NURSES AND PROFESSIONALISM: AN EMERGENCY ROOM CASE

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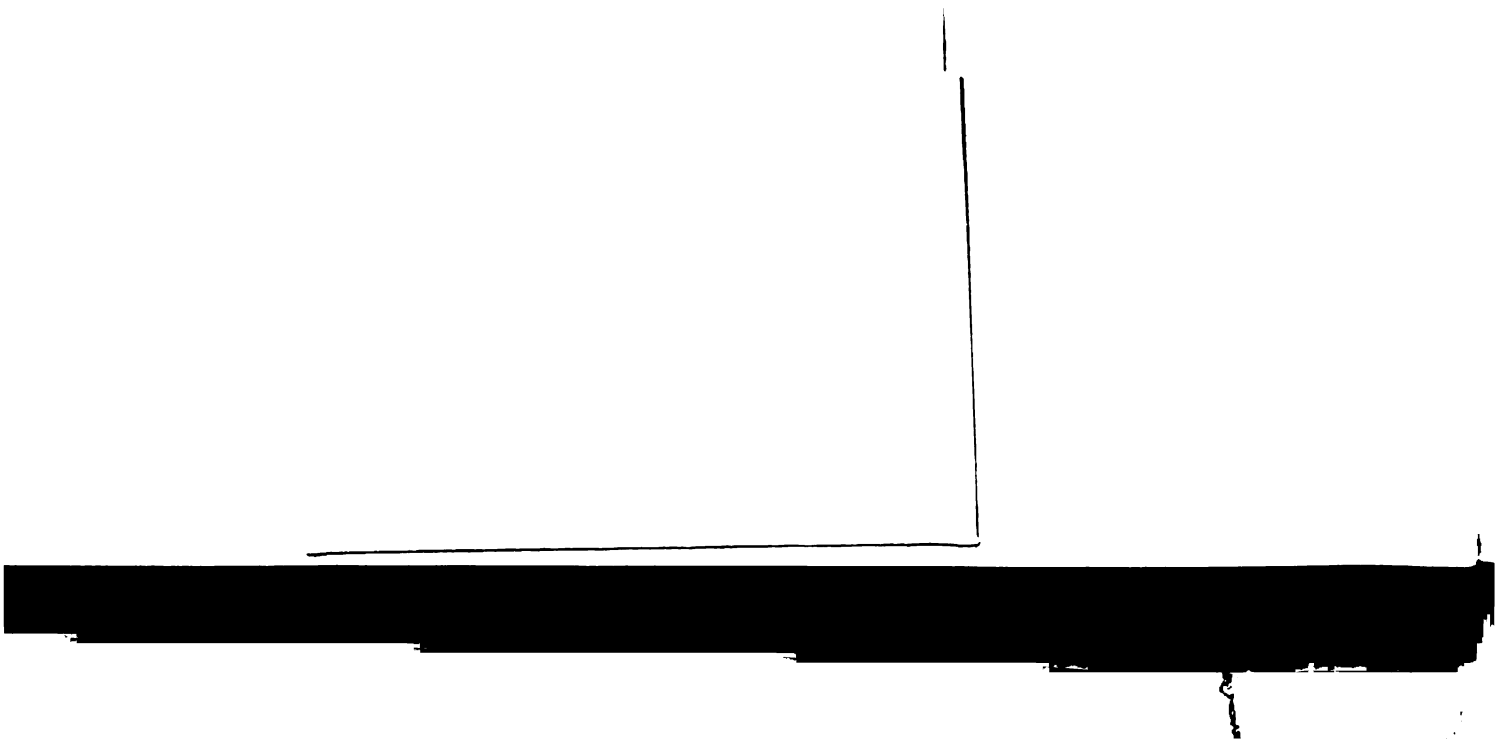

ABSTRACT

NURSES AND PROFESSIONALISM:

AN EMERGENCY ROOM CASE

By

Pamela Jane Schwingl

In a participant observation study of an emergency room in a middle size, community hospital it was discovered that nurses were actively supporting the idea of becomming professional emergency room nurses. Since this concern with professionalism was not in keeping with reports about the appeal of professionalization among rank and file nurses, the researcher attempted to pinpoint particular features or predisposing factors within the work setting which would contribute to an understanding of why nurses would account for themselves as professionals. The assembly line nature of work, and the emergency room physicians' support of emergency medicine were cited as major factors shaping the nurses' response to work. In addition an examination of the social characteristics, age, education, and marital status of the nurses helped to account for their enthusiasm about professionalization. How work in an emergency room led to a tendency to categorize patients as appropriate or inappropriate was also investigated.

NURSES AND PROFESSIONALISM:
AN EMERGENCY ROOM CASE

BY

Pamela J. Schwingl

A THESIS

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to my mother,

who was a strong woman

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I want to express my gratitude to a number of people who have been important throughout my graduate education and who have helped me develop both a sense of who I am, and, not apart from this, a sense of what I believe to be worthy of concern and study in social life.

I wish to thank Dr. Barrie Thorne, my thesis advisor, for providing substance and direction to the development of this thesis; and also for being enthusiastic and supportive in all phases of my graduate education.

I also wish to thank the other members of my Master's Committee, Dr. Bo Anderson and Dr. Marilyn Aronoff who have provided several valuable insights on the material in this thesis.

I would also like to thank my friends. Bob, Mark, Claire, Mike, Sandy and Carolyn were around and listening when I needed them.

And finally, it is with sincerity that I thank the men and women who work in the emergency room in Community Hospital. Although their view of the emergency room might be quite distinct from mine, I have in no way intended to invalidate the meaning they attach to their lives and to their work. I only hope that I can better understand the nature of work after this experience in the emergency room, and hope that this thesis can communicate some of that understanding.

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Introduction

When I began my fieldwork in the emergency room of Community Hospital, I had little notion of what I might discover. However, it wasn't long before I became aware of a number of issues and problems which were important to the nurses who spent their time "holding down the fort."[1] Professionalization seemed to be one of these issues, and one which the nursing staff spent a great deal of time discussing.[2] I was soon able to see that much of what happened in the emergency room between nurses and patients, nurses and staff, as well as what occurred among the nurses themselves could be understood in part by examining how the nurses accounted for themselves as "professionals." The more obvious methods of accounting for oneself such as one's demeanor or a vocal support of professional nursing, as well as the more subtle methods, such as a concern with one's professional time, indicated that the issue of professionalism was a salient one for several of the nurses.

During this time I was searching the nursing journals and the existing sociological literature on nurses in order to discover how the issue of professionalization and professionalism among nurses was being treated. Interestingly enough it became apparent that the nursing leaders who were writing much of the literature, were also

the people who were pushing for professionalization; and in fact, the rank and file nurses were only concerned in a very minor way with professionalization, or with the idea of becoming professionals.[3] The studies which examined how the rank and file regard professionalization were primarily attitudinal in nature, and only indicated that the nurses with professional degrees in nursing differed from nurses with technical degrees only in terms of their "professional attitude."[4] It was at this point that my interest was aroused; why were the nurses in the emergency room so concerned with themselves as professionals? Was it only a difference in education? Obviously they were not the educators or leaders of the field, nor did they all have "professional degrees."

My attention strated to shift towards examining particular aspects of the work setting. By taking a good look at the conditions of work and the organization of the emergency room, I decided that I might be able to discover what it was that made the idea of professionalism appealing to this particular group of nurses. In this way I could also understand what a "professional attitude" meant in a particular setting.

With these ideas in mind then, I have attempted to map out the "predisposing factors" which existed in the emergency room milieu, and to specify who supported professionalism and who did not, and what this meant for the day to day negotiations of work. As an introduction to

the text, I have included a discussion of nurses within the medical "paraprofessional" hierarchy, and what professionalism has meant for both the leaders and the rank and file within the occupation of nursing.

Nurses as Paramedicals: The Drive for Professionalization

The organization of work and knowledge has undergone extraordinary changes in the last century. The increasing number of universities and university-trained students, combined with technological advances which have come about since the mid-1800's have created a steady proliferation of new occupations. The kind of knowledge required in many of these occupations is highly specialized and esoteric; some observers believe this increasing specialization is making society more and more illiterate, creating a situation where a single person in one occupation couldn't possibly know what goes on in other occupations without taking several courses of advanced knowledge in many areas.[5]

This proliferation of esoteric specialties is not confined to areas like computers for example, which are products of this century's technology; there is an increasing differentiation of labor in traditional areas of knowledge as well, such as in law or in medicine. In the case of medicine, the division of labor is somewhat unique;[6] the vast numbers of new medical occupations are organized around and controlled by a central dominant profession.[7] These paramedical occupations perform many of the tasks which once were accomplished solely by physicians, while doctors have gone on to practice more refined techniques and to continue in their primary function of diagnosing and prescribing.

The paramedical occupations are characterized by a lack of autonomy; they are tightly controlled by the medical profession, and they form a rigid hierarchy of jobs which depend on, and take orders from physicians. These jobs for the most part tend to offer little chance of mobility to those who choose to be trained for them. Persons trained to be X-ray technicians are not encouraged to acquire the new training necessary to be interns or doctors, nor are medical technologists likely to be found seeking better opportunities within the occupational group of electroencephalograph technicians, for example. There is little on-the-job mobility among occupations; to change one's position in the hierarchy, one must leave the hospital and take up more formal schooling. As a result of such organization, paramedical groups are isolated, and health workers are offered little opportunity or incentive to go further within the field of medicine.

Although it calls itself a profession, nursing is located within the health care hierarchy. Like most paramedical occupations, nursing developed by taking over tasks which another occupation (in this case, physicians) no longer wished to perform. In turn, nursing has given over a number of tasks to occupations of lower status in the medical work system. For example, nurses once performed social services and activities for patients, and cleaned beds and sterilized bedpans, as well as maintaining records of admissions, deaths, and discharges. Now there are medical

social workers, LPNs, recreation therapists, central supply technicians, and medical librarians, to name a few who perform the same duties. Nurses themselves have taken over several functions which were performed only by doctors, such as dispensing medications, taking blood pressures or preparing and setting up intravenous feedings.[8] In the last few years another specialty, the physician's assistant, has developed to take over even more of the physicians tasks.

Differentiation of levels has also occured within the occupational group of nurses. Over the years several categories of nurses have evolved, differentiated by length and place of training: diploma school graduates, Baccalaureatte (four year) graduates, Masters degree nurses, two-year technical RNs (registered nurses), and LPNs (licensed practical nurses) who are usually trained in technical programs lasting not longer than one year.[9]

The frequent reorganization of tasks among paramedical groups, as well as the steady development of newer specialties and subspecialties which impinge on the territories of older occupations, may threaten the status of a particular occupation in the medical hierarchy. Leaders of particular occupations see that it is in their interest to safeguard their own niche, or to claim an exclusive mandate over a particular area of work.[10] Claiming professional rank is a powerful means for getting ahead in the race for status, prestige, and monetary gains within the medical hierarchy. However, to buttress this claim, the occupations involved

have to participate to varying degrees in the manipulation of the symbols of professionalism. Journals are filled with articles which argue how closely a given occupation meets the standards of the traditionally defined professions (e.g., that the occupation has a unique body of knowledge, and a code of ethics). Location of training within colleges and universities is eagerly sought; clothing and demeanor become the object of close attention; licensing procedures are established to give the group control of its boundaries; and often associations are formed which proclaim and push the professional status of the occupation.

To avoid the mistake of viewing any of these occupations as monolithic entities, it is important to closely examine the movement toward professionalization; who, within a given occupation advocates becoming a profession, and for what reasons?[11] Among nurses, the leaders and educators in the field (including those with the most advanced degrees), appear to be the people most caught up in the drive for professionalization. It is in their interest to see that the occupation gets its fair share of the goodies; not only are they able to perceive the distribution of resources within the various institutions they're located in, but also they know that autonomy of the occupation brings prestige to themselves and to their cohorts. These people are also those who have received much "professional" training and education, and are eager to carry on the tradition. By pushing for professionalization of the occupation, the

the leaders can gain autonomy from physicians, and can help protect the occupation from further impingement on its territory from above (for example, from people such as physician assistants), or from below (by occupations of non-nursing personnel). Thus to understand the drive for professionalization, it seems important to understand the position of nursing in the medical hierarchy. Professionalization in this sense is a powerful tool in the struggle among leaders of the various paramedical groups.

If it is the leaders of the field who are most caught up in pushing for the professionalization of the occupation, then how do the rank and file relate to this issue? It has been reported that the rank and file are only marginally interested, and on the whole care little about the issue of professionalization.[12] Part of the reason for this discrepancy might be ascertained by investigating how nursing fares both economically and meaningfully to the individual nurse at the point of entry into the field.

In order to keep the occupation of nursing in the running within the medical hierarchy, it is important that there be large numbers of nurses. As long as this condition exists, the occupation has a better chance of remaining unthreatened by non-nursing paramedical occupations. Thus nursing leaders have been recruiting large numbers of women into the field to keep the number of available nurses rather high, although not oversupplied.[13] This of course results in low wages for any individual nurse, since the supply of nurses will at least equal the demand for them. This

presents a problem for potential recruits who know that in order to get a degree, in many cases they will have to commit themselves to a number of years being trained for the occupation. In other words, the cost of becoming a nurse frequently outwighs the economic gains. This is where professionalism gets some of its lure -- by presenting the occupation as a profession which entails special commitment, and dedication and status, nursing leaders can attract women who might otherwise choose a more lucrative field. The lure of the occupational pamphlets proclaiming responsibility and autonomy for the graduates who complete their programs, and the uniforms and "professional" demeanor displayed by the representatives of the occupation probably are appealing to many women seeking a career. Throughout their education, (at least for RNs) training includes talk of professional ethics, codes, demeanor, and responsibility. What occurs after the neophyte starts to work however, helps explain the high turnover and attrition rates among nurses, and the fact that only about one third of the trained registered nurses actually work.[14]

"Reality shock is a term Everett C. Hughes used to describe the disjunction which nursing graduates experience between their expectations and the actual reality of the job.[15] Somehow the job doesn't match its description; the responsibility isn't as great as their expectations; and the routine nature of the job doesn't give the graduates the sense of excitement and responsibility which they anticipated. In

other words, the promise of professionalization remains on a theoretical level, while the bureacratization and routinization of hospital life becomes the reality.

For many nursing graduates the greatest shock is probably the distance that the nurse must maintain and is encouraged to maintain from the patient. In fact those nurses with the most status are the managerial nurses, those furthest away from patient care, while nurses aides, women with little or no formal training, have the most contact with patients. For the most part, graduates have few choices once they have entered the system. Once on the job, many nurses redefine and modify the ideals which they learned in school.[16] Thus, instead of concentrating on caring for patients directly, energy and attention is focused on activities designed to meet bureacratic standards, such as good record-keeping or efficient use of time. Reports of nursing[17] show that nurses are involved in very little decision making of a "professional" nature, and are frequently relegated to jobs which have little to do with direct patient care.[18] When nurses aren't engaged in doing particular tasks, free time is often spent with other staff rather than in caring for patients.[19]

In this study of nurses in a hospital emergency room, it became apparent that the work done by nurses was narrow in scope; the care given to the patients was organized in an assembly-line fashion. Patients were quickly treated and nurses rarely saw them again or found out how effective their treatment had been. Work was done efficiently and

quickly, and nurses were not able to spend extra time with patients; if they had though they would like to do so before they started working in the emergency room, the contingencies of the job quickly changed their minds. If this is the reality of work on the job, then what can "professionalism" mean to nurses who are engaged in work which is routine and which demands little "professional decision making? The issue of professionalization of the occupation, at least in the terms in which it is carried on by the leaders of the field, seems far removed from the experience of the nurse on the job. In the study which follows, the nurses in Community Hospital[20] will be shown as attempting to wrest some autonomy from physicians in the emergency room; they have an idea that "being professional" will bring some reward. Whether they find this a satisfying goal remains to be seen; however what will be examined is how they go about negotiating their position as staff in an emergency room setting.

The Setting and the Study

The Emergency room unit which was studied is part of Community Hospital, a moderate sized acute care hospital which is located in a capitol city of a large midwestern state, and which is privately supported and one of four hospitals serving the people in this particular community. As in most community hospitals, private physicians who have admitting privileges play a major role in the hospital, and although there are some ties to a nearby university medical school, residents and interns are not commonly seen in the hospital setting. The hospital is located in a predominantly black, poor, industrialized area of the city; however, because private physicians throughout the city make use of admitting privileges, patients using the facilities of Community include wealthier, white patients from different parts of the city, as well as Chicano and white working class people who make their living working in the factories nearby.

The emergency room is somewhat unique compared to the emergency services which are offered in most community hospitals. Instead of being directly run by the hospital's own resident staff of physicians, the ER[21] at Community is leased and operated by a group of private physicians who make this their own "practice" of sorts. Traditionally the "pit," or the emergency room, has been the

last stop for interns and residents before they went on to the more lucrative and prestigous private practices. However, there is an increasing tendency for physicians to regard emergency practice as varied and exciting, and by leasing the service out to a few physicians the practice has become quite lucrative for both the doctors and the hospital. Although this hasn't become a common practice, emergency specialists are becoming more numerous over the last few years, and there are more programs developing in medical schools which include courses on emergency practice. Along with this trend there have arisen associations of emergency physicians and journals written for practicing emergency doctors.[22]

In this particular emergency room there existed a consciousness of this arrangement as being unique, and somewhat "better" than the traditional arrangement which existed in the other hospitals in the city. The doctors themselves would comment occasionally that they felt they were running a "faster, more efficient" service than the other ERs in the city; and also they would comment upon "what a good business" they had here for themselves. An important point about this particular type of organization is that the doctors, unlike those who merely had admitting privileges in the hospital, were physically and spacially bound to the emergency room.[23] They had rotating twelve hour shifts and were integrally involved in the administration of the ER. For the doctors, the ER was a business enterprise and they

were concerned that it be successful; they have a stake in the development of its good reputation. They were concerned with being good "emergency physicians," and that they know "their stuff." The specialty of practicing emergency room medicine was important in itself, not as a passing "experience" which was important for interns or residents who might temporarily staff the ER. The notion that this was a special kind of practice, or a special kind of care was communicated to all of the staff, and, in fact, might be cited as part of the reason for the nurses' own concern with themselves as a special group doing "emergency nursing."

In Community there are three shifts which must be staffed: days (7am to 3pm), afternoons (3pm to 11pm), and nights (11pm to 7am). Each shift has its own nursing staff; in other words there is a minimum exchange of nurses between shifts. This is not true for orderlies, who often switch shifts among themselves. Clerks also have regular shifts, but frequently move in and out of different time slots. Among doctors there is much changing of work times, so that the same doctor never works on any one shift for any length of time. As a result, nursing and clerical staff all work with all of the doctors at some time during a given month. Although there is some fluidity of people over shifts, each shift maintains a loose definition of itself as a unit. Parties are sometimes thrown by the "day shift" staff on their time off; and once a nurse on the "night shift" mentioned that she had been at a party which had been held by the

"night crew."

The people who staff the various shifts in the ER differ in terms of their age and lifestyle depending upon whether they work days or nights. Nurses who work on the day shift are considered by those who work on the afternoon and night shift to be "homebodies" and are usually older, married and have children in school. One RN who works on afternoons referred to the "day people" as those who really aren't interested in working or nursing as a "career," but instead they're interested in getting away from their kids. The "day people" however view the younger nurses who work on the afternoon and evening shifts as ambitious, if not a bit over-enthusiastic. The afternoon and evening shift both consist of nurses who are predominantly single, young, and recently out of nursing school. They usually talk less about "home"-type issues, (husband and children), and instead often talk about nursing, other nurses, or activities they engage in during off-hours (skiing, camping, sewing, crafts, or sailing).[24]

In Community there is rarely ever any exchange of staff between this part of the hospital (ER) and the floors, although the emergency room does use the technical services of the hospital, such as the laboratory and X-ray. At any time in the emergency room one could expect to see any of the emergency room staff, as well as various technical, custodial, or administrative people moving in and out, performing their various tasks. There are less of these people at night, although the lab technician, the cardio technician,[25]

and the X-ray technician who work at night usually stop by for coffee and conversation; in fact these people develop close ties with the night crew in ER, at least more so than those technicians who work during the day.[26] Although there is movement between the ER and the rest of the hospital, there is never an exchange of working staff members among the various departments and the emergency room. That is, nurses or orderlies and clerks who work "on the floor" never work in the emergency room, nor do emergency staff work on the floors, even if either department needs extra help. In part this is a result of the autonomous administrative nature of the emergency room; however, this organization in turn effects the relationships which develop between nurses in different departments. There is little opportunity for nurses to get to know one another; usually if an ER nurse happens to know another nurse on the floor, it is because they attended school together, or there is a personal relationship (a friend of my brother's friend...) between them. Nurses in the emergency room usually eat lunch with other ER staff (including doctors and clerks). This differs from the usual pattern in this hospital -- nurses eating with nurses, doctors with doctors, clerks with clerks.

The actual physical setting of the emergency room (Appendix A) is an important consideration since the positioning of the various personnel seems to shape the possibilities for interaction among them. For example, the

doctors' room, which was set away from the nurses' station, provided a place in which the physician on duty could rest while there were no patients to be treated. Thus the doctor could retreat into a private space during slow times while nurses, clerks, and orderlies had to share a physically small area and were faced with the possibility of relating to each other during such times. As a result, slow periods were times when staff would talk among themselves about any number of topics, and doctors would rarely be included as participants, although occasionally they would be subjects of the conversation. The admitting clerk was also physically separated from the nurses' station by a glass partition which prevented her from hearing or seeing clearly what went on on the other side. This situation, along with the fact that the clerk was administratively autonomous from the other staff members in the emergency room, made her less a part of what went on among the nurses, orderlies, and ward clerks.

The observations upon which this thesis is based were obtained over an eight month period during which I worked as an admitting clerk on the weekend night shift in the emergency room. For several weeks, I worked extra time during the regular day shift, so I was able to get a sense of how the weekend night shift differed from the other shifts. However this analysis is based primarily on observations and conversations which occured during the night shift, and will be qualified with data from the other shifts

when necessary.

Because I was a working employee in the emergency room, observations had to be recorded at times when I was not working. Often I was able to jot down notes while working if the ER was slow, but usually I wrote notes after leaving the hospital. I tried to observe everything going on in the emergency room -- conversations between staff and patients, exchanges between doctors and nurses, conversations which I myself had with various patients and staff members, and the kinds of verbal and non-verbal interaction which took place between ambulance drivers and police, staff and patients. I also tried to become aware of my own socialization as an emergency room employee, and the changes which I experienced working in a place where crisis and tragedy were a matter of routine.

After working awhile in the ER, I realized that all that went on there just couldn't be recorded; thus my focus narrowed, and I started concentrating on the nurses who worked there and how they made sense of the emergency room. Because of the constraints of my own job as admitting clerk, however, I was not always able to be part of what occured inside of the treatment rooms, or the nurses' station. In addition, my role as part-time worker, and weekend employee at that, limited the extent to which I could become an insider, and understand the dynamics of the relationships of workers inside the ER (Appendix B).

The negotiations between myself and the staff which took place in order to establish "who I was," are documented completely in the second appendix to this report. It is hard to say to what extent my identity altered or distorted what transpired between myself and the staff. It seems important however to state that I probably was not considered a member of the group, as several of the admitting clerks were; rather, because of my status as a student, part-time worker, and medically naive, trusting person,[27] I was considered to be an outsider. Having taken the job as admitting clerk, access was not immediately problematic. However, the suspicion which existed immediately about myself, made it impossible to disclose the fact that I was a researcher; guilt, in addition to the contingencies which existed to make "data-gathering" problematic, combined to make it difficult for me to gather as much information as I would have considered desirable.

With these qualifying factors in mind then, I will go on in the next section, to describe one group of factors which seemed to contribute to the appeal of professionalism among nurses in the emergency room. The organization of work, the contingencies of boredom and crises will set the stage for an understanding of the setting in which nurses account for themselves as "professionals."

Crisis and the Routine, Excitement and Boredom in the Emergency Room

Most people imagine emergency rooms to be exciting, efficient, or tragic places where life and death decisions are made by white-clad men and women while ambulances scream in the background, and beams from their rotating lights bounce off walls in narrow hallways. The imagery suggests a place of continual crises lived out by individuals who worry in waiting rooms and later in rooms divided by gauze curtains.

This is the picture of the emergency room I had while I was considering taking a job as emergency room admitting clerk in Community Hospital, a medium size private hospital; I wondered how I could face these crises, knowing that I became weak at the thought of a simple injury. I remember feeling panic during the first few nights of work, whenever the doors to the ER would swing open; I also remember sitting at my desk, facing these doors, and preparing myself for the worst possible shock. It was interesting to watch not only my own initial reactions to the ER, but also to listen to and observe the responses of other new staff members, particularly new nurses who were hired after I had been working for some time. Although some of these people had experience in nursing, they seemed very apprehensive about working in this particular area of the hospital. Allyson,[28] a newly hired RN, paced back and forth in the nurses' station, and ner-

vously peered out through the waiting room toward the doors whenever they opened to admit a patient. Although Allyson had worked in a hospital before, she initially expressed concern that emergencies "made (her) nervous," and that "the ambulances always made (her) remember TV programs about emergency rooms."

After working in the ER for awhile however, I (and apparently other novices as well) began to see the events of the emergency room in a different light. The image of the ER as a place where life and death decisions are constantly being negotiated does not convey the total reality of the ER for the people who have become enmeshed in its day-to-day activity. Rather, the people who work in the ER find themselves dealing not only with crisis, but also with boredom and routine; times when patients complain of illnesses hich are less than dramatic, and times when there are only a few patients in the emergency room. Thus to describe the reality of the emergency room from the point of view of the people who work there, would require an examination of how the dimensions of work combine to create a milieu in which elements of boredom and tension, crisis and routine exist side-by-side.

The Unpredictable Nature of Work in the Emergency Room

Work in the emergency room, especially when one contrasts it, for example, with work done in chronic care wards, is highly unpredictable.[29] Staff members have difficulty determining how busy they might be at the beginning of a particular shift; they cannot predict what

types of patients will come into the emergency room for treatment, and what kind of work they will therefore be engaged in. Before a shift begins, the nurses, orderlies and ward clerks usually gather in the hospital cafeteria for coffee and some conversation. Invariably someone will wonder out loud how the ER has been going tonight, whether it was busy or slow, and what the next eight hours might hold. During the time I worked, it struck me as quite unusual that I was never able to predict how busy an evening would be, nor was I ever able to establish a reliable pattern or formula for determining what were busy times of the day or week. Once I casually mentioned this to some of the nurses and they agreed with me, saying that "you just never know around here what's going to happen next." [30]

All of the people who work in the ER regularly evaluate their shift or work-day in terms of how busy they were. Counting the actual numbers of patients who come into the ER for treatment is one way that they gauge how much work was done on a shift. "How many patients have we seen?" is a tandard question asked several times during any shift. This will usually be asked of the admitting clerk whose task is to keep count of the number of patients who come in. The number is a measure of the work accomplished; for example, on the day shift, 40 is seen as a reasonable number of patients, whereas during the night, this decreases to 20 or 25.

Each type of worker has different standards for assessing work done. For an admitting clerk it is important to know

how many admissions were processed, for this indicates how busy one has been during a shift. To tell the admitting clerk who relieves me in the morning that I had "six emergency admissions, nd six 'directs'" that night, means that I was very busy, and she will probably respond in a way indicating that she agrees this is a lot of work. Nurses will recount how many charts were lined up along the counter at one time during the night, or how many times they were awakened to see patients, or they will refer to the number of "serious" patients they saw in a night. Orderlies count the number of patients they have had to take "upstairs," while ward clerks count the number of people sent to X-ray.

On slow nights or during slow periods of a shift when there is little work to do there is a definite urge to complain of boredom. One slow night when it was particularly dull in the ER, Leanne, an RN who worked part-time in the ER, told a story to myself and the ward clerk and orderly about how she had decided to become a nurse. Her mother had been killed in an auto accident when she was a child, and she remembered coming to an emergency room and watching nurses and doctors "trying to save (her) mothers life." She promised herself that she would become a nurse too, in order to do the same for others. Her story concluded however, with her spreading her arms and looking around in the nurses' station,

> "little did I know that this is what it would be like; just look at us, it sure isn't as exciting as it looked then!"

Along with the urge to complain of boredom, however, is a belief that one must not complain too much for fear that the emergency room would get a "rush of bad stuff." Staff members who complain that it isn't exciting here will usually be reminded that they shouldn't say anything or they'll 'be sorry.' In the face of nothing to do in the ER, there is always the apprehension that there could be too much to do. The nervousness which one initially feels about work in the ER as a result of its unpredictable nature, eventually becomes transformed into a cynicism which characterizes those who have worked in the ER for awhile. Becoming socialized into the work milieu in the ER means that one will stand off from the crises, or protect oneself from the unpredictability

The Routine Nature of Illness in the Emergency room

Work for the staff however, is not perceived purely in terms of the amount of work or the numbers of patients who are seen on any shift. Work is also evaluated in terms of the nature of the problems which one must care for. The work of the ER (TV programs notwithstanding), does not always involve decisions of life and death. Many of the cases are far less dramatic. At any time of the day or night the chairs lining the walls of the ER waiting room might be crowded with patients who have come to seek care for colds, sore backs, or headaches -- problems which might otherwise be taken care of by the family physician or at the clinic.[31] One evening Leanne cynically mentioned that

working here was like working in a doctor's office, except for the "emergencies." She added,

> "the people on days actually see a lot more than we do at night. That's when there are more 'emergencies;' at night people come in who aren't able to get hold of their regular doctors."

The people who work in the ER on the day shift probably don't experience many more "emergencies" however, than those who work at night; an excerpt from fieldnotes taken while working on a day shift illustrates this:

> "After working here today I am astounded at the number of people who are using this place as a clinic. There certainly isn't as much excitement here as there is during the night; there are only a lot of babies crying and people coming in for "rechecks" on sutures and casts; I guess that there must be a difference on different shifts or maybe it's the daylight which makes this place seem a lot more routine! (Marian, an RN, has just remarked that she was really not in the mood again to waster her time with 'this nonsense'.)

There is consensus among the staff that "routine" complaints are something of a waste of time; nurses will half-jokingly admonish me for "bringing in all this stuff," since it is I, as admissions clerk, who "sends the patients back" for treatment. Allyson, who at first greeted every patient with a smile, after awhile in the ER took on the cynicism toward the routine patients which was characteristic of the rest of the staff. She would place her hand on her hip and shake her head when a patient complained of some routine ailment:

> "why don't they leave us alone; if they go back to bed they'll probably feel better in the morning."

Jane, another Rn, often comments quite seriously that she really hates this kind of routine work.

On the nights when there are serious emergencies, and a staff member asks how many patients have been through the ER, she may be surprised to hear that the number is so low;

> "it seemed like we had a hundred patients tonight; those few bad ones really kept us busy,"

and on other nights the number seems high:

> "I'm surprised we saw that many; it was all that little stuff though; you can certainly spend a lot of time doing nothing."

Hughes, in an essay on work,[32] mentions that people who have experience with crisis tend to believe that people exaggerate their problems. After seeing a great range of illness and injury, the staff actually perceive the less serious complaints to be trivial, and the people who bring them, to be silly and intrusive.

Nurses and staff vary in the degree to which they view these routine cases as a waste of time or as "inappropriate." This has to do, in part with how narrowly they define the function of the emergency room, either as a place for "real emergencies," or as a place which will inevitably be "clinic-like." The nurses who are more involved in defining themselves as "professionals," are also more likely to see the function of the emergency room as a place for "emergencies only," whereas their less professional colleagues tend to accept the idea that the ER will be similar to a clinic or doctors office. Why patients are seen as inappropriate by some staff members and less so by others is an

important issue. How individuals evaluate their work and the people they deal with has to do with how they perceive the manner in whichtheir work fits with their life, and the meanings which they attach to their role as nurse or doctor, ward clerk or orderly.[33] By looking closely at how work is organized in the emergency room, we can begin to understand the actual contingencies of work for various workers, as well as the meanings which workers attach to their work and to their clients.

Work and Meaning in the Emergency Room

The unpredictable nature of events in the emergency room requires a highly structured organization of people who can efficiently deal with the entire range of problems or emergencies which patients bring to them. Crises must be stripped of their unique character, and must be handled as instances of a type or category of illness or injury; that is, they must be dealt with in a rational way by people who are organized to care for the unexpected.[34] For these people who work in the ER, crises as well as "routine cases," become routinized and subjected to the bureacratic organization of tasks. There is little room for heroic deeds here; rather the constraints of the task structure make it nearly impossible for people to perform work outside of that which is defined as their "job." Instead of "saving lives," staff members are actually involved in performing their narrow function as quickly and efficiently as possible; even doctors, the people who are supposedly most free with respect to the boundaries of their work, are constrained in this setting. An examination of the organization of the work which the various staff members do in the emergency room will give the reader some idea of 1) the scope of care in which any individual staff member is actually involved, and 2) how particular patients and events in the emergency room are defined by the staff who work there.

The Organization of work in the Emergency room

Each person who works in the ER has particular tasks to perform for the care of any given patient. The tasks or techniques which are performed are standardized for particular categories of illness and injury. For example, a patient who has a burned arm will require the performance of particular tasks which will alleviate the pain of the burn and which will help allay scarring; on the other hand, a patient who complains of what he believes to be a broken leg will require the staff to ascertain if the leg is in fact broken, and if it is, to prepare the leg to be set and wrapped. Each of these tasks or groups of tasks are assigned to particular people on the ER staff, i.e., clerks (admitting and ward clerks), orderlies, Licensed Practical Nurses (LPNs), Registered Nurses (RNs), and doctors. The doctor is the central person in the organization of work. It is he who performs the final diagnosis and who treats the patient; all other people in the emergency room and those whose services are called upon who do not work primarily in the ER (lab technicians, X-ray technicians, etc.) aid in gathering information to carry out the diagnostic function, and perform most of the auxilliary tasks which are required to diagnose and treat patients. The doctor has ultimate responsibility although the information which he works with has been filtered through these other people. Each patient who admits himself for treatment in the ER

starts in motion a process of information gathering and "treatment." In order to understand the organization of work in the ER then, it will help to examine the nature of the jobs for the various categories of staff people who work there.

The job of the admitting clerk is considered to be purely clerical in nature, however there are other elements of the job which can be thought of as crudely diagnostic functions or "buffer" functions which the admitting clerk engages in. As a "paperworker" hired by the Admitting Department of the hospital, rather than directly by the emergency room (as the other staff members who work in the ER), the admitting clerk generally functions to obtain information about all patients who come into the emergency room.[35] Jokes about hospitals often center around how staff people seem more concerned about getting patients' social security numbers than actually helping them to get treated. In part, the admitting clerk is trained to concentrate on numbers, paper work, insurance forms, and charts. Her job is organized around finding out information from people who often consider giving it to be unimportant, mundane, or trivial. Although formal training of the admitting clerk includes only attention to paperwork, the work also involves acquiring sensitive interactional skills which enable the clerk to carry on the function of filling out forms for people who are uncomfortable, very ill, or even dead. In addition to these skills related to dealing with patients, the admitting clerk must

also acquire the knowledge necessary to "screen" patients or to crudely diagnose a patient's condition in order to let the rest of the staff know what problems they will be dealing with. This might include allowing a patient to be treated immediately if judged to be "serious" enough, or if the patient is not considered to be ill enough to require immediate attention, he is told "to wait," while the staff deals with the more "important things." In a sense the clerk acts as the first person in a series of "buffers" between the patient and the doctor, allowing only certain patients and information to reach him.[36]

When a patient enters the emergency room the admitting clerk quickly assesses his condition. For cases which are extremely and unquestionably serious, for example heart attacks or stabbings, the admitting clerk tells the patient to go "right through the doors" (swinging doors which open into the treatment area of the emergency room). In such instances she is not able to get the information at the desk, so she has to go into the treatment room where the patient has been situated to get the information she needs. These are often very touchy situations and require skillful handling to avoid annoying the patient too much while getting the information which is needed to "process" him.

It took me awhile before I was able to feel even a little comfortable going into the treatment room where a seriously ill or injured patient had been situated. The nurses seemed to understand that getting information from

such a person is touchy, and they would at first help me find out what I needed to know about the patient. After working in the ER awhile however, I was expected to get the information myself; and only if the patient was unconscious or dead, was I able to avoid having to ask him all the questions which would be asked of someone with a headcold. The job was made considerably easier if the patient was accompanied by a relative or friend who could tell me what I needed to know. However, even with these people it was necessary to follow some rules in order to avoid looking over-eager to fill out forms, and not sorry enough about the patient.[37]

For people who came into the emergency room complaining of a toothache or a headcold, the sequence of interaction between the admitting clerk and the patient was different, and the process of obtaining information wasn't as sensitive an issue. The patients had to give the admitting clerk information about themselves at the desk; this included name, address, insurance, place of work, birthdate, marital status, and regular physician. After this information was obtained, the clerk would tell the patients to have a seat until called.

Neither of the above types of cases presented the admitting clerk with a situation in which she had to make a decision about what to tell these people when they came into the emergency room. In contrast to those obviously serious, or numdane cases there were several types of patients who were neither obviously critically ill, nor

casually seeking help for a problem which might otherwise go away in a day or so. These patients experienced quite intense pain or discomfort and felt that their problem was serious enough to warrant immediate attention (although frequently the staff believed that they probably could have waited before being seen). Stalling techniques were required in such instances, since the staff didn't want to be bothered with these people for one reason or another, and the clerk had to keep these patients from intruding too much on the staff's time or energy. This was often a very difficult feat to perform if the patient was particularly insistent upon being seen, or if the staff was particularly insistent upon not seeing the patient immediately.[38]

Although the admissions job requires some diagnostic and interactional skills, for the most part there exists the ever present reality of the paper work which has to be done for all patients seen in the emergency room, and extra work for all patients admitted into the hospital. There are constraints on the admitting clerk from going beyond these particular functions outlined above however, and often as the admitting clerk I found myself feeling a bit frustrated about the scope of work to which I was relegated.

One night when the emergency room was especially busy and the nursing staff was short, I remember feeling helpless sitting at my desk knowing there was nothing I could do to help either patients or staff. I knew that many of the jobs which they were doing weren't completely medical in

nature, yet I had not learned, nor had I an opportunity to learn of what those jobs consisted. For example, valuables of patients admitted to the hospital had to be placed in envelopes and recorded on special forms for this purpose; this is a job which requires a considerable amount of time, yet it is one which only nurses are "permitted" to do; even had I known how to do this job, I wouldn't have been allowed to do it. Rather I had been trained to do a particular sort of paper work, the type related to admitting and "processing" patients. In training for the job I asked nurses or orderlies several times about how they performed a particular task, such as taking a patient upstairs to the floor, or taking a pulse; they would usually give me an answer, but would often add that I needn't worry about that, "(I) would never have to do that anyway."

Constraints on what tasks we did existed for all of the clerical help. However, there was one ward clerk, Karen, who was clearly an exception to this rule. When the ER got overloaded she would take blood pressures or temperatures and often asked the nurses if they needed any help. They would occasionally suggest that she do this or that, and after awhile she took it upon herself to help in such situations. Karen was a middle aged woman, very intelligent and curious about medicine and also very sure of herself. The manner in which she "took over" tasks which were outside of her own job boundaries gave her an air of heroism; if only

because she stepped out of what was necessary for her to do. It amazed me that she was able to do this and remain in the good graces of the staff. After she worked there for awhile the staff, doctors and nurses, would admiringly speak about Karen's dedication, remarking that she really "helped out in a pinch." Thus, although constraints existed for the clerical help (that all of the clerical help with the exception of Karen stuck to the "rules of the Game" did seem to indicate that there were constraints operating), it was possible for a persistent and curious person to go beyond the boundaries established for her.

The work of orderlies, a group which consists wholy of young men, was also well defined, but seemed to be somewhat less rigid than that of clerks. The orderlies cleaned treatment rooms, situated patients in these rooms, performed various errands ordered by the nurses and sometimes by the doctor, and did "heavy work" (although it seemed that there were very few times when I actually saw them doing work which was unusually heavy, this rationale was used by staff in the ER when I once asked why they didn't hire women as orderlies). Orderlies were also responsible for writing descriptions of ailments on the patiaents' charts and for taking blood pressure, pulse rate, and temperature of all patients who were to be treated. They cleaned patients also, that is, they cleaned wounds or lacerations to enable the doctor to observe the injury more clearly.

Most orderlies were college students who worked part time in the ER; and many of them were considering going to medical school or were pre-med students who were using this work experience to "get their feet wet." A few of the pre-med students occasionally complained that they were unable to perform some of the tasks which nurses or even doctors did; however it was not unusual for these young men to initiate conversations with the doctor on duty about how he dealt with this or that kind of illness, or sometimes they would converse about medical school admissions or classes. This kind of conversation rarely, if ever, went on between nurses and doctors, at least on such a casual level.[39]

Although the nursing staff consisted of RNs and LPNs, there seemd to be little observable difference in the actual tasks which they performed.[40] Both prepared procedures and techniques which were ordered by the doctor and both assisted him in treating the patient. Nurses sometimes questioned patients about their problem in more detail than either the admitting clerk or orderly, and usually they reported the patient's case to the doctor. Nurses also accompanied the doctor into the treatment room when he examined patients, and they assisted the patient in getting prepared or undressed for the examination.

The scope of responsibility and the ability to give orders to other nurses does differentiate the RNs somewhat from the LPNs. The only male RN who works in the

ER once remarked that,

> "the RN on the shift should know 'what' is in every room at all times and should know what is happening with that patient no matter what it is."

This seems to imply that there is some supervisory work involved in being an RN. This was further illustrated in a doctor's remark about RNs who work at night:

> "The RN on this shift has really got to be on the ball; she's got to run the whole show down here at night; it's a big job."

When there is an LPN working on this shift with an RN, she can help the RN perform some of the jobs; however there are tasks which only registered nurses can do, such as signing charts, dispensing medications and doing all of the nursing paperwork.

Often RNs must do the more delicate or touchy jobs in the ER. One of these jobs has to do with calling relatives or friends of a person who has been brought to the ER in critical condition. The RN usually will tell them that their relative has been brought in for some reason and that it would be good for them to come in. She usually states that they are "very ill," or were "injured pretty bad" in some accident, if they are very bad; or if they aren't critical, she will say that they are "shaken up a little bit," or they had a "little problem" with some ailment. She won't give details if pressed but will continue to insist that they "come down to the emergency room" and find out the patient's condition here. This is not a comfortable job and often nurses hesitate before making

the call, or remark that they dislike the job or feel sorry for the person being called. In this sense they are aware of being "bearers of bad news."

Once the family or friends of the patient arrives, it is the doctor who is responsible for giving details about the patients condition, although the RNs usually tell the doctor that the family has arrived. Upon arriving in the emergency room, the family of the critically ill person announces who they are (relative or friend of "so and so" who was brought here with "some ailment"), and the admitting clerk announces to the RN that "Mr or Ms 'so and so's relative is here." This is a signal for the nurse to tell the doctor that the family is here, and she will then direct the family immediately back to wherever the doctor is. This involves bearing "bad news" to the doctor, since it is a situation in which he has to perform a particularly touch kind of job.

Another job which is delegated to the RN on the shift is calling the doctor to see a patient if he is in "his room." During slow times on a shift the doctor on duty will usually sleep or read in a room reserved for the staff doctors; when a patient comes in, especially one who is complaining of a relatively minor problem, the staff will all conspire to drag out the time it takes to get the initial information from the patient and then they will often laugh about the RN on duty having to call the doctor. Often she tries to pawn off the job onto someone else, knowing full well that this is ultimately

her responsibility. In part this has something to do with the fact that particular patients are seen in a bad light by the nurses. If they arrive in a slow period after the physician has gone off to sleep, the nurses see them as indirectly responsible for "making them call the doctor." Since nurses rarely initiate encounters of any sort between themselves and the doctor, and this is one of the few times when they have to, nurses consider this job to be an uncomfortable one.

I think that the point can be made that the initiation of encounters relates to the hierarchical structure or organization of staff members in the emergency room.[41] Not only the nurses, but also the clerks rarely initiated conversation with the doctors. I always felt uncomfortable speaking to any of the doctors or having to ask them any questions; instead if I had to know information about a patient, for example whether he would be admitted to a medical or a surgical floor, or if he needed isolation or not, I would ask anyone -- nurses, ward clerk, or orderly -- before I would bring myself to ask the doctor on duty. My feelings were reinforced by other staff members, for if I asked a nurse whether my question should be asked of the doctor, she would respond that I should tell him later, or she would try to find out what I wanted to know in some other way. It was often obvious that the nurses felt no more comfortable than I did with the doctors. On the other hand, whenever I had to ask questions

about a patient or if there was room in the back, or if I should "send someone back," I also felt ill at ease about asking a nurse. As an admitting clerk I felt more comfortable asking other clerks or the orderly the same question.

The role of the doctors in the emergency room consists of seeing the patient, treating him, and ordering other staff members to perform tasks which would aid him in treating or diagnosing the patient and his problem. After everyone has prepared the patient for the examination by the doctor, and have obtained all relevant information, the doctor checks the patient, announces what tests are appropriate, or what should be done for the patient. All of the doctors who work there phrase these orders very concisely and upon announcing the orders leave immediately to carry on with their work, i.e., signing charts, seeing other patients, or returning to their room. There is a distance maintained, and the doctor seldom does anything outside of his narrowly defined role to aid any of the other staff in accomplishing their tasks. It seems in fact that the doctors are the most constrained in terms of where they place the limits of their work; either they are unwilling or unable to step outside of the jobs they are supposed to perform.

This particular way of organizing work is often referred to even by doctors, as a "team effort." However for the patient, the process of being taken care of here is much more like an assembly line. Patients often complain

about all of the various staff people asking them different questions; and also complain that any one staff member rarely knew about anything that the others were doing. Rather than a team, the roles of the various types of workers were rigidly ordered in a hierarchy where orders were given from the top down. It is true that in an emergency situation the roles intertwined and enmeshed in such a way that the workings of all staff members appeared to resemble a "team effort," but the word "team" implies an equalitarian organization of work; which even in an emergency was not present.

Thus the scope of care which any staff member can participate in is narrowly defined by what tasks are appropriate for that type of worker. The kind of contact with the patient is limited, and rarely, unless the patient is a "regular," do staff people ever discover the results of their efforts. The goal is "to get patients in and out" as quickly as possible, and all staff are evaluated in terms of how well they carry out this goal.

Language and Meaning in the Emergency Room

If the new nurse finds she is only invovled in a very narrow scope of patient care, she will also learn that patients who come into the emergency room are no longer the "people who need her help," but rather if they are patients with routine problems, they are interruptions of her work, and if they are "emergencies," they might turn out to be "especially interesting cases." Crises come within the realm of the expected and the routine, and the people who come here for help become "patients" who are defined in terms of their medical problem and are labelled as "OBs," or "kidney stones;" or in terms of the kind of work which they require the staff to perform, such as "X-rays," or "admissions." The patient's own understanding of his problem is interpreted and categorized by the staff; lay understanding is transformed into the categories of insiders in the emergency room. The process is not peculiar to ER medicine, however, nor to the medical profession in general; rather in every occupation there is a special language or taxonomic system which enables its members to deal with day-to-day events and clients. Cab drivers, janitors, shoe salesmen, lawyers, social workers all have clients whom they denigrate or praise for one reason or another, and usually these reasons have to do with the work which the clients require them to do.[42]

To work in the emergency room does rquire one to learn a new language. It is important to place people into categories of health and illness which can be used by the staff to order their activity; on the other hand, the categories of the "patient" tend to act back upon them to define patients as "problems," rather than as people who have problems. For example on one occasion during a telephone conversation with a nurse on one of the floors it became apparent how prevalent the "people as problem" orientation was:

> "hello, this is admitting. I have a person down here who has a kidney stone. He is 25 and prefers to have a double room; what have you got up there?"
>
> "Just a minute, this is the aide; I'll get the RN on the phone for you."
>
> (in the background I hear: "ER's got a kidney stone; got any doubles?")
>
> "Hello, this is the RN; you got a kidney stone, ha? Well, put him in 32, one; ther's a surgery in there too."

Not only is it important to know the language, but it is important to know how the nature of work transforms the lay categories of illness into medical categories; and how the application of the categories is influenced by social evaluations of the patient.

Whenever a person presents himself for care in the emergency room, he is screened by the staff on the basis of a number of criteria. Although the medical nature of the problem he presents is the primary element in the staff's evaluation, there are other elements which weight heavily. For example the patient's age, income, race or

lifestyle all feed into a total picture of the patient and affect the way in which his problem is considered by the staff. The successive interpretations of the patient's problem, which transforms a vague symptom into a specific diagnosis, forms a process beginning with the admitting clerk and ending with the doctors' interpretation of lab tests or X-rays. A specific example of a patient who has a vague symptom will illustrate how the patient's understanding of his problem is re-interpreted by the staff:

> One evening while waiting for the admitting clerk from the afternoon shift to finish working, I heard and observed her speaking with a patient who was black, young, and dressed rather poorly. He was claiming that he had a pain "down here." The admitting clerk asked him,
>
> "Where, 'down there?'"
>
> and the patient,
>
> "Down here, in my privates."
>
> Because this statement wouldn't be easily understood by the staff as it was stated, the admitting clerk started to probe for some condition which she might write on the chart. The statement should fit into a category which would be "reasonable to understand by the staff." For Joda, the admitting clerk, this statement was taken to mean that this patient who was black, male, and on welfare, probably had VD.
>
> "Do you think you have VD?"
>
> "No, I just can't go to the bathroom, ya know what I mean?"
>
> "Oh, then you're having trouble urinating? Okay, can you get a urine sample?"
>
> "I told you I can't go. How am I supposed to do that?"
>
> "Well, why don't you have a seat then, and the doctor will have a look at you in a minute."
>
> On the chart Joda wrote, "difficulty urinating; possible VD."
>
> When the nurse came to pick up the chart, she read the chart and asked Joda if she had gotten a urine sample from "this one." Joda responded that he wasn't sure, but that she though that 'this one' has VD, and didn't want to get a sample.
>
> "Yeah, he's the one over there (and she coyly pointed to the man who was now sitting on a chair in the waiting room.)

> He said he had a "pain down 'you know where.'"
> The nurse looked "over there" and muttered:
> "Oh, God, he probably does have it. I guess
> we'll have a look at him,"
> and screwed her face into a disgusted look.(Fieldnotes)

As one can see from this exchange, although the admitting clerk is responsible for getting from the patient a statement of his problem which can be written on the chart, if this appropriate definition is not forthcoming, she can take it upon herself to construct a problem which matches her own expectations and evaluations of such a patient. An interesting ending to this story was that the man had a urinary tract infection, not VD; that other men, usually white, with this problem are not suspected of having VD indicates that diagnoses, at least on this level, are affected by contingencies other than ones which are purely medical.[43]

The categories of patient problems which are formed by the admitting clerk are used to indicate to the staff what kind of work is coming in, so that they can judge how quickly to work, and know what sort of work and patients they will have to deal with. For example, if a woman comes into the emergency room and has an obvious bulge, and seems uncomfortable or if she is with someone who is carrying a suitcase, I ask whether she is in labor; if she replies that she is (which is usually the case given these clues), I announce to any staff in the nurses station behind me that there is an "OB" here (obstetric patient, or a woman who is about to have a

baby.) This announcement carries with it a number of prescriptions or rules about what certain members of the staff should do. The orderly has to stop whatever he is doing, and bring this woman to the labor and delivery ward of the hospital. The admitting clerk has to obtain information about her husband or family, and fill out special forms for obstetric patients. The nurses in this case have nothing to do since the woman will be going directly up to labor and delivery; and they usually breathe a sigh of relief that the patient turned out to be someone with whom they didn't have to deal.

If an old man comes into the ER holding his chest however, and announces that he has "bad pains in (his) chest," the nurses as well as everyone else mobilizes quickly to get the man back into a room and "hooked" up to a heart machine. The announcement of chest pain accompanied by the presence of an old man, carries with it rules for the nurses to get room #4 ready (the room for critically ill or injured patients), and to call the doctor out of his room if he isn't already present, and to set up procedures to facilitate the man's breathing and to reduce the pain. The ward clerk will call "cardio" on the phone, and the orderly will make sure that everything in four is clean and organized, and he will move out any other patient who is well enough to be placed in another room. To the staff this announcement carries warnings of a "real emergency," and if there have been a lot of

other emergencies on the shift, or even if there have been many patients who have come in, this man means that the staff will have to keep working and keeping up the pace for another stretch of time. If the staff has been doing little up until this time, they will usually have to break up a conversation or forego the cup of coffee they were about to have in order to care for this patient.

On the other hand if a young woman walks into the ER announcing that she has "chest pains," she isn't considered to be a possible heart attack victim, but rather she will be considered to be a "routine case." She is told to have a seat, and is called to be treated when the orderly gets around to it or when the staff finishes the last gulp of coffee. The nurses say that this is another person who "should go back to bed" (who probably has a minor ailment), and take their time helping the woman get ready for the doctors examination.

Thus in order to understand how patients are treated, or to get an idea of how interpretations of illness are made, it is important to examine how work is organized; the expectations which develop from treating patients with similar problems repeatedly gives rise to particular interpretations which serve as guides to the staff to help them determine the pace at which they work, and the jobs which they perform. To look only at individual staff members and how they relate to patients ignores the contingencies at work in the emergency room which defines for staff a particular kind of reality.

Responses of the Nursing Staff Towards Work

I have up until this point described the emergency room as a place characterized by unpredictability, by extremes of emergency and routine, overload and boredom. The work which people do here tends to be narrowly defined and job-specific; and as a result, the care of the patient tends to be segmented. Patients are labelled in terms of medical and social characteristics and in terms of the jobs which staff must perform for them. The crises which on one side of the counter might mean the reality and tragedy of life-or-death, on this side of the counter are part of a routine which workers perform daily. If this is an adequate pictur of the emergency room, it seems logical to examine how the members of this organization, and in particular how the nurses, respond to the organization of work, and how they define themselves with respect to other staff members, and with respect to the patients with whom they must deal everyday. Later I will show how the nurses who are involved in creating a professional chapter of emergency room nurses differ in their responses.

In the previous section of this paper which deals with the nature of "emergencies," I mentioned that one evening Leanne, one of the RNs, was complaining about how dull the emergency room had seemed to her that night. After this comment I began to wonder what expectations she

had brought to this job, how other nurses felt about the actual conditions of work, and how this "fit" with their prior expectations of an emergency room nursing job. When I asked any one of the nurses about what they expected this place to be like, they seemed to have a difficult time answering; however, they were easily able to state that the reality of the day-to-day work was not "what they expected it would be." At the same time these people were convinced that this was a better job than working "on the floor," and that it could even be better "if it wasn't for all the 'crap' that comes in (i.e., routine cases.) In general, nurses characterized the emergency room as a desirable place to work, although in the day-to-day milieu of the ER, there predominated a cynical attitude and frequent complaints about the patients and the work which they brought in.

One day when speaking to Mrs. Lange, the ER nursing supervisor who worked on the day shift (7am-3pm), I asked about nursing in the emergency room, particularly if the nurses who worked here had special training and whether this was considered a good place to work. She responded that the nurses acquired much of their training on the job:

> "it really goes fast down here sometimes, and you couldn't really learn ER nursing unless you get your feet wet right here."

She continued to tell me that the nurses "from the floors" were "dying to work here; it's exciting here and things move fast."

Ron, one of the RNs on the afternoon shift (3pm-11pm), remarked:

> "we see an awful lot down here; it's better experience and you don't have to deal with people who lay around for months like they do upstairs."

Jean, another RN who works days added that nursing here was a lot better than working upstairs:

> "this place is a lot better than working on the floor; down here we don't have to change beds or take care of patients who hang around for months. Patients who come here come in and leave fast."

I discovered then that at least to the ER staff, nursing in the ER was preferred to nursing on the floor, particularly because a nurse wouldn't have to be involved in long-term patient care. Rather patients are "processed' quickly and leave; and nursing is restricted to performing specific tasks and procedures which vary by the medical category of patients, and the seriousness of their condition. Contact with the patient is restricted to a quick visit into the room where the nurse perfroms the task she has been ordered to do before she hurries on to the next room to carry out more orders. Because the goal of the emergency room is to get patients "in and out fast," speed and efficiency is highly valued in an emergency room nurse. How well they set up procedures and dispense medications or just get people out, is a source of competition among some nurses; and since the scope of care revolves around such tasks, evaluations of competence are centered around how well they are performed.

Although most ER nurses concur that emergency room nursing is superior to "floor" nursing, there is another thread of concern which runs through their comments: they would like more contact with patients. I have heard RNs several times speak nostalgically about student days and their involvement with the people who served as their "case studies." Jane, a particularly good nurse judged by the standards which existed in the ER, once had a conversation with a nursing student who worked part time as a ward clerk in the ER. Jane started talking about how she enjoyed getting to know the woman who was the subject for her case study.

> "she was such a nice lady; I went to see her everyday; we had to see them all the time to keep observations on their progress, and I really got to know her, and she got to like me, too. Not long ago I found out that she died; and I was really sad. That was a really good experience though.

Ron, the male RN, would also occasionally speak of how he like to spend time talking to the kids who came into the ER; he was excited one day when I told him that a little girl had asked for him the previous day when he wasn't working. He responded that he really enjoyed "little kids," and

> "it's a really good feeling to let them know you're on their side when they come here feeling sick, and know they are going to get a shot."

The consequence of "emergency care" includes the fact that not only does one try to hurry patients along through the process, but also that one rarely sees them again to find out how they are doing or if they are recuperating.

Instead, patients are referred to private physicians for follow-up. Thus nurses seldom find out if their care helped a patient, nor do they ever get the satisfaction of seeing a patient who has been helped in the ER. Although the nurses never spoke specifically about this, it was instructive to hear them inquiring about patients who had been admitted to the hospital after being treated in the ER. Often they would call upstairs to find out how a particular patient was progressing; and news of different patients who came through the emergency room was always welcomed. Thus, nursing was considered to be a better job down in the ER because there were no long term patients, however it seemed that nurses were not totally satisfied with the brief, assembly-line style of caring for patients.

Nurses believe that the emergency room should exist to treat emergency cases only, but this definition of emergency nursing is at odds with the reality of work which involves many routine cases. Routine cases are disliked, and the work which they create is seen as "inappropriate," or undesireable. When a patient comes into the emergency room with a routine complaint, nurses often make caustic remarks about them. One night when Jane was working, I heard her comment how she couldn't believe "the guts that people had for coming here with a backache that they had for three months!" On another occasion when the ER had been particularly slow, a man came in complaining of a stomach ache; Jane remarked,

> "God, I just can't stand this kind of stuff; what do they think we're here for anyway? Babysitting?!"

Unless a patient enters the emergency room in a dramatic way, by ambulance, screeching car, carried by friends or family, or holding a bleeding wound, he will be considered "not too serious." In fact most patients need to be "proven ill" for staff members to think of them as using the ER appropriately. One evening a man came in with his brother and complained of trouble urinating. The waiting room was filled with people and the treatment rooms were all taken. The man was in much pain and his brother was persistent about wanting him to be seen immediately. When I related the problem to the nurse, she told me to tell him that everyone there had some problem and to just wait until there's room:

> "These people think that they're so sick for the littlest thing..."

As it turned out, the man did have a problem which was severe enough to warrant his admission to the hospital. When the doctor was writing out the admission order, the same nurse looked over his shoulder and said:

> "This one's really getting admitted? I'm surprised that he was that sick!"

On another morning an old woman entered the emergency room and whispered to me that she felt a little dizzy. I wrote down "dizzy" on the chart and gave it to one of the nurses. She read it and said,

> "Oh come on; why does this stuff come just when we're ready to go home?"

When the orderly returned from taking the woman's pulse he exclaimed that her pulse rate was 180/160, a very high rate, and reported that she had been nauseated all morning (a symptom of a heart failure.) After the doctor looked at her he decided that she had had a heart attack and she was admitted immediately, to the surprise of everyone. Although the staff are suspicious of many of the people who come in with serious complaints, it is true that a large number of people do seek help in the ER for minor, routine complaints; in a sense the cynicism is a protection from the numbers of patients the staff must see without being able to screen them or turn them away.[44]

Often nurses complained about doing certain kinds of work; for the most part this disfavored work was associated not only with routine cases, which some felt wasted the time of "professional staff," but also with categories of patients with particular social characteristics. Old people, black people, people on welfare, dirty people, drunks, overdoses, psychiatric patients, attemted suicides or patients with gynecological problems, or public diseases such as VD, or people who arrived in ambulances but were not especially "critical," were disfavored and disliked by the staff. In an article on emergency services (Roth, 1972) Roth states that when service groups don't have control over their clientele they will demand compliance of groups which are particularly disfavored, rather than trying to socialize them to "behave" in the way they see fit. It was frequently the people in these categories who were

shoved around, made to wait longer than other patients, and were spoken of rudely by staff members.

Some of the nurses who worked in the emergency room were intent on doing work which was "clean." Patients often require nurses to perform the "dirty work" which they were happy to leave on the floors. Drunks require them to induce vomiting, as do overdoses; old people often need to be cleaned up or need bed pans; dirty people often need to be undressed, thus nurses have to smell them; and uncritical ambulance patients require nurses to run out to meet them, for no "real" reason. None of the emergency room staff liked doing any of these things, although some of the nursing staff saw this work as a "drain" on their "professional time." These nurses would be particularly "put out" by such patient demands on their time and person. Who these nurses are and why they are particularly concerned about their professional status will be dealt with in the following pages.

Professionalism and Emergency Room Nurses

The responses of nurses toward their work in the emergency room is shaped to a large extent by the organization of work they do, and by the contingencies of crisis and boredom which exist side by side in this setting. However to avoid presenting an image of the nurses as an undifferentiated group, all responding similarly to the events in the emergency room, it is important for us to investigate how various nurses relate to the issue of professionalization, and how this fits with their experience of work in the emergency room. If we are to examine how rank and file nurses respond to the drive for professionalization, then it is important to see who is talking about it, in what way, and how their concern with professionalization differentiates their behavior on the job from other nurses who aren't as concerned about the issue. Later there will be a discussion of the factors existing within the emergency room which makes the issue of professionalization so appealing to this particular group of nurses.

One group of nurses who work in the emergency room of Community hospital are involved in setting up a county-wide chapter of emergency room nurses.[45] These nurses have familiarized themselves with the charter of the national group of emergency nurses, and are interested in stimulating some concern for this among nurses in the area. They have participated in setting up meetings with nurses from other

hospitals, and they have attended the national convention of emergency room nurses. Ron, one of these nurses, has been particularly concerned that nurses take an interest in learning more about emergency room care, and also that they begin to consider themselves as "professionals," and as people who consider nursing as not just a job, but rather as a career. Ron and other nurses have also thought that the emergency room nurses should gain more autonomy from physicians, and from the emergency room supervisor, Mrs. Lange. One plan which they see as feasible for the future is to form an independent corporation of nurses, which would certify its own members. Doctors who run the emergency rooms (in a similar way to the anner it is run at Community) would hire nurses from this group on a contract at a certain set salary. The nurses who were hired would be placed on a ninety-day trial period; those who were not "up to the standards of efficiency set by the board," would not be approved, instead only nurses who meet the standards would be allowed to stay. This board would consist of certified nurses from the emergency room, and also the doctors there;[46] all would have equal say about whether the "trainee" would be certified. Both RNs and LPNs would be approved in this way, although LPNs would be judged on different criteria. In this way nurses (RNs) who work in the emergency room would have power to certify, hire and fire, other nurses who work in the ER; in addition, the role of supervisor would be changed so that a board of nurses would have power to make decisions along with the physicians. Although their

plans are by no means complete, it is important that their vision of the future includes more autonomy and power for themselves. In this way, being "professional" for these rank and file nurses parallels the concern with autonomy which characterizes the leaders of the field.

The conflicts which frequently arise between Mrs. Lange, the ER supervisor, and this particular group of nurses is an indicator of their dissatisfaction with the degree of autonomy which they now hold. They complain that the supervisor should have more involvement with direct patient care, and less involvement with paperwork; they are also dissatisfied with the amount of authority she has in granting hours, allowing time for professional meetings, and in general her authority over the distribution of work among the nurses. Although Mrs. Lange claims interest in an emergency room nurses association, it seems that the establishment of such an association would threaten her position.

The nurses who are involved in creating these plans are primarily RNs, trained both as technical RNs and "professional" baccaulareate RNs.[47] They are young, under 35; and are for the most part single, and without families. Most of this group has worked for only a few years, although two of these nurses have been working longer.[48] These people do work full time, and seem to be concerned with nursing as a full time career. On the job, these nurses seem to be particularly competitive, and udge one another according to criteria of efficient work. Ron once mentioned that he really liked working on the afternoon shift (which was disproportionately staffed by these young, single nurses), "when even LPNs

fight each other to set up IVs." He added that this was not what it was like on the day shift, which was staffed by older married women.

> "nurses sit around drinking coffee all day and talk about their kids and their home furnishings."

The younger, career-oriented nurses, would criticize these nurses for not living up to standards of efficiency and speed. Allyson, a nurse who had been away from work for a few years to stay home with her children, was criticized behind her back for having a difficult time "getting things going and getting medications out." If a nurse doesn't fulfill the norm, "they don't belong here," according to several of these nurses.

Not only are these nurses competitive and eager to learn and perform new procedures, but they also tend to be defensive about the use of their "professional time." They are more likely to complain about their time being wasted by "inappropriate patients," and they are less likely to take over the work of staff members below them in the emergency room hierarchy. One of these nurses would complain repetitively about having to make calls for patients if the ward clerk wasn't working and able to make the calls herself. Although responses to patients are affected by how a particular nurse views the use of her time, in general the organization of work and the contingencies shaping the work in the emergency room have a great deal to do with how she will view patients. For all of the nurses there are appropriate and inappropriate patients, depending on their use of the emergency room; the

difference lies in the fact that some nurses care more about this than others. This is especially true for RNs who have been trained to expect that their time will be used meaningfully; this contrasts with the training which LPNs have which prepares them for the "dirty work" which needs to be done.

Those nurses who are less concerned with nursing as a career, or professionalization of the emergency room nurses, are either LPNs who work full or part time, or they are older women who have been away from nursing for awhile, or who work only part time in the emergency room. On the job these women spend a lot of time talking about children or the home, while the nurses who are more concerned with their professional role often talk about techniques, or medical issues, or the like. The "non-professional" will often comment that they are working for extras, and in order to help out their husbands. One older nurse remarked once that she couldn't wait until her husband retired so that she could quit working also. These nurses rarely speak of the emergency room as a particularly different place; rather many of them consider it simply a place to work. The importance of the home and family to many of these women helps explain their attitude toward work in the emergency room; rarely do these nurses express a desire to work more, or to attend conferences or meetings. Free time is spent at home, and frequently these nurses will bargain with Mrs. Lange to decrease their hours.

Thus the group of nurses who were younger and most recently graduated from nursing school, seemed to account for themselves as professionals more often and more straightforwardly than nurses who had been out longer or who were older. Not only did this group support the idea of a professional association, but they also displayed a very particular way of behaving toward patients and their work which was not present in the other nurses. Although all of the staff had ideas about what kind of work was appropriate or inappropriate, nurses who considered themselves to be professionals were particularly aware of how their time was spent, and would seem to be more disturbed by patients who represented "dirty work." Their conscientious use of time, their orientation toward work as career, and their awareness of their own lack of autonomy reflected a concern about who they were. To these nurses being professional meant that one was competent, efficient, and also that one was serious about work.

Summary

I have attempted to present a picture of how nurses in a particular setting account for themselves as professionals, and also I have attempted to show factors in the setting which would allow professionalism to be appealing to some of the nurses who work within this setting. In the emergency room milieu, nurses are confronted with work which is narrowly defined, contstraining, and segmented. Contact with patients is brief, and often is separated by long periods of inactivity, waiting for something to happen. Much of the work is routine and most often nurses here do not deal with exciting cases, but rather with illness and injury which is more likely to be seen in a doctors office than in an emergency room. It seems that the way of accounting for oneself as professional, is a way of deriving some meaning from this particular type of work. The example of professionalism among several of the hospital workers, physicians and various paramedicals, offers a means of expressing one's own importance in the face of such segmented and constraining work.

The nurses in Community's emergency room are saying something about who they are and what their work is all about by stressing the importance of efficiency and competence and the saliency of their time. It seems most reasonable to expect that the nurses involved in deriving their identity from their work are also the people who

have no investment in family; thus the nurses who see their work as having much importance are also the nurses who are young, unmarried, or without children. It is these nurses who can afford a commitment to nursing as a career.

Thus the organization of work in the emergency room, as well as an aura of concern with professionalization of emergency room staff among physicians, contributes to a consciousness of professionalism among the nurses who work there. In addition, it is only particular nurses who will be affected by these "predisposing" factors; that is, young, unmarried, or childless nurses are most likely to find the idea of professionalization appealing.

FOOTNOTES

[1]Often during various times on a shift, staff members refer to the fact that they are "holding down the fort." In part this feeling arises from the fact that the emergency unit is a small one and has a rather small staff; and the feeling that it is also isolated from the rest of the hospital gives the staff the idea that it is a "fortifiable" unit.

[2]In the later part of the thesis "professionalization" and how it is discussed by the staff is spelled out more clearly.

[3]Fred E. Katz, "Nurses," in Amitai Etzioni, The Semi-Professions and Their Organization (New York: The Free Press, 1969), pg. 73.

[4]Faye G. Abdellah, Irene L. Beland, Almeda Martin, Ruth V. Mathesey, New Directions in Patient Centered Nursing (New York, 1973), p. 21. Discusses the need for more descriptive studies on the professional nurse. Elizabeth K. Porter, "What it Means to be a Professional Nurse," in AJN, August, 1953, pp 948-50. Examines differences between Professional nurses and technical-degree nurses.

[5]Peter L. Berger and Thomas Luckmann, The Social Construction of Reality (New York, 1967),Doubleday, p.47-128.

[6]This particular work system model is spreading however. For example in law, professionals in the field are trying to develop para-legal occupations which would be organized around the central occupation of law. However, medicine has gone furthest in this direction; see Barrie Thorne's discussion of this type of organization in a report prepared for the Carnegie Commission on Higher Education; Education for the Professions of Medicine, Law, Theology, and Social Welfare, pp. 75-80, and 111-120.

[7]Elliot Freidson, "Paramedical Professions," in International Encyclopedia of Social Sciences, David L. Sills, ed., Vol 10, pp. 114-120.

[8]Robert Kinsinger, "Training Health Service Workers: the Critical Challenge," in Proceedings of the Department of Labor, HEW Conference on Job Development and Training for Workers in Health Services, Washington, DC., Feb. 14-17, 1966, p. 27.

[9]The difference between technical training and professional programs lie in the fact that the former are not considered to be fully "professional." What is interesting is that the technical programs are becoming more and more popular; especially the programs offered in 2-year colleges (associate degree programs.) These have increased from only

three programs in 1965, to 129 in 1971. (From Abdellah, et.al., ibid).

[10]Everett C. Hughes, Men and Their Work, (Glencoe: The Free Press, 1958).

[11]Rue Bucher, and Anselm Strauss, "Professions in Process " AJS, May 1961. In this article Bucher and Strauss discuss the notion that every occupational group is broken up into "segments"; that is groups within the occupation which have particular interests and postures. Within nursing, even the "rank and file" is not a totally homogenous group. For example, LPNs and RNs might see themselves at odds and represent two separate "segments" within the rank and file.

[12]Fred E. Katz, op.cit. p. 73

[13]Increasingly there has been a concern for recruiting men into the field. This would of course, raise the status of the occupation, since occupations consisting predominantly of women tend to have low status.

[14]Women's role in the family has accounted for the high turnover and attrition rate among nurses. The home, traditionally the place where women were to get their ultimate fulfillment, often wins the young neophytes. However, lest this become the total explanation, it is important to remmber than increasingly large numbers of women with children and families are working; and that often this work accounts for a larger share of the family income than just "extras."

[15]Everett C. Hughes, The Sociological Eye, Collected Papers on Work, Self, and the Study of Society, (Glencoe; The Free Press, 1971)

[16]R. Corwin, "Professional Employees: A Study of Conflicting Nursing Roles," AJS, May 1961.

[17]Rose L. Coser, Life in the Ward (East Lansing: MSU, 1962); or Leonard Riessman and John Rohrer (eds.), Changing Dilemmas in the Nursing Profession (New York; Putnam's, 1957)

[18]Hans O. Mauksch, "The Organizational Context of Nursing Practice," in Fred Davis, The Nursing Profession, pp. 109-137.

[19]ibid., p. 130

[20]The name of this hospital is fictitious

[21]"ER" will be used throughout this thesis to refer to "emergency room."

[22]From an article in Time Magazine, August, 1973.

[23]See Hans O. Mauksch, "The Organizational Context of Nursing Practice," in Fred Davis, The Nursing Profession, p. 120, for a discussion of the effects which the transient hospital physician has on the organization of nursing.

[24]Specifically, there are percentages which can give the reader an idea of the composition of each shift; During the time I worked in the ER there was some turnover on both the afternoon and evening shifts. However, the day shift remained the same during this time: there were two full time RNs and one LPN; all three were married, older than 35 and had children in school. The afternoon shift was worked by two RNs and one LPN, also, who were under 30, the RNs were single, and the LPN was married. The night shift consisted of two RNs, both who were single and under 30. There were part time LPNs who worked this shift occassionally; they were over 35, and had families.

[25]"Cardio" technician refers to Inhalation Therapists. They are a relatively new paramedical occuaption, and assist people who are having difficulty breathing, or who are suffering heart failure, etc.

[26]The night shift did differ from the other shifts in a few ways; the rigidity of relations among the staff seemed to be quite a bit more relaxed at night. Once in a while, the doctors would join the rest of the staff in talking about "little league," or side business ventures they were engaged in. The orderly was informally allowed to leave the hospital to get pizza or donuts for the group, and often big feasts were prepared in the emergency nurses' station for eating during the night. There was a sense of "holding down the fort" during the night; and people would often comment about the additional responsibility as a result of the lower numbers of staff people who were working. For a discussion of how the night staff in a hospital differ from the daytime staff, see an unpublished paper by Jean Kozak, Michigan State University.

[27]By this I mean that I was one of a few who were not involved in the medical world; even several of the ward clerks were also either nursing students, or were in premedicine programs. The orderlies as was mentioned before, were often pre-med students; and even the admitting clerks were often nursing students.

[28]All of the names which are used throughout this paper are fictitious.

[29]Although the nature of work in chronic care wards is not dealt with in detail in this paper, there are several available descriptions of such work; Rose Coser, Life On the Ward, (East Lansing: Michigan State University), 1962; Fred E. Katz, unpublished study of nurses in a 500 bed hospital in a northeastern city, 1967; Fred Davis, The Nursing Profession.

[30]All of the quotations used in this paper come from fieldnotes taken on the job, January through September 1973.

[31]This is a condition not peculiar to this hospital, but which is prevalent in all emergency centers across the U.S. In 1970, 50 million visits to emergency rooms were made, as compared to 15 million visits which were made in 1955. Increasing numbers of people aren't able to afford doctors' fees, and it is more and more difficult to find doctors who accept new patients or who can care for their regular patients. Hospital emergency rooms have taken up some of this demand for medical care (Parade Magazine, Detroit Free Press, February, 1973.) Often I have asked patients to name their family doctor; they will remark that they wouldn't be here if they had one; or that they had called their doctor and were told that they couldn't be seen for a week or so. For patients with headcolds or backaches, this is hardly a realistic time period to wait.

[32]Everett C. Hughes, "Work and Self," in The Sociological Eye, Collected Papers on Work, Self, and the Study of Society, (The Free Press, 1971).

[33]Hughes refers to the social psychology of work; how people fit their work with their life, thus giving meaning to work which glorifies it or at least makes it tolerable; ibid, p. 342-47.

[34]Hughes, ibid, Essay on "Mistakes at Work," pp. 316-25.

[35]This term was often used by admitting clerks to refer to themselves in relation to other staff in the ER. On one particular occasion I heard this being used when one admitting clerk was describing what she did to an EMT trainee, an ambulance emergency trainee who did observing in the ER.

[36]This idea can be compared to Hughes' idea about "protecting professionals from their mistakes." In a sense the clerks and orderlies serve as buffers between patients and doctors; they keep doctors from being directly bothered, and keep patients from knowing "that the doctor doesn't know."

[37]See David Sudnow, "Bad News," in The Social Organization of Dying,(New Jersey, 1967), pp 112-252. Telling patients bad news or facing and carrying on discourse with grief-stricken people is a problem for members of an organization who have to carry on with business-as-usual.

[38]This was often a point of contention between myself and the staff; I wanted to get the patients in and out of my area, and the staff wanted to be bothered as little as possible. Once one of the RNs said that the mark of a good admitting clerk was to be calm during these times

and keep putting off the patient.

[39]Orderlies with further ambitions in medicine (e.g., pre-med students) are an exception to the general rule that those lower in the medical hierarchy cannot move up to another category. Being an orderly has a sort of vestige of apprenticeship; although actual advancement requires formal schooling.

[40]The difference between RNs and LPNs are in training and performance of some tasks. Historically LPNs evolved to take over functions which regular nurses performed; RNs consider their training to be "professional;" LPNs consider theirs to be "Technical." See Dorothy Deming, The Practical Nurse,(The Commonwealth Fund, New York, 1947;)and Grace E. Fitch, The Role and Responsibilities of the Practical Nurse, (New York; Macmillan, 1969.)

[41]Erving Goffman, Presentation of Self in Everyday Life, (New York; Doubleday, 1959), p.

[42]See Ray Gold, "The Chicago Flat Janitor" (unpublished Master's thesis, Department of Sociology, University of Chicago, 1950); Erving Goffman, ibid, for concepts of frontstage and backstage; p. 106-140; Paul Cressy, The Taxi-Dance Hall (Chicago: University of Chicago Press, 1932; William F. Whyte, Men at Work, (Homewood, Ill: Richard D. Irwin, Inc., 1961) pp. 125-135.

[43]There is an extensive literature on the social definitions of illness and the problems of interpreting symptoms.

[44]Julius Roth, "Some Contingencies of the Moral Evaluation and Control of Clientele; The Case of the Hospital Emergency Services," in AJS, Vol 77, No. 5, 1972. Much of Roth's discussion of control over clientele is relevant for this discussion. That staff feel some need to "screen" clients in a place where they are forbidden to do so is one way to understand why patients are seen in such a bad light by those on the "inside."

[45]A National association of Emergency Room Nurses was established in 1968; it is relatively young and has not enjoyed wide-spread response as of yet.

[46]It seems that although the nurses are seeking autonomy from physicians, their plan does not exclude the possibility that physicians still are able to wield some power.

[47]Two of the nurses promoting this professionalism have two-year technical RN degrees; three of them have BA degrees

[48]One of the BA and one of the technical RNs have worked longer than five years. Although they are older and have been around longer, they have full-time career ambitions.

APPENDIX

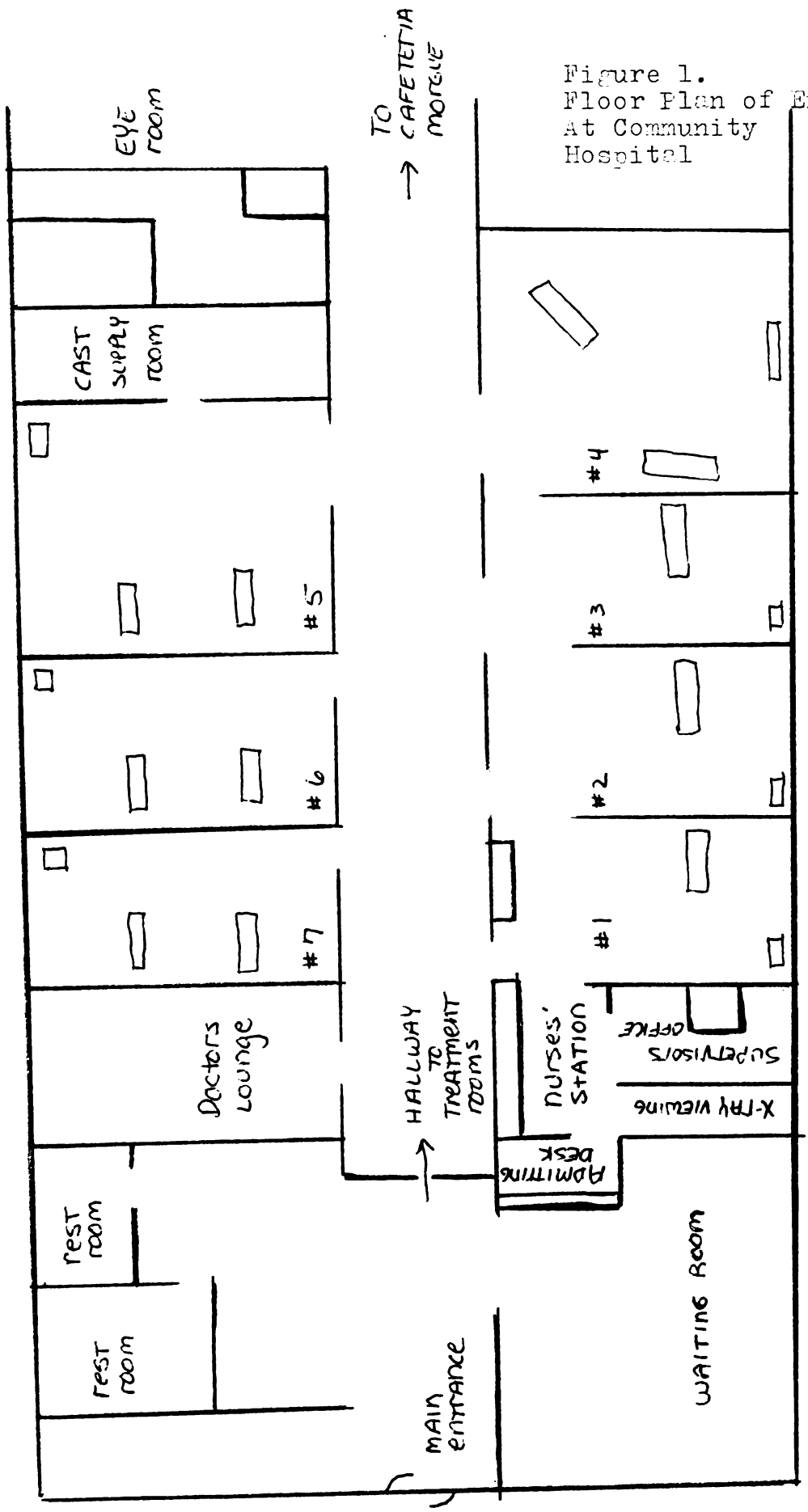

Figure 1.
Floor Plan of Emergency Room
At Community
Hospital

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