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The Accident and Emergency
Department:
Nurses' Priorities and
Patients' Anxieties

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Submitted to the University of Northumbria at Newcastle in partial
fulfilment of the requirements for the degree of Doctor of Philosophy.

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Note

In the quoted material (...) indicates that text has been omitted and ... indicates a pause.

ABSTRACT

The Accident and Emergency Department: Nurses' Priorities and Patients' Anxieties

Geraldine Byrne

This study investigated the sources of anxiety for patients in the Accident and Emergency Department and explored how patients' anxiety was influenced by their experiences in the department and the attitudes, behaviour and communication patterns of nurses and other staff.

The research was carried out in two Accident and Emergency Departments and consisted of three stages. Stage One employed structured interviews with 96 patients to identify sources of anxiety for patients in the Accident and Emergency Department and to examine the relationship between anxiety and the patient variables of age, sex, condition and department. In Stage Two in-depth interviews were conducted with 21 qualified nurses to explore their perceptions of their work and patients. Stage Three was an observational study, involving 23 patients, which examined the nature of nurse-patient communication in the Accident and Emergency Department. A Symbolic Interactionist framework was used in order to understand events from the perspective of those involved.

Patients appeared to view their stay in the Accident and Emergency Department as an event occurring within the wider context of their daily

lives and were concerned with social factors related to admission and the consequences of their illness or injury. Nurses held a different perspective and were more concerned with physical care and the organisation of the patients' stay in the department. In contrast to the patients, the nurses were concerned with short-term problems. Interaction between nurses and patients consisted predominantly of brief encounters which focused on the patients' illness or injury and their progress through the department. There was little attention explicitly directed towards dealing with patients' anxieties. A complex range of factors – interpersonal, cultural, interprofessional and structural – were found to influence communication.

A number of recommendations are made identifying ways to enhance nurses' ability to deal with patients' anxieties.

CHAPTER ONE

Introduction

Introduction

This chapter describes the background to the research and provides an overview of the thesis. The aims of the study are first presented. The context in which it arose is then discussed with brief reference to the relevant literature. Finally, the structure of the research is described and an outline given of the content of the thesis.

Aims

The aims of the study were,

1. To identify the sources of anxiety for patients in the Accident and Emergency Department.
2. To examine the relationship between anxiety and the patient variables of age, sex, condition and department.
3. To examine nurses' perceptions of their work and patients and explore how these influenced their practice.
4. To examine the patterns of communication between nurses and patients.
5. To identify any factors such as age, sex, seriousness of condition or department which may affect the interaction between nurses and patients.
6. To assess how effectively nurses identified and dealt with patients' anxieties in the departments studied.

Background to the Study

Two issues have been important in directing the process of enquiry in the present research. The first is the nature of anxiety experienced by patients in their encounters with hospital services. The second is the nature of nurse-patient communication and the extent to which nurses deal with these concerns of patients. A large number of studies have examined these issues. The volume of research generated reflects the importance they are considered to hold in relation to the quality of nursing care received by patients and to understanding nursing as a profession. Little research has focused specifically on the Accident and Emergency Department. Yet review of the literature suggests that patient anxiety and nurse-patient communication are likely to be particularly problematic within this setting.

The literature concerning patient anxiety in hospital suggests that many features which have been identified as stressful to patients are relevant to the Accident and Emergency Department. For example, an unfamiliar environment, unaccustomed routines and procedures, having to meet and interact with a large number of unknown people and lack of privacy have been cited as sources of anxiety for patients (Volicer and Bohannon, 1975). Lipowski (1975) reports being unable to cope with usual responsibilities as an important source of concern for patients. Lack of information, inadequate explanations and routinisation have also been implicated by many researchers (Robinson, 1972; Reynolds, 1978; Ley, 1979; Engstrom; 1984). Finally, some studies have found that anxiety for patients is at its peak on the day of admission (Wilson-Barnett and Carrigy, 1978; Johnson, 1980). This finding supports the view that

unfamiliarity with the environment, its personnel and procedures are important sources of anxiety for patients. Each of the characteristics described above is likely to be a feature of the patient's experience of the Accident and Emergency Department.

The nature of patient anxiety in the Accident and Emergency Department has, however, been largely neglected. Danis (1984), an American researcher, examined the fears of patients with 'minor' and non-urgent illnesses and injuries in an Emergency Department. She found that 90% of patients reported at least one fear and that common fears were related to inability to perform usual activities, pain, having to undergo an uncomfortable procedure and not knowing what was wrong. However, this was only a small study on a sample of 20 non-urgent patients. The present study, therefore, aims to examine in greater depth the nature of patient anxiety in the Accident and Emergency Department and explore its relationship to the patient characteristics of age, sex and condition.

The research is prompted by a belief that nurses have a responsibility to address patients' emotional, as well as physical, needs associated with their condition and experience of health care services. It is only by identifying the nature and extent of these needs that nurses can ensure that their practice is directed towards fulfilling them. The view that nursing should encompass social and psychological factors related to the patient's illness is one which currently enjoys wide acceptance, at least in theory. A number of models have been developed which aim to provide a theoretical and philosophical base for nursing practice (Peplau, 1952; Roy, 1976; Roper et al., 1980; Orem, 1980). It is not the intention to evaluate the advantages

and disadvantages of different models. What is important is that they all emphasize that nursing care should be patient-centred, individual and holistic. Yet the number of models which exist demonstrates that, even at an academic level, there is no consensus about what constitutes nursing practice and how it should be delivered. Nursing itself is a large and heterogeneous occupational group. There is reason to believe that different groups hold different views on what their work should involve and how it should be practised. It was important in the present study, therefore, to gain understanding of how the Accident and Emergency nurses defined their role and how such definitions influenced their practice. The emphasis they placed on dealing with patients' anxieties, in the context of an environment geared towards providing urgent physical care, was of particular interest.

The interviews with nurses revealed their priorities were dealing with 'major trauma' and keeping the department running smoothly. Their emphasis on these aspects of care appeared likely to conflict with their ability to deal with patients' anxieties. In addition, the nurses described a number of practical difficulties which were likely to constrain their attempts to deal with patients' anxieties. The literature on nurse-patient communication in hospital typically reveals it to be brief, superficial and predominantly concerned with the patient's condition (Stockwell, 1972; Faulkner, 1979; Macleod Clark, 1982; Bond, 1982). Again, little research has focused on the Accident and Emergency Department, but those that have (Wood, 1979; Toohey, 1984), support the general finding that little attention is paid to social and psychological aspects related to the patient's admission. Most of these studies, however, have concentrated on the

duration and properties of nurse–patient communication and have ignored the context in which it occurs. The understanding thus gained is limited. There is a need for research to examine the influence and constraints of cultural and structural effects on nurse–patient communication. The present study aims to address these issues with reference to the Accident and Emergency Department.

Finally, staff perceptions of patients have been found to influence the interaction which occurs (Stockwell, 1972; Strong, 1979). Sociological interest has focused on this issue in the Accident and Emergency Department. Studies by Sudnow (1967), Roth (1972) and Jeffery (1979) have found that moral evaluations of patients made by Accident and Emergency staff, and judgements of the legitimacy of their demands, exercised a powerful influence on observed behaviour. These studies have concentrated mostly on medical staff. They have also been primarily concerned with patients who occupied an extreme position with reference to staff views of legitimate attenders. The present study aims to examine, in more general term, how nurses' perceptions of patients influence their practice.

Structure of the Research

In order to fulfil the aims of the research and consider each aspect – the nature of patients' anxieties, nurses' perceptions of their work and patients and the nature of nurse–patient communication – the research was carried out in three stages.

Two Accident and Emergency Departments, within the same Health Authority were used. The two departments were studied concurrently. Thus, fieldwork for each stage was completed in both departments before the next stage commenced.

An outline of the three stages is given below.

Pilot Study: A pilot study was carried out to identify the sources of anxiety for patients in the Accident and Emergency Department and explore how their experience was influenced by the medical and nursing care received. A data collection sheet was used to record events which were observed during the patient's stay in the department and the patient's response to those events, elicited by informal interview. Twelve patients were observed and interviewed (7 in Dept. A, 5 in Dept. B). The fieldwork for the pilot study took place in the summer of 1986.

Stage One: Structured interviews were conducted with a sample of 96 patients (48 in each department) to identify the sources of anxiety for patients in the Accident and Emergency Department. The patient interviews took place from spring to autumn 1987.

Stage Two: In-depth interviews were carried out with nurses in each department to explore their perceptions of their work and patients. All qualified nurses, except those on permanent night duty, were interviewed (13 in Dept. A, 8 in Dept. B). The nurse interviews took place from spring to autumn 1989.

Stage Three: An observational study was conducted to examine the nature of nurse–patient communication in the Accident and Emergency Department. Twenty-three patients were observed throughout their time in the department (10 in Dept A, 13 in Dept. B). The fieldwork took place in the summer of 1991.

Content of the Thesis

This section provides an outline of each chapter of the thesis, and summarises briefly their contents.

Chapter Two – Literature Review

In Chapter Two the literature relevant to the study is reviewed. Definitions of the emotion of anxiety are examined. Research which has studied patient anxiety and nurse–patient communication in hospital is discussed. Themes relevant to the Accident and Emergency Department are considered.

Chapter Three – Theoretical Perspectives and Methodology

The present research was undertaken from a Symbolic Interactionist perspective. Chapter Three describes the main features of this perspective and discusses its relevance to the study with reference to examples from the research. A qualitative approach, consistent with the Symbolic Interactionist perspective, was used as the main method of data collection and analysis. The research design is described and the aims and methods of each stage discussed.

Chapter Four – Results: The Pilot Study

Chapter Four reports on the pilot study undertaken at the beginning of the research to explore patients' experience of the Accident and Emergency Department and the factors which were sources of anxiety. The methods used are described. The four main themes which emerged, strategies by which staff define and maintain the role of patient and patient compliance with that role, the nature of patients' anxieties, the nature of nurse-patient communication and staff perceptions of patients, are discussed.

Chapter Five – Results: The Nature of Patients' Anxieties

Chapter Five reports on the structured interviews carried out with patients during Stage One of the research. The development of the interview schedule is described. The findings of the structured interviews are reported. The items about which patients most commonly expressed anxiety are described. The relationship between anxiety and other patient variables, revealed by chi-squared analysis, is discussed. Finally, relationships between anxieties, which emerged using cluster analysis, are described.

Chapter Six – Results: Nurses' Perceptions of Their Work and Patients

Chapters Six and Seven report the findings of the in-depth interviews carried out with nurses in Stage Two of the research. In Chapter Six methodological issues associated with this data collection technique are discussed. Three of the core categories are described. These are 'Defining the Role of the Accident and Emergency Department Nurse', 'Nurses' Priorities and Patients' Anxieties' and 'Keeping the Department Running

Smoothly'. The influence of the nurses' definition of their role and expressed priorities on the extent to which they addressed patients' anxieties is explored.

Chapter Seven – Results: Patient Demands and the Nurses' Exercise of Control

In Chapter Seven the two remaining core categories derived from the nurse interviews, 'Legitimate and Illegitimate Demands' and 'Exercising Control in the Department', are described. These categories are concerned with how nurses' perceptions of patients influenced interaction and the strategies nurses used to maintain control over their work. The nurses' response to what they felt were 'inappropriate' demands being made upon them is explored.

Chapter Eight – Results: The Nature of Nurse–Patient Communication

Chapter Eight reports the findings of the observational study carried out in Stage Three of the research. The methods of data collection used are first described. In the following section quantitative analysis of the duration, initiator and content of topics which occurred is presented. Qualitative analysis then explores the issues which emerged in greater depth.

Chapter Nine – Summary of Results

In Chapter Nine the results of the three stages of the research are summarised and discussed. In this chapter relationships between the findings of each stage are explored.

Chapter Ten – Implications for Theory and Practice

In Chapter Ten the theoretical implications of the research are discussed. Implications for practice are presented. The implementation of change is discussed and directions for further research suggested. A number of recommendations arising from the research are made.

Chapter Eleven – Conclusions

In Chapter Eleven the overall study is reviewed. The original aims are considered and related to the study's findings.

References and Appendices

The measurement instruments included in the Pilot Study and Stages One and Three of the research are attached. The consent form used in Stage Three is also included. An alphabetical list of the references cited in the text is given.

Conclusion

This chapter has described the background to the research and provided an overview of the thesis. The aims of the research were presented. The context in which the study arose was then discussed. The structure of the research was described and an outline given of the content of the thesis.

CHAPTER TWO

Literature Review

Introduction

This chapter reviews the literature which has examined the emotion of anxiety and its incidence among hospital patients. The nature of nurse-patient communication, and its impact upon anxiety, is explored. Themes which are relevant to the Accident and Emergency Department and the findings of studies which have focused on this area are discussed.

The Nature of Anxiety

Patient anxiety in hospital is a well-documented phenomenon in nursing research and theory. Before examining the extent of the problem, however, we must define what is meant by 'anxiety' and how it is distinguished, if at all, from the concepts of 'stress' and 'fear', which are often used synonymously. The limitations of psychological research which has concentrated on defining these terms and proving their validity, without reference to the meanings of the individuals studied, is discussed in relation to the Symbolic Interactionist perspective.

The word 'anxiety' is derived from the Latin *anxietas* which means troubled in mind. This simple definition gives a useful indication of the experience of anxiety but one which clearly must be expanded to explain the origins, characteristics and consequences of the emotion.

Freud (1936, 1949, 1954, 1962) wrote extensively on the subject of anxiety. Although seeking originally to explain anxiety as a physical problem resulting from sexual dysfunction, he later developed his theory to include psychological responses. Freud (1936, 1949) identified the trauma of birth as the original source of anxiety, and perceived important developmental stages as accompanied by further manifestations of the emotion. Thus, the infant's first helpless weeks of life are characterised by the fear of annihilation, the need-gratifying stage dominated by fear of losing the mother and the stage where an awareness of separation emerges accompanied by the fear of losing the mother's love. Anxiety, according to Freud, is therefore a deep-rooted response to fundamental threats to the individual which are derived from infantile experiences.

According to Freud's theory, during the defenceless early stage of life, anxiety results in psychological trauma. Later, as the individual achieves maturity, the ego is able to operate as an alarm system in order to mobilise defences to deal with the threat. Abnormal development may, however, lead to these early forms of anxiety persisting in later life, i.e. neurotic anxiety. Freud (1954, 1962), therefore, distinguishes between objective or 'real' anxiety which is the reaction to an identifiable external danger and which serves a protective function of preventing the person from being overwhelmed by the threat, and 'neurotic' anxiety. Neurotic anxiety is of a degree which is out of proportion to the actual danger, may be evident even when no identifiable danger is present and may persist after the threat has subsided.

May (1950:191) attempted to clarify more precisely what anxiety was, and defines anxiety as,

A diffuse apprehension which is unspecific, vague and objectless. It is associated with feelings of uncertainty and helplessness resulting from a threat to the core or essence of the personality.

May is also concerned to determine whether 'normal' anxiety is different, either quantitatively or qualitatively, from 'neurotic' anxiety. Like Freud, he argues that there is a clear distinction between them. He defines normal anxiety as more proportional to the threat and subsiding when the threat is removed. Neurotic anxiety, on the other hand, is enduring, disproportionate to the threat and involves the development of defence mechanisms.

Speilberger (1972:24) also upholds a distinction between anxiety as a response to a particular situation (state anxiety) and anxiety as part of an individual's psychological make-up (trait anxiety). He defines state anxiety as,

A palpable but transitory emotional state or condition characterised by feelings of tension, apprehension and heightened autonomic system activity.

Speilberger does not label trait anxiety as neurotic but does maintain that it is qualitatively different to state anxiety and is characterised by individual differences and a proneness to experience anxiety when the self-concept of the person is threatened. He suggests that the extent to which either form of anxiety is experienced and manifested is dependent on the meanings

individuals attribute to the various external and internal stimuli, and the defence mechanisms and coping mechanisms individuals use to avoid anxiety.

Although not all researchers agree – Hamilton (1969), for example, arguing that the only difference between ‘normal’ and ‘neurotic’ anxiety is one of degree – there does seem to be some consensus that a distinction between the two broad categories is useful. As Gomez et al. (1984) point out, the theories of many writers rest on a number of different theoretical assumptions but what they share is a distinction between ‘normal’, ‘acute’, or ‘state’ anxiety, which occurs in response to a particular situation and is transitory and manageable, and ‘neurotic’, ‘chronic’, or ‘trait’ anxiety which is manifested in unmanageable states of apprehension, is persistent, and has an intensity disproportionate to the actual danger or appears in situations where there is no detectable danger.

The emphasis placed by these researchers on the need to distinguish the psychological characteristics of the individual which contribute towards anxiety does, however, have important limitations. In particular this approach ignores the meanings which experiences hold for individuals. A Symbolic Interactionist perspective proposes that these meanings, and the individual’s interpretation of them, are fundamental to understanding human experience and the individual’s response to that experience. Blumer (1969:2) writes,

Symbolic Interactionism rests in the last analysis on three simple premises. The first premise is that human beings act towards things on the basis of the meanings that the things have for them (...). The second

premise is that the meanings of such things is derived from, or arises out of, the social interaction one has with one's fellows. The third premise is that these meanings are handled in, and modified, through an interpretive process used by the person in dealing with the things he encounters.

According to Blumer (1969), psychological science which ascribes human action to 'matters such as motives, attitudes, need-dispositions, unconscious complexes (and) stimuli configurations' ignores the vital process of interpretation in which the individual notes and assesses what is presented to him. It is on the basis of such interpretations that the individual's behaviour is based.

In the Accident and Emergency Department, the individual's experience of anxiety will depend upon their interpretation of their illness/injury, the meanings they attach to events and encounters in which they participate and their expectations of the eventual outcome. How their anxiety will be expressed will depend upon the complex processes of interaction which occur between the individual and the other actors – nurses, doctors, companions – with whom they communicate. Thus, a patient may interpret admission to the hospital as a distressing and disruptive event and experience anxiety in anticipating the possibility. Whether this anxiety would be confided to a nurse would depend upon a number of factors. These would include, the interest and concern expressed by the nurse, the interpretations of both patient and nurse of whether the subject was a legitimate one to discuss and the judgements of each of the benefits of such discussion.

The nurses' interpretations also, therefore, play a significant part in

constructing the interaction which occurs. For example, if a nurse interpreted an injury as 'minor', she may not expect the patient to be anxious and may therefore ignore this aspect of the patient's admission. If, on the other hand, she believed that anxiety was justified by the patient's circumstances, she may be more likely to address it. In the present study, the nurses believed the parents of babies and young children were justifiably anxious. They were, therefore, sympathetic towards this group, even though the child's condition may not have been serious enough to warrant attendance at the Accident and Emergency Department. Adults who attended 'inappropriately' tended to be viewed negatively. The anxiety which these patients may have felt was not considered to be justified.

Some definitions of anxiety have recognised the importance of individual's interpretations. These authors have suggested that anxiety is not necessarily a negative emotion. In certain circumstances it may be regarded as a positive force. Kierkegaard (1944) saw anxiety as a potential source of human development. Every individual, he argued, has the need to grow and develop. Yet, the prospect of undertaking a new enterprise involves anxiety. Only by overcoming the anxiety can the individual progress. In recent years, humanistic psychology has perceived anxiety as a positive emotion which stimulates personal growth. Peplau (1963) defines anxiety as a response to an unknown danger that enables one to mobilise resources against the difficulty, but which is experienced as discomfort. These perspectives, in common with Symbolic Interactionism, stress that it is the individual's interpretations of events which most strongly influence whether anxiety will be experienced. Furthermore, these views propose that a person's response to the emotion of anxiety is also subject to individual

interpretation and that it is the interpretations made which guide the person's action.

In the present study, it is the individual's definitions which are regarded as important. No attempt has been made, therefore, to distinguish between 'trait' and 'state' anxiety. As Blumer (1969) suggests individual's responses are not merely the result of inherent traits and processes defined by psychologists. It is the patients' response to their experience with which we are concerned. The patients' expressed anxiety is taken as a reflection of this and it is their expressed anxiety which is recorded and explored.

Fear and Anxiety

In recent years there has been an attempt to make a distinction between the emotion of anxiety and that of fear. Wilson-Barnett and Batehup (1988:31) state,

Anxiety is often used interchangeably with stress and fear, yet this blurs the unique feature of a disproportionate response to a non-specific or unknown threat which might occur in the future. Fear is usually exhibited in the face of an identified threat.

Carpenito (1983:78) also emphasises that anxiety is a response to an unknown threat, describing it as,

A state in which the individual experiences feelings of uneasiness (apprehension) and activation of the autonomic nervous system in response to a vague, non-specific threat.

However, in reality it appears difficult to distinguish between these two

emotions. Taylor-Loughran et al. (1989) attempted to determine the frequency with which the North American Nursing Diagnosis Association's (NANDA) definitions of fear and anxiety were used by nurses. They also sought to identify any other characteristics which nurses used to define these emotions. The research took place in an American hospital where patient care plans were entered on a computer. Prior to data collection, a general orientation to the project was held for all nurses involved in the study. A review of the definitions and defining characteristics of fear and anxiety agreed by NANDA was provided. During data collection, when a nurses entered the diagnosis of fear or anxiety, a screen on the computer requested the nurse to describe the characteristics observed which had led to the diagnosis. Subsequent screens then provided subjective and objective characteristics of fear and anxiety identified by NANDA. The nurse was then instructed to select those words which best described the signs and symptoms previously listed. A total of 482 occurrences of the diagnoses fear and anxiety were collected over 10 months.

The researchers found that in the case of fear the defining characteristics used most frequently by nurses were 'apprehension', 'scared' and 'feeling of emotional disruption related to an identifiable source'. In the case of anxiety, the most frequently occurring defining characteristics were 'anxious', 'apprehension' and 'worried'. They also found that the fourth most frequently occurring defining characteristic of anxiety used by nurses was 'fearful'. Taylor-Loughran et al. note that 'apprehension' is used as a synonym for both anxiety and fear and suggest that patients may be exhibiting a fear-anxiety syndrome. For example, they suggest that a pre-operative patient may be fearful about surgery (a known object) and

anxious about its unknown consequences. In the Accident and Emergency Department it is conceivable that a patient could be fearful about a known entity, such as having to have stitches, and anxious about the unknown consequences, such as possible disfigurement.

Although the work of Taylor-Loughran et al. (1989) goes some way towards making a helpful distinction between the emotions of fear and anxiety, the defining characteristics remain blurred. Even if there is consensus, at a theoretical level, that fear is a response to a known and anxiety to an unknown, in reality the distinction appears difficult to quantify. Taylor-Loughran et al. report, 'A conclusion about the presence of critical defining characteristics that can be used to differentiate these two diagnoses (fear and anxiety) cannot be made from the results of this study'. It would seem, therefore, that while a conceptual distinction between the two emotions exists, and the meanings generally attached to the terms are different, these differences cannot be regarded as absolute. In the present study the term 'anxiety' has been used to denote feelings of anxiety, worry, apprehension or fear.

Stress

Having considered the emotion of anxiety in some detail and compared it with that of fear we may now examine the circumstances in which it is likely to occur. Many definitions of anxiety characterize it, either implicitly or explicitly, as part of the wider concept of stress. Cox (1978) describes anxiety as occurring when an individual is unable to cope with the demands, physical or psychological, which are placed upon him. To understand why, and when, anxiety occurs, therefore, requires examination

of the theoretical and epistemological dimensions of stress.

Early definitions of stress referred to it as a stimulus to which the body is subjected, for example hunger, cold, pathogenic organisms or increased workload. The individual was seen as responding to the stress by manifesting physical or psychological strain or breakdown. The stress could take the form of one intense stimulus or of a number of stimuli.

A major difficulty in defining stress in this way is that it ignores different individuals' capacity to deal with or adapt to the stress. For example, some people may experience hunger for long periods without strain, some even seeking out the experience, while others suffer discomfort. Similarly the same individual may not always respond in the same way to a given source of stress.

Another important problem with this approach is that if stress is seen as a stimulus, then a lack of stimuli – stress – must be desirable. Clearly this is not the case, the absence of any stimuli being at least as great a source of discomfort to human beings as an excess. Selye (1956) attempted to overcome this problem by characterising stress not as a stimulus but as a response to a stimulus – the stressor. Selye defined the stressor as disturbing homeostasis and the stress response as the set of bodily adaptation responses which restore it. He maintained that the same general restorative processes – the General Adaptive Syndrome – occurred irrespective of the type or site of the stressor. In the case of very intense or prolonged exposure to the stressor, the stress response may become ineffective and fail to restore homeostasis, resulting in illness or even death.

Selye's work has provided a valuable and influential definition of stress. However, it still fails to account for differences between individuals which may influence their reaction and response to a given stressor, and ignores the fact that a number of factors, such as age and experience, affect the likelihood that the individual encountering a particular stressor will experience stress.

Selye's theory of stress was developed in his later work to include the concepts of positive 'eu-stress' and negative 'dis-stress'. This acknowledges that a lack of stimuli may be experienced as stress, individuals needing to receive an acceptable level of stimuli to function to their optimum capacity. Much research has been based on Selye's model of stress. In particular, stress measurement tools such as those developed by Holmes and Rahe (1967) and Dohrenwend and Dohrenwend (1974), which identify the major life events which may be stressful and assign a value to indicate the degree of stress each is likely to provoke, have been one of the central measurement devices in stress research for many years. Proponents of this approach continue, however, to perceive the individual as passively responding to his environment and fail to account for a human's ability to interpret and control his internal and external world and the mediating factors which influence whether a stressful consequence will ensue. An enormous variety of personal, physical and social factors influence, for example, the degree of stress experienced as a result of life events such as marriage, divorce or bereavement.

In recent years, interactionist approaches have attempted to incorporate these complex processes into the concept of stress. Phenomenological researchers such as Lazarus (1966), Levi (1972) and Cox (1978) defined

stress as a mismatch between the demands made on an individual and his ability to cope. Eliot and Eisdaffer (1981) provide a framework for understanding stress as occurring within the interaction between the individual and his environment. According to this model, the stress continuum includes the potential stressor, undergoing an examination, for example, or having a heart attack; mediators such as social support, coping behaviours and defence mechanisms; the psychological mechanisms such as the emotions of anxiety and depression; biological reactions such as increase in catecholines, and consequences or outcomes such as emotional or physical illness or healthy functioning. This model of stress, therefore, describes a dynamic process across the continuum: that is, an interactive process between the individual and the environment.

Using this definition, anxiety is seen as the emotional response to a stressor which occurs in a particular individual. It is also associated with a physical response. Its incidence and extent will be influenced by a wide range of individual characteristics such as personality, experience, age, health and social circumstances. These characteristics are the mediators which may affect the ability of the individual to cope with the stressor. When the stressor is too intense or prolonged, or the individuals' resistance weakened, the individual will be unable to cope and may experience emotional discomfort (anxiety or depression) and/or physical disorders.

Cox (1978) argues that anxiety is most likely to occur when the shortfall between the demand (stressor) and the possibility of attaining a positive outcome is not great: that is, when the individual believes they have a possibility of coping. If the demands are seen as too great, then

helplessness will result. According to Cox's theory, a patient in the Accident and Emergency Department with a 'minor' injury which requires minimal treatment and which the patient perceives as likely to have little or no impact on their lifestyle, may not provoke anxiety. At the opposite extreme, a patient with a life-threatening condition requiring critical care may feel overwhelmed by the demands and experience helplessness. The patients most likely to experience anxiety would be those whose illness/injury represented a significant threat to their sense of well-being and ability to function normally, but where the problems were not perceived as insurmountable.

Anxiety in this case may not be a negative emotion. Indeed, it is argued by some that it may be related to improved functioning. Yerkes and Dodson's (1908) research, which was sufficiently influential to be described as a law by some, indicates that a low or moderate level of anxiety is associated with improved performance, although increased levels result in disorganised behaviour. It is possible that patients in the Accident and Emergency Department who experience a low or moderate level of anxiety are those who will be most able to cope with the experiences they encounter and adjustments they must make to their lifestyle.

Anxiety for Patients in Hospital

(The) in-patient population is more anxious than the non-hospitalised population. (Franklin 1974)

This simple statement reflects the fact, now widely recognised (Wilson-

Barnett, 1979), that hospital admission is a stressful experience for many individuals. As there has been little research into anxiety among patients attending the Accident and Emergency Department, it is useful to review the types of anxiety experienced by hospital in-patients. Insight may thus be gained into the nature of the problem generally and into the specific factors which may be relevant to the Accident and Emergency Department.

A wide range of factors have been identified as sources of anxiety for hospital patients. Volicer and Bohannon (1975) point to the unfamiliar environment, and the unaccustomed routines and procedures, as well as the necessity to meet and interact with a large number of strangers, both staff and other patients, and the consequent lack of privacy. They also found that patients rated the loss of independence and enforced separation from friends, family and work as stressful aspects of hospitalisation.

Franklin (1974) also points to the need to adjust to a more dependent role, to learn the ropes and rules of being a patient and having to cope with illness and treatment as important sources of anxiety. Lipowski (1975) refers to separation from the family, fear of disfigurement, being unable to cope with usual responsibilities and the fear of the withdrawal of close relatives and friends. Robinson (1972) suggests that the general atmosphere of the ward encourages apprehension and unease among patients. Wilson-Barnett (1976) found that specific aspects of hospitalisation such as 'being away from home', 'seeing someone else who is very ill' and 'using the bedpan' were sources of concern for patients. Carr and Powers (1986) also report that factors related to illness such as

pain, discomfort or progress and recovery, and factors related to hospitalisation such as sleeping in a strange bed or sharing a room with others, contribute to patient anxiety in hospital.

In the Accident and Emergency Department, patients are also likely to be unfamiliar with the environment and routines. They are likely, too, perhaps even more so than patients in other areas, to have to meet and interact with a large number of strangers. Because of their relatively short time in the department, they are unlikely to have established supportive relationships with staff or other patients. Lack of privacy is also a common feature of the Accident and Emergency Department. Sick patients may be left for some time in the corridor or waiting areas. Some may have to explain the history of their condition in the waiting area or with only a curtain between them and the next patient. Factors such as admission to hospital, separation from friends and family and inability to cope with usual responsibilities may cause concern and patients may be worried about such events occurring.

Reynolds (1978) claims that the general tendency not to inform patients of results of tests, often because they are considered routine, contributes to patients' anxiety. Certainly, several studies (Robinson, 1972; Ley, 1979; Engstrom, 1984) have cited inadequate explanations, rushed communications, routinisation and lack of understanding as sources of anxiety for patients. Others (Davis, 1972; McGilloway, 1979) have suggested that a patient's lack of knowledge about the ward, the ward team, the ward facilities and his or her own situation as a patient, may inhibit communication and result in a limited understanding of events.

Various factors associated with communication have, therefore, been found to contribute to patient anxiety. In particular, lack of understanding on the part of the patient or poor communication by the nurse have been found to be important. All factors related to lack of explanation of events and treatments may apply to patients in the Accident and Emergency Department. The patients' lack of knowledge about the department and its practices could also lead to further misunderstanding of events.

Anxiety among patients on surgical wards has been extensively researched. Janis (1958) suggested that patients needed to complete the 'work of worrying' prior to an operation. She surmised that moderate levels of anxiety helped patients to plan for the stressful aspect of surgery and rehearse coping mechanisms. More recently this view has been questioned. Johnson et al. (1971) demonstrated that moderate anxiety was not necessary for optimum recovery. Carnevali (1966) found that patients fear the anaesthetic, pain and not being a 'good' (i.e. brave) patient post-operatively. Hayward (1975) found that giving patients information pre-operatively was associated with lower required levels of analgesia post-operatively. Boore (1978) found information given pre-operatively was associated with improved recovery from surgery, and Seers (1987) also found pain and anxiety post-operatively to be closely related.

Johnson (1980) found patients scored the highest levels of anxiety 2 days prior to surgery. This was usually the day of admission which suggests that lack of familiarity with the people and routines and fear of the event of surgery may be significant factors. Wilson-Barnett and Carrigy (1978) also found that patients admitted to medical wards experienced a peak of

anxiety on admission. The finding that anxiety is at a peak on admission to hospital is of particular interest. If this anxiety is due to unfamiliarity and uncertainty associated with the event, then patients in the Accident and Emergency Department may be particularly at risk.

Several studies have examined patient anxiety in the Coronary Care Unit. Dellipianni et al. (1976) found that anxiety among these patients was high on admission to hospital, subsided during their stay and increased again at discharge. Again, the high levels of anxiety on admission may be due to unfamiliarity with events, surroundings and staff and uncertainty about what will happen. The high levels also found at discharge may have been due to worry about how they would cope at home. Vetter et al. (1977) found no difference in levels of anxiety experienced by patients admitted to the Coronary Care Unit and those admitted to general medical wards. Hackett et al. (1968) found that 80% of patients admitted to the Coronary Care Unit had symptoms of anxiety, and, furthermore, it was found (Hackett and Cassem, 1971) that staff rarely had time to explore each patient's fears fully.

Another area which has attracted a great deal of research about patient anxiety is Intensive Care. Kornfeld et al. (1974) reported that most of their patients found the experience frightening. They felt 'chained' by the monitors, drips and other equipment and were preoccupied with death. Other studies (Stephenson, 1977; Gowan, 1979; Harris, 1984; Noble, 1982) point to the constant light, strange machinery, invasive procedures, flashing lights and immobility as disturbing to patients.

The finding of Kornfeld et al. (1974), that patients were preoccupied with death, is interesting when compared with the findings of other research examining patient anxiety. It is unusual for research to report patients' concern about a possible outcome as a source of anxiety. Most of the studies reviewed have found factors associated with the experience of hospitalisation were the most common concerns. It may be, however, that this tendency is a consequence of the measuring instruments used. Most studies asked about events occurring during hospitalisation. Fears associated with the long-term consequences of an illness or the impact of their condition on the patient's daily life were not explored.

For some patients in the Accident and Emergency Department who require skilled technical intervention, such as those in the resuscitation room, factors associated with strange machinery, monitors, 'drips' and other equipment could be frightening.

Common themes in the research into patient anxiety in hospital are that it is at a peak on admission and that it is associated to lack of familiarity with people and events and exacerbated by ineffective communication. The characteristics of immediacy of admission and unfamiliarity of staff, routines and environment are typical of patients' experience of the Accident and Emergency Department. In addition, some patients require highly skilled technical interventions which have been described as frightening by patients in other areas. For many reasons, therefore, it would seem probable that many patients would experience anxiety during their time in the Accident and Emergency Department.

Little research has examined patient anxiety in the Accident and Emergency Department. Danis (1974) studied the fears of patients with minor and non-urgent illness and injuries and found that 90% of these patients reported at least one fear. Common fears were related to inability to perform usual activities, pain, having to undergo an uncomfortable procedure and not knowing what was wrong. However, this was only a small study on a sample of 20 patients. The problem of patient anxiety in the Accident and Emergency Department deserves, therefore, further investigation.

The Role of Nursing

Dealing with patients' emotional responses to their illness and to the experience of hospitalisation is a crucial and unique aspect of the nurse's role (Wilson-Barnett, 1980). The American Nurses Association define nursing as,

The diagnosis and treatment of human responses to actual or potential health problems.

In the UK the current emphasis on the use of the nursing process and nursing models reflects the concern that nurses should view their patients holistically and value their uniqueness and individuality. The nursing process aims to provide individualised nursing care by systematically assessing patients' problems, planning and implementing a programme of care and evaluating the outcome. Patients should, if possible, actively participate in the planning and implementation of their care. Nursing theorists (Peplau, 1960; Sundeen et al., 1989) point to the interpersonal

relationship which exists between nurse and patient as vital to the successful application of the nursing process. Skilful communication is seen as central to this process.

A number of models have been developed in order to provide a theoretical framework in which the nursing process may most effectively occur (Roper et al., 1980; Orem, 1980; Roy, 1976; Neuman, 1980). One of the features of all models is a detailed nursing assessment of the patient. The Activities of Living Model (Roper et al., 1980), for example, defines 12 activities of living. The nurse must assess the patient in relation to each activity and plan, with the patient, a programme of care to assist the patient either to regain independence in undertaking them or cope with any limitations. The main difficulty in the use of this, and other models, in the Accident and Emergency Department is lack of time. In addition, if the patient's problem is 'minor', the detailed investigation may identify only one or two problems. The nurse will then have undertaken a lengthy assessment which has limited practical value. For these reasons, therefore, it may be difficult to base nursing care, in the Accident and Emergency Department, on a nursing model.

Franklin (1974) states,

An important part of the nurse's function involves relieving the anxiety of patients when they are admitted to the ward. The nurse must be aware of the problem and be able to recognise the symptoms of anxiety.

The benefits to patients of having nurses who will address their anxieties are well reported. Patients with high pre-operative anxiety (when compared

to those with lower anxiety) may need increased analgesia post-operatively (Hayward, 1975), spend longer in hospital following surgery (Egbert et al., 1964) and suffer more post-operative complications (Janis, 1958).

Thompson (1989) found that a programme of in-hospital couple counselling significantly reduced anxiety and depression in first myocardial infarction male patients and their partners.

Hayward (1975) found that nursing intervention was rated by 33% of patients as the most comforting or reassuring factor. Yet research findings consistently report a lack of attention to providing open and informative communication on the part of the nurse. Franklin (1974) comments,

Nursing staff rarely recognise anxiety as an important problem, and therapeutic discussion directed at anxiety relief is nearly non-existent.

Moffic and Paykel (1975) maintain that systematic assessment is necessary to detect the prevalence of anxiety and depression but found that staff failed to recognise problems in approximately half of the cases identified.

Several studies have found a discrepancy between nurses' and patients' assessments of patients' anxiety levels. Johnson (1982) asked patients to complete the Hospital Adjustment Inventory (HAI) (De Wolfe et al., 1966). She then asked each patient to identify the nurse on duty and the fellow patient with whom she had most contact. The named individuals were then asked to complete the HAI to describe how the patient felt. Johnson found that nurses were unable to provide accurate assessment of mood and pain in their patients. They tended to overestimate the level of

anxiety they thought patients would experience and were also unable to state accurately what patients were anxious about. Johnson describes nurses as, 'not particularly good' at identifying the worries of a particular patient, and states that nurses were, 'able to identify the most worried patients but would not know what they were worried about'. Patients, Johnson found, were able to identify more accurately fellow patients' worries. She suggests this may be because patients spend more time together and have greater equality of status and role than nurses and patients. Although Johnson does not discuss explicitly why nurses are not good at identifying patients' worries, she implies that it may be due to lack of contact and communication.

Lucente and Fleck (1972) discovered a disparity between nurses' ratings of patients' anxieties and patients' self-ratings. They suggested this indicated a lack of perception of individual patient anxiety levels and prompted the recommendation that,

Additional attention to the emotional phenomena associated with hospitalisation may be in order in training health personnel.

Openshaw (1984) found overestimates of anxiety were usual, and she suggests this may be due to the nurses' feeling that they ought to report some negative moods. Carr and Powers (1986) in a study of stressors associated with coronary bypass surgery found 'significant differences' between nurses' and patients' perceptions of the degree of stress experienced by bypass patients. Nurses' stressfulness ratings were significantly higher than those of patients. There was, however, a moderate

correlation between the rank ordering of stressors by patients and nursing staff. Biley (1989) also showed agreement in rank ordering of items which would cause anxiety to surgical patients, but again found that nurses consistently assessed patients as more anxious than the patients reported themselves.

The studies reported indicate that nurses tend to overestimate the level of anxiety experienced by patients generally and are poor at identifying the actual worries of specific patients. Johnson (1982) points out that it is possible that it is not nurses who over-report but patients who under-report anxiety. Certainly Janis (1958) suggested that patients may use denial as a means of coping with negative emotions. McIntosh (1977) also found that a number of patients derived comfort from their relative ignorance. However, the evidence suggests that nurses do not accurately identify patients' worries. Certainly studies of nurse-patient communication consistently report that the quality is insufficient to allow accurate assessment of patients' anxieties or emotional support.

Stockwell (1972) described nurse-patient interaction as infrequent and brief. Macleod Clark (1982) analysed audio and videotape recordings of interactions between nurses and patients on surgical wards and found that nurses spent little time talking to patients and that conversations tended to be superficial and stereotyped. Macleod Clark writes that, 'Few conversations were entirely social and only 1.3% were concerned with emotional or psychosocial matters.'

Bond (1982) studied nurses' interactions with patients on a radiotherapy

ward and found that nurses engaged in few interactions that lasted more than 3 minutes with patients not requiring physical care. Bond points out that, 'This limitation prevented nurses from learning more than superficial details of their patients and knowing little of their (the patients') reaction to their illness.'

Hockey (1976) reports nurses as saying that they would like to give more psychological care. The reasons why they do not appear to do so are complex. Menzies (1967) suggested that the reason why nurses endeavour to maintain a distance between themselves and patients is to reduce the anxiety inherent for them in the nurse-patient role. One of the ways they achieve this is by splitting the role into well-defined tasks which ensures detachment and diffuses responsibility for the decisions taken. Others (Stockwell, 1972; Melia, 1987) have explained the limited quality of nurse-patient interaction in terms of the professional culture in which it occurs. Physical care is acknowledged as the 'real' work and talking to patients may be seen as not 'pulling your weight'. Peterson (1988) suggested that nurses generate sets of norms and values which influence the extent to which psychosocial nursing care is valued and practised.

A further body of research suggests that differences of perception between nurses and patients may lead to poor communication. Calnan (1984) found that patients were more likely to classify an injury as 'urgent' than nurses. Clarke (1982) compared the definitions of health teaching needs of patients and nurses in the Accident and Emergency Department and revealed a discrepancy in the priorities of each group. Patients rated reassurance and explanation the most highly. Nurses were more concerned

with teaching preventative measures, an aspect which patients rated as of low importance. The discrepancy found in Clarke's study between nurses' and patients' priorities has important implications for practice. Nurses may have been giving patients information they did not want and failing to provide them with the reassurance which they did want.

Ley (1976) suggests that one of the reasons for poor communication is patients' diffidence about interrupting the activities of apparently busy staff. Hackett and Cassem (1971) also found that staff in a Coronary Care Unit rarely had time to go into each patient's fears fully, but point out that more patients will admit to being frightened if sufficient time is spent with them.

Wood (1979) studied communication in the Accident and Emergency Department and found that the interaction of nurses with patients was brief, predominantly task centred and concerned with the physical care the patient was receiving at the time. Nurses appeared to restrict their contact with patients to those interactions which were necessary for the patients' progress through the department. Wood used only a small sample of 20 patients with minor injuries and the type of interactions were pre-coded on a structured checklist. Although the study provides interesting data about the number and duration of communications, no explanation is given of the reasons for their limited nature. The experiences of patients with more serious conditions in the Accident and Emergency Department were also not explored.

Toohy (1984) examined the communication between nurses and parents

of children in an American Emergency Department. Using Goffman's (1959) perspective for analysing social interactions, 16 parent–nurse interactions were observed over a 4 month period. Toohey suggests that the Emergency Department may be conceived of as including frontstage and backstage areas and that one can view nurse–patient interaction as a performance that is staged in the environment of the Emergency Department. In this environment, nurses and doctors can maintain their performance roles through strategies such as information control. Successful staging of performance provides the parent with a frontstage view of the Emergency Department. Performance disruptions may occur when parents choose to become actors by creating a scene or the united front of the team is broken, resulting in unsuccessful staging of the performance and providing the parent with a backstage view of the department.

The interactions which Toohey (1984) observed were generally brief and episodic. Nurses appeared to view their role in terms of medically delegated functions and provided little supportive care. Parents were generally unclear about the role of the nurse. Most parents had brought their child to see a doctor and did not think their child required nursing care. Toohey suggests that primary nursing, where one nurse is allocated to each patient throughout their time in the department would facilitate more supportive interventions. Toohey's study concentrated on parents of children. There may be reasons why nurses interact differently with non-adult patients, such as inexperience with children, or the belief that the parents will attend to the child's needs. The interaction of nurses with adult patients requires further study.

Gibson (1977) examined the passage of patients through the Accident and Emergency Department. She found that routine procedures were used for the processing of patients and that these processes could be typified in various ways. Thus from the patient's arrival in the department, staff would be searching for certain cues which would assist them to categorise that patient according to one of their usual typifications. The sequence of events which that person then underwent would be the routine procedure for dealing with patients of that type. Having followed through a number of cases, it became possible for the researcher to predict the course of events for particular patients. Some flexibility was also evident in that how such routines were accomplished, which rules applied and what part of the processes were recorded depended on the particular circumstances of the day-to-day running of the department.

Sociological studies have examined how social factors may influence communication with and treatment of patients in the Accident and Emergency Department. Roth (1972) and Jeffery (1979) describe the attitudes of staff to deviant patients, for example drunks, overdoses and tramps. They suggest that these patients are perceived by staff as having low 'social value' and that their interaction with them is negatively affected by this. Sudnow (1967) also explored the attitudes of staff towards caring for different sorts of dying patients in various hospital departments. He, too, found that the social value attributed to a patient affected the treatment received. Sudnow reports, for example, that when a person was brought to the Accident and Emergency Department as 'dead on arrival', the likelihood of resuscitative measures being implemented, the urgency with which they were adopted and the length of time maintained was

directly related to the age, social background and perceived moral character of that patient.

Such findings, like those of Stockwell (1972) who found that nurses interacted differently with 'unpopular' patients, may be understood with reference to a Symbolic Interactionist perspective. This perspective proposes that nurses and patients are engaged in a complex process of interpreting their own and each other's actions. Nurses have expectations of patients based on their perceptions of patients and their definition of their own role and that of patients. Behaviour is also influenced by the interaction which arises between the nurses and patients. Patients are subject to evaluation by nurses and those who are deemed undesirable, who attend 'inappropriately' or behave disruptively threaten the nurses' definition of their role and create conflict. Nurses tend, therefore, to avoid such patients or behave negatively towards them.

Jeffery (1979) reports that doctors preferred patients who provided them with opportunities to practise valued skills. No research has specifically examined nurses' attitudes towards their patients in the Accident and Emergency Department. A number of studies have, however, reported that many patients attended the Accident and Emergency Department 'inappropriately', that is, with problems which were not accidents or emergencies. Thus, O'Flanagan (1976) found that two-thirds of patients attending an Accident and Emergency Department during a 6 month period could have been treated by a GP. Davison et al. (1983) reported that 39% of patients attending one such department in the East End of London were not accidents or emergencies. Cliff and Wood (1986) also

suggest that 76% of ambulant patients studied could have been treated in the community. In the light of the work of Jeffery (1979), nurses' attitudes towards 'inappropriate attenders' merit further investigation.

Conclusion

This chapter has reviewed the literature which has examined the emotion of anxiety and its incidence among hospital patients. Research which has studied nurse-patient communication has been reported and the effect on patient anxiety explored. Themes relevant to the Accident and Emergency Department and research conducted in this area have been discussed.

CHAPTER THREE

Theoretical Perspectives and Methodology

Introduction

This chapter is divided into two sections. Section One describes the characteristics of Symbolic Interactionism as a perspective and discusses its relevance to the present study with reference to examples from the research. In Section Two the impact of the Symbolic Interactionist approach on strategies of data collection and analysis is considered. The research design is described and the aims and methods of each stage discussed.

Section One Theoretical Perspectives

A Symbolic Interactionist approach, which aims to understand the social group studied from the perspective of those involved in it, was used. A central feature of this approach is the assumption that individuals 'create' their social world. The behaviour of people is not seen as determined by external factors. Rather, individuals interpret their world, make sense of it and give meaning to it, and then direct their behaviour accordingly. It is this notion of 'mindful' behaviour, of human action rather than animal

reaction (Mead, 1964), which underpins the Symbolic Interactionist approach and shapes interpretation of situations studied. Further, it leads to an explanation of changes which occur over time by analysis of the complex processes of symbolic interaction.

In the present study of the Accident and Emergency Department, the primary assumption derived from the Symbolic Interactionist perspective is that, in order to understand the situation, it is essential to understand the perspectives of the 'actors' – the patients, doctors and nurses – who are engaged, by their presence in the department, in 'creating' that social world. The Symbolic Interactionist perspective would not regard as valid any attempt to explain the behaviour of nurses, for example, without reference to *their* perceptions of their role, *their* perceptions of patients and colleagues and *their* interpretation of both their own actions and those of other participants. The influence of these factors on nurses' behaviour must be explored. Similarly, the interpretation of patients' behaviour must take account of *their* perceptions of the department and its staff and *their* experience, and expectations, of being a patient.

To illustrate further, nurse–patient interactions in the departments studied in the present research were found to be generally brief and predominantly concerned with physical care and with the patient's progress through the department. Interviews with nurses revealed that a primary concern was, as one nurse stated, 'keeping the department running smoothly'. They also expressed their sense of constantly dealing with competing demands and pressures. As another nurse described it, 'you've got to get this job done, because you know there's another waiting for you'. The perceived constant

pressure led to the nurses feeling that the more time spent with one patient, the less was available for others.

Given these concerns, it is not surprising that nurses' interaction with patients concentrated on dealing with patients' physical complaints and with facilitating their (hopefully rapid) process through the department. Patients, on the other hand, frequently spent long periods in the department with no contact with nurses or doctors. For them, the experience of being in the department was characterised by episodic interactions with a number of different members of staff. The way in which care was delivered created an impression that the nurses were always busy, as one patient said, 'rushed off their feet'. This pattern was established so that even when the department was quiet care was given in this way. Patients, therefore, made few demands upon the nurses and asked few questions, even when they were confused or uncertain about what was happening.

Closely related to the belief, held by Symbolic Interactionists, in the importance of understanding the interpretations of individuals, is their view that these interpretations vary depending on the position the individual occupies within a group or organisation. Mead (1934) suggests that individuals have different motives and perspectives from which they view the world, depending upon their particular standpoint. Blumer (1969:58) writes,

The point of view of Symbolic Interactionism is that large-scale organisation has to be seen, studied and explained in terms of the process of interpretation engaged in by the acting participants as they handle the situations at their respective positions in the organisation.

In the Accident and Emergency Department, doctors, nurses and patients would hold different positions and these would influence the way they viewed the event of the patients' stay in the department. Thus, doctors would tend to view the patients' stay from a medical perspective and focus on the investigation and treatment of the patients' illness or injury. Nurses would possibly share this view but would also perceive the patients' stay as an organisational event to be orchestrated. Patients may view their stay in terms of the wider context of their daily life. They might, therefore, be more concerned with the outcome of their stay and the longer-term consequences of their illness or injury.

A further, closely related assumption of Symbolic Interactionism is that the process of socialisation does not occur only during childhood. The theory stresses the continuing nature of socialisation throughout adult life. While recognising the unique views of participants, Symbolic Interactionism is concerned to explore how interactions with other group members may contribute to the individual's learning sets of beliefs, attitudes and behaviours which are held in common. Thus the nurse's view of the Accident and Emergency Department and the role of the nurse in it, is influenced by information received during professional training, and by further socialisation which occurs in the work setting. Nurses, therefore, both create and are influenced by a culture which defines their work and their attitudes to patients.

For example, a view strongly held by nurses was that the 'real' work of the Casualty was dealing with 'major trauma' patients, as one nurse said, 'It's what we're here for.' Most nurses found this part of their work the most

satisfying and rewarding. This held true even though the large part of their work was not concerned with such patients. Such a view of patients had become part of the culture of both departments and was passed on informally through strategies like nurses sharing narratives describing accounts of 'major trauma' patients which emphasised the role of nurses and highlighted their work.

The opposite was also found, that patients who attended the department 'inappropriately' or with very minor illnesses or injuries were often regarded as 'dross' or 'trivia', less worthy of the attention of nurses. The consistency of these reports and descriptions suggest that such views had become part of the culture of the departments and were features which would be passed on, informally, to new members of staff.

Symbolic Interaction stresses the symbolic meanings of language. The vividness and commonality of the language used – 'drunks', 'dross' and 'regulars' – suggests such attitudes had become part of the culture. That such attitudes influenced practice was revealed by the nurses' accounts of how they dealt with such patients.

For example, the nurses consistently described the way that they dealt with the 'drunks', the group they perceived as the most inappropriate attenders, as a process of 'going through the motions'. As one nurse said, 'I know its an awful thing to say but you just go through the motions with them...(because)...you can't turn them away.'

Nurses were conscious that all patients attending the Accident and

Emergency Department, once registered, have the legal right to be seen. By adopting strategies such as that of delay, they ensured that no criticism could be levelled against their work but that they were free to carry on with activities which they regarded as more rewarding and important. The nurses described how they kept putting these patients to the back of the queue because they 'knew' there was nothing wrong with them (see page 192).

Descriptions of how they ensured that less experienced medical staff also adopted this approach, revealed how the process of socialisation operated in practice. The nurses tried to ensure that these members of staff were not fooled by these patients by showing them the patient's previous admission cards.

An exception to these delay strategies and 'going through the motions' might be made if the patient was noisy or disruptive. Here nurses would then use the opposite approach of getting the patient seen quickly because, as one nurse said, 'basically the sooner you see them the sooner you can get them out really'. Thus, although the nurses had certain strategies which they followed, they interpreted them according to the particular circumstances.

A final assumption of Symbolic Interaction underlying the present study is that of negotiation. Strauss et al. (1964) emphasise that all societies are constantly organising. It is not the case that an organisation is established and then proceeds to operate in an unvarying way. Rather, it is continually being organised and reorganised, and the members are in a constant state

of negotiation. It is important to point out the term 'negotiation' is used metaphorically. People are not necessarily engaged in explicit negotiation of their relative positions. Usually they are involved in implicit, unspoken, mutual adjustment of action, attitudes and understanding. Strauss et al. propose that we think of this *as though* it were a process of negotiation and bargaining.

Strauss et al. examined the division of labour in psychiatric hospitals and found the organisation was fluid and constantly changing because:

1. Within any group there was no firm consensus as to the proper organisation of affairs. For example different schools of psychiatry held different views.
2. Between groups there was no consensus. For example doctors had different views to nurses.
3. Even the 'weak' have power. The continued smooth-running of the organisation depends on their co-operation.

The working of any society involves the interplay of such heterogeneous groups. In the Accident and Emergency Department similar conditions were found to prevail, requiring negotiation to maintain the social order.

One issue which assumed particular importance in Department A was the recording of ECGs. This was agreed to be a nursing duty if needed for the purposes of diagnosis. Doctors frequently wanted ECGs performed for other reasons. Nurses were reluctant to undertake such a responsibility on a permanent basis, arguing that it would detract from their other roles. The doctors and nurses were therefore engaged in permanent negotiations

about who should perform the procedure and in what circumstances. Sometimes these implicit, or metaphorical, negotiations would break down, demanding that further, explicit, negotiations take place and the guidelines re-established (see page 179). Negotiation was, therefore, a central feature of the social interaction occurring between medical and nursing staff in the Accident and Emergency Department.

Symbolic Interactionism, provides a valuable perspective from which to study the social interaction in the Accident and Emergency Department and how the perceptions and behaviours of nurses and other staff influence the patient's experience in the department. Using this perspective allows the complex processes by which participants understand, interpret and create their world to be explored in detail. These processes, and the concepts underlying them, have been discussed briefly in this section. Each will be discussed in detail in the subsequent chapters.

Section Two

Methodology

The aim of Symbolic Interactionist methodology has been defined by Blumer (1969) as one which develops a naturalistic approach where the researcher endeavours to see the world in the way that those he is studying perceive it, and to evolve a sympathetic and sensitive understanding of that world in order to interpret it. Blumer (1969:73) writes,

On the methodological or research side the study of action would have to be made from the position of the actor. Since action is forged by the actor out of what he perceives, interprets and judges, one would have to see the operating situation as the actor sees it, perceive objects as the actor perceives them, ascertain their meaning in terms of the meaning they have for the actor, and follow the actor's line of conduct as the actor organises it – in short, one would have to take the role of the actor and see his world from his standpoint.

The emphasis is placed strongly on the attempt to interpret and explain the reasons underlying behaviour, as opposed to the intention to discover cause and effect relationships characteristic of positivist research. For this reason, in the present study, a qualitative approach was used as the main method of data collection.

The qualitative researcher does not rigidly adhere to a predetermined research design with, as Field and Morse (1985) point out, the consequent risk of imposing prior interpretations on the phenomena studied. Rather, a flexible approach is adopted where the research is directed by the emergent themes, developing and testing propositions throughout the process of data collection and analysis in order to guide the enquiry. Such an approach is of particular value where there has been little previous research into the subject area, or where the social context being studied is unfamiliar to the researcher. Both of these conditions applied in the present study. Little previous research has examined the sources of anxiety in the Accident and Emergency Department. A flexible, qualitative approach, which takes account of the meanings of those being studied, was therefore selected as the most appropriate.

However, although the approach used in the present study was predominantly qualitative, some simple quantitative data collection and was undertaken. Following the pilot study, in which the nature of patients' anxieties was explored qualitatively within the context of their experience in the department, in Stage One a structured interview schedule was employed to examine patients' anxieties further. Having discovered common anxieties experienced by patients, using a qualitative approach, it was considered that sufficient consensus existed about their nature to justify simple quantitative measurement.

Walker (1975) provides a discussion of the merits, and difficulties, of using a combination of qualitative and quantitative methods. He concludes that certain questions simply cannot be answered by quantitative methods, while others cannot be answered by qualitative ones. He proposes that, if used judiciously, different methods can complement each other and enhance understanding. Blumer (1969:41) also sanctions use of a combination of methods. He recommends use of,

Any ethically allowable procedure that offers a likely possibility of getting a clearer picture of what is going on in an area of social life. Thus, it may involve direct observation, interviewing of people, listening to the conversations, securing life-histories, using letters and diaries, consulting public records, arranging for group discussions and making counts of an item if this appears worthwhile. There is no protocol to be followed in the use of any of these procedures; the procedure should be adopted to its circumstances and guided by judgement of its propriety and fruitfulness.

In the present study, the structured interview schedule was used to build upon the data collected by qualitative methods and provide further insight into the nature of patients' anxieties and the type of patients who were

most anxious. The schedule used was sufficiently flexible to allow the researcher to seek further information where relevant. Thus, for example, if a patient reported anxiety about the item 'Not being able to carry on your usual activities', the researcher would go on to explore in what ways the patients thought their activities would be affected.

In Stage Three, also, simple quantitative methods were used to collect data about the duration, initiator and content of topics which occurred between staff and patients. Again, this data was regarded as complementary to the qualitative data, which explored in greater depth the patients' experience of the department and their interaction with staff.

Consistent with the Symbolic Interactionist perspective the main methodological approach used in the present study was qualitative.

However, within this framework some simple quantitative analysis was been undertaken. The methods of enquiry were chosen to most effectively facilitate understanding of the issues involved. The quantitative methods are, it is proposed, complementary to the qualitative

Research Design

The research was conducted in two Accident and Emergency Departments which were within the same Health Authority but which functioned independently. Department A was located in the city centre near a large shopping complex, university and offices. Department B was situated in a residential area which was mixed in terms of cultural and social class groupings.

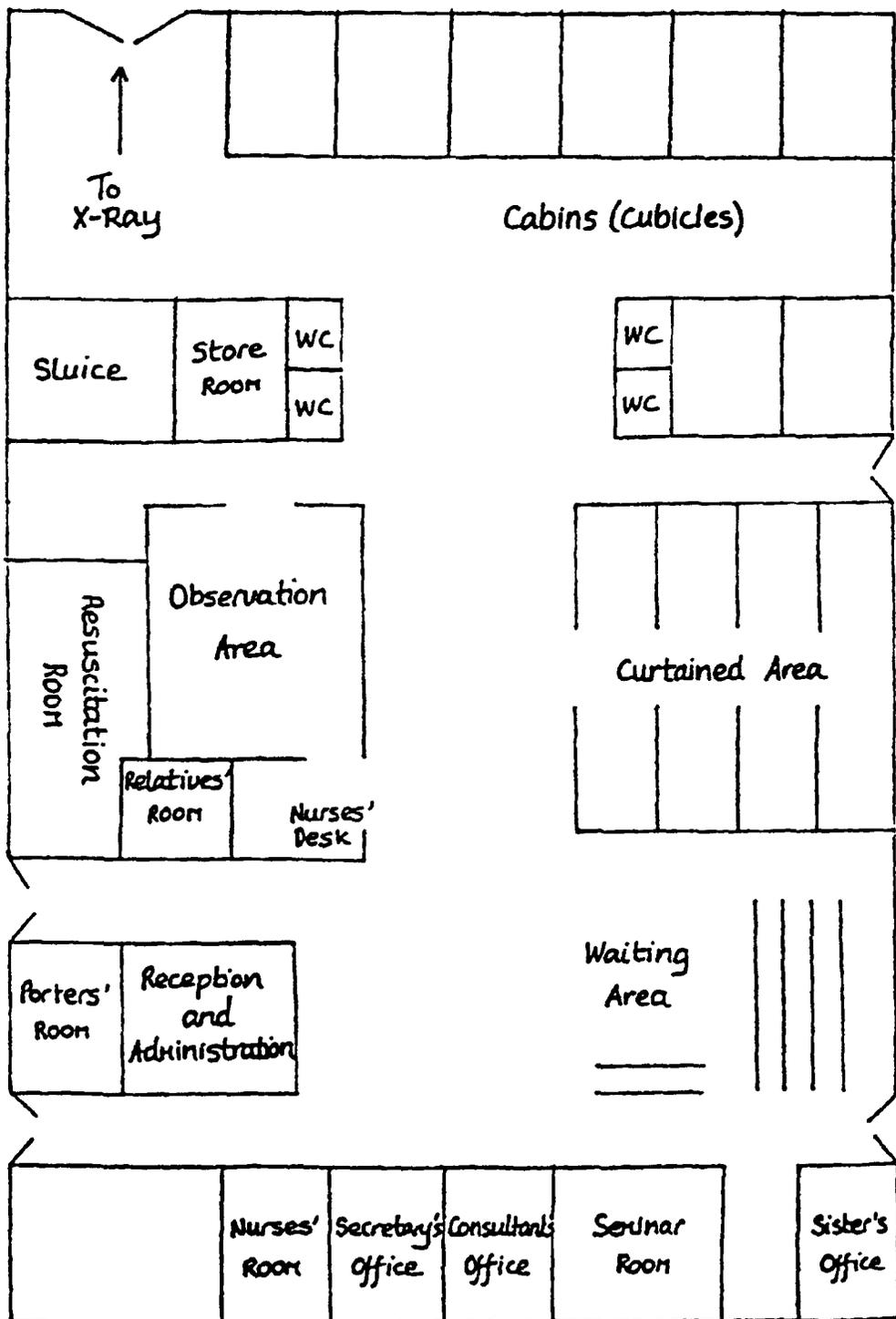
Following a pilot study, the research took place in three stages. The findings of each stage were analysed and interpreted on its completion in order to elucidate emergent themes. These were then used to direct the next stage of enquiry. A description of the two departments studied is given below followed by a brief overview of the aims and methods used in each stage. During the remainder of the chapter the aims and methods of each stage are discussed in detail.

The Departments Studied

Department A, a purpose-built Accident and Emergency Department, was divided geographically into three distinct areas (see Figure 1). 'Minor' patients, those with simple, non-urgent illnesses or injuries, were seen in the curtained area. 'Major' patients, who complained of more serious conditions or trauma, were seen in the cabins. Patients with very serious or life-threatening conditions, such as road traffic accident victims or those with urgent coronary or respiratory complaints were seen in the resuscitation room.

Nursing staff, at the start of their shift, would be allocated to one of these areas and would remain there for the span of their duty. This system allowed nurses to assume responsibility for all patients passing through the area to which they were allocated. Management of patient care was therefore devolved and the nurse in charge was concerned primarily with the overall running of the department.

Figure 1: Layout of Department A



Department B was an older department with cubicles ranged along one side of a long corridor (see Figure 2). The layout had certain drawbacks for patient care. In particular, only 2 rooms were readily visible from outside the office, where the nurses tended to congregate. For this reason ill patients were frequently left in the corridor prior to and following examination by the doctor, to allow easy observation. Lack of space also led to the use of the resuscitation room for non-urgent patients.

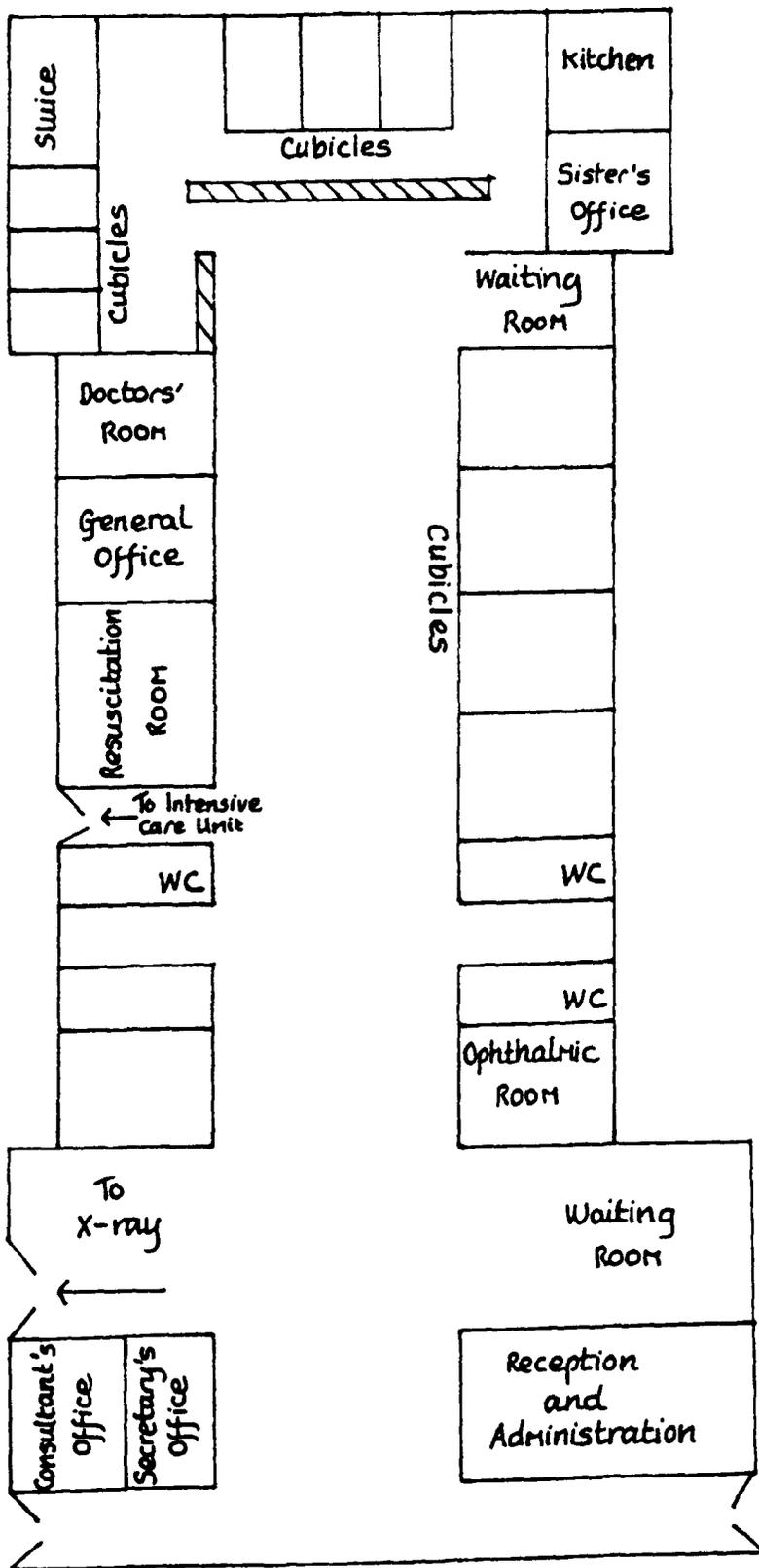
Nurses in Department B were not allocated to a particular area but tended to perform any necessary duties as they arose. The nurse in charge retained overall control and gave specific instructions throughout the day.

Although it would seem probable that the patient in Department A would receive greater continuity of care, no real differences were apparent during the observation. The potential for continuity was limited by the small number of nurses in each area and the way those nurses tended to operate as a team, rather than care for individual patients. Thus, the patient was likely to be seen by a similar number of nurses in each department.

A search of the records showed that similar numbers of patients used each department. The figures for 1989 show that an average of 124 patients were seen daily in Department A and 131 in Department B. However, Department B received more 'major' patients with serious or potentially serious conditions than Department A (an average of 44 compared to 26 each day).

Department B also usually had lower staffing levels than Department A. In

Figure 1: Layout of Department B



Department B there were typically 3 qualified nurses on duty per shift and 1 or 2 students. Department A usually had 4 qualified nurses on duty per shift and 1 or 2 students. The figures suggest, therefore, that the nurses in Department B were coping with a greater workload than those in Department A. In Department A, however, the geography meant that a minimum of 4 qualified nurses were needed on each shift to staff the separate areas.

Pilot Study

Aims

The aim of the pilot study was to identify the sources of anxiety for patients in the departments studied and to explore how their experience was influenced by the medical and nursing care received.

Method

Twelve patients were followed throughout their time in the department, their experiences observed and their reactions to events elicited by informal interview. The observations and informal interviews were recorded on a data collection sheet under a number of broad headings (see Appendix 1).

Stage One: The Patient Interviews

Aims

The aims of Stage One were,

1. To identify the sources of anxiety for patients in the Accident and Emergency Department.
2. To examine the relationship between anxiety and the patient variables of age, sex, condition and department.

Method

A structured interview schedule was used which listed events which might happen to patients during their time in the department and asked them to state the degree of anxiety associated with each, according to a rating card (see Appendices 2 and 3). The structured interviews were carried out with a sample of 96 patients, 48 in each department.

Stage Two: The Nurse Interviews

Aims

The interviews with patients had revealed that a large number were anxious about some aspect of being in the Accident and Emergency Department. The aim of Stage Two was to explore nurses' attitudes towards their work and patients, perceptions of their role in identifying and dealing with patient anxiety and to identify factors which influenced their practice.

Method

In-depth interviews were carried out with all qualified nurses in each department at the time of study (13 in Department A and 8 in Department B).

Stage Three: The Observational Study

Aims

An observational study was carried out in order to build on the patient and nurse interviews and clarify some of the issues raised. The aims of the observation were therefore to:

1. Examine the patterns of communication between nurses and patients.

2. Identify any factors such as age, sex or seriousness of condition which may affect the interaction between nurses and patients.
3. Assess how effectively nurses identified and dealt with patient's anxieties in the department.

Method

A period of 1 week in each department was spent in carrying out the observation. Ten patients were observed throughout their time in Department A, and 13 patients in Department B.

Before discussing these stages in more detail, the process of gaining access to the research sites must be explained.

Gaining Access

At the time of commencement of the study, and throughout the period of data collection, the researcher was employed by the Health Authority on a Research Studentship Scheme. Under the terms of the Scheme the researcher worked for 3¹/₂ days per week as a staff nurse in a separate clinical area within one of the hospitals. The status of colleague who was undertaking a course of study was a useful one in negotiating access. Nevertheless, the process was not unproblematic and several points deserve discussion. Formal approaches were made in the form of letters to the consultants, senior nurses and sisters responsible for the departments. These were followed by arranged meetings where the purpose of the research was explained in more detail and queries answered.

The main difficulty encountered was the reluctance by the consultant in Department A to give consent to the study. During the first meeting with him a number of reasons for withholding permission were given. The first was that as none of his patients were anxious and all were satisfied with the care received, there was nothing to be gained by the study. Secondly, the original research plan included taped interviews with patients in the departments. The consultant argued that patients had the right to request the tape to be replayed. Should they exercise this right it would destroy confidentiality and cause a nuisance to other staff and patients. Finally, he maintained that none of the patients would agree to participate. He claimed that although a few patients waiting for transport might consent to being interviewed, others would not. The final criticism was prompted by the interruption by the registrar who sought advice about setting a fractured wrist. According to the consultant, research which examined possible alternative treatments for such injuries was useful whereas the study currently proposed was not.

His refusal seemed a major block to the planned research. A number of alternative options were considered, in particular, using only one department for data collection, or trying to negotiate access to a second department in another Health Authority. Negotiations through senior nursing staff, however, led to consent being given. Intermediaries indicated that the Consultant had regarded the researcher as a potential 'spy' for hospital administration. Once these fears were allayed, no further objections were made. The only condition attached was that no tape-recorder would be used in the department. With hindsight, such a tool might have proved clumsy and intrusive within the setting. The use of

observation and informal interviews, recorded on a data collection sheet, was an acceptable alternative.

The reception by the consultant in Department B was very different. He raised no objections to the study but felt that patients might feel intimidated by use of a tape-recorder. He questioned, too, the qualitative approach proposed, emphasising that the District Ethical Committee would require exact details of the research design to be presented. His attitude towards the researcher reflected, perhaps, his view of me as an interested but harmless observer, not to be taken too seriously. A foretaste of this was received prior to the meeting with him when the sister commented, 'You're an attractive young woman, I'm sure Mr _____ won't mind you doing research in his department.'

Certainly, early fieldnotes record discomfort with his friendly but occasionally patronising manner, manifested by his jocular demands to be told what had been 'found out'. The role of 'socially acceptable incompetent' (Hammersley and Atkinson, 1983), although uncomfortable at times, is a very useful one to adopt, at least at the beginning of a study, as it allows help to be sought and questions to be asked with minimum difficulty. Easterday et al. (1977) examine the adoption of role with reference to the gender of the researcher and explore the implications of being a female researcher in an environment dominated by males. Although the nursing staff in the Accident and Emergency Department were predominantly female, the medical staff were mostly male, as were both consultants. As Hammersley and Atkinson (1977:85), in their discussion of Easterday's work, comment,

In some circumstances it may be easier for females to present themselves as socially acceptable incompetents, in many ways the most favourable role for a participant observer to adopt in the early stages of fieldwork.

In the first part of the research adoption of this role proved useful.

Certainly the consultant in Department B went to some trouble to show the researcher the department, include her in activities and allow access to records.

The nursing staff in both departments expressed interest in the study and consented to participate. After agreement in principle had been given, a meeting was arranged in each department to explain the purpose of the study and to describe the intended methods of data collection. Here the role as a staff nurse from another department who was undertaking a course, was fundamental in gaining acceptance as it established the researcher from the start as a colleague and co-professional, rather than as a senior nurse, administrator or outside 'expert'.

A brief overview has been given of the aims and methods of each stage of the research and the process of gaining access has been described. In the remainder of the chapter the aims and methods of each of the stages of the research are discussed in greater detail.

Pilot Study

Aims

The aim of the pilot study was to identify sources of anxiety for patients in the Accident and Emergency Department and to explore how patients'

perceptions of the department were influenced by the medical and nursing care received.

Method

An exploratory study was carried out to allow the researcher to observe what happened to patients in the Accident and Emergency Department and to discover patients' responses to their experiences. A relatively unstructured approach was used at the start of the study to allow exploration of all aspects of interest and to obtain patients' views with a minimum of constraints placed upon them.

At this point the researcher had no clear conception of the factors which were likely to be sources of anxiety for patients. It was important therefore to avoid misconceiving the issues involved and to ground the research firmly on the actual experiences of real patients. Because the research aims at this time were broad, a strategy of participant observation was employed to allow the issues to be explored in a flexible and open-minded way. The researcher approached patients as soon as they arrived in the department and explained that she was carrying out a study looking at what happens to patients in the Accident and Emergency Department. She requested to remain with them during their time in the department, observe what happened and ask how they felt about the various events. In order to provide a simple framework for observing and recording events, a data collection sheet, which contained a number of broad headings was employed (see Appendix 1). Observations of events which happened to patients during their time in the department were recorded on the data collection sheet. The patient's response to those events was elicited by

informal interview. This, and other points relevant to the the study, including interactions which occurred between staff and patients, were also recorded on the data collection sheet. The completed document, therefore, formed the fieldnotes of the pilot study. A diary was also maintained throughout the study in which contextual and interpersonal issues were recorded and theoretical points explored.

The researcher also spent time during the pilot study observing staff and having informal conversations with them in order to gain understanding of how the department was organised, how the nurses allocated their work and how they perceived their relations with patients and with medical staff,

Sampling

Time: During the pilot study 1 day was spent in each department every alternate week for a period of 8 weeks. Both departments were studied concurrently to avoid the possible bias of researcher experience influencing data collection and to minimise the risk that temporary circumstances would distort the findings.

Three starting times were used alternately. These were 9 a.m., 11 a.m. and 1 p.m.. No observation took place at night as the conditions were judged to be sufficiently different as to merit separate study – a task beyond the scope of this research.

Time was also sampled within each patient observation. The original intention was to remain with patients throughout their time in the department, observe events which occurred and elicit their responses.

However, in practice it was immediately obvious that this would significantly alter the patient's experience of the department. Patients frequently spent long periods alone and waiting. The presence of the researcher at this time would provide company and conversation which would not otherwise have been available.

To reduce the observer effect, therefore, a strategy was adopted where the researcher was present during, and immediately after, important points of the patient's stay in the department, including admission, examination by doctor, nursing interventions and discharge and, if the patient attended X-ray, accompanying them there. Otherwise the researcher remained in close proximity to the patient, for example in the area outside the cubicle, and returned to the patient when any event occurred. The time not spent with patients was spent observing other events which were taking place in the department.

Patients: Seven patients were observed in Department A and 5 in Department B. They varied in terms of age, sex and condition. The observation and informal interviews with these patients formed a set of case studies which provide preliminary data used to identify possible areas of interest and significant issues. In order to avoid selection bias, a strategy was employed where, following completion of one observation, the next patient admitted would be approached and asked to take part in the study. The casualty officer was asked to inform the researcher if he thought any patient too ill to be included in the study but this never occurred.

Consent

It was explained to patients that the researcher was interested in what happened to patients in the Accident and Emergency Department and how they felt about the events which occurred. They were asked for permission for the researcher to remain with them during their time in the department and to ask them questions about those events. Only one person refused to participate because she felt 'too ill'.

Permission had been gained from the medical and nursing staff in each department to observe their interaction with patients. Permission was sought from any other medical staff who attended the patient as the need arose. No problems arose in gaining consent from staff.

Data Collection

During the observational period the researcher remained with the patient at any time that a member of staff was attending to them, and observed and recorded, in written form, the events which took place on the data collection sheet. The completed document therefore contained, under several broad headings, a description of the events, conversations and communications which took place between staff and patients, conversations between patients and relatives and the patients' responses to questions raised by the researcher.

For example, the data collection sheet for one patient observed records background information such as the patient's age and condition. The qualitative data recorded include the history of events occurring during the patient's stay in the department. In this case, because the patient

complained of chest pain he was taken into the resuscitation room where the nurse performed an ECG. It records her explanation of this procedure, which was detailed, and that she 'bleeped' the doctor to request him to come and examine the patient. Also recorded is the doctor's annoyance with the nurse for calling him unnecessarily (he did not think the patient was sufficiently ill to warrant urgent attention), his hurried examination of the patient, his cursory explanation that there was, 'nothing seriously wrong, just a couple of missed beats on your ECG', and subsequent departure. That the nurse did not explore further with the patient his understanding of this explanation is also noted, and the patient's comment to the researcher that he, 'couldn't understand what he (the doctor) was talking about'.

The patient was then transferred to the cabins (where 'major' patients in Department A are seen) where the conversation between the patient and his relatives revealed their (false) belief that they were now in the 'cardiac part' of the department. Also recorded is that the 'phones in the department were not working so it was impossible for the wife to contact relatives.

The data collection sheet was, therefore, a useful tool on which to record, qualitatively, all aspects of the patients' stay in the department and to generate points for further enquiry. The researcher was able to explore issues which arose further in subsequent observations and, in the nurse interviews, to explore possible influencing factors.

Field Relations

Presentation of self when conducting observational research is fundamental to the success of the enterprise. The researcher who uses a strategy of participant observation as a means of obtaining data from and about people in their natural settings must select the role which will maximise opportunities for gaining understanding and insight. Pearsall (1965) suggests a continuum of (1) complete observer, (2) observer-as-participant, (3) participant-as-observer and (4) complete participant. The role of observer-as-participant was that selected as most appropriate for the present study. The observer-as-participant has negotiated access to the area of study in order to carry out observation, but by their presence in the field they participate in the social group they study and may also join in some activities.

Thus, in the Accident and Emergency Department, the researcher was clear that her purpose was to observe but joined in conversations which arose and in doing so was also a participant in the social group. As the staff knew the researcher was a nurse, they would sometimes request assistance with simple tasks, such as moving a patient on a trolley, which was always given. In order to maximise the opportunities for observing and understanding the department, it was important to establish good relationships with all staff members. The researcher's role of colleague from another department, and her relatively junior status, facilitated this.

In order to minimise the self-consciousness that people might feel on being observed, in her explanation to staff the researcher emphasised her interest in patients and their experience of the department, rather than in staff and

how they were carrying out their duties. Some self-consciousness was evident at first, made clear in jokey comments such as, 'Geraldine's observing us all' and, 'Are you writing down everything we do wrong'.

As Pearsall (1965) points out, however, one of the assumptions of participant observation is that people cannot for long maintain a special kind of behaviour for the benefit of a stranger. Once used to their presence, they lapse again into usual routines. In the Accident and Emergency Department, this principle appeared to hold true. The department was frequently busy and people inevitably had to concentrate on the demands of their work, the presence of an observer becoming a secondary concern. A further factor which Strong (1979) describes, is that in most medical settings the presence of an observer is not unusual to either staff or patients as there is a constant mix of new and different people and group members become accustomed to a fluctuating presence of strangers.

In participant observation the 'management of marginality' (Hammersley and Atkinson, 1977) is crucial. The 'management of marginality' refers to the necessity for the researcher to maintain a role which is sufficiently that of an outsider to allow objectivity, yet sufficiently that of an insider to allow insight and understanding. In addition to the problems of lack of acceptance, the researcher must guard against the risks of over acceptance and 'going native' which may prevent him from maintaining the necessary degree of objectivity. In the present study the threat was small as periods spent in the department at any one time were not prolonged.

With patients, rather than presenting herself as a nurse, the researcher chose to emphasise her role as research student from the Polytechnic during the exploratory study. The intention behind adopting such a role was to encourage them to perceive the researcher as a detached observer. To adopt the role of nurse may have meant that patients would be reluctant to be critical of any part of their care for fear of causing offence. For this reason smart casual clothing was worn, rather than a uniform or white coat, for this part of the study.

Data Analysis

Each data collection sheet was analysed at the end of the day and possible important issues and areas of interest identified. These were then compared with the analysis of the subsequent observation and informal interviews to establish general categories which would form the basis for further study. As this part of the study was exploratory the categories were regarded as provisional. Four broad areas were identified:

1. Strategies by which staff define and maintain the role of patient and patient compliance with their role.
2. The nature of patient anxieties.
3. The nature of staff-patient interaction.
4. Staff perceptions of patients and their influence on the delivery of care.

Each of these categories was later expanded as a result of further study and further categories developed. For example, even at an early stage it was evident that interaction between staff and patients in the departments was generally brief, and that while explanations of specific procedures were often detailed, wider explanations and supportive interventions were

minimal. Patients, however, frequently expressed concern with the probable sequence of events and expressed the desire to know what would happen to them. The subsequent stages of the research, therefore, explored this area of potential conflict by seeking to establish, quantitatively, the sources of anxiety for patients and to explore, qualitatively, how nurses' perceptions of their role and patients influenced them in identifying and dealing with patients' anxieties.

Stage One: The Patient Interviews

Aims

The informal interviews and observation conducted during the pilot study had suggested that for some patients lack of information and lack of control were sources of anxiety. Other factors identified were pain, the possibility of admission or having to have an operation. However, the number of patients observed was small and the relationship of anxiety to factors such as age, sex, condition and department was unclear. In order to examine patient anxiety in more detail it was decided to carry out structured interviews with a larger sample of patients. The aims of Stage One were, therefore, to:

1. Identify sources of anxiety for patients in the Accident and Emergency Department.
2. Examine the relationship of anxiety to the patient variables of age, sex, seriousness of condition and department.

Method

Sampling

Structured interviews were carried out with a sample of 96 patients, 48 in each department. The factor of seriousness of condition and those of age, sex and department were identified as possible significant variables. A convenience sample with a minimum of 5 patients in each combination of these categories was selected. For sampling purposes patients were classified into two categories on each factor. Thus, the factor seriousness of condition was divided into two groups – ‘minor’ and ‘major’ patients. ‘Minor’ patients referred to those who entered the department with simple, non-urgent illnesses and injuries. ‘Major’ patients referred to those who complained of more serious conditions or trauma and who had to undress for medical examination. In Department A these groups were seen in separate areas, ‘minor’ patients in the curtained area and ‘major’ patients in the cabins. As all ‘major’ patients had to undress for examination by the doctor, this was used as the criteria for inclusion in this group in Department B. The factor of age was divided into ‘young’ and ‘older’ patients. ‘Young’ patients referred to those who were aged under 40. ‘Older’ patients referred to those who were 40 years or more. The two departments studied were referred to as Department A and Department B.

Selection bias was avoided by ensuring that each respondent included in the study was the next patient to enter the department following completion of the previous interview. For the purpose of chi-squared analysis, it was necessary to have a minimum of 5 patients in each combination of categories. Sampling continued, therefore, until this had

been achieved. Table 1 shows the number of patients in each of the categories.

Table 1: Number of Patients Interviewed in Each Category During Stage One

Department A

Male, Older, Major = 5	Female, Older, Major = 5
Male, Young, Major = 5	Female, Young, Major = 7
Male, Older, Minor = 5	Female, Older, Minor = 5
Male, Young, Minor = 10	Female, Young, Minor = 6
Total = 25	Total = 23

Department B

Male, Older, Major = 5	Female, Older, Major = 12
Male, Young, Major = 5	Female, Young, Major = 5
Male, Older, Minor = 5	Female, Older, Minor = 5
Male, Young, Minor = 6	Female, Young, Minor = 5
Total = 21	Total = 27

Number of Patients Interviewed = 96

'Older' = Patients aged 40 or over.

'Young' = Patients aged under 40.

This part of the study required the patient to respond to a structured list of questions. For ethical reasons, therefore, no critically ill patients who needed to be treated in the resuscitation room were included in the study.

Consent

It was explained to patients that the researcher was carrying out a study looking at sources of anxiety for patients in Casualty. Their verbal consent was obtained before commencement of the interview. No patient refused to participate.

Data Collection

The structured interview schedule (see Appendix 2) used in **Stage One** was adapted from that used by Danis (1984), an American researcher. Prior to piloting, some changes were made in the schedule to make it more appropriate to a British Accident and Emergency Department. Questions relating to payment for health care, for example, were excluded and some changes of wording made (see page 112).

The revised schedule was piloted on a sample of 8 patients in each department. One of the main problems which emerged during the pilot study was that in Danis' research, patients were asked to state the degree of anxiety associated with each event even when the chance of it occurring was remote. This proved confusing for patients and made the result difficult to analyse. Patients were therefore asked to indicate if they thought an item did not apply. Two items were also excluded which no patient expressed anxiety about either during the main pilot study of the research or during the pilot of the structured interview schedule. These were 'The possibility that the doctor may make a mistake' and 'Being told what is wrong with you'.

Once these small changes had been made to the instrument data collection

could proceed. Patients were interviewed at the beginning of their time in the department. The questions were read out to the patients by the researcher. The first question asked patients if they were anxious about being in Casualty. If they said 'yes' they were asked what they were anxious about. Many patients responded negatively to this open-ended question. In all cases, after recording their response, the researcher went on,

Sometimes it's hard to identify worries, so I'd like to ask you about some common causes of worry in people who come to Casualty. Some of these questions may seem to apply to you, others may not. When I ask you about them I would like you to tell me whether you feel any worries or anxiety according to this card.

The researcher then handed the patient the rating card (see Appendix 3).

Role of the Researcher

The structured interview schedule was administered by the researcher as a standardised procedure. The researcher introduced herself as a nurse researcher and a white coat was worn during periods of data collection. Patients were approached at the beginning of their time in the department and their consent sought. The schedule represents therefore a 'snapshot' picture of patients' anxiety at an early point of their time in the department. Once the schedule was completed the researcher thanked the patient for participating and withdrew. The next patient to enter the department was then approached and asked to participate.

Data Analysis

Frequency counts were used to identify the items most closely related to patient anxiety. Scores were rank ordered to see which events were most

frequently rated as sources of anxiety by patients and which most frequently rated as sources of moderate or extreme anxiety.

Chi-squared analysis was used to assess the effect of each of the variables of age, sex, severity and department. Because of the small numbers involved, groups were compressed so that larger numbers would be obtained in each of the categories of anxiety. Those who had replied that an item was not applicable were excluded and the remainder of responses divided between those who had expressed no anxiety and those who had expressed slight, moderate or extreme anxiety.

The results of the patient interviews are reported in detail in Chapter Five. The main finding was that more anxiety was expressed by patients who were female, younger and who had more serious conditions. Multiple analysis with control of each variable demonstrated that all result appeared independently of the others. No significant differences were found between the two departments studied.

Stage Two: The Nurse Interviews

Aims

The interviews with patients revealed that a large number of patients were anxious about some aspect of being in the Accident and Emergency Department. The findings are discussed in detail in Chapter Five but the most common fears were related to not knowing what was going to happen to them in the department, being unable to control this, and how their illness/injury would affect their usual activities and work. The quality of

nurse–patient communication and the type of information given were therefore identified as important factors to be considered.

An interactionist perspective assumes that all human conduct is derived from individual's interpretations of their environment and occurs within a social context. Interviews with qualified nurses in each department were, therefore, conducted to explore the attitudes they held towards their work and patients, perceptions of their role in identifying and dealing with patients' anxieties and the factors which influenced their practice.

Method

Sampling

All qualified nurses working in each department (apart from those working permanent night duty) were interviewed. The total numbers were 13 in Department A and 8 in Department B.

Consent

At the beginning of this part of the study a meeting with nurses in each department was arranged to explain the purpose of the interviews and to elicit their co-operation. It was explained that, having examined the patients' perceptions of the department and the sources of anxiety for them, the researcher wanted to explore nurses' perceptions of their work and patients. In this way a more comprehensive view could be obtained. The difficulties of gaining the time and attention of nurses during the observational period were mentioned, and the value of an in-depth approach explained.

The nurses were assured that although the interviews would be tape-recorded, all information would be treated as confidential and no record would be made of the nurse's name. All of the nurses agreed to participate.

Data Collection

Because the interviews were likely to be relatively lengthy, the importance of recording them at a time and place that was convenient for the nurses was recognised. In both departments the sister's office was selected as a suitable location. This provided a room which was quiet, private and predominantly free of interruptions. The time of interviews was negotiated. In Department A the nurses felt the most convenient time was at the start of the morning shift, before the department became busy. In Department B the most convenient time was in the afternoon when two groups of nurses were on duty. An appointment was made in advance with the nurses who were to be interviewed on each day.

At the beginning of each interview it was again explained to each nurse that, having carried out interviews with patients looking at the sources of anxiety for them in the department, the researcher was interested in how nurses identify and deal with patients' anxiety in the department. It was emphasised that the researcher was also interested in their experiences of working in the Accident and Emergency Department, what it was like being a nurse in Casualty.

It was explained that although there was a list of topics which the researcher wanted to cover, these were not rigid and she would like them to feel able to raise other issues which they thought relevant. They were

reminded that the interview would be treated as confidential and that no record would be made of their name. In order to start the interview in a way that was comfortable and non-threatening, a typical opening statement, after the introductory preamble, would be,

With the other nurses I've interviewed, I've started off just talking generally first of all, till we've felt a bit more comfortable with the tape-recorder on, so perhaps I could begin by asking you how long you've worked in Casualty for?

The strategy of starting with a general introduction about how long the nurse had worked in the department and other factual questions about where she had worked before and what her reaction had been on coming to work here provided useful background information. It also proved a natural opening into more interesting topics such as what aspects of working in Casualty he or she found most interesting and why.

For example, nurses frequently said the aspects they liked best about their work was its 'variety', 'excitement' and that 'you never know what will happen next'. They compared this to working in other areas which they described as 'boring' and 'the same routine every day'. It was clear that a part of their work which they valued highly was this interesting, dynamic and exciting element. When their experience of the extent to which the actual work in the Accident and Emergency Department fulfilled these demands was explored, it was clear that a large proportion of their work did not meet these criteria. Following this thread further, it emerged that their perceptions of patients were influenced by the degree to which they met these standards. So, for example, patients who attended with minor

injuries or who attended inappropriately were often described as 'trivia' or 'dross'. The more interesting or dramatic cases were perceived as providing the 'real' work.

The interviews progressed in the form of a 'conversation with a purpose' (Cannell and Kahn 1968). The researcher had a list of topics to be covered, but these were not covered in any pre-arranged order and points which the respondents raised were explored to develop insight and understanding. This approach allowed the interview to proceed in a way which was natural and spontaneous. Any self-consciousness which was felt by the nurses because of the tape-recorder was soon dispelled and they talked in a way which seemed, almost surprisingly, honest about their work, their attitudes to patients, the difficulties they faced in carrying out their duties and the strategies they used to cope.

Each interview lasted between 40 minutes and 1 hour. On concluding the interview the researcher thanked them for participating and usually spent a few more minutes talking to them informally about themselves, herself, the research and current issues in the department or hospital. In this way, it was hoped, the nurse would leave feeling relaxed about the experience. The personal communication also further improved relations between the researcher and the nurses in the department and was useful in gaining permission for, and co-operation in, the final stage of observation in the department. The interviews had provided the nurses with the opportunity to 'have their say' about the department, and ensured that their views and perspective were taken into account.

Data Analysis

Interview transcripts were analysed using the constant comparative method (Chenitz and Swanson, 1986) and significant themes pursued as they emerged. The list of topics in the early interviews was fairly short. They were divided into four sections. The first part of the interview was concerned with collecting simple factual information such as how long the nurse had worked in Casualty, what he/she had done before, what aspects of their work they found most rewarding and which least. The interview then progressed to explore how they saw the role of the nurse in Casualty, particularly with regard to identifying and dealing with patients' anxieties. Some time was then spent discussing care of relatives, and, finally, organisational, professional and interprofessional issues were raised.

Tapes were transcribed and the contents analysed and recorded as memos. These memos then provided areas which could be explored further in subsequent interviews, which were then transcribed and analysed in the same way. As the data collection continued categories were developed which reflected the themes which were emerging.

Thus, quotations from the nurses formed the raw data. Observational notes recorded contextual and interpersonal effects such as whether the nurse had initiated the comment or whether it was a response to a question, how it was said, whether it was explored further and with what result.

Theoretical notes asked what was meant by the statement, what did it add to the understanding of the situation and how did it relate to other statements made by this nurse or other nurses?

The statements, with their observational and theoretical notes (memos), were stored in a file, according to the theme to which they were assigned. The 22 themes which were generated covered a wide range of issues which emerged as important in the research. For example, the theme 'Legitimate and Illegitimate Demands' defines how nurses perceive their patients and what characteristics the patient must display in order to have his or her demands recognised as legitimate (often related to severity of condition). It also demonstrates the characteristics which would lead patients' demands to be classed as illegitimate and how the nurses' categorisation of patients in this way affected the way in which they described the care given. As this theme developed it became clear that it applied not only to the nurses' perceptions of and behaviour towards patients, but affected their interaction with relatives too. For example, if a patient was perceived as being seriously ill, their relative was given extra attention 'whether they're anxious or not'. Sometimes memos were found to belong to more than one theme. In such instances the memo would be assigned to each relevant theme and cross-referenced to facilitate further analysis and comparison.

The twenty-two themes initially identified were compared and contrasted until links between the concepts were clarified. Five core categories were eventually established. These were, 'Defining the Role of the Accident and Emergency Department Nurse', 'Nurses' Priorities and Patients' Anxieties', 'Keeping the Department Running Smoothly', 'Legitimate and Illegitimate Demands' and 'Exercising Control in the Department'.

Stage Three: The Observational Study

Aims

Stage Three was an observational study. The purpose was to build on the patient and nurse interview data and clarify some of the issues raised. The aims of the observational study were, therefore, to:

1. Examine the patterns of communication between nurses and patients.
2. Identify any factors such as age, sex or seriousness of condition which may affect the interaction between nurses and patients.
3. Assess how effectively nurses identified and dealt with patients' anxieties in the department.

Method

Sampling

A period of 1 week in each department was spent in carrying out the observation. A total of 10 patients were observed throughout their time in Department A and 13 patients in Department B. Observation periods were varied to cover the department at different times of day. Three starting times of 9 a.m., 11 a.m. and 1 p.m. were used alternately.

As in Stage One, the strategy for patient sampling avoided selection bias by ensuring that each patient included in the study was the next patient to enter the department following completion of the previous observation.

Theoretically, any patient being admitted to either of the departments could have been included in the study. In fact, not all categories of patients were observed but a sufficient range was covered to allow qualitative

interpretation of data. The main shortcoming of the sampling strategy was that only 2 patients in the 'young major' category were included. This was a result of the tendency for patients with more serious problems to be older, but made interpretation of the observational finding related to this group difficult. 'Young major' patients were a relatively unusual category. In Stage One the data collection period had been extended to include a minimum of 5 patients in each group. Restrictions of time prevented this strategy from being employed in Stage Three. Again, no patients who were critically ill and needed to be cared for in the resuscitation room were included in the study. The breakdown of types of patients observed is shown in Table 2.

Consent

Prior to commencing the observational study, meetings were arranged with the medical and nursing staff in each department to explain the purpose of the study. Consent was obtained from both medical and nursing staff in Department B for the observation to take place. In Department A the consultant would not give permission for the researcher to be present during medical examination of patients. In this department therefore the length of interactions between doctors and patients was recorded but the number and type of the topics covered was not known. In Department B the majority of interactions between doctors and patients consisted, after the doctor had introduced himself, of a single topic, the patient's illness/injury. For the purposes of analysis, therefore, interactions occurring between doctors and patients in Department B were coded as an illness/injury topic.

It was explained to patients that research was being done into what happens to patients in Casualty and they were asked to sign a written consent form (see Appendix 4). No patient refused to be included in the study.

Table 2: Number of Patients Observed in Each Category During Stage Three

Department A

Male, Older, Major = 2	Female, Older, Major = 2
Male, Young, Major = 0	Female, Young, Major = 1
Male, Older, Minor = 0	Female, Older, Minor = 1
Male, Young, Minor = 2	Female, Young, Minor = 2
Total = 4	Total = 6

Department B

Male, Older, Major = 2	Female, Older, Major = 1
Male, Young, Major = 0	Female, Young, Major = 1
Male, Older, Minor = 1	Female, Older, Minor = 5
Male, Young, Minor = 3	Female, Young, Minor = 0
Total = 6	Total = 7

Number of Patients observed = 23

'Older' = Patients aged 40 or over.

'Young' = Patients aged under 40.

Data Collection

A strategy of observation was used in which individual patients were followed through the department and topics occurring between them and staff classified according to a coding sheet (see Appendix 5).

An interaction was defined as a period of time in which a patient and a member of staff were together. A topic was defined as a communication which occurred between a member of staff and a patient or their relative about a particular subject. Topics were timed to the nearest minute. Qualitative data was also collected about the nature and quality of the interaction. This, too, was recorded on the observational schedule at the time of observation.

The observational schedule was piloted on 2 patients in each department. No major problems were identified. The only alteration which was made was to allow more space for recording of qualitative data. The observational schedule used in Stage Three is shown in Appendix 6.

Role of the Researcher

For this part of the study it was explained to patients that the nurse-researcher was looking at what happens to patients during their time in the Accident and Emergency Department. They were asked permission for her to stay with them during their time in the department and her role as an observer was stressed. In the observational part of Stage One the researcher had sought to elicit the views of patients about each aspect of being in the department. The role adopted in Stage Three was qualitatively different, with only minimal interaction taking place between the researcher

and the patient or relatives. The researcher would remain with them during their time in the department and record events which occurred, without explicitly seeking the patient's interpretation of events.

Conversations between patients and relatives were noted if they related to the patients experience of the department, and direct comments *made to* the researcher were responded to. Sometimes patients would ask the researcher what would happen next. In this case the researcher *explained* that she did not work in the department, and was therefore not familiar with the procedures.

As in Stage One, the possible reactive effect of the researcher was a potential source of bias. The researcher attempted to reduce reactivity by locating herself unobtrusively in the corner of the cubicle during observation. Again this was facilitated by the increasing familiarity of the medical and nursing staff to the presence of the researcher. Also, as Becker (1969: 43) emphasised, the daily business of life and work has to continue, which is perhaps the observer's greatest asset,

The people the fieldworker observes are ordinarily constrained to act as they would have in his absence by the very social constraints whose effects interest him; he therefore has little chance, compared to the practitioners of other methods, to influence what they do, for more potent forces are operating.

In the Accident and Emergency Department, the constant demands of work minimised the risk that the presence of a, now familiar, researcher, would significantly affect the behaviour of staff. With respect to patients,

their experience of the department was, in any case, characterised by the presence of a large number of unfamiliar personnel.

Data Analysis

The observational study was analysed both quantitatively and qualitatively.

Quantitative analysis was used to examine the frequency, duration and initiator of topics in relation to the variables of age, sex and seriousness of condition to discover meaningful relationships which existed between them. No statistical analysis was carried out due to the small sample size and non-independence of observations.

Qualitative analysis was then used to examine the issues which emerged in more depth. The qualitative analysis considers the patient's progress through the department in relation to three phases: assessment, process through the department and discharge. These cannot be seen as entirely discrete categories. Comparative analysis of each of the observational schedules was again used to establish themes and examine issues which emerged.

Ethical Issues

Approval for the research was gained from the District Ethics Committee and the Nursing Research Committee. During the period of data collection, the researcher reported to the Nursing Research Committee at 6-monthly intervals and gained their permission for each stage prior to its commencement.

An important ethical issue concerned the confidentiality of data collected. All patients and nurses were assured of confidentiality throughout the study and no record was made of the respondent's name. The only occasion when a record was made of patients' names was during Stage Three, when patients were asked to sign a written consent form.

A second issue emerged during the study. On a small number of occasions the researcher witnessed behaviour which was of a poor professional standard. The most common example of this was patients being given inadequate information. In most cases the researcher did not intervene, judging that the patient's experience was not sufficiently exceptional, nor the omission so serious, as to warrant action. On one occasion, however, it was obvious that the patient was distressed by his lack of understanding of the information given to him by the attending physician. The researcher therefore approached the casualty officer and explained the patient's concerns. The casualty officer then arranged for the physician to return to the patient to clarify her explanation. Fortunately this incident occurred at the end of the patient's stay in the department and so did not influence data collection.

Conclusion

In this chapter the characteristics of the Symbolic Interactionist perspective have been described and its relevance to the present study discussed. The impact of Symbolic Interactionism on the strategies of data collection and analysis employed have been considered. The research design and departments studied have been described and the aims and methods of each stage discussed.

CHAPTER FOUR

Results: Pilot Study

Introduction

This chapter reports on the pilot study undertaken at the beginning of the research to explore patients' perceptions of the experience of being in the Accident and Emergency Department and the factors which were sources of anxiety. The chapter is divided into two sections. In Section One the aims of the pilot study and the methods of data collection and analysis are described. In Section Two the four categories which emerged are discussed. These were – strategies by which staff define and maintain the role of patient and patient compliance with that role; the nature of patients' anxieties; the nature of nurse–patient interaction; and staff perceptions of patients and their influence on the delivery of care.

Section One Methodology

Aims

The aim of the pilot study was to identify sources of anxiety for patients in the Accident and Emergency Department and to explore how patients' perceptions of the department were influenced by the medical and nursing care received.

Method

Observation and informal interviews were used to examine the interaction arising between staff and patients and to discover patients' responses to the Accident and Emergency Department. Individual patients were followed throughout their time in the department, the events occurring observed and the patient's response elicited. The observational and interview data were recorded on a data collection sheet (see Appendix 1).

Sampling

During the pilot study 1 day every alternate week was spent in each department for a period of 8 weeks. Three starting times were used alternately. These were 9 a.m., 11 a.m. and 1 p.m. No observation took place at night.

Seven patients were observed in Department A and 5 in Department B. They varied in terms of age, sex and condition. In order to avoid bias in the selection of patients, when one observation was completed the next patient arriving in the department was approached and asked to take part in the research. The patients' consent was sought for the researcher to remain with them during their time in the department and to talk to them about what happened. To reduce the effect of the observer's presence on the patient's experience, the researcher did not stay with the patient throughout the whole of their time in the department. She was present during, and immediately after, important points of the patient's stay in the department, including admission, examination by doctor, nursing interventions and discharge. If the patient attended X-ray, the researcher

accompanied them. Otherwise the researcher remained in close proximity to the patient, for example in the area outside the cubicle, and returned to the patient when any event occurred. The time not spent with patients was used to observe other events which were occurring in the department and, if appropriate, to talk to the nurses.

Throughout the research a distinction was made between 'major' and 'minor' patients. 'Minor' patients referred to those who entered the department with simple and non-urgent illnesses and injuries. 'Major' patients referred to those who complained of more serious conditions or trauma. In Department A, 'major' patients were seen in the cabins, 'minor' patients in the curtained area (see Figure 1). In Department B patients were not treated in separate areas. As all 'major' patients were required to undress for medical examination, the researcher used this criteria to establish the category into which the patient fell.

Consent

It was explained to patients that the researcher was interested in what happened to patients in the Accident and Emergency Department and how they felt about the events which occurred. They were asked permission for the researcher to remain with them during their time in the department and to ask them questions about those events. Only one person refused to participate because she felt 'too ill'.

Permission had already been gained from medical and nursing staff in both departments to observe their interaction with patients. Permission was sought from any other medical staff who attended the patient as the need

arose. No problems arose in gaining consent from staff.

Data Collection

During the observational period the researcher remained with the patient at any time that a member of staff was attending to them, and observed, and recorded in written form, the events which took place on the data collection sheet (see Appendix 1). The completed document therefore contained, under several broad headings, a description of the events, conversations and communications which occurred between staff and patients, conversations between patients and relatives and the patients' responses to questions raised by the researcher.

Data Analysis

Each data collection sheet was analysed at the end of the day and possible important issues and areas of interest identified. These were then compared with the analysis of subsequent observation and informal interviews to establish general themes which would form the basis for further study. Because of the small number of patients studied, the observation and interviews formed a set of case studies which provided preliminary data enabling significant issues to be identified. This part of the research was, therefore, an exploratory study, on which the remainder of the research would be based.

The data were analysed qualitatively to identify central categories. The four main categories which emerged were:

1. Strategies by which staff define and maintain the role of patient and patient compliance with that role.

2. The nature of patient anxieties.
3. The nature of staff–patient interaction.
4. Staff perceptions of patients and their influence on the delivery of care.

These categories were derived from analysis of the data collection sheet as a whole. For example, observational and interview data relating to the strategies by which staff define and maintain the role of patient, and patient compliance with that role, were derived from each section of the document. This could include investigations performed, nursing care, medical examination and treatment and information/explanation given.

Interpretation was improved by obtaining both observational and verbal accounts; both were illuminative and the data collected proved complementary. For example, observation allowed doctor–patient interaction to be recorded as it occurred. The patient’s response was later elicited by informal questioning. Such an approach ensured that the feelings and interpretations of patients were taken into account and, on the other hand, that the comments were understood with reference to the context in which they occurred. Unfortunately, because of the demands on staff it was not usually possible, at this stage, to discover the meanings or interpretations they attached to events.

In the remainder of the chapter each of these themes will be discussed in terms of its emergence and theoretical and practical implications.

Section Two

Results

Strategies By Which Staff Define and Maintain the Role of Patient and Patient Compliance with that Role

Symbolic Interactionism emphasises the continuing nature of socialisation throughout adult life (Becker et al., 1961) and suggest that individuals are socialised into the roles they adopt by means of the complex processes of symbolic interaction. Goffman (1961) gives an extreme example of this process when he argues that the kinds of experiences involved in admission to a total institution such as a prison or mental hospital may be sufficient to challenge the individual's sense of even being an adult.

Goffman (1961) argues that acts have an expressive function as well as an instrumental one. Admission to the Accident and Emergency Department involved a number of procedures, particularly for 'major' patients which had the instrumental process of preparing the patient to be seen by the doctor, but also it appeared, had the expressive function of confirming the person in the role of patient.

Thus, on arrival in the department all 'major' patients would be helped to change from outdoor clothes into a gown, all belongings packed up and placed on the same trolley on which he was asked to lie. Clearly this activity is a necessary preparation for the patient to be examined by the doctor. It also, however, transforms the person into a patient who can be

moved at will and inspected with ease. Recordings of temperature, pulse and blood pressure are then taken and a brief history of the condition recorded. These acts had, therefore, an obvious instrumental function. They also symbolically confirm the person in his or her role as patient, the passive actor, the one to whom things are done. The procedures adopted in the Accident and Emergency Department, as well as having the instrumental function of preparing the patient for medical examination also, therefore, had the expressive function of socialising them into their role as patient.

After being undressed, the patient was then almost invariably told to wait and that the doctor would be with him or her shortly. On each occasion observed, the nurse left after completion of these activities, leaving the patient alone in a room wearing an open-backed gown and lying on a trolley with no means of contacting anyone. In Department A a curtain was also drawn round at the foot of the trolley. The intention behind this act was to give the patient a degree of privacy but the effect was also to increase isolation. One patient complained of a sense of 'powerlessness' because of this practice, another of a feeling of 'claustrophobia'. In department B, where non-urgent patients were sometimes left in cubicles to wait, the fear of being overlooked was expressed, 'the worst thing about being left in a cubicle, especially with the doors closed, is that you think they will forget about you'.

The interviews with nurses during Stage Two of the study showed that they were aware of the symbolic nature by which the patient role was ascribed and assumed. The nurses described the role of the patient in

Casualty as less strongly assumed than that of a hospital in-patient because patients often remained in their own clothing and were, in effect, visitors to the hospital (see page 202). Yet the 'major' patients in the Accident and Emergency Department, did experience admission rituals which tended to limit their power and confirm them in the role of patient.

Patients demonstrated a marked degree of compliance with their role. Instructions given were obeyed precisely and patients appeared reluctant to undertake even simple activities without approval. Thus one patient observed was left in an uncomfortable position by the doctor who left her saying, 'Stay there till I get back'. Her daughter wanted to help her move but the patient refused saying, 'No, the doctor told me to stay here till he got back'. Another patient who had been left uncovered by the doctor, asked the researcher, after some time, if it would be alright to cover himself. Another, who had been told to hold a piece of cotton wool over an injection site, also asked after several minutes, if it would be alright to stop now. These instructions to patients were not intended to be so strictly adhered to but the patients' ignorance and insecurity made them frightened of not obeying instructions literally, lest they did something wrong.

Patients also asked very few questions about their stay or condition, even when they were genuinely confused or uncertain about what was happening. For example, a number of patients complained that they did not know what was happening or why they were waiting, but none asked the nurses for information.

The 'minor' patients observed did not so completely assume the role of the

patient. They remained in their usual outdoor clothing throughout their time in the department. Their process through the department was straightforward. In each of the three cases observed, the impact of their injury on their daily lives was likely to be small. One of these patients had fractured a bone in his foot, another had a small facial laceration and the third had a painful and bruised right arm. The role of the patient in the Accident and Emergency Department was, therefore, one which they assumed only lightly.

The exploratory study suggests that even though length of time spent in the department was brief, for some people attending with 'major' illnesses or injuries, socialisation into the role of patient does occur with its attendant passivity of behaviour and feelings of loss of control. Individuals attending with minor illnesses or injuries assumed the role of patient to a lesser extent. They remained in their own clothing and were less dependent on medical and nursing staff. They were also less likely to be physically isolated, as they remained in the waiting area with others to be seen, rather than alone in a cubicle. Comments by nurses indicated that they perceived the 'minor' patients as retaining a greater degree of independence and treated them accordingly as 'on an equal footing'.

Patients' Anxieties

Content analysis was carried out on the informal interview and observational data to discover sources of anxiety for patients. Because of the small sample size, and heterogeneity of patients, it is not possible to assume the anxieties expressed were typical of all patients. However,

certain trends did emerge which provided the basis for further investigation.

A recurrent theme was the concern that patients felt about not knowing what would happen to them in the department. The patient's stay in the Accident and Emergency Department was frequently characterised by delays and periods of waiting. Of the 12 patients observed, 7 complained about the length of time they had to wait. Of these, 6 felt that the uncertainty of not knowing the reasons for events or what they were waiting for exacerbated their worry. These patients made frequent, often repeated, comments throughout these periods such as, 'I don't know what's happening, I've never seen anybody', 'What's the hold-up now?', 'How long are they going to keep us here?' and 'I wish they'd hurry up with whatever they're doing'. Such comments seem to reflect the frustration and powerlessness that patients felt about the lack of information they received.

Occasionally, when no explanation was given to patients they relied on their own interpretation of events, which was not always accurate. In one instance, a patient who had been admitted with chest pain was cared for initially in the resuscitation room where an ECG performed showed his condition to be satisfactory. The doctor's explanation to the patient that there was, 'nothing seriously wrong, just a couple of missed beats on your ECG', was not understood by the patient. Nor was it further explained by the nurse. Thus, when the patient was moved from the resuscitation room to a cabin, indicating that his condition was not a cause for concern, he did not realise what this meant. Instead, he believed that he had been moved to the 'cardiac part' of the department. A more adequate explanation would

have increased the patient's understanding of events, and allayed any remaining fears he or his family had about his condition.

The long delay which followed while the patient waited for the registered medical officer (R.M.O.) to examine him was also misinterpreted. The patient and his wife assuming that it was to allow 'plenty of time to make sure the patient is settled before they go'.

The casualty officer did return and explain to the patient that the reason for the long delay was that they were trying to contact the medical doctor, but had been so far unsuccessful. Again, this information, although intended as helpful, was misinterpreted. The patient and his wife believed the casualty officer was referring to their GP whereas in fact he meant the hospital medical officer. The misinterpretation of information in this instance did not cause any distress, but it does illustrate how medical and nursing staff may believe they have kept the patient informed when, in reality, he or she has not understood their information.

Four patients were concerned about the impact of their illness/injury on their outside affairs. One male patient was very worried about not being able to go to work. Another, who was to be admitted, was worried because her house was in the process of being re-decorated and she felt she should be present to supervise the work. She had, she reported, delayed visiting the doctor for this reason. One patient was concerned that she wouldn't be able to carry out housework, another that he wouldn't be able to tend to his large garden. The remaining patients either felt any restrictions to their usual activities would be minimal or that they would be able to cope.

Another source of anxiety for patients was pain, either the possible reasons for the pain they were experiencing or the anticipation of future pain during an investigation or examination. Four patients were worried about the source of their pain, i.e. what was wrong with them. In two of these cases, no analgesia was given to the patients until after examination and diagnosis. In neither case was the diagnostic importance of pain explained to patients. Each of these 4 patients also expressed anxiety about possible future pain resulting from examination or having to undergo a painful examination.

Four patients were subsequently admitted to hospital and all expressed anxiety about the prospect. The most anxious said she was 'just so frightened', while the others felt their anxiety was tempered by the knowledge that their problems would be dealt with. One elderly patient, for example, said she thought it would be better to be in hospital where she would be properly cared for, rather than at home on her own. A young female patient with appendicitis commented that she was 'quite looking forward' to an operation, which would get rid of the pain. The final patient who expressed anxiety about admission expressed resignation, 'What's got to be has got to be'.

Three patients mentioned worries which were related to the sudden nature of their visit to the department. For example, one patient was extremely concerned about her son, whom she had arranged to meet at the bus-stop on return from her, now abandoned, shopping trip. She was worried that he would be waiting for her, not knowing what had happened. Another had been on her way to attend the hospital Out-Patient Clinic when she

had been taken ill. Her concern was that she had now missed her appointment, she wouldn't get another for some time and would therefore experience further delay in having her problem attended to. The nurses were very efficient at dealing with these problems. For the first patient they enlisted the co-operation of the police to locate and inform the patient's son of events. For the second, they liaised with the Out-Patient Department to secure an early alternative appointment for the patient.

A number of other factors also emerged as sources of anxiety for individual patients. These included fear of an operation, fear of an anaesthetic, disruption to usual routine and fears of what might be wrong. Of the 3 'minor' patients, the 2 males, denied having any worries about being in the department. They described their experience as 'quick' and 'no bother'. One of the male 'major' patients also denied any anxieties about any aspect of being in the department, describing himself as someone who 'never worried'. Wilson-Barnett (1976) found that males tended to report fewer fears than females and suggests that this may be due to sex-role differences. The present study also suggests that such a difference may exist.

The observational and interview data have, therefore, highlighted a number of factors which were sources of anxiety for patients in the Accident and Emergency Department. The most prevalent were those related to not knowing what would happen, impact on outside affairs and pain. Other factors were also indicated as sources of anxiety for individual patients. Because of the small numbers involved these findings must be viewed as tentative. A need for a more comprehensive picture of the sources of

anxiety for patients was clear. Stage One, therefore, examined the nature of patient anxieties in a more systematic way by means of a structured interview schedule.

The Nature of Nurse–Patient Interaction

The quality of nurse–patient interaction was generally brief and predominantly concerned with physical care and the patient's process through the department. The typical experience of 'major' patients has been described with reference to patterns of patient socialisation. Here, the role of the nurse observed was to help the patient into a gown, record their observations and take a brief history of their condition. For 6 of the 9 'major' patients observed this constituted the main part of the nurses' involvement with the patient. The only other interactions observed were related to arranging for the patient to attend X-ray, responding to minor needs and arranging their admission to hospital or discharge home.

Three of the 'major' patients required an ECG to be recorded, their interaction with the nurse being consequently longer. The 3 'minor' patients were seen, briefly, by the nurse on admission and for a longer period prior to discharge, when their dressing was applied.

In most of the cases observed, the nurses talked to their patients as they attended to them and explained what they were doing and why. However, once these activities had been performed they left and only returned if called, or to organise the patients' care. This was true even when the department was quiet. In Department A the nurses usually stationed

themselves outside the cabins or in the curtained area. In Department B the nurses tended to congregate outside the nurses' office. No nurse was observed to spend time with a patient unless a nursing activity was being performed, even when the department was quiet.

The nurse interviews conducted during Stage Two suggested that part of the reason for this behaviour was their desire to remain in a state of readiness in case an emergency was admitted. Thus, by avoiding remaining in rooms with patients the nurses fulfilled their aim of maintaining a general surveillance and being available to respond to needs as they arose. A second factor was the speed with which the nurses felt they had to carry out their work. As one nurse said, 'You've got to get this job done because you know there's another one waiting for you.' The nurses became accustomed to carrying out their work quickly and developed routines to facilitate this. This meant even when the department was not busy, a similar approach was used. Even when the patient was anxious, the nurses did not necessarily spend more time with them. For example, an elderly patient admitted with gall stones was both anxious about her condition and distressed by her pain. The nurse talked to her throughout the time that she helped her into a gown, a task made more difficult by the patient's deafness, and before she left held the patient's hand and said she hoped the doctor wouldn't be too long. She did not, however, spend any extra time with her, once the necessary activities had been performed or ask her about her concerns.

Nurses seemed to feel that because there was little they could do to alleviate patients' fears, there was little point in raising them. A typical

example of this occurred when a nurse reported to the researcher that the patient she had just attended to had been really anxious. The researcher asked what she had done about it, to which the nurse replied, 'Well, there was nothing I could do really. I just took her obs.' (recordings of temperature, pulse and blood pressure)

Nurses seemed, therefore, to organise care in such a way so that only minimal interaction was maintained with patients. In doing so they conveyed the impression of a busy department with staff constantly dealing with a number of different demands. Such a picture of the department was often true, but it seemed important to maintain this impression even when the department was quiet. Nurses presented an image of themselves as busy, but caring, professionals. Such a practice meant they were able to avoid getting involved with problems which they could do little to overcome. The strategy of 'popping in' on patients as a way of organising care, rather than spending prolonged periods with patients, was one way this was achieved.

Similarly, nurses often explained the reasons for delays as being due to the doctor 'dealing with an emergency'. Again, this reason was sometimes true but it was also used at times when the department was quiet rather than, for example, explaining that the doctor was actually at lunch or coffee. The perception of busyness was facilitated by the geography of the departments where, if a patient was in a room or cabin, there was little opportunity to observe the behaviour of anyone not in the immediate vicinity. Patients themselves often attributed their being left unattended for long periods as being due to the severe pressure of work on staff, and made such

comments as, 'I'm sure they're rushed off their feet'. They seemed, therefore, convinced by such behaviour, of the busyness of staff, and so tended to avoid adding to their pressure by making demands of them or by complaining.

Although nurses seemed reluctant to enter into conversations about patients' fears when they were vague or perceived as inevitable, they were efficient in organising practical solutions to specific problems. Their ability in such matters has already been described above when the nurses arranged for the police to contact a patient's son, and re-negotiated the Out Patient appointment of another. The attention paid to such matters may also reflect the nurses' tendency to focus on short-term issues. Immediate problems would be dealt with. The nurses' did not regard long-term problems as their responsibility.

In each of the cases observed during the pilot study, if no relative or companion accompanied the patient, the nurses asked if there was anyone the patient would like them to contact. If necessary, considerable trouble was taken to do this. In the later interviews the nurses revealed that they viewed contacting relatives as an effective way of reducing patients' anxieties. One reason they considered contacting relatives as important was because they believed that their relatives not knowing they were in the department was a specific source of anxiety for patients. Nurses felt, furthermore, that having a relative or friend with them during their time in the department also considerably reduced patients' anxieties. From their own perspective, too, having a relative with a patient was considered helpful as they felt relatives could be relied on to call them if anything was

needed by the patient, leaving the nurses free to pursue other activities.

The observational study has shown that the interaction between nurses and patients was generally brief and almost entirely concerned with physical care and organisation of the patient's progress through the department. There was little attempt to deal with patients' fears, although specific practical problems were dealt with efficiently. It seemed that the reactive way in which care was delivered contributed to this situation. It would be difficult for patients to verbalise fears within a system which so strongly emphasised practical and busy efficiency. Maintaining, therefore, the role of busy professionals meant that nurses could avoid having to spend time with patients when nothing practical needed to be done.

Some differences were observed in the quality of interaction which occurred between staff and different types of patients. This is discussed in the following section.

Staff Perceptions of Patients and Their Influence on the Delivery of Care

Some evidence emerged that staff perceptions of patients influenced the way in which care was delivered. The most clear illustration of this was the way in which the medical staff behaved towards two patients, 1 male and 1 female, who were admitted with alcohol-related injuries. Both of these patients were treated in a way which appeared judgemental and unsympathetic. The patients, who were both seen in Department A, were seen by different doctors. Neither attempted to disguise his disapproval of the patient.

The female patient was known to have a history of alcohol abuse, although her attendance at the department on this occasion was due to a breast abscess. The male patient complained of severe back pain, which was thought may have been due to renal problems caused by excessive drinking. The social circumstances of this patient had been recently disrupted: his wife had left him which led him to drink heavily, although, he insisted, for only two days.

The anxiety and distress of these patients was not acknowledged and the physical care they received was given in such a way as to express disapproval and lack of concern. As the male patient described it the doctor was, 'very businesslike in his manner'. The doctor made it clear that he doubted the man's assertion that he was an infrequent drinker by the way he questioned him. He also commented that there were 'a lot of drinkers in _____', the district given on the patient's casualty card, although not where he actually lived. The doctor also questioned the patient about the reasons why his wife had left him. The patient's response that it had been 'totally unexpected' was treated with scepticism by the doctor who commented that, 'she must have had her reasons'. This example, therefore, illustrates the impact that patient stereotyping had on the delivery of care. The doctor appeared to pre-judge the patient on the basis of circumstantial evidence – reported alcohol consumption and the patient's address.

The behaviour of the second doctor to the female patient was characterised by a similar disapproval and scepticism. She was particularly fearful about having to answer questions about her drinking habits. The doctor

responded to her concerns by stating, 'Well if you stop drinking, we won't have to ask you the questions.'

The experience of these patients were in contrast to that of most, to whom the doctors were polite and friendly. In particular, there was a marked difference between their experience and that of a 92-year-old patient who was admitted with abdominal pain caused by gall stones. The doctor treated her in a way which was gentle and sympathetic throughout, calling her by her forename and showing patience in waiting for her response to his questions. The nurse who accompanied her from the home where she lived was also allowed to remain with her during the examination.

The behaviour of the medical staff seemed to reflect their perceptions of the relative social acceptability of the patients. Both women were admitted and the male patient was diagnosed as having fractured ribs so the perceived seriousness of condition was evidently not the most influential factor; a more plausible explanation is that the association with alcohol affected the doctors' behaviour towards those patients.

Certainly, the nurse interviews carried out in Stage Two revealed a powerful dislike of such patients among all Accident and Emergency Department staff. The elderly patient, on the other hand, appeared to be perceived as a frail old lady deserving kindness and attention.

The nursing intervention with these patients was limited so differences in behaviour were not so apparent. The nurse was, however, more sympathetic to the elderly patient in the example quoted earlier, where the

nurse talked to the patient throughout the time she attended to her and held her hand before she left, saying that she hoped the doctor 'wouldn't be too long'. It was notable, however, that although the nurse was sympathetic to this patient, she did not remain with her longer than was necessary to carry out physical care.

Although the numbers were small, there was some evidence that staff perceptions of staff were an important factor influencing the care that patients received. Patients with alcohol-related problems were viewed negatively and this affected the quality of care they received. This raises the question of whether other social factors could affect the nature of care given to patients? This issue was explored further in the later research.

Conclusion

Although the numbers were small, the pilot study did provide a useful exploratory study from which important themes emerged. These were then used to direct the later research. In particular, insight was gained into what it was like to be a patient in the Accident and Emergency Department.

The sense of powerlessness and boredom which some patients experienced was clear, as well as the uncertainty they experienced about what would happen to them and why. The anxieties which patients expressed reflected these concerns.

The limited nature of nurse-patient interaction was also very apparent. For many patients, the amount of time spent interacting with nurses in the department was minimal. No interactions were initiated by nurses other

than when the patient required physical care, or to facilitate the patients process through the department. There was some evidence that social factors may have affected the care which patients received.

The pilot study was based on only a small sample of patients. Each of these issues required further examination to enable firm conclusions to be drawn. The central purpose of the research was to identify sources of anxiety for patients in the Accident and Emergency Department and to examine how patients' anxieties were dealt with by nurses. The first step in achieving this aim was to establish, quantitatively, the sources of anxiety for patients. Stage One of the research, therefore, sought to accomplish this by means of a structured interview schedule administered to patients.

CHAPTER FIVE

Results: The Nature of Patients' Anxieties

Introduction

In this chapter the interviews with patients, undertaken in Stage One of the research are reported and discussed. The chapter is divided into two sections. In Section One the methods of data collection and analysis are described. In Section Two the results of the interviews are reported and discussed. The findings are presented in three parts. The first discusses descriptive analysis regarding the nature of patient anxieties in the Accident and Emergency Department. The second reports the findings of statistical analysis of relationships between patients' anxieties and the variables of age, sex, condition and department. Finally, themes which emerged using cluster analysis are considered. The overall findings of the patient interviews are then reviewed and related to those of the pilot study.

Section One Methodology

Aims

The aims of Stage One were to:

1. Identify sources of anxiety for patients in the Accident and Emergency Department.
2. Examine the relationship of anxiety to the patient variables of age, sex, seriousness of condition and department.

Method

Development of the Interview Schedule

The informal interviews and observation conducted during the pilot study had suggested that, for some patients, lack of information and lack of control were sources of anxiety. Other factors identified were the impact of their illness/injury on the patients' outside affairs and pain, either the fear of its cause or anticipation of its onset. Some patients also mentioned the possibility of admission to hospital or having to undergo an operation as sources of anxiety, or reported other fears.

However, the small number of patients studied and the diversity of their conditions and experiences made interpretation of these findings difficult. In order to examine the nature of patients' anxieties in more detail, a structured interview schedule was employed. Use of the schedule allowed quantitative data to be collected concerning the nature of patients anxieties, frequency of occurrence, degree of severity and type of patients most affected. Thus, in contrast to the pilot study, where the experiences of a small number of patients were examined qualitatively, in Stage One a sample of 96 patients were interviewed and data statistically analysed to reveal trends. Frequency counts and chi-squared analysis were used to establish the relationship of anxiety to the patient variables of age, sex,

seriousness of condition and department.

The structured interview schedule was adapted from that used in the USA by Danis (1984) which listed possible sources of anxiety for patients in the Emergency Department and asked them to state the degree of anxiety associated with each, according to a rating card.

The qualitative data collected during the pilot study were used to adapt Danis's tool for use in the present study. For example, some patients had expressed concerns about their relatives, which would not have been elicited by the schedule. Two questions were therefore added. If no relative was present, the patient was asked if he or she was anxious that their relatives did not know they had been admitted to the Accident and Emergency Department. If relatives were present, but not with the patient at the time of interview, the patient was asked if he or she was anxious that their relatives did not know what was happening to them in the department.

A question related to the cost of treatment was omitted. Another question which asked whether the patient was anxious about the possibility of dying was also omitted. The sampling strategy used meant that patients who were very critically ill would not be included in the study. As the question was not likely to be relevant to others, and no patient had expressed any similar fear during the pilot study, it was thought unnecessary and undesirable to include this item. In addition to these slight changes in content, some changes in wording were made to make the schedule more appropriate to a British Accident and Emergency Department. For

example, 'Having to have a shot' was changed to 'Having to have an injection' and 'Being in the atmosphere or environment of the Emergency Department' was changed to 'Just being in Casualty'.

The structured interview schedule and rating card used in the present study are shown in Appendices 2 and 3.

Reliability and Validity of the Instrument

The structured interview schedule records expressed anxiety. The successful use of self-report questionnaires has been well documented (Holmes and Rahe, 1967; Volicer and Bohannon, 1975; Spielberger et al., 1983). For the purposes of the present study, such a tool was the most appropriate as, although structured, it allowed the verbal responses of those studied to be taken into account. However, the fact that it was patients' expressed anxiety which was recorded must be acknowledged in interpreting the data. For example, the possibility that females are more willing to express anxiety than males has already been mentioned.

That social acceptability is a factor which may affect the admission of anxieties is suggested by the different responses gained by the preliminary open-ended question and the subsequent closed-ended questions on the schedule. The first question asked patients if they felt at all worried or anxious about the experience of coming to Casualty. Only 35 of the 96 patients reported feelings of anxiety in response to this question. The researcher then continued,

Sometimes it's hard to identify worries, so I'd like to ask you about some common causes of worry in people who come to Casualty. Some of these

questions may apply to you, others may not. When I ask you about them, I would like you to tell me whether you feel any worries or anxiety according to this card.

In response to the items listed on the schedule, only 3 patients said they were not anxious about any. It may be that patients were reluctant to admit to fears or thought they were too 'trivial' to mention when asked an open-ended question. If so, this would have important implications for nursing practice as it suggests patients are reluctant to express fears unless asked specific questions.

In order to increase the reliability of data collection a standardised format was used. The researcher approached patients at the beginning of their time in the department, used the same introductory statement and asked the questions from the schedule in the same order. The patients responses were recorded by the researcher at the time of interview.

Recording of the patient's response by the interviewer introduces the possibility of bias. It is conceivable that patients may have reported a different number of anxieties in a self-completed questionnaire. However, although in some ways advantageous, such an approach may have a number of practical difficulties. The main one was the heterogeneity of the sample. Older people or those who were more seriously ill may have been unable, or unwilling, to complete a written questionnaire: these patients would therefore have been lost from the sample, introducing a selection bias or, unlike others, they would have required assistance with completion, introducing inconsistency of recording. By adopting a standardised approach, with the researcher reading out the questions and recording

responses for all patients, the problem was avoided. In addition, it ensured that no questions were omitted by patients and no completed schedules lost. All patients were assured of the confidentiality of data, prior to commencement of the interview. As well as being ethically desirable, it was hoped that such an assurance would encourage patients to respond to questions honestly.

Sampling

Following the pilot study with 8 patients in each department and the minor modifications to the schedule described above, structured interviews were carried out with a sample of 96 patients – 48 in each department. The factor of seriousness of condition and those of age, sex and department were identified as possible significant variables and used to stratify the sample.

For sampling purposes patients were classified into two categories: 'minor' and 'major'. The characteristics of 'major' and 'minor' patients are described on page 90. Patients were also classified according to age. Two categories were established. 'Young' patients refers to those who were aged under 40. 'Older' patients refers to those aged 40 and over. The other categories were sex and department – A or B. For the purposes of chi-squared analysis, a minimum of patients in each combination of categories was needed. Sampling therefore continued until each combination of categories was full. Table 1 shows the number of patients in each of the categories.

Selection bias was avoided by ensuring that each respondent included in

the study was the next patient to enter the department following completion of the previous interview.

This part of the study required patients to respond to a structured list of questions. For ethical reasons, therefore, very ill patients, who needed to be treated in the resuscitation room were not included in the study.

Consent

It was explained to patients that this was a study looking at sources of anxiety for patients in casualty. Their verbal consent was obtained before commencement of the interview. No patient refused to be included.

Section Two

Results

The Nature of Patient Anxieties

The Open Ended Question

The first question on the schedule asked patients if they were at all worried about the experience of coming to Casualty. If they responded yes to this question, they were asked to describe what they felt anxious about. Only 35, of the 96 patients interviewed, expressed anxiety about the experience in response to this question. The numbers were similar in each department, 18 (37.5%) in Department A and 17 (35.5%) in Department B.

Chi-squared analysis was used to examine relationships between response to the open-ended question and the patient variables of age, sex and condition. No difference was found in terms of age and anxiety expressed, 37% ($n=18$) of 'young' patients admitting anxiety in response to this question and 36% ($n=17$) of 'older' patients. Females expressed significantly more anxiety than did males, 50% ($n=25$) of females admitting anxiety in response to this question, compared to only 22% ($n=10$) of males (chi-squared=8.258, d.f.=1, which was significant at the 0.01 level). Those with more serious illnesses also expressed significantly more anxiety in response to this question than those with 'minor' illnesses or injuries. Of the 'major' patients, 53% ($n=26$) expressed anxiety in response to this question compared to only 19% ($n=9$) of 'minor' patients (chi-squared=11.908, d.f.=1, which was significant at the 0.001 level). Responses to the open-ended question suggest, therefore, that female patients and those with more serious illnesses and injuries experienced a significantly greater degree of anxiety on arrival at the Accident and Emergency Department than did other groups of patients.

With the exception of one patient, all those who reported anxiety in response to the open-ended question admitted to anxiety about at least one item listed on the schedule. The average number of items about which these patients expressed anxieties was 10. Of the patients who said they were not anxious in response to the open-ended question, only 2 maintained they were not anxious about any item on the schedule. The patients who said they were not anxious initially reported on average, anxiety about only 5 items.

A Mann-Whitney U test was used to determine whether those who responded positively to the open-ended question also reported more anxieties in response to the items listed. The test showed that patients who reported anxiety in response to the open-ended question did report significantly more anxieties ($U=557.5$, $p=0.001$, two-tailed). The test also showed that, when the proportion of items applicable was allowed for, the result was also significant ($U=652.5$, $p=0.005$, two-tailed).

Those patients who responded positively to the open-ended question, therefore, expressed significantly more anxieties than other patients. However, the majority of those who said they were not anxious in response to the open-ended question, did express some anxiety in response to the specific items.

Of the 35 patients who said they were anxious initially, the most common fears were related to what was wrong with them and the actual or potential seriousness of their condition, 11 patients expressing such worries. Five said they were worried about what would happen to them as a result of their illness or injury and 4 were concerned about the possibility of admission to hospital. Three reported general fear and dislike of hospital and 3 were concerned about experiencing pain. Individual fears were expressed about injections, symptoms, the prospect of surgery, possible complications and the unfamiliarity of the department. Two patients were worried that they were attending the department inappropriately.

The types of fears expressed spontaneously by patients concurred largely with the possible sources of anxiety listed on the schedule. The only

difference was that one patient was worried about a possible complication, an item not mentioned on the schedule. At the end of the schedule patients were asked if there was anything they were worried about which had not been mentioned. Only 10 patients reported further fears, but none which had not been listed in the schedule. Patients, therefore, repeated fears they had already expressed such as 'just having to have an operation' or being 'permanently damaged'. A small number of patients mentioned general points about the department that they disliked, such as one patient who said, 'I don't like all the kids and noise.' Another commented, 'I just want to get out of here. I'll feel much happier when I get onto the ward.'

Incidence of Anxieties

The maximum number of anxieties a patient could report was 28. One young female 'major' patient, expressed anxiety about 24 items. No other patient expressed anxiety about more than 18. The most frequently occurring number of anxieties reported by patients was 4, 10 patients admitting to this number of fears. The mean number of anxieties reported was 6.9. The median number of anxieties reported was 7. Of the 96 patients, 75 expressed anxiety about 10 items or less.

Patients' Anxieties

Frequency counts were used to identify the items most closely related to patient anxiety. Scores were rank ordered to see which events were most frequently associated with anxiety. The items most patients expressed anxiety about were 'Not being able to carry on your usual activities', 'Not knowing what will happen to you in the department', 'Having to undergo an uncomfortable procedure', 'Feeling pain' and 'Not knowing what is

wrong' (see Table 3). Table 4, which indicates the number of patients who expressed moderate or extreme anxiety about each item, shows that similar items were rated most highly.

The 50 patients who said they were anxious about 'Having to undergo an uncomfortable procedure' were asked what procedure they were worried about. Of these patients, 18 said they were not sure what procedures they would have to undergo. It would seem that, rather than anticipating a particular event, these patients were concerned that their time in Casualty would include a procedure which they found uncomfortable. A further 18 patients mentioned specific aspects of their examination and treatment such as having to have a bone reset, abscess drained or plaster applied. Having stitches was mentioned by 5 patients as a particular procedure they were anxious about, and injections by 3. Having to have an 'internal' examination was given as a source of anxiety by 3 female patients. Fears about X-rays were reported by 2 patients, because of the pain involved in moving rather than the event itself, and 1 patient expressed his fear of 'having a tube stuck down my throat'.

Patients who had reported feeling anxious that they would not be able to carry on their usual activities were asked in what way they thought their activities would be affected. The most common fears were about not being able to manage at home, being unable to go to work and being unable to participate in sport and leisure activities.

Of the 68 patients who said they were anxious that they would not be able to carry on their usual activities, 23 said that they thought everything

Table 3: Items About Which Patients Expressed Anxiety

Source of Anxiety	N1	P1	N2	P2
Not being able to carry on your usual activities	84	87.50	68	80.95
Not knowing what will happen to you in the dept.	92	95.83	54	58.69
Having to undergo an uncomfortable procedure	79	82.29	50	63.29
Feeling pain	88	91.67	49	55.68
Being unable to control what will happen to you	95	98.96	48	50.53
Feeling helpless	93	96.87	39	41.93
Not knowing what is wrong with you	50	52.08	38	76.00
What you think might be wrong with you	53	55.20	31	58.49
Just being in Casualty	96	100.00	28	29.17
Having to be admitted to the hospital	47	48.96	28	59.57
Having to have an operation	31	32.29	24	77.41
Being away from work	42	43.75	24	57.14
Having to get undressed for an examination	69	71.87	23	33.33
The possibility that the doctor may not be able to find out what is wrong with you	62	64.58	23	37.10
Being treated by a doctor you don't know	96	100.00	18	30.00
Having a permanent disability	46	47.91	18	30.00
Seeing blood	55	57.91	12	21.81
Your relatives not knowing you are in Casualty	51	53.12	11	21.57
Having to have an injection	74	77.08	11	14.86
The possibility that the doctor may overlook an important sign or symptom of your illness	63	65.62	11	17.46
Being cut	35	36.46	9	25.71
Having to have stitches	14	14.58	8	57.14

(Table 3 continued)

Source of Anxiety	N1	P1	N2	P2
Having to a rectal examination	14	14.58	8	57.14
Having a pelvic examination	12	12.50	8	66.66
Having a blood sample taken	59	61.46	7	11.86
Having to have a 'drip' in your arm	21	21.87	7	33.33
The possibility that the doctor may think the problem is 'all in your head'	62	64.58	6	9.68
Your relatives not knowing what is happening to you in the department	15	15.62	4	26.66
Having a tube in your nose or throat	3	3.12	2	66.66

Number of Patients Interviewed = 96

N1=Number of patients who considered item applicable.

P1=Percentage of patients who considered item applicable.

N2=Number of patients who considered item applicable and expressed anxiety about that item.

P2=Percentage of patients who considered item applicable and expressed anxiety about that item.

Table 4: Items About Which Patients Expressed Moderate or Extreme Anxiety

Source of Anxiety	N1	P1	N2	P2
Not being able to carry on your usual activities	84	87.50	30	35.71
Having to undergo an uncomfortable procedure	79	82.29	27	34.18
Feeling pain	88	91.87	26	29.54
Not knowing what is wrong with you	50	52.08	22	44.00
Being unable to control what will happen to you	95	96.87	19	20.00
Feeling helpless	93	96.87	18	19.35
Not knowing what will happen to you in the dept.	92	95.83	17	18.48
Having to have an operation	31	32.29	17	54.83
What you think might be wrong with you	53	55.20	15	28.30
Having to be admitted to the hospital	47	48.96	12	25.53
Having a permanent disability	46	47.91	12	26.08
Having to get undressed for an examination	69	71.87	11	15.94
Being away from work	42	43.75	10	23.81
Your relatives not knowing you are in Casualty	51	53.12	8	15.69
The possibility that the doctor may not be able to find out what is wrong with you	62	64.58	8	12.90
Just being in Casualty	96	100.00	7	7.29
Having a pelvic examination	12	12.50	7	58.33
Being treated by a doctor you don't know	96	100.00	6	6.25
Seeing blood	55	57.29	6	10.91
Having to have an injection	74	77.08	5	6.76
Being cut	35	36.46	4	11.43

(Table 4 continued)

Source of Anxiety	N1	P1	N2	P2
The possibility that the doctor may overlook an important sign or symptom of your illness	63	65.62	4	6.35
Having a blood sample taken	59	61.46	3	5.08
Having to have a 'drip' into your arm	21	21.87	3	14.28
Having to have stitches	14	14.58	3	21.42
The possibility that the doctor may think the problem is 'all in your head'	62	64.58	3	4.84
Your relatives not knowing what is happening to you in the dept.	15	15.62	2	13.33
Having a tube in your nose or throat	3	3.12	2	66.66
Having a rectal examination	14	14.58	2	14.28

Number of patients interviewed = 96

N1=Number of patients who considered item applicable.

P1=Percentage of patients who considered item applicable.

N2=Number of patients who considered item applicable and expressed moderate or extreme anxiety about that item.

P2=Percentage of patients who considered item applicable and expressed moderate or extreme anxiety about that item.

would be affected. These patients made comments such as, 'I can't lift my arm without it being painful, so I don't think I'll be able to do much at all.' Of these patients, 14 were male, 9 female. Not being able to go to work was mentioned by 19 patients. Of these patients, 13 were male compared to 6 females. The 8 patients who said housework or childcare would be affected were female. Although male patients seemed more likely, therefore, to express anxiety about work, it was also a concern for female patients. No male patients, however, expressed concern that their illness or injury would prevent them from fulfilling domestic duties. The data suggest, therefore, that the anxiety experienced by patients was related to their perceptions of the impact of their condition on those activities which they regarded as most important.

Leisure and sport activities were mentioned by 7 patients, 5 of whom were male. A further 6 patients, although expressing anxiety that they wouldn't be able to carry on their usual activities, were uncertain about how they would be affected. The comments made by these patients were like that made by one woman who said she was extremely anxious about not being able to carry on her usual activities but, 'not sure how they will be affected until they (the doctors) find out exactly what's wrong'.

It can be seen from Tables 3 and 4 that certain items, where the number of patients who thought the item applicable was small, were rated highly by those who did. For example, of the 47 patients who thought they may have to be admitted to the hospital, 28 (59.57%) expressed anxiety about the possibility. Of the 31 patients who thought they might have to have an operation, 24 (72.42%) said they were anxious at the prospect, 17

(54.54%) describing their anxiety as moderate or severe. Of the 42 patients who thought the item 'Being away from work' applicable, 24 (57.14%) were anxious about the possibility.

Certain medical procedures which the patients thought they might have to undergo also provoked anxiety. In particular, 8 of the 14 patients (57.14%) who thought they might have to have stitches expressed anxiety about this, as did 8 of the 14 patients (57.14%) who thought they may have to have a rectal examination. Also anxious were 8 of the 12 patients (66.66%) who thought they might have to have a pelvic examination, 7 (58.33%) describing their anxiety as moderate or severe. Two of the 3 patients who thought they may have 'a tube in your nose or throat' (66.66%) reported that they were moderately or extremely anxious about the prospect.

Descriptive analysis of anxieties expressed by patients showed that many patients were concerned with psychological and social aspects of being in the Accident and Emergency Department. Concerns regarding interference with usual activities, feelings of uncertainty about what would happen and not knowing what was wrong were common. Another frequently cited source of anxiety was pain and having to undergo an uncomfortable procedure. A small number of patients who thought they may have to undergo specific procedures were anxious about these. The interviews took place early on in the patient's stay in the department and no data was available about the type of information or advice given to patients about these issues.

Having established the type and frequency of patients' anxieties, chi-

squared analysis was carried out to discover any relationships which existed between the nature of patients' anxieties and the patient variables of age, sex, condition and department.

Relationship of Anxiety to Other Patient Variables

Because of the small numbers involved it was decided, for the purposes of analysis, to compress groups so that larger numbers would be obtained in each of the categories of anxiety. Those who had replied that an item was not applicable were excluded and the remainder of responses divided between those who had expressed no anxiety and those who had expressed slight, moderate or extreme anxiety. Using this method the effect of each of the variables of age, sex, severity of condition and department was studied.

Chi-squared analysis showed that more anxiety was expressed by patients who were female, younger and who had more serious conditions. Females and those with more serious conditions had also been found to express more anxiety in response to the open-ended question. Multiple analysis with control of each variable demonstrated that all results appeared independently of the others. No significant differences were found between the two departments studied.

Sex

For 23 of the 31 items on the interview schedule, the percentage of females who expressed anxiety was greater than that of males. Using the method outlined above, 3 items achieved statistical significance (see Table 5).

Table 5: Items About Which Females Expressed Significantly More Anxiety Than Males

Source of Anxiety	N1	P1	N2	P2	Chi-squared	Degrees of Freedom	Level of Significance
Having to get undressed for an examination	18	50.00	5	15.15	9.409	1	0.01
Just being in Casualty	19	38.00	9	19.57	3.941	1	0.05
Being cut	6	50.00	3	13.04	5.683	1	0.05

N1=Number of females who considered item applicable and expressed anxiety about that item.

P1=Percentage of females who considered item applicable and expressed anxiety about that item.

N2=Number of males who considered item applicable and expressed anxiety about that item.

P2=Percentage of males who considered item applicable and expressed anxiety that about that item.

These were 'Having to get undressed for an examination', 'Just being in Casualty' and 'Being cut'.

Age

Young people (i.e. those aged under 40) expressed more anxiety than older people (i.e. those aged 40 or above) about 24 of the 31 items, 7 reaching statistical significance (see Table 6). Of these items, 3 were concerned with lack of knowledge and control – 'The possibility that the doctor may not be able to find out what is wrong', 'Not knowing what will happen to you in the department' and 'Being unable to control what will happen to you'.

The remaining 4 items about which young people were significantly more anxious than older people were concerned with physical aspects of being in the department. These were 'Having to get undressed for an examination', 'Having to undergo an uncomfortable procedure', 'Having to have an injection' and 'Seeing blood'.

Condition

Patients with more serious conditions expressed more anxiety about 25 of the 31 items than those with minor illnesses or injuries. Three reached statistical significance (see Table 7). These were 'Just being in Casualty', 'Being unable to control what will happen to you' and 'Your relatives not knowing what is happening to you in the department'.

Chi-squared analysis has shown that more anxiety was expressed by those who were younger, female and who had more serious conditions than by other groups. The young patients were more anxious about a range of factors associated with being in the department. Some seemed to reflect

Table 6: Items About Which ‘Young’ Patients Expressed Significantly More Anxiety Than ‘Older’ Patients

Source of Anxiety	N1	P1	N2	P2	Chi-squared	Degrees of Freedom	Level of Significance
The possibility that the doctor may not be able to find out what is wrong with you	17	53.12	6	20.00	7.281	1	0.01
Not knowing what will happen to you in the dept.	34	70.83	20	45.45	6.099	1	0.05
Being unable to control what will happen to you	30	62.50	18	38.30	5.565	1	0.05
Having to get undressed for an examination	16	44.44	7	21.21	4.182	1	0.05
Having to undergo an uncomfortable procedure	36	77.78	43	51.61	5.974	1	0.05
Seeing blood	10	33.33	2	8.00	5.130	1	0.05
Having to have an injection	9	25.00	2	5.26	5.690	1	0.05

N1=Number of ‘young’ people (aged under 40) who considered item applicable and expressed anxiety about that item.

P1=Percentage of ‘young’ people (aged under 40) who considered item applicable and expressed anxiety about that item.

N2=Number of ‘older’ people (aged 40 or over) who considered item applicable and expressed anxiety about that item.

P2=Percentage of ‘older’ people (aged 40 or over) who considered item applicable and expressed anxiety about that item.

Table 7: Items About Which ‘Major’ Patients Expressed Significantly More Anxiety Than ‘Minor’ Patients

Source of Anxiety	N1	P1	N2	P2	Chi-squared	Degrees of Freedom	Level of Significance
Just being in Casualty.	23	46.94	5	10.64	15.301	1	0.001
Being unable to control what will happen to you	32	65.31	16	34.78	8.843	1	0.01
Your relatives not knowing what is happening to you in the dept.	9	40.91	2	6.90	8.555	1	0.01

N1=Number of ‘major’patients who considered item applicable and expressed anxiety about that item.

P1=Percentage of ‘major’ patients who considered item applicable and expressed anxiety about that item.

N2=Number of ‘minor’ patients who considered item applicable and expressed anxiety about that item.

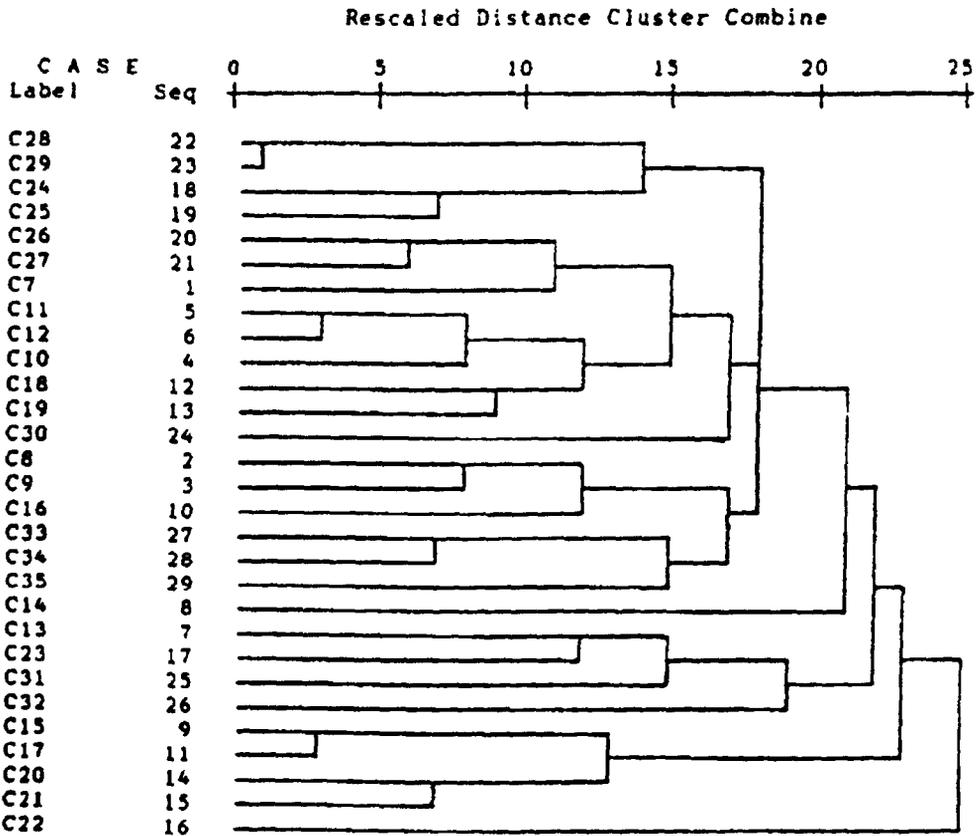
P2=Percentage of ‘minor’patients who considered item applicable and expressed anxiety about that item.

anxiety about the uncertainty and lack of control they experienced. Others were related to physical procedures and reflected patients' concern that they would experience pain or discomfort. Female patients were more likely to be anxious about having to get undressed for an examination. Female patients seemed, therefore, more embarrassed or self-conscious about this experience than males. The 'major' patients were more anxious about their relatives not knowing what would happen to them in the department. It was unusual for patients to be separated from their relatives except during medical examination. Occasionally, however, there would be confusion about whether relatives were present or, after helping the patient to undress, the nurse might forget to call the relatives. Nine patients did experience separation from their relatives and were anxious about their relatives not knowing what was happening to them. The nurses were generally concerned to ensure that relatives remained with patients as much as possible. The data suggest that this policy is useful in reducing patients' anxieties.

The Relationship Between Anxieties

Cluster analysis was used to discover any patterns which existed between the anxieties expressed by patients. Cluster analysis reveals links between the items studied. In the present study it was used to identify whether some anxieties were related to others. Cluster analysis provides a dendrogram which illustrates relationships between variables. Using this technique a number of items were found to be associated (see Figure 3).

Figure 3: Dendrogram Showing Relationships Between Anxieties



Item Code

- C7=Just being in Casualty.
- C8=Having to get undressed for an examination.
- C9=Being treated by a doctor you don't know.
- C10=Not knowing what will happen to you in the department.
- C11=Feeling helpless.
- C12=Being unable to control what will happen to you.
- C13=Your relatives not knowing you are in Casualty.
- C14=Your relatives not knowing what is happening to you in the department.
- C15=Being cut.
- C16=Seeing blood.
- C17=Having a blood sample taken.
- C18=Feeling pain.
- C19=Having to undergo an uncomfortable procedure.
- C20=Having to have an injection.
- C21=Having to have a 'drip' in your arm.

- C22=Having to have stitches.
- C23=Having to have a tube in your nose or throat.
- C24=Having a rectal examination.
- C25=Having a pelvic examination.
- C26=Having to have an operation.
- C27=Having to be admitted to the hospital.
- C28=Not knowing what is wrong with you.
- C29=What you think might be wrong with you.
- C30=Not being able to carry on your usual activities.
- C31=Being away from work.
- C32=Having a permanent disability.
- C33=The possibility that the doctor may not be able to find out what is wrong with you.
- C34=The possibility that the doctor may overlook an important sign or symptom of your illness.
- C35=The possibility that the doctor may think the problem is 'all in your head.'

The main cluster was found between the items 'Feeling helpless', 'Being unable to control what will happen to you in the department', 'Not knowing what will happen to you in the department', 'Feeling pain' and 'Having to undergo an uncomfortable procedure'. This cluster was found to be linked to a second cluster containing the items 'Having to have an operation', 'Having to be admitted to hospital' and 'Just being in Casualty'. The items in these clusters share a theme of anxiety concerning loss of control and the consequences of the health problem. Patients who reported anxiety about items within these clusters appeared, therefore, to have an overall concern about loss of control as a consequence of admission to the department.

A smaller cluster linked the items 'Being cut', 'Having a blood sample taken', 'Having to have an injection' and 'Having to have a 'drip'. These items seem clearly related to the fear of being cut. Patients who expressed anxiety about items in this cluster appeared to have an overall concern with that aspect of admission. This cluster appeared to be relatively independent of that concerning loss of control.

Two mini-clusters were identified. The items 'Seeing blood', 'Having to get undressed for an examination' and 'Being treated by a doctor you don't know' formed a small cluster. Social embarrassment seemed to link these items. The items 'The possibility that the doctor will not be able to find out what is wrong with you', 'The possibility that the doctor will overlook an important sign or symptom of your illness' and 'The possibility that the doctor will think the problem is "all in your head"' formed another small cluster. These items seemed to be linked by a concern on the part of

patients about how they would negotiate the situation of being in the Accident and Emergency Department. Both clusters share a theme about the social and interactional aspects of admission. Patients who reported anxiety about items in these clusters appeared to have an overall anxiety about how they would negotiate, or manage, their experience in the department.

Cluster analysis therefore illuminated themes in the data. It appeared that certain items were related so that patients who were anxious about one item in the cluster were also likely to be anxious about other items in the cluster. The main cluster which was evident showed a relationship between items which were concerned with loss of control and the consequences of the health problem. Social rather than medical concerns were, therefore, the most important to patients. Patients were worried about what would happen to them in the department and about how they would cope with any disruption to their lives. Other clusters linked items which were related to 'Being cut' and items which were concerned with the social aspects of admission and negotiation of the situation. The cluster analysis therefore suggests that patients' fears tended to be focused on certain aspects of their experience of being in the Accident and Emergency Department. The data indicate that each item on the schedule should not necessarily be viewed as wholly discrete. Certain items may be linked to others and reflect one dimension of that patient's wider concern about an aspect of their illness or injury and experience of being in the Accident and Emergency Department.

Conclusion

In Stage One of the study the anxieties of patients in the Accident and Emergency Department were examined by means of structured interviews with a sample of 96 patients. The results showed that the most common fears were 'Not being able to carry on your usual activities', 'Not knowing what will happen to you in the department', 'Having to undergo an uncomfortable procedure', 'Feeling pain' and 'Not knowing what is wrong'. These findings, together with those from the cluster analysis, indicate that patients were more concerned with social factors related to their admission and the possible consequences of their illness/injury than with medical matters. This is an important finding as doctors and nurses may tend to concentrate on medical matters. If so, the concerns of patients may receive insufficient attention.

The findings of Stage One confirmed those of the pilot study that lack of information and concerns about what would happen to them in the department, the consequences of their illness/injury and experiencing pain or discomfort were a sources of concern for patients in the Accident and Emergency Department. Although the concerns identified were similar, patients tended to report more anxieties in response to the structured interview schedule, than in response to informal interview. It may be that the patients felt they had to be brave when talking to the interviewer. When they were asked about specific, common worries they tended to report more anxiety.

Similarly, only 35 patients reported feeling anxious about coming to

Casualty in response to an open-ended question. However, of those who said they were not anxious initially, only 2 reported no anxieties when asked about specific items. That patients expressed anxiety in response to particular questions but not to a general enquiry has implications for nursing practice. Patients appeared reluctant to express their concerns unless asked about them directly. In order to address patients' anxieties effectively nurses would consciously have to seek to identify them. The way in which care was observed to be delivered during the pilot study would be unlikely to be effective in identifying patients' worries.

A greater number of female patients and those with more serious illness and injuries expressed anxiety in response to the open-ended question than did other groups. These patients also expressed a greater number of anxieties in response to the items listed and said they were 'extremely anxious' about more items. Chi-squared analysis also found that females, young people and those with more serious conditions were more anxious than other groups. The finding that 'young' females were more anxious is an interesting one. The reasons why this was so are uncertain. An obvious explanation is that these groups were more willing to express anxiety.

Culturally, it may be more acceptable for females to express anxiety than males and, perhaps, for younger people to express more anxiety than older people. It is also possible that the 'young' female patients were more willing to express their anxiety to the researcher, also a young female. 'Older' patients and males may have been less willing to express their anxieties to a younger person of the opposite sex.

It may, however, be that the difference was not simply one of expression,

but that a real difference existed between the groups. Cultural factors may also play a part in the sex difference found. Thus, socialisation of females tends to emphasise their sex as the one which is more expressive and emotional. This may lead to this group being more alert to, conscious of and vulnerable to feelings of anxiety. Male socialisation tends to emphasise development of confidence and independence. They may, therefore, experience less anxiety in new or uncertain situations.

Such an explanation does not, however, explain the difference found between 'young' and 'older' females. This may, perhaps, be attributed to greater experience of hospitals, health care and unfamiliar situations generally. As the individual matures, life experience may lead to them coping more successfully with previously unencountered events. The reasons for the differences found are, therefore, unclear. It is likely that the experience, and expression, of anxiety is influenced by a complex range of factors. As a Symbolic Interactionist perspective would suggest. the individual's experience, and expression, of anxiety would be based upon the meanings which events hold for them, their previous experience of similar occurrences and the interaction arising between the individual and those they encounter.

The findings from Stage One have indicated the sources of anxiety for patients in the Accident and Emergency Department. The questions of the extent to which these fears were addressed by nurses and the methods they used to do so require further examination. Stage Three of the study therefore systematically examined the interaction occurring between patients and staff in order to elucidate further its quality and duration.

The results of the observational study examining nurse–patient interaction are reported in Chapter Eight. Before examining further the behaviours of nurses, however, consideration must be given to the meanings which they attach to their work and the interpretations they make about events.

Chapters six and seven, therefore, report in detail the interviews with nurses in the departments studied and provide insight into the nurses' perception of their work and patients. How such perceptions influence the way in which nurses define and conduct their work is explored.

CHAPTER SIX

Results: Nurses' Priorities and Patients' Anxieties

Introduction

Chapters Six and Seven report on the in-depth interviews carried out with nurses during Stage Two of the research. The interviews explored how nurses perceived their work and patients. Five core categories were identified. These were 'Defining the Role of the Accident and Emergency Department Nurse'; 'Nurses' Priorities and Patients' Anxieties'; 'Keeping the Department Running Smoothly'; 'Legitimate and Illegitimate Demands'; and 'Exercising Control in the Department'.

The first three categories are illustrative of the factors which influenced the extent to which nurses would deal with patients' anxieties. These categories are discussed in Section Two of this chapter. The final two categories reflect the nurses' views of the purpose of the Accident and Emergency Department, who should use the service and the strategies they used to exercise control in the department. These categories will be discussed in Chapter Seven.

This chapter is divided into two sections. Section One discusses the methods used to collect and analyse data with reference to the Symbolic Interactionist perspective. Section Two reports on three of the categories

generated – ‘Defining the Role of the Accident and Emergency Department Nurse’; ‘Nurses’ Priorities and Patients’ Anxieties’; and ‘Keeping the Department Running Smoothly’.

Section One

Methodology

Aims

The interviews with patients conducted in Stage One had revealed that a large number of patients were anxious about some aspect of being in the Accident and Emergency Department. The most common fears were about not knowing what would happen to them in the department, being unable to control what would happen to them and how their illness/injury would affect their usual activities. It seemed probable that some of these fears could be reduced by effective communication between nurses and patients. The quality of nurse–patient interaction and the type of information given were identified therefore as important factors to be considered in relation to patient anxiety. However, during the pilot study the interaction between nurses and patients had been found to be brief and with little attempt made to identify patients’ fears. In order to understand why this might be so, it was decided to conduct in-depth interview with nurses to explore their perceptions of their work and patients.

Method

Sampling

All qualified nurses working in each department (apart from those working permanent night duty) were interviewed. The total numbers were 13 in Department A and 8 in Department B.

Consent

At the beginning of this part of the study a meeting with nurses in each department was arranged to explain the purpose of the interviews and to elicit their co-operation. It was explained that, having examined the patients' perceptions of the department and the sources of anxiety for them, that the researcher wanted to explore nurses' perception of their work and patients in order to gain a more comprehensive view. The difficulties of gaining the time and attention of nurses during the observational period were mentioned, and the value of an in-depth approach to enhance understanding explained.

It was explained that the interviews would be tape-recorded but that the information would be treated as confidential and that no mention would be made of the nurse's name. All of the nurses agreed to participate.

Data Collection

The interviews took place in the sister's office in each department. In both departments this provided a room which was quiet and predominantly free from interruptions.

At the beginning of each interview it was explained to the nurse that, having carried out interviews with patients looking at the sources of anxiety for them in the department, the researcher was interested in how nurses identified and dealt with patients' anxieties. It was also emphasised that she was interested in their experiences of working in the Accident and Emergency Department.

It was explained that although there was a list of topics which the researcher wanted to cover, these were not rigid and that she would like them to feel able to raise other issues which they thought relevant. They were reminded that the interview would be treated as confidential and that no record would be made of their name.

Each interview started with a discussion of general topics such as how long the nurse had worked in Casualty, where she had worked before and what her impressions had been on coming to work in the department. These questions provided useful background information, as well as a starting point for other lines of enquiry.

The interviews thus progressed in the form of a 'conversation with a purpose' (Cannell and Kahn, 1968). The researcher had a list of topics to be covered, but these were not addressed in any strict order and points raised by respondents were pursued to develop further insight and understanding. Such an approach allowed the interviews to proceed in a natural and spontaneous way which, in accordance with the aims of Symbolic Interactionism, enabled the meanings and interpretations of the nurses to be explored. The interviews lasted between 40 minutes and 1

hour, during which the nurses talked in a way which seemed unconstrained about their attitudes towards their work and patients, perceptions of their role, the everyday rewards and demands they encountered in their work and the strategies they used to achieve their ends.

Data Analysis

Interview transcripts were analysed using the constant comparative method (Chenitz and Swanson, 1986) and significant themes pursued as they emerged. Using this method, each transcript was examined and the data grouped according to emergent themes. These themes could then be compared with those arising in subsequent interviews and used to direct further enquiry. Thus, the list of topics in the early interviews was fairly short. They were divided into four sections. The first part of the interview was concerned with collecting simple factual information about how long the nurse had worked in the department, what he or she had done before, what aspects of their work the nurse found most the most rewarding and which the least. The interview then progressed to explore how he or she saw the role of the nurse in Casualty, particularly with regard to identifying and dealing with patients' anxieties. Some time was then spent discussing care of relatives, and finally, organisational, professional and interprofessional issues were raised.

As subsequent interviews took place, the list of topics was extended to include other issues which arose and to allow their exploration in greater depth. For example, in the early interviews the researcher asked the nurses which aspects of their work they found most and least rewarding. In the later interviews the researcher was able to elicit whether these preferences

were individual or part of a shared view. The reasons underlying these preferences and their influence on practice were also explored.

Circumstances in which an individual might be regarded favourably, despite being one of the patient types which nurses typically disliked caring for, were also probed.

Tapes were transcribed and the contents analysed and recorded as memos. Each memo would include both a quotation from a nurse and observational notes which recorded contextual and interpersonal effects such as whether the nurse had initiated the comment or whether it was in response to a question, how it was said, whether it was explored further and with what result. Theoretical notes which asked what was meant by the statement, what it added to the understanding of the situation and how it related to other statements made by this or other nurses, were also included in each memo. These memos then provided areas which could be explored further in subsequent interviews, which were then transcribed and analysed in the same way. As data collection continued, themes were developed which reflected the issues which were emerging

The memos were stored in a file, according to the theme to which they were assigned. Initially, 22 themes were generated which covered a wide range of issues which had emerged as important during the research. The memos were then analysed further by means of comparing and contrasting the data contained within each, according to the emergent conceptual themes. The five core categories listed at the beginning of the chapter were eventually established. The method used to develop the categories is advocated by grounded theorists (Strauss and Corbin, 1990) as a means of

generating theory inductively from data. In the present study it provided an effective technique for organising and interpreting, within a Symbolic Interactionist framework, a large amount of qualitative data in such a way as to make accessible and meaningful the nurses' accounts.

A potential difficulty with this approach is the risk of introducing bias and distortion. The researcher has therefore included in the text, where appropriate, an explanation of how the categories were generated and developed. The report also relies heavily on the accounts of the nurses gained by interview. Frequent use is therefore made of quotations from the data. The Symbolic Interactionist perspective emphasises the importance of the meanings and interpretations made by the participants in the area studied. In the present study the researcher aimed to elicit and expose the nurses' perceptions, rather than impose her own.

The researcher did, however, aim to develop theory from the data which inevitably requires further analysis and interpretation. The use of quotations from the data allows the nurses' accounts to be understood. Interpretive comment then discusses conceptual links between each category. Each of the five categories finally established is discussed in detail. As previously stated, for each one, an introduction explains how the category arose. The main facets of the category are then presented, with data drawn from the interviews. It is hoped that in this way the validity of the categories will be evident.

Before considering the categories in detail, a brief overview of each is given to provide an outline of their characteristics and a context in which they may be understood.

The first category, 'Defining the Role of the Accident and Emergency Department Nurse', covered the nurses' perception of this type of nursing. Nurses reported that they were attracted to work of this sort because of the drama and excitement which they anticipated it would entail. Although they found, in reality, that a great deal of the work was of a mundane nature, they continued to value caring for the 'major trauma' patients the most highly. A second aspect of their work which they appreciated was its short-term, immediate quality.

The second category, 'Nurses' Priorities and Patients' Anxieties', illuminates the ways in which nurses' perceived patients' anxieties in the departments studied and factors which influenced the likelihood of their being dealt. The relationship between nurses' attitudes, outlined in the first category, and the organisation of nursing work is discussed. Although the nurses thought that patients attending the department were likely to be anxious, physical care was their primary concern. Psychological support, they reported, was given only if time and opportunities for contact allowed. The nurses generally emphasised processing patients through the department more than dealing with their responses to it.

In the third category, 'Keeping the Department Running Smoothly', the way in which the role of the Accident and Emergency Department nurse was developed and maintained is elucidated further. Ensuring that the department functioned efficiently was identified as a central aim. The role which the nurses chiefly adopted and practised was firmly grounded on this preoccupation.

The fourth category, 'Legitimate and Illegitimate Demands', elaborates on the theme that nurses' perceptions of patients influence their interaction with them. In particular, the nurses described their care of patients whose demands they perceived as illegitimate as involving only a minimum of effort, a process of 'going through the motions'.

The final category, 'Exercising Control in the Department', is concerned with delineating the ways in which nurses maintained their role as administrators and organisers of the department and those by which they averted any threat to their authority. The strategies used included attribution of the patient role and patient compliance with it, maintenance of professional credibility and, ultimately, recourse to a higher authority.

The first three categories will be described in detail in the remainder of this chapter. The final two categories will be discussed in Chapter Seven

Section Two

Results

The three categories discussed in this chapter are concerned with the nurses' perceptions of their work and patients and the ways in which these influenced the likelihood that patients' anxieties would be identified and dealt with. Each has a different emphasis. In the first category, 'Defining the Role of the Accident and Emergency Department Nurse' the nurses' perceptions of their role are explored. How these perceptions were linked

with the aspects of their work which they found most rewarding is considered. In the second category 'Nurses' Priorities and Patients' Anxieties', nurses' perceptions of patients' anxieties are examined and the ways in which the nurses' definition of their role influenced their action are explored. Finally, in the category 'Keeping the Department Running Smoothly' the nurses' perceptions of their wider organisational function are considered. The nurses' views about how their role could develop are also included in this category and the reasons underlying their beliefs explored.

Category One: Defining the Role of the Accident and Emergency Department Nurse

Symbolic Interactionism emphasises the importance of understanding the meanings and interpretations which those participating in a group attach to events. In order to understand the actions of individuals, their perceptions of the situation in which they participate must first be understood. In the present study, the ways in which nurses perceived their role, their patients and their work were of central importance.

The category 'Defining the Role of the Accident and Emergency Department Nurse' was generated initially from nurses' responses to the question of why they had chosen to work in the Accident and Emergency Department. The majority of nurses gave reasons which stressed their view that the work would be interesting, exciting and varied. The category was developed further when their accounts of the aspects of their work which they found the most and least rewarding were considered. Responses to these early questions revealed the way in which nurses perceived the role of

the Accident and Emergency Department nurse, prior to coming to work in the department.

Although the nurses valued most highly work which was exciting and dramatic, in particular caring for 'major trauma', much of their work was not of this nature. A great deal of their work was involved with caring for patients with minor and non-urgent illnesses and injuries. However, the factors of interest; excitement and variety remained an important component of the way they saw their role. Work which offered them such experience was generally perceived as the most rewarding and, despite evidence to the contrary, was seen as the main purpose of their job. Other less 'interesting' work, and the patients who 'created' it were attributed lower importance and were, in some cases, viewed negatively. This category elaborates how the nurses perceived their work and the type of work which they valued most highly.

Contrast Between Reality and Expectations

Nurses were attracted to working in the Accident and emergency department because of the excitement and drama they believed such work would involve. However, they found, in reality, that much of their work was not of this nature. As one nurse states,

I thought it would be loads of major things and you just don't realise the amount of tripe that comes through the door.

The above statement vividly illustrates the contrast between the nurse's perceptions of what it would be like to work in the Accident and Emergency Department and what in reality she found the work to involve.

Some nurses had had experience of working in the Accident and Emergency Department as students. Among other nurses, the preconception that working in the Accident and Emergency Department would predominantly involve caring for 'major trauma' patients was a common one. As one nurse described it, 'It's not as dramatic as I thought. I thought it would be all running down corridors, cardiac arrests. It's not as dramatic as I thought.'

The idea that working in Casualty would exclusively involve rushing around dealing with emergencies is something of a cliché, but that the nurses had expected their work to involve a large amount of such activity was clear. As another nurse stated,

I think I didn't expect, em, the type of patients you get. I think I tended to expect all gore but it's not like that. Obviously you see a bit of it, but it's not what I expected.

The discovery that a large proportion of patients who attend the Accident and Emergency Department have, in the nurses' view, simple non-urgent conditions was also unexpected. As one nurse said, there was 'more dross than I expected'. 'Dross' according to this nurse consisted of 'inappropriate referrals, self-referrals or GP referrals.'

For nurses who came to work in Casualty there appeared to be a discrepancy between what they believed the department would be like and how they actually found it to be. Their perception had been that they would find it a dramatic and exciting place to work. The reality proved that much of the work was rather mundane.

Job Satisfaction

The aspects of their work which nurses found the most rewarding were those which provided them with the pace, variety and excitement which they sought. These were the features which had attracted them to working in Casualty initially and the extent to which nurses regarded them as contributing to their job satisfaction was striking, as the following extract indicates,

I like the pace of the work, because it's usually very busy. The day goes quickly and there's lots of variety. You never get bored. You never know what's going to happen next. It's a very exciting place to work. It's a very stimulating place and you see lots and lots of interesting things from all walks of life and specialities. So you don't get bored on a department like this.

This view of the Accident and Emergency Department providing a great deal of interest and variety was echoed by other nurses. Many contrasted this with their experience of ward work. As one nurse said, 'It's completely different to anything on the wards because it's different all the time.'

For many nurses it was disillusionment with the routine and uneventful nature of ward work which had led them to pursue a career in Accident and Emergency nursing. The unpredictability of work in the Accident and Emergency Department was seen as one of its attractions, as the following comment illustrates,

When I first qualified I staffed on a male surgical ward for 5 months. I found it fulfilling but also very boring because you have set routines, set operating days and so forth whereas Casualty is totally different. You don't know what's coming through the doors next. Although you have a set routine to a certain extent it's just totally unpredictable. You don't know what's coming through the doors next.

The strength and frequency with which a positive view of the interest and variety of Accident and Emergency work was expressed, suggested that a certain type of person was attracted to that type of work. This was supported by comments made by the nurses, such as that made by the sister in Department A that, 'as a nurse, it takes a certain type of personality to work in the Accident and Emergency Department'.

The nurses tended to describe themselves as unsuited to the mundane quality of ward work. The sister in Department B comments,

I haven't done a lot of medical. So it's always been quick turnovers as I call them. They come in, they get better and they go out. I don't think I would cope with the medical because I didn't like it in my training because you get the same old thing again and again.

It seemed, therefore, that nurses in the Accident and Emergency Department preferred to operate within a short time-frame. This could have implications for the type of work they were willing to undertake. Thus, in the pilot study, the nurses were efficient at organising solutions to immediate problems (see page 99). They may be less concerned to deal with the long-term consequences of patients' illness or injuries.

Among nurses as a group, the continuity of ward work with its opportunity to establish longer-term relationships with patients and their families may be attractive. For the Accident and Emergency nurses, ward work embodied 'routine' and boredom. The second sister in Department B describes her dislike of such work,

I felt right at the beginning, once I had qualified, well, what I would call an ordinary ward, it didn't hold that much interest...I find it difficult to define why I like this type of work. I suppose the day-to-day aspect changes. It's not as if you're given an absolute set routine (...) I think you'll understand what I mean by the wards. You have a certain breakfast time, pressure care time and going on from there. It was this aspect I didn't feel I could, that I didn't want to be involved with.

Their choice of work reflected the nurses' taste for variety and stimulation which, as the following nurse confirms, they thought one was either suited to or not,

I like in Casualty what people don't like in Casualty. You either like it or you don't like it for the same reasons and it's because of the complete difference in the jobs you're doing all the time. You never actually know what your next patient is going to be unless they've been formally referred to one of the specialities...but you never actually know what's going to be brought in with a 999 call and basically that's it. That's what I love.

An important feature associated with the reported variety and unpredictability was a sense of immediacy. In addition to a dislike of routine, the Accident and Emergency nurses enjoyed feeling that problems which arose were dealt with at the time. Long-term problems, at least related to patients, were exceptional. One nurse states,

I enjoy the fact that every day is different. You have different problems. So when you go home you know that tomorrow isn't going to have the same problems that you had today.

What was more rewarding, as the following comment illustrates again, was that the problems were of a short-term nature and were necessarily dealt with at the time,

When I worked on the wards I found that if you have problems you go back to them the next day whereas in an Accident Department you come to work and sort out all your problems in that day. I like that.

'It's What We're Here For'

Thus far we have seen that the attitudes of nurses in Casualty towards their work strongly emphasised its pace, variety and immediacy as attractive features. The unanimity of this view was striking. All of the nurses interviewed reported that they enjoyed, or even loved, their work and these were the reasons invariably given. Only one nurse mentioned the inherent lack of continuity which was the counterpart to the variety and pace of the work. She had not chosen to work in the Accident and Emergency Department but pressure of circumstances had led her to do so and her account reveals that for inexperienced or student nurses coping with the variety and lack of routine may also be an uncomfortable experience,

I didn't enjoy it at all when I was here as a student. When I was here for 5 weeks I absolutely hated it. I thought it was the worst place on earth. There's just no continuity, you just look after the patients and then they're gone. So I didn't want to work here when I qualified but there were no jobs anywhere else and they said I could come here for 3 months because there was a job coming up on Ward _____ and I never got to Ward _____. I ended up staying. Because I liked it when I came back for a longer period of time. I enjoyed it better.

This nurse goes on to explain her initial dislike of the Accident and Emergency Department as resulting from her own lack of confidence and the absence of secure and familiar routines,

It's not like on the wards where you can get stuck in and do everyone's blood pressure and do the obs. and the baths and everything. There's no sort of set pattern. You just do whatever needs to be done when the patient comes in. I didn't like that.

She believes that it was only when she became more confident in what she was doing that she started to enjoy her work,

I think I liked it better because I knew a little bit more what I was doing than when I was just here for 5 weeks. I felt more confident in it.

It is interesting that from a hesitant start, this nurse, like the others, came to value the variety and lack of comfortable routines. For a student nurse routines may provide a degree of familiarity and security in an uncertain environment. It seemed that once the nurse became confident in what she was doing and was perhaps able to exercise some control over her work, the features which had been most stressful and difficult became those most valued. Although she had not been initially attracted to the Accident and Emergency Department for these reasons, this nurse soon found these were the aspects of her work which were most rewarding. Another feature which she learned to enjoy was the opportunity to care for 'major trauma' patients. Again, this was an aspect of their work which was valued by all of the nurses interviewed. As this same nurse reports,

Everybody likes to get into Resus. because it's a little bit more interesting, a little break when you've been in there.

A clear distinction was made by the nurses between 'major trauma' patients, who were seen in the resuscitation room, and 'dross' or 'tripe'.

These may be seen as forming opposite ends of a continuum, although some degree of blurring is inevitable about where on the scale certain patients fall. As another nurse states, an important feature of major trauma patients was that they allowed the nurse to demonstrate certain practical, often technical, skills,

When I say 'major trauma' I include MIs (myocardial infarctions). To me an acute MI is part of, it's not strictly major trauma but I class it as such. It's where you know your skills are going to be called on.

Despite a slight degree of uncertainty about categorisation, there was no doubt about the perceived value of the two groups of patients,

It's what I think we're here for (major trauma). Let's say if I was given the choice of being with a major trauma patient and a load of dross, I'd take the major trauma every time.

The nurse's preference for patients who provided the opportunity to practise skills is significant. She also reports that 'major trauma' patients were those who 'really do need you'. Such a view corresponds with the assumption of Symbolic Interactionism that the meanings which individuals attach to their situation is of fundamental importance to understanding their behaviour. For the nurses in the Accident and Emergency Department the 'major trauma' patients who provided them with the opportunity to practise their skills were perceived as the most important. In addition to allowing the nurses to demonstrate their technical skill there was also an emotional component to the relationship. The nurses felt needed by these patients, which was also a source of satisfaction. The 'major trauma' patients therefore provided nurses with an opportunity to

feel both technically expert and rewardingly useful. From an interactionist perspective it is understandable that the nurses enjoyed caring for these patients the most.

Furthermore, these patients provided another element, that of excitement. The nurses were quite clear that, in addition to the pace and variety of Accident and Emergency work, it was the drama and excitement which they enjoyed,

I enjoyed working reception nights (on the ward) but it wasn't busy enough for me any other time (...) I came back here and I've never regretted it because I wanted to be off the ward in a way and this suited me fine. I liked it busy and I suppose that most people who work in Casualty like the excitement of, you know, you get a lot of minor stuff but it's the major stuff that keeps people's interest you know.

Again, in the above extract, it is acknowledged that busyness and excitement are what Accident and Emergency nurses enjoy in their work. This nurse goes on to say that she would prefer to work in a department which had even more major trauma patients than the present one provided.

As already suggested, a large part of the appeal of such patients was the opportunity they provided for nurses to practise their skills. The following extract captures the sense of drama and challenge which the nurse experiences when dealing with these patients,

GB: What about dealing with dealing with the major trauma patients? How do you find that?

N: I enjoy it really. I do. I love it.

GB: What is it that you like about it?

N: Oh, all of it really. Just the, your adrenalin starts to go and you think 'Ooh this is really good to deal with' and you see it right through to the

end, whatever it is (...) and you think you must do things quickly, and you can see them deteriorating in front of you, their blood pressure dropping and you think 'get the lines in, the doctor's in theatre, let's get him down here as soon as possible'. It's exciting really.

Many of the nurses described this 'rush' of adrenalin they experienced when dealing with such urgent cases, 'that sort of thing really gets your adrenalin going. We all like to get in there. We're all waiting at the door for the patient coming down the corridor.'

The image of the nurses poised ready to receive the patient is a vivid one. Part of the appeal of such patients was their relative rarity. As already discussed, much of the work of the Accident and Emergency nurse was fairly mundane, as one nurse describes it, 'more sprained ankles than anything else'. She goes on to say,

People think Casualty is like that from dawn to dusk (dealing with major trauma), but it isn't. Alright you can have one day and you'll have three or four and then you can go for weeks and not really had any because of the shift you've been on. So it's quite good to get that because you don't always get it.

In contrast to such activity caring for minor patients was described as 'very repetitive and boring'. Some nurses tolerated dealing with minor patients, regarding it as a respite from looking after major trauma patients. As one nurse said, 'It's nice to think, "Oh well, nothing too bad goes into the curtains (where minor patients were seen)'"'. However, the general tendency was to regard caring for minor patients as uninteresting, as one nurse reported, 'A lot of nurses moan when they're put to work in the accident room', where such patients were seen.

Other patients, who were referred to variously as 'timewasters and regulars', 'tripe' and 'dross' were frankly disliked by the nurses interviewed. The nurses' attitudes towards such patients and the way they dealt with them form a separate category to be discussed in the following chapter. The present category, 'Defining the Role of the Accident and Emergency Department Nurse' has indicated that nurses who work in the Accident and Emergency Department are attracted to it for the specific reasons that it will, they believe, provide them with work which is interesting, varied and exciting. Although, in reality, they found that much of their work did not possess these qualities, the work which did was that which they valued the most. It appeared that these perceptions of their work and patients underpinned the ways in which nurses organised their work and behaved towards their patients. The ways in which they did so will be elaborated in the subsequent categories of this chapter.

Category Two: Nurses' Priorities and Patients' Anxieties

The previous category identified the emphasis which nurses placed on excitement, interest and variety in their work and their positive evaluation of patients who held such characteristics, in contrast to those who did not. This second, related, category elucidates the way in which nurses perceived patients' anxieties in the Accident and Emergency Department and the factors which influenced how these anxieties would be addressed. The relationship between nurses' attitudes, examined in the first category, and the organisation of nursing work, is explored.

Patients' Anxieties

The nurses were conscious of the fact that people who attended the Accident and Emergency Department were likely to be anxious. Almost all said they thought every patient would have some degree of anxiety. The sister in Department A summarised the general consensus by saying, 'I don't think there's ever a patient that comes in that doesn't have any anxiety.' An interesting theme which emerged was the types of patients the nurses thought would be most anxious. There was a general agreement that those with more serious illnesses were likely to be more anxious than those with minor injuries. As one nurse said,

I think the majority of them probably are (anxious)...I think the majority of the cabins, I think the cabin patients (i.e. those with more serious conditions) are probably more anxious. Their injuries or illnesses are more severe and they're basically the ones who may have to stay in hospital.

The nurse here points to the severity of illness as the major reason for the greater likelihood of anxiety among these patients, a view which was shared by others. As a second nurse says,

I think the patients who go into the cabins at the bottom tend to be more anxious than patients in the curtains...because their condition is more serious than the patient in the curtains.

A second group who were also seen as likely to be anxious were the older patients. As one nurse said, 'The elderly people I find tend to be the most anxious.' For these patients it was the possibility of admission – which is likely to be also related to the severity of condition – which the nurses saw as their main fear. The only patients whom nurses thought were likely to

be more anxious were children, a group not included in the present study. As another nurse states,

A lot of the elderly ones are (anxious) because obviously they're frightened they're going to be kept in. The young, the children, tend to be scared, especially if they've had bad experiences in the past or heard horror stories from the kids at school. They're your main ones, the elderly and the young.

The underlying cause of anxiety, another nurse suggested, was the fear among elderly patients that admission would 'take their independence away'.

While it is conceivable that certain types of patients may tend to be more anxious than others, there is a danger inherent in such assumptions.

Relying on assumptions about the amount of anxiety different types of patients experience may lead to incorrect assessment of individual patients. Nurses tended to report that, although they thought individual assessment was important, they relied on their common knowledge about different patient types. The sister in Department A comments,

I think on the whole nurses tend to treat it (patient anxiety) very trivially, except possibly with the CVAs (cerebrovascular accidents) and the ill patients. I think they do realise then that it's a fairly major problem. I think with trivial things (laughs here at her own slip), with minor injuries, the nurse might view them as trivial and therefore not give any credit to the anxiety.

In many instances the nurses said they did not attempt to assess anxieties which certain patients may have, as the following extract reveals,

I wonder sometimes how much we do look at our patients holistically. That's a cut finger and it gets sorted out as a cut finger, then out through the doors. Apart from the briefest, how would you say, cursory, attention to how they did it, you know, that's how we manage it. I mean we, personally, I tend to look and if they're young and fit or say middle-aged and fit with a cut finger they can manage, they can cope. It's not one of the age groups I would be concerned about.

The interview data suggest, therefore, that although nurses believed that all patients were likely to be anxious in Casualty, they perceived certain types of patients, those with more serious injuries and the elderly, as likely to be more anxious than other groups. Their accounts suggested that they relied on generalisations, based on such assumptions, when carrying out care.

The interviews with patients had shown that although 'major' patients were more anxious than 'minor' patients, the 'young' patients were more anxious than older patients. The nurses' perception that the older patients were more anxious was not supported. It may be that the discrepancy between the patients whom the nurses thought were most anxious and those who reported most anxiety made it likely that the anxieties of 'young' patients would not be addressed.

In addition to the types of patients whom they thought were most anxious, the nurses were asked which aspects they believed patients to be most anxious about. Most described fears associated with being in the department such as, 'fear of the unknown', 'about what's wrong with them', 'about who the staff are and who's going to do what to them' and specific procedures, for example, 'I think they're worried that if they need stitches that it's going to hurt and that we don't care and we don't do

anything about it.' Fears about what would happen to them in the department were commonly mentioned by patients. The nurses, therefore, seemed aware of the possibility of these worries. A few nurses mentioned social factors prior to admission as a source of anxiety. As one nurse said,

A lot of the time what they've left at home. Just general worries. Sometimes they're worried about not getting back there...that somebody will be missing them, that they should have been in as their daughter always rings them at such and such a time, that they've caused trouble to other people if they've collapsed in the street, just the embarrassment, you know.

Again, the worries which nurses described were concerned with short-term issues. None of the nurses mentioned how patients would cope following discharge, the factor which was most commonly cited by patients. It may be that nurses were unaware of the incidence of this fear and, if so, would be unlikely to address it.

Nurses' Priorities

One of the reasons why nurses relied on these common assumptions about patients was, they reported, because they had insufficient time to deal with each patient individually. The following extract reveals the priority they gave to physical care, psychological care being accorded only secondary importance,

If it is busy then all the nice things you've been taught about what you've got to do and how to look after patients go out of the window and it's just task oriented. You've got to get this job done because you know there's another one waiting for you and there's very little...I think when it's quiet then you can look after your patients, advise them what's going on, but when it's busy the patient as a person thing gets forgotten.

As the above extract suggests the nurses often felt under constant pressure to complete one task so that they could progress to the next. The concept of holistic, individualised care was seen as an impossible ideal. The nurses reported that even when they were in the process of caring for a patient they were constantly interrupted and, in any case, were themselves conscious of other tasks they needed to perform. Attempting to cope with so many conflicting demands simultaneously made, as one sister in Department A suggests, dealing with patients' anxieties a difficult task,

I don't feel we deal with them (patients' anxieties) as well as we could. I mean you find that even if you spend 10 or 15 minutes, a short length of time, with somebody, there's people popping in, either myself being in charge, 'Can I have the keys?' and you never feel like you've given them enough and you're always in the back of your mind thinking, 'Well I've got this to do and I've got that to do' so again I think that creates a stress for you because you're not, you know what you want to do but you're not doing it as well as you can.

As the above extract indicates the nurses felt very aware that they were not always able to give patients the kind of care they would have wanted to. They were very candid about the quality and quantity of nursing care which some patients received. The following nurse reports,

Some (patients) don't get much contact at all (with the nurses). I mean, em, the trivial injuries don't get much contact at all. It's in, seen, out and that's it. With the workload you've got you haven't got time sometimes. If you've got a long waiting list there's no way you can sit down and talk with them.

The way that nurses described their experiences was very much in terms of how they themselves coped. The interactionist perspective recognises that individuals direct their action according to their own means and ends. The

nurses clearly felt that the amount of work they frequently faced and the problem of conflicting demands being simultaneously made on them were impossible to resolve adequately. The only way in which they could cope was by concentrating on their priority, physical care, and by developing strategies to do so effectively in a minimum amount of time.

The observational study suggested that nurses did not spend any more time with patients when the department was quiet. It appeared that the nurses developed strategies of care in order to cope when it was busy. These strategies then became common practice and were followed even when the department was quiet. However, the nurses felt the strategies were necessary because they were so frequently under a great deal of pressure. The work had to be organised in a way which facilitated speed and efficiency.

People Processing

Reasons why nurses tended to concentrate on the physical problems of patients have been outlined. The strategies by which they achieved this end will now be examined. The strategies employed reflected their emphasis on physical care and also the value they attached to dealing with emergencies. Two aspects predominated. One was assessment of patients. The second was concerned with their progress through the department. The way in which these were carried out and the underlying rationale are explicable in terms of the nurses' description of their work as people processing. The concept of people processing arose when one of the sisters in Department B was asked if there were any factors within the department

itself which contributed towards patients' anxieties. Her reply introduces this notion of the role of the Accident and Emergency Department nurse,

GB: Do you think there are any factors within the department itself which make patients feel more anxious?

N: I think it's the speed at which they're processed. It's a very fast process. I mean when I say that, again, the speed is relative to their injuries.

GB: What do you mean by that?

N: I mean somebody with a minor cut can get through in roughly fifteen minutes. Somebody with a possible break who needs an X-ray, now we process them fairly fast, get them to X-ray in fifteen minutes and then they sit there for an hour and a half waiting to be X-rayed, come back to us, another half hour waiting for the X-rays and all that time their anxiety, they're sitting there not knowing what's happening to them, and the anxiety is just building up.

Such a view maintains that the waiting time is the main source of anxiety for patients, a view which several other nurses shared. The fact that they felt powerless to do anything about that made them pessimistic about the possibility of reducing patients' anxieties, As another nurse states,

I think the main anxiety comes from the fact that they sit there for 2 or 3 hours waiting to be seen...but I think it's irreparable (the waiting time) in this department because (a) geographically there just isn't enough room to see patients more quickly, (b) there isn't the nursing staff and (c) there isn't the doctors. So if this department stays as it is I just don't think you'll get round that problem.

The only helpful intervention the nurses felt they could make was to try and keep the patients informed of the reasons for, and expected length of, delays. The nurses also, therefore, tended to concentrate on processing patients through the department as quickly as possible.

Patient Assessment

One nurse gave a description of the typical admission procedure for a 'major' patient,

If they came in by ambulance generally you try and get a full history off the ambulance crew. First of all assess what's happening at home, whether the relative is with them, who phoned them in, all that sort of thing. Get them undressed. Do their obs. (recording of temperature, pulse and blood pressure). Depending on how serious they were you'd take the card round and put it in the list to be seen. If you thought they needed to be seen straight away you'd tell the doctor.

The validity of the above account is born out by the observational data recorded in Chapters Four and Eight. There is a striking absence of any reference to the patients' response to their experience and a strong emphasis on carrying out a routine. The presence of relatives is mentioned as an important consideration. Nurses were very conscientious about contacting relatives. As another nurse reported, 'As far as relatives are concerned we always try and contact them as soon as possible.' Nurses felt that this was one step which they could take which would help in a practical way to reduce patients' anxieties. With that exception, the nurse's description was centred on the steps the nurse takes to start processing the patient through the department. Another nurse comments,

I think when we assess them we tend to look at the physical problems but, er, if you had time to find out what their problems were you would be able to help them, reassure them, because I've found, if I find that I'm not stressed I'm much more...I'm nicer to the patients.

Again this nurse acknowledges the emphasis on physical care. She believes that if an attempt were made to explore patients' anxieties this would be

beneficial, but the implication is that this did not always occur. A more holistic assessment of patients based on a nursing model was dismissed by most of the nurses as impractical and time consuming. In Department B no formal nursing assessment form existed. Nurses documented their care on the patient's casualty card (see Appendix 7). The possibility of using even a simple form for nursing assessment was rejected,

It's extremely impractical. It really is impractical in Casualty. If you wanted to do anything it would have to be a tick box thing, something that could be done extremely quickly because you really, you really don't have time. You're rushing off and doing new jobs all the time.

Attempts to use a nursing assessment form in the past had been, the nurses claimed, a failure,

We did start a pilot scheme which only lasted for a few days...It was just a printed sheet where you ticked boxes for this and that and the other, you know, but physically there wasn't the time to complete the forms for the amount of patients that came in so it soon got scrapped. The fact was that people were busy trying to fill out the forms and missing out on the patients really.

The view that this type of assessment was extra unnecessary paperwork was widely held by the nurses. Using such an approach for patient assessment was seen as irrelevant or, as in the following extract, ridiculous,

You had this whole load of questions and the patient thought why are they asking me all these silly (questions) – I know they weren't particularly silly, but they were for the minor patients. It does seem a bit silly when you're asking all these questions which take about 10 minutes to complete and the patient's thinking 'What a waste of time', when they're going to be there for 3 hours anyway. It's just lengthening the time for them. Plus it takes the nurse away too long from her other

duties, you know what I mean, because you're going round the department, you've got cards under one arm, you've got one in each hand, you're thinking about five things at once, and you haven't got the time basically. The thing is, you see, we do it in a way anyway, we just don't write it down.

The nurse in Department A, where a nursing assessment checklist was incorporated into the casualty card (see Appendix 8), expressed similar reservations about it, particularly the notion that it was all unnecessary paperwork, rather than an improvement to patient care. A recently appointed sister states,

Personally, I feel that the paperwork here is, there's far more paperwork (than where she trained) and you do get bogged down with it, and again it's a few more minutes off the patient's care doing the paperwork.

A common view was that the nurses were carrying out an individualised assessment of each patient but just weren't recording it. This was previously suggested by one nurse. Others shared her view, as the following comment reveals,

If you're doing the job well you're doing the nursing process anyway logically but we don't have anything actually to write down on paper.

The dislike of paperwork expressed by the nurses is consistent with their view of themselves as dynamic professionals, responding rapidly to immediate and urgent needs. The ideal of systematic nursing assessment and documentation does not sit comfortably with such a view of the nurse's role. One sister in Department A, who had recently undertaken the Accident and Emergency Nursing course summarised her own view and, she claimed, the consensus of Casualty nurses,

It (the nursing process) was a very negative aspect of the course. We sat there and it was obviously a very negative thing. Our tutor hated the subject as well and he moaned about how dry and horrible the subject was, and the only one you could vaguely say was relevant was Orem's Self Care Model. Most of the nurses I've talked to from Casualty would say, I mean including the tutor, would say, you know, it's very difficult to do a model. They talked about models because the ENB (English National Board for Nursing and Midwifery) required it. In the course they had to talk about it, but we did nothing on them. I've got a load of bumph, leaflets I've never read. I haven't really gone through them and read them. I think it's very difficult to put a model in.

This graphic description summarises the commonly held view that nursing models were dull and dry as well as impractical. It is easy to imagine that they would not be welcomed by nurses who sought work which was exciting, challenging and of an immediate nature. It was no surprise, therefore, that the value of models, and even of formal assessment, was minimised and their use resisted. A pattern of care which allowed nurses to institute action for particular events as they arose was invariably preferred.

'Popping In' as a Means of Organising Care

It's very much seeing what needs to be done and doing it, so it's very individual I suppose in that way. You see what the patient needs and you do it.

The above statement encompasses the general view that the nurses held about the way in which their work was, and should be, organised. The way in which they described their delivery of care was as a reactive process – they responded to demands as they occurred rather than anticipating them. The strategy most frequently described was that of 'popping in' on patients to monitor their condition and give necessary care.

The researcher became aware of this reactive pattern of care when a nurse described what happened to patients waiting to be seen. These patients had been assessed by the nurse and asked to sit in the waiting area until they were seen,

When it's busy you tend not to go back to people to check they're ok unless they actually look unwell or if it's a child and they're crying, then you go back. But if it is busy you do try and keep an eye on everybody. People aren't looked after properly in the waiting room and they do get very wound up by having to wait so long and you tend to only deal with them when they come storming across and start shouting at you. Then you've got to try and calm them down and tell them what's happening.

Once this reactive style had been identified it became clear that it was not just utilised in the waiting area but was a widely used strategy for organising care. Many nurses described this process, such as the following nurse who said, 'because you haven't got much time, you run in to do their observations and run out again'. Nurses used various terms, but the most common were 'popping in and out', 'dashing in and out' and 'nipping in on patients'.

Such a strategy meant that nurses could avoid spending lengthy amounts of time with patients, but feel confident that any major problems would be identified. If the relatives were in with patients the nurses felt that they could also be relied on to monitor the patient's condition and felt more confident about leaving them because the relatives would call them if necessary, as the following nurse said, 'you have to rely on the relatives and you dashing in and out as well'. Physical problems, as we have seen, were those the nurses were most concerned about. It is conceivable that such a

strategy may be useful in providing physical care but its value in addressing patients' anxieties is doubtful. The nurses themselves were conscious of the limitations of the approach as the following comment indicates,

It must be awful when you just go in and do your bit, and then they're just left. For all you say 'I'll be popping back and forwards and my name is such and such. Shout if you want something, but I'll be popping back.'

The above statement describes the quality of a large number of the interactions which occurred between nurses and patients in the departments studied. In most cases the nurses tended to carry out the physical care the patient needed according to a standardised format and then left. Any other needs or concerns were addressed as they arose, should they come to the attention of the nurse. The strategy of 'popping in and out' which they used would, however, be likely to deter patients from making any requests or demands of the nurse unless they were urgent. It was also likely to contribute towards the fragmentation of care which was a striking feature of Accident and Emergency Department nursing. Patients were normally seen by a number of different nurses. As one nurse wryly observed,

I've seen a patient come in here and have six different nurses looking after him until he goes through the door. Literally every member of staff.

It seemed, therefore, that dealing with patients' anxieties was something which happened in an opportunistic way in the Accident and Emergency Departments studied, rather than as a planned part of patient care. The nurses' perceptions and priorities, which emphasised giving urgent physical

care, seemed to foster such an approach. The physical care, too, was described as occurring in a way which was reactive and fragmentary. Such an approach would make it difficult to ensure that the anxieties of patients were identified and dealt with. However, the strategy could also have a positive value. When the department was busy, 'popping in' on patients was one way of demonstrating to patients that they hadn't been forgotten and providing some contact with a nurse.

Patients who required more physical care from nurses were also more likely to receive support. For example, the patients who were described as benefiting most from the expedient way in which supportive care was delivered were those who complained of moderate or severe chest pain. The physical care they required was deemed to demand constant attendance by the nurse, at least until the pain had been diagnosed. Thus, for these patients time was available for the nurse to talk to them. For more severely ill patients, the physical care needed was such as to reduce the opportunity for the nurse to talk to the patient. The following extract illustrates this:

The trouble is, if you get someone in with an RTA (road traffic accident) or a chest pain, you're trying to do all the things for them. Like if it's an RTA you're trying to run things through and there's two or three doctors shouting for things and you're the only pair of hands there and you're trying to talk to the patient at the same time. It's awful that. People come in with chest pain and you're waiting for the doctor, it's quite easy to chat on to them.

The patient's condition, therefore, clearly necessitates a particular programme of care. If this programme allowed an adequate amount of

time with the nurse and a manageable amount of physical care, then the nurse could talk to the patient and provide psychological support. The patients with more serious conditions, such as those complaining of chest pain or RTA victims have been discussed. At the opposite extreme it seemed that the 'minor' patients, because of the limited physical care they needed, were unlikely to be given such support. As the following nurse points out,

The minor ones, I think, don't get as much attention as the more poorly patients in the department mainly because those patients are in and out and here, there and everywhere in the department. I mean they do have the same anxieties about coming to hospital, but I must admit they don't get the same kind of care....You sort of say what you've got to say and then you're out again, whereas you might sit down and have a chat with some of the others.

What is clear from this final aspect of the second category is that patient anxiety is dealt with on an ad hoc basis. The constraints imposed by the requirements of physical treatment influenced the degree of contact patients had with nurses and the opportunity for communication. Although nurses recognised that patients were likely to be anxious on coming to Casualty, their priority was physical care. The nurses' preference for urgency and immediacy in their work made them resistant to the paperwork and planning of systematic nursing assessment. It was also clear that the nurses were frequently working under pressure and often had several matters to attend to urgently. In order to deal with this nurses developed strategies of care which were predominantly reactive. They described such strategies as being adopted when the department was busy. However, their emphasis on the routines by which they processed patients

through the department suggested that care was likely to be organised in this way even when the department was quiet.

Category Three: Keeping The Department Running Smoothly

The material in the previous categories has shown that nurses' perceptions of their work and patients influenced the way in which they delivered care. Nurses were candid about their priorities, their perceptions of different types of patients and the strategies they used to cope with the demands they felt they were faced with in their work. The present category draws on the Symbolic Interactionist perspective to elucidate further how the role of the Accident and Emergency nurse was developed and maintained by the nurses studied. A central aim was defined as 'keeping the department running smoothly'. The nurses' view of their role was influenced by their preoccupation with organisational efficiency.

Keeping the Department Flowing

This category emerged as important during the nurses' discussion of how they saw their role in relation to other occupational groups in the Accident and Emergency Department. The nurses described how they undertook a great number of tasks which were not necessarily nursing duties. The reason which was invariably given was that in doing so they fulfilled their own wider aim of 'keeping the department running smoothly'.

The sister in Department B described the difficulties they faced,

We only have one domestic, and if you want a porter you've got to ring for one. Well I mean to say, you can't ring every time you want a porter,

so you end up doing his job. Same as if the relatives want a cup of tea. We used to have a domestic that used to make the tea. You have to run and make that when you could be sitting with the patient. You could be sitting with the relatives and talking to them whereas you have to run away and do this and do that. Oh yes, you do lots of jobs.

The reason they do this, she goes on to say, is,

To keep the department flowing, Everything ticking over. That's the main thing. Keeping everything ticking over when you're busy.

The nurses in Department A reported similar actions and motives, as the following staff nurse reports,

If I have a spare 5 minutes I will write up blood bottles and forms just to get that patient through more quickly, X-ray forms and so forth. So all the doctor's got to do for the patient is come down, say 'hello' to the patient, a quick assessment, take his bloods and gone. That patient should no longer stay in the department, and he's (the doctor) got no reason why the patient should stay in the department. It's just to get a bigger, no quicker, throughput in the department basically.

From the above accounts it would seem that nurses are prepared to take on a variety of non-nursing duties in order to 'speed things up'. They saw this aim, as another nurse described it, of 'keeping the department running smoothly' as central to their role, as the following extract also illustrates,

The work's very demanding. The actual organisation is demanding but if you do it well you know the department is going to run well and you know that if you don't the department is going to fall apart. So it's very satisfying if, at the end of the day, everything has gone smoothly. You know you've done the job well.

The importance the nurses attached to keeping the department running

smoothly is fundamental to understanding their propensity to operate a system of 'people processing' to organise patient care. The priority they placed on this is implicit in their descriptions. For example, getting the patient through the department quickly was seen as more important than talking to the patient or relative. The nurses described talking to patients as something they did only if the routine allowed:

I think it is very important to talk to patients. I think a lot of people do try and see to the psychological aspect of care but I do think it's sometimes quite difficult because you have the patient for so little time. I think everybody tries but I don't know how often they succeed. I mean often, if it was in the curtains (where 'minor' patients are seen) say, you might call in the patient and you might send them to X-ray and then the next time you see them is when you're going to strap up their ankle, to tell them that they're going to fracture clinic, and you might have seen them for what, maybe 5 minutes. It is difficult to find out all the other things that's going on....It's far easier down in the cabins or in Resus. where it's on a one-to-one basis, it's far easier. It's always difficult though. Also the times when they need it (psychological support) is when you're busiest and that's the time they're not going to get it.

It is clear, therefore, that nurses felt it was important to provide psychological support for patients, but that getting patients through the department quickly was their primary aim. Talking to patients was something they did only if it did not hinder that process. It was also a feature which they felt was justifiably abandoned when they were 'busy', in order to fulfil their main objective of 'keeping the department running smoothly'.

Negotiation

A central assumption of Symbolic Interactionism is that concrete decisions and rules are constantly negotiated. Strauss et al. (1964) argue that all

social groups are constantly organising. It is not the case that an organisation is established and then proceeds to operate in an unvarying way. Rather, it is constantly being organised and reorganised. Usually these negotiations take the form of implicit, unspoken, mutual adjustment of action, attitudes and understanding between participants. In the Accident and Emergency Department nurses were involved in continual negotiations with medical staff about their respective roles and responsibilities.

The nurses saw the common purpose of keeping the department running smoothly as one which they could readily collaborate to promote. They appreciated the sense of team work and equality it seemed to foster among them. Relationships with other members of staff, however, were not regarded as so unproblematic. Their role in relation to that of medical staff was of particular concern to the nurses. While they recognised the necessity of working closely with the doctors – and enjoyed the sense of mutual collaboration – they described complex processes of negotiation as necessary in order to maintain the integrity of their role. The conflict largely resulted from their willingness to take on certain medical tasks in order to further their aim of keeping the department running smoothly and their simultaneous reluctance for this assistance to be assumed. The issue in which the conflict was most clearly manifested was recording of ECGs.

Recording of ECGs was agreed to be a nursing duty, but only if needed for the purposes of diagnosis. Frequently, however, doctors wanted them performed for other reasons. Nurses were reluctant to undertake such a responsibility on a permanent basis, arguing that it could detract from their other duties. The doctors and nurses were therefore engaged in permanent

negotiations about who should perform the procedure and in what circumstances. Sometimes these implicit, or metaphorical, negotiations would break down, demanding that further, explicit, negotiations take place and the guidelines re-established. This process is described by the sister in charge of the department, in the context of discussing the relationship between medical and nursing staff,

Sr: We had a big down point at the end of the last lot of casualty officers because they got to be pretty horrible and we were being taken very much for granted and abused really, and they didn't like it when you said.

GB: Do you see that as part of your role, to establish the boundaries between what are nurses' duties and what are doctors?

Sr: Yes, very much so. With the consultant. The crisis blew up over ECGs which is a problem in any Accident Department where it's a shared task, if you like, and there are very narrow guidelines about when the nurse should do it and when the doctor should do it. These had been ignored for quite a long time and the nurses always did the ECGs, the doctors never did the ECG's. Then when it came to the end of last year we had a lot of staff leave and a lot of new staff began and they didn't know how to do ECGs and they were turning to the doctor and saying 'You'll have to do the ECG' and they'd (the doctor) say 'I'm not doing the ECG'. There'd maybe be two nurses on duty who could do ECGs and they'd (the doctor) say 'Oh well I'll wait for her to come back from her supper and then she can do the ECG', which is pretty horrible. I mean it's just things that we're learning. It's much easier with the new doctors. We've all got into the way of saying 'I'll do it for you this time but if it's busy you do your own' and then the doctors will do their own ECGs.

However, as Strauss et al. (1964) assert, it is not the case that rules are established and then continue to operate in an unvarying way. Here, although the guidelines were agreed and everyone informed, negotiations continued in practice, as this later interview with another nurse shows,

We tell them, each new batch of doctors as they come walking in. We outline our roles, but very often, because of the workload again, it gets

forgotten about. It gets a bit hazy. We do ECGs if it's diagnostic you know, if it's going to fix on the diagnosis but sometimes the docs will automatically assume, 'Oh there's an ECG to be done', so every now and then I say 'You know, you should be doing those ECGs'. Yes, I do put them in line. I do it if we're not busy, I don't mind then, but the doctors are always busy 'I've got X number of patients to see' and they forget that we also have the same number of patients to deal with. Yes, you get a little bit of friction there sometimes.

It was evident that a central reason why nurses were willing to take on what they regarded as medical tasks was due to their preoccupation with keeping the department running smoothly. Many statements by the nurses supported this interpretation, as the following extract indicates,

We help the doctors out a lot and we do a lot of their jobs for them. ECGs which we shouldn't really, it's an extended role, but we do them. We help them with a lot of things. Mainly because it's so busy and it helps to keep things moving.

However, the nurses were also concerned that in taking on such work they did not neglect their own work of caring for patients, as this nurse continues,

If at the end of the day the patients are losing out, we do draw the line, we do say 'no' if we're really pushed.

There was clearly a tension between their willingness to assist the medical staff and their perception of their own specific role in patient care. In the departments studied, however, professional roles did tend to become blurred in the service of the nurses' wider aim of keeping the department running smoothly.

Negotiation of role was, therefore, a constant feature of the social interaction occurring between the health professionals in the Accident and Emergency Department.

Thus far, the discussions has concentrated on existing tasks and how they should be allocated. The nurses were, however, also concerned with the possibility of taking on further medical tasks, as they described it, 'extending' their role.

Extending the Nurse's Role

Their experience with ECG's had been a cautionary one for the nurses as they felt their assistance could eventually be taken for granted. Their accounts clearly illustrated their view of extending their role by taking on other 'medical' tasks was coloured by such events. Although, therefore, they considered the acquisition of some skills as desirable in order to provide care in a more convenient and rational manner, a certain degree of wariness existed, as the following extract reveals,

Well we've extended our role so far in that some nurses give IV (intravenous) drugs which is brilliant for during the night because it seems silly to get your doctor up at 2 o' clock in the morning to give an IV drug if you've got a patient in the observation ward. We've extended our role to ECGs. Sometimes that causes problems in that we only do them when they are a diagnostic procedure and so long as we've got time. Sometimes when we tell the doctors, they say 'I want an ECG on this patient', we say 'Sorry we haven't got time, you'll have to do it yourself' and suddenly it either becomes not that important or they really get their hair up about it and that's really frustrating. In my last job I did suturing, but we had a little bit more time to do that kind of thing whereas here it would be a rare occasion that the nurses actually had the time to do the suturing, but we had a little bit more time to actually do suturing. If it was used properly I think it would be very good. Sometimes the doctors

are very busy and the nurses aren't, perhaps if there are a lot of medical things going on but not much nursing. In those situations it would be very helpful if the nurse could stitch, but I think it would get abused. Like the ECGs, it would get abused.

Not all nurses were concerned that assuming more medically delegated functions would be abused. Those who were most positive about the benefits of taking on such tasks had completed the ENB Accident and Emergency course or had previous experience in other departments. As one nurse said,

I think it would be a good thing. It's the one thing I did on the course, that you do extend your roles to suturing, gastric lavage, blood-taking and everything. I think it would make the job more interesting for the nurses. Plus, it would speed up the patient's treatment. You know every abdo' pain's got to have bloods taken so you could get them done and the results would be there by the time the doctor came to see them.

The reasons they gave for undertaking more technical work were to speed up the patient's stay in the department and to make their own job more interesting. Another nurse comments,

The various departments I've worked in, I've stitched, I've put Plaster of Paris on, and I came here and I can't do any of that and I miss it because I enjoy doing both those things. I'm losing my skills and (in) both areas it worked. Maybe the turnover of patients would be quicker and we wouldn't be so busy because patients wouldn't be waiting so long.

There was, therefore, some variation of opinion among the nurses about the benefits and disadvantages of taking on an 'extended' role. They were in agreement, however, that a major reason for doing so would be if it helped to keep the department running smoothly and that it would also

make their own work more interesting. Although different views were held, there was consensus that they, as nurses, should be the ones to **decide** what additional duties they were prepared to undertake. An interactionist perspective would suggest that ultimately the extent to which **they did** so would be decided by implicit negotiation between those involved. However, a necessary preliminary would be that agreement was reached **in principle** that nurses could undertake such tasks. This would have to be achieved through formal and explicit negotiations between nurses, doctors **and** administrators.

One way in which the nurses in Department B had already negotiated a change in their role was in the assessment of patients. In the past, the **first** person the patient had contact with in the department on arrival, was the receptionist. She recorded the nature of their condition and asked the patient to wait until called by the nurse. Patients who arrived by ambulance, or who were obviously in need of urgent attention, were sent immediately to be assessed by a nurse. Recently, the nurses had reached agreement with medical staff to undertake patient Triage. Using this system, each patient would be seen and assessed by a nurse on arrival. She would evaluate the priority of their condition and, on this basis, determine when they would be seen. The Triage nurse could also arrange X-rays. One of the nurses described how it worked in practice,

The idea of it really is to assess and sort out patients into priorities and treatment really. It really is extremely helpful. It does work, you know. Instead of ending up with the department milling with hundreds of people because the bottom waiting area is overflowing and the desk reception keeps on sending more and more people down, if there's a Triage nurse on, they can assess the patient, find out what's wrong,

where the injury occurred, if they need an X-ray. If they've obviously got a broken bone you obviously want, you would write an X-ray card out, bring the card, casualty card and the patient down and personally hand them over to a member of staff saying, 'This patient needs attention now'. She will perhaps keep the other four that were minor injuries in the waiting area down there until the department here is sorted out and then we can see them.

Although the nurses were enthusiastic about Triage, they were not always able to put it into practice. The main difficulty was that it involved taking a nurse away from her normal duties and this was often not feasible. The nurses also reported that the doctors had some reservations about the system as it reduced their control over their workload. However, the sister reported that, 'If I had more staff I would have a Triage nurse all the time.'

The nurses in Department A did not operate a system of Triage. In this department, patients were seen first by a receptionist and then assessed by a nurse. They described their system as 'more or less Triage really. It just isn't called that, but we do, we are assessing everybody'. However, they did not systematically prioritise patients or arrange diagnostic X-rays, both important characteristics of Triage. Ultimately, they did aim to operate a system of Triage. One of the sisters reports,

I would like to see a proper Triage with a separate nurse. That is her job and nothing else, to be at the desk triaging patients and keeping an eye on them in the waiting room and liaising with them before they're seen by the doctor.

The benefits of Triage were seen in both departments as an effective way of keeping the department running smoothly. It also offered patients contact with a nurse at an early point of their stay in the department.

The final way in which the nurses in Department B were considering extending their role was by developing the role of the nurse practitioner. A nurse practitioner would be able to see patients with 'minor' and non-urgent injuries who did not need medical attention. One of the nurses reported that she was in the process of designing a questionnaire to obtain the views of patients about such an innovation. Again, one of the forces for such change was improved efficiency. This nurse felt developing the nurse practitioner role would 'take a lot of pressure off everybody'. Although this innovation was likely to be more controversial than Triage, as it threatened the principle that all patients should be seen by a doctor, she believed that the medical staff would ultimately welcome it,

I think they'll have a few reservations in the first instance but I think they'll probably like the idea. When they get used to the idea, if you like, and realise we're not usurping their patients.

The nurses in the departments studied were, therefore, interested in developing their role. One of the main reasons for doing so, they believed, was to improve the smooth running of the department. The innovation of Triage had been successfully negotiated in Department B, although low staffing levels meant that it could not always be practised. Although they anticipated some reservations by medical staff with respect to other changes, on the whole they felt change would be welcomed.

Conclusion

The three categories discussed in this chapter have described the work which the nurses found most interesting and described as their priorities.

They defined their role primarily in terms of urgent physical care, particularly caring for 'major trauma' patients. Caring for patients with 'minor' and non-urgent illnesses and injuries was seen as less interesting and also less important. The second main concern for nurses was keeping the department running smoothly.

Both of these concerns had implications for patients' anxieties. The nurses' preoccupation with 'major trauma' and with work which was interesting and varied indicated that this was the type of work they valued most highly. It was also evident from their accounts that this type of work made them feel useful and needed. An interactionist perspective would suggest that this type of work made the nurses feel that they were being what they considered to be 'good' nurses.

Similarly, keeping the department running smoothly was something which made the nurses feel efficient and well organised, again characteristics of a 'good' nurse. Dealing with these two aspects of their work offered the nurses the opportunity to *do* things, to carry out interventions which would lead to a satisfactory resolution of a problem.

Dealing with patients' anxieties was something the nurses said they were, at times, unable to do. They usually said this was because they were 'too busy', that they did not have time to deal with patients' anxieties as well as they would have liked to. They described how the pressure of work they faced led them to use a strategy of 'popping in' on patients to deliver care. However, this strategy was also used when the department was not busy

which suggests that it served other purposes. It may be that 'popping in' on patients was a useful way of showing patients they hadn't been forgotten about, and providing simple reassurance. At the same time it informed the patients that the nurses were busy and deterred them from asking non-essential questions or expressing unnecessary concerns.

Many of the worries expressed by patients were about aspects for which a practical solution was not always possible, such as not being able to carry out their usual activities, feeling unable to control what would happen to them or having to be admitted. By 'popping in' on patients the nurses were able to avoid having to address such fears which, if no practical solution could be offered, might lead to the nurses feeling uncomfortable and inadequate. According to an interactionist perspective, therefore, it is not surprising that the nurses concentrated on facets of their work which they could do well and were therefore rewarding and tended to avoid those which were difficult to resolve.

The insight gained into the nurses' perceptions of their work, reported in this chapter, has illuminated the factors which influenced the extent to which they dealt with patients' anxieties. It is interesting that when they considered how their role could be developed they concluded that incorporating more technical skills into their work would be beneficial. They believed that undertaking more technically skilful tasks would make their work more interesting, maintain the smooth running of the department and, at the same time, reduce patients' anxieties by minimising the time they spent in the department. Such an approach demonstrates the

nurses' desire to provide practical solutions to problems and to develop their role in a way which was rewarding to them, features which are intrinsic to understanding the nurses' view of their work and their interaction with patients.

CHAPTER SEVEN

Results: Patients' Demands and the Nurses' Exercise of Control

Introduction

This chapter discusses the final two categories generated by the interviews with nurses. These were 'Legitimate and Illegitimate Demands' and 'Exercising Control in the Department'. In the first category, how social factors, and the perceived 'appropriateness' of attending the Accident and Emergency Department with various complaints, influenced nurses' attitudes towards patients, is explored. In the second category, the strategies the nurses used to maintain control over their work are described. The themes elaborated in this chapter are related to the aspects of nurses' perceptions of their work and patients discussed in Chapter Six. The focus, however, differs in that the categories discussed in the present chapter are more concerned with the functions of the Accident and Emergency Department and the nature of the service it provides.

Category Four: Legitimate and Illegitimate Demands

In this category the ways in which nurses' perceptions of patients influenced their interactions with them are discussed. The classification which nurses made of patients had been described as forming a continuum, with 'major trauma' at one end and 'dross' at the other. It appeared that each held a corresponding position in relation to nurses' priorities.

In the present category the characteristics which lead nurses to perceive the demands patients make as legitimate or illegitimate are explored in greater depth. The specific effects such perceptions had on nurses' behaviour towards patients are examined. Nurses described themselves as taking exceptional care of patients who made demands which they regarded as possessing a high degree of legitimacy. In contrast, nurses described care of patients whose demands were perceived as having little or no legitimacy as requiring only a minimum of effort; a process of 'going through the motions'.

'Drunks, Timewasters, Abusive Patients'

The type of patients which nurses found most rewarding to care for have been described in the previous chapter. This chapter focuses on those that patients viewed negatively and examines the strategies which nurses adopted in their interaction with such patients. These patients were variously described as 'dross', 'tripe' or 'drunks, timewasters, abusive patients'. The third description exemplifies those patients whom nurses most disliked caring for and conveys the reasons why.

The terms are not necessarily mutually exclusive; individual patients may be judged to have one or more of these characteristics. The terms do indicate, however, the underlying reasons for the nurses' dislike of such patients. In brief, drunks were held responsible for the self-inflicted nature of their problem, timewasters attended the department with old or 'trivial' injuries and abusive patients were, by definition, demanding and disruptive.

The nurses' attitudes towards such patients as revealed by the nurse

interviews is consistent with the findings of Roth (1972) and Jeffery (1979). The nurses' accounts in the present study were frequently coloured by their frank disapproval of these patients, and their rejection of the legitimacy of their demands. As one nurse said,

I don't like looking after the drunks. They take up a lot of time basically and of course they want to be seen then and there before anybody else....There's the drunks and we have the regulars who come back again and again...and I get annoyed. I try not to but I do and I think 'what a waste of time'. And they're the ones that shout. They want to be seen first.

The above extract is typical of the comments nurses made about these patients and suggests the reasons why they disliked them was because they wasted nurses time and were demanding and disruptive. A further element, implicit in the previous account, that there was nothing really wrong with them, is reported by another nurse,

There's nothing wrong with them really and that makes you angry, because you think of other patients sitting there who need your time and the doctor's time.

Jeffery (1979) suggests that for patients to have their demands regarded as legitimate, they must demonstrate that they have something physically wrong with them and must co-operate with staff. The truth of this assertion in the present study is demonstrated by the following extract where a nurse described how her behaviour towards a 'down and out, a drunk' changed when he began to fulfil these two criteria,

I used to say to him, 'What a state you're getting yourself into', but he came in one day with a massive bleed, alcoholic, you know. I felt sorry

for him then because he was ill, and he was helping me to take his clothes off and he wasn't strong enough to be doing so. Then I said to him, 'It's alright George. I'll manage. Come on, just lie back and let me get these dirty clothes off.'

It can be seen, therefore, that when alcohol leads to 'real' illness, the patient's demands become legitimate and the nurse's attitude towards the patient changes. In the above extract, the patient also co-operates with the nurse by attempting to help undress. Again, this is in contrast to the nurses usual description of 'drunks' as 'unco-operative' and 'abusive'. Drunks and regulars such as those described above were the most strongly disliked patients. Those who attended the department inappropriately for other reasons, typically with a very minor or old injury were also disapproved of and sometimes resented,

They forget they've got GPs, or they don't like their GP so they think they've got the right to walk in here and be seen. Well it doesn't work like that and if you try and explain to them they get annoyed because they've trailed up here.

Although nurses disapproved of such patients there was some flexibility about whether they would be seen or not. However, if the injury was new the patients had a right to be seen, even if the injury was slight, a fact which the nurses sometimes regretted, as the following extract reveals,

If it's an old injury that should've gone to a GP we ask the doctors whether they're prepared to see them and usually it depends on how busy it is and what type of patients we've got in. Sometimes they see them but sometimes we turn them away and tell them to go to their GP. But if people come in with a new injury today we've got to see them unfortunately.

Although there were some constraints, therefore, about patients who must be seen, some degree of flexibility was possible. As a Symbolic Interactionist perspective proposes, the actors involved, nurses, doctors and patients, could negotiate access to treatment. This view that rules and regulations do not determine the behaviour of individuals is central to Symbolic Interactionism. Participants in any given situation are seen as having the capacity to base their action on their own interpretations of people and events, and their interpretations of the views of others. In the Accident and Emergency Department it was evident that nurses held a negative view of certain types of patients and that their behaviour towards patients was influenced by such judgements. One way in which they reacted towards the patients whose demands they regarded as illegitimate was by operating a process of 'going through the motions'.

'Going Through the Motions'

Because they were faced with the requirement that patients who attended the department with a recent injury were entitled to be seen, nurses developed a strategy to deal with the 'drunks' and 'regulars' who did so. The strategy they adopted is revealed in the following nurse's admission, 'I know it's an awful thing to say but you just go through the motions with them.' As she goes on to say, 'You can't turn them away'; but what they could and did do was to control how and when such patients were seen. One dilemma the nurses faced with regard to such patients was that although they 'knew' that nothing was wrong with them, there was still the possibility that one day there might be. As the nurse continues,

We have to get them seen because obviously one day something will happen. Somebody will ignore them. But they keep getting put to the end of the queue as well which they've got to because we know there's nothing wrong with them.

Gibson (1977) suggests that strategies are used to prevent such patients registering in the first place, a question which was not addressed by the present research. What was clear was that the volume of notes generated by such patients acted as a labelling device. Patients with a large set of notes were identifiable as 'regulars' because they would have 'a wad of cards'. They were, therefore, seen by the nurses as unlikely to have a genuine medical problem. Indeed, the nurses went so far as to ensure that less experienced staff were also socialised into adopting this view. One nurse describes how they prevented young and inexperienced doctors from being fooled by these patients by providing them with their previous admission records, 'Usually we forewarn the doctors and give them their previous cards to look at'.

Although nurses tended to use indicators, such as size of notes or evidence of alcohol, to determine that there was nothing wrong with the patient, they were, as we have seen, conscious of the possibility – although they thought it unlikely – of the patient being genuinely ill. If this proved to be the case a nurse could be held responsible for the failure to identify the problem. 'Going through the motions', as well as ensuring that such patients were not given unnecessary attention, also served as a form of self-protection. Use of this strategy ensured that nurses would be covered should such a patient prove to be genuinely ill.

Another nurse summarised the general view,

The problem is, you know them too well and one day there will be something wrong with them....So we always still do their observations, get them seen by a doctor, just in case. But they come here that often and there's nothing really wrong with them. They're never admitted. You never find anything wrong with them.

The nurses saw caring for 'drunks' and 'regulars' as an insurmountable problem. The 'drunks' they saw as a general nuisance who wandered in off the street because they didn't have anywhere else to go. The 'regulars' were 'inadequate people' and 'people who just like hospitals really'. The accounts the nurses gave indicated that they did not feel it was their job to resolve these patients' problems. The 'drunks' in particular the nurses felt should not be in the department and, as far as possible, they tried to ignore them, as the following extract reveals,

The drunks I don't like looking after at all...I think there should be a place for them. It's not right that they should come here, and they're shouting abuse and just carrying on. They all have to be seen because they may have done something, so they have to be seen, but we try and ignore them to tell you the honest truth. We try to pretend they're not there. If they get too bad then we have to get the law in, but you just try and ignore them and then the doctors see them.

The nurses were clear that they were not going to attempt to resolve any underlying problems the 'drunks' might have and made no mention of referring them to other agencies. Their attitude to the 'regulars' was slightly different. The nurses usually reported that they'd tried to help these people in the past and the patients hadn't followed their advice, 'You tend to get frustrated because you've been willing to help them or you've provided as much help as you can and they've done nothing about it.'

For slightly different reasons, therefore, the nurses regarded attempts to help these patients as a 'waste of time'. Furthermore, for both groups, they were reluctant to be too sympathetic and helpful towards them for fear of encouraging such behaviour. As one nurse said, 'If you give them too much sympathy they'll keep coming back again and again.'

A final function, therefore, which the nurses saw the strategy of 'going through the motions' as serving was to discourage such patients from repeated attendance. Stockwell (1972) reports that nurses were reluctant to give 'demanding' patients additional attention, lest they reinforce such behaviour. A similar feeling was expressed by the Accident and Emergency nurses towards the 'drunks, timewasters, abusive patients'.

Social Worth

So far we have focused on how nurses behaved towards patients whom they regarded as having illegitimate demands. In their behaviour towards such patients they adopted the strategy of 'going through the motions'. Nurses' attitudes towards such patients were coloured by a number of factors other than the patient's condition and by their view that such patients were wasting their time. The opposite was found to be true of those whose demands they saw as having a high degree of legitimacy. In this case too social factors appeared to have an important effect. Patients whom nurses perceived as being a genuine emergency, especially if they were also seen as possessing high social worth were given every possible attention. The following extract, where the nurse describes her care of a young boy who had been attacked, illustrates this,

I can still get upset now talking about it because he was a beautiful young boy. I said to the girls 'He can be no more than 20. I think he's about 18' and in actual fact he was 17. There wasn't a mark on him, his nails were nice, except this single stab wound directly to the heart...mind I had four of the team and four of the surgeons because I had gotten a distress call saying 'There's a young boy coming in, a possible (bought in dead), a stabbing'...and I thought 'Oh God, a youth. Let's get him the best we can' so I had everybody waiting and, em, I said to the doctors 'I've 'phoned you down because there's a young lad on his way in'.

This description markedly echoes Sudnow's (1979) account that when a person was brought into the Accident and Emergency Department as 'dead on arrival', the likelihood of resuscitative measures being implemented, the urgency with which they were adopted and the length of time maintained was directly related to the age, social background and perceived moral character of that patient. Certainly, the emphasis this nurse places on the age and personal characteristics of the boy is notable. The fact that such assumptions were commonly made is implicit in her description of how she gives the boy's age in order to explain to the doctors why she had called them down so urgently.

It is evident, therefore, that the extent to which patients fulfilled the nurses' view of appropriate attendance influenced the extent to which nurses believed patients were worthy of attention and that social factors played a part in convincing the nurses of a patient's merit.

One group who were invariably seen as worthy of special attention in the department were children. Again, a nurse describes the particular preparations made for a child with 'major trauma',

You get your major trauma, you know, anything which is out of the ordinary. Especially when you get children who are in a road traffic accident or you know you've got a baby who's come in who's arrested or something like that. I think everybody in the department is keyed up then for the arrival of this ambulance really. You do get keyed up in a way but hopefully you know how to cope with your own anxiety....I think when we have a direct link with the ambulance and I think when they come through and say 'We're bringing a child in who's been knocked over' and I think the worst things start going through your mind first but obviously you've got to arrange your staff so they're in the right place to meet the ambulance. I mean the whole department knows this is going to happen and I think everyone does get sort of keyed up.

So far we have used rather dramatic examples to demonstrate how nurses' perceptions of the legitimacy of patients' demands and their view of patients' social worth, influenced the care they gave. Social factors appeared to influence the extent to which patients demands were regarded as legitimate. This was evident in more subtle ways too. Although certain rules existed which determined which patients should get seen and which not, nurses interpreted such rules according to their evaluation of legitimacy and social worth. For example, parents of young children who attended the department 'inappropriately', were treated sympathetically,

I think a lot of the time parents inappropriately use Casualty but I would never condemn them because I can imagine a parent who is very anxious, especially if it's their first baby.

Part of the reason for the nurses' helpful attitude towards parents lies in the nurses' sympathy towards young people and children generally. Another aspect was that nurses were able to view such patients as choosing to attend as a result of a rational response to inadequate community services. There was a sharp contrast in the nurses' attitudes towards

responsible concerned parents who used Casualty ‘inappropriately’ and ‘inadequate people’ and ‘timewasters’ who did so,

I find I also sympathise with the sort of people who come in, especially parents with babies. I think, you know, the GP services are extremely difficult and these people quite often ring up for an appointment and won't be given an appointment until perhaps 2 days hence. Now if they've got a baby or a young child that they're ringing up about and wanting an appointment for, obviously they're not going to sit and wait for 2 days if they're worried about their child.

That the nurses viewed such parents as understandably worried allowed them to interpret their demands as legitimate and consequently treat them with sympathy and concern. In contrast, patients whom they regarded as attending with illegitimate demands were seen as meriting only the minimum of attention and their care involved merely ‘going through the motions’.

Category Five: Exercising Control in the Department

This category is concerned with delineating the ways in which nurses maintained their role as administrators and organisers of the department and those by which they averted any real or potential threats to their authority. Three main components were identified. The first was attribution of the patient role and ensuring compliance with it. The second involved maintenance of professional credibility which allowed nurses to exercise their authority by implicit and subtle means. The third, only evident when previous methods failed, was the way in which nurses used explicit action, with occasional recourse to external agencies, to maintain their authority.

A fundamental assumption of Symbolic Interactionism is that the process of socialisation does not occur only during childhood, but continues throughout adult life. In particular Symbolic Interactionists have been interested in socialisation into work roles. While recognising the unique views of participants, Symbolic Interactionism explores how interactions with other group members may contribute to the individual learning sets of beliefs, attitudes and behaviours which are held in common. Thus, the nurses' view of the Accident and Emergency Department and the role of the nurse in it is influenced by information received during professional training and by further socialisation which occurs within the work setting. Nurses both create and are influenced by a culture which defines their work and their attitudes to patients.

In this category the ways in which such processes of socialisation operated in practice are examined. The category also describes how nurses co-operated with each other, and other members of staff, to create and maintain the image of the Accident and Emergency Department which they chose to present – that of a busy and bustling department staffed by caring and competent professionals. Presenting such an appearance helped the nurses to maintain control over how they organised their work, as well as the type of work they undertook. The ways in which threats to their control were dealt with are also explored.

Attribution of the Patient Role

An assumption of Symbolic Interactionism is that in every social situation even the 'weak' have power. In the Accident and Emergency Department the 'weak' group must inevitably be the patients. In order to ensure the

smooth-running of the department, it was necessary for the patients to cooperate with the nurses and medical staff. One of the ways they were encouraged to do so was by conscientious assumption of the patient role.

Nurses were conscious that they were unable to exercise the same control over their patients that nurses on other wards enjoyed,

It's not like on the wards where you strip them down and put them in their pyjamas and immediately become in charge, whereas here they more or less meet you on an equal footing.

The nurses seemed, therefore, to feel somewhat constrained in the amount of power they had over their patients, as another nurse points out,

When you think how other nurses look after their patients really. Like, for example, I know everyone has to be undressed, to be admitted to hospital, stuck in a bed, and you've got to do this at certain times and all this, that and the other. Well our patients just wouldn't wear that you know. That wouldn't wash with them because, of course, they've got one foot in the outside world. They're not actually admitted.

This nurse describes precisely the rituals identified by Goffman (1961) as marking the status passage from person to patient. The nurse expresses her feeling that the patients in the Accident and Emergency Department do not assume the role of the patient as strongly and therefore the nurses do not hold the same amount of power over them.

Nevertheless, for the 'major' patients at least, a number of rituals were adopted which served to confirm them in their role as patient. These have been outlined in the pilot study and include being made to undress, lie on

the trolley in a backless gown and have all their belongings packaged neatly underneath to facilitate easy transportation. As evidenced by the pilot study, patients who underwent such procedures showed great compliance with the role of patient.

Following such admission rituals, the role of the patient as passive and undemanding was reinforced by the implicit message that the nurses were always busy. The strategy of 'popping in' on patients which contributed to this effect has already been elaborated. That such strategies were deliberate was acknowledged by nurses, one of whom reported, 'Well they soon get the message that we're busy'.

As we have already seen 'good' patients were those who co-operated with the nurses in their care and did not make unnecessary demands, in effect those who satisfactorily assumed the patient role. Those who did not behave in the required way, but were demanding and disruptive, were viewed negatively. Such a division was also found to be true of relatives. 'Good' relatives kept out of the way and did not ask demanding questions. 'Bad' relatives were those whom nurses perceived as being unreasonably demanding,

They (the relatives) want to hang around all the time. Well you get some who want to hang around all the time and others that say 'I quite understand, I'll get out of your way'.

Furthermore, as with the patients, the amount of attention they receive is related more to the patient's state of health rather than the relative's need for reassurance and support. As one nurse explains, the relatives of those

who are more seriously ill get more attention, 'whether they're anxious or not'. This issue is considered further with reference to the ways in which nurses maintain control in the department and deal with threats to their authority. Before doing so, however, it is useful to elaborate how the nurses portrayed their own role in the department and the strategies they employed to maintain credibility.

Maintaining Credibility

The nurses were concerned that in their interaction with patients they appeared as calm and competent professionals. One of the reasons for the emphasis they placed on this was that it justified patients' trust in them. Patients would have little confidence unless nurses appeared in this way. As one nurse said, 'I think you've got to try just by your confident manner to instil some confidence.'

Even if the nurse felt anxious or upset herself, it was important not to reveal this to the patient. Another nurse said,

Even though we're anxious ourselves, we try not to show it. If we're all cool, calm and collected, sort of thing, in front of the patient and say to them 'now look don't worry about that, we'll sort it out for you' then that helps.

Calmness and competence were seen, therefore, to inspire confidence. Thus, even if they were anxious the nurses felt it necessary to avoid appearing so. In a similar way, the nurses described how even when they felt angry with patients, they did their utmost not to reveal it. Not surprisingly, the nurses found they had greatest difficulty in doing so when

dealing with the 'drunks', the patients whom the following extract refers to,

You've got to stand back...You can't let your...You'd like to give them a bit of a tongue-bashing, but you can't do that. If they come and they've got a problem, if they've registered, they've got to be seen and it's got to be as polite as you can, you know, do what you've got to do and just grin and bear it and try not to show your annoyance.

Clearly, the nurses felt they had to exercise considerable self-control at times in dealing with some patients. The determination with which they do seems to be inextricably linked with their view of themselves as professionals. Moreover, they felt aware that their execution of the professional role was witnessed and evaluated by other nurses, doctors and, of course, patients. Only an incident of extreme provocation would cause a nurse to abandon her professional demeanour. The determination with which the nurses maintained their calm and polite manner reflected the importance they attached to this as part of their professional credibility. Unless patients had confidence in them and respected their judgement they were unlikely to co-operate in their care. The concept of credibility, therefore, was one which was crucial to the nurses. Even in small ways they attempted to maintain an impression of competence before patients. As well as demonstrating personal competence, the nurses wanted to convince patients of their credibility as an effective team. The following extract describes how their efforts to maintain good communication among staff were partly directed towards this end,

Plus, you don't get the patient repeating themselves four times because the nurse that calls them into the curtains can say to them 'oh you hurt your leg doing this'. I mean obviously they've got to repeat it for the doctor but I think well that helps them a bit because they think 'well they've obviously told each other what's wrong with me'.

The nurses felt it was important to create the impression of an efficient service. They were uncomfortable when things went wrong and they felt their credibility in the patients' eyes threatened, as the following nurse admits,

It can be a bit of a pain if the communication isn't there because I think sometimes you think they're looking at you and thinking 'do they really know what they're doing?' you know. If you're going back and saying 'has the doctor done such-and-such?'

In fact, nurses did everything they could to avoid appearing in such a light to patients. Even if a mistake was made, or the patient forgotten, the nurses tried to maintain credibility by appearing as if everything was going to plan or there had been an unavoidable delay. Only as a last resort would they admit to the patients that they were fallible, as the following extract reveals,

Sometimes the doctors take the patients round the back and we don't even know they're there. You go round and you think 'What's that patient sitting there for? How long have they been sitting there?' You usually try and ask the other members of staff and the doctors first who the patient is, but if nobody knows who they are you have to go and ask the patient themselves. You wonder what the patient thinks.

Exercising Control in the Department

Maintaining credibility was one of the ways in which nurses reinforced their authority and promoted patient compliance. Nurses found the strategy of maintaining a professional demeanour was an effective way of dealing with difficult patients.

The other resource which the nurse used to maintain control was reference to 'poorly people'. A frequent device was the report that 'The doctor's dealing with an emergency' or 'I'm sorry you're waiting but we do have a lot of emergencies around'.

Nurses found it stressful when their authority was questioned and had difficulty sympathizing with less sick patients whom they felt were being unreasonably demanding. As another nurse states,

For me the most stressful part (of work) is dealing with people complaining, because I get so cross because I know the reason why they're complaining is because somebody else is dying and the doctors are trying to save their lives and trying to sympathise with them is difficult, it really is, when you're getting constant complaints about the waiting and, you know, 'I've got an appointment to keep and I need to be seen now' and you try not to raise your voice but it sounds irritated. It's difficult when you know that the reason why they're waiting is that somebody else is very ill.

The frequency with which nurses used the claim of dealing with emergencies as a reason for delay was notable. There were obviously many occasions when it was justified. As the observational study revealed, however, it was also used as a reason for delays when the truth, that the doctor was at lunch or the nurse at coffee, would have seemed unacceptably unprofessional. At times the nurses felt that patients were sceptical of such explanations, as a nurse in Department A explained,

I mean, you say, 'The doctor's in an emergency' but they think of Casualty as being just these curtains. And if you say 'Well, we've got eight rooms down the bottom and we've got an emergency room' and the way they look at you, they're sort of saying 'ah yes, certainly' (said in a

very sarcastic tone) but I think without knowing the department they're not going to understand. They think they're just being fobbed off all the time.

Despite such scepticism, the nurses were usually able to exercise their control of the department by the implicit and indirect means of looking busy, being professional and maintaining credibility. One of their chief assets in doing so was the power of their suggestion, whether implied by their bustling activity or given as a verbal explanation, that they were busy with 'emergencies'. Occasionally, however, if their authority was threatened, more extreme measures might be implemented, as in the following incident described by a sister in Department A,

There was a father complaining...He was really rude...about his child waiting and I actually walked to Resus. with him and said 'That's why you're waiting. There's a little kiddie on a ventilator' and I don't regret it. I've only done that once but that irritates me. That gets me so angry.

The behaviour described by the nurse is extraordinary compared to how others described how they usually dealt with what they perceived as unreasonable demands. However, usually such demands can be quashed by less dramatic means. The incident described here represented a challenge to the nurse's control which she had difficulty in overcoming by the usual strategies. She therefore adopted an extreme measure in order to prove to the father the validity of her decision and the force of her authority. It is interesting that the incident she describes was concerned with a young child on a ventilator. Her readiness to give such a dramatic and unusual explanation to the demanding father rests, it would seem, on the strength of her assumption that such a case would be the ultimate priority. Nothing,

she was asserting, could be more important than this and no one, she believed, could reasonably doubt her conviction.

Finally, if all measures failed to avert an explicit threat to her authority, particularly if the patient was being demanding or abusive, the nurse would resort to an external or higher authority such as the doctor, hospital security or police. The nurses reported that if the patient was excessively disruptive, they would arrange for him or her to be removed from the department.

Conclusion

The nurses' accounts have shown that nurses held negative attitudes towards patients whom they believed were misusing the service by attending the department 'inappropriately'. In addition it was found that social factors such as age or evidence of alcohol influenced the nurses' judgements of the legitimacy of the patients' attendance. Kelly and May (1982) suggest, however, that these factors in themselves do not determine the nature of nurse-patient interaction. It is qualities arising between the participants which are most influential.

Thus, in the present study, the patients who were most disliked were the 'drunks'. The nurses described how they tried to ignore such patients. Significantly, perhaps, the 'drunks' were invariably described as 'disruptive' and 'abusive'. It may be that the nurses' behaviour towards such patients was as strongly influenced by the patients' behaviour towards them as by external factors. An interactionist perspective emphasises that all

communication is a reciprocal interaction. If patients did not co-operate with the nurses and instead confronted and insulted them, the nurses would respond by applying the sanctions of delay and inattention.

Understanding nurse–patient communication from this perspective also helps to explain how some ‘inappropriate’ attenders managed successfully to negotiate treatment. The parents of young children were those who were most notably successful. The nurses’ accounts indicate that these patients presented themselves as worried and uncertain. In responding to their appeal, the nurse would be able to experience the satisfaction of giving assistance and the rewards of the parents’ gratitude. On the other hand, if a parent was demanding, rather than appealing (see page 208) their needs might not be so readily met.

The way in which nurses exercised control in the department was also based on the assumption that individuals are constantly engaged in sending and receiving cues from each other about the expected nature of interaction. Nurses conveyed to patients an understanding of their expected role and patients complied with that on the understanding that to do so would ensure that their own needs would be met. It was only when such implicit communications broke down that the nurses adopted a more explicit means of exercising their authority.

CHAPTER EIGHT

Results: The Nature of Nurse–Patient Communication

Introduction

This chapter reports the findings of Stage Three of the research, the observational study. The chapter is divided into two sections. Section One reports the methods of data collection used. Section Two reports the findings of this stage of the research and discusses them with reference to the results of the first two stages. The results of the observational study are presented in two parts. Quantitative analysis of the patterns of communication observed is reported in Part One. In Part Two, the qualitative analysis used to examine the issues which emerged in more depth is discussed.

Section One Methodology

Aims

Stage Three was an observational study. The purpose was to build on the patient and nurse interview data and clarify some of the issues raised. The aims of the observational study were therefore to:

1. Examine the patterns of communication between nurses and patients.
2. Identify any factors such as age, sex or seriousness of condition which may affect the interaction between nurses and patients.
3. Assess how effectively nurses identified and dealt with patients' anxieties in the department.

Method

Sampling

A period of 1 week in each department was spent in carrying out the observation. A total of 10 patients were observed throughout their time in Department A and 13 patients in Department B. Observation periods were varied to cover the department at different times of day. Three starting times of 9 a.m., 11 a.m. and 1 p.m. were used alternately.

As in Stage One, the strategy for patient sampling avoided bias in the method of selection by ensuring that each patient included in the study was the next patient to enter the department following completion of the previous observation.

Theoretically any patient being admitted to either of the departments could have been included in the study. In fact not all categories of patients were observed but a sufficient range was covered to allow qualitative interpretation of data. The main shortcoming of the sampling strategy was that only 2 patients in the 'young major' category were included. This was a result of the tendency for patients with more serious problems to be older, but made interpretation of the observational findings related to this

group difficult. 'Young major' patients were a relatively unusual category. In Stage One the data collection period had been extended to include an equal number of patients from each group in the sample. Restrictions of time prevented this strategy from being employed in Stage Three. Again, no patients who were seriously ill and needed to be cared for in the resuscitation room were included in the study. The breakdown of types of patients observed is shown in Table 2

Consent

Prior to commencing the observational study, meetings were arranged with the medical and nursing staff in each department to explain the purpose of the study. Consent was obtained from both medical and nursing staff in department B for the observation to take place. In Department A the consultant would not give permission for the researcher to be present during medical examination of patients. In this department, therefore, the length of interactions between doctors and patients was recorded but the nature of the topics covered was not known. For the purposes of analysis, topics occurring between doctors and patients in this department were coded as a single topic relating to the patient's illness or injury (the most frequently occurring pattern observed between doctors and patients in Department B).

It was explained to patients that the researcher was carrying out research looking at what happens to patients in Casualty departments and they were asked to sign a written consent form (see Appendix 4). No patient refused to be included in the study.

Data Collection

A strategy of observation was used in which individual patients were followed through the department and topics occurring between them and staff were recorded on a schedule. The topics were classified according to a coding sheet which listed the possible content and initiator of topics (see Appendix 5)

An interaction was defined as a period of time in which a patient and a member of staff were together. A topic was defined as a communication which occurred between a member of staff and a patient or their relative about a particular subject. Topics were timed to the nearest minute. Qualitative data were also collected about the nature and quality of the interaction. This was also recorded on the schedule at the time of observation.

The observational checklist was piloted on 2 patients in each department. No major problems were identified. The only alteration made to the observational schedule, as a result of piloting, was to allow more space for recording of qualitative data. The observational schedule used in Stage Three is shown in Appendix 6.

Data Analysis

The observational study was analysed both quantitatively and qualitatively.

Quantitative analysis was used to examine the frequency, duration and initiator of topics in relation to the variables of age, sex and seriousness of condition to discover relationships which existed between them. No

statistical analysis was carried out due to the small sample size and non-independence of observations.

Qualitative analysis then examines the issues which emerged in more depth. The qualitative analysis considers the patient's progress through the department in relation to three phases: assessment, process through the department and discharge. Comparative analysis of each of the observational schedules was again used to establish themes and examine issues which emerged.

Section Two

Results

Part One: Quantitative Analysis

Frequency, content, duration and initiator of topics were analysed in relation to the variables of department, age, sex and seriousness of condition to expose meaningful relationships which existed between them. No differences emerged between the two departments studied or between male and female patients. Results of the observational analysis are, therefore, given as the average for each. The discussion concentrates on the interactions arising between nurses and patients, this being the main focus of the study.

Number and Duration of Topics

Communication between nurses and patients tended to be of short duration – 126 of the 156 topics (81%) initiated by nurses lasting 1 minute or less.

Only 3 topics initiated by nurses lasted more than 4 minutes. two of these occurring during a procedure (ECG). For the purposes of analysis, topics lasting more than 1 minute were grouped together (long topics) and compared to those lasting 1 minute or less (short topics).

The main difference that emerged was that 'major' patients received more topics from nurses than 'minor' patients (an average of 16.2 compared to 10.6). This was true of both short (an average of 12.6 compared to 9.2) and long (an average of 3.6 compared to 1.5) topics. Overall, the total duration of topics initiated by nurses with 'major' patients was longer than for 'minor' patients (an average of 14.3 minutes compared to 6.8 minutes).

Possible reasons for this may be that 'major' patients spent longer in the department than 'minor' patients and the reason for their admission usually required more detailed nursing and medical intervention and treatment. Certainly, it is not surprising that the 'minor' patients received fewer topics than the 'major' patients and that their duration was shorter. The issue in the present study is whether both groups received interactions of a sufficient number, duration and type to ensure that their psychological, as well as their physical needs were met.

The nurses reported that they believed 'minor' patients were given less attention than 'major' patients, including less psychological support. They described communication taking place in a way which was opportunistic and which, in practice, disadvantaged the 'minor' patients. Because the physical care required by 'minor' patients was frequently minimal, communication with them was correspondingly limited. The nurses

described how the progress of 'minor' patients through the department frequently brought them into little contact with nurses (see page 165). The nurses generally believed that the 'major' patients were likely to be more anxious than the 'minor' patients, but agreed that even if 'minor' patients were anxious, they still received less attention.

Interviews with patients had revealed that 'major' patients tended to be more anxious, but all patients, except 3, had expressed anxiety about some aspect of being in the department. The observational data and the nurse interviews both indicate, however, that nurses communicated less frequently, and for shorter periods, with 'minor' patients, which made it unlikely that their anxieties would be addressed.

A further finding was that 'older major' patients received more topics from nurses than 'young major' patients (an average of 9.7 compared to 6.5). 'Older major' patients also received more long topics than did 'young major' patients (an average of 2.6 compared to 1). Again, the total duration of topics initiated by nurses with 'older major' patients was longer than for 'young major' patients (an average of 15.4 minutes compared to 10.5 minutes).

'Older major' patients received more topics than 'older minor' patients (an average of 9.7 compared to 5.2), both short (an average of 7.1 compared to 4.1) and long (an average of 2.6 compared to 1.1). The total duration of topics received was also longer for 'older major' patients than for 'older minor' patients (an average of 15.4 minutes compared to 7.1 minutes).

'Young major' patients received slightly more topics than 'young minor' patients (an average of 6.5 compared to 5.5). The total duration of topics received by 'young major' patients was, again, longer than for 'young minor' patients (an average of 10.5 minutes compared to 6.4 minutes).

There was little difference between the number of topics received by 'older minor' patients and 'young minor' patients (an average of 5.2 compared to 5.5). The total duration of topics received by 'older minor' and 'young minor' patients was also similar (an average of 7.1 minutes compared to 6.4 minutes).

Severity of condition and age, therefore, appeared to be the most important factors influencing the number of interactions received by patients. 'Major' patients received more topics, and longer topics, from nurses than 'minor' patients. 'Older major' patients received both more and longer topics, than 'older minor' patients. 'Young major' patients received slightly more, and longer, topics than 'young minor' patients.

Although there was little difference between 'older' and 'young' 'minor' patients, among the 'major' patients, 'older' people received more topics and their total duration was longer. More of the topics received by the 'older major' patients lasted longer than 1 minute. Unfortunately, the sample only included 2 'young major' patients, compared to 7 'older', so conclusions are difficult to draw. The data suggest that nurses communicated with 'major' patients differently depending on their age. However, the 'young major' patients also had complaints which the nurses may have interpreted as not serious.

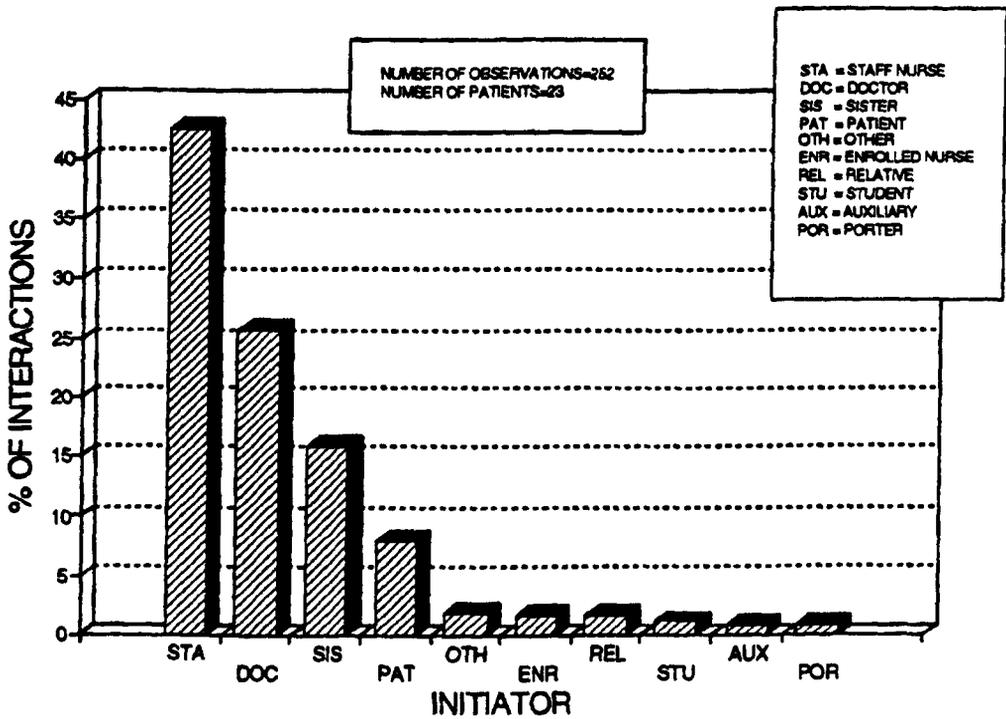
We have seen in the nurse interviews that they regarded the more seriously ill patients and the elderly as those most likely to be anxious. It would seem that those who fulfilled both criteria receive the greatest number of topics and that the overall length of the topics was greater. However, during the patient interviews 'young' patients reported more anxiety. The observational study suggests that their fears were less likely to be addressed. This issue is explored in further depth with reference to the content of topics.

Initiator of Topics

Figure 4 shows the number of topics which were initiated by different categories of people. Overall, the most frequent initiators of topics were the staff nurses, 42.5% of all topics being initiated by them. Sisters initiated 16% of topics. Twenty per cent of topics initiated by sisters were long and 18% of those initiated by staff nurses. The longest topics initiated by nurses were those that took place during the performance of a procedure or dressing.

The difference in the number and duration of topics initiated by sisters and staff nurses reflected a difference in their role. There was also a difference in the content of topics initiated by sisters and those initiated by staff nurses. Twenty two per cent of the topics initiated by the staff nurses were about illness/injury compared to 12% of those initiated by sisters. Staff nurses were more likely to carry out dressings or procedures on patients which were directly related to their illness/injury, whereas sisters, usually being in charge of the department, tended to maintain a general

Figure 4: Observational Study Topic Initiator



surveillance of all patients and would initiate a variety of different topics accordingly.

The differences found in the interaction of sisters and staff nurses appears to belie the statements made by the nurses that there is no ‘class distinction’ in the department, that ‘we all do the same job whatever rank we are’. In reality, such statements may reflect the nurses’ experience of the Accident and Emergency Department compared to other clinical areas, rather than that the nurses, literally, all do the same job. It was undoubtedly true that the sisters were more frequently in charge of the department and, therefore, were less closely involved in carrying out direct patient care. Nevertheless, the sisters shared the ethos of the department, with its emphasis on physical care, and so were likely to undertake as much

direct nursing as practicable. In addition, because of the immediate nature of the work and the relative absence of the 'routines' of the wards such as drug rounds and consultant ward rounds, more of the sisters' time was available to do so.

Only 19 topics (8%) were initiated by patients. Of the 23 patients observed, only 10 initiated any topics. Those who did initiate topics, therefore, tended to initiate more than one. Thus, 7 topics were initiated by the (7) 'older major' patients. Of these, 4 were initiated by one patient alone. Of the 2 'young major' patients, one initiated 3 topics, the other none. The topics initiated by individual patients will be discussed during the qualitative analysis. It is interesting to note, however, that of the 19 topics, 5 were about specific concerns of that patient, such as whether to undress, where to go and what had happened to their relatives, 4 about waiting times/delays, and 2 about each of the topics of fears and anxieties, impact on daily life and pain. Fears and anxieties, impact on daily life and pain were topics which, as we shall see, were infrequently initiated by nurses. No topics were initiated by patients about their illness/injury.

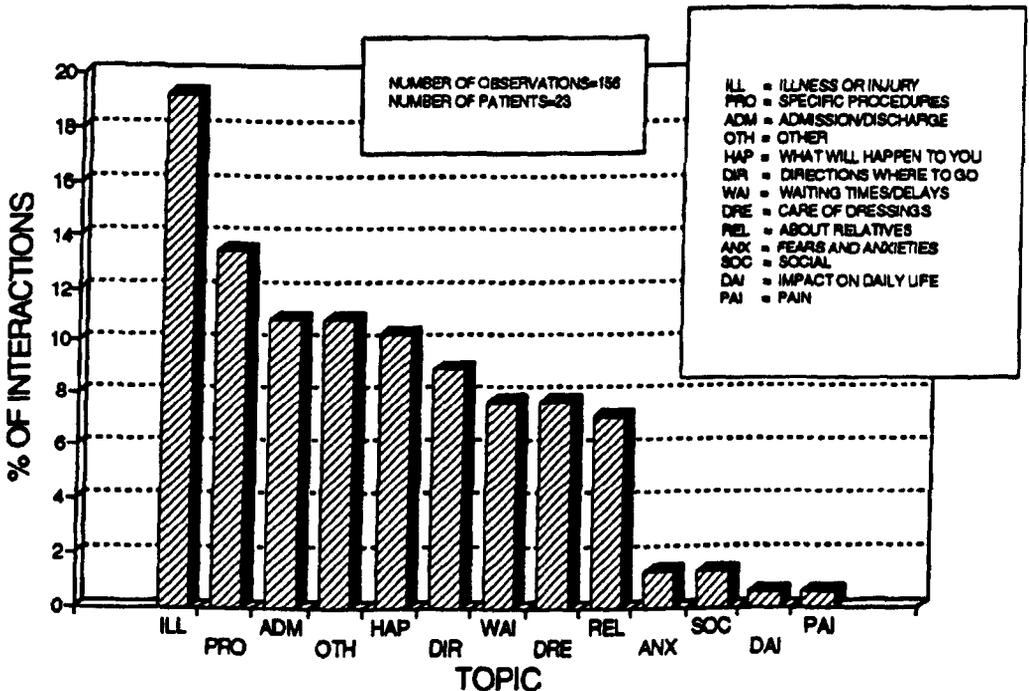
The small number of topics initiated by patients is consistent with the finding of the pilot study, that patients made few comments unless in response to direct questions from nurses and doctors. They also asked few questions, even when they were confused or uncertain about what was happening. The routines described by nurses to process patients through the department and their strategy of 'popping in' on patients to deliver care appear effectively to inhibit patients from attempting to gain the nurses' attention.

Content of Topics

Figure 5 shows the distribution of topics which occurred between nurses and patients in the departments studied. The most commonly occurring topic was the patient's illness or injury – 19.2% of all topics falling into this category. This category included obtaining a history of the illness/injury, assessment of the severity of the condition, comments about specific features of the patient's condition and informing the patient of the diagnosis. Topics which were infrequently initiated by nurses were about social circumstances (1.3%), fears and anxieties (1.3%), impact on daily life (0.6%) and pain (0.6%).

Because the patient's illness/injury occurred more frequently than any other topic, it was decided, for the purposes of analysis, to combine all other

Figure 5: Observational Study Topic Content (Nurses to Patients)



topics (non-illness/injury topics) into one category to be compared with illness/injury.

'Older minor' and 'young minor' patients received a similar number of both illness/injury topics (an average of 1.0 compared to 1.3) and non-illness/injury topics (an average of 4.1 compared to 4.3).

'Older major' patients received both more illness/injury topics than 'young major' patients (an average of 1.7 compared to 1.0) and more non-illness/injury topics (an average of 8.0 compared to 5.5). The 'older major' patients, therefore, received more non-illness/injury topics, as well as more frequent and longer topics than 'young major' patients. However, the patient interviews indicated that 'young' and 'major' patients tended to express more anxiety than 'older' patients.

Only 2 'young major' patients were observed so the difference in interaction is difficult to interpret. Both of the 'young major' patients had complaints which the nurses may have interpreted as not serious. The difference found could be due to the nurses' perception of the level and anxiety of the two age groups. Alternatively, it could be due to the perceived seriousness of the patients' condition and likelihood of admission.

Analysis of the observations shows that few topics were specifically directed to identifying and dealing with patients' anxieties. However, it may be that the non-illness/injury topics are used in an attempt to address patients' concerns indirectly. For example, explaining what would happen in the

department and the reasons for delays could be used to alleviate patients' anxieties. The nurse interviews suggested that they saw such tactics as useful. Nurses made comments such as, 'As long as you go in and tell them what's going to happen, then they're a bit better straight away' and, 'I think as long as you keep giving them information then that stops a lot of it (anxiety)'. That nurses saw patient anxiety as being appropriately dealt with, in part at least, by such indirect means is also revealed by the emphasis they placed on maintaining a calm, confident manner (see page 204). Given, therefore, that nurses do seem to deal with patients' anxiety in an indirect way, it may be that communications about topics other than illness/injury represent, to some degree, such attempts by nurses.

The interviews with nurses showed that they saw the older group as more likely to be anxious (see page 161). This perception may explain why they directed a greater number of topics, including long topics, and a greater number of non-illness/injury topics towards the 'older major' compared to the 'young major' patients. Nurses may direct more communications, including more non-illness/injury topics, towards the older group in an attempt to reduce their worries.

However, only 2 'young major' patients were observed and both had complaints which may have been perceived as not serious. It could be that seriousness of condition was, therefore, the most influential factor. Analysis of the observational data revealed that among the 'older major' patients, the 4 who received the largest number of non-illness/injury topics from nurses (an average of 11) were subsequently admitted to hospital. Neither of the young patients were admitted. It would appear, therefore, that nurses

directed more non-illness/injury topics to those patients who were subsequently admitted to the hospital.

In contrast to these patients, the 'young major' patients both complained of problems for which no cause was identified, one chest pain, the other abdominal pain. Two of the 'older major' patients also complained of chest pain for which no cause was identified. These 'older major' patients received considerably fewer non-illness/injury topics than those who were subsequently admitted (an average of 2.5). It is possible that nurses used their expertise and experience to interpret cues which informed them that these patients' conditions were unlikely to be serious. They may, therefore, have perceived them as unlikely to be anxious and consequently directed fewer non-illness/injury topics towards them.

The interpretation of the difference in number of non-illness/injury topics, and the frequency and duration of topics, which nurses directed towards 'older major' and 'young major' patients is complex. Age appeared to be important but the nurses' perception of the seriousness of the patients' condition and the likelihood of their admission appeared also to be contributory factors. The small numbers included in the present study made it impossible to distinguish between the effects of these factors. The nurse interviews would suggest that nurses use a range of cues and experiences to make assessments about patients and direct their behaviour accordingly.

Apart from nurses' perceptions of patients, all interactions may be affected by external factors such as the busyness of the department and the number

of staff on duty, as well as by the number of opportunities for interaction prompted by the demands of the individual patient's condition.

The small number of patients observed makes quantitative analysis limited. In particular, the small sample size meant that the factors of age and seriousness of condition were compounded. Nevertheless, the quantitative analysis does provide useful indicators of interaction patterns and a framework in which detailed qualitative analysis may be undertaken. The following section discusses, with reference to individual patient's experiences, how these factors affected the way that nurses identified and dealt with the anxieties of patients during their time in the department.

Part Two: Qualitative Analysis

Having examined the patterns of communication between nurses and patients in terms of type, duration and initiator of topics we may now consider in more detail how these operated in terms of the patients' experiences in the departments. The patients' progress will be considered in relation to three phases, assessment, process through the department and discharge. These cannot be seen as entirely discrete categories – assessment, for example, may be taking place throughout the patient's stay in the department. They may, however, be viewed as stages when these aspects predominate. Thus the first stage of a patient's progress through the department is usually assessment by the nurse. This is followed by a process of investigations and medical treatment, the exact nature of which depends on the patient's illness or injury. Finally, in the discharge phase disposal of the patient, either home or to a hospital ward, is arranged and any necessary instructions or advice given.

Assessment

Assessment is the first stage of a patient's progress through the department. He or she is usually seen first by the nurse, problems are identified and some evaluation is made of the urgency of the case. The assessment forms used in the two departments studied are shown in Appendices 7 and 8.

In Department A the nurse seeing patients at this point would decide whereabouts in the department would be most appropriate for them to go. The nurse making the initial assessment was usually the nurse in charge who was based at a desk near reception. If they had a minor injury she would direct them to the waiting area to be seen in the curtained area. If they were more seriously ill and required more thorough examination they would be taken down to the cabins. Here a further assessment would normally be carried out by the nurse allocated to that area.

In Department B this role was often performed by the receptionist, a further assessment being carried out by the nurse, in most, but not all cases, before the patient was seen by the doctor. The nurses in Department B aspired to using a 'Triage' nurse to assess and allocate patients. However, shortage of staff prevented the system from operating while the observation was taking place and, according to the nurses, was seldom practised.

Assessments of patients with 'minor' injuries tended to be brief (lasting less than 1 minute) and strongly related to the patient's illness or injury. There was usually no attempt made to identify any fears or concerns the patient

may have had and how the injury was likely to affect them. The purpose of the assessment appeared to be therefore the establishment of facts necessary for completion of the casualty card and subsequent medical investigation.

An example of a typical nursing assessment of a patient with a 'minor' injury, which occurred in department A, is given below:

Sr: What's the problem?

Pt: I fell over on my foot

(This information is written on casualty card.)

Sr: Are you allergic to anything?

Pt: Not that I know of

(Also recorded.)

Sr: Take a seat, you'll be called to be seen shortly.

On two occasions in Department A the only question addressed to the patients which could be categorised as assessment by the nurse was if they were allergic to anything, the nature of the injury having been recorded by the receptionist. The patients with 'minor' injuries in Department A were usually told they would be seen soon. The only person given an approximate waiting time was a young man who specifically asked what the waiting time would be. As Department B was frequently quiet during the observation period patients were sometimes seen immediately by the doctor. In 4 cases in this department patients were not assessed by a nurse at all before examination by the doctor. For one of these patients, however, having made the initial assessment, the doctor directed her to the waiting room so that a nurse could help her into a gown and record her observations before he examined her.

The experience of the patients who were not assessed by a nurse in Department B is interesting and deserves further consideration. The reason why they were not assessed by the nurse was because the doctor was available to see them as they entered the department and did so immediately. Only when the patient needed to be undressed and helped into a gown did the doctor consider it necessary for the patient to be seen by a nurse. In a sense the doctor was breaking the established rules by his behaviour in seeing these patients without a prior nursing assessment. That he did so raises interesting questions about the respective roles of doctors and nurses in the department and about the perceived value of nursing assessment of patients.

At one level, his behaviour provides further evidence for the view, put forward by the nurses, that all staff worked together and that the distinction between doctors' and nurses' in the department is blurred. However, that the nurse must be the person to assist patients to undress and record their observations, suggests that essential differences *do* exist. If the doctor can proceed immediately to examine the patient, no nursing assessment is seen as necessary. However, the doctors did not appear willing to undertake helping the patient to undress, an activity which they may have regarded as a relatively menial nursing task. It would seem, therefore, that although nurses may be willing to take on certain routine medical tasks, the doctors do not share a corresponding willingness to undertake simple nursing duties.

The doctor's behaviour, in proceeding to examine 3 patients without their being previously seen by a nurse, suggests that there is little intrinsic value

placed on the nursing assessment of patients, at least by doctors. The nurses' role is, therefore, defined as a supportive one, to prepare the patient for examination by the doctor.

Symbolic Interactionism emphasises the part that negotiation plays in defining the roles of different professional groups which work together. One might have expected nurses to have sought to establish the value of their role in patient assessment. The nurses themselves, however, seemed ambivalent about their assessment of patients. They believed that assessment was important. At the same time they did not want their assessment to be too formalised and lengthy as this would involve them in unnecessary paperwork and detract from what they saw as their 'real' work of caring for patients. They were concerned, therefore, that a detailed nursing assessment would result in an emphasis on completing forms at the expense of patient care. This was a particular fear with regard to 'minor' patients where a detailed assessment was viewed as unnecessary (see page 169).

The nurses, therefore, seemed to share the doctor's apparent assumption that a nursing assessment of patients was of limited value. Even for the 'major' patients the nursing assessment was brief and attention focused almost exclusively on the illness/injury.

A typical assessment of a patient with a 'major' condition is described below:

(The nurse escorts the patient, who complained of chest pain, into a cubicle.)

N: So what's happened?

Pt: Well, I was at work and I had this pain in my chest and my arm felt all weak.

N: What I'll do is to ask you to get undressed and get onto a trolley.

(Nurse assists patient into gown.)

N: So do you have pain at the moment?

Pt: It's not too bad at the moment. It's just with my arm being a bit weak.

N: So when did the pain start?

Pt: About 1 o' clock.

N: And had you been well till then?

Pt: Yes.

(Nurse helps patient onto trolley.)

N: I'll just check your pulse and blood pressure, OK?

Pt: Yes.

(Nurse takes patient's pulse.)

N: That's OK. I'll just put this thermometer under your arm for the moment.

(The nurse then records the patient's pulse and blood pressure and leaves the room, returning 2 minutes later to remove the thermometer, record the result and again leave the room.)

The nursing assessments of patients observed, including those of 'major' patients, were mainly concerned to gain information required for the doctor's examination, and to prepare the patient physically for that event. There was little attempt to assess the patient's reaction to what had happened, if they had any fears or worries and how their lives would be affected by what had happened.

Social circumstances were also given little attention. This was true even when they were directly related to the cause of admission. One patient in department A related that while she had been physically abused by her boyfriend, his dog had bitten her. The care of this woman centred entirely on the treatment of the dog bite. The incident which had led to its

occurrence was effectively ignored. Thus, once the nurse had established that she had been bitten by a dog, she escorted the patient immediately into the curtained area to examine the wound. After inspecting the dog bite, which was on the patient's leg, the nurse asked what had happened. The patient replied that her boyfriend had hit her that morning, they had had a fight during which his dog had jumped up and bitten her. This information was ignored. Instead, the nurse went on to ask if she had hurt her head much, where the patient had another small laceration, and to examine that injury. Although the social circumstances were clearly relevant to the injury, discussing them was not seen by the nurse as part of her job. Her concern was to treat the wound.

Throughout the patient's time in the department the nurses' attention centred entirely on the wound. It may be that the social factors underlying the physical problem were such as to prompt disapprobation from the nurses. Certainly, the nurse interviews had shown that they were unsympathetic towards patients whom they regarded as 'social problems'. The comment of one of the nurses when the patient left revealed that she regarded any effort on the part of such patients as worthless, 'It's a shame what happened, but unless they're prepared to do something for themselves, there's nothing we can do to help them.'

In some cases, personal factors such as social circumstances of the patient's reaction to their experience were touched upon, but always on a relatively superficial basis. Thus one nurse in Department A asked her patient if he had any relatives. He replies 'Yes lots' to which she responds 'So you've got plenty of relatives. You get visited a lot?' He then says 'I'm not

bothered if they visit or not really', which she ignores and changes the topic completely to ask 'How long have you had the Parkinson's?'

Similarly in Department B a patient began to relate to a nurse how he had started vomiting blood and comments, 'If you don't go to the doctor's very often, they know it's something when you do'. The nurse did not encourage the patient to say any more about this but changed the conversation by asking if he would like to sit up a bit.

These observations suggest that although the nurses were concerned about their patients, their concern was narrow and focused on the patients' condition. In both interactions described the nurses were friendly toward their patients and joked with them. The conversation may therefore be seen as having a social purpose of putting the patient at ease as well as a functional one of patient assessment.

In a practical sense, therefore, the nursing assessment seemed an instrumental activity which was designed to prepare the patient for examination by the doctor rather than being perceived as worthwhile as an independent nursing activity. The nurses were friendly towards their patients but the questions asked had a superficial social quality rather than a therapeutic purpose. There was no observable indication, in either department, that the nursing assessment of the patients in itself was a valued activity. Information that was collected by nurses was that required by medical staff. Questions about the individual's social situation, or reaction to their illness or injury did not frequently arise and, when they did, were treated in a relatively superficial manner.

It has been suggested that the reason for the limited nature of the nurses' assessment of patients was that such activity was attributed low value by both doctors and nurses. The Symbolic Interactionist perspective, which endeavours to understand the viewpoint of those involved in any social interaction in order to interpret their behaviour, suggests that the nurses had other priorities which they perceived as more important.

The interviews with nurses had revealed that they saw themselves as constantly dealing with simultaneous and conflicting demands on their time. They coped with this by attempting to perform each task as quickly and efficiently as possible in order to meet the next demand. They also tended to deal with problems as they arose, rather than developing a planned programme based upon systematic assessment.

Process Through the Department

Nursing care of the patient in their process through the department tended to be limited, fragmented and predominantly concerned with the individual's physical problem. Nurses only spent time with the patients when they had some procedure to carry out or there was a specific question they needed to ask. Analysis of topics revealed that a large proportion of nurses' communication with patients during this period was concerned with giving them instructions or directions where to go and explaining delays. The emphasis therefore appeared to be on facilitating the patients' progress through the department.

If patients were in the department for a long period of time the length of their interactions with nurses did not increase accordingly. The number of

interactions was obviously greater but most were brief and their total duration was short.

The limited nature of nurse-patient interaction is illustrated by examination of the experiences of individual patients. In Department A an elderly female patient was admitted having fallen and possibly fractured her leg. Although she was in the department for 3 hours and 35 minutes, the amount of that time spent interacting with nurses was less than 7 minutes. Part of the reason for the long delay was that she had to wait in X-ray for 20 minutes, and the department was also busy that day which meant waiting for longer than usual to be seen by the doctor. However, the interaction with nurses was minimal considering the woman's age and the likely impact on her daily life. There was no reference to these issues by nurses. The nurses' interactions with her, during this period, were concerned almost exclusively with getting her to X-ray and back, i.e. with directions and process through the department. The patient's comments to her relatives revealed that she was worried about admission and about how she would manage if discharged. These might have been appropriate subjects for the nurses to discuss with her, but they were not broached.

The nature of the patient's concerns were, however, difficult for the nurse to address. An obvious reason was that the outcome was, as yet, uncertain. Furthermore, if the patient was to be admitted, there was little the nurse could do, in practical terms, to make the necessity less worrying. Should the patient be discharged home the nurse could arrange a district nurse and social services support but there would, perhaps, be little point in raising the issue until the outcome was definite. The nurse, therefore,

would have had difficulty in dealing with this patient's anxiety at this point in her stay.

A similar example occurred in Department B where an 80-year-old woman was admitted, having fallen at home. This woman was in the department for 5 hours and 35 minutes of which fewer than 35 minutes were spent in interaction with nurses. Again, nearly two-thirds of the communications between nurse and patient were brief, 19 out of the 31 lasting less than 1 minute. This patient was also worried about the possibility of admission but no attempt was made to explore her fears. Indeed, when she expressed her hope to the nurse that she wouldn't be admitted, further discussion was effectively quashed, as the following extract reveals,

N: Now, you're going to be having an X-ray, and after that the doctor will be coming back to see you to decide what to do.

Pt: I hope they won't be keeping me in.

N: We don't know at the moment. Obviously we won't keep you in unless we have to. It's in everyone's interest to get you home if we can, but obviously we can't do that unless you're well enough.

Later, the patient asks again, 'I will be going home, won't I?', and again is told, 'We'll have to see'.

As already stated, there are specific features of the Accident and Emergency Department which make dealing with patients' anxieties difficult. A degree of uncertainty hangs over every patient until a fairly late stage so it is difficult to give information. It may be that nurses tend not to spend time with patients because they have nothing to tell them about their situation.

This patient was in the department for a considerable length of time. Most of her interactions with nurses were brief, the longest topic lasting for 3 minutes. Her stay was characterised by brief communications from nurses as they passed, such as 'Are you alright my love?' 'Are you cold?'. In their interviews the nurses described how they used a strategy of 'popping in' on patients as a means of dealing with a large number simultaneously.

Although they found it necessary to organise their work in this way, they were aware that it was not an ideal method (see page 173). However, it may be that these brief communications were a means of demonstrating concern for the patient when the nurses were too busy to spend more time with her.

As in the pilot study, patients demonstrated a marked degree of compliance in their interaction with staff, following instructions precisely and making few demands. Two exceptions to such passive co-operation were observed, both in department B. Here, after the patients had been X-rayed they were instructed to remain in the waiting area beside X-ray until they were called to return to the department. Two of the young, male, 'minor' patients became impatient with the length of time they waited and returned to the department before being called. The way in which they did so constituted a challenge to the nurses who could no longer ignore them but, if unable to attend to them at once, would have to insist they continued to wait. Both were then attended to immediately by the nurse which indicates that although expected rules of behaviour were established, they were not always enforced. These two patients had effectively jumped the queue.

The reactive strategy of care practised meant that if a patient succeeded in securing the nurse's attention, his demands might be met. As nurses dealt with patients' needs as they arose, a patient who made the nurses more alert to his needs, and his concern that they weren't being met, could have them fulfilled more quickly. Although the majority of patients took no action, many seemed aware of this possibility. A common fear was that they would be forgotten about or overlooked. Most patients accepted that nurses were busy and had many important matters to deal with. Although worried that their needs might be forgotten, they did not presume to confront the nurses or attract their attention.

Communication was also affected by the organisation of care. Patients tended to get seen by a number of different nurses and medical staff and information might not have been passed on between them. This happened in the case of a young woman who was admitted to Department A with abdominal pain. After she had been seen by the casualty officer and had had an X-ray he evidently decided that she needed a scan. Nobody explained this to the patient. Only when the auxiliary nurse said the porter would be coming shortly to take her for her scan did the patient discover she was to have one. While we waited in X-ray the patient expressed her concern to the researcher about it, 'If there was anything wrong with the X-ray they would have told me, wouldn't they?' After the scan had been performed she still had not been told why it had been necessary.

This example illustrates that patients who are not given an explanation about something may invent their own which may not, in fact, be correct. In this case then patient assumed that because she was having a scan there

must be something wrong whereas the actual reason was that the X-ray had been normal so a further investigation was thought necessary. The anxiety of this patient was not identified or dealt with by the nurses. She was one of the 'young major' patients. Perhaps, as the earlier discussion suggested, her age and condition were such that they were unlikely to acknowledge any anxiety.

One aspect of care which the nurses were concerned to give thorough attention to was explanations of specific procedures. These were often described in detail. For example, a nurse recording a patient's blood pressure explained, 'I'm just pumping it (the sphygmomanometer cuff) up...Just letting it down...That seems fine.'

The patients who required an ECG to be recorded were also given considerable information about what was involved, usually in a manner which was friendly and informal. The following extract describes the interaction which occurred between a nurse and patient in Department B, in preparation for recording of an ECG:

- N: Right sir, I've got to do a trace of your heart because you've got chest pain. Can I have you up on the trolley? Have you ever had one done before?
- Pt: Yes.
(Nurse helps patient onto trolley.)
- N: You say you've had a cardiograph before?
- Pt: Yes lots, when I had heart surgery.
- N: You're quite a hirsute gentleman, which means you're quite hairy, so I'll have to shave some of it off.
(Nurse proceeds to shave patient.)
- N: The only place I need to take a wide swathe is just here. I'm just telling you because of the sunny weather – you'll have a few bald patches (nurse and patient both laugh)...Now, I'm going to put straps round your wrists and ankles.

(Nurse fastens the straps.)

N: They're not too tight are they? I'll only put 40,000 volts through, just enough to make you hair stand on end. It can be unnerving if you've never had it before.

Pt: It's like being Frankenstein.

N: I usually say it's like a spaceman....As you know you get wired up here like a million-dollar man. Right sir, just lie there very quietly and we'll get this done very quickly.

The above extract suggests that the nurse may have helped the patient feel at ease by conducting the procedure in a friendly and joking manner. A joking manner was quite frequently adopted towards patients. Other examples observed were a nurse helping a patient into a gown humorously calling it 'this Paris creation' and another nurse who left a patient who had fractured his ankle, saying 'now don't run away, will you?' This approach appeared to lighten the patient's experience of the department but was also, perhaps, effective in avoiding more difficult topics. Patients would be unlikely to interrupt the nurse's cheerful banter by mentioning their worries and may have felt that a cheerful front was expected of them.

Nevertheless, the topics which occurred during ECG were the longest of those observed. The nurses talked to the patients at some length while they were carrying out such physical care. In contrast, nurses rarely talked to patients, except in passing, when they had no physical care to carry out and the communication which did occur was largely directed by the demands of the patients' physical needs, rather than in response to their psychological needs. Specific procedures were explained in detail but the nurses seemed reluctant to enter into explanations or conversations at a deeper level.

One measure which the nurses did invariably take as a means of reducing patients' anxieties was ensuring that relatives were contacted and informed of the patients' admission. Particular attention was given to this for 'major' patients. Of the 5 'major' patients who had no companion with them, only 1 was not asked if there was anyone they would like contacted. The nurses also tried to ensure that the relative remained with the patient as much as possible during their time in the department. Usually, the only time when they were asked to leave was while the patient was being examined by the doctor. As well as providing support for the patient, the nurses felt the presence of the relative relieved the pressure on themselves. The nurses assumed the relative would call them if the patient needed anything.

With the 'minor' patients, too, the nurses encouraged the relatives to accompany the patient to X-ray. As another nurse said, 'We try and make sure that if they're going to X-ray that their relatives go with them.'

As the nurses described in their interviews, for the 'minor' patients the period between assessment and discharge was frequently spent in X-ray. These patients had little contact with the nurses during this phase. The majority of topics initiated by nurses with the 'minor' patients during this time were concerned with directing them there, receiving their X-rays on return, and requesting them either to return to the waiting area or to enter the curtains or a cubicle to be seen again by the doctor.

Discharge

This part of the patients' progress through the department covered activities related to ending the patient's stay in the department. Nineteen of

the patients observed were discharged home and the remaining 4 were admitted to the hospital.

For patients with 'minor' injuries discharge tended to be the time when nursing involvement with them was the greatest, particularly if they had to have a dressing applied and be given advice about how to care for it. In all the cases observed the discharge of patients was carried out by a qualified nurse and the information given covered simple instructions about care of dressing, pain control and appropriate behaviour, depending on the nature of the injury.

Advice was given in the form of instructions to be followed and in a standardised format, for example, 'keep the dressing on for 2 days', 'take paracetamol for pain', 'go to your GP if you have any problems'. This may reflect the nurses' knowledge and expertise in the care of these patients so that they adhered to a specific set of instructions. On only one occasion did the nurse ask the patient if they had any questions

The nurses themselves described their communication with 'minor' patients who were to be discharged as being principally in the form of instructions to be followed. One reason they gave for this in Department A, where such patients were seen in the curtained area, was a lack of privacy, as the following extract reveals,

N: If they're in the curtained area they'll have a very minor injury, what we class as minor, it might be paramount to them. A small cut on the finger could be nothing to us but could be horrendous to them, do you know what I mean, and we tend to overlook that. I think we lecture the patients in there. We don't talk to them in accy room, we lecture them, 'This is

what you have to do blah blah blah' and they're out. Whereas in the cabins you do have a bit more...It's more...

GB: You've more opportunity to talk?

N: That's right, because you've got more privacy.

GB: Whereas in the curtained area it's more instruction oriented?

N: That's right. There is a difference.

However, privacy was evidently not the only influential factor. The 'minor' patients seen in Department B, where individual cubicles were available, received information and advice of a similar quality. Here, too, the emphasis was on giving instructions.

Patients seemed satisfied with the information they were given. Only 2 asked further questions, both about going back to work. Two other patients had expressed worries about not being able to go to work to the researcher. These were not, however, mentioned to the nurses. A possible explanation for the lack of further discussion may be a perception on both sides that patients' concerns were inevitable and there was little the nurses could do to help. For example, one self-employed businessman in Department B who had broken his leg and been told he would have to 'stay off it' was very concerned about the effect this would have on his work. He commented to his wife, 'stay off it, that's very easy to say'. But his concern was not disclosed to the nurses, perhaps because there was nothing practical they could do to help.

The duration of the discharge period for most of the 'minor' patients was longer than for the patients with more serious illnesses or injuries, even when the latter were going to be admitted. The average length of this period for patients with more serious illnesses or injuries was 2.5 minutes

compared with 4 minutes for patients with minor injuries. Partly this reflects the level of nursing involvement required in each case. Thus, if the patient needed a dressing applied this would be time consuming and the nurse would use this time to explain to the patient about the necessary care.

Responsibility for carrying out dressings and giving appropriate information about their care was a core part of the nurse's role in the Accident and Emergency Department. Both patients and nurses seemed satisfied that they did this well. The nurse who described their communication with 'minor' patients who were being discharged as a 'lecture' was nevertheless convinced that despite the emphasis on instruction, or perhaps because of it, patients were given all necessary information, as the following extract shows,

- N: I think it's quite good, the information we give them. Yeah, we do tell them what we do, why we've done it.
- GB: Who does that? Is it the staff nurse?
- N: The nurse who's dealing with them. It might be the student or whatever. And we tell them, if they've got a dressing on, to keep it clean and dry, how long they're to keep it on for. With muscle injuries we give them leaflets to do exercises and when to wear tubigrips and when not to. Yeah, it's quite good actually. I don't think patients go out of the department ill-informed.

Giving detailed instructions to patients can be seen as comparable to the emphasis the nurses placed on explaining specific procedures. Both were aspects of care which they regarded as deserving particular attention. The two aspects of care had in common a straightforward physical and practical quality, endorsed by the nurses as important. The nurses were, therefore,

conscientious about telling their patients what they would do and specific about instructing the patients about what they themselves should do.

Where they were apparently less effective was in providing support for patients' concerns which were less tangible and for which there may be no practical solution. For example, in their interviews many patients had expressed anxiety that their injury could affect their ability to carry out their daily activities. These fears were not addressed in any depth.

The nurse's role in discharging patients with more serious injuries was predominantly organisational. The amount of communication between nurses and patients during this part of their stay in the department was shorter. These patients were usually told by the doctor that they needed to be admitted – or that they could go home – and the nurse would then make the necessary arrangements. If the patient was to be admitted much of this work was 'behind the scenes', 'phoning the ward to arrange transfer and requesting a porter, the patient simply being told which ward he or she was going to. Again there was little opportunity for patients to express their reactions.

This was true even in the case observed where the patient was worried about being admitted and had hoped that she would be able to go home (see page 236). This patient made repeated attempts to discuss the possibility of admission. When eventually informed of its necessity she was still not encouraged to express her feelings about the event. The following extract from the observational notes about this patient formed an interaction which lasted only 1 minute and took place after the patient had been in the department for nearly 6 hours,

- N: Mrs_____, you're going to ward 7.
Pt: Am I, I was hoping to be able to go home.
N: The doctor said she's not happy for you to go home. You're not really managing are you? And you won't be able to manage at all now.
(The patient makes no response.)

The patient had, throughout her stay, seemed as though she would have welcomed the opportunity to discuss her prospective admission. She was, as we have seen, given little encouragement to do so, even when it became certain. Perhaps, like the possible social consequences of a patient's illness/injury, the nurses saw admission as a matter beyond their control. The nurses' might have had difficulty in dealing with this patient's anxiety as admission to hospital was necessary. However, the patient may have had specific concerns which could, if identified, have been resolved. Not discussing the issue meant that the patient's needs were not assessed and, therefore, had no possibility of being met.

Conclusion

The patient interviews had revealed that almost all patients were anxious about some aspect of being in the Accident and Emergency Department. The most common fears were 'Not being able to carry on your usual activities', 'Not knowing what would happen to you in the department', 'Being unable to control what would happen to you', 'Feeling pain' and 'Having to undergo an uncomfortable procedure'. 'Young' and 'major' patients and females were found to be more anxious than other groups.

The observational study showed that the interaction which occurred between nurses and patients was brief, disjointed and almost entirely

concerned with the patients' physical care and progress through the department. There was little attempt to identify patients' fears or to explore their responses to their illness or injury.

It was suggested that the non-illness/injury topics, such as explaining what would happen in the department and the reasons for delays, may have been used to reduce patients' anxieties indirectly. 'Major' patients received more topics and longer topics than 'minor' patients and more non-illness/injury topics. 'Older major' patients received more and longer topics than 'young major' patients.

It would seem, therefore, that the 'major' patients, particularly the 'older major' patients were more likely to be given support and reassurance. Only 2 'young major' patients were observed but the nurses did interact less frequently, for shorter periods of time and directed fewer non-illness/injury topics towards these patients. The reasons for this were impossible to establish as the two factors were compounded. It seemed that the patients' age, in combination with the severity of their illness, influenced the nature of their interaction with nurses and the likelihood that their fears would be addressed.

In their interviews, the nurses had described the elderly patients and those who were more seriously ill as most anxious. The observational data suggest that the patients whom the nurses perceived as most likely to be anxious received most attention. However, the patient interviews had shown that the 'young' and 'major' patients tended to be more anxious than the older groups. Although the 'young major' patients were more

anxious, therefore, it would seem that they got less attention.

Although the 'young major' patients and 'minor' patients received the least attention, there was little evidence that any group of patients received much attention to the psychological and social consequences of admission to the Accident and Emergency Department. Specific procedures were explained to patients and, where necessary, patients were given detailed instructions about care of their injury or dressing. These aspects of care were regarded as important by nurses and the emphasis placed on them was consistent with their preoccupation with physical care.

Less tangible and remediable concerns, such as patients' emotional response to the department, and fears about how they would manage their usual activities or cope with admission were given less attention. A number of difficulties were evident in the nurses' ability to deal with such problems. In particular, the uncertainty which characterised most patients' stay in the department and the nurses' lack of power to resolve these problems emerged as reasons why they may not have been addressed.

CHAPTER NINE

Summary of Results

Introduction

This chapter provides a summary and brief discussion of the findings from each of the three stages of the research. In the following chapter the implications for theory and practice are considered. The present chapter is divided into three parts. In the first part the nature of patient anxiety in the Accident and Emergency Department is examined. In the second part the nature of nurse-patient communication observed is reported. The third part considers these findings with reference to the nurse interviews which explored the nurses' perceptions of their work and patients.

The Nature of Patients' Anxieties

The data collected during Stage One of the study showed that almost all patients attending the Accident and Emergency Departments studied were anxious about some aspect of the experience. Only 3 patients said they were not anxious about any part of the event. Patients expressed, on average, anxiety about 8 items, out of a possible 28, on the interview schedule.

The most frequently expressed anxieties were 'Not being able to carry out your usual activities', 'Not knowing what will happen to you in the department', 'Having to undergo an uncomfortable procedure', 'Feeling

pain' and 'Being unable to control what will happen to you' (see Table 3). These items were also among those about which patients most commonly expressed moderate or extreme anxiety (see Table 4). The data suggests, therefore, that for patients in the Accident and Emergency Departments studied, concerns about psychological and social factors related to admission were as common as concerns about their physical condition and treatment.

The frequency with which patients expressed anxiety about not being able to carry out their usual activities was notable. Of the 84 patients who thought the item applicable, 68 (80.95%) said they were anxious about it, 30 (35.71%) saying they were moderately or extremely anxious. The finding suggests that, for many patients, the perceived impact of their illness/injury on their daily life was a significant worry. Patients reported that they were worried about not being able to work (and the financial implications of not doing so), being unable to undertake housework, childcare, shopping and cooking or leisure activities such as sport or holidays.

Even if only 'minor', the effects of their illness/injury could disrupt the individual's usual activities with both emotional and practical effects. It must be remembered that the data refer to the patients' perception of the likely consequences of their illness/injury, which may not necessarily correspond with the actual disruption which would ensue. Nevertheless, these patients felt that they would have to face specific difficulties related to arranging for the necessary activities of daily life to be performed and the inconvenience of some customary ones being suspended.

It is useful to consider, at this point, some of the explanations medical sociology offers for illness and its associated behaviours. Parsons (1951) elaborated the classic concept of the 'Sick Role' to explain how society sanctions the deviance of illness on the part of the individual on condition that the person observes certain required activities, including consultation and co-operation with a medical practitioner who has the authority to legitimise their position. According to the Parsonian model, the patients in the Accident and Emergency Department were in the process of gaining legitimisation of their illness/injury in order to attain the privileges and responsibilities of the sick role. The phenomena of illness is seen, therefore, from the perspective of the impact on society and assumes passive compliance on the part of the individual with the requirements of the sick role.

Yet the concern that patients expressed about the possible impact of their illness/injury on their usual activities indicates that the assumption of the sick role was not a passive process, but a stressful and disruptive experience which they sought to avert or minimise. Patients were worried that they would have to abandon their usual social roles – breadwinner, parent, housewife, sportsman – and assume that of the sick role. It may be that, rather than attending the Accident and Emergency Department as a means of attaining the sick role, patients attended as a means of averting it by seeking appropriate treatment.

An important point which emerges from this discussion is that attempts to explain behaviour without reference to the meanings and interpretations which prompt their action are of limited value. An alternative approach is

offered by the Symbolic Interactionist perspective. Here the interpretations of individuals are seen as central to understanding their action. Dingwall (1976) presents an elaborate model to demonstrate the multiple elements which shape the individual's understanding of health, interpretation of deviations from normality, factors influencing the decision to seek help, the choice of help selected and the possible responses to the chosen option. Here the individual is seen as central to decisions about their own health and as an active force rather than passively responding to external pressure.

This model offers a more useful framework for understanding the individual's decision to attend the Accident and Emergency Department, their interpretation of their experience and anticipation of their future situation. It may be that perceived impact on usual activities may have been an important factor influencing the individual's decision to attend the Accident and Emergency Department and the number of patients expressing anxiety about this item reflects this concern. In addition patients may now be understood not as passive recipients of health care services but as active participants preparing themselves for potential problems they may have to cope with following discharge.

We shall return to this issue later when we consider the nature of nurse-patient communication. Before doing so, however, the other items about which patients expressed anxiety deserve further discussion. 'Having to undergo an uncomfortable procedure' and 'Feeling pain' were both frequently cited sources of anxiety for patients, both physical factors related to being in the department. Like the impact on the patient's daily

life, the experience of pain would be an important factor influencing the individual's decision to seek medical help. The perceived nature and degree of pain could affect the decision to attend the Accident and Emergency Department, rather than utilise an alternative medical facility such as the GP. The experience of pain has been described as, 'An unpleasant and emotional experience associated with actual or potential tissue damage or described in terms of such damage' (International Association For the Study of Pain, Sub-Committee on Taxonomy, 1979). It is to be expected, therefore, that the experience or anticipation of pain or discomfort provokes anxiety. Certainly the relationship between pain and anxiety is well-documented in the literature (Carnaveli, 1966; Hayward, 1975; Carr and Powers; 1986; Seers, 1987). Wilson-Barnett (1976) also found 'Anticipating a treatment or procedure which was likely to be painful' elicited predominantly negative responses from her sample of medical patients, while Scers (1986) found that anxiety for surgical patients was associated with technical procedures, such as dressings and drain shortening, which were likely to be uncomfortable.

'Not knowing what will happen to you in the department' and 'Being unable to control what will happen to you' were also among the most frequently cited sources of anxiety for patients. The frequency with which these concerns were expressed again conflicts with Parson's (1951) view of the individual as passively assuming the sick role. Admission to the Accident and Emergency Department, it would seem, was associated with feelings of powerlessness and lack of control.

Some studies examining patient anxiety in hospital have found that patients

have a peak of anxiety on the day of admission (Johnson et al, 1979, Wilson-Barnet and Carrigy, 1978). It may be that unfamiliarity with the event, place and people, as well as possible uncertainty over outcome, was stressful for patients. Certainly, in the Accident and Emergency Department, patients were likely to be unfamiliar with the department, its personnel and routines and may have felt unsure about how they should behave and what would happen to them. The number of patients who expressed moderate or extreme anxiety about the item 'Not knowing what is wrong with you' suggests that for some patients uncertainty about the nature and extent of the illness/injury, a typical characteristic of patients attending the Accident and Emergency Department, was also an important contributing factor.

The frequency with which concern was expressed about these items suggests that patients would welcome information about the probable sequence of events, the reasons for treatment and an early estimate of the severity of their condition. In addition to providing information, involving patients in the decision-making process and acknowledging their response to events could help them feel more in control and reduce some of the anxiety they experienced. Whether this would be possible in practice is a separate issue which will be discussed in the following chapter.

The type of fears expressed by patients have been discussed. Chi-squared analysis was also used to examine the relationship between patient anxiety and the patient variables of age, sex, seriousness of condition and department (see Tables 5, 6 and 7). No significant difference was found between the levels of anxiety reported by patients in the two departments,

but young people, females and those with more serious illness or injuries reported more anxiety than other patient groups.

The reasons for these differences are unclear. It may be that these patients were more willing to express anxiety. A difference in expression could be due to cultural factors. Females and younger people might feel it was more acceptable to express anxiety than males and older patients. The latter 2 groups may have felt they should be able to cope. Alternatively, it could be that a real difference did exist. It is not surprising that patients with more serious conditions were more anxious than patients with 'minor' illness and injuries. The gender and age differences are more difficult to explain. It could be, however, that the differences are due to socialisation and experience. Males are encouraged to develop confidence and independence. They may, therefore, become more skilled in coping with new experiences and so experience less anxiety. Older people, too, could have gained confidence through experience and may have had more previous encounters with hospitals and other health settings. They may, therefore, feel less threatened by the experience of being in the Accident and Emergency Department. In the present study it was impossible to determine the reasons for the differences found. Further research is needed to explore this issue.

The anxieties expressed by patients have been reviewed. It is useful now to relate these findings to the communication observed between nurses and patients.

The Nature of Nurse–Patient Communication

Quantitative Analysis

Communication between nurses and patients was found to be of short duration and characterised by brief interactions which focused on the patients' illness/injury and their progress through the department.

Quantitative analysis showed that the longest period of interaction observed occurring between a nurse and patient lasted 10 minutes. This was the amount of time required for the procedure the nurse was performing (recording of ECG) to take place. Only 11 of the 90 interactions (12%) observed occurring between nurses and patients lasted more than 5 minutes. An interaction could include discussion of one or more topics, yet 57 of the 90 interactions (63.3%) observed consisted of a single topic lasting 1 minute or less. Time devoted to particular topics also tended to be brief. Thus, 126 of the 156 topics (81%) initiated by nurses lasted 1 minute or less.

The overall duration of communication occurring between nurses and patients in the departments studied was brief. Patients spent an average of 1 hour and 58 minutes in the department, excluding time spent in X-ray, of which only an average of 10.8 minutes was spent in contact with nurses. Patients' experiences were different, but overall the contact patients had with nurses was limited.

When we consider the type of communication which occurred it is clear that a strong emphasis was placed on the patients' illness/injury and facilitating their progress through the department. The topic which

occurred most frequently was the patients' illness/injury. Topics concerned with specific procedures, explaining what would happen and giving directions where to go occurred with moderate frequency. Topics which were concerned with fears and anxieties, social factors related to admission, impact on daily life and pain occurred only rarely (see Figure 5).

While it is obviously essential that nurses in the Accident and Emergency Department deal with the patients' illness/injury, carry out and explain procedures and direct patients where to go, social and psychological factors related to admission and the impact on the patient's daily life also deserve attention. Certainly the patient interviews suggest this would be helpful. However, a number of factors including pressures of time, uncertainty of outcome and want of practical solutions, made it difficult for nurses to deal with patients' anxieties. These issues are discussed in more detail in the following chapter.

The patient interviews revealed that 'young' patients, females and 'major' patients expressed more anxiety than other groups. The observational study showed that nurses initiated more topics, more long topics and more non-illness/injury topics with 'major' patients than with 'minor' patients. There was little difference found between the duration and quality of topics occurring between nurses and 'young' and 'older' 'minor' patients. Among the 'major' patients, however, nurses were found to initiate more topics, more long topics and more non-illness/injury topics with the 'older' group than with the 'young'. The overall duration of topics was also longer for 'older' patients.

This finding is difficult to interpret as the 2 'young major' patients had complaints which the nurses may have perceived as not serious. Among the 'older major' patients, too, those who were subsequently admitted to the hospital received more attention. The two factors were, therefore, compounded. The interviews with nurses showed that they thought older patients and those with more serious conditions were more anxious. Patients with both these characteristics might have been perceived as more anxious and therefore given more attention.

Qualitative Analysis

Qualitative analysis was used to examine the nature of nurse-patient communication in more detail with reference to the experiences of particular patients. The patients' experience of the department was considered with reference to three stages, assessment, process through the department and discharge.

Assessment

Nursing assessment of patients with 'minor' injuries tended to be brief (lasting 1 minute or less) and focused almost entirely on the patients' illness/injury. The purpose of the assessment appeared to be to record the facts necessary for the subsequent medical investigation. On two occasions in Department A the only question addressed to the patient that could be categorised as assessment was 'Are you allergic to anything?', the nature of the injury having been recorded by the receptionist. Although the verbal communication observed by the researcher would form only part of the nurses' overall assessment and it could be expected that she was also evaluating signs of pain, distress and restriction of movement, it is unlikely

that an anxious patient would be identified unless they were obviously distressed. On no occasion was any attempt made to identify fears or concerns the patient may have or how their illness/injury would affect them. Patients were then usually told to take a seat (in Department A) or shown into a cubicle (in Department B) and that the doctor would see them soon. On only one occasion was the patient given an estimate of the expected waiting time and that was when he specifically asked how long it would be.

Yet, according to the patient interviews, many were anxious about not knowing what would happen to them in the department and being unable to control what would happen to them. An initial assessment would seem a useful time to explain briefly the likely sequence of events and, as already suggested, involving the patient in their care could help them feel more in control. Providing simple information and reassurance at this point could be of particular benefit as, when the department was busy, it could be some time until the patients' next encounter with a nurse.

In Department B, 2 patients received no contact with a nurse prior to being seen by a doctor which suggests that the nursing assessment was regarded, at least by the doctor, as necessary only as a preliminary to his examination. Nursing assessment was not, apparently, regarded as essential if medical examination could take place without it.

On another occasion a doctor saw and briefly assessed a patient on arrival in the department. When he decided that she needed to undress, he said he would come back after the nurse had seen her. This point is of some

interest because although the 'major' patients spent a longer time with the nurse on arrival in the department, this was largely concerned with helping them to undress and recording their observations: that is, concerned with preparation for medical examination rather than with nursing assessment. Even for these patients whose illnesses or injuries were potentially, or actually, more severe, there was little attempt to assess the patients' reaction to what had happened or if they had any fears or worries. A nursing assessment which included attention to these aspects could be beneficial.

Process Through The Department

After assessment, the second phase of the patient's stay was concerned with their process through the department. The 'minor' patients had little contact with nurses during this phase. For the 'minor' patients much of the period between admission and discharge was frequently spent in X-ray. The majority of topics initiated by nurses during this time were concerned with directing them there, receiving their X-rays on return and requesting them either to return to the waiting area or to enter the curtains or a cubicle to be seen again by a doctor.

For the 'major' patients, too, their interaction with nurses during this period was fragmented and predominantly concerned with their physical care and progress through the department. Nurses only spent time with patients when they had a some procedure to carry out or a specific question to ask. The nurses' interaction with patients was characterised by their system of 'popping-in' to deliver care. They also relied on patients or their companion calling them if they needed anything. Although the

strategy of 'popping in' on patients might be a useful way of providing urgent physical care to a large group of patients, it is less likely to be effective in dealing with anxieties they may experience. As the strategy also appeared to convince patients that the nurses were always busy, patients were unlikely to bother nurses unless absolutely necessary. In fact, the quantitative analysis showed that only 19 topics (8%) were initiated by patients during the whole of the observational study.

One effect of the fragmentation of care was that patients who were anxious had no opportunity to express their fears even when, as on some occasions, they could readily have been resolved. The most obvious example of this was the young female patient who misinterpreted the necessity of having a scan as meaning her X-ray had been abnormal when, in fact, the normal X-ray result had led to a further investigation being ordered (see page 238). Although the doctor should have explained this to the patient, it seemed that the overall pattern of care led to the problem not being identified.

It has been mentioned that nurses only spent time talking to patients when they had some procedure to undertake. The most commonly observed was recording of ECGs. These patients benefited from sometimes lengthy interactions with nurses (up to 10 minutes). On these occasions the nurses talked to the patients in a friendly and joking fashion and explained what they were doing in some detail (see page 239). A cynical interpretation would be that nurses used this approach as a means of avoiding more difficult topics. Patients would have been unlikely to interrupt their cheerful banter by mentioning worries and may have felt a cheerful front

was expected of them. It may be, however, that nurses used these opportunities to talk to patients and, by adopting a friendly and relaxed approach, make them feel at ease. None of the patients observed gave an indication that they wished to change the pattern of communication and appeared to enter into, and enjoy, the conversation. Overall, it seemed that although the nurses were reluctant, or unable, to spend time just talking to patients, when their presence was demanded by events they did talk to them and attempted to make them feel at ease.

Discharge

The final phase of the patients' stay in the department was the discharge period. For patients with 'minor' injuries nursing involvement was greatest at the time of discharge, particularly if they need a dressing applied or to be given advice about how to care for it. In all cases observed the discharge of patients was carried out by a qualified nurse and information given included simple instructions about care of the dressing and pain control, depending on the nature of the injury.

Advice was given in the form of instructions to be followed eg. 'Keep the dressing on for 2 days', 'Take paracetamol for pain', 'Go to your GP if you have any problems'. On only one occasion did the nurse ask a patient if they had any questions.

Wood (1979) reported that patients received insufficient information.

Wood found that 6 of 20 'minor' patients observed never learnt the true nature of their injury and little information was given to patients about the care of their injury. She suggests that this may reflect lack of knowledge on

the part of trainee nurses and/or lack of communication between staff as to who was responsible for telling the patient what. The present study suggests that the information given was adequate. This may have been because in all cases observed instructions were given by a qualified nurse. Only 2 patients asked any questions both – interestingly – about going back to work.

The patient interviews revealed that a large number were concerned that their injury would affect their usual activities. These fears were not addressed. It may be that the nurses did not consider this aspect as their concern and certainly, in many cases, they may not have been able to offer any practical help. The small number of questions asked by patients suggests that they, too, may not have considered attention to this aspect as part of the role of the nurse, or that the nurses, by their lack of interest, had convinced them that it wasn't.

Yet the frequency with which anxiety was expressed about the impact on daily life suggests that further attention to this area would have been useful. Encouraging patients to express their concerns could clarify the exact ways in which their lifestyle would be affected. How the individual's personal resources and informal support network could be adapted to minimise disruption could then be considered. The nurses may have been reluctant to raise this issue if they had little practical help to offer but unless assessment is made of the probable impact no judgement can be made of the need for support. Even if no practical solution is easily available the patient would benefit from the nurses' interest and support. Dingwall's (1976) interactionist model suggests that the nurse should, perhaps, not

feel uncomfortable about being unable to offer a solution. The patient is the one who is making the necessary adaptation, whether emotional or practical, and the nurse should acknowledge this and attempt to facilitate the process.

The patients with 'major' illnesses and injuries were usually informed by the doctor that they could go home when their problem was resolved or pronounced not serious. The nursing involvement was mostly assisting the patients to dress, presenting them with a letter for their GP and checking that transport was arranged. It seemed that because no procedure, such as application of dressing, was usually required the nursing intervention for most of these patients was minimal. As the patients' health problems had been resolved or defined as minimal, this may have been all that was necessary. However, it would be useful for the final interview with a nurse to ensure that patients understood all information they had been given.

Thus far the discussion has centred on the nature of nurse-patient communication in the departments studied. Like many studies which have examined nurse-patient communication (Faulkner, 1979; Macleod Clark, 1982; Wood, 1979), interaction was found to be brief, predominantly concerned with the patients' illness/injury and paying little attention to psychological and social factors related to admission. In some respects, therefore the study seems to confirm the conclusion they draw that nurse-patient communication is in some way deficient. Yet these studies have tended to concentrate solely on the duration and properties of nurse-patient communication. Communication is analysed and presented as if it were distinct from the social setting in which it occurs. Studies

which focus on communication without taking into account both individuals' motivations and external constraints provide only a limited understanding of the issues involved. The Symbolic Interactionist perspective demands that these factors – interpersonal, cultural, interprofessional and structural – be taken into account. Using this approach it is evident that nurse–patient communication is a great deal more complex than the studies cited would suggest. This issue will be discussed further in the following chapter.

In the present study, the interviews with nurses provided insight into how nurses perceived their work and patients. By understanding the nurses' accounts, it became clear that the limited nature of nurse–patient interaction was explicable in terms of the nurses' perceptions of their priorities, the structural constraints they faced in carrying out their work and the influence of medical practice.

It is useful at this point, therefore, to review the nurses' accounts and consider their implications for dealing with patients' anxieties in the Accident and Emergency Department.

Nurses' Perceptions of Their Work and Patients

One central theme which emerged in the nurse interviews was how they defined the role of the Accident and Emergency Department nurse. Almost all nurses reported that they had been attracted to working in the department because of the excitement and drama they anticipated it would hold. Although, in reality, a great deal of the work they encountered was of

a more mundane nature, the work they valued the most was the challenge of caring for 'major trauma' patients and it was this that they saw as their most important role. As one nurse said, 'It's what we're here for'. The way in which nurses described how they shared accounts of these events – a feature of the department which was also observed by the researcher – suggests that their value had become part of the culture. Certainly the small number of nurses who hadn't specifically chosen to work in the Accident and Emergency Department reported that they soon found dealing with 'major trauma' the most rewarding part of their work.

In contrast, caring for 'minor' and non-urgent cases was regarded as dull and repetitive. Some nurses tolerated dealing with such patients regarding it as a respite from caring for 'major trauma'. However, the general consensus was that caring for 'minor' patients was less interesting.

A further feature of their work which the nurses valued highly was its short-term and immediate quality. For many nurses it was disillusionment with what they saw as the routine and uneventful nature of ward work which had led them to pursue a career in the Accident and Emergency nursing. The variety and unpredictability of work was seen as one of its main attractions.

Thus, individual's motivations influenced the type of work which they chose. The nurses in the present study had chosen to work in the Accident and Emergency Department because it offered excitement and variety. Within the department itself they sought to maximise opportunities to undertake work of this nature and, to some extent, to minimise

involvement in more mundane tasks. Among the nurses studied, their initial preference was reinforced by the culture of the work-place which had evolved.

An important secondary concern was keeping the department running smoothly. The importance which the nurses attached to this led to them operating a process of 'people processing' to organise patient care. Thus, getting the patient through the department quickly was seen as more important than talking to patients or their relatives. Talking to patients was something they only did if it did not hinder that process and was a feature which they felt was justifiably abandoned when they were busy.

Two main preoccupations of nurses were, therefore, those of dealing with 'major trauma' and keeping the department running smoothly. We can now consider how these concerns influenced the ways in which nurses dealt with patients' anxieties.

The nurses reported that they believed all patients attending the Accident and Emergency Department would be likely to be anxious. They also said that they thought that it was part of their role to identify and deal with patients' anxieties. However, many nurses reported that they sometimes did this badly and some said they had a tendency to 'trivialise' patients' worries, particularly those of 'minor' patients. The nurses felt they rarely had time to deal with psychological and social factors related to the patients' admission. The nurses described their work as consisting of constant, conflicting demands being made upon them. Their accounts describe their feelings that they were constantly in danger of being overwhelmed by the

amount of work they had to get through. The only way they felt they coped with this was to get through each task quickly and move on to the next.

Yet during the observational study the department was at times quiet and no difference in nurse–patient communication was seen to occur. It seemed that the nurses had developed strategies of care to use when the department was busy and these became accepted practice and were also used when the department was quiet.

One effect of the nurses' preoccupation with urgent physical care and keeping the department running smoothly was a reluctance to undertake a detailed nursing assessment of patients. To do so was regarded as time-consuming and impractical. Formal assessment was seen to involve unnecessary paperwork which was boring and conflicted with their ideal of work which was responding rapidly to immediate and urgent needs. Their preferred approach was to adopt a policy of responding to patients' needs as they arose. A second effect, therefore, of the nurses' definition of their priorities was their strategy of 'popping in' on patients to deliver care (see page 171).

Nurses described their interactions with patients as predominantly episodic, a view borne out by the observational study. The reason they gave for this was the volume of work they had to get through. Yet as this strategy was also used when the department was quiet, it may also have served other purposes. 'Popping in' on patients created an impression that they were busy. This allowed them to avoid work which they found uninteresting and meant they were available should something eventful occur. At the same

time it is possible that 'popping in' on patients may have been intended to reassure patients that they hadn't been forgotten.

An exception to this pattern was observed when they had a specific procedure to carry out. In such cases the interaction which occurred was more lengthy. It may be that the nurses valued these activities and did not seek to shorten them. Although patients' anxieties were not usually directly addressed during these periods, the nurses usually talked to patients in a friendly manner throughout and explained what they were going to do which may have been intended to reduce these patients' fears and help them feel at ease.

A third factor which emerged as important in understanding nurses' interaction with patients was the nurses' perceptions of patients. In particular, the perceived legitimacy of patients' demands was found to influence the nurses' behaviour.

In the present study the nurses were much concerned with the problem of 'inappropriate' attenders, that is those patients whose reason for attending was not seen as an accident or an emergency. Their categorisation of these patients is described in the section 'Legitimate and Illegitimate Demands'. Review of this material shows that nurses made judgements about patients based on their perceived social value (a concept elaborated by Glaser and Strauss (1965) to explain how social factors such as age influenced the nursing care of dying patients), responsibility for their condition and estimates of the justification of attending the Accident and Emergency Department with their complaint. These judgements influenced the

legitimacy with which the nurses regarded the patients demands and, in some cases, their actual behaviour.

The Symbolic Interactionist perspective would suggest that these views were based on nurses' perceptions of their own role and the extent to which patients confirmed this. As Kelly and May (1982) point out 'Patients come to be defined as 'good' or 'bad' not because of anything inherent in them or their behaviour but as a consequence of the interaction between staff and patients'.

In the present study the patients whose demands were regarded as least legitimate were the 'drunks and regulars'. These patients were seen as abusive and disruptive, were believed to have nothing wrong with them and were viewed as socially undesirable. They did not, therefore, fulfil the nurses' view of people who were justified in attending the department and by their non-conforming behaviour threatened the nurses' authority and their view of themselves as caring professionals.

The resentment these patients engendered and the disruption they caused led the nurses to develop strategies to avoid contact with them. The nurses described how they used a strategy of 'going through the motions' to ensure that these patient received only a minimum of attention, but sufficient to cover themselves should anything prove to be actually wrong. Another reason why the nurses adopted this approach was to discourage them from returning. The nurses were reluctant to be helpful towards such patients because as one nurse said, 'If you give them too much sympathy they'll keep on coming back again and again.'

It is clear from the review of the nurses' accounts that their perceptions of patients, definitions of their role and preferred work experiences are central to understanding their communication with patients. These factors provide a framework in which their actions may be understood. However, such internal factors are not the only significant elements. All human action occurs within a context and culture which are also influential. Of particular significance in the present study is the relationship of the nurse with medical colleagues and the associated issues of authority, autonomy and professionalism. The following chapter discusses these matters in greater depth and considers their implications for theory and practice.

Conclusion

This chapter has summarised the findings from each stage of the research and discussed them briefly. The study has examined patient anxiety in the Accident and Emergency Department. It has found that most patients attending the department were anxious about the experience and that common anxieties were related to fears about what would happen to them in the department and the impact of their illness/injury on their daily life. Nurses paid little attention to these aspects and concentrated on their priorities which were dealing with the patients' physical injury and processing patients through the department.

A number of difficulties were identified in the nurses' ability to deal with patients' anxieties. The issue which emerged as of central importance was the role of the nurse in the Accident and Emergency Department. The role they currently adopted was predominantly concerned with preparing the

patient for medical investigation and treatment and facilitating the patients' progress through the department. If patients' anxieties are to be addressed changes in the role of the nurse are indicated. The practical difficulties the nurses faced must also be attended to. Organisational changes are needed to allow nurses to deal effectively with patients' anxieties.

CHAPTER TEN

Implications For Theory and Practice

Introduction

This chapter discusses the findings of the present research with reference to the available literature. The main theoretical issues are discussed and the value of the Symbolic Interactionist perspective considered. Implications for practice are then drawn and directions for further research suggested. A number of recommendations arising from the study are made.

Theoretical Implications

The communication observed between nurses and patients in the present study appears to support the findings of previous research (Faulkner, 1979; Macleod Clark, 1982; Wood, 1979) which have found nurses' interaction with patients to be brief, superficial and predominantly concerned with the patients' condition. The conclusion invariably drawn is that nurses are deficient in communication skills. These authors recommend improved communication skills training as a remedy for what they interpret as inadequacy on the part of individual nurses to communicate effectively. However, these studies have tended to concentrate solely on the duration and properties of interactions. The context in which communication occurs has been ignored by these researchers. The present study suggests that the nature of nurse-patient communication is a great deal more complex than

these studies indicate and that recommendations to improve nurses' communications skills are over-simplistic.

The conclusion reached by these researchers, that nurses are poor communicators, is questionable. There is evidence in the present study that nurses are, in fact, extremely good communicators. Their strategy of 'popping in on patients was effective in conveying to patients that they were busy and therefore unavailable for unnecessary conversation. Similarly, the nurses' apparent avoidance of topics which were difficult to resolve is open to question. It may be, as Menzies' (1970) psycho-dynamic interpretation would suggest, that nurses were effectively 'blocking' such conversations in order to prevent their own feelings of discomfort at having no solution to offer to the patients' problems. Rather than reflecting poor communication skills, this strategy was very effective in allowing the nurses to control the topics which arose.

A further conclusion of these authors, that poor communication was a problem of the individual nurse, also deserves further consideration. Practical and cultural factors can influence the quality and extent of nurses' communication with patients. Melia (1987) found that student nurses had difficulty communicating with patients as they lacked the necessary knowledge and authority to answer patients' questions. A consequence of this was that student became evasive towards patients and learnt to 'fob them off'. Melia also found that the students' communication with patients was constrained by cultural definitions of what constituted nursing work. The 'real' work was physical labour. Students were conscious of pressure to get through the work rather than talking to patients. The influence of

cultural factors may, therefore, have important implications for the ability of nurses to talk with patients. As Heyman and Shaw, (1984:40) point out, 'There is no point in preaching or teaching improved interpersonal relationships to the junior nurse if the cultural milieu militates against this definition of their role'.

It is not just students who are influenced by the prevailing culture within a hospital setting. Peterson (1988) found that groups of qualified nurses on three medical floors developed norms and values which influenced behaviour patterns, beliefs and attitudes. Work patterns developed which facilitated the typical style of nurse-patient interaction on each unit. Peterson describes these interactions as cool, efficient and rushed on one unit, casual, warm and somewhat superficial on the second unit and brusque and businesslike on the third unit. Smith (1991) also found the 'emotional climate' on a ward was central to creating an atmosphere in which the 'emotional labour' of caring for patients could effectively occur. Smith found that the ward sister or charge nurse was the most important person in making emotional care visible to, and valued by, nurses and patients.

In the present study individual factors and the culture of the departments combined to define the aspects of work which were regarded as most important. Thus, nurses were attracted to working in the Accident and Emergency Department because of the excitement and variety they believed this type of nursing would entail. The emphasis which individuals placed on this aspect, exemplified in their preference for 'major trauma', generated a group culture which reinforced its importance.

An important secondary concern was keeping the department running smoothly. The nurses regarded doing so as a mark of their efficiency. In pursuit of this aim, the nurses were more concerned with getting patients through the department quickly than with talking to patients and their relatives. The ways in which nurses defined their role, therefore, were central in understanding their interaction with patients.

It is interesting that the aspects which the nurses' regarded as their priorities were those which allowed them to feel the satisfaction of personal and professional achievement. In contrast, psychological and social factors associated with patients' admission to the department were perhaps more difficult to resolve. For example, many of the worries expressed by patients were about aspects for which a practical solution was not always possible, such as not being able to carry on their usual activities, feeling unable to control what would happen to them, having to undergo an uncomfortable procedure or having to be admitted. According to an interactionist perspective, it is understandable that nurses, both individually and as a group, emphasised facets of their work which they could do well, and so were rewarding, and limited their involvement in matters which were difficult to resolve.

The nurses did, however, express awareness of the problem of patients' anxieties, although acknowledging that they tended not to deal with them specifically. It seemed that the nurses attempted to deal with patients' anxieties by indirect means. For example, one reason the nurses gave for the importance they attached to keeping the department running smoothly was to hasten the patients' progress through the department. As well as

representing organisational efficiency, keeping the department running smoothly could be seen as providing psychological benefits to patients. The nurses assumed that patients in the department were likely to be anxious. An effective way of reducing their anxiety was by shortening the amount of time patients spent in the department.

Further evidence that nurses used indirect means of dealing with patients' anxieties is provided by the different interactions observed with different types of patients. Thus, the nurses regarded the elderly patients and those who were more seriously ill as the most likely to be anxious. In the present study these two factors were compounded but the observational data showed that the nurses initiated more topics, more long topics and more non-illness/injury topics with these groups. Although they did not usually directly address patients' concerns, it may be that they used indirect conversation to help these patients feel more at ease.

Similarly, although the nurses did not usually talk to patients unless they were carrying out a procedure, when they were engaged in such tasks they were friendly and joking towards patients. Again such tactics could have been intended to help patients feel less anxious. Hunt (1991) studied communication between symptom control nurses and terminally ill cancer patients. She suggests that the nurses adopted a 'friendly and informal' role format at the start and conclusion of visits in order to appear approachable and help patients and their relatives feel relaxed. However a formal approach was used when compiling records, taking illness histories and assessing needs. This analysis may also be useful in understanding the nurses' interaction with patients in the Accident and Emergency

Department. During the assessment and discharge phases the emphasis was on asking specific questions and giving instructions. A formal approach was therefore used. When they were engaged in carrying out a procedure, such as recording an ECG, their behaviour was more informal and friendly. The nurses may have used these occasions to 'just talk' to patients. In their interviews, the nurses did not mention using this method to deal with patients' anxieties. It may be that being friendly and informal was an everyday, taken-for-granted approach which the nurses did not explicitly define as a nursing intervention.

Apart from occasions when they were carrying out direct care, the nurses tended to use the strategy of 'popping in' on patients to monitor their condition. The use of this strategy as a means of controlling the work they undertook has been discussed. In particular, the technique allowed the nurses to avoid the discomfort of discussing patients' anxieties which may have been difficult to resolve. While this interpretation remains helpful, the technique may also have had a symbolic significance. Chapman (1983) argues that ritual procedures which nurses perform are not only defence mechanisms against anxiety, but social acts which generate and convey meaning. Bocock (1974) defines rituals as, 'The symbolic use of bodily movement and gesture in a social situation to express and articulate meaning.' In the Accident and Emergency Department, 'popping in' on patients can be seen as a ritual act which provided the patient at regular intervals with the support of a nurse's presence. Thus, at the same time as conveying to the patients that the nurses were busy and not to be troubled with unnecessary questions or concerns, the act of 'popping in' may have served to reassure patients they had not been forgotten.

Thus far the discussion has centred on individual and cultural factors which influenced nurses' interaction with patients. An important, related, factor was the influence of interpersonal processes. Nurses' perceptions of their patients were found to influence interaction. This has been mentioned in relation to 'major trauma' patients whom the nurses regarded as deserving special attention. The issue is intimately linked with the nurses' definitions of their role and beliefs about whether patients were using the Accident and Emergency Department 'appropriately'. Thus the 'major trauma' patients were regarded as the epitome of the ideal Accident and Emergency patient. At the opposite extreme were the 'drunks' and 'regulars' whom the nurses regarded as misusing the service. The nurses described how they used a strategy of 'going through the motions' to delay these patients and ensure they received a minimum of attention.

Kelly and May (1982) provide an interesting critique of the literature relating to nurses' perceptions of good and bad patients. They suggest that factors such as patients' illness and diseases, behaviour and social background do not in themselves determine the nature of nurse-patient interaction. They argue that patients come to be defined as good or bad as a consequence of the interaction between staff and patients. This analysis provides a useful perspective from which to interpret the nurses' interaction with the drunks and other 'inappropriate' attenders. For example, the 'drunks' were invariably described as 'disruptive' and 'abusive'. It may be that the nurses' behaviour towards such patients was most strongly influenced by the patients' antagonistic behaviour and the problems of control they presented. An interactionist perspective emphasises that all communication is a reciprocal interaction. If patients

did not co-operate with the nurses, but instead confronted and insulted them, the nurses would respond by applying the sanctions of delay and inattention.

Understanding nurse–patient interaction from this perspective also helps to explain how some ‘inappropriate’ attenders managed to negotiate treatment. The parents of young children were those whose success was most notable. The nurses’ accounts indicate that these parents presented themselves as worried and uncertain. In responding to their demands the nurse could experience the satisfaction of giving assistance and the rewards of the parents’ gratitude. As Kelly and May (1982) comment, ‘The role of the caring nurse is only viable with reference to an appreciative patient.’ The influence of the interpersonal process was illustrated when a parent was demanding rather than appealing (see page 208). In this case the parent’s demands were rejected.

It is clear from the above discussion that nurse–patient communication is an extremely complex process and that attempts to describe it without reference to the context in which it occurs are over-simplistic. Individual, cultural and interpersonal factors had an important influence on the nature of communication which occurs. Structural constraints also played an important part. In the present study, the nurses felt that lack of time and the pressures of constant conflicting demands being made upon them interfered with their ability to spend time talking to patients. They felt they had to get through each task quickly in order to move on to the next one.

It was also clear that the nurses faced a number of specific difficulties in

dealing with patients' anxieties. In particular, the aspects which most patients were anxious about were those over which nurses had little control. Thus, the most common worry for patients, the impact of their illness/injury on their daily life, was, within the present structure of available services, often irremediable. Most restrictions were insufficient to require referral to social services and would be coped with by the patient and their informal supporters. It would often have been beyond the ability of the nurse to compensate for any difficulty they may encounter. Other fears related to being in the department and not knowing what would happen to them were also difficult to address. Even explaining to the patient what would happen to them was not always possible as the nurse could not be certain what the doctor would decide. It may be that the nurses felt conscious of, and uncomfortable with, their inability to resolve these issues and preferred to concentrate instead on developing their role by taking on more technical tasks.

A final factor which was identified as important was the relationship between medical and nursing practice in the department. This was related to the nurses' definitions of their role within the specific context in which they worked, but is relevant to the wider discussion of nursing as a profession. Nurse theorists are currently engaged in attempting to establish a theoretical and philosophical basis for nursing practice. The impetus for this has arisen from the desire, at least among the academic elite of nursing, to distinguish nursing and nursing practice from medicine and medical practice. One means which has been proposed is to emphasise the expressive function of nursing. As McFarlane (1976) states, 'Nursing means...to nourish and cherish.'

The emphasis of the Accident and Emergency nurses on physical care, and limited attention given to psychological and social factors, seems strangely anachronistic in the current climate of nursing with its emphasis on holistic, patient-centred care. The nurses in the Accident and Emergency Departments studied appeared to embrace the traditional medical model of care. The medical model – with its assumption that disease is a physical, organic entity which can be treated as separate to the individual – is considered by many as an untenable approach in nursing (Rogers, 1970; Clark, 1982; Pearson and Vaughan, 1986). Key features of the medical model, however, underlie many of the Accident and Emergency nurses' beliefs about their work and their observed behaviour.

One question which arises is the extent to which these activities – preparation for and facilitation of medical investigation and treatment – fall into and encompass the realm of nursing. Nursing theorists have offered a number of definitions of what constitutes nursing. Henderson (1966) emphasises the role of the nurse in assisting the individual in activities contributing to health in such a way as to promote independence. Peplau (1952), following a humanistic approach, believes nursing to be an interpersonal, investigative, nurturing and growth-provoking process. Orlando (1961) states, 'The purpose of nursing is to supply the help a patient requires in order for his needs to be met', while Newman (1979) claims that nursing's aim is to 'assist people to utilise the power that is within them as they evolve towards higher levels of consciousness'.

The American Nurses Association (1980) defines nursing as 'The diagnosis and treatment of human responses to actual or potential health problems.'

British nurses have not adopted a formal definition of nursing but, perhaps, that of Henderson is most widely used. Henderson (1966) states,

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible.

More recently attempts have been made to articulate definitions of nursing into models which provide a frame of reference by which nursing practice may be made explicit. A number of models, resting on different assumptions about the nature of the individual and the nature of nursing have been put forward. For example, the Activities of Living Model (Roper et al., 1980) is based on Henderson's definition of nursing and defines 12 activities of living, each of which has a physical, social and psychological component. The goals of nursing are to assist the individual in acquiring, maintaining or restoring maximum independence in each of these activities. The model requires the nurse to assess the patient in relation to each of these categories and plan, with the patient, a programme of care which will lead to the patient achieving independence or coping with any dependencies.

An alternative model, Orem's Self-Care Model (1980), rests on the assumption that individuals need to be responsible for their own health care. In most circumstances the individual will be able to do this. However, an individual who experiences injury, disease or illness is subject to additional demands for self-care. The individual may be able to meet these demands himself. The need for nursing intervention is only required when

the individual (or their relatives and significant others) are unable to cope with the increased demands. The goal of nursing is to assess the self-care deficit, establish the reasons for it, assess whether the individual can, at present, safely engage in self-care and assess the patient's potential for re-establishing self-care in the future. The nurse then negotiates with the patient to establish appropriate intervention. This may be the nurse taking over the activity, nurse and patient sharing the task, or the nurse providing education and consultation to allow the patient to achieve self-care. The nurse, therefore, acts in a way which is complementary to the individual to enable self-care to be recovered.

Each model has a different emphasis, but all focus on psychological and social as well as physical aspects of health and all advocate patients' involvement in their care. Their attraction for nurse theorists is that they provide a concept of nursing as a unique discipline with its own particular areas of responsibility and which nurses undertake with reference to their own body of knowledge. As Clark (1982) asserts, a model of nursing, 'makes explicit the notion that there is something called nursing which has an identity of its own, distinct from other similar activities.'

In contrast to such ideals, the nurses in the Accident and Emergency Departments studied seemed to value a role which was concerned with facilitating and assisting with medical interventions and welcomed, with few reservations, opportunities to undertake further medically delegated functions. Their attitude towards nursing models and the nursing process was of frank dislike. The nurses regarded them as impractical, time-consuming and involving excessive paperwork.

There was evidence, therefore, of a gap between nursing as advocated by nurse theorists and nursing as defined by the practitioners studied. This may not be unusual. As Miller (1985) points out, nursing theorists are concerned with 'nursing as it ought to be' and not 'as it is'. It may be as Melia (1987) suggests, that while the academic segment of nursing is pre-occupied with seeking professional status and autonomy by establishing nursing theory, the rank and file of the service section are more concerned with getting through the work. Furthermore, as Melia (1967:164) comments, 'the education segment's 'professional' version of nursing is most credible when it does not have to take account of the realities of the clinical setting.' Certainly, although nursing models have been much discussed there has been little research to evaluate their effectiveness in practice.

If nursing models were developed to helpfully distinguish nursing practice from medicine, they are unlikely to have maximum impact in an Accident and Emergency Department where the reality is that most patients attend with a specific problem for which they seek medical treatment. Although almost all health care settings are dominated by the medical profession (Freidson, 1970) the Accident and Emergency Department exists, to a greater extent than most others, for the purpose of providing urgent medical care. In such a context it is difficult for the nurses to develop their own area of expertise.

Nurse-patient communication in the Accident and Emergency Department has been discussed with reference to the available literature. It has been argued that research which focuses solely on the duration and properties of

interaction are limited and that the context in which communication occurs must also be considered. However, as May (1990) points out, this shift in emphasis simply moves the problem one or two steps up the line, from the individual nurse to the collective organisation of nursing at a local level. When the factors which influence communication are studied in depth it becomes more difficult to prescribe convenient solutions to complex problems. In the following section these issues are addressed and the implications of the present research for nursing practice in the Accident and Emergency Department are discussed.

Implications For Practice

One issue which has emerged as of central importance to nurse-patient communication in the Accident and Emergency Department is the way in which nurses defined their role. This issue is of key importance in the present study where the nurses' priorities of dealing with 'major trauma' and keeping the department running smoothly were given greater emphasis than dealing with psychological and social factors associated with the patients' admission.

Nursing Assessment

The nurses' perception of their role influenced their interaction with patients from arrival in the department to discharge. The nursing assessment of patients was brief and seemed designed to prepare the patient for subsequent medical examination and treatment. The nurses were reluctant to use a nursing model or the nursing process to make a systematic assessment of patients' needs. The assessment they did make

paid little attention to the patients' response to their experience or concerns they may have had.

Yet the patient interviews and observational data indicate that there is a need for social and psychological factors associated with admission to be assessed and effective nursing interventions made. However, if the nursing process and nursing models are rejected as impractical, how is nursing assessment and subsequent intervention to be conducted?

One possible improvement would be to adapt the nursing assessment form currently used in Department A (see Appendix 8) to include attention to psychological and social factors and to use this, or a similar form, in Department B (where no formal nursing assessment took place).

Adaptations could include assessment of the level and nature of the patients' anxiety on admission, prompts for giving patients information about the waiting time and, perhaps, expected treatment. Social and psychological factors could also be included as possible patient problems and assessment made at discharge of the likely impact on the patients' daily life.

Although an expanded version of the assessment form is simple and would be far from a panacea for dealing with patients' anxieties, it could provide a quick and practical means by which they could be identified and key prompts for giving explanations. As the nurses' main resistance to formal assessment was that it was time-consuming and impractical a simple and straightforward innovation such as this could be acceptable. Offering such an adapted form would be one step, which together with feedback from the

study, could promote awareness of the problem and the potential for change which could lead to further developments.

A simple nursing assessment form which included attention to psychological and social factors related to the patient's admission would be an improvement on current practice. However, in the present climate of nursing this may not be regarded as sufficient. The enthusiasm with which nursing models and the nursing process have been accepted by the nursing establishment suggest that failure to use a formal system of nursing assessment, intervention and evaluation, and/or a nursing model, may result in the imposition of sanctions. The inclusion of both is now required by the ENB in all nurse education programmes, including the Accident and Emergency course. It is not inconceivable that departments which resist their implementation could experience the threat of withdrawal as a training area. In the service sector, too, the current concern with accountability may have financial implications for nurses. Job descriptions in nursing are increasingly couched in terms of areas of responsibility for which the nurse is accountable and accountability rests on the documentation of nursing assessment and action.

For a number of reasons, therefore, the documentation of nursing assessment and practice is essential. A simple nursing assessment form such as an expanded version of that used in Department A could be a useful beginning. Alternatively, if resistance to models is due solely to their time-consuming nature, it might be possible to develop a tool which allows them to be used more rapidly. Walsh (1985) recommends use of pre-printed care plans in the Accident and Emergency Department. Although

these contradict, somewhat, the ethos of individualised care, they can be useful when time is short. Individual problems may always be added when necessary.

Ideally, nurses would be involved in explicitly defining their own role in a way which would guide their action and in developing appropriate documentation. Ali (1990) reports her trial of three models in a northern Accident and Emergency Department. Although she gives little information about their practical implementation, what is interesting in her account is that the nurses were attempting to establish and evaluate an explicit system of providing nursing care which was meaningful to and practicable for them. A similar action-based approach to practice innovation would be the most logical, and probably the most effective, way to introduce change in the departments studied in the present research.

Another development in patient assessment in the Accident and Emergency Department which is currently being debated is Triage. George (1976) defines Triage as,

A process by which a patient is assessed upon arrival to determine the urgency of their problem in order to designate appropriate health care resources to care for the identified problem.

Jones (1988) describes the goals of Triage as, early patient assessment, priority rating of patients, control of patient flow, assignment to correct area and initiation of diagnostic measures. Neither of the departments studied operated a system of Triage at the time of data collection. The nurses in Department B were interested in adopting this method of patient

assessment and allocation and agreement had been reached with the medical staff that they could do so. However, in practice, they found they could rarely spare a nurse to undertake the Triage duties. Clearly without sufficient resources, such an innovation would be more difficult. Ideally one nurse should be allocated solely to Triage duties each shift. Yet Jones (1988) suggests that if staffing is a major problem, then one nurse should be identified as the Triage nurse and either a system operated where that nurse is called to the Triage desk by the receptionist or where the patient goes to the Triage point located within the treatment area.

Although the definition and goals of Triage described above emphasise physical assessment and organisational efficiency, the assessment period could also be used to assess patients' worries and take initial steps to overcome them. In addition, if the nurse is the person responsible for allocation of patients and initiating diagnostic measures, she will have opportunity and authority to explain to patients the likely sequence of events and the reason for them. Finally, if the Triage desk is located near the waiting area, the allocation of an experienced nurse to that point would provide a source of information for patients and at least reassure them that they haven't been forgotten. A further advantage could be its reported beneficial effect on waiting times and patient satisfaction (Bailey et al., 1987; Jones, 1988; Mallett and Woolwich, 1990).

The introduction of Triage has important medico-legal implications. In particular, whether nurses should be exercising judgement about the severity of patients' conditions, deciding which are most urgent and ordering diagnostic measures such as X-rays. Yet although the nurses were

not always able to operate Triage in Department B they had successfully negotiated the authority to do so. Its acceptance represents a successful negotiation on the part of the nurses, against initial medical opposition, which led to what they believed was an important innovation in practice. The introduction of Triage potentially led to professional development for them at the same time as improving their ability to keep the department running smoothly, with beneficial consequences for patient care. The nurses' ability to negotiate this change in practice demonstrates that when change is seen as desirable it can be brought about.

Having discussed assessment in some detail, it is now worth considering other means by which more effective nurse-patient communication could be facilitated. Many researchers (Wood, 1979; Macleod Clark, 1982; Dunn, 1991) have advocated the use of interpersonal skills training to improve nurses' ability to communicate well. Yet, such a recommendation ignores the effects of structural constraints on practice. In the Accident and Emergency Department a number of significant barriers to effective communication exist. One is the uncertainty which hangs over each patients' treatment until a relatively late stage of their time in the department. A second, related again to medical dominance of the department, is the extent to which nurses are in a position to give patients information. For example, there could be resistance from doctors to nurses explaining to patients what might happen to them in the department. The introduction of Triage would seem to make this a more natural and realistic possibility. A third problem is practical difficulties arising from lack of contact between nurses and patients.

The Role of the Nurse

In the Accident and Emergency Departments studied much communication between nurses and patients took the form of brief, isolated encounters. This pattern of communication reflected the role the nurses predominantly played, that of preparing for and facilitating medical intervention. Again the role of the nurse and how it should develop is problematic.

One strongly held view, put forward by Jones (1986) and supported, with some reservations by the nurses in the present study, was that the most effective way in which nurses could improve the patients' experience of being in the Accident and Emergency Department was by taking on more technical tasks which would reduce the amount of time patients spent in the department. As well as having this practical benefit for patients, such a move would allow nurses to develop their role in a way which they found interesting and rewarding. In addition, as Pearson (1983) suggests, the possibility exists that if nurses do not extend their role then technicians may be employed to undertake such tasks.

An alternative view, expressed equally strongly by Eaves (1987) is that nurses should resist the lure of taking on more medically delegated functions and expand their role to include further involvement in the psychological and social sphere of care. In this way, Eaves argues, 'Nurses can concentrate on nursing and provide a humane, caring atmosphere in which doctors can go about their business of providing medical care.'

These two opinions offer apparently diametrically opposed views of what

nursing in the Accident and Emergency Department is and how it should develop. On the one hand, it is recommended that in order to improve the service to patients nurses should embrace even more closely the medical concept of care. On the other, it is argued that such a development is inappropriate and that nurses should be establishing their own area of expertise, the psychological and social, in order to provide the best service to patients.

The results of the present study, which found little attention paid to psychological and social factors related to admission by nurses would seem to provide considerable support for this second view. However, although it appears attractive, the question must be asked how realistic such a proposal actually is. The nurses in the present study held a pragmatic view of their role and also derived great satisfaction from carrying out physical care and undertaking technically skilled tasks. In view of their professed beliefs it seems unlikely that they would espouse a role which limited their opportunity to practise these skills. However, the two views are not necessarily wholly irreconcilable. The present study indicates that a major problem in nurse-patient communication was its fragmented nature and the limited opportunities for contact with nurses provided by the medical treatment of some patients.

Perhaps, rather than conflicting with the provision of emotional support, providing more nurse-patient contact by increasing the range of technical tasks which nurses could undertake would improve the nurses' ability to deal with these issues. Of course, just promoting nurse-patient contact does not necessarily mean that the nurses will use such opportunities to

talk to patients about their worries or social circumstances. Yet, the nurses were themselves concerned about the fragmentation of care and the lack of opportunity for contact. Although their concern with 'major trauma' and keeping the department running smoothly meant that they tended to avoid lengthy interactions with patients, when they did have to carry out a particular procedure they usually spent this time also talking to the patient. While patients' anxieties were not discussed explicitly the nurses were friendly and seemed to put the patients at their ease and it was at these times, if ever, that social factors were mentioned.

The move towards assuming more technical tasks, although problematic, does offer the potential benefits of increased nurse-patient contact, with the possibility of greater attention to psychological and social concerns of patients. The nurses in the present study were not opposed to providing emotional support to patients but they did not rate it as highly as physical care and would not jeopardise the latter by devoting special time to the former. If providing emotional support was not seen as contradictory, in terms of time, to their other, more valued, activities, there is a greater possibility that it would be given. It could be argued that from the point of view of providing information, the nurse is a poor substitute to the doctor. Yet, the demand for this change is derived from the volume of medical work generated in the Accident and Emergency Department in proportion to the numbers of medical staff available. The development of the nurses' role in this way is one possible solution which could lead to a higher quality of care.

The possibility of introducing such change appears a realistic one. Nurses

in the departments studied already undertook tasks such as gastric lavage, application of Plaster of Paris and recording of ECGs, and the distinction between medical and nursing roles is blurred. In addition, several of the nurses had already acquired these skills, either through experience in other departments or during professional training. They were prevented from practising them by hospital policies. Such a situation is not unusual. Jones (1986) found that of 163 departments studied, only 47.2% allowed nurses to suture and only 3.7% allowed them to cannulate and start intravenous fluids. Of the nurses who had undertaken the ENB Accident and Emergency course, 50% were not allowed to practise their skills because of local restrictions.

A great deal of pressure exist for Accident and Emergency nurses to develop their skills in this way. Indeed Eaves (1987) reports the results of his own study of Accident and Emergency nurses which found that 65% approved of their undertaking more technical procedures both for the benefit of the patient and for a more interesting workload. The patients' need to receive appropriate health care with a minimum of delay in conjunction with the nurses' willingness to undertake such duties suggests that such a development is a logical step. Although Jones' (1986) work points to inconsistencies in practice, an optimistic view is that while 50% of suitably qualified nurses were unable to use their skills, the remaining 50% were. It is likely that pressure from Accident and Emergency nurses at a national level, together with local support, will lead to eventual change. Although initial resistance may be encountered from medical staff the experience of the nurses with ECGs suggests they would, on the whole, welcome such assistance rather than resist it.

The role of the nurse in the Accident and Emergency Department is clearly a controversial one and there is no simple formula which can be applied. The advantages and disadvantages of different options must be weighed and an acceptable balance achieved. Nurses in the Accident and Emergency Department need to work towards clarifying their role in a way which considers all aspects of the patient's condition, psychological, social and physical, and develop documentation which facilitates holistic nursing assessment and intervention.

Thus far the discussion has centred upon the nurses' perceptions of their role and their relationship with medical colleagues. The nurses' perceptions of patients deserves further attention. The nurses' attitudes were found to be generally based on their view of the function of the Accident and Emergency Department and, again, their role within that service.

'Inappropriate' Attenders

In the present study the nurses were much concerned with the problems of 'inappropriate' attenders, that is, those patients whose reason for attending was not seen as an accident or emergency. The nurses made judgements about patients on the basis of their perceived social value, responsibility for their condition and estimates of the justification of attending the Accident and Emergency Department with their complaint. These judgements influenced the legitimacy with which the nurses regarded the patients' demands and, in some cases, their actual behaviour. The 'drunks and regulars' were the patients whose demands were regarded as least legitimate. These patients were seen as demanding and disruptive, were believed to have nothing wrong with them and were viewed as socially

undesirable. The nurses described how they used a strategy of 'going through the motions' to ensure these patients received only a minimum of attention. The nurses did not regard it as part of their role to deal with these patients' problems and were also reluctant to be helpful towards them in case this encouraged them to return.

Stockwell (1972) reported that nurses resisted paying attention to patients whom they regarded as 'demanding' lest they should reinforce such behaviour and the patient's demands become overwhelming. A similar process appeared to be operating in the Accident and Emergency Department. The accounts of the nurses indicated that many of these patients were suffering from social and psychological problems, as well as physical problems which were often related to alcoholism. The fact that most reattended suggested that ignoring these problems may have been a short-term solution. Referral to other agencies, both social services and voluntary, could prove a more effective response. Yet, according to the nurses, such a responsibility did not form part of their role nor did such people want help of this kind. The nurses often presented their lack of attention to these matters as resulting from previously wasted efforts.

The problems of 'drunks and regulars' in the Accident and Emergency Department is a difficult one to resolve. The nurses, and indeed the medical staff, were in the front line of what were essentially social, rather than medical, problems, although it is difficult to draw a clear distinction between the two. Roth (1972) argues that the moral evaluation of patients in the Accident and Emergency Department represents attempts to establish mechanisms of control over inappropriate demands for service.

While this may be true, it offers little insight into how the problem may be resolved. The nurses were reluctant to assume the responsibility of dealing with these patients' problems. It might be that the services available for these patients are inadequate. On the other hand, voluntary and social services do exist to meet the needs of such people. It may be that greater co-ordination is needed between the various agencies. The Accident and Emergency Department staff could act as a useful link between the patients and the appropriate agencies. Unless co-operation and co-ordination exists between the network of services, the problem of 'drunks and regulars' in the Accident and Emergency Department is likely to remain entrenched.

What is of particular interest to the present study is the insight gained into the ways in which nurses perceived their patients and how this influenced their behaviour. As we have already considered, the nurses' definition of their role was predominantly medically oriented. Patients who fell outside the perceived remit of their role were disliked and sometimes subjected to sanctions, especially if they also behaved in a way which was unacceptable. On the other hand, patients who presented with physical injuries or acute illnesses which were deemed to warrant the expert care the department could uniquely offer were valued highly, especially if related social factors were also regarded as favourable (see page 197).

Jeffery (1979) suggests that doctors in the Accident and Emergency Department valued most highly patients who provided them with opportunities to extend their knowledge and practice their skills. The emphasis the nurses placed on 'major trauma' patients, dealing with whom they regarded as the most important of their duties, shows that nurses also

valued these patients most highly and regarded their most precious skills as being technical ones.

However the emphasis placed on 'major trauma' was not necessarily merited in view of the typical clientele of the department. Most patients who attended complained of simple and non-urgent or 'major' but not immediately life-threatening conditions. There was a discrepancy, therefore, between the patients whom the nurses regarded as most deserving of their efforts and the majority of patients who attended. Caring for 'minor' patients, who provided the bulk of their work, was described as mundane. Its chief merit appeared to be as a respite from more demanding activities. In addition, the nurses regarded as tenuous the claims to legitimacy of 'minor' patients who attended with 'trivial', non-urgent or old injuries who were likely to form a large proportion of this group.

Although such patients would usually be seen, the negative attitudes of nurses towards the 'minor' patients may partly have influenced the care they received. The observational study showed that 'minor' patients received less attention from nurses than 'major' patients and that communication was largely routinised, consisting mostly of instructions to be followed. In addition, the nurses themselves reported that they tended to 'trivialise' the anxieties of these patients and concentrate on 'processing' them through the department.

An interesting exception to the somewhat judgemental attitudes nurses expressed towards 'inappropriate' attenders was found in their view of parents of babies and young children. These patients were not included in

the observational study but the nurses' accounts revealed that although their medical condition was often insufficient to warrant the demands of this group being considered legitimate, the social factor of the child's age invariably guaranteed they would be. The nurses were generally sympathetic towards them and viewed these parents as 'understandably worried'. There was a sharp contrast, therefore, in the way nurses viewed responsible, concerned parents who used Casualty 'inappropriately' and 'time-wasters' and 'trivia' who did so. With this exception, the general view of the nurses was that if only 'inappropriate' attenders could be discouraged, they could concentrate on caring for 'major trauma' and other legitimate cases.

The type of patients attending the Accident and Emergency Department has been examined by a number of researchers (Pease, 1973; O'Flanagan, 1976; Davison, 1983; Cliff and Wood, 1986). These studies have found that a large proportion of patients attending complained of 'minor' injuries or non-urgent problems. In 1962 the Platt Report recommended the change of name from Casualty to Accident and Emergency Department largely to deter people with non-urgent problems from attending. A review of the literature carried out by Driscoll et al. (1987), which found estimates of inappropriate attendance varying between 35% and 75%, suggests that the nominal change has had little practical effect.

Calls have been made for increased public education to deter people from using the Accident and Emergency Department 'inappropriately' (Worth and Hurst, 1989; Bellavia and Brown, 1991). Yet such programmes are unlikely to be successful as they fail to address the underlying reasons why

such patients attend. Various factors have been implicated as contributing to the problem, including homelessness, not being registered with a GP, desire for a second opinion, expectation of avoiding the waiting list and, perhaps most importantly, inability to assess the seriousness of an injury or the implications of delay (Davison, 1983; Cliff and Wood, 1986; Walsh, 1990). Although a public education programme could prove useful, it seems that, as Dingwall's (1976) Interactionist model would suggest, inability to interpret the severity of an illness/injury and lack of access to, or understanding of, Primary Health Care facilities will mean that some individuals will always choose the Accident and Emergency Department as an acceptable treatment centre.

One of the effects of large number of 'inappropriate' attenders using the Accident and Emergency Department is to increase the waiting time for all patients. Rather than continuing to regard the demands of these patients as 'inappropriate', a more positive response would be to develop the service in a way which is responsive to those demands. One method, already discussed would be to use the system of Triage to determine the priority of patients and to manipulate the waiting times of individual patients accordingly. An additional approach would be to develop the role of the nurse-practitioner in the Accident and Emergency Department.

Maglacas (1991) defines nurse-practitioners as,

Professional nurses whose basic and post-basic education has given them additional knowledge, skills and attitudes, and who assume responsibility for health assessment and the management and delivery of services at the first level of a health care system.

The role of the nurse-practitioner would include providing a service for those patients who did not need medical treatment for example, patients with small cuts, bruises and strains. She could also provide reassurance and advice to those who were simply worried and could carry out health education. She would be able to refer patients to the Accident and Emergency facilities, where appropriate, or to GPs and other agencies.

The nurse-practitioner would be a specialist nurse with both clinical expertise and training in interpersonal skills. She would be completely responsible and accountable for all areas of her practice. Without the constraints which other nurses in the Accident and Emergency Department faced, she would be able to provide a service to patients which included assessment of the physical, psychological and social components of each patient's problem and provision of, or arrangements for, appropriate care.

Provision of such a service would also relieve some of the burden of attending to 'inappropriate' attenders from other nurses, and doctors, leaving them with more time to carry out their work of dealing with accidents and emergencies. If lack of attention to psychological and social factors related to admission was due to lack of time, as the nurses reported, and, perhaps, to negative attitudes towards 'inappropriate' attenders, nurses might find themselves more willing and able to deal with them. The introduction of the nurse-practitioner could therefore be beneficial for all patients.

Clearly this innovation would be a major development. At present the concept is in its infancy. The emergence and development of this role

during the 1980s has been focused mainly on Primary Health Care Centres. However, Barking, Havering and Brentwood Health Authority (1988) report its successful introduction in an Accident and Emergency Department. They reported increased satisfaction for patients because of reduced waiting times and that patients appreciated the advice and reassurance they received from the nurse. Nurses in Department B were interested in this option for nursing development and one nurse was in the process of designing a questionnaire to discover patients' views on the subject. Although a long-term aim which would need a significant input of training and resources, the role of the nurse-practitioner seems an important and realistic development particularly as, in the long-term, it could provide a cost-effective means of dealing with increasing demands on limited, and expensive, Accident and Emergency resources.

Structural Constraints

The discussion thus far has emphasised ways in which the role of the nurse could be re-defined in order to improve the quality of care given to patients. It is important, however, not to ignore the effect of structural constraints upon nursing practice. One major problem which was identified was the fluctuating workload. The departments were frequently extremely busy and the nurses had difficulty coping with the volume of work generated. This was a particular problem in Department B, where a smaller number of nurses coped with a greater number of potentially or actually more seriously ill patients (see page 55). However, in Department A, the need to staff the resuscitation room, cabins and curtained area (see Figure 1) meant that only 1 or 2 qualified nurses were allocated to each.

The nurses, therefore, developed strategies to cope when they were busy. If staffing levels were improved the nurses would not so frequently be working under pressure and could develop patterns of care which enabled them to deal with patients' problems in greater depth. There would be less need to concentrate on physical care and more time available to talk to patients.

A second problem which was identified was the gap between the needs of some patients for assistance with necessary living activities and the provision of current services. Patients whose illness or injury would have a major impact on their life would either be admitted to the hospital or discharged home with district nurse and social services support. Other patients, with minor injuries, would be able to continue their normal activities without disruption. A group of patients existed, however, whose injury would interfere with their ability to carry out necessary activities of living, but whose needs were not sufficiently severe to merit referral to statutory services. Some of these patients would be able to rely upon assistance from family, friends and neighbours with tasks they were unable to carry out themselves. For others, there existed a gap between the patients' need for assistance and the provision of current services.

There is a need for services to fill this gap. However, a number of difficulties exist in meeting this need. One problem is the difficulty in assessing the patients' need without access to the home environment. A second problem is that these patients' needs are immediate and temporary while the services available are often fragmented, complex and relatively slow to respond. A balance must be struck between thoroughness of

assessment and speed of response. An additional problem is that the services available are subject to continual change. This is a particular problem with voluntary services which are dependent upon the availability of volunteers and funding.

One possible approach would be to have an identified person within the department who would act as liaison for patients not requiring comprehensive domiciliary assessment. To employ someone specifically for this purpose would be unnecessary and expensive. A more realistic option would be to identify 1 or 2 members of nursing staff within each department who would have structural links with domiciliary health and welfare services. These nurses would be able to keep abreast of services available and refer patients appropriately.

A second approach would be to have a supply of selected aids to living available in the department. These could then be lent to patients on a temporary basis. Aids suitable for this purpose would necessarily be limited. The range available would need to be carefully selected in consultation with the Occupational Therapy Department. The use of these aids would also need to be monitored and their provision subject to regular review with both the Occupational Therapy and Physiotherapy Departments. Finally the needs of patients being discharged with minor injuries which will interfere with their daily activities should be included in a review of services. The services available may need development to make them more sensitive and accessible to this group of patients.

The Symbolic Interactionist Framework

In the present research a Symbolic Interactionist perspective has been used to explore the interaction between doctors, nurses and patients in the Accident and Emergency Department. Use of this perspective allowed insight to be gained into important features which influenced communication and practice. The theory proposes that human behaviour must be understood from the perspective of the participant and that the participants' interpretations may vary depending upon their position within the organisation.

Thus, in the Accident and Emergency Department, the nurses' view of the patients' stay emphasised physical care and organisation of the patients' progress through the department. These were the features which the nurses, from their standpoint, interpreted as important. The nurses seemed to be operating on a short time-scale which focused on these activities. Patients, on the other hand, appeared to view their stay in the department as an incident occurring within the wider context of their daily lives. They were, therefore, more concerned with the outcome of their visit and the longer-term consequences. Social factors were more important to patients, particularly the impact of their illness/injury on their daily lives.

A second important assumption is that in any encounter participants are constantly engaged in interpreting their own and each other's action. Thus, qualities arising within the interaction itself will influence the behaviour of each participant. In the interaction between nurses and patients, the way in which patients behaved towards nurses influenced the way in which nurses

behaved towards patients, and vice versa. Thus, for example, patients who were co-operative, were able to provide a reasonable justification for their visit and were appreciative of the nurses' efforts would be treated sympathetically. Patients who were demanding and disruptive were disliked and tended to be ignored or avoided.

Finally, the concept of negotiation proved useful in understanding, particularly, the relationship between doctors and nurses in the department. It was evident that the two groups were in a constant process of organising and reorganising their respective roles through implicit and explicit negotiation.

Symbolic Interactionism has, therefore, proved a useful perspective from which to understand the complex processes of interaction occurring within the Accident and Emergency Department. A criticism often levelled against this approach is that it ignores the effects of structural constraints on human behaviour. In the present research an effort has been made to consider the effects of such constraints on nursing practice. In particular, the pressures of work which the nurses faced, the medical domination of the Accident and Emergency Department and the restricted mechanisms for referral have been discussed.

The Implementation of Change

A number of changes in current practice have been suggested by the current research. These are, the need for appropriate documentation of nursing assessment, intervention and evaluation to be developed, the

development of Triage as a means of patient assessment to be initiated and maintained, the opportunity for nurses to undertake additional technical skills to be promoted, the role of the nurse practitioner to be explored and the need for closer links with external agencies to be established. The practicality of each of these innovations has been briefly discussed as they were described. It is useful, however, to consider the wider issues involved in change which are relevant, in general terms, to all of the innovations.

Bennis et al. (1976) identify three major changes strategies:

Empirical-rational, which is based on the belief that people are guided by reason and they will use rational thought to calculate the need for change.

Power-coercive, which emphasises that those in control of an organisation will identify the need for change and that those below will comply with their plans.

Normative-re-educative, which emphasises a bottom-up approach where those who work in an organisation are actively involved in the process of change.

In the context of the changes presently being considered the normative-re-educative strategy appears the most appropriate. The present study has found that nurses develop strategies to control their work. Unless they are actively involved in the process of change it is unlikely to be effective. The most important step, therefore, in the initiation of change is involving nurses in discussion of the findings of this research and facilitating reflection on their own practice and where change could be beneficial.

The nurses were conscious of the limitations of their practice in dealing

with patients' anxieties. The innovations which have been suggested are all prompted by the the need to facilitate dealing with psychological and social factors related patients' admission without jeopardising the nurses' ability to deal with their physical needs.

Many of the innovations suggested are likely to be welcomed by nurses. Certainly Triage, an 'extended' role and the development of the nurse-practitioner role within the department would offer them the possibility of professional development and greater autonomy in their work.

It is perhaps not with the nurses but with medical staff and hospital management that resistance to change is most likely to manifest. Some of the changes suggested are likely to impinge upon the medical role and may threaten their authority. Yet, the nurses in Department B had successfully negotiated permission to practice Triage. If the change is perceived as beneficial to doctors, and of course to patients, it can introduced. To a great extent, indeed, the need for change has arisen because of the increased pressure on the small number of medical staff available. Such pragmatic concerns are likely to have a significant impact on the nature and extent of change. In both departments studied the patients' experience was characterised by lengthy periods of waiting until a doctor was available. Allowing nurses to develop their role in the ways suggested appears the most realistic solution to what is otherwise an increasing problem. To achieve this end would, however, require guidelines and policies to be altered and provision made, in terms of education and resources, to support these developments. It is perhaps these two factors which may prove the greatest barriers to change. Changing hospital policies

is a slow and bureaucratic process. Resources are typically scarce. Yet the changes recommended offer a means of making maximum use of the resources already available, the nurses, whom in many cases already had the skills needed.

A change has been suggested in the nature of the service provided in order to help overcome the problem of 'inappropriate' attenders. This is the development of the nurse-practitioner role within the Accident and Emergency Department. Again this innovation would require resources in terms of education and training but, again, could prove a cost-effective means of dealing with increasing demands on limited, and expensive, Accident and Emergency resources.

A need has also been identified for closer links between the Accident and Emergency service and other agencies. Unless relevant services exist and they are accessible, the nurses will continue to have difficulty in helping patients to cope with limitations in their ability to perform the necessary activities of daily life. Similarly, greater co-ordination is needed with agencies who may be able to assist the 'drunks and regulars' who repeatedly attended the department. The use of the Accident and Emergency Department by such patients has long been regarded as a problem. Unless alternative facilities are available and a mechanism for referral developed and used, it is likely to remain so.

Implications for Research

The present research has highlighted a number of areas which deserve further investigation. One issue which arose is that 'young' female patients

expressed greater anxiety than other groups of patients. Possible reasons for this have been discussed in Chapter 4. It may be that the difference was one of expression. This could be due to sex differences in patients' willingness to express anxiety generally or a reaction to the age and sex of the researcher. Alternatively, it could be that a real difference existed in the degree of anxiety experienced by these patients compared to other groups. This could be due to differences in expectations and experiences of health care systems or differences in the way in which people interpret and cope with disruptive life-events. It would be useful for further qualitative research to look specifically at this issue and explore the meaning of illness to different age groups and sexes. Differences in patients' perceptions of health care services also deserve study.

A second issue which arose in the present study was the difference found between the nurses' communication with 'older' and 'younger 'major' patients. In the present study the two factors were compounded. Both the 'young major' patients had conditions which proved not to be serious. It may be that the nurses were aware of this probability and therefore devoted less attention towards these patients. Among the 'older major' patients, those who were subsequently admitted and who may, therefore, have been more seriously ill, received most attention. Again, further qualitative research could usefully explore how nurses' perceptions of the patients' age and seriousness of condition influence their interpretation of the patients' level of anxiety and need for reassurance. How these interpretations influence practice should also be studied.

A third area for valuable future research is the innovation and evaluation of

change. The nature of nurse–patient communication has been extensively researched. This study has examined nurse–patient communication in the Accident and Emergency Department, an area which has previously received little attention. There is a need now for research to examine changes in practice and evaluate their effects. An action research framework is advocated as the most useful for facilitating and evaluating change. Action research has been described as ‘A cyclical process of fact-finding, action and evaluation following which the process begins again’ (Ketterer et al., 1980). Webb (1989) suggests that it is an approach which has much to offer nurses because they can use it to identify problems, devise programmes of action to solve problems or improve standards and carry out and evaluate these plans.

Using this approach, nurses in the Accident and Emergency Department could reflect on their practice, identify areas where change could be beneficial, plan and carry out a programme of change, evaluate its impact and consider further changes which may be indicated. Action research may include qualitative and quantitative measures. Qualitative research is useful for understanding the experiences of both patients and nurses in the Accident and Emergency Department. Quantitative measures are useful to evaluate the impact of changes made. Both of these approaches would be useful within the action framework proposed.

To give an example, nurses in Department A might decide that the introduction of Triage would reduce patients waiting time and the length of time they spent in the department. It could also improve patients’ satisfaction with care and increase the nurses’ own job satisfaction. In

collaboration with a nurse researcher, the nurses could evaluate current experience. Quantitative measures could be employed to study patient waiting times and overall duration of stay. Qualitative research could explore patients' experiences in the department and satisfaction with care. The nurses' job satisfaction could be measured using one, or both, approaches. The nurses could then implement the change – Triage – and, together with the researcher, evaluate its effects. Assessment could then be made of the impact of the change. The innovation could be adjusted and modified in order to enhance the benefits of the change and these alterations also evaluated. In this way the process of change is gradual and consistent and the change is directed by those involved, rather than imposed from above.

A final area which deserves further research is the availability and accessibility of support services. It seemed that currently available services are either not sufficiently sensitive to the needs of patients or the systems of referral are not convenient. A review of the service available would be useful. This could then be used to identify gaps in the service and also to plan a mechanism by which the network of services was co-ordinated.

Conclusion

This chapter has examined the findings of the present study with reference to the available literature. Implications for theory and practice have been discussed. The role of the nurse in the Accident and Emergency Department has emerged as of central importance. The role they currently adopted was predominantly concerned with preparing the patient for and

assisting with medical treatment and facilitating the patients' progress through the department. If patients' anxieties are to be addressed, changes in the role of the nurse are indicated. At the same time, increasing pressure on the Accident and Emergency service means that innovations may have to be made in order to cope with rising demands.

Changes in the role of the nurse are often prompted by changes in demand (Williams, 1974). The demands identified are two-fold. On the one hand, there is the need to reduce the amount of time patients spent in the department waiting for medical investigation and treatment. On the other, is the demand of information and support for patients. It has been proposed that it may be feasible to expand the role of the nurse to meet both these needs. This would mean developing the role of the nurse to include more technical and assessment activities at the same time as enhancing their ability to communicate effectively with patients.

Innovations in nursing such as Triage, acquisition of additional technical skills and the advent of the nurse-practitioner offer the opportunity for change of this sort. However, in order to ensure that these activities do not simply become additional technical or bureaucratic additions to the nurses' duties, it is necessary that nurses have a clear philosophy which guides their practice. Nurses need to reflect on their practice, clarify their aims and develop a framework in which to define their role in relation to patients and other health professionals, particularly medical staff, with whom they work.

In order to do this effectively nurses need support. Nurse educators have a role to play in facilitating the process of reflecting upon and defining the

role of the nurse in the Accident and Emergency Department and in providing opportunities for further education and training. Nurse managers have a role to play in providing resources and support in the process of implementing and maintaining changes, without which no change is possible.

As well as some re-definition of the role of the nurse, some organisational changes were also suggested which would improve the nurses' ability to deal with matters about which patients were anxious. Not all patients' problems can be dealt with by the nurses themselves. Nurses need to be able to refer patients to appropriate agencies. The availability and accessibility of services needs to be reviewed and an efficient referral mechanism established.

All change needs to be evaluated. In accordance with the philosophy of change proposed, which advocates nurses themselves examining their practice and identifying areas which deserve development, an action-based programme appears the most appropriate. An action research framework is, therefore, recommended as the most effective means of implementing and evaluating the changes suggested.

The issues arising in this research have been discussed in relation to the two departments studied. Many of these issues have wider implications which would be likely to be relevant to other Accident and Emergency Departments. A number of recommendations, arising from the present study are made. These are summarised below.

- ◆ *The need for nurses to clarify their role within the Accident and Emergency Department.*

Nurses need to reflect on their practice, clarify their aims and work towards defining their role in relation to patients and medical colleagues.

- ◆ *The need for appropriate documentation for nursing assessment, intervention and evaluation to be developed.*

All nursing activities should be documented. Nurse should work towards developing tools which are suited to their area of work and which facilitate their practice.

- ◆ *The development of Triage as a means of patient assessment to be initiated, maintained and evaluated.*

Triage offers the possibility for nurses to assess patients at an early point of their time in the Accident and Emergency Department. This offers potential practical benefits in the form of reduced waiting times and early initiation of diagnostic measures. It could also allow nurses greater opportunity to provide patients with information about the likely sequence of events and explain the reasons for them.

- ◆ *The opportunity for nurses to undertake additional technical skills to be promoted.*

Patients in the Accident and Emergency Department should have their needs met quickly and effectively. Extending the role of the nurse in the Accident and Emergency Department offers a means by which

unacceptable waiting times may be reduced and greater nurse–patient contact facilitated.

- ◆ *The role of the nurse-practitioner in the Accident and Emergency Department to be explored.*

The development of the nurse-practitioner role offers patients **greater** choice in health care. It may relieve some of the increasing pressure on the service by providing an opportunity for patients with ‘minor’ and non-urgent conditions, who do not require medical examination, to consult an experienced nurse-specialist. The professional autonomy inherent in the nurse-practitioner role will facilitate a service which enables all these patients’ needs – physical, social and psychological – to be addressed.

- ◆ *The need for nurses in the Accident and Emergency Department to receive adequate support.*

The Accident and Emergency Department is a front-line service which deals with a wide-ranging and fluctuating demand. Nurses who work in this are need educational, managerial and financial support in order to carry out their work effectively and develop their role in a way which is responsive to demands.

- ◆ *The need for improved co-ordination between the Accident and Emergency Department and other agencies.*

Some patients attended the Accident and Emergency Department with needs that would not be most effectively met by that service. Others could benefit from support services to help them to cope with

limitations in their ability to perform necessary daily activities. It is necessary that mechanisms exist by which such patients may be referred to appropriate hospital, social service or voluntary agencies who may be able to help with their problem.

Conclusions

Introduction

In this chapter the overall study is reviewed and the original aims are considered in relation to the study's findings. The recommendations are then considered with reference to current changes taking place in nurse education.

Review of Study

This research arose from a perceived need to examine patient anxiety and nurse-patient communication in the Accident and Emergency Department, an area which has received little previous attention. The patients' experience of the Accident and Emergency Department is likely to be characterised by sudden onset of symptoms, or recent injury, unfamiliarity with the department, its personnel and routines and uncertainty about outcome. These factors have been found to be associated with anxiety in studies which have examined the experience of patients in hospital.

Studies of nurse-patient communication in hospital have found interaction to be brief, superficial and predominantly concerned with the patients' condition. The Accident and Emergency Department exists primarily to provide urgent physical care to patients. If communication is limited on hospital wards, where the duration of the patients' stay allows at least the

possibility of establishing relationships, communication may, perhaps, be still more problematic in the Accident and Emergency Department where the patients' stay is brief and a strong emphasis placed on physical care. The study aimed, therefore, to examine the nature of patients' anxieties in the Accident and Emergency Department and explore how they were addressed by nurses within the context of an environment geared towards providing urgent physical care.

The research was conducted in 2 Accident and Emergency Departments which were within the same Health Authority but functioned independently. Following a pilot study, the research was carried out in three stages. Stage One used structured interviews to examine the nature of patients' anxieties in the Accident and Emergency Department. In Stage Two in-depth interviews were carried out with qualified nurses in the two departments studied to explore their perceptions of their work and patients. In Stage Three an observational study was conducted to discover the nature of nurse-patient communication and how patients' anxieties were addressed in practice.

The study showed that most common anxieties expressed by patients were 'Not being able to carry on your usual activities', 'Not knowing what will happen to you in the department', 'Having to undergo an uncomfortable procedure', 'Feeling pain, and 'Being unable to control what will happen to you'. The interviews with nurses found their main priorities were dealing with 'major trauma' and keeping the department running smoothly. The nurses recognised that patients were likely to be anxious in the department, and believed it was their responsibility to deal with such concerns, but

acknowledged that they often did not do so. The nurses reported that they were usually too busy to deal with patients' anxieties and also admitted they had a tendency to 'trivialise' some patients' worries. Practical difficulties, such as lack of contact with patients and the degree of uncertainty which hangs over each patient until a relatively late stage of their stay in the department, also limited the nurses' ability to deal with patients' anxieties. Nurses' perceptions of patients were also found to influence their interaction with them. The observational study found that nurses' interaction with patients was brief and predominantly concerned with the patients' condition and their progress through the department. However, if nurses were carrying out a specific procedure, they were friendly towards patients and chatted informally, which may have been intended to help the patient feel at ease.

In the light of these findings the aims of the study may now be reviewed. The first aim was to identify the sources of anxiety for patients in the Accident and Emergency Department. The most common fears expressed by patients have been described above. These items were also among those about which patients most frequently expressed moderate or extreme anxiety. The findings show, therefore, that patients were as anxious about social and psychological factors associated with admission as with physical aspects.

The second aim of the study was to examine the relationship between anxiety and the patient variables of age, sex, condition and department. No differences were found between the departments studied, but chi-squared analysis showed that young patients, females and those with more serious

conditions expressed more anxiety than other groups.

The third aim was to examine nurses' perceptions of their work and patients and explore how these influenced their practice. The emphasis placed on dealing with 'major trauma' and keeping the department running smoothly has been described above. The nurses had been attracted to working in the Accident and Emergency Department because of the excitement and variety they believed it would offer. In their work they sought opportunities to gain such experiences and valued them highly. Dealing with 'minor' and non-urgent cases was regarded as less interesting and also less important. Keeping the department running smoothly was an important secondary concern. The nurses valued getting patients through the department quickly more highly than dealing with their responses to the experience. It seemed that nurses emphasised aspects of their work which were rewarding and allowed them a sense of achievement. In contrast, patients' anxieties were often about matters which were difficult to resolve. The nurses may have avoided discussing these issues as they felt uncomfortable at having no solution to offer.

Nurses' perceptions of patients were also found to influence the interaction which occurred. The most extreme example of this was the nurses' behaviour towards 'drunks and regulars' which they described as 'going through the motions'. The nurses' attitudes towards such patients appeared to be based upon the nurses' definition of their role and their interpretation of the patient's behaviour. Thus, the 'drunks and regulars' were seen as attending the department 'inappropriately' and were, therefore, making 'illegitimate' demands upon the nurses. The 'drunks' were also described as

behaving in a way which was demanding and disruptive. The nurses, therefore, applied the sanctions of delay and inattention to punish these patients and discourage them from reattending.

Not all patients who were regarded as 'inappropriate' attenders were viewed negatively. The parents of babies and young children were viewed as understandably worried and treated with sympathy and concern. It seemed that social factors, in conjunction with interpersonal processes, facilitated these parents' successful negotiation of treatment. Thus, the child's age would predispose the nurse to look favourably on the parent's demands. If the parent was also appealing, rather than demanding, the nurse would be likely to view their request positively.

The final aims of the study were concerned to examine the nature of nurse-patient communication in the departments studied. The fourth aim was, therefore, to examine patterns of communication between nurses and patients. The communication observed was found to be brief and predominantly concerned with the patients' illness/injury and their progress through the department. Many interactions took the form of brief encounters which lasted one minute or less. In their interviews the nurses had described how they used a strategy of 'popping in' on patients to monitor the patients' condition and deliver care. Little attention was paid to psychological and social factors related to the patients' admission. However, when nurses were engaged in carrying out a specific procedure they were friendly and informal towards their patients. Although patients' anxieties were not usually directly addressed, the nurses may have used friendliness and informality to help patients feel at ease.

The fifth aim of the study was to identify any factors such as age, sex, seriousness of condition or department which may affect the interaction between nurses and patients. No differences were found between the two departments studied or between male and female patients. Nurses were found to initiate more topics, more long topics and more non-illness/injury topics with 'major' than with 'minor' patients. This may probably be explained by the difference in time these patients spent in the department and the requirements of treatment. Among the 'major' patients, the 'older' patients received more topics, more long topics and more non-illness injury topics than 'young' patients. However, in the present study these 2 factors were compounded and it was impossible to distinguish the effect of each. The nurses believed the 'older' patients and those with more serious conditions were more likely to be anxious. Patients with both of these characteristics received more attention. However, the interviews with patients had found that the 'young' patients were more likely to be anxious. It appeared that the anxieties of these patients were less likely to be addressed.

The sixth, and final, aim of the study was to assess how effectively nurses identified and dealt with patients' anxieties in the departments studied. The observational data suggest that nurses did not consistently assess social and psychological factors associated with the patients' admission. They did not usually address patients' anxieties directly. It seemed, however, that nurses may have used indirect means of reducing patients' anxieties. Thus, they were concerned to hasten the patients' progress through the department, they were friendly and informal when carrying out specific procedures and they interacted more frequently, and for longer, with the 'older major'

patients, whom they believed were most anxious. Also, although their strategy of 'popping in' on patients conveyed to the patients that they were busy and not to be troubled with unnecessary questions, it may also have had a symbolic significance of reassuring the patients that they had not been forgotten. The study found that a complex range of factors – interpersonal, cultural, interprofessional and structural – influenced nurses' interaction with patients.

Overall, the role of the nurse in the Accident and Emergency Department emerged as the issue of most importance in the present study. The nurses' emphasis on dealing with 'major trauma' and keeping the department running smoothly appeared to sometimes be at the expense of their ability to deal with patients' anxieties. Their perceptions of patients, which was also intimately linked to their definition of their role, also influenced communication. In addition a number of practical difficulties arising from pressures of work, the nurses' lack of contact with some patients and the limited access to, and availability of, support services were identified. A number of recommendations were made which were intended to facilitate the nurses' ability to deal with patients' anxieties, without having a detrimental effect on the delivery of physical care. Suggestions were also made about how change could be implemented and evaluated.

Nursing as a profession is currently undergoing a period of change. Following the United Kingdom Central Council's 'Project 2000' report (1986) changes are taking place in the structure of basic nurse education which will influence practice at all levels. Of particular importance is that student nurses receive a theoretical input at a higher academic level and

study the individual in health before looking at illness. This change in emphasis could have an important impact on the way in which nurses perceive their work and patients. A second significant feature is that student nurses are encouraged to develop a critical and questioning approach towards nursing practice and to examine, at a theoretical level, the role and function of nursing. Finally, 'Project 2000' aims to establish nursing as a research-based profession. The changes 'Project 2000' promises should, therefore, enhance the process of change recommended in the present study. In particular, education of the type advocated by 'Project 2000' should improve nurses' ability to critically reflect on their practice, clarify their role, and implement and evaluate change.

Summary

In this chapter the overall study has been reviewed. The original aims were described and related to the study's findings. Finally, the recommendations arising from the present research were considered with reference to current changes in nurse education.

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Appendix 1: Data Collection Sheet (Pilot Study)

Investigations:

Nursing Care:

Medical Examination/Treatment:

Information/Explanation:

Factors Related to Condition (eg. acute onset, exacerbation, accident):

Factors Related to Symptoms Experienced:

Relatives:

Impact on Outside Affairs (eg. work/leisure/usual activites):

Previous Admission to Casualty?

Possibility of Hospital Admission?

Length of Time Spent in Department

Relationship Between Anxiety and Process Through the Department:

Further Points/Comments:

Age:

Sex:

Occupation:

Diagnosis:

Date:

Time of Arrival:

Time of Departure:

Department:

Appendix 2: Structured Interview Schedule (Stage One)

This questionnaire is designed to find out more about the worries of patients who come to Casualty. Coming to Casualty often causes patients to feel worried or anxious. I'm interested in any worries or anxiety you may feel.

Can you tell me if you do feel at all worried about this experience?

(If yes, can you describe what you feel worried about?)

Sometimes its hard to identify worries, so I'd like to ask you about some common causes of worry in people who come to Casualty. Some of these questions may seem to apply to you, others may not. When I ask you about them, I would like you to tell me whether you feel any worries or anxiety according to this card. If you feel that an item mentioned is unlikely to happen to you in the department please state that it does not apply.

(Hand rating card: A=does not apply / B=not at all worried / C=slightly worried / D=moderately worried / E=extremely worried)

Are you worried or anxious about the following?

* Just being in the Casualty?	A	B	C	D	E
* Having to get undressed for an examination?	A	B	C	D	E
* Being treated by a doctor you don't know?	A	B	C	D	E
* Not knowing what will happen to you in the department?	A	B	C	D	E
* Feeling helpless?	A	B	C	D	E
* Being unable to control what will happen to you?	A	B	C	D	E

- (If relatives not present)
- * Your relatives not knowing that you are in Casualty? A B C D E
- (If relatives present)
- * Your relatives not knowing what is happening to you in the department? A B C D E
 - * Being cut? A B C D E
 - * Seeing blood? A B C D E
 - * Having a blood sample taken? A B C D E
 - * Feeling pain? A B C D E
 - * Having to undergo an uncomfortable procedure?
(If so, what procedure?) A B C D E
-
- * Having to have an injection? A B C D E
 - * Having to have a 'drip' (intravenous infusion) into your arm? A B C D E
 - * Having to have stitches? A B C D E
 - * Having to have a tube in your nose or throat? A B C D E
 - * Having a rectal examination? A B C D E
 - * (If female) Having a pelvic examination? A B C D E
 - * Having to have an operation? A B C D E
 - * Having to be admitted to the hospital? A B C D E
 - * Not knowing what is wrong with you? A B C D E
 - * What you think might be wrong with you?
(If yes, what do you think might be wrong with you?) A B C D E

* Not being able to carry on your usual activities? A B C D E
 <If yes, in what way do you think they may be affected?>

* Being away from work? A B C D E

* Having a permanent disability? A B C D E

* The possibility that the doctor will not be able
 to find out what is wrong with you? A B C D E

* The possibility that the doctor may overlook an
 important sign or symptom of your illness? A B C D E

* The possibility that the doctor may think the problem
 is 'all in your head'? A B C D E

* Have you thought of anything that you are worried
 or anxious about that I have not mentioned?
 <If yes, what?>

AGE:

SEX:

OCCUPATION:

DIAGNOSIS:

DATE:

TIME:

DEPARTMENT:

CATEGORY:

Appendix 3: Rating Card (Stage One)

A = DOES NOT APPLY

B = NOT AT ALL WORRIED

C = SLIGHTLY WORRIED

D = MODERATELY WORRIED

E = EXTREMELY WORRIED

Appendix 4: Consent Form (Stage Three)

Dear Patient

I am a research nurse who is carrying out a study looking at what happens to patients during their time in Casualty. With your permission I would like to stay with you while you are in the department and observe the care you receive.

All data collected will be treated as strictly confidential.

Geraldine Byrne
Research Nurse

* * * * *

I have read and understood the above statement and give consent to the presence of the research nurse during my stay in the department.

NAME..... DATE.....

Appendix 5: Coding Sheet (Stage Three)

TOPIC TYPE

- 1 = Introductory/About him/herself.
- 2 = About what will happen in the department.
- 3 = About specific procedures.
- 4 = About patient's illness/injury.
- 5 = About waiting times/delays
- 6 = About relatives.
- 7 = About facilities available.
- 8 = About social circumstances.
- 9 = About fears/anxieties: Reassurance.
- 10 = About care of dressing etc.
- 11 = About potential problems, complications.
- 12 = About impact on daily life.
- 13 = Pain.
- 14 = Admission/discharge arrangements.
- 15 = Social.
- 16 = Directions/Instructions where to go
- 17 = Other.

INITIATOR

- A = Patient.
- B = Relative.
- C = Doctor.
- D = Sister.
- E = Staff nurse.
- F = Enrolled nurse.
- G = Student nurse.
- H = Auxillary nurse.
- I = Radiographer.
- J = Social worker.
- K = Porter.
- L = Other.

Appendix 6: Observation Schedule (Stage Three)

PATIENT DETAILS

Date:.....	Time of Entry:.....
Age:.....	Time first seen:.....
Sex:.....	Time of Departure:.....
Dept:.....	Reason for attending:.....
	Classification:.....
	Disposal:.....

OBSERVATION NUMBER ()]

INTERACTION NUMBER []

TIME STARTED []

TIME FINISHED []

<u>Topic Type:</u>						
<u>Initiated by:</u>						
<u>Time:</u>						

Observations:

INTERACTION NUMBER []

TIME STARTED []

TIME FINISHED []

<u>Topic Type:</u>						
<u>Initiated by:</u>						
<u>Time:</u>						

Observations:

INTERACTION NUMBER []

TIME STARTED []

TIME FINISHED []

<u>Topic Type:</u>						
<u>Initiated by:</u>						
<u>Time:</u>						

Observations:

INTERACTION NUMBER []

TIME STARTED []

TIME FINISHED []

<u>Topic Type:</u>						
<u>Initiated by:</u>						
<u>Time:</u>						

Observations:

INTERACTION NUMBER []

TIME STARTED []

TIME FINISHED []

<u>Topic Type:</u>						
<u>Initiated by:</u>						
<u>Time:</u>						

Observations:

INTERACTION NUMBER []

TIME STARTED []

TIME FINISHED []

<u>Topic Type:</u>						
<u>Initiated by:</u>						
<u>Time:</u>						

Observations:

INTERACTION NUMBER []

TIME STARTED []

TIME FINISHED []

<u>Topic Type:</u>						
<u>Initiated by:</u>						
<u>Time:</u>						

Observations:

INTERACTION NUMBER []

TIME STARTED []

TIME FINISHED []

<u>Topic Type:</u>						
<u>Initiated by:</u>						
<u>Time:</u>						

Observations:

INTERACTION NUMBER ()

TIME STARTED ()

TIME FINISHED ()

<u>Topic Type:</u>						
<u>Initiated by:</u>						
<u>Time:</u>						

Observations:

INTERACTION NUMBER []

TIME STARTED []

TIME FINISHED []

<u>Topic Type:</u>						
<u>Initiated by:</u>						
<u>Time:</u>						

Observations:

Appendix 7: Assessment Form - Department B.

PLEASE USE BALL POINT PEN

ACCIDENT & EMERGENCY DEPT.

USE CAPITALS THROUGHOUT

Surname		1 Mr 2 Ms	Referral Number	
First Names			DOB	
Address			Arrival Date	
Tel No			Area Code	Time
Age	Yrs	Mo	Attended before this year?	
			1 Yes 0 No	
Family Doctor				
Mode of arrival		1 Walking 2 Public Transport 3 Private Transport 4 Ambulance 5 Other		
Source of referral		1 Self 2 G.P. with letter 3 G.P. no letter 4 Ed Estab 5 Work 6 Other Hosp. 7 Police 8 999 9 Other		
Incident		1 Home 2 Work 3 Ed Estab. 4 Sport 5 RTA 6 Public Place 7 Unspecified		
Location of incident		Area Code	Time since incident or illness. Days	
Occupation		Code		
Examined by Dr.		Investigations		
Surname		At (Time)	Xray	ECG Haem Bioch U'sis Bact. Hist B Bk.
Code				
Patient Group	Diagnostic Group	Anatomical Site	Multiple Conditions	
	(1)	(1)		
	(2)	(2)	Research	
Disposal				
Time left Department		1 Home, Discharge to GP 2 Home, Review in A & E Dept 3 Home, Review in OPD (including F C) 4 Admitted to this Hospital - Ward 5 Transferred to other Hospital 6 Died in A & E Dept or B I D 7 Took own discharge 8 Other (e.g Police custody)		

DRUGS GIVEN IN A/E DEPT. (1)	Dose	Route	Doctor	Nurse	Time

-A26-

