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# Seeking care for nonurgent medical conditions in the emergency department: Through the eyes of the patient

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## Introduction

The policy goal of shifting nonurgent visits from the emergency department to nonemergency health care settings is commonly devised, planned, and implemented without considering patients' perspectives. The purpose of this study was to gain an understanding of the context in which patients choose to seek health care in an emergency department. Human science provided the framework for this exploratory descriptive research study.

## Methods

This study was conducted at an urban, university emergency department in Denver, Colo. Uninsured adult patients triaged as nonurgent who were being discharged home were eligible to participate. Eligible patients from 15 randomly selected shifts were asked to participate. Following their ED visit, open-ended interviews began with the question, "Can you tell me the story, or the chain of events, that led to your coming to the emergency department today?" Each interview was audiotaped. Transcripts were analyzed to identify common themes. Patients also rated their severity of illness from 1 (not severe) to 5 (life-threatening), and they rated their satisfaction with the health care they received from 1 (not satisfied) to 5 (extremely satisfied).

## Results

The 30 study participants ranged in age from 17 to 60 years; 22 participants (73%) were women. Most patients (73%) rated their severity of illness as 3 or less and their satisfaction with the health care they

received as 4 or more (83%). Five themes for seeking care were identified: (1) toughing it out, (2) symptoms overwhelming self-care measures, (3) calling a friend, (4) nowhere else to go, and (5) convenience. Despite the fact that the patients had nonurgent medical problems, their stories revealed that distress in their lives had influenced their need for emergency care.

## Conclusions

Access was prominent in the minds of uninsured patients seeking ED care for nonurgent medical diagnoses. Typically, patients did not perceive themselves as having an urgent problem, had been unsuccessful in gaining access to alternative non-ED health care settings, and found the emergency department to be a convenient and quality source of health care. The patients' stories relayed a context for ED visits that goes beyond medical diagnoses. This perspective has important implications for quality care delivery and for including patients in planning ways to access emergency health care. (*J Emerg Nurs* 2000;26:554-63)

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**A**pproximately 95 million visits are made each year to emergency departments in the United States,<sup>1</sup> and most urban emergency departments report a significant problem with overcrowding.<sup>2,3</sup> Although television programs often depict emergency departments as places filled with persons struggling to stay alive, that scenario does not always reflect reality. Despite an increase in acuity among ED patients in past years, the majority of patients do not come to the emergency department because of life-threatening problems. The use of emergency departments for non-life-threatening problems was reported as early as 1849 in England.<sup>4</sup> In 1992, Padgett and Brodsky<sup>5</sup> estimated that 85% of ED visits were made for non-life-threatening reasons, with about half of those reasons further categorized as nonserious. Within the context of the current health care system, in the United States as well as in other countries, emergency visits for nonserious medical problems are regarded as "inappropriate."<sup>6,7</sup> Health care and insurance systems are now focusing considerable efforts toward shifting inappropriate visits from the emergency setting to nonemergency settings, such as ambulatory primary care clinics, in an effort to reduce

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overcrowding and costs.<sup>8-10</sup> However, on what basis are visits categorized as inappropriate, and what are the underlying assumptions of the people who make these decisions?

The health care delivery system in the United States is based on the anatomy and physiology of the body,<sup>11</sup> quite apart from the mind, spirit, family, and community. This paradigm is conspicuously manifest in the highly technical and fast-paced emergency department. The categorization of inappropriate visits, then, is based on a medical problem, or more correctly, the lack of a significant medical problem. Although some people may debate about whether to categorize patients prospectively, according to the patient complaint, or retrospectively, according to discharge diagnoses,<sup>12</sup> the debate is clearly rooted in the medical framework of physiologic dysfunction or disease. Based on this framework, coming to the emergency department to seek care is considered a simple behavior that is in direct response to a physiologic (body) crisis.

Emergency providers' solution to the problem of inappropriate visits is the "further development and evaluation of tests of higher specificity for the early diagnosis of nonurgent conditions."<sup>10</sup> The implication, then, is that persons with nonurgent conditions could be triaged out safely. The ED process is all about getting patients in and out quickly, and ideal visits are characterized as short.<sup>13</sup> People who come to the emergency department for reasons perceived as "inappropriate" become stones in the river, impeding the flow of the department.

Policy makers are intent on shifting patients from emergency to primary health care settings.<sup>14,15</sup> Managed care programs across the United States are devising strategies such as patient co-payments, requiring prior authorization to be seen, and denying access to ED care to change help-seeking behavior. However, policies aimed at shifting care from the emergency to the primary care setting have not always achieved their intended effect of decreasing ED visits. Among patients studied in London, where all persons have a general practitioner to provide them with health care, only 7% had tried to contact their physician before seeking care in the emergency department,<sup>16</sup> and only 30% of persons calling for ED advice had first tried to call their physician.<sup>17</sup> The proliferation of freestanding emergency departments in the 1980s had little effect on the ED census. Prior authorization for medical services may not decrease emergency department use (or be safe) across all patient groups.<sup>18,19</sup>

The policy of shifting visits to primary care settings is based on numerous assumptions, one being

that a primary care system is ready and waiting to care for these patients. This assumption is far from the reality in most cities. In one study that took place in Colorado, 34% of emergency patients had no access to health care other than the emergency department.<sup>20</sup> For persons without access to primary care settings, the emergency department is their safety net for care, their last resort for accessing health care.<sup>2</sup> After surveying patients at a large municipal hospital, Habenstreit<sup>21</sup> concluded, "Emergency rooms are a rational and appropriate choice for routine health care, in light of the existing alternatives."

Another assumption underlying the policy of shifting patients out of the emergency department is that significant cost savings will be realized. Cost savings is, indeed, the predominant issue of health policy.<sup>14</sup> Although costs may be excessive for ED care, when one looks at the cost as a part of the total health care budget, the numbers are relatively small, representing less than 1% of the health care bill in the United States.<sup>14,22</sup> In addition, some ED costs are fixed. Minimal staffing and equipment must be provided, regardless of the census, and the doors of the emergency department are always open. After a cost analysis of visits in 6 Michigan hospitals, Williams<sup>23</sup> cautioned that shifting nonurgent ED visits to primary care would result in less cost savings than expected. Although ED costs are incurred, patients get care, perhaps when no other care is available.

Additional assumptions that may not hold true for all persons are that (1) given a choice, patients would prefer care delivered in a less hectic primary care site and (2) the continuity of care and focus on prevention afforded in primary care sites in all cases necessarily affords better care. In a survey of adults who sought care at a health maintenance organization urgent care center, only 47% said they would have preferred a visit with their primary care physician (within 1 or 2 days) to urgent care.<sup>24</sup> What about the other 53%? Given the current health care system, it may be that some people may prefer receiving episodic care to the option of developing an attachment with a primary care provider. Marginalized, socially stigmatized persons may prefer the anonymity offered by the ED setting.<sup>25</sup> Others may find a 1- or 2-day delay in accessing primary care too burdensome once they have made the decision to seek care.

Reagan<sup>14</sup> stated that each player involved in the health care system—doctors, nurses, patients, administrators, legislators, and insurers, just to name a few—has a unique perspective about the system.<sup>14</sup> However, a perspective often lacking in the current debate is that of the patient. Many private and public agencies are planning and implementing programs

based on the assumptions of administrators and health care providers, whose lives of privilege differ extraordinarily from the lives of those they serve. Access to care is being planned by persons for whom access may not be a problem.

### The patients' perspective

We wondered if there is another perspective that should be considered (aside from that of getting patients out of the emergency department). What would we think if we understood patients' reasons for coming to the emergency department for nonurgent care? Why do people choose to come to the emergency department? What are their needs and expectations for care? If we focus on the perspective of the patient, perhaps we might gain new insights. Listening to the perspective of the patient may provide what Senge<sup>26</sup> calls "leverage," which is sometimes a simple act, yet is capable of effecting great change because of a shift in perspective. An understanding of patients' help-seeking behaviors could serve to guide program planners in the development of systems that provide accessible, cost-effective, quality care. System changes could integrate the perspectives of the many players involved, keeping the patients' perspectives central.

### The phenomenon of seeking help

In an early study of help-seeking behaviors, Zola<sup>27</sup> found that "Neither the mere presence of symptoms, neither their medical seriousness nor objective discomfort seems to differentiate those episodes which do and do not get professional treatment." Since then, stress and social networks, including employment status, have been found to affect help-seeking behavior.<sup>28-31</sup> Literature regarding help-seeking behavior has generally identified antecedents of seeking help. Padgett and Brodsky,<sup>5</sup> working from a psychological perspective, synthesized earlier help-seeking models<sup>32,33</sup> and identified *predisposing*, *enabling*, and *need* factors. These factors were then related to 3 stages of help-seeking behavior: (1) problem recognition, (2) deciding to seek help, and (3) deciding to use the emergency department. Becker et al,<sup>34</sup> working from a medical anthropology perspective, identified the following 5 factors influencing the decision of adults with chronic asthma to seek emergency care: (1) assessment of the condition, (2) identification of persistent or worsening symptoms, (3) assessment of the condition in relation to other responsibilities, (4) desire to be self-reliant, and (5) fear of death. Along with describing influencing factors, Becker et al<sup>34</sup> described a push-pull dynamic among persons with asthma who struggled to decide whether to seek ED

care, as they balanced delaying treatment against seeking care too soon.

In developing a theory, the association between help-seeking behavior and other concepts has been explored. For example, Becker et al<sup>34</sup> introduced the concepts of self-reliance and self-mastery with regard to help-seeking behavior. From a nursing perspective, Roberts<sup>31</sup> related the concept of seeking help to social support, and developed a typology for categories of lack of support. Despite the fact that exploring ED help-seeking behavior is important to emergency nursing, little has been published in our practice journals about the concept.

### A human science perspective

Human science offers the opportunity to explore help-seeking behavior from a perspective that is different than the traditional medical perspective. Rather than focusing on medical diagnoses, costs, or psychologic modeling alone, a human science framework allows for the exploration of the lived experience of the person seeking help. In human science, the person and caring is preserved in efforts to find meaning.<sup>35,36</sup> In our research, we hoped to preserve the person and human care in understanding, "Why are you here?"

### Methodology

We used a narrative descriptive study design<sup>35,37,38</sup> to explore the context in which patients decide to seek care in the emergency department. The purpose of the descriptive method was described as follows by Parse et al: "[it] focuses on discovering the meaning of an event in time...based on conversations and observations."<sup>37</sup> Sandelowski<sup>38</sup> stated that, through the narrative method, "Researchers can gain insight into the way human beings understand and enact their lives through stories."<sup>38</sup> Included in the concept of seeking help is the process involved in making the decision to go to an emergency department. This study focused on voluntary help-seeking behavior for non-life-threatening problems among noninsured people.

The study was conducted at an urban, teaching, trauma center emergency department with an average daily census of approximately 100 patients. Adult patients (age 18 years or older) who met the following criteria were eligible to participate: (1) they were enrolled in (or eligible for) the CU Care Program, an internal, managed care pilot program for the medically uninsured at the University of Colorado Health Sciences Center;<sup>39</sup> (2) they were discharged from the emergency department; and (3) they were triaged as nonurgent upon their arrival in the emergency department. Nonurgency status was based on a triage category of greater than 2 (triage categories range

**Table 1**  
ED visit characteristics of participants

Name	Age (y)	Day of wk	Time of arrival	Diagnosis
Mary	33	Monday	11:50 AM	Dental caries
Cleta	46	Tuesday	8:00 PM	Dyspnea of unclear origin
Sophie	19	Tuesday	8:30 PM	Urinary tract infection vs pyelonephritis
Trisha	20	Thursday	10:30 AM	Gastroesophageal reflux
Michael	39	Thursday	11:00 AM	Upper respiratory infection
Loretta	23	Saturday	12:30 AM	Hematochezia
Linda	32	Saturday	1:00 AM	Sexually transmitted disease
Arthur	21	Monday	12:15 AM	Streptococcal pharyngitis
Margaret	39	Monday	2:20 AM	Urinary tract infection
John	60	Tuesday	4:20 PM	New onset diabetes mellitus; herpetic lesions
Peg	43	Wednesday	11:40 AM	Knee contusion
Julie	30	Wednesday	8:07 AM	Epigastric pain
Rick	36	Monday	9:20 AM	Herpetic eye lesion
Guedi	24	Monday	9:02 AM	Abdominal pain—unknown etiology
Sue	38	Monday	9:05 AM	Viral gastroenteritis
Sandi	25	Monday	10:09 AM	Premature ventricular contractions
Calvin	31	Friday	8:19 PM	Penetrating finger injury; thumb
Dena	27	Friday	9:28 PM	Abdominal pain secondary to biliary colic
Bruce	36	Thursday	12:20 PM	Mild hepatitis
Judy	45	Thursday	1:06 PM	Pneumonia
Lenore	17	Monday	1:42 PM	Assault; pregnant
LaDonna	23	Monday	2:47 PM	Nausea, vomiting, diarrhea; pregnancy
Scott	22	Thursday	3:26 PM	Frontal and maxillary sinusitis
Paula	23	Thursday	4:15 PM	Asthma, upper respiratory infection, nausea, vomiting
Shiela	23	Thursday	3:30 PM	Contusions
Tony	23	Monday	5:47 PM	Sinusitis
Wonda	22	Monday	6:18 PM	Sinusitis and upper respiratory infection
Yvonne	41	Saturday	8:35 AM	Scapular pain
Denise	33	Saturday	8:55 AM	Sinusitis
Deborah	36	Saturday	12:30 PM	Gingivitis, toothache

from 1 [life-threatening] to 4). To achieve a representative sample, patients were enrolled during fifteen 4-hour time periods randomly selected from a block, including all days of the week and times of the day. The research protocol was approved by the Colorado Multiple Institutional Review Board. Patients were reimbursed \$5 for participating in this study. Participation was voluntary and confidential.

During selected shifts, an investigator (JKM) explained the study to eligible patients, obtained written consent, and conducted interviews immediately after discharge. Patient interviews were nonstructured and began with the question, "Can you tell me the story, or chain of events, that led to your coming to the emergency department today?" Interviews were audiotaped and transcribed word for word. Written transcripts were audited against the audiotapes by the interviewer to check for transcript reliability. Research team meetings provided discussion and consensus in identifying, naming, and synthesizing common themes at 3 points during data collection. Data management was facilitated by the use

of a computer software package for qualitative data (HyperRESEARCH, ResearchWare, Inc, Randolph, Mass).

Selected demographic questions were asked of each patient after his or her interview. In addition, patients were asked to rate the severity of their illness from 1 (not severe) to 5 (life-threatening) and their satisfaction with the health care they received from 1 (not satisfied) to 5 (extremely satisfied). Triage category, discharge diagnosis, and length of ED stay were collected by chart review.

## Results

Thirty patients were interviewed (Table 1). Their ages ranged from 17 to 60 years (mean, 31 years); 73% were women, 33% were from ethnic or racial minority groups, and 67% reported no primary care association. Most patients rated their severity of illness as 3 and their satisfaction with the health care they received as 4 (73% and 83%, respectively). In interpreting the data, 5 recurrent themes were identified (Table 2).

**Table 2**  
**Help-seeking behavior in the emergency department: category descriptions**

Category	Descriptors
Toughing it out	<ul style="list-style-type: none"> <li>• Well, I've been suffering with this toothache for 9 months. And I've been trying to tough it out and tough it out and I had nowhere to turn to.</li> <li>• So I jus' been trying to bear with it. Then I just couldn't handle it anymore, so I came in.</li> <li>• At the time, at the time I just wanted to be put out of my misery, a shot, anything just to get rid of the pain.</li> <li>• I just basically laid down in bed and I suffered for a while there.</li> </ul>
Symptoms overwhelming self-care measures	<ul style="list-style-type: none"> <li>• They tried massaging it too, my daughter, and that didn't do any good. I even took a hot bath, and that didn't do any good, so I figured I better just come in, see if you could tell me what's wrong with my shoulder.</li> <li>• I didn't sleep at all last night due to my toothache, I was up all night long. See, I've been controlling it with aspirin, and anything else I can get my hands on, like um, ibuprofen, my mom has some of those so I took that.... It's been continuously worse. And, last night I was up every 2 hours taking aspirin after aspirin...cold washcloths on the cheek, and the whole 9 yards. And, finally, I called my work today and said I can't come in.</li> <li>• It just hasn't been getting any better with general cold remedies I've been taking, some Robitussin 12-hour cold and flu, cough gel caplets, some Dimetapp cold tablets, some aspirin, and nothing has been able to knock this loose from me.</li> <li>• I went and bought some Monistat 7 but it didn't seem to...it hasn't been working that well. I was just up and I decided to come because the burning was getting worse.</li> </ul>
Calling a friend	<ul style="list-style-type: none"> <li>• My neighbor Rinny came over 'cuz she saw my door open and she was like, "Well, what's going on?" I told her and she stayed there with me 'til the ambulance got there.</li> <li>• My friend came with me. I just told her I needed to go.</li> <li>• I spoke to my mother about it. And um, she actually brought me to the emergency department. She said my Dad had the same thing and it was just, it was polyps or something...but she said I should probably come in.</li> <li>• I called my Mom on Monday because I was in so much pain. And well anyway, I have a little baby and I really can't take care of him real well and I was at home by myself. And I was tryin' to get hold of her...And this morning, she told me to go to her house, and I went to her house. And she kind of took care of me during the day.</li> </ul>
Nowhere else to go	<ul style="list-style-type: none"> <li>• I called the dentist and they don't see you unless you have a lot of money up front. And so, I came to the emergency room.</li> <li>• And when we called the clinic where I normally go, they were filled up and couldn't take any more and they instructed me to come in here, to the emergency department.</li> <li>• I called the hospital to make an appointment, but they couldn't see me until January. Their best advice was really to come into the emergency room.</li> <li>• So I called...to see if I could get in the clinic this morning...and I talked to a nurse down there and they were shorthanded, only had one doctor, and said there was no way. And I told her there was no way I could come in tomorrow on Friday. And based on what I described to her, she suggested that I should come down and be seen in emergency because it sounded like I needed some antibiotics, or at least [to] be checked out completely.</li> <li>• I called Aurora Regional. And I told her what was going on. And I said, "Should I wait?" and she said, "No, you should probably have that looked at, checked out."</li> </ul>
Convenience	<ul style="list-style-type: none"> <li>• And then I had to wait for my son to get over to the house so he could bring me in because I don't have a car.</li> <li>• I work 7 to 3:30. But the thing is, our day gets started at 5:30 in the morning and ends like at 7:00 at night. After we go to work, bring everybody back that rides with us. Get our checks, go get them cashed. By the time we hit the door at the house it's 7:00...that's why our days are really long, that's why it is easier to come in at night.</li> <li>• And then we waited for her boyfriend to come home to bring us to the emergency department.</li> </ul>

**Toughing it out**

The first theme was "toughing it out." For example, a patient explained, "I've been suffering with this toothache for 9 months...and I've been trying to tough

it out and tough it out and I had nowhere to turn to." In the stories that patients told, many explained that they had tried to "bear with it" and "suffered" before deciding to seek help in the emergency department.

**Table 3**  
**Stories of distress**

<b>ED arrival</b>	<b>Why they came</b>	<b>Discharge diagnosis</b>
Cleta, a 46-year-old woman; arrived in the emergency department on a Tuesday at 8 PM	Actually the story began over a year and a half ago. We've been through a lot of stress trying to get our granddaughter back...And it was a 6-month ordeal... which cost us our jobs, my husband and myself. It cost my son his job. And, just, trying to get it all back has built up enough stress to where I am now having what we think are probably panic attacks. Which feel like heart attacks.	Dyspnea of unclear origin
Trisha, a 20-year-old woman; arrived in the emergency department on a Thursday at 10 AM	And then I got up and started throwing up blood... I tried to catch him [her husband leaving to work], he didn't hear me scream out for him, he was already halfway down the hill. I went ahead and called the ambulance and the ambulance came up about an hour later...I was mostly worried 'cuz I'm 11 weeks pregnant. That's the only thing that went through my mind.	Gastroesophageal reflux
Margaret, a 39-year-old woman; came to the emergency department on a Monday at 2 AM	I recently just found out—today—that my fiancé has another woman, and he's been with her for awhile. Since my infection has gotten worse I just decided I better come tonight...I thought...I might have some disease. The last 6 months or so we didn't use any condoms, you know, any protection.	Urinary tract infection

### Symptoms overwhelming self-care measures

The second theme was “symptoms overwhelming self-care measures.” One patient said, “I didn't sleep at all last night...I've been controlling it with aspirin, and anything else I can get my hands on, like ibuprofen, my mom has some of those so I took that.... It's been getting continuously worse. And last night I was up every 2 hours taking aspirin after aspirin, cold washcloths on the cheek, and the whole 9 yards. And, finally, I called my work today and said I can't come in.” Patients described the self-care measures they had instituted, which most often consisted of over-the-counter medications. For many persons, the decision to seek care occurred when symptoms crescendoed, despite their self-care measures, and began to have an impact on their ability to function. Pain was the predominant symptom, and when it had an impact on sleep and work, patients sought care.

### Calling a friend

The third theme was “calling a friend.” For example, “I called my Mom on Monday because I was in so much pain. And well, anyway, I have a little baby and I really can't take care of him real well and I was at home by myself. And I was trying to get a hold of her. And this morning, she told me to go to her house, and I went to her house. And she kind of took care of me during the day.” Friends and relatives were called for

support, as well as for advice. Mothers were called most often.

### Nowhere else to go

The fourth theme was “nowhere else to go.” Patients were sometimes unsuccessful in gaining access to nonemergency care settings, as illustrated by the following statement: “When we called the clinic where I normally go, they were filled up and couldn't take any more and they instructed me to come in here, to the emergency department.” Indeed, 13 patients (43%) related calling ahead to a health care provider for an appointment and were referred to the emergency department. The health care provider was often an office, clinic, or the emergency department itself.

### Convenience

The final theme was related to convenience. One patient explained, “...I work 7 to 3:30. But the thing is, our day gets started at 5:30 in the morning and ends like at 7:00 at night. After we go to work, bring everybody back that rides with us, get our checks, go get them cashed. By the time we hit the door at the house it's 7:00. That's why our days are really long, that's why it is easier to come in at night.” Work schedules, child care, and transportation barriers affected patients' choice of the ED setting for their health care.

### Concept synthesis

In exploring how the categories related to one another and to the interview experience itself, we began to feel like we were, as Van Manen<sup>40</sup> states, “pulveriz[ing] life into minute abstracted fragments and particles that are of little use to practitioners.” We kept recalling the patients’ stories. We considered the related concepts that had been introduced with help-seeking behavior in the literature, such as social support, self-reliance, and self-mastery. Although they are all useful in examining help-seeking behavior from a certain lens and in some cases were adequate, they still did not capture the tone or depth of life experiences that were embedded in the stories.

As we reflected on the interviews and listened to the tapes repeatedly, we were struck by the distress in patients’ lives that brought on a visit to the emergency department. However, this distress—contrary to the medical model—was not solely physiologic; it was not just about the body. For example, problems with social support or grieving were the foundation for the distress that some patients suffered. Three examples of stories that express the distress in patients’ lives are provided in Table 3.

### Discussion

Uninsured patients’ reasons for seeking care in the emergency department are far more complex than can be conveyed by a medical chief complaint or diagnostic label. Patients cope with distress and make decisions to seek care by consulting a circle of friends and relatives. Patients spoke about “trying to tough it out” before they decided to come to the emergency department. Worsening symptoms, despite self-medication, and their effect on sleep and work influence help-seeking behavior. Many patients try to access nonemergency care settings before they go to the emergency department. Work schedules and transportation barriers also have an impact on decision making.

Our findings demonstrate the existence of distress in the lives of uninsured patients who seek help in an emergency department for a nonemergent medical problem. For some persons, familial and social relationships had been disrupted. For others, distress was related to physiologic health, spiritual health, or social support. Many aspects, or layers, of life were disrupted, and no matter the layer on which the disruption occurred, the entire person was affected and in need. The concept of distress emerged to encompass the lived experience of persons seeking help in an emergency department. The ED visit was, in many ways, like sending out a distress call.

The distress experienced by the person contrasted starkly with his or her discharge diagnosis. Indeed,

the patients’ discharge diagnoses seemed almost trivial when juxtaposed to their stories. Their medical diagnoses were estranged from their life experiences.<sup>35,40</sup> The distress they experienced touched the totality of the patients’ lives and was far from simple. This situation is contradictory to the understanding of ED visits from the medical perspective, which is based exclusively on an objectifying, reductionistic, physiologic model.

Malone,<sup>13</sup> an emergency nurse scholar, reported a similar phenomenon among another group of ED users labeled “frequent flyers” whose visits are also commonly judged inappropriate. Malone reported that the emergency department is often used as a public almshouse, where “a visit to the emergency department meant something more than a medical care visit.” She went on to describe the compliance required on the part of heavy users to be accepted: “...patients would agree to collude with clinicians in medicalizing their problems; that is, in allowing their complex, multifaceted social and medical problems to be defined as medical diagnoses and addressed through medical measures alone.” This collusion might explain why, despite the fact that their care was limited to a medical problem, patients in general were satisfied.

Cassel,<sup>41</sup> a physician who has written about the paradox between the focus of medicine on the body and one’s lived experience, has described suffering as “the state of severe distress associated with events that threaten the intactness of the person.” Sacks,<sup>42</sup> another physician, has written about his experience with persons who have postencephalitic disease, and he discussed the multidimensionality of the human experience: “We have already stressed the inseparability of a patient’s illness, his self, and his world, and how any or all of these, in their manifold interactions, through an infinity of vicious circles, can bring him to his nadir of being.” Works by Malone, Cassel, Sacks, and others encourage us to continue to reflect and develop alternative ways of looking at, and understanding, the human condition in the setting of the emergency department.

The paradox between medicine and the life experience of patients can also be discovered in reflecting on the following definition of emergency services: “Emergency services are those health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and/or unscheduled medical care is required.”<sup>43</sup> When this definition is adhered to within a medical framework, visits that are not for urgent or severe physiologic problems

are deemed "inappropriate." Two emergency physicians stated in a letter, "Not even the most zealous emergency physicians could argue that an emergency department is the appropriate setting to refill a prescription for hydrochlorothiazide in an otherwise asymptomatic patient."<sup>9</sup> However, what about viewing help-seeking behavior through the lens of human science, beyond medical problems? For example, the essence of an "RX refill" visit may be, "I was robbed last night, and he took my backpack, with all my meds." In many cases, visits previously considered nonemergent and to be triaged out become indicated and necessary. Focusing only on the patient's physical body illness, separate from his or her life experiences, negates the circumstances that precipitate ED visits.

Although inappropriate visits when seen from the perspective of the patient can become indicated and necessary, additional questions arise. What type of care best meets patients' needs? What type of system would allow for patients' life experiences and distress to become integrated into their care? In the current health care system, many nurses and physicians are listening to patients' stories, yet their attention and interest in the life experiences of patients are not acknowledged and valued. Alternative care systems might best meet the needs of patients whose body needs are not emergent. This alternative system would need to be available (at least by phone) around the clock, because life crises do not limit themselves to 9 AM to 5 PM, or even until midnight. Perhaps, as conceptualized by Malone,<sup>13</sup> a "slow track" setting is in order, where the social, economic, and structural barriers to health may be addressed.

Although the patients in our study did not have emergent medical problems, they nonetheless arrived in the emergency department seeking help. This study provides a glimpse into the distress experienced by patients and allows us to argue that the "appropriateness" of ED visits should not be judged by us or others based on chief complaint alone. Our findings provide an impetus to develop care systems that bring to the forefront the biopsychosocial needs of the patient and their perspectives in seeking care. These systems might include roles for ED-based patient advocates or social workers.

### **Implications for care**

As alternative care settings are considered, this study has significant implications for emergency nursing practice in the current health care system. As emergency nurses, opening ourselves up to the acute distress that is experienced by patients who seek our care presents new possibilities for care. Without appreciating the patients' perspective, visits are easily

labeled as inappropriate, and nurses, physicians, house staff, and clerks may wonder, "Why are they here with this trivial complaint?" After listening to the patients' perspective, we realize that the inclusion of "with this trivial complaint" in our question is a gross error. It is up to us not to triage, label, and cure, but rather to ask and attempt to understand a person's response to the simplified and perhaps metaphysical question, "Why are you here?"

Sacks<sup>42</sup> stated that in answering the question, "How are you?...it is not legitimate to answer this metaphysical question with a list of 'data' or measurements regarding one's vital signs, blood chemistry, urinalysis, etc. A thousand such data don't begin to answer the essential question; they are irrelevant and, additionally, very crude in comparison with the delicacy of one's senses and intuitions." This investigation has awakened us to the contrast between "looking for better tests of prediction" and understanding the distress of patients presenting to the emergency department for care.

Although we describe a paradox between the life world of patients and the medical perspective, we are not advocating the dissolution of the perspective of anatomy and physiology. As Sacks<sup>42</sup> stated, "Not that one lens is preferable over another, patients need diagnosis and treatment, as understanding and care, both are needed and complementary." Openness to various ways of looking at our world is necessary to avoid one perspective (the medical) from becoming hardened into ideology.<sup>44</sup> We hope to remain open to new possibilities in describing and understanding help-seeking behavior in the emergency department.

This study also provides important information for triage nurses. Regardless of whether they act in person or in the context of providing telephone advice, triage nurses identify patients with a critical illness who require emergent care. However, what about those who do not require emergency medical care, whom nurses judge to have a lower level of illness severity? An option occurring more frequently in today's health care system is that of triaging patients to schedule non-ED appointments. In these cases, the triage encounter becomes very important. Understanding why patients seek care, with an appreciation of the context of their decision, will provide insights into the nurse-patient relationship in triage. By listening to patients and understanding the context in which they are seeking care, triage becomes an important occasion for caring.

### **Future explorations**

Further reflection and experience is needed to examine another question: the meaning patients find in

their ED experience. We interviewed persons immediately after they were discharged. It is likely that the meaning of the ED help-seeking experience might change as time passes. In addition, this study was limited to adults without insurance and without a medical emergency. Help-seeking behavior may differ for persons seeking help for children, for persons who are insured, and for persons with medical emergencies. Help-seeking behavior also may differ regionally, based on the availability of health services for the underserved.

We hope that others will continue to dialogue with patients, as espoused by Stivers,<sup>45</sup> to allow those in the world to speak for themselves. Barsky<sup>46</sup> advised physicians to be alert to instances in which patients may have "hidden reasons" for seeking health care. We would go a step further and suggest to health care providers that *all* patients have reasons for seeking help that are generally hidden and that we do not notice. Two "voices" exist in medical encounters: the "voice of medicine" and the "voice of the life world."<sup>47,48</sup> It is our hope that this article will encourage us to be open to asking and listening to the voice of the life world and to asking patients who come to the emergency department the metaphysical question, "Why are you here?"

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