 8:** *Yeah because there's only so much that we can do so that's how we do it. Yeah I've seen, I've felt that in the last few years that that has changed and my level of anxiety has gone up because of it.*
6. **Researcher:** *I know exactly what you mean*
7. **Nurse 8:** *Yeah, my level has gone up to the point where I go I don't know if I want to handle this anymore, it's interfering with my ability to do the job that.... I find myself distracted with anxiety whereas before I go okay well*

this is going to be taken care of, this is going to be, the system's going to work, right? Whereas now more so I go well I don't know and I'm worried about this and that and the other thing and I have found myself wearing down too where at one time I would have gone. Well just a few weeks ago something happened with a patient, where I'd have gone, no that's not acceptable. I really have this high level of concern for this person so you need to get in there you need to, this. I accepted when a physician said no, this is what we've assessed, this is what we see and according to, this is procedure and then carry it on and then this patient was really sicker. But I find it happening on a more frequent basis all the time, more frequent basis to the point where you just goYeah, really you're putting patients a risk on a more regular basis..... Oh it's phenomenal. You know I have a lot of sympathy but I work with first of all let me say that I work with some really compassionate, intelligent, capable, well-educated people but what I see the pressures doing in terms of how people receive what comes to us from the outside is demoralizing, really

8. **Researcher:** *So tell me about that*
9. **Nurse 8:** *The pressure is to get people in, get people through so you get an unending line of people coming to you, you've got to make choices between, you know, the sickest and the sickest of the sickest.*

In this previous excerpt, this nurse is describing her practice using significantly strong language. She uses the phrase “working on the edge of safety” several times to present to me how her practice is beginning to feel (excerpt 1 &3). She links her story to her historical perspective in having practiced in this department for so many years. In this excerpt, she is now presenting herself as being almost overwhelmed with anxiety in her work. She is clearly demonstrating that she fears for those who seek care in this ER, to the point where she is not sure she “wants to handle it anymore”, and where she is “distracted with anxiety” (excerpt 7). She makes a point of pointing to the pressures of the “system” rather than her capable, compassionate and intelligent coworkers, as the cause of this anxiety. The ethical tension within this nurses’ narrative is clear and compelling.

In excerpt 1, she makes a comment about a new policy that had just been initiated, where physicians could go into the waiting room, assess patients in one of two newly constructed assessment rooms, and then initiate orders for treatment and diagnostics. One nurse is assigned on each shift as the waiting room nurse, and it is her responsibility to work with physicians to carry out their orders for these people in the waiting room as best as she can. It is important to note that these rooms have no call bells, oxygen, suction or monitoring equipment, and so they are not considered treatment rooms. Of particular concern too, is that the waiting room nurse has no opportunity to conduct a history and physical assessment of the patients for whom she is asked to initiate treatment and diagnostics.

During my observations, there was a great range of nursing practice that was considered acceptable by the waiting room nurses. Practices that did occur while patients were still in the waiting room during my observation included things such as ECG's, blood work, IV initiation, IV analgesic administration, and even nitroglycerine administration for chest pain. During my field observations, an ECG technician had come to the desk to complain bitterly about having to do an ECG on a patient in the hallway, thereby potentially exposing this patient to people passing by. She refused to do this, and I remember the pride I felt at this small act of resistance. I also remember shadowing a physician as he saw patients in the waiting room. One of his tongue-in-cheek questions was, "what if one of the patients in the waiting room comes back with positive troponins, can we get paramedics to start the intravenous heparin?" Many nurses were very uncomfortable initiating treatment without having a bed and emergency resuscitation equipment available for the patient, or having

had the opportunity to assess the patient beforehand. In this excerpt, this nurse is expressing her concern about the practice of waiting room nursing, which she feels is pushing the edge of safety. The responsibility for this potential slippage in safe care then lies almost exclusively on the nurse, who has to make the decision regarding initiating the doctors orders, or delaying their treatment until a safer treatment bed is available, and only after she has had the opportunity to conduct a full nursing assessment of the patient.

During my field observations, frequent discussions were held between nurses and with physicians regarding the professional tension created by this waiting room practice. For example nurses frequently discussed the time that had elapsed between the physicians writing the orders, and the time that these orders were initiated, as if this felt like a flaw in their practice. For these emergency nurses, this was very stressful, as their customary practice was to initiate treatment as soon as possible after the physicians had communicated their order. The onus for initiating treatment had previously resided with the triage nurses whose responsibility it was to find beds in order to initiate treatment. However, this new waiting room practice now further shifts the weight of responsibility onto nurses, in that they now have the opportunity to initiate treatment *in* the waiting room, should they choose to do so. Every nurse I interviewed expressed concern about this waiting room nursing practice. The nurses' reluctant subjection to the waiting room nursing role, was another example of their uneasy subjection to the discourse of limited resources and the institutional discourse of efficiency.

Physician's comments expressed the same kind of concern:

Physician 1: Obviously as a physician there's some concern from a medical-legal perspective that there is now increased understanding of who is on

shift and when and how many patients are being seen and who saw what patient in the waiting room and what communication was made to get that person into a bed as soon as possible, so there are, there's certainly some of those concerns from an M.D. perspective, you know, am I going to be sued because I didn't do enough for this patient? Or I saw them in the waiting room and I ordered something but the order didn't get executed five hours later because there was no waiting room nurse from 2400 till 0700. So, yes, I think there definitely problems, yes I think there's still an accident waiting to happen no question about it. I do think that our, our administrators have a daunting task ahead of them to, to try to address some of these situations because that often requires higher ups and government, it requires money, it requires the initiative and the will power to do something and that's definitely going to take time. So, yes, I think it's definitely a precarious situation

Of note however, was that I heard very little complaining from the physicians regarding the delay in nurses initiating orders during my field observations as well as the interviews with physicians. It was as if they understood that the nurses had little ability to actually fulfill what was being asked of them in this role. Another aspect of this situation, is that there is an advantage for the physicians to be able to initiate orders on patients in the waiting room, and that is that they could now be earning money from people waiting for a treatment bed as their reimbursement is tied directly to the orders that they initiate. If physicians are unable to see new patients and write orders, they are not able to make money in this ER, and many physicians made comments about this to me during my field observations. So the waiting room full of patients waiting for care has significance for physicians beyond their inability to help these waiting patients with their health issues, they are unable to be compensated for their time in the department.

For the nurses however, it occurred to me that the waiting room nursing in which these ER nurses were required to engage, was yet another extension of the high stakes context

within which they were being asked to practice. The nurse's narrative in this previous excerpt ties together many "conditions of possibility" which have allowed nurses' practice to veer ever closer to the edge of safe practice as the nurse in the previous narrative describes. She describes the waiting room nurse practice, scarce beds in which to treat patients, the pressure to push people through treatment, and the scarce time to spend with patients to ensure they will have follow through for their health issues as all contributing to this shrinking and more dangerous practice.

In excerpt 7 she presents the lack of confidence she has in her practice, and the ability of the *system* to work to help those who have come to seek help for serious health issues. She presents the tension she feels as interfering with her ability to do her job. In this excerpt she also presents being reluctantly put in the position of questioning the decisions of the physicians when she says how she was once able to accept the decisions physicians, and at least have the capacity to challenge situations she saw as being unsafe for the patient. She now describes her practice in terms of being worn down and demoralized, by being asked consistently to work on the edge of safety.

Another nurse described her experience with waiting room nursing in the following way:

Nurse 7: *For example, shortly after it started, I was the waiting room nurse, there was an order for a patient to have nitro. So to me that is crossing the line so I went to my charge person, I said I have a concern here. My charge person said, well they've had nitro before, I said they've had a prescription but they've never taken it before, oh well that's good enough then go ahead and do it. So now I'm tied up with this patient for 45 minutes in a room that has no call bell and earlier that day I had a patient go syncopal on me, once again no call bell, she ended up being fine and I'm an emergency nurse so I should be able to handle that stuff, okay fine, but if she had lost consciousness because of a cardiac arrest that would have been*

slightly different, wouldn't it? Anyway, so now I'm with this patient and he's nitro for 45 minutes, all by myself, no call bell, I let the triage nurses know that I was there but they are way too stinking busy to come and check up on me. So I now have portable oxygen and of course I've done a twelve lead, I'm with this patient giving him his nitro trial, drawing labs, doing, establishing the IV so that if he crashes with his nitro I can give him a bolus and I'm all by myself, right, I have no one, no back up at all ... I was crossing the line with the nitro as far as I was concerned..... the nitro helped and that was even more scary, right? Yeah. Because there I am dealing with a true cardiac patient.....To me that was crossing the line, so a couple months later, I'm at triage and it seems like almost everyday you're up there there's new guidelines as to okay now this is what you do, this is what you do, don't do this, this is what you do, this is what you don't do, black and white. Well obviously it's not black and white. So one of the nurses had said, no I think there was an order for morphine on one of the charts, I think is how it wentFor somebody in the waiting room. I said, well I won't be doing that order and other nurse said, well yeah, there's no reason you can't do morphine, I said well I don't feel comfortable with that. Oh, yes we're giving narcotics in the waiting room. I said since when, well since always. I said well no, that's not true. Anyway, I didn't give the morphine, I didn't feel comfortable with it, I was crossing the line with the nitro as far as I was concerned

In this previous excerpt, this nurse is presenting the waiting room nursing initiative as one more attempt at dealing with the wait times, to improve efficiency and flow in the department. She links this to a sense of peril that the nurse is yet again required to shoulder. She also presents this as an erosion of her practice, and being pushed to “cross the line” (excerpt 3). This nurse depicts her practice as slipping into perilous territory for the patient, as well as herself as a nurse, and this is presented as an ethical tension for her. Nurses are not obligated to initiate orders from physicians on patients in the waiting room, but the physician’s written order places the nurse in a very awkward, hazardous, and ethically tenuous position. Nurses are caught in the uncomfortable position of choosing whether to initiate care that might indeed be beneficial to the patient, or to resist being pushed into unsafe practice. There is no formal communication between the physician and the nurse

regarding the probable delayed initiation of the orders, nor is there a formal policy regarding this practice. However, the physician is now somewhat relieved of his obligation in that he has formally submitted his orders, even though he fully understands that there is little chance that the waiting room nurse will be able to initiate his orders in the usual time frame. The initiation of the waiting room nursing role, instigated to improve efficiency and flow in the department, creates a reversal in the nurses' practice away from standards they know to be essential to safe nursing practice such as conducting a nursing assessment prior to the administration of medications. This not only shrinks their practice to a level that could be seen as unsafe, it leaves the nurse to shoulder the burden of her decisions in an invisible, yet profoundly significant moment. The constructed identity of nurses in their practice has now significantly yet quite imperceptibly shifted in response to the prevailing institutional discourse of efficiency and flow.

This nurse makes another comment regarding waiting room nursing later in the interview, only this time it is to make a distinction between experienced and inexperienced nurses:

1. ***Nurse 7:** Safety in the waiting room I think is a huge issue. I'll go back to the patient that I gave nitro to. If it had been a less experienced nurse I'm not sure they would have stayed with the patient to be honest with you, or the administration of narcotics in the waiting room. Once again this is a younger nurse who told me, yes absolutely we give narcotics in the waiting room and there's me twice the age who's saying no, this isn't a good thing. I think there's, so seeing patients in the waiting room, I think there's a higher chance of situations being over looked possibly, possibly because the nurse might think oh well I've seen that patient, I've drawn labs on them, I've started an IV so their going to be okay but that's were the reassess nurse comes in, right, making sure that she's on top of her reassesses. Which is really difficult when, because often times the reassess nurse....., they haven't taken the original history but also when you're supposed to be doing*

your reassesses and you've got ambulance, after ambulance, after ambulance, like 10, 12 in a row coming in

2. **Nurse 7:** *Absolutely, you've got, have you got time to do your reassesses? No. Can you leave the ambulance check-in's to the nurses at the window when she's 12, 15 people deep? No. Could the ambulance patients wait? Most of them they could, even though the paramedics don't think so, most of them could afford to wait while I'm doing a couple reassessments in the waiting room who are patients all by themselves*

In the previous narrative, a significant piece of what this nurse is referring to in describing the waiting room nursing practice is that junior nurses are allowed to do waiting room nursing, but only more experienced nurses are allowed to do triage nursing. This puts the triage nurse in the uncomfortable position of having to follow, or reassess patients that have had treatment or diagnostics initiated by another more junior nurse. So now the very difficult situation in the waiting room is escalated because patients are having treatments initiated that require close monitoring, and this is now being left in the hands of one junior nurse. This junior nurse very often might have as many as 15 patients with orders initiated, and because these patients have not had diagnostics completed, their acuity is not really known which adds to the unpredictability. The waiting room nurse's practice is further compromised by her inability to do a full nursing assessment in the waiting room. She presents this as a situation that further erodes the safety of the care she is able to provide. Her description of the patients as "all by themselves" (excerpt 4) depicts the tension she feels regarding the circumstances of patients waiting for a treatment bed.

1. **Nurse 2:** *.....And then we're pushed, we're pushed to make sure that they go in and they come out and that they're moving and if they haven't moved the triage nurse is coming to us, well what are we doing, what are we doing? We're still waiting for the consult of the cardiologist so we have to phone the*

cardiologist, get the physician and we constantly are phoning everybody just to keep on top of the flow to keep going

2. **Researcher:** *Right. So that's that constant pressure if somebody's in a monitored bed that you need to maybe move them to non-mon and a constant pressure of knowing, of an awareness especially if you do triage, I would imagine, if you've been on that front line, that constant awareness of knowing what's sitting in the waiting room*
3. **Nurse 2:** *Yeah, and we know, they'll tell us*

The previous excerpt provides a glimpse into the constant pressure felt by nurses working in the treatment area of the ER. In this excerpt, the nurse is presenting her practice as being “pushed” to align with the discourse of efficiency and flow. Using the word push demonstrates her resistance to being asked to practice in this way. This description of her daily practice presents her constant awareness and orientation to flow in the department. The nurses and physicians in the treatment area of the ER are constantly made aware of the situation in the waiting room, as well as patients who are on their way in by way of ambulance or STARS air ambulance. The nurses and physicians in the treatment area in this way are directed to constantly think about those potentially critically ill patients who are waiting for their care, so the orientation of their practice by necessity is continuously being subjected to pressures to be efficient.

Those working in the monitored bed area where space is really at a premium, and where access to this kind of a bed could quite literally have life saving implications, are particularly influenced by this pressure. The gaze of nurses and physicians directed at their patients by necessity again, always includes an assessment of their entitlement and need for these precious beds. The constant communication between nurses and physicians regarding patient flow, is in effect a constant rehearsal and reinforcement of this orientation to

efficiency and the potential availability of life and death resources. Each health care professional thus is conscripted to constantly evaluate and re-evaluate how their practice aligns with these discourses *as they engage with patients*. The pressure created by scarce resources, in particular scarce beds in which to assess and treat patients in the emergency department, and the ever present threat of potentially failing to provide life saving treatment for those who are waiting for care, again create conditions of possibility for the institutional discourse of efficiency, as well as the biomedical imperative of diagnosis and treatment to reign.

Institutional Pressures, Limited Resources: Pushing the ‘Care’ out of Healthcare

The interviews with nurses and physicians revealed that they were aware of the implications this pressure had on their practice. This next excerpt is from a nurse who had worked in this department for over thirty years:

1. **Researcher:** *So tell me about some of the changes that you've seen, how about just generally. What, what are the changes that you've seen in your practice?*
2. **Nurse 7:** *Volume, we've seen changes in volume, we've seen changes in acuity*
3. **Researcher:** *So higher volume*
4. **Nurse 7:** *Absolutely higher volume. Way back when, when you did a night shift you would all gather in the staff room and, and at that time of course there was smoking in the hospital and so police were there, fire fighters were there, paramedics were there, k-9 were there with there with their dogs, the men were smoking pipes and cigars, and then every two or three hours a new patient would come, you'd play Trivial Pursuit, you'd play Monopoly, you were able to play these board games that had, that took hours and hours to play because you had hours and hours. So a patient would come in every two to three hours and so Susan did the previous patient so then I'd take the next patient and it didn't involve a whole lot because the physician was right there and so the nurse would go into the assessment and start the IV, do the lab work and then the physician was right there and then two hours later*

another new patient would come in. It's a far cry from now when you have upwards of 24 hour waits in the waiting room on some days, and an average of easy 40 or more patients waiting for admission in the hospital every single shift.....

5. **Researcher:** *So what do you think is missing now? What do you think you don't have time for now that you may have had time for in the past?*
6. **Nurse 7:** *Oh, a lot of the basic nursing care, the basic nursing care I think is really going down hill and there just isn't the time to do all the little nice things for patients and often its things that even include food, you know, like feeding your patients and things like that, you know when you think of it it's probably two hours past the time when they should have eaten. Its basic little things that you don't have time for because you're juggling all these other things*
7. **Researcher:** *One of the things, one of the things that's come up in my previous interviews with nurses is they feel like they don't have time to spend with families, you know, to, have you had....*
8. **Nurse 7:** *To explain things as well as you should and even to stand there and talk to your patient, like I mean there was a time when you were doing nursing care and you were learning all about you patient at the same time and you were asking about their families and what they did for a living and things like that, you don't even ask those questions anymore, really there isn't time. You don't want to get into long discussions because you know you can't stay at the bedside and listen to them*
9. **Researcher:** *Yeah, that's so true and I've heard that, the teaching thing as well kind of falls through the cracks, has that been your experience?*
10. **Nurse 7:** *Yeah, like teaching is very, very quick and fast and people, you know, in that situation only hear probably a third of what you're saying, you know, but you're giving all these explanations like you'll get your stitches out in so many days, and do this and take care of the wound, do this and you know their probably only picking up about a third of what you say, you know, but that's all, those few minutes when your talking to them before they leave is all they get, you know..... Absolutely, the acuity in emergency is higher because if you think that patients are waiting, are actually being willing to wait in our waiting room for 24 hours to get a bed in the back obviously, obviously they're sick. It's not an ingrown toe nail that's going to keep you in our waiting room for 24 hours whereas 30 years ago people would come in with ingrown toe nails that that'd had for three weeks and it was really bothering them. What else has changed now is way back then everybody had a family physician, they were not difficult to find, they were not difficult to get into, now because of the big influx of people into our city,*

we have a population of over a million people, we only have three functioning emergency departments in acute care hospitals which is not nearly sufficient to handle the volume. Plus people just don't have access to family physicals because there are no family physicians out there that don't have open practices, that are accepting new patients and even if patients are able to find one, they're not able to get in for months is what I'm hearing. I know one time, this was an interesting exercise for me because we, as routine, give our, give patients who do not have family physicians a list of family physicians that we are told are all accepting new patients and they are set up for quadrant of the city. So I say to them, whatever works best for you, or is closest to your home, just give those physicians a call. So I was in the minor emergency treatment area this one day, a patient did not have a family physician so I gave them the list. They came back about a week later and I said so, you know I know for a fact I gave you a list of family physicians, what happened with that? This person, bless them, had called every single physician on that list, not a single one had an open practice, and that would have been about a year and a half ago, a year and a half, maybe, yeah, about a year and a half ago..... Yes, the dynamics of the department, the dynamics of emergency medicine absolutely have changed because thirty years ago absolutely we could have looked after the lump on your ear and your ingrown toe nail and your halitosis and your gastro reflux that you've had for six years. We could have covered all of that but not now, we can't do that any more we need to, unfortunately, treat your one presenting complaint if at all possible but how can that be possible? I'll go back to the elderly failure to thrive, that come in with a multitudinous of problems that we do have to get to the bottom of, right. So it's, it's a catch 22 in emergency medicineIt's huge, huge part of the population so it is a catch 22. We need to have rapid follow through in order for the system to work efficiently and yet patients are sicker and sicker and with more and more issues and part of that is perhaps because there are no family doctors, because there is poor follow through in their discharge so they, you know, they may come in with two problems and then four weeks later, because those two problems haven't really been addressed properly, now we've got four problems and so they come back for twice the amount of time and yet we still can't admit them because there are no beds in the hospital so we send them home yet again with improper follow through so a couple weeks later now we've got six problems.....So, and this person, this patient had done everything in her power to establish a relationship with a consistent physician

11. **Researcher:** *That's definitely, definitely something that I see as well. Like I see emergency turning into something....*
12. **Nurse 7:** *A walk-in clinic*

13. **Researcher:** *Something that it wasn't before. So tell me, talk about that a little bit, how that has changed what you do*
14. **Nurse 7:** *I'll have to think about that, how has that changed?*
15. **Researcher:** *How has that changed the dynamics of what goes on in the emergency department?*
16. **Nurse 7:** *My answer to that question is kind of like the frog in the water theory, you know, where you stick the frog in the cold water and you gradually heat it up and he doesn't know he's getting boiled to death Because, I mean, I've been in emergency for so long so you just gradually adapt to all the changes right, so it doesn't hurt quite so much (laughter)..... So I know we've come a long way but to think of specifics, oh gosh..... See we still, in spite of the fact that very few people have family doctors. When our patients are discharged our doctor still writes follow up with family doctor*
17. **Researcher:** *Even though there's a good chance....*
18. **Nurse 7:** *Even though, exactly. so that's why I'm having trouble answering the question because I'm not sure that our practice in reality has changed in that respect to be honest with you and many patients won't speak up and say but I don't have a family doctor. They'll just say yes doctor, yes doctor, yes doctor and they come back to us or go to a walk-in clinic, you know, or do the tour throughout the city accessing physicians and not having any consistency there I was thinking of something else that may have affected this. In years gone by, even ten years ago, for example, all these cardiac or possibly cardiac patients would have been admitted to hospital for a minimum of two to three days observation and from an emergency perspective, we relied on the cardiac nurse to do the discharge teaching because everybody was admitted. So from an emergency nurse perspective, we felt comfortable not teaching because we knew or we assumed that that aspect would be covered from the cardiac unit, either the cardiac nurse or the cardiologist. Whereas now, as you well know, very few of our patients are being admitted. They're being sent to out-patient clinics, specialist clinic's*

In this previous excerpt, this nurse is depicting her practice in terms of how her practice has changed over thirty years. I had actually worked with this nurse in this department for a short while over thirty years ago, and so I was familiar with her depiction of how things had been in the past. I remembered the board games on night shift, and the many

opportunities we had to socialize with fellow nurses, physicians, paramedics, firemen and policemen in the staff lounge. This memory for her was a link to a much less pressured time, where nurses had the opportunity to get to know the patients in their care (excerpt 8). In this interview, this nurse also speaks of the young nurses who have known nothing else in their practice, other than a department and a system that is functioning with severely limited resources. She is clearly linking the limitations she sees in her practice, including the slippage of basic nursing care, to the increase in patient acuity and volume that they are required to deal with amidst severely limited resources.

This nurse presents her own practice as losing what she presents as *basic nursing care*. This is a term traditionally used by nurses to describe the patient focused, nurse initiated, simple, yet highly regarded interventions such as the provision of basic comforts and pain management, nourishment, and therapeutic communication. She presents her narrative in a way that demonstrates the loss of this basic nursing care in her own practice because of time constraints. She presents herself as reluctantly having to let go of this basic nursing care that in the past was an important aspect of her care and her identity as a nurse.

This nurse also presents her understanding of the difficult circumstances that patients are faced with in the current milieu, including the incredibly long wait times they are asked to endure. In this narrative, this nurse is presenting the patient as needing *more* care now because of the circumstances they are asked to endure when seeking emergent help as a result of the incredible wait times. She portrays those seeking emergent treatment as being victimized by the current state of affairs, much as the health care professionals working in this environment are. In the previous excerpt 12, she describes the downward spiral of care

being the result of several things. She describes the need to push people through the department as having a negative impact on therapeutic communication, including the time available for patient teaching that could influence their subsequent need to seek care. She also describes the loss of connection to her patients and their families because of the lack of time available to communicate (excerpt 8). She also describes the significant lack of family physicians to follow patients after discharge as placing patient in a suboptimal position that could subsequently result in additional need for emergency room services. In this way, her portrayal is one of shrinking emergency room practice for an increasingly acute patient population, who now has fewer supports outside of the hospital, potentially resulting in an increase in the demand for ER services.

In this previous narrative, the nurse describes the way these changes in resources and the acuity of patients seeking care have affected her practice as being like the frog in the water who does not realize he is being boiled to death as the heat is turned up. She describes these changes as having occurred gradually and perhaps thus less noticeably. One of the examples she uses is the traditional piece of advice offered by physicians to most patients leaving the ER, which is to follow up with their family physician, despite the emerging reality that many patients seeking care in the emergency department do not have a family physician. She portrays patients as being submissive in these encounters who are unlikely to assert themselves by admitting to the physician that they have no family physician. So in this account, it is the relations of power between the physician, the patient, and the nurse that produces a barrier to a new practice that would accommodate the reality that many

patients are left to manage their health issues on their own without support from a physician.

In the last excerpt of this previous narrative (excerpt 24) the nurse also describes how the availability of more sensitive and immediate diagnostic tests such as serum troponins now can accurately confirm whether a patient has had a heart attack within a few hours. In the past these patients would have been admitted for at least a couple of days until less sophisticated diagnostics available at that time confirmed that they had not had a heart attack. So in the past, follow up teaching for patients with suspicious chest pain was most often done by nurses on the cardiology floors to which they had been admitted for observation. Now, as she describes, these patients are most often sent home, and the teaching component is still often left neglected. So the improvement in diagnostics has resulted in less time spent with health professionals, and thus less opportunity for health professionals to offer education or even emotional support as patients deal with these potentially serious symptoms.

A New Technique of Assessing Patients: Changing the Gaze of Health Professionals

The lack of space to assess and treat patients, was described by many nurses as having serious implications for the way in which emergency nurses practiced, in particular the assessments that were made at the triage desk. This nurse goes on to describe some of the agonizing decisions they are asked to make in their practice, in choosing who of the sickest of the sickest should be treated first.

1. ***Nurse 8:** Well, it's not that there's no minor things, there are minor things that come to that window, right, but the way that things get to be down graded isn't necessarily always based on the presenting, objectively presenting symptoms, okay. God help the person who comes up there with*

any prior history on their, any prior history admitted or that we know about of fibromyalgia or psych history no matter what their complaint is, it's going to put a lot of people into the mode of well, including doctors, I see it, including doctors. Okay well this was their complaint, however, they've got this history. Excuse me but the coincidence is you can have this and you can have this. We can have something really seriously going on with you but when you've got five people ultimately really sick people to decide between, those factors are going to influence a lot of people and heaven help you if you have, if you present with anxiety as well as. I mean if you feel really sick or your loved one is really sick, you're going to come up there likely and present with some anxiety

2. **Researcher:** *So how do you think that effects, how do you think that effects, how do you think that changes the way they're perceived?*
3. **Nurse 8:** *I think they got moved to the back of the line unfortunately, taken perhaps less seriously. Hopefully the good thing about having more than one person up there is having one person go, okay this is how they're coming off with you, this is what I'm seeing when I reassess them. You know, if it comes to that right. Plus you know, you've got Emergency Medical Services, TOCP, you've got a number of eyes on those people potentially, right, so if somebody takes, judges somebody with a particular filter in mind, well you know, they're anxious or they've got this history, someone else may have the opportunity, maybe maybe not, have the opportunity to be a little bit more objective*
4. **Researcher:** *So that's interesting that you say filter. So, and I know the job of the triage nurse is to make rapid assessments, right?*
5. **Nurse 8:** *Of course, of course. And it's hard, it's really hard. I think given the job to do, you know a lot of people are up to the job but given that the pressures and you know the impossibility of some days, literal impossibility of getting people into beds in a timely fashion. I mean we don't expect to ever meet CTAS except on CTAS 1's, you know.... You just don't expect any of it, you know, that's the ideal but that's not what's going to happen, you know most days, and some days absolutely not. And then given those pressures to get people, get people in and you've got to make those decisions. It is, it influences people to make a different judgment to suspect of coming up and going let's see I wrote this, suspect people of foolish anxiety, okay.....you know I can't have that many people that sick today, I just can't do it. (Laughter) I've only got three beds, I can't have seven patients, you know, or I've only got three beds, I cannot have fifteen patients in those three beds, you know. Even on, in a less pressured system we would all go yeah, let's put those people in those beds, let's err on the*

side of caution, now we have a tendency to err on, oh what would you call it? The side of omission to omit these particular possibilities

6. **Researcher:** *So talk, explain that a little bit*
7. **Nurse 8:** *Okay so before, if you're less pressured you'll go, you'll err on the side of caution as a responsible professional, I believe. You'll go okay, so this person is anxious but they've also got, you know, this, this, and this that definitely sounds like the, definitely sounds like symptoms for a particularly bad outcome, you know. Like we got to look at them, we've got to look at them in a timely fashion, okay so you get them into a spot where you'll do all those things to find out, right. You don't have the spots okay, so you've got to choose between people who have to get into the spots and get those things done. So you eliminate the ones that are, that have other factors involved, okay. Well this one clearly has these complaints, the other one may have these complaints but they've also got other things that could be influencing that within them like anxiety, like you know..... Histrionic presentation. History. Well you have to choose, you have to chooseIn a pressured situation*
8. **Researcher:** *The ones that come and can present clearly*
9. **Nurse 8:** *Right, clearly and nothing else going on. You don't have any history like, like just last week we got somebody in there who's got all these things going on, he's also got a history of having left in the past*
10. **Researcher:** *Of having left the department*
11. **Nurse 8:** *Of having left the department in the past.....Like sort of, you've got these points that you would give to somebody for symptoms in a disease but you've also got these points, very informal, nobody would ever want to, you know, officially admit to but people admit to in the coffee room all the time, of not*
12. **Researcher:** *Of reducing their credibility*
13. **Nurse 8:** *Of reducing their credibility, that's the point, it reduces their credibility.*
14. **Nurse 8:** *Doctors do it too.....Nurses do it, doctors do it. So like I say instead of maintaining a high index of suspicion for possibility, urgently we develop high index suspicion for patient being over anxious, lack of coping skills, leaving us, you know. Even among people who fit the criteria for risk for a particular disease*

At triage, nurses are required to assign a CTAS score according to the strict biomedical criteria that determines whose life is most at risk, as previously described. The decisions triage nurses make however, are not based solely on this, as they also have the imperative to choose who of the many CTAS 2 and 3 patients will indeed be seen first, and who will wait (these are patients who should be seen within 15 or 30 minutes as set out by the CTAS criteria). They have no alternative but to make these decisions, because of the lack of resources in which to assess and treat these patients. The nurses therefore are put in the agonizing position of having to *choose*. This excerpt describes this tension clearly:

1. **Nurse 8:** *It's that flow that you're, you know, trying to achieve and it's not even a flow it's just get, yeah, I got three beds, I got fifteen people who need them. You know and I'm not talking about the, you know, fifteen others who are out there sick, I'm talking about fifteen sick people who need a bed and those others, yeah we'll deal with them on a reassessment, etcetera, etcetera, but these are the ones first off in my mind*
2. **Researcher:** *Right. So the patient, there's a lot of onus on the patient to present in an acceptable way?*
3. **Nurse 8:** *Oh, is that fair? I mean God help us, is that fair?*
4. **Researcher:** *Yeah, but its true isn't it?*
5. **Nurse 8:** *It is*
6. **Researcher:** *To present in the right time frame*
7. **Nurse 8:** *In the right time frame*
8. **Researcher:** *Early enough but not too soon. You have to show some diligence in having wanted to deal with this yourself, but not wait too long to the point where you're sort of negated just because of the length of time that you've had...*
9. **Nurse 8:** *And remain a very reasonable, calm person when you're talking to the nurse, you know, and when you're talking to, and when you're waiting in the line up....Which is risky..... You know, there's certain people that come to emergency, that's true, certain type but I think it's because of the daily grind of not enough room to fit everyone, you know, and.....In the*

appropriate and timely fashion according to the complaint, according to the assessment. Like CTAS is useful, you know, it's probably put in for a lot more reasons than just being useful but it's useful, however, like I said, we don't expect to meet it except on CTAS 1's and unfortunately the daily grind blunts our sympathy, you know, and our sense of urgency for particular situations, you know, and in some cases where it would otherwise have prevailed and I see, what, what I found recently, I see it among nurses and doctors but I see among new nurses is this kind of a reward for that suspicion of those feelers for the people who are anxious, feelers for the people who've got other things going on. Going well if you're not too sympathetic, you're an emerge nurse, you know what I mean? So, after a while, the reward's built into that and

10. **Researcher:** *So if you don't get taken*
11. **Nurse 8:** *If you don't get taken in*
12. **Researcher:** *Taken in, I've heard that a few times*
13. **Nurse 8:** *If you don't get taken in then, yeah*
14. **Researcher:** *Then that means that you've got good assessment skill?*
15. **Nurse 8:** *Right, which I don't agree with. I think that there's a factor there for sure but I think it, like I say, it blunts our sympathy and it can also blunt our professional assessment, our objective professional assessment of people*
16. **Researcher:** *That's really important; it's like a compassion fatigue*
17. **Nurse 8:** *Yeah, exactly*
18. **Researcher:** *And I know I've seen that myself*
19. **Nurse 8:** *But it's become cultural, when there's rewards for it, it's become cultural, You know what I mean? It's not just okay, I feel this is happening or I see this is happening to someone, but when you see it going on, there's a certain acceptance of it, an actual, yeah good for you!*

In these previous two excerpts, this nurse describes the effect of having to ration beds to the very sick seeking care. In this context, what is being accomplished is that nurses are required to not only look for those whose life is most imminently in danger, but to look for reasons to justify why certain patients need to wait. As this nurse presents, their gaze, and particularly the triage nurses' gaze is thus directed to look for imperfections or anything

that might raise their suspicions in the patients' stories, in the patients' presentation of themselves, or in the way they have managed their health. Patients who have waited a long time to seek help, patients who present as histrionic, or whose anxiety seems to color their story, patients with a psychiatric history, patients who have left the ER in the past without being seen, are all seen as justification for the need to wait in this nurse's description.

This nurse's description resonated deeply with what I had also observed during my field observations. I had frequently overheard nurses' discussions at the triage desk regarding their justifications for sending someone to the waiting room. In fact, this had been one of the most frequently discussed issues in their communication with each other as well as with physicians. The CTAS scoring was easily determined from the criteria set out. However, it was the way in which they negotiated their practice to deal with the extremely limited beds that pushed them to create this invisible, informal and ever shifting framework for decision making that had monumental implications in the care of patients seeking treatment. The many hours of observation I had conducted at the triage window had demonstrated to me how these decisions were fluid, and dependant on the state of the department as well as the knowledge and experience of the triage nurse. Because this piece of their practice had never been formalized, each nurse would no doubt have their own set of assessment parameters that they saw as significant, and each nurse was placed in the position of carrying the burden for their decisions.

In this narrative, this nurse presents nurses' and physicians' practice as including the skill of not being „taken in'. Nurses' and physicians' practice is in this way constructed to include an assessment of the credibility of patients' stories, and according to this nurse's

narrative, this is rewarded on an informal basis in the culture of the ER. Their gaze is thus directed to include not only an assessment of the patient and their health issues from a scientifically objective stance through CTAS scoring, but also an assessment of the veracity of their stories, and their entitlement to more immediate care. They are looking for cracks in the way patients have managed themselves and their health issues as a means of supporting the agonizing decisions they are asked to make again and again in their practice. So part of what is being accomplished in the context of limited resources is a very fundamental shift in the way nurses and physicians engage with those seeking care, and this nurse is clearly presenting her resistance to practicing this way.

This nurse links this change in her practice to blunting her sympathy as well as her objective professional assessment (excerpt 9 & 15). In framing it in this way she is presenting this as a source of professional and ethical tension for her. She presents this as a change in nursing practice that she has witnessed over her thirty year career. Nursing practice from this perspective is thus realigned. Initiating a caring and trusting relationship with clients traditionally has been fundamental to nurses' care. Not only nurses' practice, but also physicians' practice is thus disciplined by the limitation of resources, and the institutional discourse of efficiency and flow. The result is a profound shift in their stance in interactions with those seeking care, and that is a shift away from initiating the interaction from a caring perspective. This reversal away from the traditional caring gaze is profoundly significant. Just as the new techniques of observation, palpation, percussion and auscultation made visible the hidden machinery of the body in the late eighteenth century (Foucault, 1994), this new technique of assessing patients also creates a language

which makes the bodies of those seeking care visible in a certain way, a “language” by which those seeking care can be read. What is being read is beyond the signs and symptoms of a disease, it is their alignment with the prevailing discourses in this environment.

What this technique appears to be accomplishing is to potentially change the very nature of the encounter with those seeking care. This new technique opens up space for “ethical discretion” on the part of health professionals, where objective scientific assessments make room for subjectivity (Armstrong, 2002, p. 162). This reversal of the health professionals’ intention and gaze places them in the ethically tenuous and even dangerous position of making very important decisions regarding the initiation of potentially life saving care using criteria that are subjective, arbitrary, formally invisible and unacknowledged, and emerging from a discourse of economics, efficiency, and scientific rationality. It erodes the foundational stance of caring from health professionals’ daily activities. It places those seeking care in the unsuspecting position of being required to demonstrate their worthiness for immediate care. It places those seeking care in a relationship with health professionals that is hierarchical, placatory, or servile, rather than mutually respectful and caring. It places those seeking care in a competitive relationship with others seeking care, however imperceptible this might be, where their deservedness for immediate care is open for inspection through this new technique.

The orientation of health care professionals to efficiency, flow and scientific rationality, creates a new relation of power with those seeking care. The new relation of power is made possible as patients are solicited to orient to the discourse of limited resources and the institutional imperative of efficiency in their health care encounters, as described previously

by Nurse 1. Those seeking care become applicants or contestants for scarce resources. The constitution of their identities, the “political anatomy” of their bodies is a reflection of this new clinical gaze (Foucault, 1995). The political anatomy of their bodies is thus in part constructed by the discourse of economics and efficiency. The bodies of those seeking care are no longer objective and inert, but responsive to this prevailing institutional discourse. Moreover, the constructed identities of nurses and physicians as well their everyday practice have now profoundly shifted. The shame and the discomfort in the words of the nurse in this last excerpt, revealed her recognition of this ethically dissonant reality: “God help us, is that fair?” (excerpt 17), she had said after her description of who would be left to wait.

I remember having been struck with how the messiness and complexities of peoples’ lives were missing in the discourse between health professionals and those seeking care during my field observations. Now it becomes apparent that some of this messiness might indeed have caught the attention of health professionals in their assessments. When pressed to make decisions regarding who should receive the most immediate care, messy issues that catch the attention of health care providers are issues such as a previous psychiatric history, a history of a nebulous disease such as fibromyalgia, a history of having left the department in the past, or an overly anxious or histrionic presentation. These messy issues not only reduce the credibility of those seeking care, they confound the rational scientific assessment that is so heavily revered and relied upon in this environment. All of these messy issues invite health professionals to look beyond the narrow lens of the strictly biomedical CTAS scoring as they are pushed to practice within the context of severely

limited resources. In this moment of scarce resources, while health professionals expose their acknowledgement of the messier issues that affect the health and the presentation of those seeking care, they are drawn to making choices that most comfortably align with their strong biomedical orientation, that fit neatly into scientific rationality, that satisfy the every present discourse of economics and efficiency, and all of this occurring in an outwardly invisible way. The nature of the encounter, the direction of health professionals' gaze, and the accomplishments of this encounter are now profoundly shifted through health professionals' orientation to the lack of resources and the institutional discourse of efficiency. Power is exercised through this new clinical gaze, this mechanism of power, and this serves to construct the identities and practices of both the health professional and those seeking care. As this nurse's narrative suggests however, there is an uneasy subjection to this way of practicing.

In the preceding three chapters, I have presented an analysis of field observations I conducted in a large urban ER, as well as an analysis of interviews with women who had sought ER care for symptoms of heart disease and interviews with health professionals working in an ER. These analyses provided insights into the construction of subjectivities for both the women who sought ER care, and the health professionals who provided it. The analyses provided insights into the precarious context of their everyday existences which contributed to an ethical tension. It was their uneasy self-subjection to the discourses of biomedicine and the institutional discourse of efficiency and economics that contributed to the construction of identities and practices for both. The resistance and alignment of individuals to these privileged discourses in their everyday activities provided insights

regarding ethical tensions they encountered as they engaged in their “person-building activities” within their complex everyday existences (Gubrium & Holstein, 2001, p. 11).

These analyses have implications for understanding health care practice from both a theoretical and practical perspective that will be offered in the following chapter.

Chapter 7

Paying Heed to the Uneasy Subjection: Creating a New Health Care Ethos in Support of Those Seeking Care

Looking Back

My data collection significantly began with field observations in this incredibly busy ER. These initial observations were powerful in providing context to the narratives of women with cardiac symptoms as well as health professionals that I later interviewed. The high stakes and perilous nature of ER encounters showed itself repeatedly and unrelentingly during my field observations. These observations provided insights regarding the life and death implications for ER health professionals' practice as well as for the lives of those seeking care. The emotional and anxiety ridden accounts of women dealing with their heart disease left no doubt as to their understanding of the potential lethal consequences of their cardiac disease. This understanding was not directly articulated during my field observations or in any of the interviews conducted. This understanding regarding the ever-present possibility of death that resided in the practices of ER health professionals as well as women with cardiac symptoms revealed itself indirectly in their narratives as a reluctant and uneasy subjection to privileged discourses. They each seemed obliged to align themselves with the privileged discourses of biomedicine and the rational and efficient use of scarce health care resources in their everyday activities, including health care encounters. Each was constantly in the shadow of the sinister possibility of death, and alignment with these privileged discourses seemed to offer the safest guidance for the ongoing interpretive work required of them within the messy complexity of their

everyday lives (Gubrium & Holstein, 2001, p. 11). However, the uneasiness with which they subjected themselves to these discourses pointed to an ethical tension that requires attention.

The interviews with physicians and nurses provided many insights into their constructed identities and practices. Nurses and physicians all talked about the passion they had for their work in ER, and the opportunity it offered to make a profound difference in the lives of those seeking care. This passion however, was now also eclipsed by their uneasy self-subjection to the efficient application of biomedicine. Their constructed identities and practices shifted away from the very thing that initially drew them to practice in the ER setting, which was the opportunity to make a difference in the lives of those seeking care.

Both physicians and nurses described the overwhelming sense of precariousness that they felt in their everyday practices. Their narratives revealed a constant awareness of the potential needs of patients in the department, in the waiting room, as well as those who had not yet presented themselves for care, and health professionals were drawn to orient their practice to the discourses of efficiency and *flow*. The potential life threatening nature of illnesses presented to them also seemed to validate their alignment with the biomedical perspective, which clearly offered the most prudent option in managing these kinds of events. This seemed to limit the possibility for understanding and treating all health issues from a broader and more holistic perspective.

Nurses described being *pushed* into unsafe practice through the initiation of institutional efforts to minimize wait times such as the waiting room nursing role. Nurses and physicians continually justified their actions through ongoing dialogue, and the ongoing surveillance

they conducted on themselves to monitor the efficiency of their practice served to reify this way of practicing. The lack of resources in which to treat patients caused incredible wait times for those seeking care, and nurses and physicians were drawn to look for reasons to justify their decisions as to who must wait. This shift in their gaze seemed to change the nature of the caring encounter as patients' assessments now included an orientation to their deservedness for immediate care. The institutional imperative of efficiency related to the serious lack of resources within which to treat patients in the ER, was a prevailing discourse to which health professionals were reluctantly compelled to align themselves. Health professionals' practice was constrained in these ways, and the possibilities for understanding and addressing the health issues of those who sought care, was consequently constrained as well.

The predominantly submissive posturing of those seeking care in the emergency department during my field observations was remarkable. The waiting room full of docile bodies that had seemed so surprising to me during my field observations, was perhaps an accomplishment of the traditional discourse of biomedicine that has predominated health care for so long, where those seeking care are triaged according to whose life is in most imminent danger and most urgently in need of lifesaving biomedical expertise and treatment. These waiting bodies could also be seen as the accomplishment of the discourse of efficiency, economics and flow, where the rationing of, and orientation to, limited health care resources by health professionals served to discipline those seeking care. Upon further reflection however, those waiting were not merely docile bodies, these were bodies who had subjected themselves to these discourses as they waited,....and waited....to be seen.

Women seeking care for their cardiac symptoms in this study were conscripted to view their illness in a political and economic sense through wait times and the unmistakable overstretching of the health care system apparent in the emergency room. Power was thus invisibly exercised through this discourse.

In the interviews I conducted with women who had sought care for cardiac symptoms, each had described in detail the profound anxiety they had experienced in their daily lives. This anxiety was not only in relation to their symptoms, but in relation to that moment when they were required to seek emergent care, when they literally felt their life might be in peril. The very thing that was most significant for them in their day-to-day existence with cardiac disease could now potentially be putting them at risk for delayed treatment. Health professionals were forced to make decisions about who must wait for care. The informal framework that was created to support these decisions included an assessment of the merit of patients' presentations and their deservedness for care, and anxious or histrionic presentations were seen to be less credible. The life threatening nature of women's heart disease, with the understandable anxiety that it provoked, offered the paradoxical potential of putting them closer to the margins of health professionals' priorities. Perhaps through the countless interactions these women had experienced with health professionals in the past, this was not lost on them, if only in a very subliminal way.

The ER encounters for the women in this study were not just about what occurred in the ER, it had much broader implications for them which they felt compelled to speak about in their interviews. I had been initially frustrated with the women's resistance to discussing their experiences in the ER in their interviews. This frustration pointed to my own

professional bias regarding how a health care encounter should be viewed. My own view of the ER encounter was that the primary focus should be directed toward what occurred within the physical walls of the ER. I experienced tension because of women's resistance to focus their narratives on the ER encounter itself. The discourse to which I was orienting was that health care can be viewed and analyzed with a primary orientation to health care providers' practice. Women's view of this encounter was much broader as was shown in their narratives, even though this broader view did not enter into the dialogue in the ER health care encounter during my field observations. The interviews had provided women with the opportunity to voice this important understanding. They described not only the complexity in their lives which they needed to negotiate in managing their heart disease, they described the complexities involved in seeking care, and the implications of subjecting themselves to care. Their discourse was also one of economics of sorts, where their struggling to seek emergent care involved weighing the "costs" of seeking treatment to their personal lives, against the potential cost to their health and perhaps their life in not seeking treatment.

The women in this study provided insight into their wary view of the ER health care encounter which requires careful attention. The narratives of women with heart disease in this study demonstrated their tenuous connections with health care professionals, their loss of trust in health care, and their profound anxiety related to the daily self management of their illness that they were compelled to take on with little support. As Anne noted in her narrative:

*I don't feel like I have anybody who's looking out for my best interest right now.
Like I don't have a family doctor and the cardiologists are very hard to get a hold*

of and they're very, you know, you get passed around. You get one that operates on you and then you get one who attends you and then you get one who discharges you and then you go to [cardiac rehabilitation] and there's different ones there, and who's got all my information in one place? Like, who is taking care of me?...Who's got control of this? Because I don't...I need to have a sense of somebody knows what's going on not just me, someone to help me (crying)

Most significantly, women in their interviews had expressed a sense of distrust in how their care might unfold. They described their ER encounters as outsiders, and they explained in great detail those times when their experiential wisdom had been discounted, and when their anxiety had not been recognized, suggesting that they had felt marginalized in their own health care encounters. When women did seek emergent care, they often did so uneasily because of previous care seeking encounters. Perhaps their reluctance to seek care was an accomplishment of their uneasy subjection to these privileged discourses in the ER. Their private identities, their experiential wisdom, and the acknowledgement of the anxiety ridden complexity of their lives within which they needed to manage their health issues, was eclipsed by an orientation to these privileged discourses, and the possibilities for the understanding and management of their health was constrained.

The Reluctant Self-Subjection to Privileged Discourses

In the current social milieu, where discussions of the sustainability of our expensive health care system are unrelenting in the media, in parliamentary discussions and decision-making, and in the board rooms of health care facilities struggling to meet budget targets, health and health care have come to be discussed and understood in terms of economics. All of these discussions are surely escalated in the midst of a global economic crisis, where the loss of national economic viability is a very real threat in countries around the world. Today, when the economic sustainability of our health care system is in crisis, a discourse

of ethics emerges in the midst of the discourse of economics, efficiency, and the rational distribution of limited health care resources. Self-subjection to this discourse is made possible because of the overwhelming supremacy of the “ethical substance” in ER encounters as previously described, in which participants are either seeking to access, or seeking to give access to health, and perhaps life itself (Foucault, 1984 p. 352). The ER provides a heightened view of the orientation to these discourses, where they reveal themselves in the health care encounter itself, within the narratives of health professionals and women who have sought emergent care for cardiac symptoms.

Lurking in the shadows of the going concerns of the ER is the ever dominant discourse that health and health care have become a major economic dilemma that might only be rationally resolved through the efficient application of biomedicine onto those seeking care. This becomes a condition of possibility that allows certain mechanisms of power to evolve and operate in the context of the ER, perhaps in the context of our current health care system as a whole. It is here where biomedicine is valorized, and where health professionals’ gaze and their practice are seduced to align with the institutional imperative of efficiency and economics. This seduction is perhaps made possible because of health professionals’ primary concern for having life saving treatment available for that next critical case as they struggle to practice in the context of severely limited resources, to be prepared to make that life saving difference they all spoke about in their interviews.

Lurking in the shadows of women’s private lives, in the minds of those seeking care or those contemplating seeking emergent care, is this same discourse of economics and efficiency. The many apologies from those seeking care during my field observations, their

submissive posturing in ER encounters, the angst so clearly apparent in women's interviews regarding their decisions to seek care, all point to this discourse. The orientation of health professionals to the privileged discourse of biomedicine served to eclipse the private context within which women managed their heart disease, and women presented themselves as outsiders in their health care encounters, including those in the ER. Their loss of trust in health care as well is particularly significant given women's continued delay in seeking emergent care for cardiac symptoms. It is the significant accomplishments of the subjection to the privileged discourses presented in this study that requires our careful attention regarding implications for practice. The generative nature of this health care encounter is also significant understanding that might support the creation of a new ethos in health care.

Creating a New Ethos

Construction of the ethical self.

The findings of this study offer the possibility for the emergence of the ethical self in health care encounters, both for those giving and receiving care. This ethical self, as previously described, is one who emerges as free to resist the mechanisms of power such as those inherent in ER encounters, as one who can resist the subordination of their life to biological life, as one who can choose to construct their identity in a certain way, and who can choose how to engage in everyday life. The possibility of the assemblage of this ethical self may require the creation of a new ethical climate, a new "ethos" in health care, for both the health professional and those seeking care. Ethos has been described by O'Sullivan Burchard (2005) as "the values and beliefs of a community", which supports a shared

sense of belonging as well as shared responsibility, and it is this definition that I would refer to in this discussion (p. 355).

Health care professionals' reluctant orientation to the institutional discourse of efficiency and economics in this study changed the very nature of their practice, and this change in orientation had significant consequences that cannot be ignored. The ethical tensions experienced by participants on both sides of ER encounters in this study, suggests the need for a new ethos in health care encounters, particularly those in the ER. This new ethos might allow for the emergence of the ethical self as suggested by Foucault, where a sensitized view of the health care encounter emerges from understandings such as the ones generated in this study.

Challenging the discourse of limited resources.

The uneasiness with which health professionals subjected themselves to the discourse of economics and efficiency was reflective of their limited ability to fulfill their most fundamental mandates as ER health care professionals, and that was having the unimpeded ability to offer life saving treatment. They were being required to practice in a system so severely lacking in resources that patients' lives were literally put at risk. Although none of the health professionals interviewed or shadowed labeled this as ethical distress, the analysis of the data gathered pointed to this tension. Limited treatment spaces available to health professionals in this study put them in an ethically tenuous position of rationing healthcare resources, and this resulted in a significant shift in the way they entered into an encounter with those seeking care. The shift appeared to be a move away from the

traditional ethic of caring in health professionals' practice, to one of distributive justice where the need to allocate life-saving treatment efficiently justified their way of practicing.

Maxwell (2009) offers a particularly apt critique of the ethics of the "scarcity paradigm" in the provision of health care (p. 219). He describes the scarcity paradigm that currently predominates in healthcare delivery today as having been created by healthcare administrators in an effort to control healthcare costs. Policies have been enacted that claim to be directed at optimizing efficiencies and thus make optimal use of limited healthcare dollars, but also help to ensure that private investment in healthcare facilities are optimized. Maxwell argues that policies directed at improving healthcare workers' productivity, shortening hospital stays, and limiting the number of active beds, have been presented as an economic necessity, and have created a culture or a "paradigm of scarcity" in hospital settings, where health professionals' time is at a premium (p. 221).

The scarcity paradigm operating in our current healthcare environment puts health professionals in the ethically tenuous position of having to ration their care and their time, or perhaps of having to choose between the ethic of caring, and the ethic of justice in their practice. Maxwell (2009) points out that the conflicting principles of caring and justice are not new to medical ethical debates, and that the principle of justice has traditionally won over caring in these debates because of the supremacy of professionals' responsibility to offer life saving treatment. Maxwell's contention however, is that chronically limited resources where health professionals time is *intentionally* always scarce, creates an "acute deficit of justice" (p. 220). He argues that those who are in the most vulnerable states of health, for example those who are dying require a great deal of health professionals' time.

Health professionals' time is so limited however, that these people may be left without proper care, and so justice is often not realized. Justice in this way cannot be separated from caring, and this implies a professional obligation to ensure that "just compassion" is enacted (p. 219).

In this study, people with potentially life threatening conditions were frequently required to wait for treatment in the ER. This created an ethical tension for both those giving and seeking care. Women in this study articulated their understanding of the need to ration care. The following comment from Nickie demonstrated this:

..... Even when you phone 911, this better be like almost death, like you don't want to disturb someone to come and get you to have someone else die coming to get you and there's nothing wrong you.

For women in this study, an ethical tension emerged even as they contemplated getting emergent care as this previous example demonstrates. ER health professionals who had state-of-the-art life saving equipment and expertise were rendered impotent in their ability to offer care because of severely limited treatment beds, and were required to stand by and watch the suffering of those in the waiting room who so needed their care.

Women in this study tearfully described small acts of caring by health professionals in their interviews, and how this had been so significant for them. I remember this as a very poignant revelation for me, because in my mind, caring was an inextricable part of health care. These acts of caring should not have been so surprising to them so as to elicit such an emotional reaction, and yet they were, and again I heard the distant echoes of all of these women's previous health care encounters. These women in their care seeking for a life-

threatening illness, as well as others I had observed during my field observations, had experienced not just a deficit of caring, but a deficit of justice. Women's emotional accounts in this study should remind us of the importance of this fundamental aspect of healthcare encounters. As others have pointed out, our work as healthcare professionals should include a resistance to accepting limited resources as the status quo, particularly because of the potentially serious consequences for those in need of our care (Canadian Nurses Association, 2000; Maxwell, 2009; Rodney, Doane, Storch & Varcoe, 2006; Storch, Rodney, Pauly & Fulton, 2009).

Optimizing care within the healthcare encounter itself.

Perhaps the context in which health is currently being managed has not been sufficiently analyzed or considered in our current health care system. The context in which health is being managed is changing, to a large extent because of economic constraints imposed on health care institutions, and hospitals across the country have downsized their capacity (Health Council of Canada, 2005). The limited resources which health care institutions operate within, has pushed much of the responsibility for health care onto the individual themselves. The extremely limited number of beds available for inpatient treatment have shortened hospital stays, and led to the introduction of many outpatient services as well as an increasing reliance on home care services to manage the care of patients who have been discharged from hospital (Health Council of Canada, 2005). The number of Canadians without access to a regular family physician is increasing. Recent figures reveal that in 2005, 17% of Canadians did not have a regular family physician (Nambalamba & Miller, 2007). The latest statistics from the Alberta Medical Association suggest that physician

numbers have increased only marginally since then, despite the increasing population of Alberta (College of Physicians & Surgeons of Alberta 2012). The shortage of family physicians and a lack of alternative primary care providers, such as nurse practitioners, has diminished the support for people's health concerns, and increased dependence on drop-in clinics or ER's for health care. Health care has become increasingly transient, fragmented, and impersonal in this way.

One of the nurses in her interview referred to changes in ER practice as being similar to the frog in the water being gradually boiled to death without his recognition. Just as the water's temperature rose imperceptibly until the frog was boiled to death without taking the opportunity to hop out, the context in which most of the "taking care of health" is occurring is changing. The overflowing waiting room in the ER is metaphorically the boiling pot. The precariousness inherent in the everyday going concerns of the ER is merely an extension of the precarious context in which individuals are left to manage their health. The triage window represents the point of tension between the precarious context of the institution, and the precarious context of individual's private lives, and perhaps we need to widen the slit in the triage window to allow these individual contexts to become part of the new ethos in health care. The ER waiting room itself only represents those that have brought themselves to seek emergent care, whereas the real waiting room extends into the homes of people such as the women in this study. For anyone with health issues, and most particularly those with potentially life-threatening health issues, an unimpeded link between their private lives and the health care that might save them, is imperative. This will also require a new ethos in health care which supports and encourages this connection.

Challenging the Current Conditions of Possibility.

David Armstrong (2002) in his book *A New History of Identity: A Sociology of Medical Knowledge* provides a compelling discussion regarding the changing perceptions of the patient using Foucauldian philosophy. He uses medical texts to trace contemporary perceptions of health, developments in treatment, techniques of examination, and patterns of health care. This historical analysis provides an account of the changing construction of patients' identities. One of his insights is that prior to the advent of institutional health care, people were required to manage their health on their own, perhaps with the aid of a physician, who would come to their home, or see them in their own homes (Armstrong, 2002). In this way, there was an overarching sense of familiarity and individuality in the health care encounter, and time was not disciplined to meet institutional goals of efficiency and economic sustainability. Health was viewed from within the messy complexity of individuals' lives. Health care has become increasingly institutionalized with the rise of the modern hospital, however this is now changing.

Since the 1970, there has been a turn towards patient centered health care (Armstrong, 2002). Placing patients at the centre of concern in the *delivery* of health care however, does not quite capture what the results of this study imply. One of the implications from this study is that the orientation of health care encounters needs to be turned around to orient to the *support* of individuals in *their* management of health concerns, where the private context of health becomes valorized. Delivering biomedical care more efficiently does not attend to the complexity within which individuals manage their health, and where most of the "taking care of health" occurs today.

In response to recent serious concerns about the safety and integrity of Alberta's health care system, an in depth survey was conducted by the Health Quality Council of Alberta (2012). Wait times for emergency department (ED) services as well as cancer services were examined (Health Quality Council of Alberta, 2012). The conclusions of this report were summarized in terms of ED output factors, throughput factors, and input factors, all of which related to improving efficiency and flow in the ER. Of note is that only 20% of people visiting ER's in Alberta were admitted to hospital, so 80% of those seeking care in the ER returned home and did not receive institutional care. The fact that *most* of the patients seeking care in the ER do not receive institutional care should demonstrate that most patients seeking care are not in life-threatening circumstances, and so health professionals' heavy reliance on the biomedical perspective required to deal with these issues in the ER may not be justified. This survey would have benefited from patients' perspectives, or an analysis of factors contributing to their requirement for ER services, including the *context* from within which individuals are required to seek emergent care.

The Alberta Health Services recent action plan entitled *Becoming the Best: Alberta's 5 Year Health Action Plan 2010-2015* revealed that their plan to improve Albertan's health fell almost exclusively into the domain of improving the access and efficiency of health care delivery (2010). These reports are reflective of the current view of health care that is predominant today, where health care is viewed primarily in terms of the delivery of care, and little attention is paid to the individual optimization or management of health.

The perspective of the method used in this study incited us to "hear the distant roar of the battle" as described by Foucault (1995), where a certain version of social reality

emerges as the one that counts in everyday struggles. Mechanisms of power operated to privilege certain dominant ways of knowing, and it was an orientation to these discourses that served to construct the understandings, practices, and identities of women as well as health professionals. The theoretical perspective of the method used for this study, required a careful consideration of the context in which these constructions occurred, and it is this understanding that perhaps has the most significant implication for practice in the management of health. An understanding from this study is that every health care encounter provides us with an opportunity for “person-building” as described by Gubrium and Holstein (2001, p. 11), where understandings of the self are constructed, including an understanding of how to negotiate everyday existences. As previously described, health care encounters are *of* consequence, and also *have* consequences, and this is an essential view that needs to be recognized in order for a new ethos in health care to emerge.

The management of health is increasingly becoming an individual endeavor carried out in the context of individuals’ private lives, and perhaps it is the roar of this everyday battle like Anne’s, that demands attention. Within the orientation to the privileged discourses expressed in this study, was a reflection of a traditional hierarchical understanding of health care institutions as central and omnipotent in the management of health. The diminishing capacity for hospitals to manage health care concerns suggests a new reality that might require the privileging of new discourses in health care. The privileged discourses in this analysis of ER encounters may be out of step with this emerging reality. The uneasy subjection of health professionals and women with heart disease to these privileged discourses may be a reflection of this dissonance that requires our attention. Health

professionals' knowledge and expertise are valuable resources in the management of health that is constrained by their reluctant self-subjection to discourses of efficiency and economics. The ethical dissonance reflected in the narratives of health professionals who were reluctantly compelled to align their practice with privileged discourses of efficiency in this study must be recognized. Emerging new privileged discourses should first require an orientation to the individual's context in the management of health concerns, and the patient's perspective must be included in a mutually respectful and non-hierarchical exchange in health care encounters. The accomplishments of privileging institutional and biomedical discourses in the management of health is showing itself in the overflowing waiting rooms of the ER, where patients wait, and wait.....to be seen.

The need to challenge policies that have created this current state-of-affairs in healthcare is essential, as previously described. However, one must be cautious not to assume that working to change health policy will necessarily result in outcomes that are in the best interests of those in need of care. History has taught us that health policies enacted by government have most often been directed at managing the cost of health care, and not necessarily improving the health of people. We must not forget that health care professionals, and nurses in particular, have at their disposal the venues, the skills, and the ability to make a real difference in people's lives at the level of the healthcare encounter. Knowledge that is generated in studies such as this, can not only support our ability to help people in *their* management of health issues, we can help them to become aware of the impact of government policies on healthcare delivery, and to even encourage them to consider these policies when it is time to vote (Campbell, 2012).

Education programs for physicians, nurses, as well as other health professionals, should orient to an understanding of the larger context in which health is being managed today. Health professionals' education programs should give them the skills to identify and address issues of justice in their care, and to practice "just compassion" as Maxwell suggests (Maxwell, 2009). These programs should be designed for students as well as working health professionals. An understanding of the impact of policies on health care should be essential knowledge in the education programs for health professionals, for example those policies that have created the current shortage of health care resources. Programs such as this could serve to change the ethos within healthcare delivery to allow for the emergence of the ethical self, for both health professionals and those seeking care. The generative nature of health care encounters should be well understood by health professionals as well as those seeking care in order to allow for a more thoughtful and inclusive ethos in the health care encounter. A reliance on the traditional hierarchical model of health care does not take into account the new emerging reality where health care institutions are increasingly less able to effectively manage the health issues of those seeking care. The findings of this study confirm the need for a broader and more inclusive understanding of health and health care, including sensitivity to the accomplishments of the healthcare encounter itself as this research suggests. These kinds of understandings could encourage the creation of health policies that support individual health both within the healthcare encounter, and within the context of individual's lives. The privileged discourses in health care encounters must be disturbed for the sake of our health care system as well as for the optimal support of those with health issues.

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Appendix A

Invitation to Participate

For Cardiac Client

You are invited to participate in a research study exploring:

Emergency Room visits of women with heart symptoms.

Heart disease is the leading cause of death for women in Canada. There are many things we need to understand to improve the health and reduce the death rates for women with heart disease. For example, many women are not seeking care in Emergency as quickly as they should for their heart symptoms and this may be putting their health at risk. If you are a woman who has sought care for heart symptoms in an Emergency department, and are willing to talk about this experience by participating in this study,

Please contact or leave a message for Heather Russell at:

~~440-5072~~ or e-mail: ~~hrussell@mtroyal.ca~~

Heather Russell is a Doctoral student at the University of Calgary who is interested in having interviews with you in order to understand your Emergency Room encounters.

This study is being carried out as part of a program of studies within the Faculty of Nursing at the University of Calgary.

*Supervisor : Dianne Tapp, RN, PhD
Interim Dean & Associate Professor
Faculty of Nursing
University of Calgary
Ph 220-6332
e-mail: dtapp@ucalgary.ca*

Appendix B

Invitation to Participate

For Health Professionals

You are invited to participate in a research study exploring:

Emergency Room visits of women with heart symptoms.

Heart disease is the leading cause of death for women in Canada. Unfortunately, the mortality rates of women with heart disease continues to be higher as compared to men. There are many issues that we as health care providers need to understand to improve the health and reduce the death rates for women with heart disease. If you are a health professional who has cared for a woman with heart symptoms in an Emergency department, and are willing to participate in this study by talking about this emergency encounter, or are willing to be shadowed in your work in the Emergency department:

Please contact or leave a message for Heather Russell at:

~~440-5072~~ or e-mail: ~~hrussell@mtroyal.ca~~

Heather Russell is a Doctoral student at the University of Calgary who is interested in having interviews with you in order to understand your Emergency Room encounters.

This study is being carried out as part of a program of studies within the Faculty of Nursing at the University of Calgary.

Supervisor

Dianne Tapp, RN, PhD

Interim Dean & Associate Professor

Faculty of Nursing

University of Calgary

Ph 220-6332

Appendix C: Consent Form

Cardiac Client Interview

Title: Emergency Room Encounters of Women with Cardiac Symptoms

Researcher: Heather Russell, R.N., M.N., PhD (c)

Principal Investigator: Dianne Tapp, R.N., PhD., Interim Dean & Associate Professor,

Faculty of Nursing, The University of Calgary, Calgary, Alberta, Canada.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research project is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the study:

The purpose of the study is to learn about your experiences in seeking care for heart symptoms in the Emergency Room. From listening to you, the researcher hopes to understand your experience of being looked after in the Emergency Room. This information should help health care professionals to develop plans for caring for people who are having heart symptoms, and who seek care in an Emergency department

Description of the Study:

If you consent to take part in this study you will be interviewed once about your Emergency Room encounter for your heart symptoms. The interview will be arranged at a time and location that is convenient for you and will typically last one to two hours. The interview will be tape recorded, and will be later typed by the researcher or a typist. There will be no financial costs to you if you participate in this study. There will be no financial compensation for your participation in this study.

Voluntary Participation:

Your decision to take part in this study is strictly voluntary. You may refuse to take part without this affecting your care in the hospital or at home. If you decide to take part, you have the right to ask the researcher any questions concerning this study at any time. You also have the right to withdraw from the study at any time. If after an interview you wish to change your mind about taking part, you may call the researcher and ask that the tape be destroyed. There are no risks anticipated as a result of your participation in the study. Some persons may find the conversations could evoke emotional distress. The researcher will be prepared to provide you with a list of, and if necessary a referral to appropriate counselling services. In the event that you suffer injury as a result of participating in this research, no compensation will be provided for you by the investigator. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

Confidentiality:

Unless you tell others, only the researcher, the typist, and the faculty supervisor will know that you are taking part in this study. All tape-recordings will be kept in a locked filing cabinet and will be erased at the end of this study. Computer files of data obtained will be password protected as well. The typed transcripts of your interview will be stored in a locked cabinet and be kept for five years. After completion of the study, typed transcriptions will be shredded. Data from the interviews, in the forms of excerpts, may be used in the presentation of findings for teaching purposes. At no time will your name be identified on any documents. Interview data may also be used in a future study, but prior ethical approval will be obtained.

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

If you have questions now or in the future concerning matters related to this research, please contact:

Dianne Tapp, Principal Investigator, Faculty of Nursing, at 220-6332

Heather Russell, Principal Collaborator, at ~~440-5072~~

If you have any questions concerning your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, The University of Calgary, at 220-7990.

Participant's Signature

Date

Investigators and/or Delegate's Signature

Date

Appendix D: Consent Form

Health Professional Interview

Title: Emergency Room Encounters of Women with Cardiac Symptoms

Researcher: Heather Russell, R.N., M.N., PhD(c)

Principal Investigator: Dianne Tapp, R.N., PhD., Interim Dean & Associate Professor,

Faculty of Nursing, The University of Calgary, Calgary, Alberta, Canada.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research project is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the study:

The purpose of the study is to learn about your experiences in caring for women seeking care for heart symptoms in the Emergency Room. From listening to you, the researcher hopes to understand your experience in this Emergency Room encounter. This information should help health care professionals to develop plans for caring for people who are having heart symptoms, and who seek care in an Emergency department

Description of the Study:

If you consent to take part in this study you will be interviewed once about your experience in caring for women who come into the Emergency Room with heart symptoms. The interview will be arranged at a time and location that is convenient for you and will typically last one to two hours. The interview will be tape recorded, and will be later typed by the researcher or a typist. There will be no financial costs to you if you participate in this study. There will be no financial compensation for your participation in this study.

Voluntary Participation:

Your decision to take part in this study is strictly voluntary. You may refuse to take part without this affecting your care in the hospital or at home. If you decide to take part, you have the right to ask the researcher any questions concerning this study at any time. You also have the right to withdraw from the study at any time. If after an interview you wish to change your mind about taking part, you may call the researcher and ask that the tape be destroyed. There are no risks anticipated as a result of your participation in the study. Some persons may find the conversations could evoke emotional distress. The researcher will be prepared to offer referral to appropriate counselling services. In the event that you suffer injury as a result of participating in this research, no compensation will be provided for you by the investigator. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

Confidentiality:

Unless you tell others, only the researcher, the typist, and the faculty supervisor will know that you are taking part in this study. All tape-recordings will be kept in a locked filing cabinet and will be erased at the end of this study. The typed transcripts of your interview will be stored in a locked cabinet and be kept for five years. After completion of the study, typed transcriptions will be shredded. Data from the interviews, in the forms of excerpts, may be used in the presentation of findings for teaching purposes. At no time will your name be identified on any documents. Interview data may also be used in a future study, but prior ethical approval will be obtained.

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

If you have questions now or in the future concerning matters related to this research, please contact:

Dianne Tapp, Principal Investigator, Faculty of Nursing, at 220-6332

Heather Russell, Principal Collaborator, at ~~440-5072~~

If you have any questions concerning your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, The University of Calgary, at 220-7990.

Participant's Signature

Date

Investigators and/or Delegate's Signature

Date

Appendix E: Consent Form

Health Professional Observation

Title: Emergency Room Encounters of Women with Cardiac Symptoms

Researcher: Heather Russell, R.N., M.N., PhD(c)

Principal Investigator: Dianne Tapp, R.N., PhD., Interim Dean & Associate Professor,

Faculty of Nursing, The University of Calgary, Calgary, Alberta, Canada.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research project is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the study:

The purpose of the study is to learn about your experiences in caring for women seeking care for heart symptoms in the Emergency Room. From listening to you and watching your interactions, the researcher hopes to understand the interaction of these women with health professionals in the Emergency Room encounter. This information should help health care professionals and women with heart symptoms to develop plans for managing their heart disease.

Description of the Study:

If you consent to take part in this study you will be observed by the researcher during your regular working hours in the Emergency department. The observation period will be negotiated with you, but will typically last 2-3 hours. The researcher will make notes about her observations which you will have the opportunity to see and discuss with the researcher. If at any time you think the researcher should not be present simply ask the researcher to leave the observation. There will be no financial costs to you if you participate in this study. There will be no financial compensation for your participation in this study.

Voluntary Participation:

Your decision to take part in this study is strictly voluntary. You may refuse to take part without jeopardy. If you decide to take part, you have the right to ask the researcher any questions concerning this study at any time. You also have the right to withdraw from the study at any time. If after an observation period you wish to change your mind about taking part, you may call the researcher and ask that the field notes be destroyed. There are no risks anticipated as a result of your participation in the study. The researcher will be prepared to offer referral to appropriate counselling services if you become distressed during the observation period. In the event that you suffer injury as a result of participating in this research, no compensation will be provided for you by the investigator. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

Confidentiality:

Unless you tell others, only the researcher, the typist, and the faculty supervisor will know that you are taking part in this study. All tape-recordings will be kept in a locked filing cabinet and will be erased at the end of this study. The typed transcripts of your interview will be stored in a locked cabinet and be kept for five years. Computer files will be secured with a password. After completion of the study, typed transcriptions will be shredded, and electronic files will be deleted. Data from the interviews, in the forms of excerpts, may be used in the presentation of findings for teaching purposes. At no time will your name be identified on any documents. Data obtained through this observation may also be used in a future study, but prior ethical approval will be obtained.

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardy. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

If you have questions now or in the future concerning matters related to this research, please contact:

Dianne Tapp, Principal Investigator, Faculty of Nursing, at 220-6332

Heather Russell, Principal Collaborator, at ~~440-5072~~

If you have any questions concerning your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, The University of Calgary, at 220-7990.

Participant's Signature

Date

Investigators and/or Delegate's Signature

Date