

## **The Organisational World of Emergency Clinicians**

*By Peter Nugus*

*Winner of the Jean Martin Award*

This article outlines my PhD journey into the organisational world of emergency clinicians. I completed a PhD on the sociology of emergency department (ED) care, in 2007, in the Centre for Clinical Governance Research (CCGR) in the Faculty of Medicine at UNSW. It was an ethnography in two Sydney EDs, focusing particularly on communication between emergency nurses and doctors with those of inpatient hospital departments. I thank the editors, and the TASA executive, for the opportunity to write about this journey in *Nexus*, and for their support for early career researchers, evident in granting the *Jean Martin Award*.

The aims of my PhD were to describe and illuminate through empirical investigation the under-recognised organisational labour of emergency clinicians; and to expound the significance of this work for the ability of the ED and the hospital to deliver collaborative, patient-centred care. I undertook, and thematically analysed transcripts from, 12 months of ethnography in the EDs of two tertiary referral hospitals in Sydney. This included informal and formal observations. Formal observations included accompanying nurses and doctors of three levels of seniority over two full shifts each in each ED (24 shifts). I also conducted 80 semi-structured interviews with emergency nurses and doctors and nurses and doctors from inpatient departments, and 56 unstructured “field interviews”.

I always thought I’d do a PhD at some stage. I wasn’t in a hurry. I hadn’t really thought of intellectual life as a career. Deep down, I think I’d seen it as an indulgence. This might come from a regional Queensland upbringing. I completed a research masters by distance (MAHons) at UNE, on monarchist and republican discourses in Australia, under the guidance of Associate Professor Peter Corrigan, in 2002. I am fortunate to be the beneficiary of Peter’s continued advice and support. I found juggling a thesis and working full-time immensely difficult (How do

people with families do it?). However, the growth, joy, and confidence in the message that came out of completing the thesis propelled me urgently to seek out a PhD.

In early 2004, I responded successfully to an advertisement for a PhD scholarship in the CCGR under Professor Jeffrey Braithwaite, the Centre's director, funded by the NSW Clinical Excellence Commission. I was equally fortunate to have been able to choose my area of research within the broad area of "patient safety". Clinician contacts at CCGR kindly provided me with the opportunity to briefly observe and talk to staff in various settings. I thought the ED would be exciting, particular the way communication happens and roles are upheld and challenged in negotiating care under trauma conditions. This aligns with popular conceptions of ED work from *ER*, *House* etc.

### *The politics of patient transfer*

After observing for some time in one of the two EDs to which I was granted access, and Human Research Ethics Committee approvals, I came to believe that the real drama in the organisational work of emergency clinicians (doctors and nurses) was in interdepartmental relations. There was obvious cultural resonance among emergency clinicians for what might be called "the politics of patient transfer". Staff frequently used terms from *House of God*, a legendary novel by Samuel Shem (1978), which parodies the patient-passing games which hospital interns have to learn. The book popularised terms such as "turfs" and "bounces" from one department to another, and descriptions of particular inpatient departments and clinicians as "walls" or "sieves", depending on the relative ease or difficulty with which they could be persuaded to admit patients into their department. In a similar vein, a Canadian emergency physician, Grant Innes, wrote a spoof article in the Christmas 2000 edition of the *Canadian Journal of Emergency Medicine*, entitled "Successful hospitalization of patients with no discernible pathology".

I was surprised that, despite the cultural fascination with EDs (evident in media reports and people's interest when hearing that one researches EDs), little research, sociological or other, had focused on the structural relationship between the ED and inpatient departments. For better or worse, the prominence of the hospital in the health (or "illness") system is increasing, rather than diminishing (Iedema et al 2009). The ED is the key link between the community and the hospital, serving as the gatekeeper of its differentiated services (McCusker et al, 2001). Sociologically, I was engaged by the relative absence of organisational sociology in the sociology of health and illness and the need for a structural perspective, argued by Davies (2003) and Griffiths (2003) in review articles in *Sociology of Health and Illness*.

#### *Bureaucracy, negotiated order and symbolic interactionism*

The hospital, into which emergency departments seek to transfer patients, is a classic bureaucracy, in that differentiation among occupations and departments is founded on specialised knowledge (Du Toit 1995). Balancing this relatively structural focus, the order of the hospital is continually being negotiated, although hospitals, like any organisation, are "more or less stable at particular points in time" (Allen 2000: 331), featuring relatively stable orders of roles and identities (Strauss et al 1963). The emphasis on negotiation reflects the concept's home in the theory of symbolic interactionism. Actors both reflect and create social structures, in ways often unknown to them, as they seek to align meanings, or the "definition of the situation" (Goffman 1959).

#### *The "whole body" versus the "fragmented body"*

The research showed that ED clinical work centrally concerned assessing, diagnosing, treating, and managing the organisational trajectory of, continually arriving patients. Maintaining the "flow" of patients continually arriving meant that interdepartmental relations were an inherent feature of ED work. "Fragmented body" departments are structurally more powerful than "whole body" departments. Inpatient doctors have specialized knowledge of particular organs

of the body, mirroring the structure of the hospital. This means that they can decide if, how and when to become involved in the care of ED patients. This is expressed dramatically in the following telephone conversation.

“George” still waiting on phone – going red (He’d asked the cardiologist to see the patient). “Yes, I know it’s a renal problem, but she’s your patient. I know. I know. Yes but – I know.” Red face – livid. “Look, she’s had – No. You guys but the medication you gave her destroyed her kidneys and now she’s back in hospital. (Pause.) Listen. We need to stop the medication you’re giving her. (Pause.) No, because her kidney was fine. She didn’t have chronic kidney failure. She had normal kidneys that are being poisoned by your medication. Oh, whatever”. Slams the phone down. *To researcher*: “I wish they had one of those screens attached to the phone so he could see my size. Little smart a\*\*e. You wanted to talk to me?” (Unstructured observations, Hospital A, p.214).

The aged care department, as a “whole-body” specialty tended to become a fallback position, if inpatient teams were reluctant to review or accept admission of a particular patient.

“We [doctors in geriatric medicine] had to have a meeting with the ED ... We had to say, ‘don’t ring us and say “Oh, this woman’s 85 so she’s yours”. The average age of admission of patients in this hospital is 80’. We have a joke that if no one else will take them [emergency clinicians] push them over and ring us ...” (Interview, Geriatric registrar, Hospital A).

### *Selling patients*

In response to the bureaucratic power of the hospital, emergency clinicians convey extensive organizational knowledge and skills to progress patient pathways. Informal networks and organisational knowledge are core features of what has been called “post-bureaucratic” work (Heckscher & Donnellen, 1994), which feature alongside, but, in the case of emergency clinicians, also challenge, bureaucratic power. In particular, emergency clinicians case-shape

patients into the organ-specific structure of the hospital. In short, this involves “selling patients”.

Inpatient registrar: “Selling is the proper way – not demanding. The burden of proof is on Emergency. They have to prove that the patient is worthy of your care. They have to ‘buff’ the patient to make it look good ... You must target the selling to the speciality, like pneumonia. Not: ‘Oh, shortness of breath, you must come’. You list the symptoms. I want evidence to come down. Not airy fairy stuff ... They must properly discuss it. You can’t cry wolf. It must [be] a succinct not crappy referral ... Tests take time but they give evidence” (Interview, Inpatient doctor, Hospital B).

Selling patients involved minimising and maximising particular aspects of the patient case to appeal to a particular medical or surgical specialty. The clinical-organisational craft of emergency medicine and emergency nursing was built up interactionally into a set of mutual role expectations. There was considerable evidence that clinicians across departments behaved according to the roles they occupied, and expressed empathy for the role-based circumstances of others, such as the inability of emergency doctors and nurses to control inflow, and the busyness of inpatient doctors who have patients on many wards.

### *Structural power and vulnerable patients*

The research showed that patients whose presenting conditions do not align unambiguously with a single organ find it difficult to be transferred efficiently and effectively. Because the conditions of older patients, and those with chronic diseases, are less amenable to single-organ classification they are systematically disadvantaged in the ED. Although most patients might receive appropriate care, the lens of symbolic interactionism helped to show a patterned order of unequal power in the hospital.

Mutually understood and influencing roles also contribute to making qualitative research trustworthy and widely applicable. From a symbolic interactionist perspective targeted

observations of particular clinicians did not merely involve individuals. Whole departments – in fact patterns and role expectations of international communities (of emergency doctors and nurses) – presented themselves to me in the interactions among emergency clinicians. Contrary to most initiatives in health reform, education, licensing and performance measurement, redressing the needs of vulnerable patients in the ED requires structural reform – beyond benevolent clinicians with well-developed communication skills.

*Please contact the author for sources cited in this article, and sources in which particular aspects of the research have been published.*

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