An Ethnographic Exploration of Moral Agency in Emergency Medicine

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ABSTRACT

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This study examines the visibility of moral agency in the daily work and production of healthcare in emergency medicine at an urban emergency medical center in the United States. Through detailed ethnographic research, this study investigates how the work of paramedics, nurses and physicians within their professional practice spheres of emergency medicine constantly resolve challenges that make their moral agency visible. Several themes emerge from this study by examining and closely noting how these individuals interact and express less a principled bioethical script, but instead a personal one that is or is not explained by their professional role in treating patients. This study follows the daily conversations and interactions that embody the local moral worlds of emergency medicine in paramedics, nurses and physicians and how each of these professional groups work *through* and *around* medical and patient care issues to create care. As these individuals within their professional role address challenges in emergency care, it is their interactions and conversations that make visible the moral agency of the individual healthcare worker. By examining the domain of these work lives this study investigates the ongoing and new conflicts and resolutions for the healthcare workers and how they assert moral agency; the intersubjective local moral worlds of care; use of technology to mediate care; and the structure of medicine in emergency medical care.

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Introduction

This study examines the visibility of moral actions and care as assertion of moral agency of emergency medical workers through observation of communications and interpretation of meaning in the words and actions as they interact with one another and patients in critical care emergency medicine. While the majority of my time was spent standing in the resuscitation area of the emergency department, the work of pre-hospital emergency care was also part of my field research and included in this study. The words and actions of the healthcare workers represent the production of medicine within the professional healthcare roles of paramedics, nurses and physicians in this study. In the United States, hospital emergency medical centers are unique because nobody can be refused emergency medical care. Consequently, the individuals choosing to create care in emergency medicine do so within a community of healthcare workers whose interest at a most basic level is to urgently fix the health issue regardless of who the individual is or their ability to pay. Within such a non-discriminatory frame of medicine and health, how work is accomplished and the visibility of moral agency[1] of healthcare workers becomes a unique point of study.

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[1] Agency, specifically moral agency in this study relates to the various healthcare providers studied here as they act with specific commitment to care and creating something better as healthcare practitioners. Discussions and more specifically definitions on agency have previously defined agency in relation to structure and how an individual can reproduce, resist of alter structures (Bourdieu 1995 [1977], Laidlaw 2014, Holland et al. 1998). The idea of distinct *moral* agency remains a point of debate for many currently writing in contemporary moral anthropology (Cassaniti and Hickman 2014). The divisions Cassenti and Hickman make the case for is an ethical pluralism wherein moral inconsistency can exists among groups (2014: 254).

Based on fifteen months of research in emergency medicine, I observed the day to day interactions, conversation and work of paramedics, nurses and physicians in critical care emergency medicine. I investigated how the daily production of work as care for patients constitutes the local moral worlds of these three professional groups who make visible the very personal unstated moral agency of these healthcare workers as they practice medicine to create medical care. Care and the work creating care is in itself a moral act, but those creating care do not constantly think and review their actions as moral actions. The actions are reflexive care and part of practice to correct the ailing or failing body. Seen this way, I observed how the ongoing work of emergency medicine is inherently for the healthcare workers a moral production of medicine. In observing these professionals in emergency healthcare, this study examines how the individual actions of the professionals work to get patients to *better* within a professional role that is confined by professional hierarchy and pedagogy. Thus, in this study I examine and discuss the daily work of these individuals as they address challenges in emergency critical care and how the work reveals open spaces that make visible how individuals working within the confines of their professional practice maintain and exert their moral agency through work practices.

The meaning of care and how to achieve trust in contemporary western healthcare has significant and historic grounding. The origins of the Hippocratic Oath reveal how healthcare is a social contract between the vulnerable patient and the physician. This

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As a researcher I cannot assume to know any other individual's personal agency in the world. However, I use the term moral agency to describe the relevant interactions and work when healthcare workers overcome social and structural barriers to achieve patient care or that reflect specific moral attitudes about patient care. I reference moral agency throughout this study as a moral position observed as care or concern that is important to the individual worker and how they will create care to achieve what they believe is best for the patient.

contract has political origins from a time when the Romans and the Greeks parsed out oaths to bear witness to a physician's commitment to those who are ill and not the politics or allegiance to homelands. That arc of human caring bound to oaths and personal standards remains visible in the interactions and communications between healthcare providers in sometimes obscure and opaque actions and words. By examining moral actions in the context of emergency healthcare work this study investigated how healthcare workers act and interact expressing less a principled bioethical script, but a personal one that is not always explained by their professional role and title in treating patients. A moral order or morality in this study is examined and defined as part of the personal and often ambiguous component of conduct in caring and working in healthcare wherein moral ambiguity can arise as individual workers are involved in making decisions or following orders regarding the treatment of patients. Central to these observations is the visibility of a phenomenology of moral actions rooted in unstated moral agency of the healthcare workers as medicine is produced.

To examine the visibility of internal moral expressions in healthcare workers, I relate interactions of paramedics[2], nurses and physicians as they go about their work tending to patients in emergency medical situations. The work and decision making that repeats itself throughout the constant emergency care interactions of these professionals has a continual effect on the healthcare worker that shapes their practice within the context of their specific

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[2] Paramedics are a higher level of pre-hospital care worker under the larger rubric of Emergency Medical Services (EMS). When I refer to paramedics with nurses and physicians I am referencing the larger EMS worker group. I specifically follow EMS workers in Chapter Three where I use the more generalized term EMS and then other terms that refer to training levels achieved by EMS workers.

roles as healthcare professionals. That process shaping of work and decisions is part of the personal as well as professional expression of how to treat patients. Consequently, the visibility of the moral expressions of care becomes in part social as workers interact and in part visual as part of interactions as emergency care is produced. I studied these daily interactions and examined how those constant interactions are personal moral expressions during the production of care as work in emergency medicine. The work then may appear straightforward or even seem as a series of mechanical events that are part of medical treatment and pedagogy. However, through this analysis I delineate how healthcare workers in critical care emergency medicine work *around* and *through* problems to create care. The working around and through to create proper care are part of the interactions I observed that reflect moral agency in healthcare workers. This study examined not only those interactions as part of care and the ethical moral basis of action, but also the structural constraints of each of the professions and how the construction of professional levels of paramedic, nurse and physician constrain or present challenges to create care.

Chapter One

The Sociocultural System of Emergency Medicine

The production of healthcare in emergency medicine is not a system that has a normative or a predictable pattern of patient care. In emergency medicine, there is a constant realignment of responses by workers as each body is treated and stabilized. Emergency medicine is often described as teamwork as groups work seemingly together (Vosk 2002). The constant work of healthcare workers in the emergency department and their communication and interactions at first impression was just work. Parsing out the actions of various workers and ongoing motivations that were not simple medical methods and protocol is an important part of this analysis. I observed varied modes of communication within the culture of emergency medicine. Thus, in this first chapter I briefly delineate the parameters of emergency system as a sociocultural system. I then discuss how a holistic approach is most useful for understanding the multiple ontologies of moral agency involved in emergency care and how processual theories are useful in interpreting the multiple professional groups and their actions.

Annemarie Mol's theoretical explanation of multiple ontologies in medical practice is a valuable theory for explaining why reductive measures are not helpful and that a more holistic approach is useful. In her discussion on multiple ontologies she raises the point that to examine medicine you can neither reduce it to multiple networks nor reduce it to discourse (2002). Instead, in medicine she discusses what she calls "multipliers" (Mol

2002). Mol illustrates multipliers of social worlds giving the example of surgeons and social workers who share perception and ways of talking about a patient but are of different social worlds: she describes versions of worlds where an individual may be both a musician and a surgeon to bring life to the dynamic aspects of healthcare workers performing roles or functions; she describes the multiplier of frame which can change for the professional but also for the combined frame in medicine for helping people (2002: 67-70). Any single order Mol contends becomes part of a processual term wherein coordination of medical enactments occur (2002: 71). Using this construction, emergency medicine is a frame for observing multiple ontologies of frame, perception and action. The processual nature of medicine in the constant care and goal of restoring health remains the fluid structure in which the work of care production occurs. These distinctions are particularly useful when considering the varied roles, heterogeneous patient cases and interactions. I use the term multipliers in this study because it is useful to explain shared perceptions about a fact or issue for healthcare workers that are from both different social and professional levels. The collective perceptions of work and how it is accomplished may differ for the physician and the nurse or paramedic, however there is shared moral grounding in the goal of healing and moving the patient to stability and getting better. Multipliers is an important concept when considering the professional in their role as paramedic, nurse or doctor because it places the individual with specific training and personal experience at the center of the work produced. Thus while structural and political demands may shift, the healthcare workers are still the salient social norms that explain or represent moral order in the production of emergency medicine. Others argue that moral agency is an implicit part of the relationship and interaction in critical care (O'Keefe-McCarthy 2009). The subtle point to this order is that

the structural changes while influential in political and cultural norms do not equate the humans or human actions that make moral agency visible. Thus the moral agency is not immediately visible or an apparent part of those whose work is to deliver care and create better health in critical care emergency medicine. Consequently, in this study the visibility of moral agency through ongoing 'multipliers' as they work is visible from the observation of how healthcare workers work *around* and work *through* issues that conflict with their structurally set or determined role as paramedic, nurse or doctor and how the individual views their role.

M.G. Smith presented a processual theory that illustrates interrelations between groups. Similar to M. G. Smith, Mol rejects making conclusions of examining a single line of reasoning or discourse, but instead to examine the many contingent structures and discourses (Mol 2002). Mol's multipliers in the hospital paradigm describe a paradigm of connectedness that is never devoid of meaning. In so doing she is able to reject Foucault's coherent discourse (Foucault 1984) and reject Latour's formulation of network (Latour and Woolgar 1986) in favor of shifting meanings and interaction (Mol 2002: 65). This study engages the frame of multipliers and connectedness to explain the layered cultural constitution and shifts of work produced that are proposed in this study of emergency medical care worker phenomenology and interaction with technology. The shifting frames directly relate to how healthcare providers move within an essential role of patient care and related ongoing processes while maintaining a personal position and identity within the bounded workspace. The levels are shifting and multiple including maintaining a frame of work ownership that is a shared process; ordered hierarchy of physicians, nurses, residents,

technicians in the hospital; distinct social worlds professionally as well as; a perspective that is personal and simultaneously professional.

Within the frame of multipliers, medicine in critical emergency care reflects the *biomedical position.* The *biomedical position* first described as scientific medicine – or Western medicine that indicates the values and norms of its creators (Hahn and Gaines 1982). This position as proffered for Western medicine is one where medical knowledge and healing are a deductive process of reasoning based on known biological facts and medicine as practiced determines patient treatment from these facts (1982: 216). However, Hahn and Gaines also describe biomedicine as ethnomedicine which reflects the beliefs and practices of the practitioners (Gaines 2010). It is this intersection where assumed facts (science) administered as ethnomedicine wherever medicine is practiced that I focus on the phenomenological practice of healthcare workers in emergency medicine which reveal the personal moral agency of the individual. It is at this junction that the phenomenology and expression of personal agency by healthcare workers occurs through interaction and use of technology. In relegating the critical care area of the emergency department as a biomedical example *vis a vis* Hahn and Gaines as a sociocultural system, it is important to understand how it fulfills the definition wherein it 1) has its own domain of knowledge and practice; 2) it evidences a division of labor and rules of action and 3) it has means by which it is produced and can be altered (1982: 217). These elements are useful in providing a specific sociocultural system definition for emergency critical care. The definition also reifies the holistic approach in this study that examines emergency medicine from several points of view to understand the system within critical care emergency care to describe the

interrelated issues of ongoing care and moral agency of the individuals within the socio cultural system.

The methods of study remain important to being able to make the relevant definitions and where visibility occurs to identify moral agency of those creating care. By viewing the whole emergency management of patients from prehospital care as well as the ongoing work within the critical care areas of emergency medicine, the groups of individuals bound by professional role and the moral response as part of care are visible. These observations use anthropology to examine the structures, interactions that reveal work as care. This study examines the visibility of local moral worlds and the role of healthcare workers in creating change and working *around* and *through* unresolved care issues while fulfilling professional healthcare roles. Healthcare and the various roles are rooted in a responsibility that medical practitioners take to care and to the best of their abilities restore health. Critical care emergency medicine works to stabilize and possibly diagnose medical issues for the patient. In finding ways to observe moral agency through visible actions of emergency healthcare workers as they stabilize patients, this study attempts to distinguish how and under what circumstances do healthcare workers act in the care of patients in ways that make visible their work as more than just care of a patient but part of a personal moral to justify a personal moral stance or attitude of the individual who is acting within the confines of their professional role.

Fulfilling a social need to affect emergency care reveals where caring is more than a pedagogical practice. Within the work of care moral rules are less defined but part of personal phenomenological work to create care. A work that has no specific script or ritual

actions. The experiences, skills, knowledge base and confines of each healthcare worker profession shape the worldview and interactions making visible each moral action.

The research detailed here follows emergency medical workers as they advance care with the intended outcome to move a patient toward health. What lies between that intended outcome and how the individual as a healthcare worker[3] must get the job of care done creates momentary and sometimes sustained glimpses into the personal that works within professional confines. Those momentary glimpses are often professional work changes or ways of getting work done to accomplish care that are examples of working *around* or *through* an issue or problem to achieve the desired care for the patient. These workarounds expose the nature of human interaction and expression that reveal the moral self and personal interest in moving the patient to something better. Some express it fully, while others do so in actions that support the change for better for the patient, revealing a personal intervention and a moral position - unstated. I return to more specific definitions and examples of healthcare workers finding ways to work *around* and *through* issues throughout this study. Care and medicine as work reflect the constant moral work of healthcare. What is different in this study is that I examine and discuss how these interactions and work make visible the moral self of healthcare workers. In examining the specific groups of healthcare

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[3] Berlinger introduces the term healthcare worker with specific clarity that I find useful in this discussion of workers in the emergency department. Although she is discussing workers across the hospital, her point is just as relevant when she notes:

> "... "professional" could suggest, incorrectly, that the concerns being discussed are limited to physicians and nurses, or to clinical professionals. ("Worker" is not an ideal term for this purpose but it is clearer than "staff", a term that tends to exclude senior clinicians and administrators.) Because healthcare work involves aides and administrators as well as nurses and doctors, it is helpful to keep the full range of people in mind when thinking about how work gets done and how ethical challenges cross professional boundaries."(Berlinger 2016).

workers I describe their interactions and provide dialog to account for the visibility of specific moral actions and interventions in critical care emergency medicine. Before examining each of the groups separately, I present a clinical event that I designate as *a critical encounter.* In this clinical situation the varied groups of emergency medicine workers come together as a group to collectively create care in the resuscitation area of emergency department.

A Critical Encounter

On this particular morning, Stephen, a third year resident is assigned to the resuscitation (*resus*) area of the emergency department. While *resus* often has a series of very ill patients that quickly rotate through as they are stabilized or sent to critical care areas in the hospital, today Stephen is coordinating care for five very "sick" patients. Three are critically ill. The nurses assigned to *resus* have been keeping up to the best of their ability, following orders logged into the computer, monitoring patient vitals, drawing blood, administering meds. The routine of *resus* with residents, nurses and Attending physicians is the same for the other areas of the Emergency Department. However in *resus* the ratio of nurses to patients is 1:3. The other areas of the emergency department can have nurse to patient rations of 1:8 on average, but as high as 1:12. The difference is that the patients in the *resus* are critically ill and need continuous monitoring requiring more nurse and

physician oversight. At the 7:00 a.m. shift change, one resident is assigned to *resus* with a second team of residents and Attendings[4] splitting the work from 9:00 a.m. onward.

Stephen, the resident, is on the phone with a nurse manager: "I need another nurse in *resus*....yes, Stacy and Troy and working very hard, but we....but...okay....okay....thirty minutes". He hangs up the phone looks back at his computer and continues to type. The physician computers face the nurses' computers with a ceiling to counter glass partition separating them. Nurse Troy tells Nurse Stacy that he has to get the labs out for the patient and walks out of the *resus* area with a tray. Nurse Stacey nods while inputting information into the computer. Throughout this morning there is a constant back and forth with the family that is surrounding the patient in *Resus* 3, Mr. Sampson. The patient at bed 3 arrived in *resus* three hours earlier with what the physicians thought was a bowel obstruction. He is waiting for a CT[5] and is clearly in pain. His adult children are with him, they, with their spouses stand around his bed. The daughter is very vocal about what he needs and throughout the morning she has made clear what needs to happen. She says: "He specifically wants *his* gastroenterologist."; He is in "too much pain!".

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[4] Attendings are physicians who have completed their residency and in the case of UED and other teaching hospitals, they usually have teaching duties for the residents and medical students. Residents are medical doctors who are licensed to practice medicine but training in a specialty. For ease of reading, I capitalize Attending when discussing Attending physicians in this study. Residents are physicians, medical school graduates who are doing further training in specialized areas such as emergency medicine prior to receiving board certification. Attendings are physicians with responsibility for training residents and medical students. At UED Attendings are part of the professional faculty at the University.

[5] CT is a computerized tomography, also known as a CAT scan or computerized axial tomography. CT/CAT is a type of imaging that uses X-rays to provide three dimensional imaging and can provide greater detail of soft tissue physiology.

The patient has a visibly distended abdomen and is moaning in pain. The daughter says to Attending Johnson and resident Stephen: "He was swimming yesterday!...his regular 45 minutes to an hour...he was fine yesterday". The daughter is intermittently weepy and her husband holds her hand as she strokes her father's head with the other. Attending Johnson and resident Stephen explain to the family that they need to get a nasogastric tube placement to suck out the air in his stomach. Mr. Sampson is resisting the treatment and the daughter is frustrated. As the daughter's mood changes with her frustration at her father resisting, she says loudly to her father: "You have to cooperate! They can help you!" Mr. Sampson responds while rolling over on his side: "Leave me...I don't want to...let me go...". The daughter is near his head stroking his forehead: "No Dad, don't say that...we need you...you are going to be fine...".

Attending Johnson goes back to the computer side of the *resus* and looks at the patient from behind the glass barrier where the Attendings and residents do their charting. Resident Stephen says to Attending Johnson: "...the daughter said that his wife just passed last month". Attending Johnson nods and then goes back to charting on the computer.

A resident from the gastrointestinal (GI) group that Stephen is familiar with comes down to *resus* and asks about two patients:

Stephen: "You are here!" (Clearly expressing some relief)

GI Resident 1: "Yes, you have two for me?"

Stephen: "Yes, Sampson in 3 and Arroyo in 5."

GI Resident walks between 3 and 5, looking at both patients briefly: "Well, 5 first since he seems to be crashing..." the GI resident looks back at 3 before walking in to the patient in bed 5.

A nurse and a tech attempt to help Mr. Sampson sit more upright. A supervising fourth year resident is called-in to help Stephen get the nasogastric (NG) tube in place for patient Sampson. The NG tube is finally inserted and some of the air is removed from his stomach. With the tube in place Mr. Sampson appears more comfortable but he keeps curling up and sliding down in the bed. The family drifts in and out of the area where Mr. Sampson appears to be comfortably resting. The daughter tends to linger by her father. As the oxygen levels on Mr. Sampson begin to drop, Nurse Lily goes over to him. Nurse Lily who has not been in *resus* all day was called in to support Troy and Stacy. As she looks for the Pulsox on the patient, she is explaining to the daughter that "these things sometimes fall off". She is looking in the sheets and calmly looking at his hands when she realizes that the Pulsox is attached. The patient's daughter is pointing at the monitor. The daughter yells, "help him! Something is wrong, help him!". Resident Stephen comes over and the process of alerting the rest of the emergency staff of an active code[6] in the emergency department begins to take shape.

Arturo from patient services is talking to the daughter trying to get her out of the *resus* area. The daughter is screaming "Save him! You have to save him!". Arturo is very calm and slowly backs her out of *resus* asking her to come sit with him while the doctors work . She continues: "You have to save him...you can't let him die!".

Nurse Melissa is at the head of the crash cart calmly repeating meds and orders. She is – as ever – calm. She is holding several syringes and requesting adrenalin from another nurse. Tech Jason is doing chest compressions. Nurse Lily is hanging an IV and starting

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[6]Code in emergency medicine indicates cardiopulmonary arrest.

another IV access point. A page overhead indicates active resuscitation in *resus*. An Attending who rarely makes eye contact or conversation with the nurses and techs comes in with a large case on wheels and pulls out an auto compressor – the compressor is a mechanical device that fits around a patient and mechanically delivers chest compressions. The device was originally built for use by pre-hospital emergency medical service to use when transporting patients in active cardiac arrest. The Attending fumbles with the machine bringing it into *resus*. He is immediately shooed away. Nurse Melissa looks up and rolls her eyes as attention is briefly diverted to the Attending trying to introduce his machine to the ongoing code. Attending Rice is able to intubate the patient and you can hear the rhythmic breathing from the ventilator starting. At the head of the bed is a pulmonary technician who monitors the ventilator. While Melissa continues to check what is needed by calling out drugs administered and still necessary, nurse Lily calls out: "If you don't need to be here, please …leave". Nurse Melissa furrows her brow and says just as loudly: "We all need to be here". There is a brief silence with only the sound of chest compressions and the mechanical breathing of the ventilator.

A patient in bed 2 breaks the silence saying he needs food. The code is ongoing. Resident Stephen: "We have no chest compressions – we need chest compressions". There is a loud banging on the glass door outside *resus* "LET ME IN!!!". Arturo leaves the ongoing resuscitation where he was standing back observing. He goes toward the door to attempt to calm down the daughter who continues to pound on the sliding door that separates the *resus* area from a hallway.

The resident at a monitor: "We are getting S node…getting wave form".

Resident 2 who was pulled in to work on the code "I'm in!... I do not hear pneumothorax...check left..."

Attending Johnson: "It's coming up on ...[15 minutes]...lets try to pace him."

Resident Stephen looks at Lily and asks her something.

Lily: "Yes, he was tachy, then bradycardia".

As the compressions continue there is an attempt to reconstruct how this happened. What happened, what was the sequence of events, why did he code?

Resident at monitor: "There is small electrical activity."

Chest compressions continue. For another thirty minutes, the compressions and stopping to check for heart activity continue.

Attending Johnson: "Ready to call?"

There is silence. The mass of physicians and nurses, who have assembled and switched on and off with compressions and monitoring for the last hour, begin to walk away. Some are sweating and red-faced. Nurse Troy looks at the clock as Resident Stephen calls the time. A patient somewhere else within the *resus* breaks the silence by asking for a nurse. Nurse Jena answers the patient without leaving or stopping what she is doing as she finishes recording information from a handwritten note on the crash cart into the computer:... "okay, give us a minute". Stacy draws the curtain closed around Mr. Sampson and the tech goes in to "clean".

Near the Attending and resident side of the computers, a dialog is ongoing between Attending Johnson, nurse Lily, and resident Stephen. A social worker joins them. They are discussing the events and the details. This takes less than five minutes. The Attending, social worker and another Attending leave the *resus* as a group. The social worker says as

they are leaving, "Arturo has them (the family) in the room off of ...". Attending Johnson washes her hands at the large washbasin opposite the beds and wipes her face with a paper towel. Her expression turns from her ever pleasant poker face, to a stern unreadable expression as she heads out of *resus* into an exterior hallway with the group going to discuss the death with the family.

Many questions remain unanswered regarding what happened to Mr. Sampson, what were the medical issues and how did his care and coordination of care unfold in the *resus* unit that morning and afternoon. Two days later, I heard Stephen talking to another resident who is taking over for Stephen in *resus*. Steven mentions "the shitstorm last Tuesday" when talking to another resident. A week later, nurse Troy was still thinking about what had happened and mentioned to me: "I knew something was wrong when they came in…it wasn't going to be good – the daughter, the father said he was done...I knew something". The constant expectation for the patient of a medical encounter is that "the medicine" works. In this interaction, the patient was in pain. The family had specific expectations and they were commanding their father "to live" and the healthcare workers to "save him". How the interactions of that day unfolded for the patient and the family in what ended as an unsuccessful resuscitation continued to be a point of reference for the healthcare workers involved. Each of the healthcare workers has specific and ongoing training to attend to and address the patient – the human body. Each of the healthcare workers also has their own discourse and perspective in the ongoing physical and verbal dialog – to practice medicine and help the patient. Over the course of days and weeks, the references made to this particular code – Mr. Sampson – are discussed and mentioned, making visible the personal and professional reactions to the event of that day. Collectively, the team was unable to

save the patient, however individually they each still had an internal and external dialog regarding the events with Mr. Sampson and what had happened that morning. It is at this intersection of action and dialog that a discourse of speech and acts reveal what Kleinman calls local moral worlds (Kleinman 1995). In the case of Mr. Sampson, some of the boundaries were visible as the group shooed away the physician who wanted to bring in his automatic compression machine. Other boundaries were less immediately visible. Lily was not comfortable with the additional observers to the resuscitation. Her verbal outburst was not acceptable to her co-workers.[7] How are these boundaries visible and is that visibility part of the practice of medicine or is it routine personal interaction? The dialog within the *resus* is ongoing as patients are continually supported and the healthcare workers have a mutual understanding of the language and process in this collective work of restoring health. The shared space and understanding of working toward restoration of health is a point where the moral points of the varied disciplines converge. These points of shared action are multipliers of understanding and work (Mol, 2002) and bring together the work and anticipation of saving the patient. In this *critical encounter* there is a hopeful continuity when electrical activity is mapped. That crescent of hope crashes as "time" is called. The patient, Mr. Sampson's heart did not restart. Further action is futile. Those involved drift away.

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[7] As a teaching hospital, it is common that the resuscitations in the *resus* area draw a crowd of medical students and physicians as well as additional nurses and technicians. The educational component of what is going on in a *resus* and what needs to get done can vary from patient to patient. Additional people to do chest compressions are always helpful as the work is not at all easy and requires several people to switch on an off throughout any resuscitation.

The team – unscripted – worked together. There is a physician that leads the check and nurses that guide each other in checking medications, but the work of resuscitation on a code is a community of health professionals acting together. Each individual may occupy their own expertise as they work together, however they also occupy their professional healthcare role. The local moral worlds of professional groups come together with their own meaningful ways of dealing with the gravity of moral issues. The transgression of Lily asking additional people to leave was a break from the team. She broke convention and the way of creating care. The local moral world of the staff required participants actively involved in supporting the code and onlookers. For Lily the team of nurses need only consist of active participants working on the code. The physician who entered with his compression machine and experimental protocol for using it was a brief unaccepted lapse in the physician group attending to the code. The failure of the resuscitation continued as a point of reference and barometer for those who were part of the code. The professional and personal moral affinity for the work and loss continued as dialog between staff over the days and weeks that followed.

The local moral worlds and differences within the worlds as the various professional groups move together to produce work is an ongoing observation throughout this study. The critical encounter is set as an example: here the physician and nurse groups are visible, with specific tasks and interactions that are part of production care. The local moral worlds of each group have unwritten norms of action that are also visible in this code. The nurse works to produce care for the patient that includes the individual nurse role and the role as part of a team. The nurse also has moral positions or opinions as part of a larger group of those involved that includes observation of others within the nurse practice group. The

break and transgression from the norm was the nurse asking others not involved in the code to leave. Similarly, the physicians have set standards of directing care that may vary based on their local moral world and those involved. In the critical encounter that break was the attempted introduction of additional measures such as the auto compressor. The local moral world of the physicians include the moral position and interaction of directed care by the leader physician in the code as well as Attendings such as Dr. Johnson as specific measures of the resuscitation are followed by the team.

Emergency medicine remains unique in the manner in which it must continually provide care, without stopping, to all people, with no discrimination to race, class or ability to pay. The actions of those as healthcare workers who choose emergency medicine also choose, not to exclude, all are deserving. The groups that deal with the individuals have individual moral position, local moral worlds broken down by pedagogy and role and then unified work products as part of emergency medicine. The work is social in interaction but requires the individual to participate from an unstated and unwritten moral position with local moral worlds.

Observing Communication and Actions in the Production of Emergency Medicine

The critical encounter discussed is a specific illustration of the interactions of a team during a code. The interactions followed established protocols of chest compressions, intubation, ventilation and pharmaceutical support that are all part of the healthcare practices rooted in scientific pedagogy. That pedagogy encompasses multiple medical disciplines.

Each discipline has its own indoctrination, hierarchy and culture that come together as part of the distinct culture in emergency medicine. The hierarchical trainings of paramedics, nurses and physicians are bounded by specific roles based on education and training in the emergency department. As exhibited in the critical encounter, communication between all groups assembled is crucial. Communication in the emergency department has several forms. There is the constant din of instrumentation, computers and devices that monitored patients creating communication as an ongoing part of medicine. There are ongoing dialogs and verbal instructions, requests and interactions. There is also communication through specific instruments and objects and through gestures as part of everyday actions in the emergency room. While it was not immediately apparent to me as the ethnographer, the moral grounding and actions through care was not initially visible as part of the ongoing commotion and communication in the emergency department.

As I stood in the same spot, the day to day and moment to moment communications were easily tracked and followed and recorded in my notes as patients were treated and moved through critical emergency care medicine.[8] While I have an understanding of science and more broadly medicine, I do not have the specific pedagogy of a clinician. My point of entry for my field research was watching emergency medicine work initially on a research

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[8] Communication can have a range of meanings. In much of the literature regarding communication the preferred mode of breaking down and understanding interaction has been discourse analysis which is sometimes but not always distinguished as Conversation Analysis (CA) in sociolinguistics and discourse wherein CA extracts specific interactions in ongoing discourse (Wilce 2009, Hakimnia et al. 2014, Abrahamson and Rubin 2012). The most prominent work in CA that relates to specific work in medicine was investigations of tools and conversations in surgery where the analysis was used to show knowledge production in various roles (Goodwin 1995, 2007). In this ethnography, communication retains the broader capture to understand meaning in both words, action, interactions to better reveal the phenomenological nature of moral work in healthcare professionals in critical care emergency medicine.

project that required observation of ongoing work in the *resus*. However, as an anthropologist I observed communication and actions in the constant production of work to create patient care. The tracking and treatment of patients follows protocols and diagnostic norms set out in emergency rooms as patient intake, triage, stabilization, hospital admit or discharge. I observed the communication and production of medicine. As often reluctant healthcare consumers, this protocol is what we all would want and expect. However, through these protocols, diagnostics and a day-to-day routines, something less static pervades the conversations and interactions of healthcare workers I observed. As an ethnographer, I observe communications and interactions that include hostile reprimands of inappropriate behavior between different levels of nurses and physicians and other workers. While friction among workers is not constant, the foundation of actions that I observe is to find a way to get the care the provider feels, believes, knows is best for the patient. Any friction was a mere flare of perceived inappropriate care or processing patient care. Those flares of human interaction were characterized by scholars in the Manchester school of anthropology as part of behavior that can vary from situation to situation but may have common indications within groups (Gluckman 1971). In his writings, Gluckman is assessing the failure to make accurate modes of comparisons in observing the ordinary and the need to be aware of what was not routine. Similarly, what emerges from the day-to-day observations in this study is the profound interest and foundation of healthcare workers to "make better" for patients through their constant work and commitment to care. This mantra of "making it better" is a meme for the healthcare providers that as part of an anthropological inquiry brought clarity for how the actions, interactions and communication

of the workers were often personally rooted in the moral because of their constant interest and work in creating care.

Flexibility and patience are essential for any field researcher. What became crucial for me was to hold back my assumptions about communication and meaning and observe the social, not so much to count discrete observable facts, but instead to observe the ongoing human social productions that are part of the ongoing production of medicine. To observe the ongoing, I also keep in mind Gluckman's nod to what is not normal. It is then through ethnography and constant consideration of observations that make note of what is said and not said that such longer term observations are possible.

Medicine is communicated through objects as well as human interaction. The social can take various forms. While medical protocols and how orders are relayed to a computer are not thought of as social, as human beings carry out orders and interact with one another, computers, and the patient – the work, care and production of medicine manifests a social reality. Consequently, I observe both the standard modifications and personal changes to routine. These were not changes to medical practice, but individuals finding ways to promote a moral good and doing so by working within the confines of their profession. The changes or sometimes maneuvers to work around and through issues to create care or moral good are key to identifying the moral through visible actions and interactions.

These observations were made at my field site, a site that included a resuscitation (*resus*) area of emergency department as well as pre-hospital care in ambulance shifts throughout New York City and its' outer boroughs. Through the days and some nights, I had the honor and the privilege to observe the very meaningful points of care by healthcare workers who devote their days and nights to the well being of those in need of "better". For

those patients to get better, feel less pain, the healthcare providers attend to them within well-scripted protocols to treat the sick. Those protocols appear as expected training and methods of providing treatment – a ritual behavior for treatment or diagnosis and due to the nature of emergency work, from the perspective of the patient the ongoing productions of medicine often appears random and a pass of the patient from one medical expert to another. Each patient diagnosis may present a different picture to each medical specialist. It is the specific attention, specific human interest and action of those healthcare workers that I address in this ethnography. That human interest and the expression of care are both personal and professional. For the individual, the work reveals in many a personal orientation that is rooted in a moral sense of self that is administered through the work of stabilizing patients and getting them to the next point of care. It is in part an observation of reproducing care, but rather than the rote reproduction of care as part of education and work, this ethnography examines the moral position and how it is visible in the construction of care and its production through the individual healthcare providers.

The reproduction in work is part of education and medical practice, however the use of "norms" as part of community or enculturation of behavior is often discussed as part of cultural observation of discourse (Geertz 1973, Bourdieu 1995 [1977]). The issue with calling the personal position of healthcare workers as part of a cultural norm is that the individual moral position and expression of it is not always visible or necessarily part of an expressed norm of behavior.

Bourdieu specifically notes:

> "In a determinate social formation, the stabler the objective structures and the more fully they reproduce themselves in the agents' dispositions, the greater the extent of the field of doxa, of that which is taken for

> granted. When owing to the quasi-perfect fit between the objective structures and the internalized structures which results from the logic of simple reproduction, the established cosmological and political order is perceived not as arbitrary, i.e. as one possible order among others, but as self-evident and natural order which goes without saying and therefore goes unquestioned, the agent's aspirations have the same limits as the objective conditions of which they are the product." (165-167)

While others writing in moral anthropology push back against Bourdieu's theory of practice specifically because of limitations (Faubion 2012) that practice theory constricts actors to specific roles. Others, reimagine Bourdieu's inculcation as a method where pedagogy in medicine can be observed and understood but that the moral individual and way of knowing remain separated (Emmerich 2015). It is this observation of what is understood regarding pedagogy and professional action as separate that I seek visibility of moral action through care. It is this intersection of work as hierarchical knowledge, training and title and the care created that I observe the workarounds that are sometimes spoken or written ways of performing work. Other times actions that reveal moral actions of healthcare workers who must remain "separated" or "detached" from the patient. I return to the term workaround throughout this study not as an examination of when they occur or how they evolve but as a useful term that explains actions of the healthcare workers relative to a personal and professional moral expression of care. Similarly, the individuals that have greater autonomy in directing their work or how it should progress in determining care work *through* issues as part of creating care. From the direct experience of professional work, the conscious moral is visible. The narrative is central to phenomenological description linking the action with the human (Jackson 1996). That phenomenology allows me to examine the moral individual and their way of knowing that is evident in their work conduct.

These are healthcare workers who when working toward an unstated goal that involves patient care find ways to workaround or through issues that makes the co-productive work of ethics and personal moral judgment visible in their actions, interactions or words. In this ethnography, I discuss several professions in emergency medicine and consider what is rooted in the individual healthcare worker that makes visible their moral position. Considering the individual healthcare worker apart from a pedagogical role makes the individual moral positioning visible and part of a personal eudemonic[9] standpoint. The eudemonic is a moral good where the individual – here as caregiver is his or her best self in service as part of work providing care. Some describe the individual who works toward a moral good as separate from Kantian ethics but instead a theoretical position where the individual continually attempts to make the best life for those involved (Campbell and Christopher 1996). While Kant finds the eudemonists definitions of happiness and duty circular in the manner in which individuals act and create happiness out of duty (Kant 2009 [1797]), I believe that the definition is helpful to illustrate the professional imperative that is evident as care. The work is not about personal happiness but doing what is best for the patient, a patient often noted as *my* or *your* patient when discussed between various healthcare workers. The work in hospitals requires a routinization of acts that outside of attempts to cure or heal would seem violent or at least violative of the human body thus requiring an analytic understanding of the work or frame of mind. While delimiting emotions may prove useful to accomplish critical care, emotional understanding of the human condition remains critical to creating care. The acts however are part of a pragmatic

[9] Socrates theory of eudemonism was described by Plato in *The Republic* as happiness where man is his (or her) best self (Plato 2015).

to create healthcare. Those doing the work may openly reflect on what counts as normal such as using "restraints" instead of "tying down" the crazy lady or "sedate" instead of "drug" the confused patient are part of routinization that transforms normal (Chambliss 1996). The characterization of behavior and what is normal is part of clinical practice and communication of normalizing the patient condition and getting that patient to stability in critical medicine. The visibility of what is normal comes from the ways of doing healthcare work. The outside observer could just describe the ongoing process of medicine in what appears to be mechanized orders and responses of various healthcare workers. However, as this study engages that ongoing work and interactions, the ways of describing that behavior are in part of describing what is normalizing for the healthcare workers and their view as part of their codependent personal and moral and ethical world where as individuals who have a specific work role make visible their moral self as they work. Thus the strange transformation of medicine is done through a language of action to create care.

Co-constructing Ethics and Morality in Anthropology and Emergency Medicine

Moral Anthropology has varied representations and ways to make visible the ethics and phenomenology or human moral behavior. These representations include the work of scholars who describe moral anthropology as 'moral making of the world' (Fassin 2012). Fassin, however cautions that most who study moral anthropology do not view their study as the study of moral anthropology but investigate moral questions emanating from a specific domain of interest (2012: 4). Fassin's distinction is important to this study because it

expands how moral situations or interactions are visible and accepts within such a definition how the use of tools, such as ethnography, are useful to reveal and expose human moral position in activities and interactions.

To discuss the visibility of moral actions through activities and interaction in work, understanding the day-to-day process is important. In critical care emergency medicine, there is a process and protocols that are part of the constant attempt to apply best practices to stabilize humans who are in pain or failing to thrive. It is at that point of physical pain, breakage or failure to thrive physically that various teams of medical professionals attend to patients using various diagnostic procedures and criteria to rank the physical condition of patients in order to provide information on the priority of treatment. In that prioritization, the most critically ill are sent to the resuscitation or *resus* area of the emergency department. The healthcare professionals responding to patients in the *resus* are required to respond by stabilizing the patient for, most often, more specialized medical care elsewhere in the hospital. The interaction between the healthcare worker and the patient is one where information about a patient, their circumstances that brought them to a critical area of the emergency department visit can come from bystanders, the patient, family members, an ongoing patient medical record or a combination of these well intended helpers. Those stories or sometimes the response and condition of the body become the beginning of a communication between the patient and the healthcare worker and the healthcare workers with one another to initiate medical treatment. The broad differential diagnosis to determine long-term goals of specific disease issues is not the ultimate goal in emergency medicine as patients are stabilized. Emergency medicine has its own differential diagnosis for emergency management of cases. The cases are the individuals in some aspect of health

crises. I mention this to briefly note that there are patterns and repetitions to the types of cases discussed and worked through in the emergency department. I want to avoid reductionism as I go forward with the varied cases and analysis to note that it is the specific interactions and long-term observations that allow for the assimilated evaluation of the medical endeavors mapped out and observed in this study. Thus the whole person, part of the whole group and working within the larger frame of emergency medicine is part of the phenomenology of moral agency.

One of the first themes that appears in discussions of moral agency of healthcare workers returns the discussion to bioethics and a principled understanding of interaction and treatment of patients. The anthropological approach to bioethics is described in the literature as an approach that examines the everyday interaction of the healthcare workers involved in delivering care (Kleinman 1995).[10] While Kleinman makes this distinction to bioethics, I mention it here for two reasons. First it is important to distinguish the clinical bioethicist and roles played in a hospital setting that Kleinman also notes in distinguishing the bioethical as codified norms (Kleinman 1995). Second, the local moral worlds (1995: 45-46) and position of healthcare workers is not without overlap in 'principled' bioethics and integration in how healthcare workers in the clinical setting express or define a personal or professional position. The tricky issue is the middle spaces where issues that are not implicitly defined as ethics reveal the individual moral position of the healthcare worker.

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[10] Kleinman in a discussion of Anthropology of Bioethics emphasizes the distinction of anthropology raising questions that emerge from "grounded experiences of sick persons, families, and healers in concrete contexts." Kleinman goes on to distinguish ethical discourse "as codified by abstract knowledge held by experts about "the good" and ways to realize it" and he explains moral as part of social commitments of individuals as they participate (Kleinman 1995).

This distinction is important for this study as the local moral worlds of individual healthcare workers I observed sometimes reference "ethics" and discuss what is right or wrong in a treatment situation use principled terms now codified as part of medical practice. The principled terms are helpful in that they provide a language and thus way to communicate what is distressing for the patient. However, those principled terms are not always used to declare internalized moral position as situations and interactions develop. What should be clear is that the constant nature of critical care in emergency medicine does not lend itself to principled reflection and thus the local moral worlds and moral position of the individuals working to effect care are exposed and a continuous part of care. The exposure to some of those moral actions are clear in this study by the healthcare workers working *through* and *around* as part of a constant process to create care. The clarity of these observations comes only through the lens of a study that in a holistic way does not parse out the various groups represented in creating care but studies and observes them collectively over time. Thus, the collective actions and reactions of all of the well scripted parts creating medicine may reveal just the practice. Yet, through detailed observation of daily interaction of the entire organism of emergency medicine the phenomenological moral world is discerned as part of a common language of care.

Anthropologists and other social scientists have had a long-standing interest in ethical or moral behavior. The use of bioethical terms and the place "bioethics" has taken in medical practice are part of a study of social construction in medicine (Fox and DeVries 1998). As such, bioethics has become part of a larger corporate fiber that often has institutional use but cannot be used to define the personal and profession as individuals rapidly work in critical care emergency medicine. In this study, the observations and use of

bioethical terms are often seen as tools or words to validate practices that may be personally or professionally felt and acted on in specific situations.

The use of principled bioethics may be part awareness, part language. What I want to redirect here is the pedagogy of bioethics as an instructional tool and the use of bioethics by any hospital, or corporate use of bioethics as part of the discipline as a tool of power. The premise of principled bioethics is moral action. Thus, principled bioethics exists as part corporate entity and part conscious understanding. Consequently, in this study, I push back against a theoretical moral space constructed by society or moral facts and the judgment of moral action as part of conscious understanding and action. This analysis instead explores moral self-making and choice as part of everyday life (Throop 2012, Das 2012, Mattingly 1998). Through observation of the ongoing social interactions the production of medicine as stabilizing bodies reveals the constant work and goal of moral care.

If we consider the moral space based on profession such as a paramedic, a nurse, physician or nursing assistant we can begin to understand the differences in interaction, understanding and response to each other and the medically emergent situation. In unpacking those interactions, rules are not enough to understand the moral space healthcare workers occupy (Mattingly 2013, Laidlaw 2002). The situations and interactions are both professional and based on trained knowledge, but many of the patient interactions or conversations regarding patients are also social. There are several threads of reasoning to consider when reviewing the literature on social interaction and moral position of the healthcare worker.

Fassin points out how the ongoing debate regarding universalism and relativism in cultural assessments are made and that cultural evaluation of issues with morally weighted

actions are most often analyzed from a relativistic point of view (Fassin 2012). He makes the point in his analysis of moral anthropology as subject matter is universalistic. In doing so he notes Kant's approach as 'human'. However he pushes back on the philosophy of Kant to underscore Durkheim's descriptive approach noting "moral facts" are phenomenon like any other (Karsenti 2012). Fassin in discussing universalism in moral anthropology then introduces Weber's "binding norms", which cannot be subjective but are "facts". In doing so, Fassin is able to unfetter the troublesome arguments of moral anthropology as relativistic assessment. In this way, the flipping being between codified norms and small changes is the window to the changes and point of observation. If considering a universalistic perspective in healthcare production – in this case critical healthcare, are actions taken and developed because of codified norms, or is there something else that guides the reason, discussion, or sometimes unexplained actions? That transition is not one where the individual is constantly moving between codified norms as noted by Kleinman in defining bioethics, but the healthcare workers are functioning within the local moral world of their particular clinical setting as healthcare workers within their professional roles as they administer care in the emergency medical setting. The important point in this evaluation and in my argument is that cultural norms of power may differ within each of the various groups of healthcare providers in the emergency department. Each groups occupies their own professional role in care. The structure in which care is produced, the hospital or in this case the emergency department can also be part of reinforcing norms in behavior. That care is for each professional agency that can embody norms of conduct and what is consider correct or moral behavior.

An example from the beginning of my observations where the social interaction of the healthcare workers became part of their awareness of me and my assumed role changed the way some of the staff behaved. Almost six weeks into my daily observations in the *resus*, I had gotten to know some of the nurses who were constantly rotating through various parts of the emergency department. Most days I stood in the same spot, taking notes. One nurse pointedly asked me what my research was and why I was there every day. Another, and most likely many others, made their own assessments and evaluations as to why I, unlike other 'uniformed' student researchers stood and took notes every day. One morning, one of the informed nurses who had asked me directly what I was researching, decided to play a joke on her colleague when her colleague complained to her about having to wash her hands so many times now that I was "counting". The nurse who made her assumptions believed I was part of quality control assessing protocol violations of patient care and counting hand washing. The joke went on for a day as the one nurse goaded the other in hand-washing. She then joked with me about the gold stars I would hand out. The joke was up and everyone laughed and then the prank continued to be part of ongoing conversations about me and my research. The point here was multifold in my acceptance into my field site, but also made me recognize some of the assumptions that the healthcare workers made and believed. The nurses were accustomed to an institution that monitored them and as a group put together their own ways of dealing with their assumptions. Some asked direct questions and others did not. Handwashing may be an example of protocol, however it is also a moral act in any function of hospital patient care so that germs are not transmitted from one patient to another. While a small moral duty, it was symptomatic of other

observations where there were norms of conduct in the hospital that are visible expressions of moral conduct for all three groups observed.

Hand washing became moral behavior. The observer and interaction were social, but it was the individual and her perception of "correct" behavior (continued hand washing) that persisted. The implication of individual and collective action as part of norms is a focus that deserves fuller explanation. To examine this, I discuss Durkheim and a positivist inclination in his writing on morals. I also examine how morals and agency of healthcare workers is put in conflict with understanding morals and groups as I define how this study examines and answers how group norms and personal norms overlap and are sometimes personal and distinct and other times in conflict.

In *The Determination of Moral Facts* Durkheim describes the simultaneous duty and obligation for individuals to act morally (Durkheim 1993 [1887]). Durkheim's interest in morality was ultimately to make guilds or groups responsible for creating collective social structures with specific norms.[11] These positivist inclinations however visible today in organized religion or behavior in following a corporate edict or guidance, however, as part of representing individual values within this study, it is just as important to locate situations that are without collective cohesion premised on moral action. The assumption then is that the right action would not occur without the collective. While the collective may provide laws, it is important to still examine the healthcare workers and individual actions that

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[11] Durkheim wrote this in specific contrast to Kant's moral law as an exercise of free will. Durkheim found the socialization to groups to reinforce the norms. The historical perspective of the time that Durkheim was attempting these pronouncements, so too were others, and Durkheim separated himself from philosophers as he believed as a sociologist that the moral too could be understood as facts (Durkheim 1993 [1887]).

cannot be reduced to quantifiable tasks or actions. Durkheim is mentioned in this context to not only examine in contrast with Kant, but also because the positivist nature of his claims is central to what most consider "good science".[12] In medicine, "good science" is the measure of what I most often observed as an art of healing, or in the case of critical care emergency medicine, stabilizing the patient for the next specialist.

The moral norms of groups are often expressed in anthropology as discourse where local worlds are cultural processes (Kleinman 1995, Shweder 1991). The idea often advanced in anthropology is that ethics is a type of codified knowledge and the moral is the local world for the individual (1995:45). In this research, I examine the local worlds within the situations that arise of the broader hospital system. Other anthropologists redirect the argument noting that the "Durkheimian legacy" is reductionist in the analysis of social action (Mattingly 2013), turning instead to virtue ethics and phenomenology (Mattingly 2010, 1998). In turning to virtue ethics, Mattingly explores and uses Aristotle's Nicomachean ethics as a way to understand how people in their lives work toward good (Mattingly 2013). In working toward that good, this study exposes examples of social language and action toward moral that exists as a constant text of action. Just as relevant a lens is that of Zigon considering moral breakdowns where he considers the unreflective state of moral being where an individual must find ways to act to achieve moral (Zigon 2007a). In these ways the internal phenomenological pursuit is ongoing and visible as part of human

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[12] Heidegger becomes an important touchstone here when I consider how moral behavior is evident in the day to day critical care. He reminds of the individual's inability to escape the past or the future but part of a constant moral evaluation (Heidegger 2010 [1953]).

interaction and experience. These experiences remain visible as part of the interactions of individuals viewed in groups that are part of the collective whole in emergency medicine.

To examine the various meanings and moral agency of healthcare workers in the emergency department as they treat patients, I use several positions both theoretical and descriptive from the literature. Examination of healthcare worker interactions also requires an understanding of the premise that healthcare in the United States in grounded in ethical principles. Emergency medicine is a unique part of that moral grounding because it does not discriminate based on insurance or ability to pay. That healthcare in the United States that has accepted and raised norms and conditions of bioethics as part of care reveals some of the dilemmas and points of dissent evident in healthcare delivery that follows through a system predicated on human interaction at every medical decision.[13] Consequently, I include in this section a brief review of the bioethical norms or "principles" often invoked or identified in patient care. While part of assumed patient care these principled norms cannot be analyzed in every situation as the conditions of unscripted care do not allow for ongoing reflection of principled norms. The norms for patient treatment however persist and can be considered or analyzed by healthcare practitioners and others who may later review a patient record.[14] The

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[13] Ezekiel Emanuel raises the issue of medical ethics presuming medical dilemmas are part of technological advancement but argues that the ethical dilemmas exist because of liberal political philosophy that informs decision making in medical ethics (Emanuel 1991).

[14] Beauchamp and Childress define what is now often referred to in conversation regarding ethical discourse as "principled" ethics in their seminal work Principles of Biomedical Ethics which explain and define the four major terms that came out of the Belmont Report. While the Belmont Report was specific to guide principles in treatment of human research subjects, the principles of autonomy, justice, beneficence and non-maleficence are now part of medical training wherein patient "rights" are also part of the agreement, interaction and discourse as a patient enters into treatment. These "rights" included autonomous decision making, as well as respect and standards for informed

assigned norms and how medicine is practiced using definitions or principles to guide or explain medical practice is viewed in this study, not as an ought or guiding norm[15], but as a varied piece within the healthcare worker interaction with patients.

Patients entering the hospital, do so with a narrative, stories, and sometimes just as a body with vital information. Regardless, the patient enters the hospital with assumed rights. Those rights are often considered "principled" norms of care; autonomy, non-maleficence, beneficence, justice. While each of these are considered norms of patient care, they are also in some ways codified in the United States under patient rights and protections. These norms and potential rights or codes frame the ontological and describe moral position and definitions of moral and personal position in medical practice of assumed action on or to the patient. As the overall interest is to examine the interactions of individuals within groups and local moral worlds, a principled counting of actions would be overly reductionist and miss the point.

The facet of bioethical discourse as both descriptor and interpretation of behavior is one way to examine the multiple frames in observing critical care communication and interactions.[16] Those frames and viewpoint of the healthcare worker then become part of the

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treatment. Appendix II is an example of a patient Bill of Rights that must be posted within a hospital (NYSDOH 2015(rev)).

[15] Ought and moral claims have a well debated past in philosophy that I will briefly address to note Hume's position elaborating that moral conclusions cannot by made from premises where moral words are absent. This is often shortened to NOFI 'No Ought From Is'. The simplest reduction of NOFI for the purpose of this study observes the constant interaction of individuals involved in vital health decisions, putting their position as healthcare workers at an implied moral point of action (Hume 1993 [1896]).

[16] While Goffman provides clear social performance frames where moral action can be identified in various frames of interaction. I believe it is equally important to draw from Garfinkel to clearly note

patient situation and process of creating healthcare. However, the assumption that the constant frame of conduct for healthcare workers is through principled bioethical norms seems unrealistic. This does not equate to an unethical frame, but a frame that is instead personal and acted out as part of a personal capacity in creating care. The moral lens then is not created or viewed by the ethnographer through a constant checklist of principled norms but it is an unreflective part of the constant lens for individuals – healthcare workers – creating care. The visibility of moral acts then is part of observing the local moral worlds of the healthcare professionals as they produce care. Potentially then moral agency is visible in the local moral worlds and practice of medicine. Consequently, how individuals act within the confines of their job in healthcare becomes a significant part of this analysis. It is the noumenal aspect of the care provider, unstated and undeclared by the healthcare worker that constantly aligns care with moral actions.

The definitions of what is moral and what can be called moral anthropology are part of an ongoing evolution in the field of anthropology wherein the gaze turns to human rights and universal principles of rights and wrongs. As discussed, the work in this ethnographic work does not use the principlism of bioethics, although I include examples where

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the basis of immersion and interaction. Garfinkel notes the need for complete immersion in a system to understand the daily production of work.

In this work (1967:33-36), Garfinkel references Kant's moral order as a means for normal ordering of everyday life. In so doing Garfinkel reveals in part his interest to get beyond the transcendental moral order to look at interaction in moral order. I find this particularly relevant here because Garfinkel is clear to note the interest in how social structure is maintained through interactions. It is however my interest to examine the internal structure that is perhaps inverted here as the social structure and communication causes the moral order, personal and professional to become visible (Goffman 1967, Garfinkel 1967).

healthcare workers discuss bioethics or use principlism to describe why they have a conflict. This study examines instead the universal norm of healthcare workers creating care as a moral norm. Moral or ethical intention is universal, often culturally bound (Shweder 1991) and visible in human conduct when that individual healthcare workers work to make better as part of their profession. The personal universal ethic and intent in emergency medical care is the healthcare worker who works *around* and *through* the structural and pedagogical confines of their title and role to create care. This study examines how the various practice groups of paramedics, nurses and physicians work within personal and professional confines to create care.

The definitions of the moral experience and interaction are not necessarily quantifiable. In the literature of moral anthropology, the studies do not always rely on specific definitions to examine what or how an individual reveals a moral position through work. In this ethnography the word moral and ethical are easily interchanged to describe or identify intent, understanding, motivation and often action of a healthcare worker. The broader descriptions of ethics and moral visibility in this ethnography are based on the observations of interactions and not definitions based on moral philosophy. However definitions are important in understanding how actions or moral visibility is evident or can be described. A specific definition of moral noted in the Oxford English Dictionary places the origin of the word *morality* with Cicero pertaining to the character of the individual as good or bad, virtuous or vicious (OED 1961[1933]). However, Cicero's is a translation from *ethikos* from Greek into Latin as *moralis,* both terms that have often remained synonymous. The original meaning of *ethikos* or ethics was related to codes or how humans ought to act, what was proper. The distinction in this study is domains of knowledge that

performs duties to create care and not the constant reference to capture ethical codes. The codes that constitute bioethics and guide on moral and the words and codes used to capture or create guides for right are an important distinction because while healthcare workers may know or have reference to codes, it is the often more subtle actions and conversations that reveal actions and are most important to my observations and this writing. Consequently, the observations and often corrections made by emergency medicine healthcare workers I observe, are not based on a bioethical codes that could be outlined but instantaneous responses and corrections to perceived necessary actions or interventions. This means that while there is an ongoing systematic means for treating and caring, rarely are overt references made to code or "ethics" as healthcare workers continually work to do what they perceived as "best". Thus, while definitions and codes may be helpful in identifying or describing transgressions or violations of duties, this ethnography examines the personal expression of moral action through specific interactions and sometimes stated speeches. These are the unwritten codes where healthcare providers place both professional moral norms and personal norms as part of their work.

The anthropology of work and moral interactions that make visible moral, ethical or personal position of healthcare workers encompasses not just a description of healthcare worker action but also a reliance on the premise that the interactions and practices to produce medicine require the healthcare workers to have moral and ethical standards that continually guide or direct the work of medicine. The defined terms of right and wrong and the deliberations regarding what *ought* to be done and what *is* done in medicine are part of well established discussions in bioethics that define and describe the difficult decisions in medicine. While the definitions and political changes that move the definitions of bioethics

could describe individual events as political, the point in this ethnography is instead to observe the expression of moral agency of the healthcare workers.[17] As noted in defining moral and ethical, healthcare workers do not necessarily hold or define terms that lead to actions based on acute descriptions. Instead, the everyday practices of healthcare fall short of proscribed normative principles. Yet, the work in producing care continues as moral acts. Didier Fassin describes the need to return to Durkheimian notions of moral facts that can be observed as objects but then he turns towards Max Weber and emphasizes that any such fact observed is a value judgment and explicitly subjective (2012: 8-9). Putting Durkheim in conversation with Weber in this manner as Fassin does is important in this study because where Durkheim allows for observation of moral actions as discrete observable facts, Weber's insistence on subjectivity in any value judgment (Weber 2011 [1949]) balances the essential human component that is part of medicine and care provision as patients are moved through the emergency medical system I describe in this study.

As with other observations as an outsider, any individual and interaction observed has its own unique and complicated perspective. The actions of care that represent moral behavior may be part of a job description but also may be part of personally held values that represent the individual acting to create care. Those values that illuminate the moral self while always part of humanity are not always visible and may not seem evident. The everyday practice of medicine can fall short of normative principles (Marshall and Koenig 2004), which medicine as a discipline often defines through bioethical definitions and

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[17] The politization of bioethics may assert other pressures within the work product of medicine. Elsewhere politics with a large P was described as the Aristotelian pursuit of the "good life" and politics with a small p associated with the Machiavellian pursuit of self-interest (Pellegrino 2006).

pedagogy. That structure of pedagogical bioethics, may guide or inform, but it cannot define the human doing the work of care. This observation of the constant and ongoing collaborations in emergency medicine requires a recognition that moral actions is visible through description of interactions and dialogue as well as conversations. These observations also require the acknowledgment that normative principles do not need to apply to make visible what is a moral action but in the case of emergency medicine takes on the terms of stabilization or treatment.

Everyday, emergency medical services from pre-hospital care workers such as paramedics to nurses and doctors in the United States, take care of patients who are brought in to emergency departments of hospitals in need of urgent medical treatment. As the patient is attended to, cared for and processed through stages of care in emergency medicine, various medical professionals treat the patient. Each medical professional has his own set of training and skills that is offered to patients as part of medical practice. Each medical professional has his own motivations, skills and personal and professional experience that move him to care for patients – often in rapid succession. The motivation, care and the visibility of the moral human healthcare worker is illuminated as the workers cope with a medical system changing to accommodate business models in medicine and healthcare that must navigate finances and competition to meet the needs of the communities where they reside. These individuals constantly navigate the confines of individual professional practice and policy to express individual ethics or purpose in helping patients. I discuss these navigation practices as working *around* and *through* their professional roles in emergency medical practice as these professionals work to get patients safely to the next point of patient care.

The role of these healthcare workers and the service they provide is especially crucial in urban settings where the emergency medical service of a hospital is often times the only option for people without standard or routine medical care. Most healthcare workers are aware that they could work in locations that are not as demanding as an urban emergency department that straddles both the urban poor and elite, but for almost all of the workers I came to know, they preferred their location. Some had worked in posh upscale hospitals and sought out places like Urban Emergency Department where they felt more connected and that they could make a difference. In one study of nursing care that included various hospitals around the country, the researcher makes the point that specific ethical deliberations are a point of privilege and not necessarily allowed to all healthcare workers, specifically nurses, but are part of an institutional discourse of more powerful healthcare workers within the hospital corporation (Chambliss 1996). While Chambliss's work did not focus on emergency medicine or a single institution, he focuses on the interactions of nurses and their position of caring noting the mantra of "we [nurses] care, doctors cure" (1996: 79). Chambliss notes that the flaw in hospital ethics as committee and education is that the committees do not include the day to day operational issues that nurses face with their patients as they continually care and work as part of the bureaucratic machinery of the hospital. This study at a fast paced urban emergency department that is part of a large teaching hospital allows for that unique recognition of ethical best care. That concern to ethics and the care of healthcare workers is where this study relocates the care and moral visibility of those who silently workaround and through issues to assert their ethical position to help patients.

The emergency healthcare workers I observe throughout my fieldwork have many names for their type of work often calling themselves adrenalin junkies or drive through workers. While each of these groups of healthcare workers — the paramedics, nurses and physicians have collective professional identities, they also have their own experiences and motivations that they bring to their work. It is with the individual as part of a collective that I converse and examine how the individuals and groups of professionals as healthcare workers express themselves as moral agents. It is with and through their personal position and their work that constantly binds and re-centers them as healthcare workers that I examine their most intimate interactions and personal moments as they work to stabilize, sometimes save, and sometimes lose "their" patients.

Working Around and Through Emergency Medicine Interactions

Through codes and regulations, institutions in the United States and the medical systems treating patients have acknowledged – at least in part – some human rights regarding healthcare and access to it. In medicine, access to emergency care and the ability to fulfill the need to urgently repair bodies that are damaged or failing stems from a human norm or moral imperative to preserve human life. On a larger scale, this preservation of life as *healthcare* in the United States is a commodity bought and sold to the patient. In this context of care, the emergency department is different because care is provided regardless of ability to pay. Access to emergency medicine which is rooted in the historical foundation of medicine should be provided with the same integrity to all in need and that access is part of

a rich history of social justice and access to care.[18] The bases of emergency medical care are rooted in moral imperatives that span pedagogical roots in medical history and the training of physicians, contemporary bioethics, and justice wherein there are duties in medicine are for those trained in the art to serve those in imminent need.[19] However, medical equality is not reproduced throughout the medical institution. While the emergency department may treat all patients with the same level of care and sort them accordingly, once a patient is stabilized, the ongoing decisions regarding care for the adult population are based on insurance and ability to pay for specialized care.

The physicians in emergency medicine are keenly aware that specialists who come down to assess patients and consult on the specialized medical issues do not hold the emergency medicine physicians in as high a regard as their fellow specialists. One emergency department director characterized the friction between the emergency department and attempts to admit patients with the various specialties as "the upstairs downstairs thing". However, emergency medicine is a specialty where residents train to be able to stabilize and attempt to diagnose all manner of unknown illness. One still vivid example was a discussion between two residents regarding their wait for an ophthalmologist to come down

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[18] According to John Bell, the moral-religious principles applied in generation of the medical code of ethics was that "every duty or obligation implies, both in equity and for it successful discharge, a corresponding right". This principle of reciprocity set up much of the foundation of trust and reciprocity in medical care in the United Sates wherein the public has an expectation of care. (Bell 1999 [1847])

[19] The rich history of ethical care and moral behavior in medicine can be traced to various oaths such as the Hippocratic Oath that focuses on responsibilities of the physician toward the profession and the patient, then later professional oaths were developed that were virtue based focusing attention on physician virtue, wherein some note that the culmination in the American Medical Association (AMA) code of ethics of 1847 was largely based on Percival's teachings moving toward professional ethics (Baker et al. 1999).

and treat a patient suffering from a gouged eye-socket. The residents decided to keep all of the blood filled gauze and linens because they were frustrated with the ophthalmologists passive attitude of what they considered an urgent situation and that the ophthalmologist would consider normal levels of bleeding and not imparting urgency on the issue. The issue for the emergency medicine doctors seemed however to be greater than the patient blood and urgency, for them it was more a lack of response and respect in answering their professional request.

Often emergency medicine physicians take additional specializations and board certification as part of ongoing training. Even though emergency medicine is a newer board certification as sub-specialty,[20] emergency medicine physicians as reported in a recent national survey are now a middle-paying specialty with pediatrics being the lowest paying and orthopedic specialists the highest.[21] The medical institutions are not immune to the costs generated by specialists and the need to attract highly regarded specialists is part of the consumer based healthcare that funds the hospitals. In the emergency department, the varied specialists made their importance known and were often conspicuously visible when they would come into the emergency department in large posses to visit and consult on patients.

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[20] In 1979 the American Board of Medical Specialties recognized Emergency Medicine as a medical specialty even though specific residency programs in emergency medicine existed before the formal recognition. The formal recognition and the specialization is an important distinction for emergency medicine physicians as their role and the work they provide is often a point of contention with the specialist groups that 'take-over' patients from the emergency department once patients are stabilized and sent to other parts of the hospital (EMRA 2005).

[21] Emergency Medicine Physicians as reported by survey data collected as the Medscape Physician Compensation Report 2016 of over 19,000 physicians in 26 specialties. The self reporting of these physicians at an average $322,000 (Medscape 2016).

The brief initial description of *a critical encounter* is an examination of the varied interactions at the hospital as an institution that illustrates the social and cultural issues present in the emergency department. The perceived professional worth of certain specialists and the emergency medicine workers whose constant labor was to stabilize and move patients in the emergency department to other floors in the hospital. The interactions reveal not just work within the hospital but exposes the greater disregard for the patients that need care by specialists while they wait in the emergency department. Those producing care at the emergency level constantly work within a space that embraces equality and an ethics that emphasizes human moral worth. However, the actual institution of medicine and the cultural construct of healthcare in the United States, I contend, does moral violence to the less fortunate and disenfranchised as they are processed through a system to a point. The limit of care is access to other areas of specialized care. The stabilized patient is returned home, not necessarily able to access further specialized interventions. Thus, access to further care in the form of specialized medicine is unequal. The disparity in care and the knowledge of the unequal access has collateral effects on those working in emergency medicine.[22] The access to care and how patients are moved through the system by

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[22] Moral distress is discussed in the literature for nurses and physicians. In nursing the potential and awareness of moral distress is well established as part of acute care nursing where moral distress is described as frustration, depression and anxiety when nurses feel they can not get the appropriate action for a patient (Corley et al. 2005). Surveys of nurses giving reasons for leaving an emergency medical position due to moral distress point to nurse discomfort with orders to sustain treatment, distress in working with less competent individuals and maintaining treatment that contravenes the wishes of the patient or patient's family (Fernandez-Parsons, Rodriguez, and Goyal 2013). The issues are raised as a point of discussion in both nursing education and practice. The collateral effect for many individuals in nursing are the inevitable shift and change in jobs as well as personal emotional toll. In further consideration of the overall hazard of moral distress and interaction among nurses and physicians, a *Crescendo Effect* is described regarding the collateral and continued effects

emergency medicine healthcare workers over time made visible care actions that in some cases clearly changed patient health for *better*. The small actions and work of those individuals are small pieces of moral visibility in care.

Moral agency and interactions of healthcare workers can be examined moral attitudes from several different healthcare reference points. As previously noted, the nurses occupy the largest number of employees in the emergency department. They are tasked with caring for patients and following on orders from residents and Attendings and other healthcare workers involved in the medical plan of the patient. The nursing staff follows orders and creates change to stabilize patients often under difficult circumstances. In doing so, nurses often find ways to fix or change a situation or work*around* to help patients. Nurses however cannot contradict or create medical treatment without raising the issue to the physician in charge. Consequently I discuss how the work produced includes the introduction of machines or individuals that support the nurse and advance a specific medical action or intervention.

Nurses and physicians are required to document all work produced and patient interactions in the course of care. The documentation that is now electronic and includes time stamps and limits to patient record access serve as a useful check and in some cases safety for those following orders. However, when orders are followed and the nurse or other individual causes harm, the nurse then bears the full repercussions and disciplinary actions of inappropriate care. While the workaround is not the single focus of this study, it is a

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of moral distress in critical care units. The effect was first studied in the NICU and has been used to address the need to address moral distress within departments (Epstein and Hamric 2009).

useful point of discussion when describing the moral and ethical expression of healthcare workers as they assert their role in the production of safe patient care.[23]

Another component of emergency care that makes visible the personal moral position of healthcare workers are the narratives of emergency medical service personnel. The pre-hospital care teams (paramedics) are sometimes a transport role, but they often provide life sustaining services under difficult circumstances. The varied roles and assignments of these workers are points of interactions where I observe the decision making process and how they interact and care for the individuals they are called to help. The paramedics have a certain amount of autonomy when making decisions at the point of care outside the hospital. Examples of that autonomy includes how to upgrade a patient that paramedics believe is in need of critical attention and making recommendations to the patients they transport as to where the best hospital is for the specific problem. The paramedics I spent time with were constantly working *through* situations to get their patients to the next best point of care. These individuals made clear their work and intention through ongoing personal narratives that lay bare the personal moral investment of the healthcare worker in their work of getting the patient to a better more stable situation.

Finally, the interactions of residents, Attendings and other physicians in the emergency department illustrate a narrative with variation in the interactions with patients

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[23] At a conference hosted by the Hastings Center titled: *Bioethics Meets Moral Psychology*: May 19, 2016, (Open Society Foundations), Peter Ubel noted in his talk that in conversations with engineers, if they have questions on how to re-engineer a medical device or change a process, they go to the nurses using the product because they have ways of working around most problems with products. Workarounds are how we re-engineer, but as a group working without input into design and change, I observed nurses attempting to push back against changes and feeling they did not have a voice to create change but knew the necessary changes that should be made.

and each other as professionals. The physician narrative was one where there is ongoing dialog about patient treatment needs, treatment options and where the patient needs to go nest. The goal of treatment in *resus* is to stabilize the patient and move them to the next place. Consequently the physicians I observed in the *resus* were very much aware of the need to keep patients moving and stabilize them as quickly as possible to get the patient to the next point of care. As illustrated in the case of Mr. Sampson earlier in this chapter, patient status can change dramatically and quickly. Accordingly, the narrative of interactions of physicians in *resus* reveal the personal and consequently moral worlds they inhabit as they attempt to create and secure health and stability for patients as part of their work. Moral agency is visible in not just a decision making capacity of physicians. It is visible in the personal values and commitment I witnessed as physicians worked through situations to get patients to something better, more stable, less pain. Contemporary and ancient literature describing the necessary qualities of and character of emergency medicine personnel point to need for innate virtue and courage (Pellegrino 2006, Tauber 2008, Larkin et al. 2009). The point being made is that trust of the public and honor of the profession, a profession where the people who seek emergency care are at their most vulnerable depend on those from whom they receive care to manifest these character attributes.

To investigate these spaces created and used by nurses and physicians and in the case of emergency medical services (EMS), the quasi-clinicians in medical care, I position critical clinical care in an ethical and legal framework that binds or requires specific conduct based on a rich history of expected medical conduct that is bounded by hospital bureaucracy. Within this expectation of conduct is the moral individual who is bound by ethical codes in medicine, personal belief and the socio-political construct of healthcare that is a business

with a separate legal framework. Within such conformity the manufacture of work *arounds* and work *through* occur as constructs I observe so that the healthcare workers accomplish care and thus make visible their moral agency. In the case of nurses, the historical advancement of nurses has been one of increased responsibility and decision making due in part to greater medical knowledge and technological advancement and should not be considered a closed evolution (Freidson 1988). Nursing as a practice continues to expand in training and certifications. Consequently, greater responsibility without the autonomy of action creates problems especially when nurses as a working group are part of a union.[24] While the nurses union claims to protect and allow independence of its workers, hospital management controls the union work through specific agreements and protocols which often leave healthcare workers exposed and not necessarily protected by the union in cases of emergency room overcrowding and patient management. Accordingly, these observations are part of the fluctuations that are dealt with as the individuals work and adapt to their changing environment. With the residents, the healthcare workers are physicians that are finishing a specific training in emergency medicine. The role is as a physician, but not completely independent as a professional. The role of physician and personal growth of the individual remain in a learning mode. While some studies describe changes and even decreases in moral judgment through medical school, it is assumed that moral character of physicians is reified through advanced training (Hegazi and Wilson 2013). In the

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[24] The nurses union in New York is the New York State Nurses Association (NYSNA). The NYSNA self site as the largest professional association for registered nurses. The 1199SEIU is the largest union in the country with over 400,000 members and includes nurses, techs (nurse aids), pharmacists social workers, housekeepers. The 1199 is considered a powerful union, but as more than one nurse explained to me – "it is all very blue collar".

interactions and medical production of care, I consistently witness the physicians working *through* – not to get through personally, but to get the patient to a better condition, better level of care. The constructs were not simply the mechanical work or practicing medicine. Over time, I observed shared understandings that allowed for coproduction of care.

Another facet of patient care requires physicians, nurses, and others to adapt to the corporate changes and demands of a hospital that houses the emergency department. The public as patient engages with the emergency department as part of a cultural expectation and trust that those with the knowledge can and will alleviate the disease or malfunction in the body. The relationship is with the immediacy of healthcare, however the structural parameters of the hospital and business of medicine cannot be ignored. Consequently, as I discuss the various interactions I also examine the relationship between constructed and ongoing relationships of disease (nature) and institutions (Hahn and Kleinman 1983) and the expected interactions between the individual bearing the disease or illness and those treating disease. I examine this relation in incidents when patients demand specific drugs and demean or criticize work of healthcare workers using hospital metrics or healthcare mandates in treatment procedures. The ethnographic descriptions and detail that follow in this study illuminate some of the difficulty healthcare professionals can have in attempting to get patients to better. The conflict and structural issues in creating care in medicine has been illustrated in various ways. In a paper describing the ongoing conflicts between commerce and medicine, the issues of the historical role of medicine are separated from healthcare as a commodity and financial institution with links to industry (Dolgin 2006). However that continuum no longer separates medicine from finances because healthcare is now a commodity. The historical separation between care and payment shifted. The issues

regarding work and care of patient are relevant because they also illustrate hospital structure and the corporate issues that can bind the work process which can distress healthcare workers as they attempt to help patients. For each of the groups (prehospital, nurses and physicians) I present a continuum in the chapters that provide detail to the healthcare workers working through and round issues. In doing so, I attempt to examine and show or make visible that pre-theoretical awareness of moral norms (Veatch 2003) independent of the hospital or commodity of medicine to better understand how the hospital and tools within it are part of what guide or train an individual within a given discipline.

To examine these constantly changing situations, the narrative stated by the healthcare workers has various forms that includes their dialog, statement that healthcare workers make to me and their actions and interactions with one another. Human actions offer a narrative that the ethnographer can follow (Mattingly 2010), which in the emergency department is visible as part of the work production of caring for and treating sick people. Within the emergency department, those groups working together are divided by training and then divided again by length of time in the field and interpersonal relations. The hierarchies and dynamics within the emergency department are part of a larger narrative that also should be noted in the way that the narrative is altered and moves through groups of individuals and professionals. The shared perceptions that are part of ongoing and continually initiating treatment for patients are part of ongoing and continual interrelations between groups. Consequently, while my interest is to observe the potential visibility of a moral foundation in the work, the confines and the structure of the environment make clear that the visibility of that work and a 'common morality', may be different in each group.

Observing the process and pressures that influence how the individual must operate or maneuver within a hospital system reveals healthcare workers within groups that have ways of working with and through the system that supports their professional work. In working within the system and the interrelations, the individual healthcare worker also acts to preserve their own agency personally and professionally. Writing in 1998, M. G. Smith presented a processual theory and mechanisms which raise the issues of how interrelations within groups occur (Smith 1998). M. G. Smith's theoretical frames contribute to the political and social process to address the dynamics and interplay of the social and political process in the delivery of medical care. The processual frame is a material aspect to this theoretical frame because the actions and interaction while based in correcting an ill, or a disease state, there is no single way to define an individual moral action or thought or how the individual healthcare worker may use structure in the system to achieve care.

The processual frame is important here for me to push against consequentialist reasoning wherein medical care is a series of actions only due to consequences. While that is a simple explanation for any repeated actions, in this study my interest is to examine the individual as professional and as part of a collective with personal, professional and external variables contributing to actions. A consequentialist frame for understanding moral position or actions that appear to have personal or moral reason would be an easy way to explain actions in medical care. Certainly in emergency medicine, we like to believe that the social world and professional actions are predictable. However that is just the point that leads me to consider frame as advanced by Goffman. The analysis in this study is part of a variable frame. In observing emergency healthcare workers and understanding frames as free social structures allows for observation of the individual and their interaction with an immediate

environment (Goffman 1967). This overlay of different frames makes the individual with the process and their actions visible. Discussing Marcel Mauss and Alexander Gofman, Sykes promulgates how the totality of social life that penetrates a work (2005). Furthering this point, is the understanding that social systems are 'total social facts' (Sykes 2005). The facts are the interactions and the visibility of the experience and actions within frames where the individual as part of their professional group is visible working within confines yet expressing specific values and moral actions.

The individuals in this study occupy professional space as paramedics, nurse and physician. The professional pedagogy is a frame where the individuals act and function. Detailed in the chapters, I look at the interactions and of the healthcare workers and their constant balance as the work within their frame to restore humans to a specific point of health. Within those frames of professional position and work, I examine what reveals the moral or ethical frame. Ethics and moral frame, that which defines moral essence, cannot be mentioned without mention of Immanuel Kant's categorical imperative[25]. In Kant's categorical imperative moral acts are most simply noted as duty and this evaluation is most

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[25] Kant identified a categorical imperative and argued that to act in the morally right way, people must act according to duty. However that categorical imperative is often misunderstood as a norm for all moral reasoning, but instead for rules or maxims and not necessarily actions. This is important for anthropology in making observations of how groups make those rules or in the case of identifying or observing actions this reasoning allows for a better understanding of what Kant called the moral compass of internalized norms. I note this as part of a discussion on internalized norms and the categorical imperative because he described an operational nature that he believed allowed people to act in different ways and establish that more internal moral compass. These interpretations of Kant's belief in using the categorical imperative are noted by Roger Sullivan. The anthropological perspective is one where I believe it would be useful to use that interpretation of understanding the moral compass as part of what is being observed in an individual's action. Didier Fassin describes this elsewhere with a reflection to Aristotle in the individual ability to imply Aristotle's ethics of virtue and as such allow for the personal ascendancy of personal ethical frames (Fassin 2012, Sullivan 1983).

often put in opposition to Aristotle's ethics that are inhabited and expressed out of virtue[26]. As such the duty virtue dichotomy is one long debated an deserves note to appreciate the issue of actions as intentional, thought out, or part of an individual's essence or self. Consequently, the visible frames of action reveal the individual, working within a professional role evincing the personal. While the question of individual motivations and actions cannot be answered completely, this study seeks to investigate the visibility of moral actions through several work frames within emergency medicine.

The frame also encompasses the view of the workers that see not only patients as individuals but bodies. Bodies as objects become part of the facts within medicine. This is a theme of care and what heightens the interest in the personal moral position central to this study. Bourdieu creates within his framework of objects of study a structuralist debate that Latour and Woolgar specifically differentiate in their observation as scientific facts observed, but not exchanged, as seen in their model of facts in the laboratory (Latour and Woolgar 1986, Bourdieu 1979). Specific to observation of facts, Latour notes that with greater development of science and technology it is easier to trace both physical and social connections (Latour 2007). Latour is clear in his ideal of Actor Network Theory (ANT) that it is the unit by unit understanding of interactions in science that allow scientific facts to advance (2007: 117). In the emergency department, interactions I observe conversation and action that as discussed previously are multipliers and cannot be reduced or homogenized in

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[26] Grenberg discusses the ongoing issue of moral values in emotional responses and the ongoing debates in anthropology surrounding these issues. Grenberg investigates Kant's position on emotion and moral feelings noting that moral judgment can be viewed rooted in emotion and that there are ways to make this clear. She examines how emotions cannot justify a moral position from the point of view of Kant's categorical imperative (Grenberg 1999).

a linear fashion. The facts are discerned and used by professionals to treat the patient and are constituted by the verbal communication between nurses and other medical personnel; the visual presentation of the patient; the unspoken actions and gestures of the nurse and other clinical personnel as they use tools and technology in the care of the patient (body). The transmission of knowledge between the various healthcare practitioners combines and multiplies actions. The actions involve: how the healthcare worker understood or assessed the patient; what the patient or someone at the site communicated regarding the patient and the patient history; how the physician or other health professional received the communication in combination with communicating that information to the nurse or other healthcare workers. While these may be part of observed fact, these observations also assume additional work and decisions that are part of unsaid and instinctual knowledge based decisions on the part of the healthcare providers and their working environment.

In another characterization of interaction, Charles Goodwin sought to characterize how situations in which multiple individuals seek to communicate, do so with multiple "semiotic resources" (Goodwin 2000). Goodwin describes action in communication unfolding in events as a combination of words and semiotics and specifically argues against looking separately at language or events but observation situated in the environment and context of that environment (Goodwin 2000). Consequently, the situations as they arise in the emergency department, and specifically in the *resus* area, the use of objects to personally justify a position whether is it personal, professional or moral are not universal. Each situation and individual may use technology differently. What I observe in this research is of how tools and technology are informative, advance medical care, but similar to Goodwin's assertions, what I observe is in context of the specific situations where

healthcare workers use the technology or objects as part of an unstated purpose to reify their professional or personal position.

Local Moral Worlds

The diverse experiences of any individual are unequal struggles that make the individual unique. In discussing the individual Kleinman provides a critically important point of characterization and understanding how individuals as well as professionals act and inhabit moral experience. Local moral worlds are a way to think about and consider how other individuals think about morality from the context of their actions and work within a group (Kleinman 2006).[27] The local moral world of any individual will influence the other within that group (Kleinman 2010). Kleinman further informs us that these local moral worlds are spaces where the local ethics differ from that of the viewer and they are simultaneously a social process and subjective process (1999a: 369-372).[28] The local moral

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[27] In various writings, Kleinman goes on to describe what he calls local moral worlds, not necessarily as ethical or good, but what the shared experience that is thought of as moral (Kleinman 1999a, b, 2006). Kleinman makes reference to secular and nonsecular examples that are often in bioethics described as relativistic examples of accepted practices concerning the care and treatment of others. The arguments can be thought of in another way as relativistic for that group of people or moral thinking. In a discussing the context of which illness occurs as a local moral world, Arthur Kleinman and Joan Kleinman discuss how illness is understood as interpersonal and in context to the culture. In their writings, they stress the difference of the western biomedical model to that of cultural models basing their research on data investigating neurasthenia, schizophrenia and China (Kleinman and Kleinman 1997).

[28] Kleinman pulls apart the anthropologists "local worlds" and looks at the local experiences as experiences that make up a local moral world for individuals. In doing so in his book *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*, he also censures himself in various

worlds of paramedics, nurses and physicians are then of specific interest in how they relate within one another and then with the other groups. They maintain specific pedagogies and within that training in specific ethical discourses. Medicine in the United States has undergone various transformations in how the professionals relate to the patient and how the patient has rights wherein the practice of medicine has an ever-present ethical lens. In this study I examine the context of work in medicine and how individuals as professionals act and interact expressing less a principled bioethical script, but a personal one that is or is not explained by their professional role and title in treating patients. My interest here is not to consider morality as *other* and an unknown perspective, but that it is part of the personal and often ambiguous part of conduct in caring and working in healthcare where moral ambiguity can arise as healthcare workers are involved in making decisions or following orders about healthcare and treatment. In the same way as an ethnographer, from where I stand, I observe something different from those doing the care, so too does the perspective differ for healthcare workers who perhaps knows a repeat patient, or has followed a patient longer than those that are doing work or giving orders on how to care for a patient. Local moral worlds characterize the noumenal individual placed in work and professional confines.

In the subsequent chapters I describe and discuss the local moral worlds of emergency healthcare workers who balance the demands of their work with their personal

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cases between description (moral) and prescription (ethical), making the distinction that as he gives life in his ethnographies he moves between the two as he makes clear his interest in describing without distorting the actual experience of the individual by giving expression to it as moral or relevant (228-234). Again, to be clear, Kleinman does this in context of cultural interactions in China and "other" cultures. The individual however, in their interaction with each patient and health crisis enters and exists in a local moral world that is unique and challenging with varied personal and professional identities woven into the interactions (Kleinman 2006).

position. That process of understanding meaning making in a work world which requires interactions that make it constantly social is essential to understanding the process and the actions that are a relevant part of the narrative to understand the personal (Chaudhry and Chaudhry 2012, Mattingly, Lutkehaus, and Throop 2008). In the various accounts of healthcare worker interactions, there are the obvious and ongoing medical actions. The medical actions are part of social actions where all parties must account for what they do. As the actions unfold, the entire experience – medical, interactive, social are all interactions, which make visible to me the various traces and suggestions that are evidence in the interaction of materials or tools, and dialogs that allow me to see both the personal and the moral position of the individual and the professional. The personal moral agency is the individual, the one where in interviews and extended conversations the worker distinguishes the moral as personal and the ethical as what follows a code. It is here within the emergency medical world that I problematize the concept of medical culture and local moral worlds to understand how emergency medicine work constitutes both the personal and the technological subjects for both patient and caregiver within both the scripted confines of medicine as a practice and commodity and the individual healthcare worker with personal human goals, understanding and moral worlds.

Throughout this study I will examine and discuss local moral worlds and the groups of practice within them. These local moral worlds provide an unfettered lens where I examine the sub-culture of the emergency department and the professional groups of nurses, physicians, and other health care providers as they interact to advance patient restoration away from death and how they do so, often reflecting personally held beliefs by using non-human agents. The phenomenological inquiry to human agency in medical care is important

because it challenges the normative structures (bioethics) assumed to guide care in medicine. I believe this can be observed as professionals work together and within their professional groups.

Workers also represent their personal and group status created by the hospital culture, specific professional training, and their unique personal perspective that multiplies along the care continuum in creating patient care. The entire culture of a hospital is difficult to characterize, however the working parts of the hospital have their own way of acting and conducting the practice of medicine (Foster and Anderson 1978). The critical care section within emergency medicine also has its own culture. The area of emergency care where the most critically ill are treated is discussed throughout this study as the resuscitation area or *resus*. The *resus* has a defined domain of knowledge and practice restricted to a category of the most critically ill patients that are treated to be stabilized and then moved elsewhere in the hospital or to a lower staging area of the emergency department. The rules and division or labor are very clear in how medicine is practiced in the *resus*. Examples of this are by roles of nurses, respiratory therapist, physician, residents and other healthcare workers responsible for changing the status of patients from critical to stable. Producing biomedicine and how it can be altered and multiplied through interaction is also relevant in defining the separate sociocultural construct in the *resus*. The *resus* requires specific diagnostic and repair of human bodies that does little to understand the dynamic of the human condition that this research addresses by describing multipliers in emergency medicine, technology, and how the phenomenological understanding of the workers affect or direct treatment of an individual as they proceed through the medical care system. The subcultural lens of emergency medicine as an egalitarian segment in American medicine

allows for the unfettered actions to always reveal an underlying good made visible through the social interaction and cultural values ascribed within that unique domain.

Background, Field Entry and Visibility

The unstated foundation of moral care as individual healthcare workers work is that through observation of their day-to-day interactions the universal moral actions are visible. The visibility here is not through patient narrative and service assessments of hospital conduct, but through observation of daily routines of the healthcare workers. The workers however know and understand the constant flow of patients each have stories that present as bodies to fix. Throughout my observations of the varied practices and professional groups in emergency medicine I saw that there is a core, a moral weight that guides the work and practices of those who choose to do this work which addresses the moral boundaries and the expression of them through actions. The visibility of something so poorly defined is part of my seeing the stories of the individuals I observed outside the frame of principled bioethics, beyond the understanding of corporate structure, and without the aid of the healthcare worker interpretation.

The stories in medicine are part of the fabric that defines the interaction of the patient story-teller (Charon 2006). The patient's story is often referred to by physicians as part of the medical record and it is noted when there are gaps or inconsistencies. The patient is then noted as an unreliable historian. Yet that story is a medical assessment when the physician then makes an evaluation and passes on the patient "differential diagnosis" as part of a case

history. As a student of anthropology, I have been extremely privileged to be able to observe, talk with and discuss the stories, not so much of the patient, but to be present to listen and understand the healthcare workers' point of view and how without prejudice – they work to treat and move the stories forward. How I arrived at this and my privilege to stand from day to day among these healthcare workers is also a brief story that I relate here to frame my background and entrance into the field.

As a student of research ethics, I was constantly reminded of the altered relationship for patients and clinicians in clinical trials. The bioethical construct was no longer one where the bioethical issues are sorted through the rubric: define the issue, problematize the solution, and then offer a long term and short term solution. Instead, one of the constant problems for the patient in medical research is the therapeutic misconception. The misconception for the patients and sometimes others attending to the patient is that research is equivalent to treatment or therapy known to cure or ameliorate disease when clinical trial and experimentation is neither curative nor therapeutic. Patients in clinical trials are subjects and part of an experiment. The subject response to the experimental treatment intervention is data. While the patients are protected by statutory requirements that include review through Institutional Review Boards (IRBs), the clinical experiment is never free of risk. My formal study of bioethics and specifically research ethics was in response to my own career where I found myself increasingly antagonistic to the data mining and clinical trial review and regulations that defined my work in pharmaceutical and biological product development.

My interest in research ethics was rooted in the multifaceted and socially situated context of harms and social justice. I had worked for many years in pharmaceutical research

and development. The corporate professionals working in both large and small companies seem to believe and often pronounce that their work and product development was to create products to help people. The process however is imbedded in a system that requires profit margins for products and investing in potential new products. The reality of product development is long and multifaceted with the common goal of creating products that have revenue where shareholders can see a return on investment. I worked in several stages of the long process of drug development. Working in clinical trial research, I was responsible for reviewing hundreds of trials and thousands of pages of oncology data on Phase I clinical studies. In these studies that have the goal of determining a maximum tolerated doses, patient after patient is exposed to new hopeful oncology drugs to cure illness where the patients in Phase I oncology trials rarely have the possibility of recovery. While Phase II and Phase III studies have the potential to offer less tragic outcomes, the patients enrolled are often under their own hope of recovery fueled by a misconception of being cured, or relieved of an illness for "just a little longer life".[29] At the root of any study and any patient is the hope and the promise of better.[30] Some patients describe that they have an interest in participating in a clinical trial and see it as giving blood, or similar to people who sign-on as organ donors and report doing so for a greater good. These patients indicate that they want to be part of a clinical trial so that they can be part of something they feel is a contribution to

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[29] This was a quote from a friend and colleague who worked on a contract with me at the National Cancer Institute. She had wanted to be considered for a clinical trial after receiving a diagnosis of multiple metastatic late stage cancers.

[30] McKay and Dennett explore the evolution of misbelief from several perspectives and include a commentary from others regarding misbelief as a human adaptive condition. Others go further to discuss how this misbelief is part of survival and human evolution (McKay and Dennett 2009).

science or a required social norm to help in society. I have also heard a similar personal reflection noted by individuals involved in medical research who have an interest in creating something better. While we can never completely understand the meaning from what individuals state or we observe in their behavior, there are moments of clarity and understanding that are visible.[31] It is that visibility of the actions and where personal moral agency of the individual are visible as I examine the day to day work production in this study through observation of the varied levels of emergency medicine.

In my research career I turned initially from government and academic clinical research, to corporate safety and regulatory where I entertained my own illusion and misconception that I was taking part in the watch-dog and monitoring functions of the corporate pharmaceutical machine. The study of bioethics was an obvious next step for me after working for companies that actively circumvented proper regulatory practices in working with patient populations. The problem solving that came with regulatory oversight pharmaceutical development and manufacturing was interesting because I was working with

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[31] While this study does not reflect a discussion of perceptions of truth in understanding and action, it is an important point to note and mention regarding many of the ongoing discussions in symbolic interaction and phenomenology. Specifically, the works of both Dewey (1958) and Garfinkel (1967) come to mind. Dewey describes the mind in terms of social communication which is important when we consider the constant social interaction of individuals in medicine that include the patients and their personal perceptions and relations to the various levels of health care providers, but also the various perceptions and communication of the healthcare providers themselves. More recently, the patient narrative has become a point of study in both medical education for health care providers, but also for individual patients as the focus turns to choice in healthcare. Garfinkel offers a different perspective from Dewey in that the actions and communications are often constrained by rules. The rules are such that individuals will act and react within the boundaries often set by social rules. That social construction of rules with the individual is important but cannot be sorted out separately as noted by Dewey and Garfinkel. Instead, it is the individual identity with or without the frame of social constraints that continues to act and find their personal position that I describe and investigate here (Garfinkel 1967, Dewey 1958).

American companies that often had issues to resolve with their foreign subsidiaries. Often the solutions to issues were revealed after simply spending time with the rogue subsidiary or the manufacturing plant that was having production issues. In some investigations, reviewing data and compliance records required by statute were not revealing the manufacturing problems because the problems had nothing to do with protocols but had more to do with the workers and how they interpreted orders. The difficulties were often cultural. The solutions were social.

The companies I worked for had manufacturing production in the United States and overseas. The parallel production was supposed to be identical mirror images. The identical production is what Federal regulators approve and monitor, however small fixes crept into standard operating procedures (SOPs) at each manufacturing site that created unforeseen problems. As regulatory, I was often called upon to find out why two identical facilities had unequal output and production problems. The issues and the miscommunications that were assumed as production or mechanical were most often culturally rooted. The solutions I offered came from spending time and not just looking at what workers said they were doing, but by spending time and being part of a social group and understanding the interaction and work of the manufacturing employees in the physical spaces where problems were occurring. At the time, I had no anthropological understanding of the qualitative assessments I was attempting to explain to management. These observations of what I was assessing can only come now after being trained in qualitative research. I can make these observations now after spending five years studying anthropology. However, this personal background is relevant to this study to explain my interest and what has led to my study

within the field of not just anthropology but the social and ethical structures that are used to describe and understand the healthcare workers I observe as part of my research.

After studying IRBs in post communist transition countries as part of my bioethics studies and research, I continued to question the power authority in working relationships in medicine. Instead of patients, investigators and IRBs, I began to examine how individuals working in medicine saw or understood their role in treating patients. If personal moral agency exists in professionals providing patient care, is it visible and with whom and under what conditions? Medicine and the understanding of those producing, seemed to present a culture free narrative that could be followed. If a culture free narrative does exist in the United States, the closest medical discipline is a discipline where no-body is turned away. Emergency medical care in the United States cannot turn away anyone based on class, ethnicity or ability to pay. Emergency medicine is type of medicine where the patients are not selected by insurance or presenting themselves to a specialty, but face the healthcare workers without a bond or specific interest in their care. Emergency medicine is one of a few disciplines in medicine where the human condition must be attended to physically and often emotionally.

With this perspective, my argument is that despite all of the varied and specialized trainings, schooling and specialization that include the paramedics, nurses, nurse techs, and doctors who all work together in creating emergency medicine, that at the heart of the work is moral agency of the individual practitioner. Each of these practitioners has chosen to work in the constant unpredictable discipline of emergency medicine. That individual healthcare worker has their own personal and professional moral agency with varied and different visibilities within each group. It is that moral agency that is unstated but made

visible through work. I investigate the point of moral agency as visible through actions in emergency medicine where the human condition is constantly constructed and deconstructed in the constant effort to stabilize and care for patients.

Thesis Organization

In Chapter Two I examine medicine and the social as well as organizational and cultural processes of emergency medicine in the United States. In this chapter I also provide examples of how healthcare workers shift and work within spaces and structure of emergency medicine to create care and how moral agency and acting to reify a specific position or opinion on patient care leads to the necessity to work around and through issues as part of producing care.

Chapter Three is one of three chapters where I narrow my focus and discussion to healthcare workers. Chapter Three examines the work of EMS as they work *through* calls to ultimately ensure what they believe is right for any given patient. EMS are the paramedics that within the greater hospital system are noted as prehospital care or EMS. Here I explore the personal moral position of those healthcare workers and the effects of both patients brought to the emergency department and EMS relations and interactions with healthcare workers in the emergency department. In this chapter the personal moral attitudes of EMS and the moral place of proactive work to get patients to better and how EMS workers make sense of their work in prehospital medicine. The work of EMS and the various restrictions on their work made evident of how these healthcare workers work to make clear and re-

center their personal moral agency while transporting patients to various hospitals. EMS narratives reveal a shared knowledge and actions, challenges and affirmations of the care accomplished in their work. The trauma of the patient is varied, but real and dealt with by each EMS worker within professional lines with and sometimes without support. While their work was sometimes medical, the role they often took was to reinforce health as a right.

Chapter Four is an examination of the role of nurses. I discuss and define how work*arounds* are used to be able to advance personal ethical standards that reveal moral agency in patient care. This chapter explores how nurses negotiate their position with personal interaction as care as well as tools and technologies to fulfill their well defined duties, but do so within personal judgments to have a desired interaction and goal of care.

Chapter Five is an investigation and analysis of the interactions and roles that physicians and physicians in training fulfill as part of emergency medicine. In doing so, I examine interactions that make clear the dynamic in the creation of health and how the dynamics of interaction reveal not just roles and conduct put the moral agency of the physicians and those with whom they work. As they work, they also continually reinvest their personal view revealing how the social process is part of the continuing moral economy of providing care.

Chapter Six is an analysis of the themes that emerge from the data. In this chapter I revisit the three considerations posed in Chapter Two. In review of these considerations in examination of the data I discuss how the premise of visible moral agency has overlap in local moral worlds, technology, and the structural constraints of medical practice in emergency care medicine. I briefly discuss forward looking thoughts on further research

and the value of understanding moral agency of healthcare workers. This portion reflects on medical anthropology and bioethics to examine the basis of a moral argument in doing a study that considers the moral position in healthcare work as part of personal agency of healthcare workers. The medical ethics literature proscribing conduct of patient interaction in medicine relies on principles modeling that is thought to shape the narrative interaction between patients and those attending to them. That model and the constraints of it have had an enormous positive impact on how patients can take part in shaping their own narrative. However, my interest in performing this study and the analysis of the data toward an understanding of moral position in emergency critical care medicine, reveals healthcare workers whose personal moral agency guides their professional narrative and patient care. While the predominant understanding in medicine is that a medical model incorporates and establishes as part of a framework the moral order for practicing medicine, in this study I observe the personal moral order of healthcare workers and how they shape their practice of medicine.

Throughout this study I return to an important variable in the practice of medicine. The shaping of practice in emergency medicine remains unique because emergency medicine retains a special integrity in medicine within the hospital in that emergency medical centers cannot turn away patients. The idea of an emergent issue or situation causes a stop or suspension to fix the problem. That entrance and intersection is the opening that individuals working in emergency medicine to also suspend the bureaucratic machine or for-profit insurance checks under the guise of human care. This study examines those actions and how the moral is visible as the individuals involved in treatment create care. Through examination of paramedics, nurses in practice and the work of physicians, this study

highlights the universal moral intersection of the local moral worlds that is distanced from each of the professional work silos by pedagogy and the bureaucratic scaffold of medicine.

Chapter Two

Medical Constructs and Urban Emergency Department (UED)

This chapter provides a descriptive platform to understand how I investigate the structural confines that brace emergency medicine through federal law as well as the local confines and hierarchical structures of practice at UED.[32] In this chapter I review relevant aspects of federal law and use interactions I observed to explain some of the internal structural confines at UED. In examining the structures I also review how the structures and discourse are part of making moral agency visible in the various professional groups at UED. Using a processual rubric, I explain the back and forth nature of work in the UED work structure that influences work production and interaction among the various professional groups. Finally, I discuss UED as a field site and the physical spaces I occupied and observed healthcare production.

Medical care is shaped not only by the ability to deliver effective care but also through medicine, technology and changes to clinical practice routines. Medical care and practice is also shaped by federal policy, the insurance industry, malpractice and the power of each of these institutional forces to direct how medicine is practiced in the United States. In an emergent situation, the patient is at their most vulnerable as they interact with emergency healthcare workers with whom – in most cases – they have no relationship or

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[32] UED is the fictitious name I give to the academic hospital and medical emergency center where I did my research. All of the names of individuals and contacts have been changed to provide anonymity and protect the identity of the many health professionals and patients discussed in this study.

prior interactions. Emergency medicine medical centers in the United States must accept and process patients as part of United States federal law under the Emergency Medical Treatment and Labor Act (EMTALA, 1986). While healthcare is a commodity bought and sold to the patient, in emergency care the emergency department is different because care is provided regardless of ability to pay. This distinguishes emergency medicine from other forms of medical care such as an optional clinic or a clinical trial. That position of non-selective patient acceptance also puts those who choose to work in emergency medicine in a unique group of healthcare workers dedicated to serving the public. In various discussions with emergency department nurses with no affiliation to UED, I was cautioned against thinking that the emergency department physicians have any compassion: "...think about it, they just go in, fix, they don't even have to know the patient's name – they don't have an interest in the human, they like fixing".[33] The sentiment was cynical, however it was interesting to contrast with one of the UED nurses who told me more than once: "we don't bond...I tell the new nurses if they want care with connections, go to ICU". In the emergency department, there is no time for the healthcare worker to bond. While true, through this study I make clear that a lack of bonding does not equate to a lack of ethical treatment or moral agency and commitment to patients in emergency work of the healthcare worker. The moral agency of the individuals is clear through actions and interactions and the local moral worlds that they inhabit which also work to reify specific moral disposition toward care.

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[33] This quote is from the sibling of an emergency medicine surgeon at Cowley Shock Trauma in Baltimore, Maryland.

While the healthcare workers all have set standards of training, they also have practice standards regarding ethical treatment of patients. Ethical practice standards are maintained by physicians through their code as emergency medicine physicians (Richardson and Hwang 2001). The Emergency Nurse Association, a professional association for Emergency Care nurses, asserts an ethical practice standard in a mission statement to advocate for patient safety (ENA 2011). These standards however are also understood and expressed in different ways.

Throughout my time at UED, nurses in the emergency department repeatedly expressed their duty in the emergency department is to ensure patient safety. The point was made very explicitly by one nurse manager in the emergency room, when discussing what was important to him he states: "I tell them that you are the only thing between God and the patient...you do your job and the patient does not have to see God....". With a focus on patient safety, conflicts may appear as power struggles in attempts for nurses to – as they describe – protect patients. When I ask Attending physicians the same question, I often receive a blank stare, followed by the remark that in the emergency department they stabilize patients and solve problems. At one point during my observations at UED a physician reminded me that the emergency room also has another area of the hospital for non-admitted patients that need to be monitored. There was no direct reference to safety regarding the non-admitted patient area of the emergency room. The reference to a separate space to monitor patients could be interpreted as a reminder to me that patient safety is medical stabilization and *de facto* part of the process. It is part of medicine and thus the ethical course of treatment in care for patients. The safety of the patient seems implied in the stated need to stabilize a patient, however it was a recurring theme repeated to me when

nurses talked about their role and how they protect the patient. When EMS workers were asked the same question about what they believed was the most important part of their work, they most often quickly noted that their role is to get patients safely to the emergency department.

The federal codes[34] and professional practice standards in combination are examples of how healthcare workers employed within larger practice groups follow a rubric in emergency medicine similar to that characterized by Scott Frickel and Kelly Moore as New Political Sociology of Science (NPSS) (Frickel and Moore 2006). In NPSS, Frickel and Moore acknowledge trends in science and technology and the unavoidable political influence on science production in institutions (2006). NPSS is a useful approach to understanding the complexity of politics and capital markets on science and in this case medicine. I mention NPSS here because of the unavoidable influence that politics now has on medical practice, a practice where the trust of the public relies upon the ethical conduct and behavior of those granted license to practice. Additionally, the complex nature of a hospital in the production of health is not simply a deterministic forward movement, but one involving complex interrelations and external pressures. Within these hospital structures each hospital, similar to any corporation, embodies a culture. That culture is a combination of political influence as determined through law, but more importantly the internal expectation and tolerance of the hospital administration wherein the specific paradigms of patient care and patient interaction are accepted based on institutional norms and then

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[34] I will discuss in greater detail later in this chapter the federal regulations that established some of the guaranteed rights of emergency care in the United States. The Federal codes here are to reference those standards and the established standards of patient care within professional groups.

repeated throughout the hospital. Since this study examines how and when moral actions as an expression of moral agency become visible when healthcare workers work around issues to maintain and exert personal and professional agency, acknowledging the political influence of the corporate hospital hierarchy is relevant. In a hospital construct, there is embedded power that works within the constructs of federal and local laws. In structuring how to observe the production and use of science in emergency medicine, it is helpful to consider the position of the healthcare worker within their departments within the institutions shaped in some measures by regulations and the corporation.

The emergency department of a hospital is one facet of any hospital. As discussed the emergency department has the distinct culture that sustains the code of taking all comers. Consequently, the emergency department incorporates individuals as employees with their individual mores and personal identities within their professional roles and the pressure of the role that is unique in emergency medicine. These pressures are manifested as professional performance, professional responsiveness, but also the personal and collective response of healthcare workers to patients and professional demands. Considering then both the hospital construct and the professional pressures, individual responses in work are more easily sorted out by considering a processual framework as noted earlier in the works of M.G. Smith. Institutional, professional and personal pressures direct work and interactions of healthcare workers. The processual framework is helpful to the ethnographer because it allows a better understanding of the movement and interactions of the various healthcare workers in institutions. Also, the processual framework is helpful in understanding interactions in the interwoven bureaucracy of the hospital where the individual actions are met by both institutional and professional pressures. I introduce a processual framework

here to better explicate the dynamics of positionality of healthcare workers within their professional groups and how the interrelations of their corporate and social identities are evident at UED. That positionality braced through organization becomes important to understand worker moral position and how working around and through issues is part of moral care and production. The processual approach allows us to examine the action of the individuals and group while considering, training and the organizations in which they are performing their responsibilities (Smith 1998).

M. G. Smith notes the dynamic nature of individuals within groups and the necessity to study and describe the context in which the individual operates. In this study I describe individual actions within each professional group who work around and through issues to evince personal moral issues with specific care situations. In M. G. Smith's explanation of structural process he points out the highly elastic nature of member units within processes (Smith: 84). In using this model the elasticity is important to understand how individuals with specific roles as healthcare workers have their own personal position within it. This is of course at the core of being able to describe and identify the individual actions within a professional frame of action and how the individuals that are part of collective groups assert personal authority in care. For this reason, consider the role of the nurse as a healthcare worker who may work with as many as five other healthcare workers on a single patient that is assigned to the nurse. Thus while the nurse is part of an aggregate assigned to the patient, yet he does not perform the same work as the others in the aggregate who may be medical students, residents in training and an Attending physician. Figure 1 is an organizational chart that is useful in understanding the reporting structure and in some sense isolation of certain health professionals in the emergency department at UED.

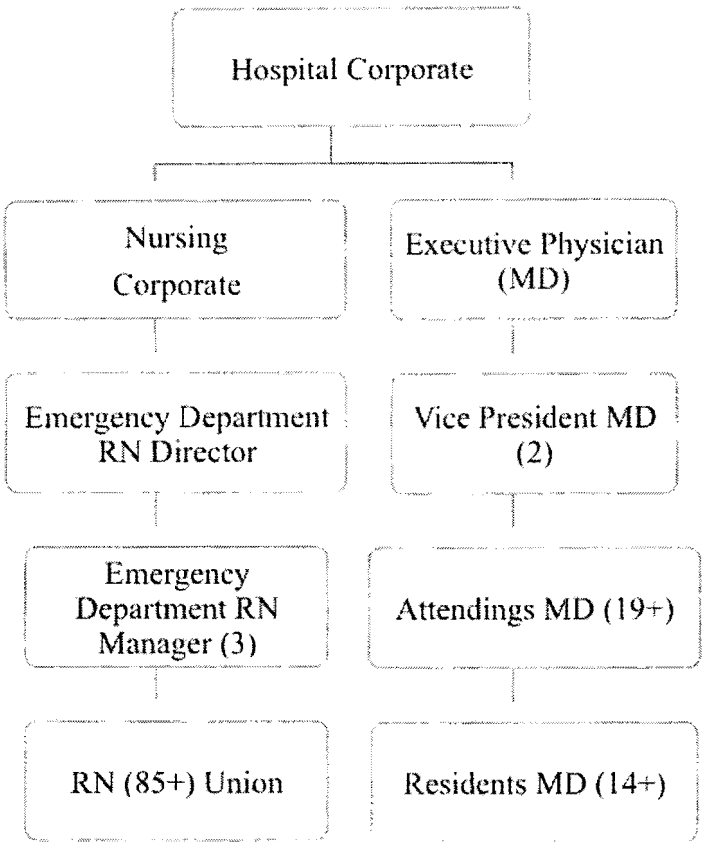

Figure 1 UED General Organizational Chart

The work hierarchy and organizational chart in Figure 1 represents a general overview of the working order for physicians and nurses in the emergency department. The numbers in parenthesis are the number of healthcare workers hired in each position during the time I was at UED. The plus sign indicates that the number has been variable with numbers of individuals actually hired for the position at any given time. This chart provides a visual of how physicians and nurses have isolated reporting structures within UED. Within the nursing reporting structure the staff responsible for patient care are all union and all levels above including direct managers and coordinators are part of corporate management and non-union. There is no overlap of the physician and nursing work

hierarchies. Although the physicians are responsible for all work produced and directed in patient care administered by the nursing staff.

The nurse has his own micro group within the institution that is not necessarily part of the aggregate for that patient. That group then has another macro institutional group such as a union that has other effects on the aggregate. In the case of UED the interactions with the aggregate requires that the nurse consult the medical record, read the notes and follow specific functions requested of the higher level medical team. The nurse however if over-assigned[35] to patients may have concern with the macro group to pressure the institution not to assign more than eight patients for care. While the nurse may protest the institutional construct, the macro group (the union) cannot necessarily help or defend the nurse in her institutional responsibilities and the nurse must count on her non-institutional intermediate peer groups to support her work best interest to care appropriately for the patient.

To clarify and better illustrate operational status within perduring institutions, M.G. Smith's processual framework is useful to understand the operational status within the hospital framework. Figure 2 illustrates the process order where work production occurs. Medicine as an entity represents a larger perduring and perpetual corporation (Smith: 226). UED has norms and specific relations with specific social standings that define perduring corporations (1998: 83). The individual or person is different from their role (e.g. nurse, physician). However each role has formations of dyads that interact and change. The

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[35] Over-assignment of patients to nurses was defined at UED when a nurse has more than eight patients assigned to them at one time. This happened frequently at UED when there are far more patients than staff. While the nurses union has a process for the nurses to fill out a protest form, the nurses are still responsible for all patients assigned, and as was often noted, it is the nurses license at risk or the nurses job if there is a complaint or problem with patient care.

representation is helpful in highlighting the individual who has ongoing social, institutional and role constraints but also continually works around and through situations to evince moral action(s) as medical care.

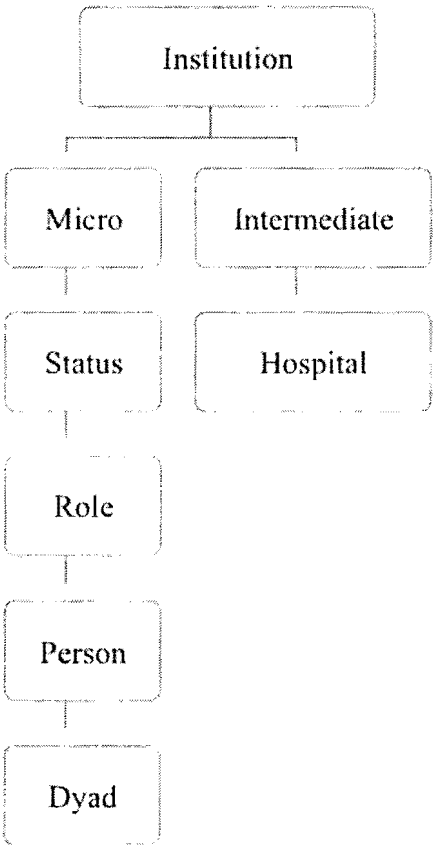

Figure 2 Process Orders of Work Production

The institution of medicine represents a place in society where individuals, in this study healthcare workers, have varied status positions as defined by the specific institution of the hospital UED. Within the institution of medicine individuals fulfill roles at different levels. The nurses must be part of a union unless the nurse opts to be part of the corporate role and takes a management position. The nurses have some measures through the union to

state grievance, but ultimately their day-to-day management is through the nurses that are part of corporate management within the emergency department. Here I provide an illustration of some typical interactions:

At 6:50 a.m. the nurses have a huddle to discuss relevant events from the previous shift and to get their assignments. The charge nurse from overnight is holding a clipboard and the nurses are massed loosely in a large hallway that separates three of the emergency areas from the ambulance bay. Some are talking in small groups and people pay attention as the charge nurse begins:

> "52 with 25 waiting for beds, have a 2:1 on 16, no deaths." There is some commotion about the 2:1 because it means that two technicians are assigned to sit with a patient who is potentially harmful to himself or others but for some reason is critical enough to be kept in the emergency department. The issue is that the 2:1 ties up resources and the nurses have less assistance. A 2:1 is unusual as most patient monitoring where the patient is a danger to themselves are 1:1. There is audible grumbling and the group seems crankier than normal for a Thursday morning.
>
> After going to assigned areas, a nurse says to another nurse in the main triage area "I have two transfusions…I am not able to…". She says this while filling out a "Protest of Assignment Form" that has the nursing union seal on it. The Nurse Manager sees her filling it out and then when the nurse hands it to the manager, the manager states: "You need to give triplicate...form". The manger says this looking at the form and not taking it from the nurse. The nurse with two patients to transfuse says "this is what they have...". The nurse manager says: "…triplicate is with three pages..". The nurse leaves and comes back twenty minutes later with a triplicate that is handed to the manager.

The entire interaction seemed odd because re-assignments are often considered and other nurse managers often assist when the patient census is high. Transfusions require two

nurses so that all ongoing work is cross-checked and validated by two people in the computer. As described in the Process Order of Work Production (Figure 2), the interactions reveal the institutional norms of the hospital and the institutional and status roles of the nurses as well as groups and individuals that are differentiated through titles and reporting structure. The process is relevant and repeats itself through other interactions in the hospital. The status and work order where the person is also different from the *role* is illustrated in other interactions I discuss in this study. The following is an interaction between an Attending and a medical student. The following dialog is an example of dyads, people and roles. In this exchange a new medical student has seated himself at the computer area where the Attendings and residents assigned to *resus* respond to and chart orders for patients:

> Attending (to the new medical student): "Who are you?"
>
> Student: "Medical Student" looks expectantly at the Attending..
>
> Attending: "What have you done?" The question is about what rotations and work the student has completed.
>
> Student: "I am here."

The Attending returns to the computer with no further questions for the student. The medical student did not address a competency or skill from previous rotations to other departments in the hospital which is what the Attending wanted to know about the student. His role as a student and any assignment in the *resus* area of the emergency department is dependent on his abilities and how they are understood or perceived by the Attending. The Attending has a role in instructing students. While initially ignored, the medical student is

later not so gently advised where to sit as part of his new emergency department rotation making clear his place and role.

These representations are useful because the individual, hierarchies and roles of the profession are visible. The visibility of the individual helps remove the analysis away from generalizations about occupations and structure (Harrison 1994). The processes and the representations of care in medicine are visible with changes to authority in medicine (Starr 1982). With authority is medicine as a practice that has changed, so too has physician autonomy (Freidson 1988), but medicine as part of corporations has somewhat counter intuitively put more pressure on the relationships between the patient and the healthcare provider (Heritage and Maynard 2006). The visibility of the healthcare provider relationship comes with the changes patients have had to make to pay for healthcare as a product. These changes collectively are visible as processes that are constantly now defined for workflow and work order that require hierarchies defined within systems. The process then within these systems is visible per profession and how the individuals work to act within those frames of process. These systems are of course inherently social in their interaction with each other. They are also social as creations within our society and part of the evolution of humans learning to treat and heal, and do so within the greater capitalist frame. Simultaneously the social work of healing and care of the body while scientific is inherently moral in the basic actions and intent to heal. The frames and constrictions on the constructions of delivering care are pathways that are part of a process that while part of institutional roles that have been operationalized. Consequently, care too has been operationalized. The larger social units in society may have other specific effects that are

outside the parameters of this study, however brief mention should be given to the arc of justice that made possible national healthcare.

Emergency Medicine and The Affordable Care Act (ACA)

At the initial time of this writing, Senator Mitchell McConnell (R, Kentucky) was making progress with the incoming administration toward dismantling the affordable Care Act (ACA), more affectionately know as Obamacare. The dismantling of the ACA has now evolved under the Trump administration to repeal and replace the Act. That noted, at the time of my field research, the humanitarian vision of the ACA was intact as law. Those visions of healthcare as a human right have had some changes that started with the 2012 Supreme Court changes allowing States to opt out of Medicaid expansion as part of the ACA. When the Supreme Court in 2012 removed the Federal requirement that States expand Medicaid funding, the broader reach of Medicaid was weakened in the potential for the ACA to establish funding for the underserved underinsured.

Within the Medicaid expansion provisions, the ACA includes processes for States to provide incentives to hospitals to decrease readmissions and repeat visits to emergency departments. While the motivation is to ultimately find ways and institutionalize cost reductions to Medicaid, the potential outcomes and process itself is part of an ethical foundation in care. A simple example brought to my attention one day came from a case manger. She said to me with her back to the patient. "See there bed 4A, that is an example of how we can change the system..., we have a problem and if we do this right, he will have

a life...look at him. He has his mind, he is relatively healthy, he just can't move...". The case manager who had worked for thirty years with patients in critical care now had no patient contact, but as patient issues arose, she addressed them. In this instance, she found it personal and the paraplegic was wasting away with mediocre care in a state nursing facility. She told me that this will be her cause, for as long as she could get involved. As a lower level manager reviewing ongoing cases in the emergency department, she involved social work and using cost systems to the hospital as the reason, made the hospital get the patient in a program and facility where he could "do work" and begin to care for himself. The example although small, showed how the personal interest and the ability to not just do a job but caring enough to do so makes a difference in the life of another individual. This nurse did not just enter case suggestions for resolution for a social worker to follow-up on at some unsaid point. She made it a point to find an environment where the individual could be a productive part of society and out of a constant spiral that kept returning him to the hospital due to mediocre care and dependence on a nursing home.

This single example falls into line with a series of events that have pushed hospitals to act in a patient's best interest. While it would be fortunate to think that this is done for completely ethical reasons so that patients are given the best life, the incentives to do so are part of a New York State program linked to Medicaid reimbursements and the ACA for the State and hospitals (NYSDOH 2015). The program penalizes hospitals for returning patients to healthcare facilities where the patients end up returning to the hospital. Consequently, healthcare workers such as the case manager are empowered to identify and work with various other health professionals in the hospitals to stop the cycle of readmission to the hospital. The hospital as a corporate entity has requirements of conduct that are regulated

by State and Federal agencies, similarly, each of the professions within the hospital and within the emergency department also must comport with various certifications. The case manager may have been doing her job, she may have been part of a collective acting morally and advancing a higher ethical standard, but that standard and her interest was her own. The motivation of the hospital was economic.

How a country treats its people through laws and services can reflect the social environment of how citizens treat one another. If there is a right to healthcare and States' lawmakers support national initiatives and make laws that extend this to their electorate, there is a greater possibility of moral dialog about health and citizenry. This study does not make the comparisons across States, however this is a study of individuals within professional capacities. On a daily basis I observed EMS who while professional to a fault when with patients, bitterly complained about abuse of "the system" when they were tasked to be a taxi service to take people to the hospital that were on public assistance. I also witnessed ways in which EMS attempted to continually educate the public. One example was a patient who was experiencing tachycardia and hyperglycemia while literally surrounded with boxes of doughnuts. With respect and patience the EMS explained the necessary lifestyle changes to the patient and gathered family while stabilizing and getting the patient onto the ambulance and to the emergency department. My chief interlocutor and head of the prehospital care providers at UED, Dr. Rahm, worked tirelessly to build an infrastructure of pre-hospital care regional cooperation teams of EMS that were trained to triage and care for patients in remote areas without bringing them into hospitals. Throughout this study I observe how the lives of workers on any given day shift to accommodate personal moral truths by creating or ensuring care.

In dialogs and studies regarding healthcare and human rights, the ACA expansion is part of discourse that continues regarding the need to assume that all people have a right to health and how such public moral proclamations change the nature of care. Horton and colleagues note five ways the ACA and understanding how individuals are affected and changed by it: 1) to demystify the making up of costs by exploring how the healthcare sector constructs cost of service for insured and uninsured patients; 2) by deconstructing the standards of care by investigating the social process that make new technologies part of standard of care; 3) examine whether insurance companies manipulate the system to maximize profit by as noted in the article increasing certain premiums; 4) documenting the current shape of corporate governance by studying up of how biomedical and technology companies , insurance companies and other groups with an interest in profit from medical production work to transform medical production to meet their financial interest; 5) analyze healthcare reform as part of the crisis in capitalist accumulation by examining how a federal law meant to level care by providing an ability to receive healthcare national also does so without changing the ability of insurance and pharmaceutical companies ability to leverage and profit from the healthcare system (Horton et al. 2014).

In addressing these five analytic steps, Horton et al point out this is an important step in being able to "challenge" the global spread of market-based medicine (2014: 12-13). The five points raise many issues that tie into this study examining the visibility of moral agency of healthcare workers. The use of technology and development of technology that rapidly becomes obsolete may not necessarily be used as readily and perhaps with greater caution in routine and emergency medicine. The message can go in two directions. The for profit message does not in itself undermine the good in patient care, however the mitigation of

unnecessary technology and inappropriate technology is worth study, repeating and part of training. The following interaction is a small window into some mediation of technology use and policy confines.

In an exchange between an Attending and a first year resident, the point was clearly made by the Attending regarding proper use of expensive tests. The Attending motions the waiting resident over. The resident has been waiting in line to go over his "plan" for a patient assigned to him:

> Attending: What is the treatment plan?
> Resident: I am waiting for the CT to come back, but have ordered...
> Attending: Wait....wait... (Attending is looking down and then looks back up at the resident)...why are you ordering a CT?
> Resident: We discussed, that the patient had a history of ...
> Attending: ...right, but since when do I suggest ordering a CT
> *(The Attending is using his hands to touch a different finger as he lists problems with ordering the CT)*
> ...expensive test, some radiation.... for a non-critical patient issue...
> Resident: Well when he came in I thought...

The exchange continued and the resident took the patient off the CT waiting list. The point here is to Horton's in that there are reasons to *not* introduce some technology that can be go-to technology that may not be indicated to solve the problem. Additionally, hospitals may require justification for using expensive technology and those prescribing it may consider weighing the actual benefits of information that may or may not change a diagnosis. However technology as necessary or optional from an anthropological point of view also provides an interesting platform in how insurance companies and other payers justify or delay continued expenses for developing technology that may or may not be necessary in

every day or even emergency patient care. Also interesting is that the physician is fully aware of the insurance limitations and finds a way to require the technology or not use it based on the needs of the patient. The conflict for the physician in writing orders is part of a moral drama that repeats itself not so explicitly as drama each time but a conflict to get a patient what they need for what the physician deems appropriate care. In medical anthropology there is an understanding that in cases where patient life/death suffering occur the use of routinized medicine is used instead of specifically opening a discussion of the difficult moral dialog (Good 1994). The identifications of such specificity that actions are necessary when considering morally imperative actions and here Good acknowledges the need of his staff, his students, to act in a moral and personal manner. These specific allowances are rarely noted elsewhere in the literature. Yet, in his discussion of specific hospital related events, Good explains that "the shaping of the experimental world of our moral lives by instrumental rationality, highly routinized procedures, and both technical and technological management" (1994:85). While this piece of literature specifies moral action, the social and policy lens continue to examine the systems and structural changes that cannot consider medical moral overrides of policy. It is the specific structure and changes to systems where the structural is what can cause the work to overlook the moral in the interest of process and hierarchy.

The changes in healthcare may also turn the lens on how people are treated and those treating are affected. In ethnographies of both professional behavior and patient behavior as people wait to be seen for treatment in emergency department noted both frustration and shame by staff when patient waits are unacceptably long (Burström et al. 2013). The frustration of staff and an inability to address patients in a timely manner revealed some of

the hesitancy that exists between the healthcare professional groups. While the techs rarely have any issue telling a nurse their opinion, and many bluntly give information to a physician, I observed reticence in nurses who would either not specifically demand a physicians attention or would do so only in critically urgent situations.

In one situation a nurse is frustrated at not being able to "order" a throat culture for a patient who had been waiting for six hours for what could be, in his opinion, diagnosed with a throat culture. The nurse found a sympathetic physicians assistant (PA) to order the test and do it. In that interaction the PA was surprised that the nurse was not allowed to do it without specific orders. The nurse used the PA to work *around* a situation that the nurse found morally troubling. In so doing, he alleviated his own distress and still worked within the confines of hierarchy to accomplish his goal of patient care.

In another case Tia, a nurse who has been at UED for over fifteen years, is well known and liked by both nursing staff and physicians is frustrated by the lack of physician attention given to a patient that is under her care. Tia mentions to me that she doesn't think her patient should be in the acute care section. Tia is worried that the patient was put incorrectly in the general acute care area instead of *resus*:

> Tia stands next to the Attending desk waiting while the Attending talks to a medical student (intern). After a while, they notice her.
>
> Attending: "yes…?" Tia mentions her patient and that she thinks it might be stroke and that the patient needs urgent care.
>
> Attending: "Why do you think it is a stroke?"
>
> Tia: "Come, he has new symptoms…" Tia makes the hand motion to follow while starting to walk toward the patient. The Attending is followed by an intern as he walks away from *resus* toward the 'Acute Care' side of the emergency room.

Patient friend: "He can't move his left arm."

The Attending does a stroke exam testing strength, symmetry… "and the face…"

the Attending notices a droop in the face "How long Ago?"

Patient friend: "9"

Attending: "a.m or p.m.?"

Tia leaves the patient and the physician and goes back to the cart. She begins to get the required tubes for blood work to check for a stroke.

Tia: "I just wanted to make sure…I was not waiting." Tia says this to herself and to me. By now the Attending has gone back to the computers near *resus* without saying anything to Tia. Tia checks the computer for the orders to do the blood work she believes necessary.

Back at his computer near *resus*, the Attending is discussing with the intern what Tia wanted him to see and the process for the patient. The Attending discussed the varied standards for stroke noting: "Emergency Medicine and College of Cardiology have different standards for treating patients…Emergency Medical physician standard with two negative… escalate at six and twelve hours, then we discharge, cardiology differs with high risk…"

The lecture was part explanation as to why he was not moving the patient to *resus* that Tia had him come over to evaluate. The explanation was also to relate what the process in the emergency department is for the patient. Tia had brought the patient to the attention of the physician and resolved some of her fears, however the patient was not upgraded to the level of risk and oversight that Tia wanted when she asked that her patient receive immediate attention.

That detail reifies an important aspect of moral action wherein perceptions of empathy and empathy of others can determine moral behavior (Malone 1999). Tia's

interactions were part of good nursing but also part of what she saw personally and morally as her duty to keep the patient safe. She sought out someone who may see her point of concern since the nurse that placed the patient in acute care instead of resus did not see the need to elevate the risk status of the patient. The physician who was training an intern discussed the patient as part of the educational system. There was no relationship and the process allowed for the patient to be left as a lower priority even though the nurse treating the patient had attempted to advocate and establish a different procedural outcome for her patient. Tia had attempted to work *around* the initial triage that placed the patient in acute care instead of *resus*. Tia's local moral world was one where the care of this patient required further evaluation at a higher clinical level. She sought out the Attending. His level of care was determined pedagogically through accepted norms and he did not see the imminent harm that Tia feared. An additional point of analysis in these situations where nurses are confined to act by structures is that healthcare workers maintain the moral position of getting what a patient needs and sometimes endure a repeated moral distress as they attempt to advocate for what they believe a patient needs. The idea of moral distress is not particularly new to nursing. Moral distress is described in a variety of situations and in complex situations such as emergency medical care it occurs when individuals have clear moral concern or judgments but difficulty being able to resolve them (Thomas and McCullough 2015, Jameton 2013). Within this study the moral distress is not the obvious action but becomes the visible indication of other actions as healthcare workers, specifically nurses work or attempt to secure safe care for their patients. Thomas and McCullough use a specific taxonomy to describe ethical significance to distress levels with an interest in resolving distress they contend violates and weakens professional and individual integrity

(113 - 115: 2015). These examples and the reality of distress in creating care are part of the local moral world of the healthcare provider.

In another interaction, an individual was brought into *resus* . EMS brought the patient through normal triage assessment. At triage the patient was quickly elevated to the *resus*:

> Resident: "EKG?", he looks at the nurse that upgraded the patient to *resus*, then to the EMS, then he looks back at the patient...The resident appears stunned as he looks between the patient and the EKG that was handed to him.
>
> Resident: "How long has this been going on?"
>
> Patient: "When I walked to the bus." The patient looked at the young doctor after stating his morning walk to the bus was the beginning of the chest pain as if this should be a satisfactory answer. The young doctor leaned forward expecting something (perhaps more detail).
>
> Resident: "Have you ever had a heart attack?"
>
> Patient: Shakes his head and quietly says "no"
>
> Resident: "You are having a heart attack now."
>
> The resident says this with some exasperation but what appears to be with the intent of making the patient understand that this is serious.
>
> Patient: "Am I going to die?" The patient looks surprised and is suddenly engaged in the conversation the physician had been attempting to have with him.
>
> Resident: "No, we are going to take care of you. You are going to the cath lab for a small operation…"

The resident continues to explain in detail what will happen in the cath lab. He explains that they will thread a probe from his femoral artery into his heart to see the blockage and perhaps put in a stent. The patient does not appear to understand what is being said. He opens his mouth several times to speak but does not say anything. The resident is pacing

with his phone, looking at an EKG. The cath lab attendant appears and works with the nurse to put the patient on a portable heart monitor and take the patient up to the cath lab.

The resident in *resus* that received the patient was agitated because of what he perceived was a lack of urgency and understanding by the other healthcare workers regarding the fragile and urgent patient situation. It was morally wrong not to be more engaged for a patient in such a tenuous and risky physical situation. The process had not been followed to expedite a patient who should immediately be placed in *resus*. EMS brought in the patient and they waited for triage placement by the UED nurse. The line of gurneys of patients brought in and attended to by EMS often trail up and down the hallways waiting for triage on busy days at UED. The local moral world of the *resus* resident was breached when a UED patient having a heart attack was not appropriately tracked into *resus*.

The patient did not immediately get to *resus* because the EMS team did not have data that would elevate the immediacy of the issue. The EMS team was a Basic Life Support team (BLS) that did not have the advanced training of an Advanced Life Support (ALS) team that would most likely have done the EKG and elevated the issue prior to arriving at UED. The encounter relied on verbal communication instead of data that would have elevated the care. The data represents a proven metric for evaluating a heart condition. The input and output of data instead of conversations reveal another issue that is often referenced in healthcare ethnographies of professional groups. A conversation instead of following metrics may have expedited the patient and alleviated the following rush and anxiety to get the patient stabilized and to the cath lab.

Communication by nurses with patients and among nurses with one another are a critical part of nursing care. However, the attempts to quantify and expedite care through

metrics that include communication often miss the point of creating good care. Adrienne Pine discusses findings from three years of research where she observed and taught nursing professionals as the nursing profession negotiated the introduction of not just electronic health records but also the introduction of "health scripts" for nurse communication with patients (Pine 2011). From my own research, nurses often self-refer to themselves as "the caring profession", and in so doing – being caring – knowing their moral position of care and not wanting scripts to communicate with patients. The nurses in Pine's work found that the introduction of reductionist measures based on metrics to obtain markers for corporate standards left little time of acknowledgement within the profession for measures that are part of patient caring. The metric discussed by Pine include "Disney" metrics of reminding patients of their excellent care and other statements that had little to do with either care of interaction or helping patients (2011: 269). Illness in Pine's model is categorized and detailed through the computer in metrics. What issues ensue are that the nurse as provider, is guided not by experience and interaction with the patient but by programmed metrics of the computer that remind the patient that they are happy to have excellent care. The metric however in hospitals and how patients see or believe their care is delivered is quantitative through measurement surveys – something quantifiable by response and number. These metrics are now being used by hospitals on a corporate level and the nurses are held accountable for what happens with reports. In one morning nurses huddle, a nurse manager reminded nurses or the need for good approval ratings from the client/patient.[36] The nurse

[36] The idea that a patient is a client supports an NPSS trend of the infiltration of medicine as business. Doing so seems to have the perverse effect of reducing the patient position of an individual in need of care and rehabilitation to one where the patient is a client in need of service.

manager went on to report to the amused group of nurses and techs that the emergency department had gone from a 16% to 42% approval rating by patients within the quarter and that everyone should keep improving that rating. Another time a nurse with more than twenty years at the UED emergency department said to me:

> Nurse Mary: "...the patient I am interviewing says I talk too much and she is going to report me....I am interviewing her for her history and she says she is reporting me..." she types on the computer and then continues "the patient said the pain meds does not work, ...to tell the doctor she needs Dilaudid..." (Mary rolls her eyes and continued to input information on the electronic record).

While this particular nurse, was well known to the emergency department as dependable and good with patients, she had concerns about being reported and the possible consequences. Simultaneously this patient was requesting a powerful controlled narcotic while threatening the nurse with "reporting". The computer and quality of care metrics were known to the patient and used abusively by a patient in pain who may or may not have been exhibiting drug seeking behavior. The metrics however do not account for the patient mental condition when they report or malign the care they received. The consequences are felt by not only individuals but also the group. While the nurse may know better than to allow it to bother or distress her, she still responded and reacted to it. She mentioned it verbally and she still had

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The underlying assumption with healthcare providers or at least nurses in particular is that they provide the best care for patients to the best of their ability at all times. The patient as client reduces the individual healthcare worker to a provider with a numeric representation. While metrics in healthcare seem reasonable for some fields, emergency medicine where all individuals are cared for regardless seems least reasonable to institute metrics of creating "happy clients". The metric seems even less relevant during the times when nursing staff may support ratios of one nurse to more than eight patients. Similarly the ability of the physicians to attend to an overload of patient would lead to unhappy "client" metrics.

to interact with the patient. She was annoyed that her care was challenged – it was a challenge of her care and her moral position in care.

Computer informatics remains helpful to understanding patient status and continuity of patient care. Medical Informatics carefully documents the need for detailed patient electronic records to provide information in emergency situations (Jensen and Bossen 2016, Chacour Bahous and Shadmi 2016). The first Ebola infected patient in the United States presented twice to the emergency room. His electronic record clearly indicated he had just been in Liberia, but attention was not paid to reading the nurses notes and there was no alert system in place. While the "alert system" may be the learned message from the U.S. Ebola patient, the more nuanced read is in the unread notes written by the nurse.

The knowledge base of the nurses and other support staff reflect a professional position and what they believe, feel and say their role is in caring for patients. That role and how they move within it has not only preconceived notions that are made visible in the way the public interacts with them but also the way they as health professionals respond and more often privately react to the way they are treated. Their internal work process and morally visible orientation to the confines of the process is clear in interactions where the nurse continues to perform a role and must also interact with a perceived role. Similarly with the physicians in their care for patients as they work in a system that fails at the very prioritization that is designed to care for the most emergent patients first. The physicians work autonomously within the system relying on the metrics. The physician can then turn back to where the individuals made mistakes in the system and question who failed the system and not why the system failed.

Emergency Medicine, Practice and Federal Regulations

The process and controls include metrics for expeditious care, patients as happy customers, and most importantly follow rules to ensure consistent ethical treatment. Emergency medicine plays a critical role in the delivery of healthcare in the United States. The emergency department is where millions of Americans are treated each year when they experience sudden and serious illness or injury. Americans however also rely on emergency departments for their acute care needs (ACEP 2014). As previously discussed, access to emergency care is fundamental and guaranteed under EMTALA. That access creates complications for emergency departments. EMTALA sets the requirement that emergency departments screen and stabilize any individual presenting to an emergency department regardless of ability to pay (EMTALA, 1986). However, the availability of emergency departments, the capacity to treat patients and availability of emergency department staff have proved challenging to provide consistent care above a failing grade (2014: 4). The ACA has also altered what an emergency room is within the practice of medicine. The Medicaid expansion under the ACA has been reported to have led to a spike in Medicaid patients in the emergency department of up to 300 percent through 2014 (Medford-Davis et al. 2015). However, those individuals purchasing private insurance through the ACA with a higher deductable have led to lower use in the emergency department as primary care. Overall, the recent (within four years) changes in access to emergency departments across the country have changed how hospitals consider their emergency departments. Where emergency departments are a cost center for a hospital in some areas, an emergency

department in other areas may be a revenue center.[37] These changes and considerations within a hospital and the running of an emergency department have an impact on how emergency rooms are required to change and how they are run as part of a larger hospital corporation. Naturally these changes affect those working in the emergency department as they manage the changes in patient flow and work to follow new metrics and create improvements under the ACA. While hospitals compete for patients, hospitals continually attempt to make the emergency department a more efficient part of reducing costs. The actions to streamline emergency departments as part of a response to changing external policy also have a direct effect on individual healthcare workers delivering care.

The changes within emergency departments may include changes in workforce, how the workforce is managed, and introduction of newer more efficient ways to expedite patient flow through the emergency department. During my field research, the emergency department at UED went from a department with pediatric, geriatric, acute, critical and fast track to an emergency department to a pediatric, geriatric, two levels of acute care and non-critical emergency care. With these changes also came an observation unit for the emergency department where patients who are not yet admitted to a specific floor or department but are cared for and monitored as a non-admitted patient once stabilized in the emergency department. The changes reflect similar streamlining of patients to provide care and then admit to the hospital as necessary. However, the intermediate space of non-

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[37] In conversations with hospital administrators in the emergency department, the constant complaint was pressure from the corporation and not being able to properly fund the emergency department because it is considered a cost center in the hospital. In a 2014 analysis of emergency department profitability, Wilson and Cutler establish how emergency department profits will continue with expansion of the Affordable Care Act (Wilson and Cutler 2014).

admitted patients is also a way to expand without turning away eventual hospital admissions. While some workers said the changes were fine, some said it was too fast, others said that it was harder now that the groups are separated and they cannot "take over" and help each other like they did before when they need to take a break. These observations came mainly from nursing staff who cover for each other during "required" breaks or to simply leave to use the restroom. In response to a conversation with a nurse who had been working in the emergency department for less than five years, she said: "I couldn't do this for 30 years, I don't know how that could happen". The other nurse (with more than twenty years in the emergency room at UED) responded that it wasn't "this". She continued by noting: "It is a caring profession, and we were able to take care of our patients". Residents asked the same question usually asked what I meant. If I clarified my question about emergency department changes and asked about the changes to the patient flow, they would usually say that it is more efficient, but that they rotate through other hospitals and every emergency department has a different way that "works".

I include these observations on the longer-term employees of my field site as a brief view of how the larger changes in the United States and the medical environment affect those who are part of the larger medical machine in a hospital environment. While the mission of those providing care and attempting to restore health may not change, political and social forces act on the local world of the emergency department. For the healthcare workers in the emergency department, their environment and the tools they have to do their job continually changes, consequently, this study may be able to observe, map and describe the local moral worlds of those doing healthcare, however the larger system as a structure of

medicine within a large hospital has a direct effect on those healthcare workers providing care.

Addressing Medical Discourse, Work Production and Moral Visibility

Considerable reporting of emergency medicine exists as part of larger metrics of medicine and healthcare in the United States. In the literature, emergency centers are described from varied perspectives that include the profit/loss perspective of hospitals; intervention from the federal governments to ensure acceptance of all patients; interactions with prehospital services (EMS); and various studies of waiting rooms and emergency medicine protocols and best practices. The studies of emergency medicine are varied but rarely have included the qualitative analysis of a study that engages a non-medical participant observer. As that outsider as observer I examine the local moral worlds and ethical standards in medicine that are continually evolving for those healthcare workers and the collective institution of emergency medicine that produces healthcare.

During the days, weeks and months I observed in the emergency medical department at UED, my fieldwork included the daily observations in the *resus* and acute care areas of the emergency department as well as shifts in the ambulances riding along with EMS crews.[38] The emergency department is a uniquely situated environment to observe a 'local

[38] Research was conducted at an urban teaching hospital which characteristic of the city, received both a severely underprivileged population and a wealthy affluent population. The EMS observations were throughout Manhattan and sometimes the outer-boroughs.

moral world' by being able to observe the day to day lived work of EMS, nurses, physicians and various technicians within a larger urban teaching hospital system. In this research I apply a holistic view of the system of critical care emergency medicine to examine the complexity of paramedics, nurses and physicians who occupy and produce care in emergency medicine. This complex fieldwork site setting generated interrelated themes through several frames of observation, each with sub-sets of questions for me as an observer. Goffman describes frames to observe patterns in knowledge when observing participants (Goffman 1974). The acts and interactions between healthcare workers and healthcare workers and patients sets up multiple interactions and frames for observation. Those various interactions are what allow me as the ethnographer to identify in sometimes those briefly held interactions of groups in a local moral world. Others have investigated frames in medical interaction as part of understanding communication and frame switches between caregivers, patients and physicians (Tannen and Wallat 1987). The frames they identified described how healthcare workers, in their study a pediatricians, moved and altered frames to best care for a patient and communicated with the parent caring for a child. While the physicians had previously intuited the shifts to make clear communication, Tannen and Wallat describe the mismatch in schemas and frame in the communication between physicians and parents (1987: 214-215). Those mismatches and the interest in correcting that frame to create understanding are the intersection and moral world for each of the participants in the interaction. The interrelated themes within the critical care emergency medicine dimension include the local moral worlds of each of the professional groups and the personal moral agency of healthcare workers made visible as he or she performed daily duties.

First, how do emergency care workers manage their care and assert moral agency within the confines of the emergency department to act and exist within a local moral world as part of their work? In nursing practice and more recently in training medical students, there is an acknowledgement of moral distress and the issues surrounding management of it (Callan et al. 2007, Corley et al. 2005, Hegazi and Wilson 2013). The management of moral distress in nursing acknowledges the need to assert moral agency in the work of care (Hamric 2012). The acknowledgement of the moral distress and difficulty addressing it are both an acknowledgment of the need to address moral agency and recognition of managing threats to moral agency. The nursing literature points to a need for nursing administration and institutional support needed for nurses (Corley et. Al., 389). Contrast the need for support in nursing with physicians where the physician training laments a progressive lack of moral engagement in the medical student to physician populations as students become physicians (Hegazi and Wilson, 1026-1028). Hegazi and Wilson make the point in their research that medical students show a decline in moral judgment competence during their process of education to become physicians 1025-1026). These engagements of moral distress and moral development or loss there of, represent some of the issues ongoing with healthcare workers providing care in medicine. Neither the medical students, newly minted physicians nor the nurses lose their moral agency, however the argument is made for both professional groups to be able to find ways to engage and express moral engagement of issues in patient care. The need for expeditious attention to patients and pressure to do so was in part what makes visible or provides some measure of evidence of personal moral boundaries and expression of moral acts of the healthcare workers I observe and discuss in this study. While most medical students can point to specific bioethical codes of what is

often called 'principlism' in ethics, the observations here are made apart form ethical codes or bioethical principles.[39] Instead, this study examines how individuals engage with work in the ongoing emergency work that is inherently morally engaged.

Some of the daily routines of the teams coming together to care for patients revealed the moral worlds that healthcare workers held and were sometimes visible and collectively visible as professional groups respond in patient cases. Other observations appeared to be ways to work within the confines of limited resources to provide adequate care for patients. In the course of my research, the pedagogy for physicians included ongoing training with Attendings, residents and medical students. The interactions allowed me to observe personal position and orientation toward healthcare as residents and medical students were required to not merely give answers to medical questions regarding disease and treatment but also why this particular patient should receive a treatment and to what benefit. Often the inquiry from the Attending persisted, pushing the student to respond specifically with reasons and not just rote answers of textbook medical procedures but answers that require an awareness of contingency and unknowns that could arise. While the questions seem part of an expected pedagogy of training new physicians, the answers and discussions often had more to do with what was right for 'this patient' under a specific set of circumstances. In other situations the process and what should be done was "part of a process". Those interactions revealed individual and collective moral actions and attitudes reflected in how

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[39] Bioethical principles as detailed by Beauchamp and Childress as Autonomy, Respect for Persons, Nonmaleficence, Beneficence and Justice (Beauchamp and Childress 1979).

patients, other clinical staff are treated as well as how rules, a system of rules and interactions are bent, broken or suspended to meet a goal or desired outcome.

The constraints of what is done for a patient or in a given medical situation can create conflict and sometimes frustration for the healthcare workers involved. The ongoing or new conflicts and resolutions are moment to moment insights and markers that make visible the moral positions of healthcare workers where conflicts and resolution do not just involve norms of behavior, or expected medical norms,[40] but reflect personal moral dialog. How they respond or explain their place in the situation also provided insights into what Zigon calls the self articulated of their own embodied moralities (Zigon 2012). While Kleinman's local moral worlds describes the situation and cultural moment of a local moral world, Zigon describes a moral breakdown wherein the distinctions of everyday life differ from a conscious ethical moment (Zigon 2007a, Kleinman 1999a). In all three aspects of emergency medicine discussed, the self articulation and conscious ethical moments were sometimes visible as all of the work being produced was to move patients toward health and in the *resus*, fulfill the specific role to stabilize patients.

The work production has defined a process, however the nature of medicine and interaction was also fluid based on other factors. The Attendings and residents construct plans based on the data they had to be able relieve pain and stabilize patients. These plans

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[40] The biomedical principles are specifically outlined in the practice of medicine for research ethics (States 1979). However, while there is no similar document representing all four principles in the day-to-day conduct of medicine and clinical practice, the principles have become an expected norm in the conduct of medical care in several different ways. In defining how these principles relate to clinical patient care: patients have the autonomy to direct their care; nonmaleficence means that care should not create greater harm or unnecessary risk; beneficence requires care should be provided so that the best interest of the patient are advanced; and the principle of justice demands that individuals are treated equally such that different treatment is not received due to gender.

were constrained by time, resources, and prior knowledge about a patient. Then conversations and plans were often meaningless or completely changed when admitting physicians 'came downstairs' with different orders. The shifts in care based on immediacy of the emergency department or prior long term knowledge of a patient from an upstairs hospital team was a gap or opening that revealed how the best care or doing what a patient thought was best had variability that did not necessarily change what was morally right. These changes made visible the intentions of those carrying out orders to get patient to "better". Where then does the moral frame shift and how do the healthcare workers who are engaged in treatment change their view of appropriate care? Was the care provided not appropriate once changed? Where others who had different ideas but no voice vindicated and allowed to observe or was there a shift in their frame of care for the individual. The individuals providing care are inherently interested in what is best, that moral frame is a constant negotiation viewed through practice and work confines.

Second, how do we understand the interaction, dialog and perception of healthcare workers as part of a phenomenology of morality? Does observation of conversation suffice, actions, or reports from healthcare workers? Are there individual values that appear to be collectively felt or understood? The professional interactions also occupy a social space where interaction and roles represent more than following an order or placing an order in a computer. The emergency room personnel include a wide range of expertise with nursing staff making up the majority of the workers. In my research there was some consistency in dialog of what it personally meant for individuals to be a nurse and what brought them back to work for twelve hours of continuous work three and four times each week. Was it possible however to see shared values in what nurses believed was moral behavior or just

instances that reflect momentary individual moral positioning. Were the positioning, the fatigue and orientation toward the patient different for a resident or an attending? The emergency room as a field site allowed me to witness the various way healthcare workers worked through and around issues. With these observations, I attempt to demonstrate how any working *through* and working *around* an issue affects the patient and consequently should be considered a moral decision and part of a personal and professional interaction. Throughout this research working through, around and with others manifests in many different ways, through technology, proscribed procedures, hierarchy of work, and personal decisions.

Finally third, how can we observe the intersection of the ethical, moral and personal in simultaneously interrelated yet independent facets of healthcare production that is both personal and part of a larger political frame in medicine? Is there any conduct or behavior among healthcare professionals within a local moral world that reflects moral position for healthcare workers? If so, are there differences across those providing care? Throughout the time I was in the emergency department, I witnessed changes in behavior that included interaction with technology to secure appropriate care but also changes that required healthcare workers to help each other, often across professional disciplines.

Field Research and Emergency Medicine at UED

My field site in emergency medicine allowed me to observe a highly regulated and structured medical field designed to fix and heal people in need of urgent medical care.

Access to emergency medicine as a field site where I was able to view ongoing moral positions and ethical dilemmas of healthcare workers as they learned and practiced medicine presented various challenges. While emergency medicine is an ideal setting for which I remain grateful for the opportunity, I have no clinical certifications. Consequently, my entrance to my field site was as a student-researcher. The student researchers are mostly undergraduate students from New York City Colleges and Universities that volunteer to train and work as a researcher to assist with research projects at medical institutions. The interest and motive for these students is to have the opportunity to work with physicians, possibly author a research paper and then go on to medical school. Regardless of my educational and professional background, which provided a solid foundation and ease with understanding the science, medical process and certain protocols in clinical treatment, I was not an undergraduate with aspirations of medical school and I remained an outsider to all of the levels of clinical hierarchy. The reception of the various staff at having an individual stand among them scribbling notes day after day and hour after hour was initially mixed. With most healthcare workers that saw me on a daily basis, they warmed and I was able to have conversations and discussions with various nurses, technicians and physicians. Although the emergency department is used to a continual influx of outsiders and various research protocols, the well-defined hierarchies in the medical unit made access to *all* healthcare workers difficult. Initially, I was introduced as a graduate student in anthropology, which was of interest to some, but because of my non-medical student-researcher role I was never viewed as a participant in the departmental practice, work that often requires anyone and everyone to stop and participate. Often, however, I was asked to

retrieve "things" and "people" which I very happily did, but in situations of critical involvement, I observed.

As a student researcher, entry to my field site was initially as part of a research study where I observed and recorded EMS personnel hand-off of critical patients to *resus* physicians. This study allowed me immediate and continued access to the *resus* area where I was allowed to continue to view critical care emergency works throughout my stay as an ethnographer. My regular and consistent presence was helpful in establishing my role as apart from other student-researchers whose time in the emergency department was less consistent. Working with an Attending initially, I was able to initiate conversations with other Attendings and residents. The position allowed me to have broader access to the healthcare workers working in the department. Unlike prior ethnographers who focus on a single group of medical professionals,[41] I chose to observe all groups as they interact with each other and technology as part of medical production. While any one of the varied professional groups could provide a point of study, the social interactions collectively of the groups and my lack of alignment with any particular group made visible to me and allowed me to move between different professional groups and observe the varied positioning of the healthcare workers and their professional interactions. The combination of the bounded medical site, community of hierarchical professionals and changing protocols and administrative burdens allowed me to examine the medical decision making models and interplay of the personal and professional in an atmosphere where medical practice was

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[41] For examples of ethnographies targeting specific groups, ethnographies of Nurses and limited autonomy (Traynor, Boland, and Buus 2010) ; and an ethnography of physicians experiences (Zafar 2014).

being continually amended and expressed through life and death and the human body continually amended and restored or transformed through and with technology.

Most generally, the public entering the emergency department of a hospital does so as a place to start to fix a health issue. What is wrong will get better and the healthcare workers charged with care and trusted with medical knowledge will know what to do and succeed at their task. The patient is the subject, but the healthcare workers, technology and the tools to handle the patient become part of the dialog. While technology represents things and healthcare workers as subjects engages the things with the patients, the technology and people become part of the narrative, the conversation, and the production of medicine. The assembly and interaction of these pieces makes visible the scaffoldings constructed by healthcare workers as they create patient care. The personal, with motivations, personal morals, history and training is part of a narrative. It is the meaning of such narrative that I investigate in this study.

Each of the healthcare workers in the dialog and sequence is professionally tasked with a part in the medical sequence to restore the patient. When patient conditions deteriorate or mistakes are made, were they wrong as a team, as individual healthcare workers? Which parts are mutually exclusive and which are dependent parts in any variation of events? A bioethicist examines any one sequence and discusses how all objectives within a principled identification of roles were met.[42] The observations take place

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[42] Some references in sociology describe bioethics as a newly created field that emerged due to a need but then critically call it "a hegemonic paradigm" most often independent of the necessary analysis where 'Principlism' replaced the embodied values lived by social agents (López 2004, Fox and DeVries 1998). López argument maintains that bioethics as principlism used in an alien and

throughout the varied interactions. As an independent observer I consider the various interrelated groups and their boundaries. Through this study, I examine the emergency department that is both bounded geographically and bounded through changing internal protocols as well as bounded by changing technology and demands for technology. These physical boundaries are of interest because they are useful to understanding the social and cultural construction of the healthcare workers who make up the collectives of professionals working together to restore health. How the individuals with separate professional roles use the technology or other limitations as part of professional and personal identity and profession are then useful to understand the individual who takes on a profession that has a specific goal of restoring health.

Spaces and Work Flow at UED

The UED hospital is an urban academic hospital that sits between some of the wealthiest and poorest neighborhoods in New York City. UED in New York City has various sections to it that include the *resus* unit, geriatric emergency care, pediatric emergency care, various levels of urgent care and acute care. Patients that are stabilized in

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authoritarian way does not engage the necessary sociological exposure of social processes and discourse necessary for restoring ethical practices to the social.

In defense of principles in bioethics it is important to also point to the repeated need to provide a principled approach and laws that grew out of abuses to minorities and vulnerable populations used in medical research. The research violations of individuals resulted in the first code of ethics in treatment of human research subjects with the Nuremberg Code following Nazi research atrocities and then in the United States the Belmont Report led to U.S. Regulations (Shamoo and Resnik 2009).

the *resus* are usually placed in acute care until they are admitted to the hospital. Some urgent cases in the *resus* go directly to the Intensive Care Unit (ICU) or Medical Intensive Care Unit (MICU). Other than the EMS ride-alongs my research observations focus on the acute and *resus* areas of the emergency department.

As a patient walks into the emergency department, they proceed first through several sets of automatic doors that on most days are propped open. A patient who walks into UED encounters a mostly empty waiting room with a high desk where a business associate, security guard and registered nurse talk to patients, register and check-in the patient. From here, the patient is directed to either triage for further evaluation, urgent care, pediatrics or sometimes directly to the *resus* area of the emergency department. The most critically ill patients in need of close monitoring or stabilization are sent to *resus*. A patient sent to *resus* walks or is wheeled through a few more automatic doors and then is met by a team that rapidly assess and works to stabilize[43] the patient. At UED, the *resus* space contains five beds referred to in this study as *Resus* 1 through *Resus* 5. Curtains partition the first four *resus* beds and a fifth has glass doors for isolation as necessary. The nurses have a countertop with a bank of computers where they sit with their backs to the patients as they record and receive patient information into computers as part of the now ever prevalent electronic healthcare record (EHR). Sitting at the screen they can also check for lab work

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[43] To stabilize a patient is a requirement of all hospital run emergency departments. Under federal law stabilized is defined as:

> "... to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to [a pregnant woman having contractions], to deliver (including the placenta)" (2005).

that has been completed or new orders from a physician that are sent to the nurses via the EHR. The process of stabilize, check, admit and observe the patient repeats throughout the day and shifts of nurses and physicians. The constant goal is to use the tools, resources and understanding of the human body to move the body away from crisis and to another part of the hospital or discharge. The interactions are a constant interaction of humans with technology and each other.

The interaction of humans with technology is a continued point of investigation in anthropology (Browdin 2000, Casper and Morrison 2010, de Laet 2012, Lock 2001). The convergence of individual training, personal phenomenology, and technology are part of a continuing dialog that knits objective knowledge, group behavior, and autonomous decision making with technology. In this study I observe the cultural construct of how professionals occupy their role as paramedic, nurse and doctor. In this observation of the role interaction I also observe their interactions with patients and with patients mediated through technology. The cultural constructs within the hospital and specifically within the emergency department are partly determined by practice standards. There are also stated and unstated codes of conduct wherein work groups participate together to create care. While these interactions within medical roles has been a point of study (Cadge and Hammonds 2012, Hoeyer 2007, Mertz et al. 2014, Lock 2001), the intersection of moral agency, technology within critical care emergency medicine remains unexamined. As such, I discuss these roles and interactions relative to the visibility of moral agency of the healthcare worker within local moral worlds. The point of study that emerges from the data is an awareness of the individuals as part of healthcare groups with local moral worlds who through their work find ways to create care as they maintain their personal moral concern to create care.

Chapter Three

Emergency Medical Services (EMS) and the Work Through

Starting Spaces and Observations

Entrance to my field site started with meetings, many meetings. I am forever grateful for the introduction that I had through mentors who made the necessary calls and introductions to the director of UED. I made the suggested cold calls where I spoke with assistants of the director, and then one afternoon I received a call. The woman who was the director was pleasant but professional and direct with her questions as I explained my interest and the value of qualitative research and observing in her busy emergency department. I made a request for a limited time to begin at first, for three months. She was silent for a time on the phone and then asked: "What could you possibly learn in three months of observation?". I saw her point and explained that I hoped that this would be a pilot to a larger study for my thesis, but that it was part of a study requirement to do fully immersed fieldwork between the first and second year of my doctoral program. She seemed sympathetic to my interest and asked: "Would you be willing to work on other projects?". Of course I told her I absolutely would work on other projects. "I think I may have someone who is doing some research, can you come in to talk?" The time and date were set and I met with my contact, Dr. Rahm, who explained his research and what he needed someone to do and that he needed somebody who could be in the emergency department a minimum of fifteen hour each week. He mentioned that he has had other student researchers but they are

not able to provide the continuous hours necessary for this research project. Since this was field research, I assured him my time in the emergency department would be more than fifteen hours each week and that I would be there for consecutive hours each day.

After having a few additional vaccinations and showing I had recently had a negative PPD (tuberculosis), I was allowed to start an orientation that included fifteen training modules and exams on research ethics and related regulations and the history of biomedical research in the United States. With these requirements met, I began my observation and spent three months doing my observations and working on the research project for the Attending physician Dr. Rahm. That research required that I observe and record the interactions of emergency medical service providers as they handed off patients to the critical care or resuscitation (*resus*) area of the emergency department. The *resus* is an area in any emergency center that is equipped for and receives the most critically ill patients. Following the first three months of research, I maintained contact with my interlocutors and returned full time to my field site continuing research June 2015 through June 2016.

The day to day allowed me to stand in the often crowded area of the emergency room *resus* and then as part of the "EMS research project" recording the handoff as EMS gave reports on patients as they were brought-in and left patients with the physicians and nurses in the emergency department. In the EMS research project I was required to create specific data sets that were extracted from the recorded conversations and a list that I developed with Dr. Rahm that allowed me to check-off what I heard and saw that was not audible on a recording. This research was an opportunity for me to be extremely close to the physicians, nurses and paramedics as they treated critically ill patients.

I was clear with both my interlocutors, the director Dr. Johnson and Dr. Rahm, that I would be taking notes and observing and that I hoped to conduct interviews as possible. I was told that any formal type interview with staff members would have to be done during staff breaks if the healthcare workers felt they had time. After the Urban Emergency Department Academic Teaching Hospital IRB reviewed my Teachers College IRB approval I was told UED considered it adequate for them and my purposes. I was able to start my fieldwork. Dr. Rahm's protocol allowed me to have a clear view of minute to minute interactions in the production of critical care medicine. The view however is not without distortions. In a description of her thesis research in a neonatal intensive care unit, Renée Anspach discusses what she terms the 'dilemma of discretion' where researchers are concerned with boundaries to the point where an ethnographer would avoid asking questions or initiating conversation for fear of offending (Anspach 1997).[44] Like Anspach, I was grateful for my position as an ethnographer but cautious and respectful of the house of medicine. I did not want to disturb or draw attention to my constant observation. While the focus of this research is not my interaction as an ethnographer, it is important to note that the hospital or any healthcare setting where there are constant interactions as part of the routines

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[44] Anspach further elaborates her initial fear and then continued feeling that raising concerns or asking questions jeopardized her research position. She elaborates about how this can stifle an ethnography that could be otherwise more dynamic. In her essay co-written with Nissim Mizrachi, Anspach provides detail of incidents that she witnessed in neonatal care that ethically violated the rights of an infant's parents and that put her in a questionable legal position for having not only witnessing events but having them in her field notes (Anspach and Mizrachi 2007).

Anspach's discussion of the difficulty as ethnographer and individual witnessing event resonated with me due to the often unpredictable and unfortunate events that I witnessed and often by virtue of being present in the room played a role in how a care event unfolded.

that these are also social spaces. The spaces were social spaces of interaction between healthcare workers as well as patients.

In one of the early interactions, a tall, assertive but pleasant Attending saw me hesitate as the *resus* medical team received an active cardiac arrest (CA) patient from the paramedics. As she saw me unsuccessfully attempting to get closer to the interactions for the purposes of Dr. Rahm's study, she rather forcefully took my arm said: "well, get in there" and pulled me into the arena of care and pulled the curtain around me and the team *resus*citating the patient. From that point on, my task supporting the research protocol was part of the expected routine as I stood each day in my "spot" in the emergency department. As part of my daily fieldwork progressed, various staff in the emergency room began to ask: "why aren't you in your *spot* today?" if they saw me coming and going with an ambulance crew or if I was late getting into the emergency room. The routines and familiar faces were important for the nursing and tech staff. The residents and Attendings sometimes questioned my presence at my "spot", but most often if a physician approached with a question, it was to ask me the name of a nurse or tech.

As noted, the research protocol was my entrance to observing the work in the emergency department. From this point of entry I observed how the work of repair on bodies occurred throughout different groups and processes in the department. In the same way that bodies in medicine are the rationalized medical knowledge to be understood and practiced upon, so too was administration of a research protocol an observation of interactions and repair on the body. The subjectivity and the varied agenda as a researcher made for a rough start to some of the days I spent observing in the emergency department. Despite the clear understanding and acceptance of the medical research protocol, prior to

getting used to my presence and "spot" the nursing staff had difficulty understanding the necessity of my constant and daily presence – was I watching and recording them? As detailed in Appendix III, my method of recording was detailed note taking. The work was constant. While I always attempted some discretion as I took verbatim notes of conversations and interactions, the constant standing and note talking was noticed. In the beginning, the tension for me was often palpable. The physicians often asked me questions directly and for those who had an interest in my field research, they asked me questions and would bring up issues they thought would be of interest to me. One senior Attending looked at me and said: "Your demographic is ...different, what is your research?".

Although prehospital care provided by EMS workers was not a focus at the outset of the project, as I observed the interactions and demands of healthcare workers and how they placed their role and what was important to creating health and stabilizing patients, it became clear that EMS had a socially and culturally constructed moral placement to their work and perception of their role as "street doctors".[45] The paramedics and other pre-hospital care emergency workers were often disregarded by the nurses and not necessarily valued by all physicians. Yet, EMS persists as individuals and as a group representing a professional role that maintains an important part of emergency medicine in the United States. My chief interlocutor, Dr. Rahm, strongly encouraged that anyone doing research with him in the emergency department participate in ride-alongs with the pre-hospital care

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[45] In the ride-alongs with paramedics, I had more than one paramedic tell me that they were sometimes known as "street doctors". The statement when made is very revealing about how these individuals regard their role in the community and with the public.

teams, also known as EMS.[46] While he asked *if I would like to*, it was also made clear to me by him that one cannot understand the interactions and the role of work in the emergency department without knowing the work of the EMS prehospital care teams. Thus, following more paperwork, I spent time with both advanced life support (ALS) and basic life support (BLS) teams as part of my field site. My daily field site however was the emergency department at UED which was part of a much larger university academic research and teaching hospital. Thus, while the physical boundaries of this field site are wide ranging, the focus of this study is the many healthcare workers with varied professional training and disparate educational and professional backgrounds as they carry out their responsibilities helping patients in need emergency medical care.

Every day at UED I saw many EMS workers lined up with gurneys waiting to register patients to the emergency department. The hallways were usually clear in the morning but by mid to late afternoon, EMS would be standing with their patients sometimes five to seven in a row along the corridors. The process for EMS bringing patients to UED and for most hospitals was the same. Unless the patient handoff to the emergency department was in active cardiac arrest, EMS would provide information to nurses in the triage area. A nurse would check vitals, briefly discuss medications and then patients would

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[46] The EMS workers are divided into two categories based on education and hours of prior ambulance work as part of their education. Advanced Life Support (ALS) are paramedics and can administer certain medication and have advanced airway equipment and cardiac life support equipment. They can also start IVs, administer medications, and perform more advanced procedures. The Basic Life Support (BLS) have significantly less training hours, can use AEDs and have tools for traumas, but cannot administer most medications. The differences were explained to me by EMS. In one instance I observed in the *resus* where a patient that was in need of more advanced life support, the physician attending to the patient asked EMS why the patient had not received and IV and other measures, the EMS looked at the physician and tapped the patch on his shoulder. The shoulder patch that notes EMS-B indicates the level of education, equipment and training that the EMS-B has.

go to a designated area of the emergency department. Pediatric patients were rarely made to wait. I had seen EMS bring in patients in full cardiac arrest as they actively continued compressions while moving patients from the ambulances through doors and into the *resus* to handoff patients to the UED emergency staff. I had seen EMS frustrated with UED staff in the *resus* for not listening the first time as EMS gave vitals and presented the patient case to UED staff who walked away or talked over them as they attempted to detail issues regarding the patient. The process known as handoff is often studied and well documented as a point of interaction in need of better transitions. The relationship between UED nurses and physicians was never contentious. It was however sometimes strained. It was with this knowledge of the patient handoff to *resus* and check-in with the nurses as patients are sorted into the emergency department that I started my first ride-along with a UED EMS crew.

At 4:45 in the morning, traffic into New York City is swift. The thought occurs to me that the bizarrely fast speeds being driven by those of us cocooned in our cars heading into the city are heading to some sort of early morning shift work. Few white collar professionals need to relieve or "sign-out" the next shift by 6:00 a.m. I get to the cross-streets near the hospital where I was told to find the ambulance unit I had been cleared and assigned to spend the next 12 hours with as a 'ride-along". I spotted the ambulance across from the ambulance bay where two paramedics were clearing out their belongings and a third was receiving a set of keys. When I walked-up to introduce myself they were discussing a problem with the keys. They had only one set. The keys worked only in the

front and could not be used to lock and unlock the back. As I later learned in various conversations over several ride-alongs, unlocked ambulances are often stolen.[47]

Another issue on this particular morning was that the paramedic coming onto shift said her partner had not showed-up yet. One of the paramedics coming off shift can leave but one must stay to complete the narcotics sign-off and wait until the second member of the new shift arrives. The sign-off and exchange of shift for the ALS units requires a transfer of a narcotics pouch that includes documents regarding the prior shift transfer and the use of drugs, restocking of drugs and signing the pouch to the next shift. The two paramedics looked at each other as one moved papers to expose a large clock on the dashboard of the ambulance. They both seemed to indicate an understanding or pattern of the paramedic who was late. The paramedic leaving (Wayne) asked if Ella (the paramedic that was late) was just getting off another shift. The partner who was waiting (Tara) just shook her head. There was some sort of understanding between them regarding the wait. While we waited, Wayne related issues from the night shift. Throughout my time with the various EMS crews, there were always stories. The telling of stories were not the expected stories of bravado but something I realized over time was more of a way to unburden the day's events and relate issues shared by paramedics.[48] While we waited, Wayne seemed to want to relate some events that bothered him from the prior shift:

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[47] The tragedy that occurred and cut short the life of dedicated paramedic Yadira Arroyo is an unbelievably tragic example of an ambulance theft in New York city. The single mother of five was struck and dragged under her unit when Jose Gonzales attempted to steal it on the evening of March 16, 2017. There are no words to describe this unimaginable tragedy that happened to an individual who devoted her life to helping others.

[48] Several accounts in the United States and Australia discuss accounts of story telling in paramedics as part of action and presenting themselves as competent in a job where they often must make decisions for unanticipated events (Tangherlini 2000, Lazarsfeld-Jensen 2014). While Tangherlini

Wayne: So, listen to this…so we get this call….this is one of those calls where they [here Wayne is referring to the emergency department] don't listen… and we got to the house and there was this woman and the daughter wouldn't take her to the hospital so somebody had called us. This lady looked really bad. She kept saying she was hungry and nobody would make her a sandwich. We took her vitals. Her BP was low, her glucose was through the floor and she was tachy. We call ahead[49] because we think she is about to crash, but we start an IV and gave her an Ensure and she starts to look better…you know her color comes back. We get to the ED, and the nurse says: "why'd you bother us – she is fine" and they take her. We get them fixed up just a little and they don't look so bad."

Tara: "I hate that, they act like you don't know what an emergency is and then..."

Wayne: "Wait… that's not it, we bring another patient later in the shift and that same nurse, stops me and says: 'you know that patient you brought earlier…she died'. She just says this and walks away. No emotion."

Tara: "That is cold."

While we waited for the second paramedic, Wayne's story seemed to reveal more than illustrating a story to pass the time. He was frustrated and saddened. He discussed how sad the older woman who was not cared for at her home made him and then was upset that their call and bringing the woman to the emergency room was not handled appropriately and that

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touches on the issue of self-deprecation, what I observed was a professional resistance to a days work of difficult and mostly unappreciated work that is often part of group belief where individual knowledge may not agree, but the discussions are part of group understanding(Hakli 2007).

[49] 'Call ahead' here indicates they phone into the emergency room through the FDNY dispatch that they are coming-in with a critical case. The issue is relevant here because the paramedics, and in this case Tim with the call, do not feel that the hospital nurses receiving the patients listen to them when they believe there are issues to report.

on the same day when the nurse told them of the woman dying – she did so with no empathy. He was clearly affected by the interaction with the nurse. What defines moral is also a reflection of interactions and how one individual action affects the actions of others (Pence 2008). Wayne and his partner had done what they deemed appropriate to help a distressed and physically fragile woman. They left the woman with the hospital staff and made clear that she looked better but was in bad shape. Wayne was reflecting on how as EMS they were not heard or listened to when transferring patients. These reflections and stories are part of identity and have implications in relieving stress (Simon 1997). The stress is certainly the stress of the job, but it is also discussing with another EMS, that they often understand the physical issues of the patients. The care they provide is of value and to discuss and tell the story relates the moral good and worth of the work.

It is now 6:40 a.m. and Wayne has been very patient. Ella (the medic coming on the shift) called Tara to say she is parking the car and will be right there. They finish the sign-off of the Unit (ambulance), and Wayne says as he is walking away: "Oh and we had Austin twice" He holds up two fingers as he is walking away. Tara smiled and rolled her eyes and asked me "Have you met him?". Our second call is Mr. Austin. As we approach the address for Mr. Austin, he is out front on the steps with his oxygen tank next to him as he smoked a cigarette. The call on the 911 system stated that the caller had shortness of breath and difficulty breathing. The shortness of breath was a high priority call and therefore this crew – an ALS crew was sent to the call. As Tara drove, Ella climbed in back with me, filled out paperwork, put Mr. Austin on BiPAP (forced oxygen) and gave him medication through the oxygen filtration in the BiPAP.

This section of the study explores how EMS workers reify the legitimate space of individuals in the public in need of care by providing a safe promise for better. The legitimacy for these people, the public in general is to provide to them the care and dignity at an equal level and the same attention, with care. In that space for "better" is the personal moral position. They do so by working *through* the cases encountered. The EMS moral position, concern and sometimes distress from an inability to change or mitigate a situation are often quite clear. The individuals discussed in this section constantly walked into unknown situations to assess strangers and work through whatever the issues are that EMS can do to stabilize the patient and get the patient to the next best place.

The representations here are individuals where 911 was called for them. While no two calls are the same, 911 calls represent the trust and contract of institutions with the public. What is morally relevant with this group of healthcare workers is how the individuals who fill those institutional constructs embody a moral and ethical position that is part of care. That care does not privilege class, social or economic status. That brief trust and dignity with which each call is handled contributes to the brief trust of the patient. That patient then proceeds to access care on equal terms with others receiving medical attention in the emergency department. As I observed through the varied calls, the patients are often individuals who experience the continued dysgenic effect of healthcare institutions that except for urgent situations or crisis are unreachable as points of healing.

EMS: A Point of Entry

The Institute of Medicine has issued two reports regarding racial disparity in medical care which discuss both access to emergency care and the inconsistent emergency care systems across the United States (IOM 2003, 2007). These reports which are the most explicit analysis of emergency care and racial disparity do not capture how racial disparities in medicine exist at the point of entry with emergency medical care and the interactions of those emergency situations. In combination, these two reports discuss the models and disparities in emergency medicine while both noting the need for more research of the individuals and actual EMS production of services. In one study that was a meta analysis and included triage data from EMS to the emergency departments, analyzed the data for disparity in triage based on race or insurance (Oster and Bindman 2003). In this study, Oster and Bindman found no difference in prioritization (triage) based on race or ability to pay. This study is particularly important in the face of established institutional bias since it reports how EMS as a point of entry is not where racial bias occurs. Since hospital emergency departments and the EMS pre-hospital care are often noted as the "safety net of healthcare" (Blanchard, Haywood, and Scott 2003), it seems unsatisfactory, at best, that the extension function of emergency medicine remains unexamined in how the healthcare workers providing prehospital care are regarded by the profession and those with whom they interact and to whom they attend. It is this prehospital care safety net in our society where I examine the often noted and neglected groups of both patients and the EMS care providers as they respond to both the underserved as well as the well-insured seeking medical care.

This care in the form of EMS providers requires the trust of the public and the people being stabilized and transported to the emergency department. That trust and the question of producing and promising better health is where my research begins as EMS provide a role of transport, counsel and stabilization of underserved individuals in their communities. I examine how EMS personnel relate to and perceive their role with the public and their personal role in producing medical care. I contend that EMS performs their duties with a specific moral position and that it is a personal moral agency that is part of both social and personal worlds EMS inhabit. In a nod toward implicit moral agency, others in healthcare note that as part of the caring profession of nursing, moral agency is an implicit part of the relationship and interaction in critical health care medicine (O'Keefe-McCarthy 2009). Other claims regarding moral agency in everyday action argue that such moral acts, even fleeting, are rooted in epistemological teaching (Zigon 2007b, Rorty 2011). In this study, the moral compass of individuals observed is their personal agency in the world and explained by them as what they "do" revealing their conduct as moral phenomenology lived and experienced, reified in their daily work. The phenomenological approach is significant because it allows for examination of the ambiguous that can weigh on actions and interactions (Desjarlais and Throop 2011). While it is difficult unless specifically voiced to know a moral position, some actions in the context of care reveal it. The interactions and observations of these moral acts as care are part of the local moral worlds of the individuals and the understanding they have with one another as part of a group working to address and support strangers by providing care.

In the emergency department, medical care of illness is a complex set of social and political constructions to effectively deliver care to patients, part of what is the material

shaping of illness (Good 1994). Bodies as objects or body alienation is part of contemporary medical practice (Scheper-Hughes and Lock 1987). As alien, the body can be worked on and fixed, in a certain symmetry to the machines that are used to monitor and keep the body safe. Scheper-Hughes and Lock extend a symbolic equation of "humans as machines" in regard to the body as a commodity (1987: 22). In the emergency department, the input and output of bodies, while safeguarding bodies, makes the body an object but also a commodity that is part of the organized practice of medicine. A body is thus implicitly in emergency medicine promised better or restored health. EMS however brings in these bodies, and in doing so, is often rendered as little more than a stabilization and transport team. This part of the study reflects on the individuals who, as part of who they are, do more than transport. I argue that it is this healing promise for better and how it is carried out by EMS that begins the journey for the marginalized often cared for by EMS as these healthcare workers find ways to work *through* problems to effect patient care.

By exploring how healthcare workers work within the structurally defined parameters of emergency medicine to create care and negotiate personal hazards to care for the abused and forgotten health emergencies, I examine the temporary healing power of EMS authority and the promise for "better". As an ethnographer, I examine how EMS affects the structural on the daily life of those deemed emergency cases by outsiders who call 911. A few of the interactions I discuss in this study to illustrate how the EMS work and make their moral intent visible include calls to the presumed heroin addict in the street; the violent student during recess; the young woman staring on the corner of a busy street. The call and response represent a cascade of lives that are delivered to various emergency departments in the city with a promise of helping to get ..."better". As part of my analysis, I

explore the sense of the individual as public and then patient where communication is shared through aberrant physical and sometimes psychological behavior to identity self and the body that is taken and promised healing. The exploration builds on phenomenology of perception[50] that is then realigned in the greater bureaucracy of medicine for healing. The perspective of suspended liminal[51] interaction is also discussed as interactions in care reveal how technology and institutions represent the potential better health and life change in vulnerable populations caught in a web called to them and by them for help.

The personal space and relationship of EMS with the public is unique. The interactions of EMS with people seeking care reveal a proactive nature and in both cases where care is sought for them and EMS respond by answering the call. Both interactions encompass the attempts by EMS to aid those in need. However, the unique perspective witnessed in these examples, as well as numerous others, were attempts by EMS to make a change for the individuals. EMS was helping – not to simply avoid tragedy but to make

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[50] Phenomenology of perception is a study of what is internally structured and understood for an individual. It is distinct from a scientific study of mind or disease, however such phenomenology of perception for healthcare workers is possibly what those individuals build as someone whose personal and ethical agency is involved in their work.

Maurice Merleau-Ponty explains human action as part of sensory that "precedes knowledge". This research examines a dualism of the individual professional with their personal intuitive and perceptive knowledge of how to treat that which is bounded by the dualisms of subject (patient) and object (medical illness). This dualism puts the phenomenological care provider in confrontation with an entire working order of bodies that have already been typed by science to exist in a certain prescribed function or definition (Manara, Villa, and Moranda 2014, Merleau-Ponty 2002 [1958]).

[51] Liminal here is what Victor Turner called a reconciliation of pragmatic and symbolic action. The distinction that Turner raises in his use of liminal is that the frames referenced of those being studied are not part of a concrete system that can be typed where he references various cultures (Turner 1975). This is important when in a study that examines closely three different levels of professionals that find ways to work around and through issues with the result of making visible over time the moral position and intent of those providing care. The symbols and operations, communication to workaround to achieve the goal varies with each group, which as Turner makes clear in noting how signs can be part of communication and cognitive properties (1975: 152) which is what this study describes to make clear the moral visibility.

these individuals understand and commit to being better. While we think in the context of health and better health, theirs – the EMS workers, seemed to commit personally to each patient. What I observed in the actions, experiences, and actions of these workers, was to lead these individuals/patients/subjects away from personal danger. That action is one piece that makes the EMS actions morally relevant. The people I observed that were treated or attended to by EMS were consistently disadvantaged economically, socially and had the added vulnerability of a compromised health situation.

The moral component of EMS interaction was reasserted in EMS interactions in varying degrees as the patient was delivered from a crisis in a public sphere to the hospital. However, while the moral function persists, there is also an inherent reproduction of political order when EMS moves those in need of medical care from the street to the hospital. This repetition of order reflects what Bourdieu discusses as symbolic norms of function as repetition of an ideal order (Bourdieu 1995 [1977]). Bourdieu's description regarding ideal order is important regarding EMS because it explains the need for order and reproduction in medicine. Thus, that reproduction is also consequential when considering the unpredictable nature of EMS work. The ongoing listening, calming and advising are part of work that is also social service. However, what was apparent in these interactions was EMS insertion in critical issues that were simultaneously health emergencies and moral drama. The structured pluralistic norms of healthcare and ideal order could not be successful with the situations that occurred were there no EMS representation of moral norms. Those norms were held internally and expressed through the constant vigilance of getting patients to or through to something better.

Each EMS call was a crisis demanding and intervention for health – or repair. The 7:15 a.m. call came in for "a woman in distress" corner of 1st avenue and 114th and...then it was not clear. I sat in the back next to the gurney of what I kept calling the "truck". EMS calls it a "bus". The dispatch call it a unit. Most of us know the bus as an ambulance. The bus lumbered forward out of our shaded waiting spot on a side street and the hot summer air flooded through the vents as the bus lurched and turned through traffic. On this day, I was riding with a BLS team. The BLS teams had fewer required training hours, did not perform invasive procedures and did not carry narcotics. Roberta resisted using the sirens unless traffic was especially bad. She made the hulking truck-bus seem agile while her partner Meera, in the passenger seat, simultaneously spoke with 911 dispatch and dialed into a computer as we circled the block attempting to locate the woman that was in some sort of distress. We circled the described two-block radius twice and called back to dispatch. Meera then spotted a woman hunched over with a man next to her leaning against a wall. The man left as the bus approached. The woman appeared young, she had a vacant expressionless stare. She was tall, slender and somehow unbelievably both calm and tragic. She had a very placid expressionless face. I stood by holding a case that contained oxygen and other equipment as I attempted to make myself useful with the constant on and off loading of equipment. The woman nodded when Roberta asked if she needed help. She did not answer when Roberta asked if she had called 911. The description seemed to fit and Roberta and Meera proceeded to figure out what was wrong and what they could do to assist. Meera intuitively took over from Roberta speaking to her in a low and soothing voice. Meera hunched against the wall next to the woman. Meera asked when she has last "used". It was maybe six hours ago but "maybe yesterday too" came the response. The

patient stared at the ground and said nothing for a time. Meera waited patiently, giving her time to speak. Eventually, the subject said that she was afraid she would hurt too badly today. Roberta broke the calm wanting to know if she was in pain. The would-be patient looked up at Roberta briefly then stared down again saying that she did not want to feel …her words faded. Meera coaxed her to try to walk toward the ambulance holding her by the arm and shoulder. She spoke in whispers to Meera.

I wondered how her triage or ranking into the hospital would be handled. In my observations of the resuscitation area of the emergency department, the suicides attempts of the well heeled were often quickly followed by the appearance of a personal physician or therapist that seemed to materialize at the bedside. Next to the private physician was the fraught or even an annoyed spouse who explained circumstances to physicians and nurses. The EMS patient on this call had no connections to offer as a contact – a formality with the paperwork as we sat in the ambulance. The ambulance was called *for* her because someone else called. The subject told EMS she wanted to live without pain. Meera did not make promises, she listened and understood that the patient was suicidal and needed to be somewhere else. Again, there was a promise of "better". Meera soothed and confirmed to her that she had made the right choice and they would take her to the hospital where they are prepared to help her. As with the others, the patient, the subject was signed-in to the closest hospital that would accept her case. Roberta and Meera with completed paperwork at the emergency department had her sign the papers and wait until a triage nurse released EMS of the subject.

It was early June and particularly hot for early summer. Temperatures at ten in the morning had climbed past 90 degrees (F). Between calls, we sought out shade and propped

open the hood of the truck in an attempt to cool the engine. On the next call from dispatch, the police department got to the call site before us. It was not immediately obvious, but the call was at a school. As with most urban schools, there is no grassy lawn. Roberta and Meera both commented that these calls were the most unpredictable and for them "bad, just bad". I wasn't sure what that meant. We walked up six flights of stairs that were progressively warmer as we ascended carrying the twenty-pound transport chair and other equipment to assist with medical intervention. I had not understood the nature of the call when we received it. Meera and Roberta debated taking the chair. They were uncertain about what the call was and did not know if we would be transporting someone in the chair. We hauled the chair along with us anyway. The noise from the classrooms intensified as we opened the door from the stairwell and made our way down a hallway on the sixth floor. We were led into what seemed like a multi-purpose room and storage facility where four very large men stood in different parts of the room with one child – one student – a boy cowering near an iron screened window. Roberta started asking questions. One of the officers began talking to her. There were at least three ongoing conversations. Meera looked around the room and without asking questions went to the boy and told him who she was and why she was there. Roberta began speaking with someone – perhaps a teacher or administrator. She wanted to know about a guardian or parent. She then asked for a phone and they attempted to reach the boy's mother.

The boy was not physically hurt. EMS had been called to remove him because he had physically lashed out at a teacher. The boy was 12 years old, possibly large for his age, but very obviously a child. From where I stood, I could see he was simultaneously withdrawn and terrified. The school counselor stood close behind the boy while Meera

continued to try to talk to him and attempt to engage him in a conversation. After twenty to thirty minutes, the call from the mother came. She could not, possibly would not, talk to her son – somehow that was against a rule. The mother made it clear that she wanted him taken to a certain hospital that is well known for pediatric psychiatry services. She said they had a therapist there – someone that knew them. Roberta spent some more time on the phone and then had to call back the mother to inform her that the requested hospital was in overflow and could not accept her son. Roberta had to repeat several times that the hospital was in overflow and that they were not accepting any more children.

Meera abruptly and with confidence and calm turned and asked for some space. The two men hovering near Meera and the boy wandered toward the police that were talking with another man in the room. They seemed to be taking some sort of report and taking down information. Meera walked with the boy to another corner of the room to continue to talk with him. She was – very apparently trying to calm him down. And, she was gaining his trust. It was clear that none of the adults – school principal, a counselor, two teachers – had any interest in this child staying in the school. They were clustered in groups in this large vacant room. They were all men. After another ten minutes of Meera speaking with the boy, she asked Roberta to make sure someone had the boy's school bag or what he needed and whoever was riding with us. She was brief and direct. She kept her attention focused on the child. The boy placed his hands on his ears and faced the side of the wall as we walked through the crowded hallways. Some kids at one point were jumping up and down as we passed saying to an officer that they saw what happened. We all kept walking. We were a large posse with the boy and Meera somehow walking together as a unit, Roberta, myself and then two police officers.

Meera joined me in the back of the bus with the boy and the school counselor. The school counselor was given paperwork. The boy never looked at the man and tried to continually turn away from him as we rode in the bus to the emergency department. It was just after 1 p.m. by the time we registered the boy with his school counselor at the designated hospital – a hospital without a pediatric psychiatry unit.

We were back on the bus and Meera was clearly annoyed with how the situation appeared to have evolved. She said that the boy never had a chance. "...can't you see how hostile the room was?" "The counselor wanted him restrained" she said this with exasperation. Roberta nodded and said that she wanted to raise her kids outside of these schools where misunderstood kids and medicated kids...her voice trailed off for a time. She then picked up the dispatch radio and called-in that the unit (the EMS team) was available again. Both Roberta and Meera were single mothers. They were both in committed relationships and both had family helping out with the daily activities of school and homework for their children. I had a glimpse of their lives when we headed out earlier that morning. Each of them checked-in with their kids as they headed out for school. Meera received a report on what was eaten for breakfast and Roberta wanted to make sure a child remembered gym shoes.

In another instance, the talk is not always about informing or relating medical knowledge, but medicine is a reassurance. There was a certain amount personally at stake that the right thing could and would get done when EMS went into situations. With the last call, both Roberta and Meera seemed at a loss. The search and constant move "to better" comes out in conversations relating stories and having taken part in an attempt to change those stories. The moral position for these healthcare workers was very directly part of how

they handled and attempted to handle the patients in each call. EMS participate if momentarily in a social world that they must quickly access and respond to analytically. They apply medical knowledge, but also in many cases there is an ongoing sociability that crosses between intersubjectivity[52] and phenomenology. The actions and the issues dealt with are simultaneously social and moral. The knowledge may be applied as it is constantly negotiated through conversation and actions.

Making observations on the twelve hour shifts with EMS provided me with greater insight to the EMS workers personal perspective, how they viewed their role, and what it meant to them personally and professionally. There was a lack of continuity as I never was assigned to the same team EMS team. However, the visibility of personal moral agency as part of care as the EMS worked *through* situations was repeated.[53] On an ALS ride along with Ella and Tara, Ella worked two consecutive shifts piecing together a twelve-hour shift that I was on and then another six-hour shift with another company. The double shifts were common for many of the EMS workers. Ella had been doing EMS work for 18 years and often was assigned to work with Tara who had been doing paramedic work for three years. Tara drove and Ella seemed to mentor and talk about the process. We were passing one hospital and there were several fire department trucks and a very large ambulance-looking truck.

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[52] Intersubjectivity is mutual understanding and coordination around a common activity (Duranti 2012).

[53] When back in the emergency room I would see the EMS crews bringing in patients and they would usually ask about my research and when I was riding along with their unit again giving me the schedule and telling me which partners would be good to ride-along to observe. Over six ride-alongs, none were repeated EMS crews. When I asked Dr. Rahm about scheduling a repeat with any of the groups, he said it would be unlikely.

Ella said to Tara: "Look wow…it's the MERV!...Have you ever had to call that?"

Tilting her head back toward me Ella continued for my benefit.

Ella: "The MERV is used when you have patients that can't fit into your regular bus…did you hear the call?"

Tara looks down at the screen to see what calls have gone through where the MERV was called.

The interest and fascination with having to take a call with the MERV surprised me. MERV is short for Medical Evacuation and Rehabilitation Vehicle. MERVs are used to stabilize patients at the scene of large scale emergency situations and some are designed for mass stabilization and transport. Other MERVs have capabilities to transport large patients that require cranes or other mechanical measures that are not part of routine EMS care. I couldn't tell if it was something she was just fascinated with or something else. Perhaps there was some interest in the potentiality of aid and care and working through a problem where EMS would be required to call for a MERV.

Later the same day while we were waiting to register a patient at the UED emergency room, Tara nudged me to watch what was going on in the *resus*:

Ella: "That is the code we heard called-in". I glanced in at the group assembled in the *resus*. Two physicians left the group and approached a woman sitting in the hallway next to where we were waiting and said to her:

Physician 1: "We just shocked him again and cannot get a …we can continue CPR…" He said this to her as she looked up from her seated position. She was on the phone.

Woman: "Well, you can come here tomorrow, yes I am at the hospital". The woman who the physicians had been addressing about the death said this into her phone. Of course this did not make sense with what the physician was telling her.

A young woman wearing the research smock/uniform I wore each day in the emergency department brushed passed me and Ella. She had been one of the many

"observing" the code in the *resus*. She was wiping her eyes. She ran out toward an exit to the street.

Ella nudges me back to the patient we brought in that is now being registered by a nurse... "...see they called it, too late".

The cold reference to continuing or stopping the resuscitation to the woman seated seemed in such contrast to the EMS calls where everything was done regardless. It wasn't clear how long the code had been going on or what the relation was of the woman who did not seem to register what the physicians were telling her of the death. Ella seemed annoyed by what was going on in the *resus*. The issue of multipliers resurfaces here in that Ella has a shared knowledge base with those doing the resuscitation. She seems to believe that something went wrong – with the same knowledge, faster or better care, that person could have been helped – the *resus* event was momentarily part of her collateral world. Similar to Wayne's story early that morning, she had a personal moral position, her agency was affronted with the loss of life.

While taking the next call we waited for a supervisor to bring meds we had run out of on the bus and were necessary to respond to the call. The paramedics are out of albuterol and ipratropium. Both medications are used to help people in respiratory distress. The medications are considered routine but in the last month, the EMS workers kept talking about a "shortage". When the supervisor arrived, he said he had been to two or three 'places' and finally got the meds. The entire piece did not make sense, but he seemed to make sure that the crews he was supervising would have the meds. Of course what was not known at the time is that the parent company that UED contracts through for the EMS work was in financial trouble. The company was bought by a for-profit company and was later in

the news as having been run into the ground.[54] The healthcare workers attempting to treat the public were frustrated but doing their best to continue to provide care in the streets. While we waited for the supervisor to arrive with the meds Tara filled out paperwork and then listened and nodded as Ella talked about continuing codes on people that were long gone. She talked about having gone into a hotel where somebody coded in a lobby bathroom and had been dead for a while but that they had to go through the lobby doing CPR so it didn't look bad for the hotel. Tara chimed in about the body being warm and Ella picked up her sentence saying that the residential houses and nursing homes where the person died over night but if they are still warm, they must do CPR. They both sat there in the front just staring. They seemed to be reviewing situations or images. Nothing was said for a time until there was a knock at the window. The supervisor had some meds – not a full restock, but enough to finish the shift.

It was close to four, two hours to go and the next call is a code at a private doctors office. The office was an oncology clinic. The patient was in a room by herself receiving a chemotherapy infusion. When a nurse came back to check on the patient, the woman was unresponsive. The fire department was already there and an FDNY (Fire Department New York) ambulance crew was also present. An anesthesiologist who was called-in from another clinic in the building had already intubated the patient and she had been shocked

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[54] In an article titled "What Can Go Wrong When Private Equity Takes Over a Public Service", the New York Times reported in detail why some of the pharmaceutical needs of The lack of medications on the buses and the problems turned out to be due to a larger problem with the corporate entity running Transcare who paid the employees and maintained the ambulances. In the same way the emergency department have laws based in basic human rights regarding treatment, so too do the rules that regulate how EMS attend to and must respond to the public need. However similar to ambulances and hospitals bought by for-profit corporations, bankruptcy allows the companies to close (Ivory, Protess, and Bennett 2016).

twice. Air was being forced into her lungs by manually "bagging". The oncology room was full of medical professionals as Ella took charge asking for equipment, getting the patient on a monitor, and requesting chest compressions resume. She commanded the room and stabilized the patient for transport. The hospital was two blocks away and we made our way through a series of one-way streets. The *resus* staff was ready as we came into the *resus* area with the patient. The *resus* staff took information from Ella and Tara and we left back out into the street. In the ambulance bay outside of the *resus*, Ella's excitement was palpable. "We said no, and we pulled her back!" she exclaimed making a gesture with her hand of pulling something from in front of her into the air behind her. It was close to 6:00 p.m., "we have 20 minutes left – we could still get another call!" She said this with a strange concerned but still excited look.

Ella and Tara had very different personal styles in the way they approached the public and their work. Ella seemed to truly love making the changes in people's lives and getting them to a better place. The actions Ella took were part of creating better and continuing to satisfy that personal need with each call and the resolution of taking each person to the next place. While Tara said less that demonstrated a need to confirm positive moral judgment of her actions, she clearly had an interest in doing a job that helped people. Tara however also seemed to have some cynicism of the many people who were constantly calling 911 and the EMS system and using it as a medical taxi service. Like other EMS providers I spent time with on ride-alongs, Ella and Tara never demeaned or debased the people who were clearly abusing the system. For many of the EMS I met, the medic role includes an identity of rescue and changing peoples lives for better.

In creating change and helping people, getting people to a place where they can get better is part of a narrative for paramedics of life-saving and rescue. The scene at the oncology clinic where Ella and Tara came in and were given command to change the trajectory of the patient in cardiac arrest seemed both traumatic and triumphant for the paramedics. They entered a room full of highly trained medical personnel and performed. They proved themselves. The FDNY was present, but the call was specifically for the paramedics. The rescue scene presented a stage with high stakes for rescue and the two paramedics performed.

On another day of EMS as a ride-along I listened intently to the radio driving into the city. Traffic on the west side of New York City was heavier because the FDR, a major artery that runs along the East side of New York City was closed as police searched for a gun that had been used to shoot and kill a police officer the night before. By 5:30 a.m. I somehow made my way over to the assigned ambulance. I introduced myself and waited in the back of the ambulance. We left around 5:50 am and there was another paramedic in the back with me. I asked if they handled the shooting. He said: "...we were right there when the cop was shot...but they (the police)...XX'd it." He used a number to indicate a specific code the police use when the police just run to the hospital with a trauma. We drove to 125th and Park Avenue. The paramedic coming off of his shift gets out of the back of the van, never making eye contact with me and goes into the train station. After dropping him off, my team for the day was Tim and Manny. They both seemed amused that they had a ride along and both were talking about the police shooting.

Manny: "Cop got shot.."

Tim: "I's playing softball across the river – then all I saw was ...lights..."

Manny: "He dies like at 11:20 at Harlem (Harlem Hospital)" turning to me: "You seen their trauma?..it's different from yours". Manny says this to indicate the difference in the *resus* at UED and Harlem Hospital.

Tim: "sirens for 12 hours!"

Manny then starts in with a story about a woman on I95 drunk driving with her three year old in the car and crashes into a semi. Manny was expressing his frustration as he continued to describe how the woman wouldn't let them (the paramedics) touch the kid when they get to the crash site.

The story was not really a follow-up to the discussion on the trauma except that he said you never like the kids to be quiet if they have been in trauma "a wreck". He was discussing his issue of care and what was wrong with the parent. He was unable to have the parent understand. There was no connection to the correct worldview for Manny. He was explaining part of a view he had with his dissonance with the public.

Tim and Manny told stories. We sat in traffic throughout the morning due to the east side FDR highway closure, it provided a time for stories. They both asked if I had seen the "K zombies". I thought they were being funny and they were surprised that I had not seen them in the emergency department. I reminded them that I was mostly in the *resus* area and they thought the zombies probably did not qualify for *resus*. Tim and Manny explained that the zombies were "these people" that smoked a potpourri that was sold in small bags in the bodegas and small shops along "here". Here at that point in the morning was East Harlem north of 121st street. They explained that they called them zombies because they were like the walking dead and then they just drop to the ground, which was about the time that EMS is called in to deal with the still very much alive human. The narrative seemed important in different ways and the stories wove throughout the day. The day included someone who

flagged down the ambulance as we were stuck in traffic, calls in East and West Harlem, the Bronx, Mid-town and a high-end building on Fifth Avenue.

The next call was in the South Bronx. The call had previously been on the 911 list for dispatch as abdominal pain. Once the call was upgraded to difficulty breathing, our unit was called. The call was regarding a 16-year-old girl. We walk up to the fifth floor of an apartment building. We are met at the door by two young men. The apartment is large with multiple rooms and beds. The room she was in did not seem age appropriate with cartoon posters on the walls in Korean and Chinese. Down the hallway there appeared to be many more rooms with beds on the floor. Doors closed as we walked down the hallway. The girl spoke only Spanish and refused to get out of bed or speak with EMS. There was little English spoken from the time we went into the apartment. Both Tim and Manny tried unsuccessfully to engage her in conversation. She did not have shortness of breath. She was breathing fine. The complaint was abdominal pain. Manny and Tim conferred with each other as to which hospital they should take the girl. Manny and Tim then argued with what seem to be handlers of the girl although at one point they decided they were both brothers of the girl. The brothers said they want her to go to one hospital but Tim and Manny wanted her at a specific university hospital where they believe they have a better pediatric emergency department.

Patients can direct where they are taken when EMS comes to transport to an emergency department. Tim and Manny were overstepping, however with a sixteen year old girl the case for a pediatric emergency department is acceptable to anyone who might raise the issue regarding their decision to take her further than the closest community hospital. The brothers are silent through the trip. Later when I ask Tim and Manny if they insisted on

the university hospital because they thought she might get social services support they were quiet. Tim wanted to know if they could discuss that. I asked if they have training to spot that type of abuse. Manny said no, but they know it when they see it "it wasn't really a breathing problem was it?". His question was rhetorical, but the tension on the street and as we rode to the hospital in the ambulance was revealing. While emergency room staff are trained to see abuse and human trafficking, it raised the question for me if EMS are specifically trained to identify trafficking. It also seemed that they were unsure of the situation and therefore took her to the larger academic hospital instead of the smaller local hospital that the two brothers kept requesting for the young woman. As with other EMS runs, Tim and Manny worked *through* and perhaps it was a working around the issue and used their authority to get the young patient to the place that they thought best for her.

Each of the 911 calls and responses are small stories that reveal an important narrative in piecing together critical response, care, and personal moral position of those responding and delivering care. Throughout the hours and days with EMS, I observed the constant calming force of EMS on their public. Each story played forward a potential tragedy that is momentarily intercepted and moved toward "better". The promise for better for those in need was simultaneously personal and social. My observations shifted as I understood how moral position and work of healthcare workers is visible in the constant work to create something better for the strangers EMS encounter.

Systems, Support and Changes in Health

The system of medicine was supporting attempts to stabilize people and bring them to the hospital. This stability is held however in definitions of physiology and medical practice defined not only by scripted pedagogy but also structural constraints of hospital bureaucracy. The brief descriptions of EMS interactions with the public called-in were a different stabilization – that fit into a frame but were redefined with each call that was immediately private, intimate and very public as the promise of change for better. That promise of change is a change in power. The power is relinquished and trusted to strangers. Strangers who have built from their own personal moral foundations a trust and morality based on the promised good of healthcare but these healthcare workers build on their own personal ethics of care that do not necessarily ascribe to deontological medical norms of bioethics used to define actions in medicine. It is here in this dichotomy of institutional rule-based ethics and what is expected for health that I believe it is important to examine what is amalgamated in the personal and social morals of those that deliver health care. The promise is one not only as the job of EMS in responding to crisis but is simultaneously personal, professional and structural. That amalgamation of the personal, professional and structural and what is different in the personal and structural morality of care and how anthropology makes this investigation is also part of a disparity in which those seeking care via these 911 emergencies are no longer disenfranchised or unequal to those lying next to them on another stretcher as they are brought into the greater medical system, but people that are equal.

To examine the balance of equality and inequality, I believe that it is important to consider an argument advanced by Jennifer Morton regarding education. Morton presents an argument about how skills learned in the every day functioning of middle class homes are simultaneously social, emotional and behavioral competencies (Morton 2013). Morton argues that it is not that children from impoverished homes do not have practical skills but that they acquire behavioral competencies appropriate to their communities and that those communities start with expectations and conduct at home. While Morton's argument is specific to education and what cannot be learned from an online classroom, she raises an important, persistent, issue regarding inequality that I believe translates across structures and is very specific to how personal phenomenology and morality are simultaneously structural and unequal in how Americans access and interact with healthcare providers and healthcare institutions. While Morton provides specific insight to inequality in education that follows people to the time they would reach college, that same skill set translates to personal health and accessing healthcare. In emergency medicine the repeated practices of poor health and unequal access outside emergency care are evident. Cases like Mr. Austin or the girl who was in pain and would not speak to EMS are examples of individuals where the system of emergency care is healthcare. In their communities of practice, these individuals as patients also interact and are administered to as patients that continually receive emergent but inconsistent medical care as they cycle in and out of the emergency medical system for care. However, unlike education where the ongoing human interaction encourages changes in behavior and learning, it seems that the structure and access to care that is always temporary and rarely consistent is its own dysgenic effect on the individual and their communities. The individual subjects have but one recourse – to engage emergency medicine. That

recourse is often strangers in uniform as EMS. This relates significantly to the social context and anthropological understanding of how these same people from unequal economic footing are also momentarily visible as they seek care and are cared for, albeit it often briefly, as morally relevant in the world. Consequently, it is the moral visibility of those in need, made perceptible by EMS who worked around and work through situations to evince their own moral worlds. The example of Manny and Tim getting the girl to the pediatric emergency department instead of the one familiar to the brothers illustrates their personal moral involvement and action.

I use the terms EMS working *through* issues to distinguish emergency medicine working *around* issues I discuss in reference to other staff in the emergency department. EMS is assigned to cases as they receive calls from a central New York City dispatch. The work of EMS has shared understanding and knowledge of procedures and process that requires coordination of activities with several levels of professionals from the time that EMS encounter a call to delivering the patient to one of many city emergency departments. EMS work *through* the situations to get the patient where the next point of care in a hospital. The moral visibility for these individuals was not evident in the need to adjust practice or find ways to work around a situation. The moral visibility was more directly a result of the parameters of their title, the extent of their training and then transferring what they had done – to get the patient to better – to the hospital. The examples and EMS stories are not discursive summaries of time spent in emergency medicine. The work produced is not just mechanical interaction of transporting patients. The work is personal and part of care and the local moral world of the EMS that live it.

The disconnect for some EMS workers was in how they as paramedics were regarded or how their judgment was regarded regarding their reports of patient status as they handed off patients to nurses and physicians in the emergency department. In the first example, Wayne revealed his moral agency when he was doing his job, helping someone who as EMS they knew was unstable when they transported the malnourished elderly patient he discussed in his story. He discusses how he handed the patient to the next level and he was saddened by the outcome and how the nurse reported the death to him. His moral investment in the patient and in the next group responsible failed. His professional position as a paramedic did not carry the necessary authority that the nurse required to take him seriously as the patient was brought into the emergency department. The difference in power and the lack of care by the nurse seemed to confirm for him the lack of humanity and understanding that there is value in the EMS work and that their work is as important, morally relevant. The EMS work *through* issues and deliver their patients to the emergency department. That delivery to the hospital emergency room includes an expectation that the patient, their patient, is handled and attended to properly and gets better. The stories and interaction reveal not a hegemonic conflict of power and resistance to get their work done but individuals guided by working through situations to get patients to *better*. The EMS crews had the autonomy to act and treat as they saw fit to help each patient. These individuals were able to act *through* the issues and assert their moral agency and create care within the frame of their local moral world. This naturally occurs within the limits of their training, especially considering that there are both ALS and BLS EMS training and crews. Pre-hospital care had its own hierarchy based on education and hours of work, however their autonomy to treat in the field was their own. As expressed in some of their conversations

related in these stories, the difficulty for them was what would happen to a patient once they delivered them to the emergency department.

Chapter Four

Nursing and Working Around as an Ethical Frame

The production of modern critical emergency medical care requires a complex synthesis of clinical facts, knowledge, personal and subjective judgments to attend to critical emergency patient care. The facts are generated through a mediation of complex and changing medical technology that is as diverse as electronic healthcare records EHR, body imaging, and devices to deliver drugs and detect changes in patient health status. In critical emergency medicine, these events occur in a hospital space that is bounded by an internal bureaucracy and management but also permeated by federal and state policy to carry out the singular task of patient care. In this chapter, I offer a perspective of the way nurses work within the confines of training, bureaucracy and medical data to assert their moral position. In this chapter I discuss through examples and analysis how nurses use both personal interaction and communication as well as technology to assert moral position. While asserting a moral position is not necessarily an overt physical act, the act of working *around* issues to advance care a nurse determines must or should be addressed makes visible moral actions to assert care. Additionally, I examine how the advancement of medical technology has created a space for health care professionals, specifically nurses, to mediate their ethical position as clinicians attending to care by using the tools of technology and sometimes bureaucracy to reify personal boundaries while fulfilling professional responsibilities in patient care in emergency medicine.

Nurses are the majority of the workforce in any emergency department and most if not all hospitals (Administration 2010). At UED, the emergency department has over 95 nurses employed with forty active in the emergency department on each 12-hour shift.[55] The workload for any nurse can vary from four patients per nurse to over twelve when the census of patients in the emergency department is high. When the workload is high, the nurses often describe that their professional ability as a nurse becomes compromised. Throughout my time at UED, nurses often stated that they are unable to provide the necessary specific care to each patient. It is not only within periods of high patient volume that stresses the system, it is also the work related requirement to work through a myriad of problems that makes the nursing role and how they negotiate their role and place in the process of care an interesting point of study. The emergency department receives and is required to treat many patients with various levels of medical problems. For most nurses who choose emergency work, they like the constant challenge and fast pace of work. Many said they could never do the "other" type of care and like how every day is different. The often fast paced demands of the emergency department, gives rise to work*arounds* to accomplish safe patient care. In computer technology and engineering workaround is the often used term used to describe patching of obstacles to make designs work. Borrowing the term workaround from computer technology, I use the term workarounds in this study to describe daily ritual in nursing to "just get things done" (Powell and Davies 2012, Apesoa-Varano 2013) but specifically in relation to visibility of moral agency. As issues are worked *around* to relieve

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[55] The number of nurses and nurse-techs vary each day. At the morning "huddle" before the 7 am shift, the overnight nurse manager goes through the overnight issues, who is assigned to what area and how many have called-out for the day. The pool of nurses (RN, not techs) was 95 when I started in 2013, by June 2016 the pool of nurses was 84 with 12 employment offers waiting for reply.

dissonance for a perceived medical care inconsistency, getting things done by working around achieve the goal of asserting personal moral agency for a given situation. In naming nurse use of various tools or changes in expected behavior a workaround, I might miss both motive and technique. Consequently, in observation of technology-use to reify personal and professional standards of medical care, through fieldwork, in this section I examine when and how tools and workarounds occur; what tools (or technology) are used to work *around* problems; and what potentially motivates the workaround. My interest is to examine some consistent behaviors where workarounds by nurses' use of tools, or refusal to use tools, occurs to alleviate ethical dissonance or personal discomfort and consequently assert moral agency.

How do nurses and other healthcare workers mediate their moral agency with technology or pushing back on technology or policy? In this section, I describe how various healthcare workers in critical emergency care successfully use bureaucracy and technology to achieve clinical practice and negotiate personal moral position for the safety of the patients under their care in critical emergency medicine. As with the EMS workers, this idea of moral agency is not a concrete moral issue voiced in terms of needing to change or work around due to a moral need. It is an observation of actions and work that I examine as nurses act to get to what they perceive as right. As such, the use of technology becomes part of working around issues to achieve a goal where the patterns get repeated to achieve goals that have also been called trajectories (Timmermans 1998). Timmermans explains that trajectories shifts in practice being done until it is internalized and then written into a paper or process (1998: 427). The description of changes of process that are then repeated until they are internalized work practices and within hierarchical systems become

institutionalized resembles Kuhn's model of scientific thought acceptance (Kuhn 1996 [1962]). These are not however scientific breakthroughs as described in Kuhn's model of paradigms but behavior and procedure changes that work to advance better care a well described pattern first advanced by Thomas Kuhn.[56] If the changes or adjustments in practice create or advance patient safety and ethical treatment, then that model of scientific thought and acceptance cloaked as better process is an advancement in a moral platform for moral action. In changing the care or treatment trajectory to ensure safety or ethical treatment the healthcare worker or nurse is asserting moral positioning. What is relevant in this study is the potential for internalizing change and working *around* issues for a better moral outcome that potentially and unknowingly are part of non-metric driven changes to patient care.

The continued development of highly technologically driven science and medical standards for patient care is part of continually learning environment for healthcare providers as increasing technology becomes part of healthcare delivery. Consequently, where technology is now part of highly technologically driven healthcare, the tools and protocols to use technology, are part of communication and sometimes reveal professional

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[56] In Kuhn's 1962 treatise on scientific revolutions, he suggested that change in science followed a specific type of revolutionary paradigm. That paradigm can be seen in healthcare in the United States as the call for ethical conduct such that healthcare is a human right were finally codified in the United States under the Affordable Care Act (ACA). Following Kuhn's paradigm the first action in healthcare is a concept. In hospitals there was the concept of principlism and bioethics and the patient centered model of care. The broader ethical model that came later was the concept that everyone should have the right to affordable healthcare. The second step is the commitment of influential people. For the ACA this would be those crafting the legislation and then policy makers advancing the policy – specifically President Obama. The next stage would be committee review, which would be the debate and dialogue around the ideas and written proposals. The final step is the new framework takes place and changes occur with the advanced system of the ACA in place. (Kuhn 1996 [1962]).

agency of those delivering care to patients. While the tools are part of patient treatment, technology and protocols become means to achieve varied goals when healthcare workers need to care for patients.

Any patient entering an emergency department has an expectation of care in their treatment. The patient expectations is an inherent framing of expectations of care, however the medical conduct for the various levels of healthcare workers and what is done for any given patient is bounded by hospital and legal bureaucracy. Within this expectation of conduct is the moral individual nurse who is bound by ethical codes in medicine, personal belief and the socio-political construct of healthcare that is a business with a separate legal framework. For the healthcare workers as well as the patient, they each have their own agency and perception of care (Vuuren and Cooren 2010). The historical advancement of nurses has been one of increased responsibility and decision making due in part to greater medical knowledge and technological advancement and should not be considered a closed evolution (Freidson 1988). That combination of greater responsibility, knowledge base and personal agency indicates potentially greater autonomy for nurses. In the emergency department at UED, the nurses had little recourse but to document all action in the health record, did not have autonomy to direct care and were simultaneously deemed to have no initiative.[57] Nurse autonomy at UED may or may not be representative of other institutions.

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[57] In a conversation with Dr. Rahm who was also responsible for the EMS pre-hospital care units, he was surprised when I told him about the number of his EMS paramedics that were studying to become nurses. His response was that it was a "waste" and that the nurses aren't proactive like paramedics. This sentiment was not only his frustration. In another conversation with a fourth year resident who was on his way to a position as an attending at a university hospital in Pennsylvania, he said: "...it's frustrating to need to guide them [the nurses] for things they know...they don't have decision capacity..."

The bureaucratic confines and processes within the greater UED hospital system may be partially accountable to how nurse autonomy is advanced throughout the hospital system. The issues of nurse oppression are an ongoing point of discussion and may reveal visible workarounds to create moral care across a broader area of hospital departments than exclusively the emergency department. This aspect of the study is exclusive to nurses in the emergency department and how within their local moral world they assert moral agency to create the care they believe necessary.

The moral work of care is visible as nurses and other healthcare workers use technology in critical care emergency medicine to mediate professional and personal boundaries as they fulfill a role of patient care in a critical care framework. The development and production of the nurses' role and the underlying political and continued social constraints that reveal possible foundations for these actions are also discussed and explored. The technology and knowledge that has served to allow for greater responsibility and as Freidson described as an evolution of nursing (1988: 64), is also used to negotiate their personal position within a bounded framework of hierarchical work production of patient care in the hospital.

The complexity of the nurses position includes, demanding work, marginalization and a hospital system that often challenges their ability to perform their work (Dubrosky 2013). The position of nurses work is often described as invisible yet under authoritarian reign of the hospital (David 2000, Ballou 2010). Dubrosky defines nurses as a group where oppression in the workplace is universally felt (Dubrosky 2013). Using Iris Young's "Five Faces of Oppression: justice and the politics of difference", Dubrosky defines nurses as an oppressed group due to structural norms as well as a historically and continued women

defined occupation (2013: 205-206). Nursing is still a female dominated job with 90% of registered nurses in the United States are female (Labor 2012). While being female does not obligate oppression, the historical position of women in perceived support roles is magnified. Understanding how the nursing profession has suffered from a lack of autonomy and authority that may reflect some of the practices that create mantras of patient safety and actions resulting in workarounds as part of personal agency.

The overall conflicts and marginalization may contribute to the workaround where technology and tools use mediate their position in the hospital. In Elements of a Sociology for Nursing, Timothy Diamond describes the process of how nursing is objectified by the administration, hospitals and medical establishments (Diamond 1984). Diamond describes boundaries within nursing that include an invisibility when the nurses are part of a capitalist institution of medicine, but that nurses have choice in their how they produce their work which makes nursing part of a larger political society (1984:16). Consequently, the actions and shaping of work is a constant part of nursing.

The political shaping of nurses is also bounded by the nurse union at UED. Some evidence of activism was visible at UED in the form of colored leaflets in the break room and at workstations. The leaflets usually announced various call-ins to support statewide nursing union initiatives. With few exceptions, the nurses wore various union buttons and bold red and white ID card holders that indicated their union support. In a conversation with one of the emergency department directors (a physician), he seemed simultaneously amused and annoyed with the nurse union. He said that he did not believe the nurse union advocated for the best protections for the nurses in negotiations. The example he gave was from the most recent negotiation where the largest push by the union had to do with medical

insurance for the emergency department nurses and not what he thought was a more important demand that would require the hospital to bring in additional nurses when the patient census in the emergency department is high. He said that patient care demands in the emergency department can get routinely over a ratio of one nurse to ten patients and that if the nurse makes a mistake it is her license on the line. The director continued by saying that said he has a great team of nurses but that he cannot protect them and that they are fired for mistakes. The implication was that when the census is high, the nurses make mistakes and that is but one example of the Union failing the nurses. He also said he also said that the Union negotiated for contract issues that the nurses would have gotten anyway and that the Union made issues where there were none. He used the example of pay increase and health insurance as part of standard benefits in a competitive hospital.

Nurses and Personal and Professional Identity

There is an expansive literature describing how social organization informs personal identity (Stets and Burke 2000, Holland et al. 1998, Callan et al. 2007). Identity, role formation and social organization for nurses appeared complex to me as I witnessed what I thought were odd judgments in treatment and use of technology. Over time, I realized that I was watching a type of role fulfillment and documentation of actions that was meant to insure patient safety and personal position in the emergency department for the nurse. In the professional setting, the social identity includes expectation of professional performance, which can be thought of in this research as the "good nurse" (Kirpal 2004). While nursing as

a discipline has meaning to many patients, the literature specifically notes the difficulty in self described identity for individual nurses (Deppoliti 2008). As such, the role formation and negotiation for nurses that is both personal and professional in critical care emergency nursing may have additional challenges. The work is fast-paced and technologically driven. Patient processing and treatment requires acceptance for competency within the social organization of nursing practice. The sense of identity comes not only from personal competence but inclusion in the practice. That inclusion has social organization requirements for the nurses, but it is also work that is technologically driven by the nature of current medical practices for health production. Consequently, negotiating personally and professionally requires use of tools and technology.

How nurses negotiate their moral and professional administration of patient care is discussed in the literature in terms of the difficulty nurses have conducting work and maintaining ethical standards. I found in my research that autonomy of decision making for nurses is often described in terms of needing legal cover for decisions. Traynor et al., describes a "powerlessness" felt by nurses in their decision making which is also hampered by hospital bureaucracy (Traynor, Boland, and Buus 2010). Traynor discusses the necessity of nurses to circumvent "wrong" decision making by using both clinical and organizational skills (2010: 1510). Similarly, the same space of discussion is necessary for discussion on ethics and being able to alter the practice environment to meet ethical concerns (Pavlish et al. 2012). In this study, I posit that technology and other tools are used by nurses to create pathways to open ways for nurses to negotiate personal moral balance reveals not only the need but also accepted skills as well as personal and professional skills for legal and moral

self protection. In the situation noted here, a nurse uses other staff and the EHR to make sure a patient gets what she believes the patient needs:

> In the *resus* a patient has just come in with elevated troponin levels and the nurse goes to get the equipment to do an EKG. The resident says he does not want it done, but the nurse is concerned. Instead of confronting the resident who has already told her he doesn't want it, she shows the electronic healthcare record to another nurse and a tech. The record shows a symbol that indicates the need to do an EKG. The other nurse and tech noting the symbol as part of the patient record go to the patient and start the EKG. The nurse that was told not to do the EKG, does not do it but gets it done based on her getting others to react to a known standard.

After having specifically asked about a test the nurse believed was necessary, she found a way to have the test done based on input already available in the patient record without personally doing it. She had to simply show the request to the individuals who would get it done. She found a way to work*around* the direct orders to get something she believed was important for the patient. These actions revealed a moral visibility of the individual in her work and actions as she cared for the patient.

Tools, Technology and Nursing

Technology and nursing has a special relationship in creating care and asserting personal moral agency. The most general understanding of healthcare by the public is one wherein nursing is subsumed under physicians as the medical model of treatment (Matheson and Bobay 2007, Diamond 1984). While the largest number employed in an institution, this

does not dictate any greater power to nurses as a group in the institution. The early educational foundations of nurses as assistants to physicians has often been cited as an artifact that created what is often called an oppressive relationship between nurses and physicians that persists in healthcare production today (Matheson and Bobay 2007). Nursing is often reflected as deferential to a physicians' role under such a model, such inferred relations between doctors and nurses however may not accurately reflect how healthcare is produced as conceived by the various healthcare providers responsible for patient care. This interface of how healthcare is conceived by nurses and produced within the business of medicine may reveal a fissure in role and expectation in nursing practice in large urban medical practice. In this research the cultural landscape in the emergency department allows me to observe the varied positions of nurses as they interact with each other and technology may also reveal interaction and professional boundaries that require further study. In this study the care of the nurses differs from that of physicians and paramedics not just pedagogically but due to the construct of authority and autonomy to act and exert or not exert autonomous decisions in patient care.

The immediate interventions in emergency medicine require that healthcare workers treating patients have a breadth of knowledge regarding treatment and what tools to use to best restore health. Tools in emergency medicine may be as simple as a bed with varied angles; a board to place under a patient during chest compressions when giving life support; sophisticated diagnostics that include an MRI, CT; electronic health records (EHR); or a combination of varied tools and techniques used to diagnose, stabilize or maintain patients as they are returned to health. The minimum technological interventions for the time patients are admitted and remain in *resus* include oxygen level, heart rate, and temperature.

Tools used to administer medical treatment are part of ongoing medical advancement, yet technology use can have different meanings and use among medical staff (Wikström, Cederborg, and Johanson 2007). The prevailing thought has been that the best advances to alleviate pain and penetrate the body with greater acuity to prolong life is an inevitable good (Lock 1997). The potential technology is expansive and includes many facets of patient evaluation and care. Nurses in the *resus* use technology to interpret and guide how best to care for critically ill patients. That technology is for some situations, the measure and the entire identity of a patient. The information collected reveals what needs to change, making clear what should be next to restore the health status of the patient via technological measures. For each *resus* patient, technology use changes based on patient health status.

Technological use as a tool places the nurse in the position where technology mediates the care provided. According to O'Keefe-McCarthy, technology use can distance nurses from patients such that technology in critical medicine assumes its' own moral agency (O'Keefe-McCarthy 2009). The construct of care then becomes a nurse with a professional and personal agency that is distanced from patients through technology and interface with tools that can assume its' own agency to treat and care for a patient. O'Keefe-McCarthy argues that moral agency is an implicit part of a nurses relationship and interaction in critical care (O'Keefe-McCarthy 2009). In interviews with UED nurses, they claimed they do not bond, but that bonding is part of the role of *other* critical care nursing. As technology is enmeshed in medical care, how a nurse constructs patient care can include constant technological mediation.

The use of a technical judgment – that of one that is measured or secured through data raises no issue of values (Anspach and Beeson 2001) and can be acted upon in a manner that is professionally and personally defensible based on constructed norms. With technology however, the norms and expected practices of healthcare are monitored, documented, and followed as part of both professional accountability as well as corporate (hospital) accountability in various quality metrics. As outlined in the review of the literature, the introduction of various technologies changes the basis for professional autonomy in healthcare (Timmermans and Kolker 2004). In turn, as the tools and technology become part of clinical practice and accountability as medical professionals also changes. Nurses however, have specific roles in patient care that require both a social and technological interaction. The knowledge gained in a social interaction with patients is part of a nurse's moral positioning in a nurses care for patients (O'Keefe-McCarthy 2009). However, as technology becomes part of that care, technology can be used to negotiate or impede moral space between a nurse and a patient (2009: 789). If technology constrains that moral relationship, it too can be used to distance and contain a nurse's personal identity.

In the following case and interaction paramedics brought a woman in her early fifties into the *resus*. She was found in the bathroom at a nursing home where she volunteers. She had lost consciousness but was now conscious but unable to move the right side of her body. Because she was a stroke alert patient, neurosurgery was immediately notified and she received a CT. A mass visible on the CT indicated a cranial bleed. The problem quickly became access to a surgery room and surgeons to relieve the pressure from the bleed. The nurses treating the patient were increasingly nervous that the patient may code. There was a brief discussion by the neurosurgeons of doing the boreholes to relive the pressure in the

emergency department. There were several simultaneous interactions that went on within a 15 minute timeframe that involved stopping medication that had been started that could compromise the patient – the chief resident of the emergency department was fuming at the nurses who were following the neuro consult orders that contradicted his plan and practice of care. The neurosurgeons were on the phone explaining to the family member what needed to be done "immediately". Within the hour, a family member showed up with a garbage bag that looked like it contained clothing. Somewhat apologetically, he said: "I had to go get it or she'd miss it.". During this time Nurse Lisa gets on the phone with a nurse in neurosurgery giving information and arranges to have the patient moved upstairs even though there was 'no room'. Lisa tells one of the residents that upstairs can free up the bed if he gets the intubation done. Then, the BP went to 225/104. Lisa got on the phone and said, "I'm bringing her now." The resident, Lisa and Tech Sid quickly hooked the patient up to a portable heart monitor, oxygen and set out to walk the patient as quickly as possible to neurosurgery. I follow the group. Sid knows all of the back hallways and elevators. Attempting to make small talk with the family member, the resident asks if she is his sister. He says, no his mother. The resident seems at a loss. In the neurosurgery pre-operative area Lisa hands paperwork to someone at a desk and the surgeons start to explain to the son what they are doing.

In this situation the nurse very directly affected the care. She literally worked *around* the situation to get the patient the direct and necessary care. On the way back to *resus* Lisa asked me if I knew about the patient. I said I figured out that she was homeless but thought it was great she occupied herself with volunteer work. Lisa said, "Yes, think

about that...and think about that she is now getting neurosurgical care here...*here.*". She was smiling.

Lisa feared that if the patient did not get up to surgery quickly, she would code in the emergency department with a cerebral hemorrhage. When the patient's blood pressure suddenly spiked, Lisa stepped up the plans to move the patient. The potential outcomes were not in the patient's favor – unless she got upstairs – which Lisa "got done". There was visible contentment with getting it done for the patient. As we crammed into the elevator, Sid smiled slightly and said: "That was close.". Lisa is a nurse with more than thirty years experience and is always calm, direct and while she discusses how much she enjoys her work and knows how much she does to change lives. She is also careful in how she works around the system. During my time observing, I did not see any repercussions for what Lisa would say was "good nursing" when she worked to get a patient the necessary care that could be considered outside normal hospital operating procedures. She obviously enjoyed getting a patient to better care. With nurse Lisa there was never bravado or repeated stories. She just got the work done, for the patient. Lisa's story with the stroke patient is a useful representation of moral care. The case depends on several factors that may not serve to quantitatively reify morality as imbedded in workarounds. However it does examine how care is moral behavior and the individual care giver possess and demonstrates value of any patient and that these are values free of economy, ability to pay and discriminatory practice. Lisa expected nothing in return. She was doing her job. She was providing the best care possible. She expressed and made visible her moral agency.

Medical Production and Health Making

There are several different approaches and ways to describe the nursing care and how nurses went about producing care at UED. The examples of nursing care in Chapter One, most specifically the *critical encounter*, are examples of coordination of nursing work to affect care. Chapter Two provided examples of daily interventions to create care and some of the difficulties and distress encountered as part of nursing work and moving care forward as part of working in the emergency department. In this section I examine the overall process of communication and identify technology-use as part of medical production and the use of technology to maintain personal role definition for the nurses, which was stated by nursing staff as ensuring patient safety. This construction of objects builds on the theoretical framework of Conversation Analysis (CA) where objects are defined through use and interaction (Rawls 2008, Koschmann et al. 2011, Gill and Roberts 2013). This examination regarding nurse use of tools in mediating boundaries builds on work originally defined by Garfinkel and Goffman (Garfinkel 1967, Goffman 1974) regarding object definition (Heritage and Stivers 2013). However Goffman also cautions against strict use of role in understanding what is going on in conversations or interactions (1974:129). Goffman further clarified pieces of interaction in "frame analysis" when he sought to answer in situations with the very blunt question: "What is going on here?" (8). Goffman acknowledges the nature of actors working together and the individual choices are part of sense-making so that individuals are working in context to make their own sense of a particular situation (Goffman 1974, Heritage and Stivers 2013). These two concepts are important in defining how as an ethnographer I was able to view the ongoing work practiced

in the emergency department. Using Goffman's paradigm of frame, I saw patterns of patient treatment that had prescribed protocols for nurses to use that were changed or mediated to fit a nurse's view of patient safety. Within those frames, I was able to observe the object-use by nurses to achieve the work product of patient care where nurses used objects and technology to achieve care but also confirm their personal position so that they felt protected in personally, morally, and professionally. Both personal and professional protection are part of an identity within a nurses role, the moral protection nurses are able to assert through tools is the nurses ability to what they believe is most humane in clinical care.

For nurses in the emergency department, technology and tools have varied uses. There is the intended purpose but also also evident are ways medical tools and technology are used as objects to create physical boundaries and even mediate social and professional spaces. Some tools in emergency medicine are interactive for professionals as they perform distinct roles in patient care. Some tools used by nurses are individual and mediate jobs and actions regarding how professionals care for patients. I observed how individual actions of nurses are part of both group and individual production of critical emergency medicine within a combined goal of patient care. As opposed to physician, technicians and other support staff, nurse utilization of technology and tools reveals an unexpected dynamic. Nurse use of tools provides a pivotal position to begin to investigate technology as tools and as objects in use in an emergency department to create health, create distance from patients as bodies, and observe how nurses establish professional and political boundaries within the emergency department. Unlike other healthcare providers in the emergency department, the role of nurses in safeguarding patients remains constant. The use of tools, objects and interactions makes the work, care and vigilance of patient safety visible thereby making

visible the moral acts through care. Other clinicians such as medical students, Attendings, and residents transition through the emergency department, with varied responsibilities for each patient. The nurse must consistently care for the patient, and more acutely in the *resus* the nurse is responsible for maintaining several critical patients simultaneously. Consequently, how nurses balance their role and used technology to do so became an interesting point of analysis.

Similar to other institutions, hospitals rely on data to provide various services to their clients. The clients in hospitals are patients whose ailment provides clues and data for processing, diagnosis, and treatment. The body as the point of data sometimes provides verbal information that is useful, but in critical care, much of the information relies on measurements from machines and output or remedies provided by hospital professionals and other machines to readjust any known indices that are out of order. The overarching assumption with technology and tool use is positive and that technology advances the healing of a body.

In this section I depict examples of how nurse work in the *resus* use tools and protocols to mediate personal moral agency and professional position in producing health in the emergency department. In *Experience and Nature*, John Dewey discusses tools as not just instruments, but transformative pieces of an experience which in science are part of the production of knowledge (Dewey 1958). With tools in a clinical setting, they too can be transformative in knowledge production providing very basic results such as determination of a heartbeat or more advanced tools to administer drugs or oxygen to assist in breathing. Tools also have other transformative value described as embodied with the user so that a tool is part of habit in affecting care or a tool can be disruptive so that it is unusable in a

routine (Schubert 2011). The *resus* requires specialized knowledge and ability of nurses and physicians to act quickly and decisively in many cases of patient care. Tool use in the *resus* can include life support tools such as respirators, tubing to supply air and catheters to reach directly into the blood supply. Many of these tools can support life, but many can also create barriers and emotional and personal distance between the patient and the healthcare provider. The invasive nature of tool-use can be both intimate and invasive in nature. Tool use is also simultaneously distancing so that the sometimes difficult procedures that nurses must administer seem detached. The wide range and acceptable use of tools provides the basis for tool-use by nurses to serve multiple purposes as they create care and "make health".

The nurses form a body politic (Scheper-Hughes and Lock 1987) within the emergency department. This means that the nurses are a collective body that interacts within a system but has its own defined structure. It is the mediation of tool-use as individual with a group understanding that I investigate through observation and interviews with the nursing staff. Each medical determination I observed in the *resus* required both nurses to use tools to professionally assess and mediate patient care. The determinations are most often made individually and reported as part of the patient record. The nurses are individually responsible for the care of patients assigned to them, yet they follow processes within a group to produce care within the emergency department. Consequently, the nurses work together, train one another, and represent the most constant interaction between the patient and getting the patient safely to the next level of care. Nurses however stand alone in any external or legal evaluation of patient care and safety.

Bodies as Objects, Technology and The Nurses Role in Care

The rapid advancement and changes in medical technology have changed the practice of medicine. Technology is used to provide medical care to the patient. The patient is the object of care as part of practice. Tools provide the information (data) and deliver the medical process so that decisions are made regarding the object's biological status. The biological status is data. The information then must be acted on by a team – not in isolation – but a medical process that is reported and recorded in patient chart, images and transferred to various healthcare workers who also interact with the object as a patient. The object and practice of medicine is however intertwined (Mol 2002). The hospital staff receiving the patient is responsible for performing care, do so by communicating the urgent medical needs of the objects, and perform specific duties as part of practice. As the duties are carried out using medical technology in the form of various tools to test, diagnose, and administer health care nurses must constantly negotiate professional norms and appropriate use of technology as dictated by procedure and requested or dictated by physicians in charge. Information is used to establish what Ann Marie Mol describes as "coherence" in developing a diagnosis (62-64), tools are used to establish coherence. Consequently, what I observed was a negotiation of space in producing work while using technology (tools) to control and assert professional standards and personal moral commitment. The moral duty is personally held and internalized. The external materialization of the moral is expressed or asserted through a negotiation of coherence in actions and tools of the profession. The tools are part of training where the nurse safeguards the patient. The coherence through technology links that role of nursing with the physician and patient.

In addition to safeguarding the patient, nurses use the tools to safeguard their personal (moral) and professional position. Nugus et al observed emergency department boundaries through an extended research study and determined *post hoc* three directions that define patient care in the emergency care as: discharge of the patient; admission to the hospital; referral and management of the patient (Nugus et al. 2010). These observations of the daily ongoing intersection of work and patient care revealed an understanding of unspoken objectives in delivery of care in the setting Nugus studied. A lack of familiarity with the setting allowed Nugus to draw his conclusions. In a similar manner, my observation of how nurses use resources and technology to negotiate their role within the emergency department showed me how tools are part of moral, political and personal negotiation of patient care by nurses in the emergency department. Computers used as pat of decision-making process in sociality of communication and acting on patient care in the emergency department (Ackerman et al. 2012) are part of tool use in the care of patients. Technology is used within the social professional context of the emergency department as part of a network of non-human tools that professionals use as part of administering to the patient. The computers are part of an accepted practice of medical record keeping that within the theoretical framework of Latour, make these specific tools part of actor network (Latour 2007). While Ackerman uses the Actor Network Theory (ANT) in establishing the role of the computer in patient record keeping, she notes that social context and use of computers should not be simplified as such without accounting for the complex decision making process in the emergency care (Ackerman 2012: 2379). The complex decision making where technology creates an interface between nurses and patients ensures patient safety through automation of some health practices, but also creates physical distance

between the patient and nurse. A central part of caring for patient by nurses is insuring the safety of the patient. Malone in her research on vulnerability in emergency nursing describes how patient vulnerability and suffering can be simultaneously a bond and a necessary barrier between the nurse and the patient (Malone 2000). It is this dichotomy of caring, yet distancing where the importance of protecting patients as bodies allows nurses to maintain personal and professional identity. Emergency department nurses use tools and technology to accomplish these goals.

The body is evaluated through technical reproduction and confirmation of medical diagnostics. Material shaping of illness renders the body (a patient) as illness and object (Good 1994). Byron Good describes the medical drama involved in care includes the object of illness, the disrupted body that harbors the illness (1994: 172) as part of the overall medical process. Good argues that medicine constructs a practice of the bodies while Foucault's traditional analysis of the body describes the body as a single object (1994: 69). Similar to Mol, Good favors a collective explanation of bodies to describe medicine. In this study each of the professional groups examined are examples of the process and the moral visibility through actions where care provides visibility or an overall good and ethic of care as the parts are examined to stabilize the whole.

How health care workers negotiate identity and patient care through technology, keeping the patient as a body and as an object safe seems more the Foucault(ian) explanation. Yet, the collective practice in creating health affirms Good's definition of bodies as objects as part of practice. As discussed, bodies as objects or body alienation is part of contemporary medical practice (Scheper-Hughes and Lock 1987). While body-alien, the foundation to the ongoing care remains the undescribed moral need to repair. This

administration of care is a combination of professional training and personal negotiation of the hospital situation to shape and care for the body. It is then the bodies that the medical professionals attend to, keep safe, and restore to health are the focal point for those restoring health.

Tools and technology are often used by nurses to mediate their role and position both morally and professionally. Prior work described nurses' use of knowledge and management of disease as a manner of controlling and using indirect ways for nurses to influence medical practice (Traynor, 2010; Salhani 2009). Observation and interviews in this study reveal practices to influence patient care which has been addressed elsewhere as a struggle for nurse autonomy (Traynor 2010). In the literature, the studies describe indeterminate actions of nurse reporting on issues they "sensed" (2010:1509) were wrong and there is a reinforced stigma of nurses "intuition" which subordinated nurses autonomy and knowledge (2010: 1509-1510). Here in this study however, I observe tool use to negotiate autonomy, and in certain situations, observed tool and technology use to safeguard professional position and personal moral commitment that are in turn expressed within the confined of nurse practice. Some examples of major themes in negotiating personal position as a nurse are related herein.

Asserting Authority over Physicians in Patient Care

Throughout hospitals, physicians hold a position of authority and respect. In the emergency department, there are varied levels of physicians which include not only residents of various fields of medicine such as surgery, neurology, psychiatry, but also Attendings and clinical fellows whose primary work is in emergency medicine. The varied

levels of physician clinical training in the emergency department can lead to some conflicts between nurses and physicians that are either new residents of the emergency department or physicians training in other medical specialties called-in to do specific work in the emergency department. In interviews and conversations with emergency department nurses, they all commented their work is to care for the patient and make sure the patient is safe. With a focus on patient safety, conflicts may appear as power struggles in attempts for nurses to – as they describe – protect patients. The following observation as an ethnographer provides an example of how a nurse exerts her expertise and produces what reflects a higher ethical consideration for the patient by refusing to implement specific tool-use. Directions are transmitted through the computer in terms of orders. Various non-invasive processes are continuously ongoing which do not require documentation. Some of these include requesting a technician to get vital signs for the nurse or to have a tech assist with insertion of an IV. It is not uncommon to hear a doctor say to a new patient, that they are going to get an IV for medication and IV hydration but we are going to wait for the nurse because they are much better at it. In one *resus* patient, where the physician needed a blood sample as well as a urine sample to make a determination about further testing, the physician asked the nurse to use a Foley and get the urine *now*.:

> Nurse Cora, whipped past me talking to me and the tech (who was working with Cora prepping materials for the patient), she was agitated. Cora said: "...completely harsh, I told him he can wait, he needs a small tube and *that* [the Foley catheter] is unnecessary". Nurse Cora was visibly agitated at having to tell the resident that it was unnecessary and just to "calm down" because the patient was getting fluid and would be able to give him urine soon. Cora used the word "barbaric" at one point while she was verbally fuming about the physician's orders. Inserting a Foley

> catheter just to get a sample was completely unreasonable in Cora's view of reasonable patient care. A catheter for a non-mobile patient is normative and routine for patients in resus who are at high risk or unstable.

Inserting a Foley catheter just to get a sample was completely unreasonable in Nurse Cora's view of reasonable patient care. Asking for it if the person could give the sample was not necessary and unethical. The tool in question was a painful procedure that the nurse refused to perform because she believed it unnecessary and she withheld use of the tools in this particular situation. There are several tools and objects in this occurrence. As I was standing there and informed of the ongoing issues, as an observer I was also an object such that Nurse Cora was able to express her disdain for the physician request and explain her ethical position and distress in maintaining her position to protect the patient from what she believed was undue harm. Her actions and words were overt and meant to protect both the patient from undue discomfort and protect herself from inflicting unnecessary pain on a patient. For the ordering physician, the Foley was an ends to more immediate data to move the patient forward. For Cora the immediate harms were greater than the faster acquisition of data.

In another interaction a nurse intervened against what he observed was unnecessary medicalization and restraint.

> Nurse Owen recognized a frequent flier back in *resus*. Frequent fliers are patients seen often enough to know them (usually by name) when they come into the emergency department. Nurse Owen asks the *resus* nurses why the patient (Mrs. K) is agitated and in restraints. Nurse Mimi looks up with raised eyebrows toward the patient to Chief Resident (Dr. Haupt) assigned to the patient. Nurse Owen shakes his head and looks at her monitors and start talking to her. Nurse Mimi tells Owen that

> Dr. Haupt said that if Mrs. K goes off BiPAP she will be hypoxic in two hours. Owen says he doesn't think so because her oxygen saturation is fine. He proceeds to take off the restraints and remove the forced BiPAP. He then fitted a single-lead nasal oxygen supply to Mrs. K. Nurse Owen returned periodically to check on Mrs. K. Mrs. K no longer needed restraints and did not become hypoxic.

Nurse Owen changed the technological intervention and used tools he believed are not only be more comfortable for Mrs. K, but also seemed to assert an ethical standard to relieve his distress at seeing Mrs. K restrained and agitated. With information about what the physician ordered, he opposed it, intervened in what was less distressful for him and the patient.

In another interaction, Nurse Ceci is walking through the emergency department looking for the nurse taking care of patient in room 9:

> Ceci: "Your patient's at 81."(81 is too low for an oxygen reading and can indicate a variety of issues for a patient).
> Nurse Sydney: "Thanks, I'll get orders."
> The attempt at "orders" was not immediately successful and fifteen minutes later I see one of the nurse coordinators talking to the third year resident assigned to the patient asking him to put in the orders for BiPAP for the patient.
> I look over to room 9 where two nurses are with a respiratory tech fitting the patient with BiPAP.

In this interaction Nurse Ceci was concerned about a patient but could not directly insert herself in the solution. The nurse attending to the patient got the coordinator involved to request that the resident put in the computer orders to have the patient on BiPAP. The respiratory tech and the nurses acted without the authority of orders in the computer. The respiratory tech that helped the nurses was one that has a good relationship throughout the

emergency department. Some of the other respiratory technicians I saw over the months may have been less helpful in initiating therapy prior to "orders" being completed in the computer. Clearly the interest was patient safety and the nurses worked within their system and around the computer system to intervene and start a process to keep a patient within safer oxygen levels. The nurses used both their management in engaging the coordinator and the respiratory therapist by starting forced oxygen for the patient.

In another sequence, Nurse Leanna is walking through *resus* where a patient is being examined and changed:

> Nurse Leanna: "Hey!...Curtain?...can you pull it?" She says this to the nurses and residents working on the patient as she walks through from one side of *resus* to another part of the department. She roles her eyes and audibly mumbles "...they don't think..."

The issues in this interactions is simple patient respect and dignity that Leanna in walking by rightfully noticed and addressed. She is asserting authority but also addressing an issue of human dignity.

Self Protection and Decisions

Interactions between various levels of medical authority and process of diagnosis and treatment of the patient are the basis of determining tool-use by nurses and object/body processing to accommodate nurse perception of patient safety. Some interactions reveal use of medical process and tools to assert nurse interpretation of patient need and possibly an indication of nurse moral/ethical/ position.

Nurse Lisa: "...what do you do when they say to give more and check every

30 minute?" (regarding morphine)

Nurse Beth: "It will be 5…you trained me well."

The interaction between Lisa and Beth above relates a conversation regarding how and when to check medication on a patient when a specific narcotic is administered to a patient. Beth had just completed a four month orientation with Lisa and was passing by Lisa after Beth retrieved the narcotic from the dispenser. Lisa was confirming a safety process about drug administration that protected both the patient and the nurse. The physician most likely knew how the 30 minutes was adequate and based on pharmacokinetic standards of narcotic absorption, yet the nurse used the tools (morphine and time) under a different understanding that represents a professional protocol - unwritten, where these nurses check patient vitals in five minutes and not 30 minutes when administering the narcotic. This is an unwritten protocol and understanding between nursing staff to ensure patient safety. The understanding to check earlier than thirty minutes also is a liability and safety check for the nurses responsible when administering potentially lethal narcotics.

In another situation that more clearly demonstrates how to apply a quick fix to a system that cannot be worked through and where the nurse did not immediately have alternatives to diffuse a situation. In this scenario there is a nurse alone in the triage/intake area where paramedics bring patients from the ambulances to be assessed and assigned to various areas of the emergency department.

A paramedic wheels in a woman on a stretcher who is clearly in discomfort and states: "…she's 40 weeks."

Patient: "..4^{th}.." she does not manage to completely state "fourth child.."

Paramedic: "her fourth"

The nurse looks up and sees Jay from patient services writing something at a desk near the door: "Jay…can you take her to emergency maternity?"
Jay, not looking up and still filling out a form: "I need to finish this, I am with a patient" Jay heads out with his paper to the waiting room to someone who is waiting there and enters into a discussion showing them information on the paper. After a few minutes Jay returns. The patient is gone. He does not ask about the patient. I ask the nurse who took the patient to maternity emergency. She states: "I called 911"

While I was a little stunned, she worked within the system to get a new paramedic "order" initiated to get the patient over to the correct part of the hospital which is half a block away. The woman was barely able to speak and the nurse was not sending her to *resus* but the emergency maternity delivery area in another part of the hospital.

Patient Safety

The constant mantra of nurses regarding patient safety was often visible in simple interactions between nurses using different tools or technology.

Checking orders given simultaneously to various healthcare workers regarding medication:
Waiting to see orders on the computer
Nurse S and Nurse A at computers:
Nurse S: "…something for pain?"
Nurse S to Nurse A "did ***you*** give for pain?"
Nurse S "did they give for pain?"
Nurse A: "yes."
Nurse S: "Not…(she makes a face and raises eyebrows).., almost gave again"

There seems to be some resolution on the pain meds already given. The patient is the object that is needs medication. The technology – computer is the object used to recheck and then verbally confirm what occurred. The disconnect was between the individuals and potentially giving the same medication twice. The issues were resolved through a rhetorical about what was being read on the computer regarding orders and who already gave pain medication. The constant here is the patient safety that is actual point of discussion, however the patient is entirely removed the actual dialog and to the prior analysis regarding bodies as objects and alien, this interchange is an example where one could be led to believe that the work and nature of interaction of critical care emergency medicine is constantly an autonomous check and recheck of data through technology. However the constant reflection of the individuals providing care is an essential and important component to moving patients to something better.

The following involves an interaction about whether or not a patient can be transferred to another area of the hospital from the emergency department without a cardiac monitor:

> Nurse Jasmine to the *resus* resident: "Can he go up without a monitor?"
> Resident (glancing briefly at the patient): "Yes, I think he will be fine."
> Walking into the *resus* Nurse Helen stops Nurse Jasmine while saying "...stroke patient...it's a rule...he must be on a monitor...it's the a rule!...he must..."
> Jasmine explains to Helen that the resident is fine with it. Helen looks annoyed and frustrated.
> Helen: "Okay, document."

The interaction while brief was a display regarding patient safety and then rules and how documenting was part of the safety for the nurses. Documentation in the EHR was Helen's

way to cede to what Jasmine was doing that was against the "rules". Rules that were in place to protect the patient. The remedy was to document that the physician in charge said to go ahead and move the patient without the heart monitor.

A nurse responding to data informs actions by others and initiates a cascade of responses by the physicians and counter responses by nurses regarding action to treat patients. This cascade of patient care includes many pieces of technology and tools. The computer as a tool is used to document patient status and is the proof in both a legal and medical trail of patient treatment. This patient record is for patient safety but also serves as a footprint for patient care when others assume care simultaneously or sequentially. Consequently, the data from the computer is more than a patient record as it is used to reify positions of professionals in the emergency department as well as communicate patient health status.

The nurses in the emergency department at UED frequently discussed their role in patient safety when discussing their work. In both interviews and in remarks regarding patient care, patient safety was a maxim repeated by the nursing staff. Making sure patients are safe while they are stabilized to their next point of care requires nurses to constantly monitor the patient status. The monitoring is done with tools that describe patient health and by use of other tools by nurses to administer drugs, oxygen and take blood for analysis. Healthcare workers such as the medical technician in the emergency department also serve as tools –objects that are used to fulfill tasks in patient care. On more than one occasion, the technician assigned to *resus* was asked to translate from Spanish to English for nurses as

they assessed the patient or needed personal data.[58] It was not uncommon to see a physician holding a phone between them and a patient as a translator on the other end of the phone facilitated a conversation through the phone held up between the doctor and patient. Other people used as tools to mediate patient care were the pharmacists. Although pharmacists are healthcare practitioners, on more than one occasion I saw nurses request the pharmacist to come into *resus* to confirm drug flow, set up a drug pump or confirm actions that had been requested by a physician. I was informed by nursing staff that they request pharmacists to ensure appropriate dosing if they have a question or are unsure. In one tragic event that unfolded over several hours in the *resus*, the nurses requested that a pharmacist to come to the *resus* with an electronically controlled infusion pump also called a PCA (Patient Controlled Analgesia). The woman was in the end stage of her cancer, she was dying and the physicians had prescribed morphine. The nurses were not comfortable giving repeated doses of morphine and calling in the pharmacist with a machine so that the patient could self administer the morphine by pressing a button that triggered the machine to release measured doses of morphine. The nurse actions of introducing the pharmacist and the PCA (technology) as tools is an example of a wide range of various tool, technology and object use by nurses as part of ways to navigate patient care where objects and people are

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[58] Limited English Proficient (LEP) patients is the term given to patients that cannot completely communicate or understand English. The 1964 Civil Rights Act is the federal law that protects patients in need of translation and requiring hospitals to provide translations services by linking the Act to Title VI as the basis for not discriminating based on language. Federal financial assistance is funding received by hospitals. Medicaid is one example of such funding to hospitals. Others include National Institute of Health research grants, Medicare payments and other health related federal money. While the state by state laws remain variable, the federal requirement has been advanced through executive order to ensure translation services for those in need (Chen, Youdelman, and Brooks 2007).

introduced to alleviate the pressure of in this case administering large doses of morphine and redirect care through objects.

Analysis of the Workaround

In emergency medicine, nurses occupy specific roles in patient care. While that role is influential in how work is done in the department, it is also dependant on interaction and taking "orders" from other healthcare workers within the medical hierarchy. The process of patient care in critical medicine requires expertise in varied aspects of medicine. The healthcare workers in critical medicine, not unlike other fields, use varied problem solving strategies based on experience and training (Ilgen, 2011). Observation of nurse experiences and problem solving revealed use of tools and conversations regarding those tools to support decision-making and protect themselves professionally; in advancing the safety of the patient; and to protect personal ethical boundaries as individuals treating humans – bodies.

The structural aspect of nurses as a body politic and the structure of hospital work are described by Salhani and Coulter as part of nurse self-governance in a micro-political dynamic (Salhani and Coulter 2009). The bounded nature of the work within the hospital and the need for nurses to assert personal boundaries may reveal an illusory heterotopia (Foucault 1984) for the onlooker regarding the work being produced, as often noted for patient safety. While the check and rework of work produced reflects patient safety, it also represents the nurses' ability to position themselves to control their everyday work product.

In this part of the study, I discuss how the work produced by nurses uses tools and technology to ensure patient safety. In various examples I describe how nurses accomplish this by inserting additional checks with technology, refusing to use a tool that the nurse believes unreasonable, and using a different technology the nurse believes is still therapeutic and also more comfortable for the patient. These examples illustrate the constant interventions through objects where tools and technology mediate the personal, professional and moral position of the nurse in patient care. Tools and technology were a part of working around a personal position. These workarounds as illustrated do not fit the definition of workaround to avoid work, but they were used to define how work gets done revealing the moral boundaries and care of the healthcare worker.

The working around and guarding or positioning of moral boundaries while personal and self protecting for these professionals, also exposes professional confines of nurses within the processual workflow and structure. The nurse differs from the paramedics who may earn less than a quarter of what a nurse earns, but have autonomy to direct care out on the street. The nurses use protocols that allow them to initiate certain work practices prior to checking if orders for a patient are in the EHR. However the confines of how care is directed contribute to the need for nurses to create practices and workaround situation for their moral safety and safe as well as sometimes ethical treatment of the patient. The example of nurse Cora being upset and visibly angry about the resident insisting on a Foley catheter revealed the vulnerability Cora felt for the patient and confines of her position or any other nurse to push against the limits of her reporting confines and saying no to an order.

When I started doing the daily observations in the hospital, I was constantly reflecting on what appeared to be divide between nursing staff and physicians. I was often surprised by a lack of coordination and direct communication between physicians and nursing staff. The exception of course was the orders that were carried out through the EHR. When I consider how working around issues occurs, workarounds by the nurses often appear as strategies to get things done for reasons that are not necessarily immediately visible as ethically rooted, however many were. Some of the strategies may be for patient safety and certainly some were to personally ensure that a belief about what *should* get done for a patient gets done. In discussing the ethics of workarounds, Berlinger notes that it depends on how the workarounds relate to the healthcare work (2016:34-36). It was rare to see a workaround as a specific change or deviation from a rule. The workarounds were most often part of well engrained personal decision making process that guided specific actions. The work and ways to get work done for patients was less duty-based ethics of moral theories rooted in principled approaches, but part of what sustained the particular nursing practice of the nurses I observed. The principled approach could be labeled onto the nurse actions, however that label of non-maleficence as an example for Nurse Cora and the Foley catheter is not how she understood the problem and how she worked around the problem. Nurse Cora's response was personal, phenomenological response to the event. Thus, as with the paramedics that worked *through* situations that reflect their personal position of "better" for a patient, the workarounds that I have described regarding the nursing staff, were also the point of visible moral care where nurses worked around and through a system within the confines of their work.

In the literature on moral distress in nursing, the theme of limited nurse autonomy simultaneously discusses nurse reporting and telling stories of consistent moral actions (Manara, Villa, and Moranda 2014, Traynor, Boland, and Buus 2010, Wilkinson 1987, Jameton 2013). The autonomy and lack of authority to act or voice issues in medicine may have a long history in the political and qualitative assumptions regarding nursing. As that historical relation may stand, what I describe is how nurses work or act in ways that reveal a personal moral position regarding care of patients. The working around issues illustrates one way that moral expression is visible.

Emergency medicine as a clinical field allows for quick snapshots of the various interactions where the personal interaction reveal the personal moral. Within those quick snapshots, nurses may continue to state that they don't bond. This of course is true in that there is little or no time in relation to clinical contact especially when the work is to stabilize a patient to get the patient to the next point of care. However, the bonding is one that has a greater moral importance in that they occupy a personal and professional space where they commit to the patient care, well being and safety. While it is difficult to generalize from the data, the interactions observed do reveal the constant or at least ongoing examples of visibility of moral agency and action in nursing care.

Chapter Five

Physicians and Physicians in Training

Emergency medicine is a board certified discipline requiring the physician to have a broad range of clinical skills and the ability to quickly translate and apply knowledge while directing the care of patients. In this section I describe the role and complex work of the emergency department physician from the point of view of a physician's work as part of a morally grounded profession. I discuss several examples of physician interaction as they work to care for critical ill patients.

The American College of Emergency Physicians (ACEP) describes the multiple sources of moral guidance for emergency physicians as moral pluralism that creates ongoing challenges for emergency physicians (ACEP 2017). The multiple sources include constant advances in technology, disadvantaged groups of the public, rising healthcare costs and the effort to address these varied and often simultaneous issues that present on any given patient case. The recognition of the various sources and moral pluralism noted by ACEP is revealing. The ACEP description uses ethically charged language to describe the multiple pressures that include a few of the specific issues that this study observes as points of moral action and moral positioning by other healthcare workers. In pointing to the moral challenges, ACEP identifies the unique moral nature and challenges of the physicians who choose emergency medicine as their medical specialty. Without specifically stating it, this selection is part of a local moral world for the group of individuals choosing to participate in emergency medicine. Although each physician in any given interaction maintains their own

world view while applying inclusive medical knowledge and moral standards, they collectively occupy a moral position in the social and greater political nature of individuals for whom they care. As previously discussed, Kleinman introduced the phrase to describe the local moral experiences of physicians and the moral judgment of what matters contextually in a given cultural situation (1995:44-46). I use the expression to capture the varied levels of healthcare workers. The culture and systems at UED create processes where moral expression occurs. The physicians occupy a space and process that differs from the nurses and paramedics. The residents are training as they treat patients within the context of their new profession. The process is fraught with moral change often noted as cynicism and a regaining of moral fortitude (Shim 2010). The process and working within the system of medicine and caring for patients simultaneously expands the skills of the physicians as well as relies and tests the personal moral fortitude of the physician. Most medical schools send physicians out as newly minted doctors with a recitation of the Hippocratic Oath. The well known oath to "do no harm" has been handed down to physicians for hundreds of years as a reminder of the special position of trust that a physician has with the public when patients place their body in the hands of a physician to assess and make decisions. It is as a symbolic reminder of their ethical duties when treating the vulnerable who place their trust in them as part of a newly minted learned profession. The local moral world of the physicians that I discuss in this section has a few perspectives to define.

Along with the expectations of society that fold into the role of the physician is the physician's personal moral agency. The personal moral agency of the individual who chooses to practice emergency medicine is unique. As discussed, emergency medicine takes all comers. However as individuals, each physician interprets their relation to their work as

physicians in different ways. For some physicians their role and work is medicine as science. In one conversation between an Attending and a medical student, the Attending enthusiastically described how thrilling her medical school rotations were at Westchester Medical Center because it was not only a public hospital but also a Level I trauma center. The Attending's enthusiasm for her medical science was palpable. The emergency physician has a perspective on work and brings with her the perspective of a professional local moral which is both a domain of knowledge and being.

Regardless of the individual physician, it remains that medicine and the role of the physician has a well chronicled contract with society.[59] ACEP as an organization of the profession recognizes this in some of their writings that preface the need for understanding moral codes and ethics[60]. One can expect and assume that the physicians working in

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[59] In a discussion of medical ethics, Albert Jonsen discusses the historical duties of physicians:

> "Alongside the ethics of medical decorum stands a more grave morality: certain injunctions that define the duty of the good physician. Sometimes incorporated in solemn affirmations such as oaths, or in stringent rules dictated by church state or profession, these duties enjoin the physician 'to benefit the sick and do them no harm'...duties linked to deep moral beliefs..."

While the roots of such expectations hark back to the Greeks, these expectations also provide a straightforward script for understanding self-held beliefs of individuals who pursue medicine (Jonsen 1998).

[60] The need for codes and reference to understanding as part of practice is made here regarding expectations for emergency medicine physicians:

> "Ethical concerns are a major part of the clinical practice of emergency medicine. The emergency physician must make hard choices, not only with regard to the scientific/technical aspects but also with regard to the moral aspects of caring for emergency patients. By the nature of the specialty, emergency physicians face ethical dilemmas often requiring prompt decisions with limited information...the underlying assumption is that a knowledge of moral principles and ethical values helps the emergency physician make responsible moral choices. Neither the scientific nor the moral aspects of clinical decision making can be reduced to simple formulas. Nevertheless, decisions must be made. Emergency physicians should, therefore, be cognizant of the ethical principles that are important for emergency medicine, understand the process of ethical reasoning, and be capable of making rational moral decisions based on a stable framework of values." (Sanders et al. 1991).

emergency medicine do so in part because of the egalitarian nature of the work. These healthcare workers choose not a moneyed elite discipline or specific discipline that narrows the focus of medical practice, but a discipline of medicine that requires a constant change in issues observed and often rapid interaction with the public with no pre-selection of the professional or economic status of your patients. The patients arriving at UED for emergency care are both culturally and economically diverse. While a principled approach to interaction as a physician provides a well honed script of appropriate physician to patient discourse, the individual physician as well as the patient come with their own personal and professional history. The ideal of a physician and patient interaction is one where the physician understands the medical issue, diagnoses the disease and is able to alleviate pain and suffering. These expectations of patient and physician are inherently moral (Kleinman 1999b). The expectations are moral because of the vulnerability and lack of knowledge or ability to change a medical problem. That interaction and the potential consequences is one that is moral in its roots of trust to a professional who can heal.[61] Additionally, for physicians there is personal worth tied to that moral norm of exacting health and healing. In neurosurgeon Paul Kalanithi's posthumous published memoir he notes in relation to his personal moral position:

> As a chief resident, nearly all responsibility fell on my shoulders, and the opportunities to succeed—or fail—were greater than ever. The pain of failure had

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[61] Although society can reflect on Christian moral teachings citing disease as God's wrath to even present day Evangelical Christians who site AIDs as God's displeasure with sinners, it is the same Christian ethics that define healing and the sacrity of the body. Keith Thomas gives a full description of the relationship between Christian mores and influences linking health and morality (Thomas 1997).

> led me to understand that technical excellence was a moral requirement. Good intentions were not enough, not when so much depended on my skills, when the difference between tragedy and triumph was defined by one or two millimeters (Kalanithi 2016).

The duties of the healthcare workers creating health or attempting to stabilize health are real and mixed with a combination of personal and professional roles of service and commitment to others. While choosing neurosurgery as opposed to emergency medicine, Kalanithi recognized the unique moral position of his practice. For the emergency medicine physician the role and expectations has an added commitment to serving the public.[62] The physician however also remains separate in her function and autonomy as a healthcare worker from nurses and pre-hospital care workers. Kalanithi's quote relays the responsibility that is fundamental to the work of a physician. The quote also makes clear the moral requirement that is imbedded in the responsibilities and nature of the work of a physician. What deserves at least brief mention is that with such knowledge and responsibility also comes power. That power has various forms in medicine. In the interactions of creating care and making decisions, the power is the autonomy to use the knowledge to act. Those acts are the care which for physicians are partly the instructions on action. The instructions may include medication, interventions, additional diagnostics or the elimination of any of the aforementioned interventions. In this section, I examine examples of interactions of physicians as they go through their work and how the local moral worlds of the physicians

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[62] Article VI in Principles of Medical Ethics of the American Medical Association states:
> "...a physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care."(Association 2016)

are visible, the work physicians take on or disregard and how their personal moral agency may or may not be visible through the ongoing working constraints of emergency medicine.

Public Knowledge and Medical Reality

Physicians and their patients present what seems to be an uncomplicated relationship. An individual with a complaint or issue relies on the knowledge of the physician to relieve or attempt to relieve the problem. The contingent issues in critical care and modern technology available to healthcare workers introduce complications and in some instances reveal personal limits as well as greater depth of the individual physician. Technology however is also folded in medicine and becomes what shapes medical action and in turn embodies morality (Verbeek 2008). That embodiment is not that technology becomes the agent but that it co-shapes human actions such as the way the physician interacts with the patient through technology. In some cases that co-shaping is part of decisions that shape discourse and treatment of patients.

In the following interaction, discourse involves multiple issues. On this particular morning a young woman in her middle thirties is in the *resus*. There are also two other critical patients that have recently been added to *resus*. Peter, a third year resident I refer to as Dr. Peter, has just finished a receiving a report of the conditions of patients and now at 7:00 a.m., he begins to follow the patients that came into the emergency room overnight. While the patient looks healthy, monitoring her blood pressure remains the critical issue for an as of yet undiagnosed endocrine disorder. During the course of the morning, an

endocrinologist comes by to see the patient as well as other physicians. The patient must wait in the *resus* of the emergency department where she can be closely monitored until a bed is available for her in the ICU. Her group of family waiting with her has now amassed to a husband and a sister as well as a friend. The friend comes into the *resus* talking on the phone and with some bags of food. She excitedly tells that group that she talked to another friend and she thinks its "this" and pulls out an iPad and shows her friend the medical description of a disease. The husband appears agitated and after four hours of waiting for a bed, the husband begins to yell at the *resus* nurse. Prior to his yelling he says to the friends and his wife… "how long has it been, four hours and nothing..?". He then turns to the nurse and the following exchange ensues:

> Patient's husband: "How can you still not have a bed!?" The patient's husband says this while walking from the patient's bed toward the nurses' computer where the *resus* Nurse Ceci is inputting information on a patient EHR. Ceci does not look at him as he gets closer and he continues to makes statements in a menacing and loud tone.
>
> "Should we change hospitals!?" [said loudly] The patient's husband is quite tall and he is looking down at Ceci who is a petit Filipina woman whose good nature is rarely challenged. Without looking at the agitated man, Ceci picks up the phone and calls patient services.
>
> Patient Friend: "Jed, Jed, it's not her fault…"
>
> Patient Husband (Jed): "WHAT!"
>
> Patient: "Jed!"
>
> The patient and her posse go back to talking among themselves.

During this time, Resident Peter (Dr. Peter) is working on the issues of a 97 year old brought in by EMS where Dr. Peter suspects abuse of the 97 year old. He is on the phone

trying to get the 97 year old admitted to the hospital instead of returning her home to the care of a family member:

> Dr. Peter: "...well EMS saw it, yes, previously ambulatory, they find her in her urine and ...no, I think she should be admit--, Okay, so the first number for her, and med number, yeah, I will let you know...three...okay...thank you."

Having watched the agitated family around the endocrine patient in *resus*, Dr. Peter finishes the call, puts down the phone and walks toward the patient. The patient, patient's husband, and the friend all start talking at once when Peter walks over to the patient. He starts to answer their questions:

> Dr. Peter: "...well, performing the test takes six hours, the results...yes, like your hydrocortisone, ...your body normally produces more in the morning and that will increase your blood pressure and you wake up – whatever time you get going..."

Arturo from patient services came directly to the *resus* to help Ceci manage the patient family and deal with the immediacy of the bed issue. He is on and off the phone a few times on the *resus* area phone attempting to negotiate a bed in ICU for the endocrine patient with the agitated husband. The conversation with the endocrine patient and Dr. Peter is ongoing:

> Patient: "...but normally I get (names several medications), but nobody gave them to me here..." ... "...they were giving me both..."
> Dr. Peter: "But if there are different levels, it can be dangerous...they need to stabilize (you)."
> Patient: "I feel like stabilization is..."
> Dr. Peter: "...I think something is going on..."
> Patient: "They have me on this too..." The patient rustles through a bag of medications and hands it to Peter.

Dr. Peter: "Thing is, it is terrible and great, but the thing with stress hormones like cortisol is the predictability -- and it can be hard to control with certain diseases."
"...I, I have not gone through all of it, I know from some textbook chapters, but a lot I do not know and the blood pressure drip is best monitored in the ICU. Dr. Peter turns to look at the husband: "There is only one hospital in the New York area that does not go to the ICU to monitor. But you want to be in ICU so the nurses can have eyeballs on the monitor and that is why you are back here in this part (*resus*), so they can watch."
Patient: "Thank you"
Patient friend and the husband both say thank you. The group is visibly calmer.
Arturo: "I just got an update..." He hands a note to Dr. Peter
Dr. Peter: He turns back toward the patient: "They ordered a bed for 10:00 a.m..."
Patient friend: "So I had a conversation and it seems... or other people talk about POTS..could it..."
Dr. Peter: "POTS disease is more about heart rate than blood pressure...your medical issue is blood pressure...but it is worth asking your endocrine about it, I am an emergency medicine physician...that..."
Patient friend: She interrupts Dr. Peter mid-sentence..." ...but isn't there someone...a Dr. House type .. you kn-..."
Dr. Peter is shaking his head and cuts her off: "That is ridiculous – no one person with all of the specialties – each one of the specialties (in medicine) is a six or seven year... or more training process...The show (House) is rheumatology? This is endocrine."

Dr. Peter returns to the computers and is talking with the Attending: "How much more do I need to admit the woman found in her urine and feces?"
Attending Rahm: "Send to medicine."
Dr. Peter: "For non-ambulation?" He asks this while typing...Dr. Rahm, nods in reply while typing on his computer.

> Ten minutes later, Peter hangs up the phone and says to Dr. Rahm: "That was radiology, she has breaks in her spine...medicine won't touch her and neuro won't do an intervention because of the dementia..." He says this with exasperation.

The cases Dr. Peter was handling were not unique to the type of day a third year resident covering *resus* would be responsible for handling. The cases do not have some of the turmoil as the case of Dr. Sampson discussed earlier in this study, however they are as morally relevant for Dr. Peter. The concurrent cases Dr. Peter handles both represent examples of a physician who is morally engaged and interested in ensuring the patients get to the right situation to help them meet better health. Dr. Peter shows exasperation at his inability to fix the situation with the 97 year-old patient brought in by EMS. He works to find appropriate placement within the hospital and find a plan that did not return her to an environment where she would be subjected to care that he suspects was abusive. However his challenges mount as more is learned about his patient condition and the structure of the hospital as an institution acts to limit his possible intervention and placement. Regardless of moral interest in getting the patient to the right care, he finds he is continually limited in his power to do so. He is frustrated at the impasse he has reached at being able to obtain the appropriate care for this clearly vulnerable 97 year-old patient.

While Dr. Peter does not use words like vulnerable, he views the limitation of the patient condition as one that must be mediated by him as a physician. With the endocrine patient, Dr. Peter did not use morally weighted words, however he was able to disengage conflict with the patient and the family not by just stating facts in response to their questions (which he did in answering varied queries), but by making the dialog with the patient reciprocal. Dr. Peter made clear his concern and why having this patient at this hospital and

having to deal with the emergency department was in her best interest, her safety, her well being. He made clear a shared expectation and value for the patient. He is implicit in his knowledge and what he knows is best for the patient. He created order and allowed a group of people who felt frustrated and vulnerable aware of his position as a physician while indicating the risks in leaving. The same work could have been done with less personal involvement or investment in the patient, but that is not how Dr. Peter conducts his work as a physician. It is this unique position that he does not parse out in terms of ethical standards but operates from a personal perspective of knowledge and responsibility to his patients.

The conflict physicians feel regarding the work they produce in caring for their patients can be ongoing especially in emergency medicine. The interest in restoring health can extend beyond the visible restoration of health. In the following resuscitation, I follow a third year resident (Dr. Robert) who I observed through several successful resuscitations. At 7:50 a.m. the *resus* notification bell rings.[63] Nurse Mary picks up the phone and writes on a scratch piece of paper: "10 min, CA". She starts to walk the paper to the Attending side of the divide and is met by Chief Resident Robert (Dr. Robert) and an Attending Dr. Cormey. The following series of interactions and conversation develops:

Dr. Robert addresses Mary: "No ROSC?"
Dr. Cormey: "Did they say?"
Overhead Page: "Cardiac team to Cardiac…"
Nurse Mary now on overhead page: "*Resus* notification …in…"

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[63] The resuscitation "bell" is a very loud bell that rings when EMS is coming to UED with a critical case that will require immediate transfer and attention. The bell is operated through the 911 system and the bell ringing is usually followed by a call that describes that status of the event and how many minutes from the hospital the ambulance is in transit.

Dr. Jake: "Rob, are you in *resus*?...(Robert nods in response to Jake who came-in to guide the cardiac intervention and resuscitation, Jake is a fourth year resident) ... okay your show.. (Jake backs out of *resus*, giving anyone a chance to ask him to stay. Jake does not seem to want to leave but eventually finishes backing out of the area.)"

Nurse Mary picks up the phone and says quietly: "I need someone else in here..."

Mary and another nurse are prepping for entry of EMS at *resus* area 3. They are checking the crash cart and making sure the portable monitors are ready for the incoming code.

EMS enters doing compressions as the CA comes in - EMS lines up the gurney with the *resus* bed and are about to move the patient. Someone yells out "board?" and someone passes over a large board that is placed under the patient as compressions continue and the patient is moved from the EMS gurney to the wider hospital bed. A resident immediately takes over compressions from EMS. There are medical students and residents that alternate with compressions. There is an interaction with the nurses as Nurse Tia is attempting to verbally confirm with Nurse Mary that is handing off and administering meds. Another nurse is sitting at a computer and also writing down the time and what meds are given.

Dr. Cormey asks for a report.

A soft spoken EMS starts to give the report...

Dr. Robert repeats what the EMS worker said and states quite loudly: "patient at 7 a.m. unresponsive with no ROSC..."

EMS then starts to continue to give information of patient status stating: "7:34 got ROSC."

Dr. Cormey: "Can we give Calcium (Ca) and bicarb?" This is said as a question but it is a statement of what needs to get done.

Nurse Mary: "Calcium and epi" (She states what meds she is administering)

Respiratory Therapist: "airway confirmed." said from head of patient by the respiratory therapist as a physician finishes intubating the patient

Dr. Wendel walks in with another nurse she has asked to help. (The nurses often call Dr. Wendel 'mamma bear', tough but will look out for the nurses)

Nurse Mary: "Calcium"

Dr. Cormey: "Can we give Calcium"

Dr. Robert: "Pushing Calcium and Bicarb…"

Dr. Robert: "Lets stop for pulse…1, 2, 3,"…"Pulse, check cardia…no pulse?"…"epi?"

Nurse Mary: "755, 750 – can we get a line?"

(another change of residents doing compressions)

Dr. Robert: "...probably a little faster…" noting the need for faster compressions by the resident or student that just took over compressions

EMS: "no pulse with us"

Nurse C: "they gave bicarb, 1 epi…"

Change of compressions called out: "1,2,3…"

EMS: "the right arm cannot be compressed against anything because of the IO…"

Dr. Cormey: "Grab the IO gun" he says this nodding with his head toward the wall where it used to be kept.

Student: "Where is it?"

Dr. Cormey: "Against the wall." (There is some movement of equipment crammed into the corner as the student attempts to find the IO kit)

Dr. Cormey: "Trevor, come over here… in front of the curtain….Trevor" (Trevor is a visiting medical student)

Dr. Robert: "have a pulse – great …go in central line"

A medical student begins to put together the kit for a femoral artery line is putting on a face mask with a shield…she is with Dr. Jake who starts to talk her through how to insert the femoral line.

Dr. Robert: "Can we get calcium and sodium bicarb?"

Nurse Tia: "writing down medication …."…"8:05 Calcium…:06 Bicarb"

Nurse Tia: "How many epi did we give?"

Nurse Mary: "3rd bicarb?"…"last at 8:06"

Dr. Robert: "We have 2 IOs"..."... "Ca going in, 3rd bicarb"

Nurse Tia: "everything documented so just..."

Dr Robert: "Trevor, I want you to put a finger on the carotid to the feel pulse..."

Nurse Mary: "Just calcium and bicarb, 3 and 3

Nurse C: "this it?...looking at clock" (she says this no-one in particular)

Respiratory Therapist who is at the head of the patient and Nurse Mary make eye contact raising her brow. Mary raises her brow and makes a face, somewhat questioning. Mary walks to medication room and to get more bicarb and calcium

Dr. Cormey: "no temp, treating hypothermia..."..."internal temp to..."

Nurse Tia: "almost 25 minutes"

Dr Robert: "Any other suggestions? ...over an hour (total)"

Dr. Cormey: "Lets give another dose of epi."

The chief resident and the medical student continue to work on inserting a line to access the femoral artery.

Dr. Robert: "Don't you want to check for ..."

Dr. Cormey: "yes...stop...pulse?"

Dr. Robert: "any cardiac activity?"...

Resident at the monitor: "none"

Dr. Robert: "Unless there are any objections – call it"..."time of death 08:21"

The three alternating on compressions back away from the patient. The two working on the femoral access point continue to work – this is completely instructional at this point. Dr. Robert is with another medical student discussing the position of another valve on the intubation.

Nurse Mary is going through the crash cart. Mary says to Trevor as he is leaving "Thank you".

At the Attending desk, Dr. Robert is on the phone attempting to notify the next of kin. Nurse Mary is with the tech cleaning up the patient. Mary nods with her head indicating the curtain to the tech and the tech pulls the curtain around what they are doing.

Dr. Robert: (on the phone) "...he has a legal relation?...he's a ward of the sate?...hello...yes still here...can you give me the phone number?" Dr. Robert repeats back the number to the person he has been talking to. He immediately dials the number he just wrote down.

Dr. Robert: "...yes...I am a doctor in the emergency medicine department at UED and I am calling about Mr. Albert Mercat...do you have any idea of the relationship with this patient?...okay...."

Dr. Robert repeats back another number and again dials the number he is given.

Nurse Mary: "Do we have family..." She says this coming out from the curtain, she says it to nobody in particular.

Nurse Tia: "They are trying to get [X] Home on..."

Nurse Mary: Shouting toward Dr. Robert who is talking on the phone again "...Tell ...in the *resus* room..." (She assumed he has located a next of kin)

Dr. Robert: "Hello is this? Is ..., my name is Dr...., I am an emergency medicine physician at UED, I just called an office? ...okay...can I ask what is your relation to Mr. Mercat, yes Albert Mercat?...legal guardian...yes, UED hospital...he was found non-responsive this morning and worked on by EMS for 30 minutes and we worked on him here for 25 minutes....he just died a half hour ago."

"Not that I am aware of..."

"You are listed at next of kin.."

"He's at UED ... where the body will be held until it is released elsewhere"

"I don't know, how close..?"

"So he's a ward of..."

Dr. Cormey returns to the computers opposite the *resus* nurse computers where the Attendings and residents assigned to *resus* enter data and answer calls. He is watching Dr. Robert. He seems aware that Dr. Robert is a little agitated by not only the failed resuscitation but also with Dr. Roberts attempts to locate a next of kin.

Dr. Cormey: "They *said* they got ROSC?"

Dr. Robert: "*We* got ROSC once."

Nurse Tia: "Are they coming?" (The nurses are still waiting to find out if someone is coming to see the body, a next of kin)

Nurse Mary: "You talked to a legal guardian?"

Dr. Robert: "They will take care of ...and funeral arrangements..." He didn't answer Mary, he seemed to be reviewing what would be done for the patient.

Dr. Robert then turns to me: "It was just this person...it was a man who was his social worker...he seemed to care. ...the State...he (the patient) was a ward of the State."

Nurse Mary: "...So we don't need to wait anymore?"

Nurse Tia: Scowling at Mary... "No."

Nurse Mary: "So...death...due to..."

Dr. Robert: "Dr. Cormey is working on it..." Dr. Robert cut her off when she said this. Dr. Cormey the Attending was filing out the necessary "papers" on the computer and making the arrangements to get the body to the morgue where the legal guardian would get the body for the appropriate funeral arrangements. Dr. Cormey took over for Dr. Robert from here and it was clear that Dr. Robert didn't appear to want to deal with the nurses questions on when they could have the death certificate to move the body.

Nurse Mary on overhead Page: "Need SA[64] to *resus* with a mop"

Dr. Cormey: (on the phone with nursing facility): "Can I speak to doctor in charge for taking care of someone at your facility, yes Mr. Mercat, Albert Mercat.. ...I need to speak with someone."

"...notified the nursing home, we have the death certificate..."

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[64] SA is short for Service Associate. These are custodial staff.

Dr. Robert's internal dialog became fully audible as he turned to me with an inexplicable vacant look that expressed sorrow and frustration. He seemed surprised and frustrated for the man he tried to save when he found no immediate relations and discovered that the social worker volunteered to be his guardian. He stated: "...the State, ...he was a ward of the State.". This is not the information he wanted or expected. He had kept the body from being sent to the morgue so that he could get someone who might want to see the body, to see him before he was sent to the morgue. Clearly Dr. Robert considered the patient as more than a body that needed a death certificate to release it to a morgue. Dr. Robert had worked with the team to try and achieve the best outcome for his patient. The resuscitation attempt failed. Dr. Cormey had tried to remind Dr. Robert that it was EMS that *said* they had ROSC. The implication was that he should not take it so hard, because the EMS just *said* they had it, which does not necessarily mean that they could have turned the patient around. Dr. Robert was quick to retort that they got ROSC in the emergency department. While the man was in his late thirties, the interest of Dr. Robert is not patient age or the statistical norms, but the knowledge that the chances for survival are increased dramatically when there is ROSC, or return of circulation. At the moment Dr. Robert did not seem to consider other factors that can interfere with resuscitation.

Dr. Robert's actions and his personal reactions have meaning not because I have transcribed a dialog, but because actions are significant, have personal and spiritual meaning to the individual and are part of the humanity witnessed. Actions are part of care and the local moral world inhabited by Dr. Robert as he dealt with the individual as an individual who never awoke from his cardiac arrest. In this study I repeat these experiences to explain the how Dr. Robert internalizes that moral disposition and the personal nature of his attempt

to change the course of this person's death. He worked through the cardiac episode. He was buoyed at one point when ROSC was established and then attempted to complete the resuscitation with the team. There is no workaround to death. The nurses wanted the body out. Then after death of the patient Dr. Robert attempted to bring closure and dignity for the patient. The internal monologue was suddenly audible. Then without provocation my presumed silence and observation is audible as he turns to me to relate what he learned about his patient and the patient's guardian.

In Dr. Robert's work with and for his patient, my interest was to not only detail the interactions, but also provide narrative to the connections of the physician to his patient. A patient who never conversed with him, a patient that had a name and a life story that was important to Dr. Robert. There was no simple rationality that dictated Dr. Robert's reaction. He was personally guided to act and with that seemed affected by the entire situation. Dr. Cormey attempted to assuage some of Dr. Robert's self reflection by providing the calculated logic of potential survival of the patient when Dr. Cormey mentioned a lack of confirmed ROSC. Dr. Robert quickly brushed the attempt aside as he reminded Dr. Cormey that in the resuscitation attempt that were able to get ROSC. While I cannot directly link his emotions to his actions, I believe that his interactions with those around him and his attempt to bring dignity to his patient after death were exemplary of Dr. Roberts moral self as a human and a physician. He worked within his capacity and training. The turn of events weighed on him.

Palliative Care

The word palliative is synonymous with analgesic or soothing. It took me some time to figure out and place what the role was of palliative care at UED. I learned that palliative care has a medical group at UED assigned to assist the department even though Palliative Care is a separate department and floor in the hospital. The palliative care teams that interacted with the emergency department however are often only considered for end-of life care, which is not the actual intent. As a point of clarification hospice care, that is often confused with palliative care is a type of palliative care for patients with a medical diagnosis that informs them that they have six months or less to live. During my time at UED, I did not meet any palliative care nurses, however I had the surprising pleasure to talk with and interact with several of the palliative care medical teams that would come down to the emergency department. Dr. Naima was responsible for assisting and working with the emergency medicine physicians on palliative care support for the patients. She came down to the emergency department a couple of afternoons each week depending on her rotation. Her work in coming down to the emergency department was to help with cases that needed palliative care or to help with difficult issues with patients that present in chronic pain and intractable disease. She also would take the delicate cases and discuss with family members the options for care, pain, resuscitation and other uncomfortable issues that the emergency physicians do not have the time or resources to discuss.

One afternoon, Dr. Naima came down to the emergency department. She always came over to where I was standing and we would check-in with each other. She often asked

me about a case she was dealing with and what I thought. While I always reminded her of what I was doing, she very kindly made comments about my outside perspective and then usually she answered her own questions. Today she came down with a resident that was doing a rotation with her. They came over to *resus* and she introduced her resident to me. Dr. Naima stopped the director of the emergency department and asked if there were any cases she wanted her to look into. Dr. Johnson smiled her ever pleasant smile and said, "actually, yes come over here" and Dr. Johnson led Dr. Naima and her resident over to *Resus* 4. During this interaction I attempted to go back into my observation mode, taking notes as they discussed the patient in *Resus* 4. The patient in *Resus* 4 had a difficult morning in the emergency department, and had been in the emergency department for more than 24 hours.

From early in the morning tech Franny has been with the patient in *Resus* 4. Tech Franny has been at UED for over twenty years and is always doing her work, supports whoever needs her, but while she goes mostly unnoticed, her competence and ability to get work done is well known to the nurses and senior medical staff. The patient Franny was dealing with in *resus* was a 1:1. A 1:1 is an assignment where a member of the hospital staff must sit with a patient. The patient may not be left alone under any circumstances. The reasons requiring a 1:1 include patients brought to the emergency department for any suicide attempt (they are monitored so that there is no risk of patient elopement[65]), patient harming themselves, or if a patient is in some sort of altered mental state. These patients are in a

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[65] Elopement, or a patient that elopes is a patient that leaves the emergency department prior to having finished a medical workup and discharge or placement into care in another area of the hospital.

medical state where they are too sick to be in the psychiatric emergency department or have hurt themselves badly enough that they must be monitored within the emergency department. The patient Franny was tending to today was both. The patient leans over the bed and spits onto the floor. There is nothing to contain her spit and Franny admonishes her. Tech Franny says to the patient: "...not on the floor...that not nice don't..." Franny says this in the kind measured way that tech Franny does everything. Franny continues talking to the patient and letting her know she needs to cooperate. Franny stays next to the side of the bed with the patient, cleans up the patient and simultaneously attempts to soothe her.

As part of this research, description of the interactions with palliative care, I include simultaneous ongoing events and dialog in the emergency department within a consecutive time frame of events and interactions in the *resus*. In doing this I include the interruptions that are part of moving between patients as part of the dialog noted in this section to provide a fuller illustration of the afternoon. Nurse Tanner comes over into *resus* from the EMS intake area to Attending Johnson. He says to her: "Another upgrade coming in, heart transplant patient, possible *resus*". At *Resus* 4, Franny continues to negotiate with her patient as her patient attempts to get out of bed. The patient at *Resus* 4 has managed to move her legs between the bars of the bed and is becoming tangled between the bars and the sheets. Dr. Johnson sees Franny trying to negotiate with the patient and comes over to *Resus* 4 and says firmly to the patient: "We don't want you to fall...you need to sit back". Her words have little meaning to the patient as the patient continues to move around in the bed.

> Dr. Johnson: "Have somebody put in the orders." She says this directing her request toward where the residents sit at computers opposite the nurses.

Resident Mack at the computers: "Haldol?"

Dr. Johnson: "Lets get that…she's agitated.."

In the middle of *resus* the heart transplant patient has arrived and EMS is translating what he is saying through labored breaths: "says 2-3 days SOB…Tachycardic..and he needs wound care…" EMS is directed by Nurse Beth to place the patient in *Resus* 3.

Dr. Mack is on the computer, he is somewhat smiling as he types in orders and hands something to a nurse: "We have six listed at *resus*". Dr. Mack is always in a good mood, enjoys the challenge of *resus* and pointing out that they currently have more patients than beds in the critical emergency area. Nurse Beth walks by with a cardboard box top that she is using as a tray. I kid her about having lost the other box top from the day before. She says: "No, this is new today, they took it (the other box), because somebody called it dirty…germs". I was surprised the box was tolerated at all, but few people question Nurse Beth. In *resus* she is efficient and today they need her speed.

During this time, the palliative care team of Dr. Naima and her resident were at one of the unused monitors reviewing the patient record of the patient in *Resus* 4. Dr. Naima pulls me into the conversation saying: "Nadine, I think you'll find this interesting.". Dr. Naima nods her head toward the patient in *Resus* 4. This is not an easy engagement in conversation for me because I do not have the ease or rapport with Dr. Johnson as I do with Dr. Naima. Dr. Johnson is a force to be respected and feared.[66] I listen intently but at a

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[66] In one interaction with the executive Vice President for Emergency Medicine at the hospital I saw him standing in a hallway finishing a cup of soup. I asked him: "Army or Navy?" – he smiled and said "Navy!" with a charitable laugh and smile – he then said: "…but I am standing finishing my lunch out here because Dr. Johnson is in there (indicating *resus* with a nod) and she will yell at me!".

distance. Dr. Johnson is discussing with Dr. Naima the patient at *Resus* 4 that Franny continues to monitor. "The patient at 4 [*Resus* 4] has no family but we don't have any definition on a DNR."[67] Dr. Naima suggests that her group will look into it. She goes over to a computer and motions for me to look at the forms she has pulled up regarding patient competence. We go over to the computer and Dr. Naima prints out some forms. I look at the forms and suggest that she use forms that do not require next of kin signature unless she knows of one. We are both at the computer. She takes the printouts and goes back to Dr. Johnson. On the other side of *resus* in the acute care areas, there is the ongoing need for support from other areas of the emergency department:

> Nurse Chrissy yells out: "We need *resus*! At 6B we need *resus*" (6B is part of the greater Acute Care in the emergency department. It is outside of the *resus* area but well within earshot.)
>
> Dr. Mack walks over to the area swiftly to assist. Another patient keeps walking around with a gown and walks between the two areas, pacing and limping.
>
> A nurse comes over to the *resus* area: "...radiology urgent finding on a report..."
>
> Dr. Johnson: "On what patient?"
>
> The Cardiology consult which is always a large posse of residents and students with an Attending comes through *resus* looking form the heart transplant patient that was brought to *resus*. They look at several patients before being directed to their patient at *Resus* 3.
>
> Palliative care (Dr. Naima and her resident) are now with the patient at *Resus* 4.:
>
> > "Mrs. X, Mrs. X...are you feeling any better?" Mrs. X does not move or answer.

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[67] DNR is the abbreviation for Do Not *Resus*citate. DNI is the abbreviation for Do Not Intubate. The conversation is not about a DNR, however the papers they discuss are about being able to file a DNR/DNI.

Dr. Naima seemed frustrated at getting no response and I realize she probably does not know the patient was given a dose of Haldol.

Dr. Naima to Dr. Johnson: "...this is what we found out... that there is a daughter but she refuses contact, but no other connections and the son we have a phone number with no voice mail and no record of his doing anything in the past with Mrs. X to indicate any interactions...there is no DNR." (there is discussion about how she has two different primary cancers, metastases and schizophrenia)

The palliative care Attending and the emergency department Attending agree that intubation is not what should be done and that the DNR would prevent that. Without the DNR they would be forced to do so. I had looked through the forms with the palliative care Attending and she discusses how just managing pain and then having a patient on a vent they may never get off of the vent. The developing situation is compounded when there is no next of kin and the patient can't communicate. They are frustrated at being at an impasse with finding a next of kin that could be a legal representative for the patient. At one point in the discussion with Dr. Naima and her resident, I ask if they ever call for a bioethics consult or if this is how the issues are solved? The answers are varied and multiple, but the palliative care duo express quite bluntly that the consults are not effective. There is some mention of the time involved in getting the consult, that issues are too pressing. The resident mentioned the creation of more problems by calling for a consult.

While the discussions regarding Mrs. X and the DNR/DNI are ongoing, the internal medicine resident assigned to Mrs. X comes into *resus* from upstairs. She is very obviously annoyed if not angry about her patient: "...who gave her...?!...her platelets are too low...can you stop the heparin drip!" The resident is clearly upset, she is now talking to the

tech, the nurse and the palliative care resident who is also there: "...She is admitted to internal medicine, *we* have to mange her care...who said ... Haldol?!..." The resident is attempting to get information while checking her patient. She is talking with palliative care who is making the case for the DNR/DNI. She walks away from the conversation and goes over to Dr. Mack and the internal medicine resident says: "I get a call from cardiology saying my patient looks pretty bad..." Dr. Mack pulls up the patient chart and they begin to go through it. The internal medicine resident who is clearly upset leaves.

Dr. Naima then proposes to Dr. Johnson to get the three signatures regarding the patient competence since they have no next of kin. They mention the resident from internal medicine and that she was "upset...tear(y)". Dr. Naima and Dr. Johnson continue to discuss how to avoid intubation.

> Dr. Johnson: "I want to avoid that too.., I leave here at 3:00 and you will have another Attending. I don't know how comfortable they will feel about signing."
>
> Dr. Naima looks at the palliative care resident who says: "The daughter won't deal with her or answer the phone anymore."
>
> Dr. Naima: "But if we let her..."
>
> Dr. Johnson: "She may code...and we will have to intubate."
>
> Dr. Johnson will follow palliative, she also reminds Dr. Naima:
>
> "They (internal medicine) have left her down here now for over a day.."
>
> "...the sudden concern is alarming..".

Mrs. X is moved within the afternoon upstairs to an internal medicine floor. Her code status was not resolved in *resus* that afternoon.

Dr. Johnson's comment regarding 'sudden concern' suggests a certain antipathy toward the care internal medicine has for their patient after having left the patient in the emergency department for over twenty-four hours. The internal medicine resident reacted strongly and with offense to the care and medication Mrs. X was receiving in the emergency department. Both the emergency medicine team and the internal medicine doctor were acting to care for the patient in a way they believed was best for the patient. They both had authority to work through what is best for the patient. Dr. Naima and Dr. Johnson come up with the best possible scenario to add a DNR/DNI request to the patient record and a way to get the necessary signatures. Simultaneously, the internal medicine resident worked through the piece by piece medicalization of her patient that had been parked in *resus*. The emergency medicine team had the added burden of attempting to find away to forestall a long term and protracted death for the patient should she become unstable and require intubation and resuscitation.

While palliative care as a group supporting UED or as professional discipline does not have the far reaching or broader academic reach of bioethics, the ongoing issues of pain and supporting patients that palliative care deals with are clearly ethically and morally rooted issues. The discussion relating to the DNR and the DNI is quickly problematic because any person requiring resuscitation usually requires intubation, consequently a DNI as a binding document can often be interpreted as a DNR when it is not the same. The line between feeling better, alleviating pain and actually fixing a problem or restoring a patient to health are distinct parts of medicine in the emergency department that are also part of emergency management and then separated out by specialized care group. The moral basis of care however remains the same. The forms and signature became the workaround for

palliative care. Palliative care saw this as a solution to what the emergency department physicians believed would be a patient who would code and require intubation.[68] The potential solutions carried moral weight. So too would not acting and having to intervene with intubation and resuscitation that would potentially leave the patient on life support. Both issues present ethical challenges. In a discussion of moral dilemmas and meeting ethical challenges, the following captures issues of the profession of medicine and how the essential solution is through physicians as a moral community.

> "Many physicians still want to remain faithful to the primacy of the patient's welfare and the idea of a profession. Others see no reason why physicians should be held to a higher standard of ethical conduct than anyone else. What is most distressing is the pervasive conviction that the citadel of ethics has already fallen, that it is no longer possible to be an ethical physician ...To resolve the central dilemma of professional ethics, we must draw on the idea of the profession as a moral community that will use its moral power to stand against the forces eroding personal integrity, and will encourage and support those physicians within the community who have the will and courage to adhere to traditional standards of ethical behavior." (Pellegrino and Thomasma 1993)

The argument Pellegrino and Thomasma raise is that the health of society requires the force of moral collectivity in action by physicians. They agree that the moral actions and care are due to any individual patient, but that physicians must work together to affect moral care. From the collaborative work of Dr. Johnson and Dr. Naima with her resident, they appear to have achieved an understanding of collective moral commitment to the patient. The resident responsible for Mrs. X would disagree.

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[68] In another discussion regarding patients coding, a resident told me regarding a potential code on a frail 92 year old woman that if "that" patient coded on her while she was in *resus*, she would "SLOCO". She explained that slow code is an orchestrated code where you don't really do all of the compressions and violent interactions on the patient. She said with a nod to the patient in B at the time: "look at her she is frail – her collapse as soon as we started compressions, it would ...no I wouldn't do a code – even if she was not DNR.." SLOCO seemed to be a type of workaround by medical staff when there was no DNR in place and the doctor believes more violence would be done in the process.

The resident who was clearly upset about her patient Mrs. X had been told or tipped by one of her cardiology friends/residents that her patient downstairs in *resus* looked bad. The resident clearly had a difficult relationship with emergency medicine because of the care she perceived her patient was receiving. She found the heparin administration irresponsible and the Haldol unnecessary. Her working *through* was to continue to treat the patient through her various illnesses. The emergency medicine physicians had a difficult relationship with the patient because they had been left with a critically ill patient whose continued care could present the patient with more harm to the patient should the patient need resuscitation. The facts for each of the concerned groups had to do with the perceived best interest of the patient. Both set of interests were based in what the physicians felt strongly as best for the patient – the least harm. The situation where a patient presents and there is a question of whether to introduce a DNR/DNI into the patient file is a delicate one. The emergency medicine physicians considered the hour-to-hour condition of the patient and how to resolve the difficult questions regarding the patient mental and physical status as well as potential of recovery once intubated and on a ventilator. The internal medicine group was incensed by the medical choices made for the patient prior to even considering a DNR/DNI while the emergency department physicians were surprised at the reaction when the patient had been left for more than a day in the emergency room. This interaction presents two groups of physicians both working toward what they felt was the best interest of the patient based on their understanding of the patient and the facts. Both groups maintain external views that differ based on the facts that each possessed. Each group views their objective of care as responsible medicine. While both represented physicians caring for a patient, the local moral worlds of the two groups differed in what they each believe is

ethical moral practice for Mrs. X. That medical practice is, in western medicine, a science based on replication and an understanding of risk and treatment to constantly achieve care. Putting those facts and truths together is what Daston describes when she defines moral economy wherein moral and ethical assumptions justify decisions in healthcare that become healthcare delivery (Daston 1995).

Moral economy[69] is relevant here as a description that anthropology can use to investigate culturally constituted meaning and actions of healthcare workers that are morally invested in their patient care. In these economies, she is clear about the organized system and values:

> "What I mean by a moral economy is a web of affect-saturated values that stand and function in well-defined relationship to one another. In this usage, "moral" carries its full complement of eighteenth- and nineteenth-century resonances: it refers at once to the psychological and to the normative"... "Here *economy* also has a deliberately old-fashioned ring: it refers not to money, markets, labor, production, and distribution of material resources, but rather to an organized system that displays certain regularities, regularities that are not always predictable in their details."... "Much of the stability and integrity of a moral economy derives from its ties to activities, such as precision measurement or collaborative empiricism, which anchor and entrench but do not determine it." (1995:4)

In Daston's writing about truth and values she makes clear it is not about individual psychology, but that it is about mental states of collectives (1995:4-5).[70] Daston's premise

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[69] Lorraine Daston uses the term moral economy to describe "affect-saturated values that stand and function in well defined relationship to one another". This definition seems well suited to describe bioethics as an institutional system (Daston 2014).

[70] Edward Palmer Thompson discussed moral Economy in his book *The Making of the English Class* and then a 1971 article "The Moral Economy of the English Crowd in the Eighteenth Century". Thompson's position was evidence must be examined in historical context. He highlighted how markets are political constructions and that crowd pressure (moral outrage) has an effect on the social/economic nexus (Edelman 2012).

folds well to help explain Pellegrino and Thomasma and the persistence and need to form moral communities. The moral economies are dynamic and include values rooted in a process that is part of a culture. The tipping point in a moral economy model in the emergency department on a micro scale is illustrated in the interactions with the emergency department not wanting to intubate a patient that would become vent dependant and the internal medicine doctor who was upset with what she perceived as harmful and disrespectful care given to her patient. Both groups were advocating for their patient and without reservation were taking what they believed was the most compassionate and moral approach to care. The moral economy of care in emergency medicine maintains a difficult balance with all of the contingent groups that interact with the department and the norms held by each of the groups.

Routines and Training

While Daston pushes against any personal psychology in moral economies, the individual position is part of the collective that trains and creates care. The following interactions and mixed stories reveal a reflection of methods and patients as bodies as well as a push-back against any patient as an item, thing or objective piece of study. These observations are a small piece of ongoing discussions and dialogs in the *resus* area and immediately surrounding it as part of the production of emergency medicine.

Opposite and behind where the residents and Attendings sit at computers, there is another bank of computers that are lower and face into the main area of the acute care in the

emergency department. This area of the acute care has a large open space that fills with patients. The space between the beds on any given day can have two extra rows of patient beds with as little as one to two feet between the beds. The PAs and medical students sit at three computers that face the open area where beds accumulate on busy days. A PA is at a lower computer and standing opposite him at another computer is a medical student (MS). The medical student looks to be her early twenties, long dark hair and somewhat animated and less tired than most of the other healthcare workers in the emergency department. The following dialog starts and is later resolved by the end of the day:

MS: Are you doing an NG[71] on Mrs..."
The PA looks up at the student from his computer
MS: "Are you doing a nasogastric on..."
PA: "Yes...but why?"
MS: "Can I do it?...I need one more to graduate."
PA: "Need to talk to the surgeon...the sur.."
MS: "Okay, just let me know..."

The medical student then goes to find the Attending to discuss a patient she had just done a medical history with and now believes that her patient is ready to see the Attending... "Your patient..."
After the medical student leaves the Attending area, the PA goes over to the Attending...
PA: "You know your patient..., she said she does not want anyone without an MD after their name touching her..."
Attending Johnson: "Well ..."

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[71] NG stands for nasogastric tube. An NG is inserted through the nose into the stomach and is used to siphon out air or liquids in the stomach. An NG is required when patients are prepped for any type of gastric or bowel surgery. While the NG is not painful is extremely uncomfortable and for obvious reasons must be done accurately to be able to siphon from the stomach and not the lungs.

PA: "I guess that means no PA? …she sent the medical student away..."

PA: "So she'll wait..", Attending Johnson nods, but then looks back toward the PA who has gone back to his computer.

Attending Johnson: "I know when I was in the hospital I was specific that I did not want any medical students taking care…" She walks away part way through the conversation she started with the PA regarding medical doctors and students and the choice of caring for a patients.

Dr. Mack is back in *resus*: "I will miss the *resus* tomorrow, I'll be going crazy in Geri –, but I guess if in intake also miss *resus* ...(– I pointed out that the comparisons were to *resus*) – he said yeah – "it's love hate.."

Dr. Mack was almost always in a good mood and seemed to thrive on the chaos that *resus* situations could deal to the resident. He performed well under pressure and genuinely enjoyed his work as a fourth year resident. What struck me about Dr. Mack is that he was his own local moral world. He was not phased by the ongoing competing medical issues that developed and just kept working through the problems. He cared, he made sure patients were attended to and seemed to do so with ease. He did not get stuck on the moral pluralism of the irreconcilable ongoing medical issues. Other residents worked through issues as he did, but they often made their moral position clear through exasperation of frustration. Dr. Mack worked through issues which occurred to me as someone more senior, more experienced. Dr. Mack worked through issues with the constant knowledge that he was creating care. Dr. Mack and Dr. Johnson worked side by side on computers facing the *resus*. There was an overhead page "L&D upgrade". This meant that a physician assigned to *resus* needs to go to intake regarding a labor and delivery (L&D) patient. Following this

overhead page, there was some back and forth between Attending Johnson and the resident Dr. Mack. Attending Johnson said she would look into it and walked over to intake.

Dr. Johnson: "No, …don't know why they page for L&D..its okay (Dr. Mack had gotten up to go)..I'll go…" Dr. Johnson says this as she walks over to intake...

Nurse Krissy: "Oh hiyyy..yes we have to chart all L&D that come into the emergency department" This was said by Nurse Krissy who lengthens her vowels to have long words but very clipped high pitched sentences.

Dr. Johnson: "But we don't take L&D…"

Nurse Krissy: "I'm just following what we have to do...you can talk to Gina our supervisor – but the new rule is that we must chart all L&D that come into the ED."

Dr. Johnson: "But what good does…"

Nurse Krissy: "I don't…you can talk to …"

Dr. Johnson: "I am happy to help – where is the patient?" she says this looking around the hallways where the EMS stretchers are lined up before getting sorted to different areas of the emergency department.

Nurse Krissy: "Over here..." She is waving and pointing in the general direction and pointing to a pregnant woman that looks like she is in great discomfort…"

Dr. Johnson: "She goes into the area…"

After getting the L&D patient over to the specialized maternity emergency room, Dr. Johnson is part of an ongoing discussion at the Attending desk between two Attendings and the PA.

Dr. Johnson: "Well, assume its patient choice to transfer..." … "If it is a choice it is not an EMTALA issue...the patient has been accepted by liver service not ER …to leave the ER is a choice and we are not required, therefore not EMTALA.."

PA: "But...the part that does not make sense..."

Nurse Troy comes over and is waiting around *resus* – he is usually calm – but looks like he needs to talk NOW – he does not interrupt. Attending Johnson sees him after he comes back a second time.

Nurse Troy: "Your patient wants to walk out." Nurse Troy watched Dr. Johnson with an expression of anxiety and expectation.

Dr. Johnson: "But..."

Nurse Troy: "Explained, but not understand..."

Dr. Johnson: "So, the patient really does not get how dangerous it is..."

Nurse Troy: "No..."

Dr. Johnson: "Lets get somebody in here that can explain in Spanish better..."

There is an attending new to UED on the phone: "He is...well...it is with a brain tumor...no, not really complaining, he lost consciousness...not so much..ya..sorry..what did you..(she puts her hand over her other ear) ...no not weak, but trouble balancing the drugs and food". The physician is explaining to the patient's service doctors[72] about their patient and why their patient is in the emergency department. The emergency department Attending wants some guidance on a treatment plan for their patient that has a brain tumor and needs medical support for a patient that already has a treatment plan with another group of doctors. It was not uncommon to see chemotherapy patients in the emergency department. These patients seemed especially fragile and ended up in the emergency department when they would call their doctors in various states of crisis and would be advised to go to the emergency room. Dr. Johnson is explaining to another resident the movement of patients through the

[72] Service doctors are physicians caring for patients with specific medical issues. These patients will come to UED because their physician has their medical practice affiliated with the hospital and will direct their patients to go to UED if they are in crisis. The most common examples include oncology, gastroenterology and cardiology.

emergency department and how it may be best to see if they can move a patient out of the emergency department and to the emergency department observation floor. Around the other side of the divide Nurse Beth is directing another nurse as to where she can put a patient that has been upgraded to *resus*.

Nurse Beth: "2's [*resus* 2] open"

Nurse Clara: "This is Mr…, he is an LVAD patient." Mr… pulls himself out of the wheel chair and into the bed.

Dr. Mack: "Aside from the device, how are you feeling?"

Patient at *Resus* 3: "Pain was…"

Attending Johnson comes from around the corner: "3 just tested and came back positive for flu"

Dr. Mack: "2 [*Resus* 2] too"

Nurse Natasha pulls up her mask and makes a motion with her hand as she states: …"Do you want these pulled (indicating the curtains as a barrier)?"

Dr. Mack: "I have swabbed more flu in the last week than 3 months prior"

Attending Johnson: "It is that time of year"

I look back over and the patient in *Resus* 3 now has a mask on and Nurse Beth is over washing her hands at the sink.

Dr. Johnson: "Be careful with the change in the system, some software designer decided that they know better that the physician and can change what might be a simple order…we had a physician put in and order for a head CT and the order came up as a differential MRI of the head.."

Back at Attending desk:

2nd Year Resident: "So, its not completely clear to me when we can go straight to MRI…"

Attending Johnson: "When WE deem it [is] medically necessary"

> The PA is at Acute 1 with the surgeon who is with a different patient. The PA pulls the surgeon aside and asks: "Can the medical student do the NG?" The Surgeon looks surprised but kind of smiles…nods
> PA: "She said she needs one more to graduate"
> Surgeon smiling nods: "…okay…okay."

In the same way that decision models for making medical diagnosis of people leave little room for personal agency of the medical patient, so too do decision models regarding how a physician can prescribe treatment leaves little room for the personal and the moral agency of the physician making a decision on medical treatment. The physicians have greater autonomy in directing patient care and do not bear the same duress or moral threats to personal moral agency that other healthcare workers sustain and must work *around* or *through*. The decision making, structural constraints and challenges in care are constant and all demand resolution.

The following examples that include: the patient in *Resus* 4 where the emergency department was in conflict with her treating team in internal medicine; the continued education of a medical student and the patient refusal to allow a medical student to take a medical history; the ability for the physician to make decisions based on "when WE deem necessary"; and new rules about "charting" and Labor and Delivery patient that the nurses knew and the director and other Attendings were not aware of the new procedures. These are all part of the shifting frames and decision models allowing for individual assertion of personal and professional moral agency and maintaining the moral economy of care. The nursing staff created a process that redirects others who may have more power within the

structure but must comply with rules that maintain a standard of better patient care. The varied pieces reflected here together to represent the continued flow throughout the emergency department wherein the frames of any one of these conversations and interactions that are part of the constant process of administering care also represent frames of conversation wherein the talk, the diagnosis and work being done represents a specific performance of role that the physician must work through. Goffman discusses those performances of role with specific effects as frames (1974:507-509). The frames however are held by that individual within the local moral condition as the personal or an embodied disposition (Zigon 2008). The disposition and those frame is also salient as the frames shift with the physicians moral frame or embodied disposition. The frames happen as the physicians work through the varied and concurrent medical issues and patient crises. The physicians use rules and structure to impart care as they deem most important for the patient and shift as necessary to create rules that are most appropriate as the patient condition shift or changes based on information available. That ongoing creation of care is a constant embodiment and frame the moral agency as the local moral world of the healthcare worker.

The frames are also helpful to focus clarity to the individual phenomenology of the healthcare practitioners as they care for patients. There are several moments within the flow of dialog that Dr. Johnson speaks in specific terms that are moral frames of healthcare. She mentions EMTALA relative to a patient wanting to leave. EMTALA as a legal measure provides structure for the mandating patient care to any emergency room. She points out that the patients are free to leave and that the hospital is not in violation of EMTALA if they go elsewhere. However, in the case of a patient who wants to leave where Dr. Johnson and nurse Troy are concerned, regardless of an individual's ability to leave and her inability to

force a patient to stay, she is concerned for the patient and considers other ways to make clear to the patient the danger of the medical health situation for the patient. As a physician, Dr. Johnson is working in a more powerful position than nurse Troy to discuss with and convince the patient not to leave. Nurse Troy is concerned, frustrated and goes to Dr. Johnson in an attempt to have her help keep the individual, the patient safe. The pattern of finding ways to accomplish the constant goal of healing and patient safety repeats itself for each of the varied levels of healthcare professionals as the healthcare professionals work within the confines of their professional autonomy to care for patients. The moral actions are specifically visible as these professionals must work around and through to achieve the common goal, one that is personally and professionally held as moral actions are conducted in creating patient care.

Like the other physicians, Dr. Johnson is in the more rarified position in the emergency department. As a physician, her standing with patients is one of authority by virtue of her training and title. That authority does not necessarily reveal greater moral visibility, however the position as a physician does allow the autonomy of decisions regarding course and specific treatment for patients. In the case of Mrs. X who has a diagnosis of schizophrenia, has terminal cancer and from the point of view of the emergency department was left parked in the emergency department by her internal medicine team is one example of morally laden conflicts that must be parsed out between physicians as care is determined for a patient. The decision process left in the emergency department to physicians and palliative care physicians was one where the decision was morally laden and culturally bound to next emergency steps. The next emergency care steps were Mrs. X to become unstable would be to intubate her and put her on a ventilator. This option was

morally problematic for Dr. Naima and Dr. Johnson. The harms to the patient should she code would be greater than the care. The physicians making decisions on the case were did so under the autonomy of their positions and training. While unstated during my observation, the decision making was based on doing no further harm to the patient. The paperwork allowing them to make such a decision however had to be part of the patient record. When the resident from upstairs found out about her patient and came down to the *resus*, her anger was palpable as she questioned the decisions being made on drugs and treatment. Her moral position was clearly to stabilize and care for her patient, however that stabilization was different from that of the emergency medicine physicians whose work was to stabilize.

In the case of Mr. Sampson and Mr. Mercat, the physicians and other healthcare workers dealt with failed resuscitation attempts and death. In the *resus* each code follows a specific medicalized process and those doing the work, do so with dignity and respect for the patient. These moral precepts are expected and understood. Parts of the hospital, such as hospice and even palliative care have organized governance and charter regarding the proper death bureaucratized in the hospital order giving moral dignity to death (Broom 2012). The physicians in the resuscitation attempts worked in the constant moral capacity to restore life with the tools at their disposal. The actions failed, the residual work of the physicians as they sort through their lack of an ability to change a situation relate to the process – what went wrong with Mr. Sampson from abdominal distress to cardiac arrest. The conversation of the physicians related to the actions taken that could not be changed. The personal agency of the physicians dealt with being able to follow medical protocol and retain life for their patients. Dr. Robert attempting to revive Mr. Mercat represented another

interaction where Dr. Robert revealed a moral loss when the resuscitation failed to revive Mr. Mercat. As Dr. Robert worked to find next of kin and learned the patient was a ward of the state, he seemed at further loss. Dr. Robert's agency as a physician revealed in his personal moral position in his attempts to find the appropriate individuals who could give meaning and dignity to the life of Mr. Mercat.

The construct of care is within itself a moral act. The moral visibility continues even as the bodies fail and the power to change the health of the patient is finite. There is coherence in the actions of the individual caregiver. As physicians, the agency is the ability to work through the issues and provide medical treatment that is care. In so doing the actions and work is moral.

Chapter Six

Themes on Care and the Practice of Emergency Medicine

Throughout this study the discussion returned to a comprehensive argument about the unique conditions of emergency medicine work that makes visible moral agency of the healthcare worker. The core actions observed were professionals bounded by their service and the specific culture at UED as emergency healthcare workers. The observations are holistic in that all facets of work production are part of the analysis and the healthcare workers involved in critical care emergency medicine. Within this recognition of an examination of the overall process and the visibility of moral actions there is a recurring theme of individual moral agency visible in the social interactions of healthcare workers as they contribute to work production. Individual actions and specific facts in medicine are part of a holistic domain of emergency medicine. That domain includes the conventions of healthcare worker moral agency, local moral worlds, technology and structure as part of creating care and getting patients better. This concluding chapter includes a summary of these four themes that emerge from the holistic view of the every day work in emergency medicine.

In recounting and describing the words and interactions of paramedics, nurses and physicians as they stabilize patients in the emergency department, throughout this study the constant consideration was how individually and collectively these professionals negotiate their understanding and actions of their professional position to create what is best in the

care of their patients. Likewise, each of these groups has ways that are not necessarily known to them through their interactions, words and care that make visible moral agency of care. It is through this data describing the varied interactions that the observations and analysis of the constant moral negotiation played out through medical practice that is part of providing care under physically critical and time sensitive constraints.

In Chapter Two three considerations in viewing and then understanding any moral meaning in the work process in critical care emergency medicine are discussed. These considerations were posed as open questions on how to examine from a holistic view what is visible and when to describe or label actions as moral or even if an action of a healthcare worker is possibly based on specific moral intervention. In these considerations for the study, the first proposal was to examine the production of care that shifts within each profession and how moral care for any individual healthcare professional might be visible as part of day to day work. Second, ways to examine moral agency as visible through actions that are part of medical practice in an effort to understand and gain insight into the phenomenology of care and moral agency of individuals – professionals producing care and thus demonstrate the local moral worlds of the paramedics, nurses and doctors observed at UED. The exposure to work at UED showed the ways individuals within the professional groups work *around* and *through* issues to produce what they believe is the appropriate care. The third consideration was to examine the intersection of medical interaction, personal and moral care as part of a larger structural convention of medicine within the confines of hospital structure. Then in Chapters Three, Four and Five a series of brief narrative interactions of paramedics, nurses and physicians and the norms of their practice showed how these groups as individuals and within local moral worlds function using the confines

of technology and protocol to achieve the desired moral outcomes. These chapters explored the daily and sometimes moment to moment journeys of these professionals laid bare the unremitting and constant moral work of care in emergency medicine.

An analysis of this ethnographic data demonstrated how moral sensibilities are not owned by any single professional discipline. However, what became apparent was that each professional discipline created ways to affect care to assert and sometimes reify personal moral agency. While the creation of care would seem as a direct result of the practice of medicine, in this research the analysis of the ethnographic data showed how within each of the local moral worlds of the professional groups there are consistent patterns in creating care that reflected moral agency. Chapter Three discussed how paramedics work *through* situations and often discuss their care and ways of getting work done. Chapter Four provides a description of the ways nurses work *around* obstacles to getting patients to the care they consider necessary. Chapter Five related the work of physicians and how they establish care and work *though* situations to create care. Within these patterns of care, each group works within the practice of medicine and each professional confine, but does so while finding ways to reify a moral position. The personal moral sensibility is how the individual inhabits the local moral world of their professional job within the emergency department. That local moral world reacts to and is confined by the hospital structure and the production of medicine. That hospital structure and the processual confines that make this analysis possible are part of a specific culture at UED that informs this data.

In anthropology the study of culture is to describe and possibly understand the social groups and constructed ways of living that direct norms of action. This study describes the culture of UED and how it operates within a larger system of medicine with its own

uniquely American confines bounded by various regulatory and statutory concerns. This definition makes bureaucracy as culture part of what shapes the moral actions and expression of personal agency in the professionals discussed in this study. Accordingly, at UED the individuals working within their local moral world found ways to manage or assert moral agency as part of their practice of medicine.

These patterns and the constant realignment through work to create care have consistent elements across the professional groups. The control of how work is achieved to create moral care demonstrates the personal agency of the individuals. The consistent process of working *around* and *through* among the members of professional groups indicates not common agency but instead elements that are part of the medical system that are potential foci for future investigation.

The themes that emerged from observing the groups operating within the UED are: the individual worker who asserts a personal moral stance regarding specific issues of patient care; the local moral worlds of each of the professional groups of paramedics, nurses and physicians; technology as a constant and changing tool used to assert care and obtain moral care; and the hospital structure that has the interrelated component parts of work flow and management reporting of professional groups. The four themes discussed as moral agency, local moral worlds, technology and structure also engage as part of a processual order discussed in Chapter Two because in the production of emergency medicine the themes overlap and are interrelated. Consequently, the themes that emerged from the data are constantly braced and realigned due to institutional organization within the hospital and greater practice of medicine. Additionally individuals and groups working within the structural confines of medicine act and make visible their moral agency in response to

structure and hierarchy that does not reflect an abandonment of duty or profession but instead a sometimes unconscious other times willful expression and work to create care. This concluding chapter discusses these themes of interaction to illuminate the unique ways moral agency is the constant underlying premise to work in the emergency department and a potential point of future study. Even through the data discussed here represent a holistic approach to the study of critical care emergency medicine, the study is specific to the unique culture of how these groups and individuals assert their moral authority through care and within the structural confines at UED. The visibility of these examples of moral agency is an opening to understanding the work of care and possibilities that care has in shaping hospital culture and structure instead of hospital structure shaping how individuals as healthcare workers find or seek out ways to care.

Four Themes from the Data

Moral Agency

The individual worker and their moral agency referenced as working to assert a personal moral position or idea on specific care issues is visible in paramedics, nurses and physicians in situations throughout this study. While it is difficult unless specifically voiced to know a moral position, some actions may indicate personal moral agency, one that is unreflective, personally held and advanced through care. Each of the professional groups made clear through their work what was right or wrong in various urgent care situations. The moral agency of these individuals is often challenged when presented with issues that they either do or do not have the tools or authority to change. Chapter Three includes several scenarios where the paramedics have their moral agency offended or challenged as

part of their ongoing work as prehospital care workers. The ongoing scenarios and stories included the constant work for this group of professionals as they stabilized the patient and then handed their patient off to the care of an emergency department. This chapter also included a discussion regarding how prior to getting to the hospital emergency department, paramedics maintain autonomy to act and direct patient care and in doing allowed them to determine what is best for any given patient until they handed off the patient to the emergency department. This section discussed how these pre-hospital care workers work *through* the situations to create care that reflects more than just transport. Examples include; the suicidal addict that Roberta and Meera coaxed and gently escorted to the emergency department; chain smoking Mr. Austin who meets the ambulance crews at the foot of the stairs with his oxygen tank and cigarette while complaining of shortness of breath; the young student expelled from school for undetermined violent behavior. Some would say the interactions are purely professional. These examples displayed how asserting care is part of working *through* situations to assert moral agency in their work as part of the local moral world of EMS.

The nurses whose work is detailed in Chapter Four illustrated the work *around* as a tool to assert moral agency. These individuals do not always have the autonomy to act when confronted with distressing challenges to what they believe is appropriate care. Some nurses like Cora may confront head-on the issue and challenge orders such as inserting a Foley catheter when unnecessary. Other nurses found ways to alleviate unnecessary pain and suffering by working *around* issues by involving others to accomplish a task, use technology and protocols to mediate what they believed should be done for a patient or get other professionals involved. The nurses used resources that included technology and other

individuals to create care and asserted their moral agency. In the case of Nurse Lisa managing a way to get the patient to neurosurgery, she worked within her knowledge of hospital hierarchy to call individuals and work around the limitations of care in the emergency department to get the patient to appropriate care. The collaboration within groups and specifically nurses is part of the overlap of local moral worlds where the production of care is a multiplier using various skills and understanding within medicine to accomplish the same goals of patient care. Additionally, the multipliers worked to help assert individual agency and reifying a personal moral issue in achieving patient care. These shared moral boundaries are part of local moral worlds. Thus as with individuals working *through* or *around,* issues are part of groups that share the boundaries and within the local moral worlds find mechanism to assert their moral agency together. Examples include the nurse-initiated changes to scheduled time for checking on patients administered narcotics and EMS transporting patients directly to a hospital they personally believe better suited to their perceived issues of patient care.

One way moral agency was visible in physicians in this study was their unremitting working *through* issues to get patients stabilized and to the next point of care. The physicians discussed in Chapter Five confronted procedural boundaries in moving patients out of critical emergency care and constantly found ways to work *through* the issues. In the case of Mrs. X, the moral agency of asserting the best care engaged two different groups with differing opinions on what is best for the patient and asserting their agency in what care meant for Mrs. X.

Moral agency is an underlying force made visible through actions of the healthcare workers. Moral agency is the constant stimulus in the undercurrent to care that weaves

through structural confines as healthcare workers find ways to ensure care. Moral agency is individually asserted and publicly held through principlist values dictated as part of pedagogy in theoretical trainings. Moral agency however is unheard, unstated and only visible through observation over time.

Local Moral Worlds

The local moral worlds across professional groups in emergency medicine share the constant preliminary goal of stabilizing the patient. Within this initial goal are several professional spheres of knowledge and work that all come together in the production of care. Daily in *resus* and acute care, reductive verbal measures that differ by professional working group in the emergency department occurred. An Attending or resident may refer to a patient as "COPD at *Resus* 4" or "sickle cell at 14" while the nursing staff may describe a patient in terms of "pain meds at 14" or "falling out at *resus* 5". The expressions were not monikers for the patient but descriptors that had significance for the physicians regarding immediacy of disease related events to address where the nursing staff may denote specific patient issues pertaining to the immediate care necessary. Both indicate to an outsider perhaps an objectification of the individual behind the disease or pain. The varied uses of terminology and how they differed among medical professionals reflect both a scientific and cultural production of the patient medical status. Thus, these interactions reflect the medical work and their engagement with the patient. That engagement reflects the local moral world of the healthcare worker.

The physicians scientific discourse represents potential disease history and immediacy. The cultural discourse is about the disease assigned to the patient. An analysis

of these patters in discourse suggest that even though the patients present as objects of medicine as they are stabilized a plan is necessary for moving the patient forward and out and that the urgency to do so is for the care of the patient present and also the next patient – future patient in imminent need of medical attention. The constant in this local moral world is being able to care for those in need. The local moral worlds of the professional groups maintain their understanding of what moving the object means and as they act within their separate realms of profession, the local moral worlds briefly overlap. The right thing or what ought to be done to repair or alleviate pain is always present in emergency care. Reflective choices are few in emergency medicine leaving the constant movement from unreflective moral work as part of an expectation in emergency care. The care is done with constant awareness of the exceptional events that unfold in critical care emergency medicine where public trust leads in the moment to moment work to sustain and stabilize life.

The idea of moral and ethical are often overlaid and then split apart at the convenience of describing normative behavior of the way individuals ought to engage in as ethics and moral as the particular right and wrong. While the definitions and bifurcation of the terms along the lines of ethics as codified for expected conduct and moral as the individual right and wrong, these ideas fuel significant debate on appropriate characterization of ethical versus moral behavior. The moral in terms of moral experience as part of local moral worlds defines the local intersubjective experience of lived with others. The term local moral worlds captures a significant scope and difficulty of group identity that in emergency care is rooted in groups defined by pedagogical practices that define the titles of paramedic, nurse and physician.

The local moral worlds are an important part of understanding the emergency room healthcare workers as the individual and their personal role and outside work identity create a scenario of deeply engaged healthcare workers whose personal and professional identity merge in their local moral world as care givers. Throughout my time standing and observing, workers would stop to tell their stories of work. The work most often described belonging and knowledge as healthcare workers saw themselves as part of something and always creating and attending to care. These local moral worlds may be specific as to a function for a technician or may be broader for an Attending who each sees their role as healthcare workers within varied communities.

In the analysis of the healthcare workers, the local moral worlds of the healthcare workers are also performative. The workers are fulfilling duties that are part of training, but the work also requires unstated commitment to constantly perform acts of care. The individual moral situation and identity as creating care then flows together as they engage in the practice of care using both language and action. The acts do not occur as part of pre-emptive measures that identify the work as clinical ethics or moral identifiers. The work and interactions as patients are cared for and healthcare workers interact are instead a series of actions and interactions. Those interactions and local moral worlds of the paramedic, nurse and physician may then result in workarounds or re-engineering a procedure to "get through" a particularly difficult situation to get a patient to appropriate care or stability.

The work *through* and *around* of the healthcare workers as moral actors within local moral worlds however is of particular importance in the analysis of this study and the potential forward looking implications. As healthcare workers act, react and go through the actions of emergency medicine, their actions interaction and how the local moral worlds are

part of norms in how care is expressed became visible. Those interactions and observations are present in various captures as an observer and ethnographer. Local moral worlds is also an important frame to identifying groups that share local moral worlds but are mismatched in what their expectations are of each other as professionals. The mismatch in emergency medicine works as multipliers where moral agency is not clear between two different local moral worlds. In the case of Mrs. X the local moral worlds of two physician groups differed. It is the individual as acting based on beliefs of appropriate action and how those moral actions are part of a daily process. Local moral worlds are not a relativistic interpretation of what is ethical based on cultural norms. The universal issue remains that each practice group sought the most appropriate care for the patient. Both parties operated from the best ethical care they determined appropriate for Mrs. X. What remains of interest is constant frame and re-frame of the often rapid changing status of patients and the healthcare professionals as various members of groups and their response to the changing frames as part of local moral worlds. Similarly, in the case of Nurse Cora and her dispute with the physician demanding a Foley catheter for an ambulatory patient makes visible the differences in local moral worlds of Cora and the physician. Cora's care for the patient and what she considers necessary for her patient and the physicians and his need to have faster patient data are at odds. These are most obviously a difference of opinion, however what is visible is also a difference in how each sees the patient and how there is cultural representation from the differences in the moral worlds at that moment. The EMS workers also reflect a separate local moral world that reflects how they see their work in relation to their responsibilities to their patients and role in clinical care. The lived experience of Paramedic Wayne telling his story to Tara expresses the local moral world of the EMS and

how they see their work and service to the public and their patients. The interaction exposes the values and how he sees his work and understanding of patients as different from those working in the hospital. The recognition of the local moral worlds reveal what matters for the varied groups and are a point of introspection and possible learning when considering how these groups may understand each other better as they work toward caring for patients in emergency medicine.

Technology

In varied scenarios in the emergency department, a healthcare worker responding to data about a patient informs actions by others whose responses should align and realign to respond to and ultimately treat the patient. The process is part pedagogical training, and part structure in terms of who does what work and the interface of healthcare workers with technology. In emergency critical care, this cascade of patient care includes many pieces of technology. Technology includes all of the devices that interface with the patient in creating care. In addition to machines and an array of equipment, the technological cache available to healthcare workers when delivering care include machines as well as calling-in resources of additional technical support such as pharmacists, respiratory technicians, social workers and language translation services.

The computer is a piece of technology used to document patient status and is the proof in both a legal and medical trail of patient treatment. As such, the computer is part of growing bureaucracy and hospital structure as well as a way to communicate, store data and ensure patient safety. This patient record is for patient safety but also serves as an electronic footprint for patient care when others assume patient care simultaneously or sequentially.

Consequently, the computer is but one example where the data are more than equipment or patient records because the technology is used to reify positions of professionals as they administer through the computer to create patient care. Patient status is continually transformed as it is carried as a separate identity in the computer and is an ongoing part of the interaction of healthcare delivery through technology.

Observing the healthcare worker groups made visible how the interaction with technology as part of the structure represented the computer as a technological interface and as an example of overlap of the local moral worlds across the varied professional groups. Such an approach shows how the component themes overlap and are interactions in the assertion of agency in care. The success and failure of technology or in this discussion specifically the computer, is an example of how technology works as a multiplier in the lives of healthcare workers. As a multiplier and frame for local moral worlds, technology overlaps with several points that make visible the moral agency of the healthcare workers. Then those frames revealed individual moral situations, collective moral position and interpretation of day to day events. The responses, frames and way the professionals engage is thus multifold as professionals, patients and technology are all part of active engagements in care.

Although technology-use to administer medical treatment is part of medical advancement, technology-use can have different meanings and use among medical staff. When the nurses introduced the PCA pump to administer morphine to a dying patient instead of repeatedly giving the drug, they introduced technology to protect their moral agency and still allow the patient pain relief. The physicians prescribing the morphine they wanted the nurses to administer to the patient did not consider the introduction of the pump

as anything more than a convenience for the nurses. Technology-use placed the physician or nurse with an interface to the patient where technology can mediate the care provided. Technology-use can also distance nurses and others from patients such that technology in critical medicine assumes its' own moral agency. The instances where nurses called others to use machines to administer narcotics to patients as they were dying. The construct of care then becomes an individual with professional and personal agency that is distanced from patients through technology. Health professionals can then interface with technology and then that technology can assume its' own agency to treat and care for a patient. That distance and the use of place-markers, such as emotional distance through technology, may seem like an abdication of responsibility. Looked at another way, it is a preservation of self or moral agency of the individual.

Interactions with technology however are not in social isolation. In Western medicine the interactions with technology are constantly mediated by the medical model of restoring to health and the philosophical overlay of bioethical medical practice wherein technology is a norm in practice which when withheld violates an expectation or practice or care. In this research technology is used to establish coherence. However while technology exposes coherence, it is the individual professional groups that worked within their specific confines of local moral worlds and exposed their personal commitment in their approach to patient care. That coherence links the trades of nurses, physicians and paramedics in their ethical placement of care. Technology is for many interactions a place-marker that allows the worker to solidify through technological tools their personal requirements and standards of care for the patient. Consequently, these interactions as observed in this study, decorticate the individual actions held by the constraints of professional position. As a

researcher observing the interactions I was in the unique position to examine the negotiation of space in producing work and observed technology-use to control and to express professional standards. In making these observations I access the phenomenology of personal moral commitments evinced as individuals performing in the professional roles of paramedic, nurse and physician as they validate moral agency.

The complex decision-making where technology creates an interface between workers and patients ensures patient safety through automation of some health practices, but also creates physical distance between the patient and professional. Consequently, that distance is an important segue in understanding how workers to assert an individual role or moral stance in care can use technology.

Technology can be acted upon in a manner that is professionally and personally defensible based on constructed norms of non-bonding as data is collected and related to how to treat the patient. That technology if reified as an entity of non-negotiable fact is part of technology-use that change the basis of professional autonomy and decision making. In turn, technology becomes part of clinical practice and accountability and moral position as medical professionals. Healthcare workers however, have specific roles in patient care that require both a social and technological interaction. Those interactions make visible the unstated moral, the being moral in the world.

Structure and Medicine

Structure and Medicine in this study is reflected in the processual nature of hospital work production in the United States. The processual structure includes the management hierarchy as well as the groups that work within the various employee groups that include

the paramedics, nurses and physicians discussed in this study. As discussed in Chapter Two, the structure is not a social form of power but institutional organization that complies with United States legal codes as well as practices of healthcare rooted in pedagogy and historical practices in American healthcare.

The constraints on how medicine is practiced are embedded in both the hospital system and its specific reporting structure and work related organizations as well as boundaries set within federal and local laws. That structure represents a scaffold comprised of laws and regulations. Onto that is the rich science of human health and repair. Like any other accredited hospital, UED followed statutory parameters, but it also has its own unique parameters that make this study and focus on structure unique. UED's structure included the academic teaching hospital which encompasses academic hierarchies and the constant growth of a learning institution. As such, UED is a distinct social system whose structure can be discussed in terms of a processual rubric that is neither static nor completely unburdened by limitations of bureaucracy.

For those working in emergency medicine the structural issues were never one dimensional or based on any one legal constraint or hospital policy. The structural constraints also include professional boundaries. The separation of physicians and nurses as professionals where nurses are meant to act based on orders placed into the computer is often taken to extremes and remained a point of friction. Throughout my time at UED, nurses expressed disappointment when Attendings who had worked in the emergency department wouldn't, perhaps couldn't, call the nurse by name and verbally discuss specific cases with them. Orders for patient care entered in the computer are a safety for the patient, the nurse and the physician. However, there were situations where physicians hid behind

the practice of directing care through technology. In one event, a nurse was furious because a "dementia" and "an imminent fall issue" were entered into the computer by a new attending instead of telling the nurse. The new Attending was later reprimanded when the nurse manager made it clear to a more senior Attending that while it is important to chart hazards, it is unacceptable to not inform the nurse or others responsible for care of the patient. The hiding behind technology is not unidimensional. The example in Chapter Five discusses a situation where Dr. Johnson is blindsided by a new charting policy added through nursing management.

Throughout the time spent at UED, it was clear that the nurses had their organization through the union and then reported into hospital staff nurse managers that reported into the hospital physicians. Hierarchy and structure is part of what was worked *around* and made visible the moral actions. For the physicians, they also pushed back against structure and the practice of medicine being determined for them based on hospital metrics. The conversation in Chapter Five when Dr. Johnson reminds a young physician that an MRI is used "when we deem necessary" and not based on a computer metric provided to them through the EHR.

How healthcare workers reacted to the various constraints and boundaries of hospital structure and conventions are part of what made moral actions of individuals visible. The boundaries were multifold and included hierarchy of training, pedagogy, protocols, material structure, political and physical boundaries through which workers found ways to work around an issue or reflected on issues and worked through barriers to get patients to better. This study examined and described the phenomenological differences in moral economies of the groups as they fulfill roles to produce care. The point where the individual as a healthcare professional must workaround and through an issue to achieve their perceived

morally correct action to maintain moral agency reveals the testing point of norms for what they deem necessary for patient care. These points of workaround and continual assertion of care are reactions and interactions to the given structure of medicine and the working confines. The functions and interactions in care are visible in various interactions. How the healthcare workers actions arise out of breaches or compromises to moral agency of healthcare workers due to structure or protocol is an important point of study. Pushing against those breaches or affronts keeps the structure of the institution from creating norms that misalign with individual moral agency which are part of larger local moral worlds of practice groups.

This study also examined points of failure in technology and differences in perception and training in those perceived uses of technology that end in failure. Somehow it is the cases that end in the body failing that the work of care and medical knowledge that the personal agency of care is violated when all alternatives to care are exhausted. The body is then symbolic and a point of interaction. This distinction is foundational in being able to examine both discourse of healthcare practitioners as part of the study and suspend the socio-political constructed aspects of care. Thus the forces and structural constraints on local moral worlds and personal agency is intertwined with actions creating the moral economies of care and ultimately the actions of those choosing to be part of medical practice.

Concluding Remarks

The Process of Interaction and Viewing the Moral

The literature in cultural anthropology and anthropology of moral theory has to this point reinforced the idea of the cultural norms built of individuals with similar ideas. This research advanced the idea of emergency medicine as a unique point of study where moral agency is visible. Threats to validity in the interpretation of data are unavoidable (Maxwell 2005), consequently I do not presume universality of this specific emergency department . I cannot conjecture that the use of workarounds and intervention with tools and procedures to negotiate personal and professional position in the care of patients which makes moral actions and possibly intent visible is a universal facet of all healthcare workers. The actions of any individual responsible in the care of patients are both an action of clinical training and social/political constraint. The social/political constraint in the circumstances described by individuals as healthcare workers navigating their professional and personal identity within a larger hospital framework of caring for patients. The workaround through tools, protocols and interactions represent not only pieces to communicate and assert medical knowledge and process information, but also as noted in the analysis represent how healthcare workers control their personal and professional position. The tools, protocols and interactions become transformative in a worker ability to direct their personal and professional autonomy as they practice in their role as healers.

The observations in this study reveal individual professional negotiation within the system is through medicine and various protocols and knowledge bases within the practice of medicine. More importantly, I discussed ways that individuals as part of local moral

worlds change care when driven by moral agency. These are non-metric assessments. The work product relies on metrics and collectively establishes the most fundamental aspect of medical care in critical care medicine, that of action and non-action in allowing a body to heal or cease. It is the transformation of medical practice to one of communication though objects as tools that has realigned a dynamic of patient healing where in these observations, the healthcare workers assert their autonomy and personal moral frame through object use and non-use.

In pulling apart the potential causes of action by healthcare workers when actions and sometimes changes to work mediate action we observe how the institutions drives the scientific work product and consequently creates the production of medical care. If we were to look at healthcare worker production of work as an autonomous scientific endeavor, the production of medicine in the emergency department has not fulfilled the necessary cultural and material conditions necessary as elaborated by Merton, for development of science (Merton 1973) – or in this situation medicine. The acts in emergency medicine do not fulfill the premise of autonomous development. Medicine within, specifically emergency medicine while open to all who come is still part of medicine, now constrained by bureaucracy. I believe however that others would argue that it is the very change within the social structure where healthcare workers use tools or objects within their system that allows for change in the system (Jasanoff 2005). This is the small opening in care and treatment that continues to move patients toward health and reveals – or makes visible moral agency. The interest of the healthcare workers to produce work in a specified manner is in part a reaction to the hospital structure and the confines of their position. I believe further investigation is warranted to better understand how the various levels of healthcare workers

view their position within the hospital. The emergency department as *sui generis* is a construction of a moral foundation. The barrier of partial care of care to a point is shattered making visible the ability to provide medical attention based on priority and emergent need.

Safety of patients is not politically motivated, however the response and the way that nurses are required to function because of constraints due to pay, hours or union representation may reveal a political binding that defines dimensions of a given worker's role and personal agency within the hospital. As an example, the mantra of patient safety that was repeated was genuine, yet it was also useful to the nurses in negotiating their position when caring for patients and working around issues they labeled as creating the best care under the mantra of safety. Nurse work seems to have found the needed rubric of safety and tool use to perform their duties without personal or professional compromise.

The idea that culture is not variable but relational (Fischer 2007) is helpful to understanding the processual nature and understanding how healthcare workers within a system work around and through to produce care. Here the social system of emergency healthcare, caries the cultural value of providing good care and constantly working with a structure. The cultural value remains important because the moral visibility through work*arounds* and working *through* issues to achieve care is not a mere conceptualization of consciousness of the worker but it is part of a paradox of human moral behavior and the need to resolve distress, thereby asserting agency. The paradox is not that there are any simplistic wrongs, but that creating care – the moral act often takes working around or through the system. This study examined events that were unknown but predicated on

medical practice norms. The inductive realization was one where behaviors created paths to workarounds to evince moral norms.[73]

The premise of a moral self is often ascribed to culturally specific constructs of society. In this study, I am careful to note that I set forward a premise to understand the existence and evidence of personal moral expression within varied interdependent roles in critical emergency medicine. In those roles the resolutions and how healthcare workers dealt with ways to assuage their feelings or what they believed was a correct outcome had varied presentations within the greater medical establishment. What we as a society tolerate or expect as normal has its own evolution and standards. Ruth Benedict wrote:

> It is as it is in ethics: all our local conventions of moral behavior and of immoral are without absolute validity, and yet it is quite possible that a modicum of what is considered right and what wrong could be disentangled that is shared by the whole human race. (Benedict 1934)

The polymorphous subject of the moral world, moral person has evidence in the visible transitions created by healthcare workers. The moral positionality of the individual appears disconnected in the "collective professional". I advance throughout this study the idea that the recurring process of the individual is one where as a healthcare worker, the individual within their professional group constantly align what is sometimes visible other times less visible to generate a moral outcome for a patient or care situation. Through this

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[73] Others in anthropology speak specifically to the necessity of inductive model construction in anthropology and that ethnography is not journalism and not theoretical sociology (Goodenough 1970).

research the moral becomes visible while still part of the constant day-to-day activities within the production of emergency medicine. The struggle for a balance of moral, personal and professional agency was repeated through interactions observed by the various healthcare workers. The interest and demands of the work require the physician to be virtuous and consequently morally engaged beyond identifiable principlist ethics.

The ethical and more specifically bioethics charged deliberations are social as healthcare workers are each involved in care (Barilan and Brusa 2011). Moral agency is repeated and visible in each of the groups observed. The confines of the pedagogical station of medical knowledge and profession change the autonomy and consequent ability to assert personal agency in what is right or good for the patient. The limitations then change the nature and the ways in which the workers accomplish work due to those limitations. Clearly there is not one greater moral group. Morality remains plural but expressed within specific confines of the individual.

References

Emergency Medical Treatment and Active Labor Act (EMTALA), codified as amended at 42 U.S.C. §1395dd. 42 C.F.R. Parts 488, 489, 1003, 1994.

Abrahamson, Jennie A., and Victoria L. Rubin. 2012. "Discourse structure differences in lay and professional health communication." *Journal of Documentation* 68 (6):826-851. doi: http://dx.doi.org/10.1108/00220411211277064.

ACEP. 2017. "Clinical and Practice Management, www.ACEP.org/Clinical---Practice-Management." American College of Emergency Physicians Accessed February 26, 2017.

ACEP, American College of Emergency Physicians. 2014. America's Emergency Care Environment, A State-by-State Report Card. USA: ACEP.

Ackerman, Sara, Kathleen Tebb, John Stein, Bradley Frazee, Gregory Hendey, Laura Schmidt, and Ralph Gonzalez. 2012. "Benefit or Burden? A Sociotechnical Analysis of Diagnositic Computer Kiosks in Four California Emergency Departments." *Social Science and Medicine* 75:2378-2384.

Administration, Health Resources and Services. 2010. The Registered Nurse Population:Findings From the 2008 National Sample Survey of Registered nurses. edited by United States Department of Health and Human Services. Washington, D.C.: HHS.

Anspach, Renée R. 1997. *Deciding Who Lives: Fateful Choices in the Intensive-Care Nursery*. Berkely: University of California Press.

Anspach, Renee R., and Diane Beeson. 2001. "Emotions in Medical and Moral Life." In *Bioethics in Social Context*, edited by Barry Hoffmaster, 127-129. Philedelphia: Temple University Press.

Anspach, Renée R., and Nissim Mizrachi. 2007. "The field worker's fields: ethics, ethnography and medical sociology." In *The View from Here: Bioethics and the Social Sciences*, edited by Raymond De Vries, Leigh Turner, Kristina Orfali and Charles L. Bosk, 48-66. Malden MA: Blackwell.

Apesoa-Varano, Ester Carolina. 2013. "Interprofessional Conflict and Repair: A Study of Boundary Work in the Hospital." *Sociollogical Perspectives* 56 (3):13.

Association, Amaerican Medical. 2016. "AMA Code of Medical Ethics: Principles of Medical Ethics." www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page Accessed September 26, 2016.

Baker, Robert B., Arthur L Caplan, Linda L. Emanuel, and Stephen R. Latham. 1999. *The American Medical Ethics Revolution: How the AMA's Code of Ethics Has Transformed Physician's Relationships to Patients, Professionals, and Society.* 1 vols. Vol. 1. Baltimore, Maryland: The Johns Hopkins University Press.

Ballou, Kathryn A. 2010. "The Authoritarian Reign in American Healthcare." *Policy, Politics, and Nursing Practice* 11 (1):8.

Barilan, Y. Michael, and Margherita Brusa. 2011. "Triangular Reflective Equilibrium: A Conscience-Based Method For Bioethical Deliberation." *Bioethics* 25 (6):304-319. doi: 10.1111/j.1467-8519.2009.01797.x.

Beauchamp, Tom L., and James F. Childress. 1979. *Principles of Biomedical Ethics.* New York, NY: Oxford University Press.

Bell, John. 1999 [1847]. "Introduction to the 1847 Code of Ethics." In *The American Medical Revolution: How the AMA's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Society*, edited by Robert B. Baker, Arthur L. Caplan, Linda L. Emanuel and Stephen R. Latham, 317-323. Baltimore, Maryland: The Johns Hopkins University Press.

Benedict, Ruth. 1934. "Anthropology and the Abnormal." *Journal of General Psychology* 11 (1):59-82.

Berlinger, Nancy. 2016. *Are workarounds Ethical? Managing Moral Problems in Health Care Systems.* Oxford: Oxford University Press.

Blanchard, Janice C., Yolanda C. Haywood, and Carol Scott. 2003. "Racial and Ethnic Disparities in Health: An Emergency Medicine Perspective." *Academic Emergency Medicine* 10 (11):1289-1293. doi: 10.1197/S1069-6563(03)00501-3.

Bourdieu, Pierre. 1979. "Symbolic Power." *Critique of Anthropology* 4:77-85.

Bourdieu, Pierre. 1995 [1977]. *Outline of a theory of practice.* Great Britain: Cambridge University Press.

Broom, Alex. 2012. "On Euthanasia, Resistance, and Redemption." *Qualitative Health Research* 22 (2):226-237. doi: doi:10.1177/1049732311421181.

Browdin, Paul E. 2000. "Biotechnology on the Margins: A Haitian Discourse on French Medicine." In *Biotechnology and culture: bodies, anxieties, ethics*, edited by Paul E. Browdin, 265-267. Bloomington: Indiana University Press.

Burström, Lena, Bengt Starrin, Marie-Louise Engström, and Hans Thulesius. 2013. "Waiting management at the emergency department - a grounded theory study." *BMC Health Services Research* 13:95. doi: http://dx.doi.org/10.1186/1472-6963-13-95.

Cadge, Wendy, and Clare Hammonds. 2012. "Reconsidering Detached Concern: the case of intensive-care nurses." *Perspectives in Biology and Medicine* 55 (2):266-82.

Callan, Victor J., Cynthia Gallois, Melissa G. Mayhew, Tim A. Grice, and et al. 2007. "Restructuring The Multi-Professional Organization: Professional Identity and Adjustment to Change in a Public Hospital." *Journal of Health and Human Services Administration* 29 (4):448-77.

Campbell, Robert L., and John Chambers Christopher. 1996. "Beyond Formalism and Altruism: The Prospects for Moral Personality." *Developmental Review* 16 (4):108-123.

Casper, Monica J., and Daniel R. Morrison. 2010. "Medical Sociology and Technology: Critical Engagements." *Journal of Health and Social Behavior* 51:S120-S132. doi: 10.2307/20798321.

Cassaniti, Julia L, and Jacob R Hickman. 2014. "New directions in the anthropology of morality." *Anthropological Theory* 14 (3):251-262. doi: doi:10.1177/1463499614534371.

Chacour Bahous, Marta, and Efrat Shadmi. 2016. "Health information exchange and information gaps in referrals to a pediatric emergency department." *International Journal of Medical Informatics* 87:68-74. doi: http://dx.doi.org/10.1016/j.ijmedinf.2015.12.011.

Chambliss, Daniel F. 1996. *Beyond Caring: hospitals, nurses, and the social organization of ethics*. Chicago: University of Chicago Press.

Charon, Rita. 2006. *Narrative Medicine: Honoring the Stories of Illness*. New York: Oxford University Press.

Chaudhry, Abid Ghafoor, and Hafeez ur Rahman Chaudhry. 2012. "Anthropo-Medical Orientation: Reflections on Medical Anthropology and Cultural Riddle." *FWU Journal of Social Sciences* 6 (2):146-165.

Chen, Alice Hm, Mara K. Youdelman, and Jamie Brooks. 2007. "The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond." *Journal of General Internal Medicine* 22 (Suppl 2):362-367.

Corley, Mary C., Ptlene Minick, RK Elswick, and Mary Jacobs. 2005. "Nurse Moral Distress and Ethical Work Environment." *Nursing Ethics* 12 (4):381-390.

Das, Veena. 2012. "Ordinary Ethics." In *A Companion to Moral Anthropology*, edited by Didier Fassin, 133-149. Oxford: John Wiley and Sons.

Daston, Lorraine. 1995. "The Moral Economy of Science." *Osiris* 10:3-24.

Daston, Lorraine. 2014. "The Values of Science." In *Moral Anthropology: A Critical Reader*, edited by Didier Fassin and Samuel Lézé, 221-230. London and New York: Routledge, Taylor and Francis Group.

David, B.A. 2000. "Nursing's gender politics: Reformulating the footnotes." *Advances in Nursing Science* 23 (1):11.

de Laet, Marianne. 2012. "Anthropology as Social Epistemology?" *Social Epistemology* 26 (3-4):419-433. doi: 10.1080/02691728.2012.727196.

Deppoliti, Denise. 2008. "Exploring How New Registered Nurses Construct Professional Identity in Hospital Settings." *The Journal of Continuing Education in Nursing* 39 (6):255-62.

Desjarlais, Robert, and C. Jason Throop. 2011. "Phenomenological Approaches in Anthropology." *Annual Review of Anthropology* 40:87-102. doi: 10.2307/41287721.

Dewey, John. 1958 *Experience and Nature*. Unites States: Dover.

Diamond, Timothy. 1984. "Elemets Of A Sociology For Nursing: Considerations On Caregiving And Capitalism." *Mid-American Review of Sociology* 9 (1):3-21. doi: 10.2307/23253072.

Dolgin, Janet. 2006. "Debating Conflicts: Medicine, Commerce, and Constrasting Ethical Orders." *Hofstra Law Review* 35 (2):705-735.

Dubrosky, Rebekah. 2013. "Iris Young's Five Faces of Oppression Applied to Nursing." *Nursing Forum* 48 (3):5.

Duranti, Allessandro. 2012. *Linguistic Anthropology*. Cambridge: Cambridge University Press.

Durkheim, Emile. 1993 [1887]. *Ethics and the Sociology of Morals*. Edited by Robert T. Hall, *Great Mind Series*. Buffalo: Prometheus Books.

Edelman, Marc. 2012. "E.P. Thompson and Moral Economies." In *A Companion to Moral Anthropology*, edited by Didier Fassin, 49-66. Oxford: John Wiley and Sons.

Emanuel, Ezekiel. 1991. *The Ends of Human Life: Medical Ethics in a Liberal Polity.* Cambridge, MA: Harvard University Press.

Emmerich, Nathan. 2015. "Bourdieu's collective enterprise of inculcation: the moral socialisation and ethical enculturation of medical students." *British Journal of Sociology of Education* 36 (7):1054-1072.

EMRA. 2005. "A Brief History of Emergency Medicine Residency Training." Emergency Medicine Residents' Association, Irving, Texas, Last Modified 2005 Accessed November 21, 2016.

ENA. 2011. *Emergency Nursing Scope and Standards of Practice*. Des Plaines, IL: Emergency Nurses Association.

Epstein, Elizabeth Gingell, and Ann Baile Hamric. 2009. "Moral Distress, Moral Residue and the Crescendo Effect." *The Journal of Clinical Ethics* 20 (4):330-342.

Fassin, Didier. 2012. "Introduction: Toward a Critical Moral Anthropology." In *A Companion to Moral Anthropology*, edited by Didier Fassin, 2-17. Oxford: John Wiley and Sons.

Faubion, James D. 2012. "Foucault and the Genealology of Ethics." In *A Companion to Moral Anthropology*, edited by Didier Fassin, 67-84. Great Britain: John Wiley & sons, Inc.

Fernandez-Parsons, Robin, Lori Rodriguez, and Deepika Goyal. 2013. "Moral Distress in Emergency Nursing." *Journal of Emergency Nursing* 39 (6):547-552.

Fischer, Michael M. J. 2007. "Four Genealogies For a Recombinant Anthropology of Science and Technology." *Cultural Anthropology* 22 (4):539-615. doi: 10.1525/can.2007.22.4.539.

Foster, George M., and Barbara Gallatin Anderson. 1978. *Medical Anthropology.* New York: John Wiley and Sons.

Foucault, Michel. 1984. "Of Other Spaces, Heterotopia [Des Espace Autres]." *Architecture, Movement, Continuite'* (5):4.

Fox, Renée, and Raymond DeVries. 1998. "Afterword: The Sociology of Bioethics." In *Bioethics and Society: Constructing the Ethical Enterprise*, edited by Raymond DeVries and Janaedan Subedi, 270-276. Upper Saddle River, New Jersey: Prentice Hall.

Freidson, Eliot. 1988. "Profession of Medicine." In, 440. Chicago: University of Chicago Press.

Frickel, Scott, and Kelly Moore. 2006. *The New Political Sociology of Science: Institutions, Networks, and Power*. Edited by Daniel Lee Kleinman and Jo Handelsman, *Science and Technology in Society*. Madison, Wisconsin: University of Wisconsin Press.

Gaines, Atwood. 2010. "Millenial Medical Anthropology: From There to Here and Beyond, or the Problem of Global Health." *Culture, Medicine and Psychiatry* 34:7.

Garfinkel, Harold. 1967. *Studies in Ethnomethodology*. Englewood Cliffs, New Jersey: Prentice-Hall, Inc.

Geertz, Clifford. 1973. *The Interpretation of Cultures*. New York: Basic Books.

Gill, Virginia Teas, and Felicia Roberts. 2013. "Conversation Analysis in Medicine." In *The Handbook of Conversation Analysis*, edited by Jack Sidnell and Tanya Stivers, 575-592. West Sussex, UK: John Wiley and Sons Ltd.

Glaser, Barney G., and Anselm Strauss. 1967. *The Discovery of Grounded Theory: Stretegies for Qualitative Research*. Chicago: Aldine.

Gluckman, Max. 1971. "New dimensions of change, conflict and settlement." *International Social Science Journal* 23 (4):548-563.

Goffman, Erving. 1967. *Interaction Ritual*. New York: Anchor books.

Goffman, Erving. 1974. *Frame Analysis: An Essay On The Organization of Experience*. First ed. New York: Harper and Row.

Good, Byron J. 1994. *Medicine, Rationality, and Expereince: An Anthropological Perspective*. Cambridge: Cambridge University Press.

Goodenough, Ward H. 1970. "The Growing Demand for Behavioral Science in Governement and Its Implications for Anthropology." In *Applied Anthropology: Readings in the Uses of the Science of Man*, edited by J.A. Clifton, 215-224. Boston: Houghton Mifflin Company.

Goodwin, Charles. 1995. "Seeing in Depth." *Social Studies of Science* 25 (2):237-274. doi: 10.2307/285534.

Goodwin, Charles. 2000. "Action and embodiment within situated human interaction." *Journal of Pragmatics* 32 (10):1489-1522. doi: http://dx.doi.org/10.1016/S0378-2166(99)00096-X.

Goodwin, Charles. 2007. "Participation, stance and affect in the organization of activities." *Discourse & Society* 18 (1):53-73. doi: 10.1177/0957926507069457.

Grenberg, Jeanine. 1999. "Anthropology From a Metaphysical Point of View." *Journal of the History of Philosophy* 37 (1):91-115.

Hahn, Robert A., and Atwood D. Gaines. 1982. "Physicians of Western medicine: An introduction." *Culture, Medicine and Psychiatry* 6 (3):4.

Hahn, Robert A., and Arthur Kleinman. 1983. "Biomedical Practice and Anthropological Theory: Frameworks and Directions." *Annual Review of Anthropology* 12:305-333. doi: 10.2307/2155650.

Hakimnia, Roya, Inger K. Holmström, Marianne Carlsson, and Anna T. Höglund. 2014. "Exploring the communication between telenurse and caller - A critical discourse analysis." *International Journal of Qualitative Studies on Health and Well-Being* 9. doi: http://dx.doi.org/10.3402/qhw.v9.24255.

Hakli, Raul. 2007. "On the Possibility of Group Knowledge without Belief." *Social Epistemology* 21 (3):249-266. doi: 10.1080/02691720701685581.

Hamric, Ann B. 2012. "Empirical Research on Moral Distress: Issues, Challenges, and Opportunities." *HEC Forum* 24 (1):39-49. doi: 10.1007/s10730-012-9177-x.

Harrison, Michael I. 1994. "Professional control as process: Beyond structural theories." *Human Relations* 47 (10):1201.

Hegazi, Iman, and Ian Wilson. 2013. "Medical education and moral segmentation in medical students." *Medical Education* 47:1022-1028.

Heidegger, Martin. 2010 [1953]. "Conscience as the Call of Care." In *Being and Time*, 264-288. New York: State University of New York Press, Albany.

Heritage, John, and Douglas W. Maynard. 2006. "Problems and prospects in the study of physician-patient interaction: 30 years of research." *Annual Review of Sociology* 32:351-374. doi: 10.1146/annurev.soc.32.082905.093959.

Heritage, John, and Tanya Stivers. 2013. "Conversation Analysis and Sociology." In *The Handbook of Conversation Analysis*, edited by Jack Sidnell and Tanya Stivers, 659-673. West Sussex, UK: John Wiley and Sons Ltd.

Hoeyer, Klaus. 2007. "Person, Patent and Property: A Critique of the Commodification Hypothesis." *BioSocieties* 2 (3):327-348. doi: http://dx.doi.org/10.1017/S1745855207005777.

Holland, Dorothy, Willliam Lachicotte Jr., Debra Skinner, and Carole Cain. 1998. *Identity and Agency in Cultural Worlds*. Cambridge Massachusettes: Harvard.

Horton, Sarah, Cesar Abadia, Jessica Mulligan, and JenniferJo Thompson. 2014. "Critical Anthropology of Global Health "Takes a Stand" Statement: A Critical Medical

Anthropological Approach to the U.S.'s Affordable Care." *Medical Anthropology Quarterly* 28 (1):1-22.

Hume, David. 1993 [1896]. *A Treatise of Human Nature*. Oxford: Oxford: Clarendon Press.

IOM. 2003. Unequal Treatment: Confronting Racial and Ethinic Disparaties in Healthcare. In *Institute of Medicine; Board on Health Ciences Policy*, edited by Brian D. Smedley, Adrienne Y. Smith and Alan R. Nelson. Washington D.C.: National Academies Press.

IOM. 2007. Emergency Medical Services: At the Crossroads. In *Institute of Medicine; Board on Health Care Services*, edited by Committee on the Future of Emergency Care in the United States Health System. Washington D.C.: National Academies Press.

Ivory, Danielle, Ben Protess, and Kitty Bennett. 2016. "When You Dial 911 And Wall Street Answers." *The New York Times*, June 25, Business Day.

Jackson, Michael. 1996. "Introduction: Phenomenology, Radical Empiricisim, and Anthropological Critique." In *Things as They Are: New Directions in Phenomenological Anthropology*, edited by Michael Jackson, 1-50. Bloomington: Indiana University Press.

Jameton, Andrew. 2013. "A Reflection on Moral Distress in Nursing Together With a Current Application of the Concept." *Journal of Bioethical Inquiry* 10 (3):297-308. doi: 10.1007/s11673-013-9466-3.

Jasanoff, Sheila. 2005. *Designs on Nature: Science and Democracy in Europe and United States*. Princeton: Princeton University Press.

Jensen, Lotte Groth, and Claus Bossen. 2016. "Factors affecting physicians' use of a dedicated overview interface in an electronic health record: The importance of standard information and standard documentation." *International Journal of Medical Informatics* 87:44-53. doi: http://dx.doi.org/10.1016/j.ijmedinf.2015.12.009.

Jonsen, Albert R. 1998. *The Birth of Bioethics*. New York: Oxford University Press.

Kalanithi, Paul. 2016. *When Breath Becomes Air*. New York: Random House.

Kant, Immanuel. 2009 [1797]. *The Metaphysics of Morals*. Edited by Karl Ameriks, *Cambridge Texts in the History of Philosophy*. Camridge: Cambridge University Press.

Karsenti, Bruno. 2012. "Durkheim and the Moral Fact." In *A Companion to Moral anthropology*, edited by Didier Fassin, 21-36. Oxford: John Wiley and Sons.

Kirpal, Simone. 2004. "Work identities of nurses: Between caring and efficiency demands." *Career Development International* 9 (3):274-304.

Kleinman, Arthur. 1995. *Writing at the Margin: Discourse Between Anthropology and Medicine*. Berkeley: University of California Press.

Kleinman, Arthur. 1999a. "Experience and its moral modes: Culture, human conditions, and disorder." In *Tanner lectures on human calues*, 355-420.

Kleinman, Arthur. 1999b. "Moral Experience and Ethical Reflection: Can Ethnography Reconcile Them? A Quandry for "The New Bioethics"." *Daedalus* 128 (4):69-97.

Kleinman, Arthur. 2006. *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*. Oxford: Oxford Univeristy Press.

Kleinman, Arthur. 2010. "Four social theories for global health." *The Lancet* 375 (9725):1518-1519. doi: https://doi.org/10.1016/S0140-6736(10)60646-0.

Kleinman, Arthur, and Joan Kleinman. 1997. "Moral Transformations of Health and Suffering in Chinese Society." In *Morality and Health*, edited by Allan M. Brandt and Paul Rozin, 101-118. New York: Routledge.

Koschmann, Timothy, Curtis LeBaron, Charles Goodwin, and Paul Feltovich. 2011. ""Can you see the cystic artery yet?" A simple matter of trust." *Journal of Pragmatics* 43 (2):521-541.

Kuhn, Thomas S. 1996 [1962]. *The Structure of Scientific Revolutions*. 3rd ed. Chicago: The University of Chicago Press.

Labor, United States Department of. 2012. "http://www.bls.gov/cps/cpsaat11.htm." Bureau of Labor Statistics Accessed December 15, 2013.

Laidlaw, James. 2002. "For an Anthropology of Ethics and Freedom." *Journal of the Royal Anthropological Institute* 8 (2):311-332.

Laidlaw, James. 2014. *The Subject of Virtue: An Anthropology of Ethics and Freedom*. Edited by Johnathan Spencer and Michael Lambeck, *New Departures in Anthropology*. Cambridge: Cambridge University Press.

Larkin, Gregory Luke, Kenneth Iserson, Zach Kassutto, Glenn Freas, Kathy Delaney, John Krimm, Terri Schmidt, Jeremy Simon, Anne Calkins, and James Adams. 2009. "Virtue in Emergency Medicine." *Academic Emergency Medicine* 16 (1):51-55. doi: 10.1111/j.1553-2712.2008.00315.x.

Latour, Bruno. 2007. *Reassembling the Social: An Introduction to Actor-Network-Theory*. Oxford: Oxford University Press, Inc.

Latour, Bruno, and Steve Woolgar. 1986. *Laboratory Life: The Social Construction of Scientific Facts*. Princeton: Princeton University Press

Lazarsfeld-Jensen, Ann. 2014. "Telling stories out of school: Experiencing the paramedic's oral traditions and role dissonance." *Nurse Education in Practice* 14 (6):734-739. doi: http://dx.doi.org/10.1016/j.nepr.2014.10.001.

Lock, Margaret. 1997. "Displacing Suffering: The Reconstruction of Death in North America and Japan." In *Social Suffering*, edited by Arthur Kleinman, Veena Das and Margaret Lock, 404. Berkeley and Los Angeles: University of California Press.

Lock, Margaret. 2001. "The tempering of medical anthropology troubling natural categories." *Medical Anthropology Quarterly* 15 (4):478-92.

López, José. 2004. "How sociology can save bioethics . . . maybe." *Sociology of Health & Illness* 26 (7):875-896. doi: 10.1111/j.0141-9889.2004.00421.x.

Malone, Ruth. 2000. "Dimensions of vulnerabiity in Emergency Nurses' Narratives." *Advances in Nursing Science* 23 (1):11.

Malone, Ruth E. 1999. "Policy as product: Morality and metaphor in health policy discourse." *The Hastings Center Report* 29 (3):16-22.

Manara, Duilio F., Giulia Villa, and Dina Moranda. 2014. "In search of salience: phenomenological analysis of moral distress." *Nursing Philosophy* 15 (3):171-182. doi: 10.1111/nup.12048.

Marshall, Patricia, and Barbara Koenig. 2004. "Accounting for Culture in Globalized Bioethics." *The Journal of Law, Medicine & Ethics* 32 (2):252-266. doi: 10.1111/j.1748-720X.2004.tb00472.x.

Matheson, Linda Kay, and Kathleen Bobay. 2007. "Validation of Oppressed Group Behaviors in Nursing." *Journal of professional nursing : official journal of the American Association of Colleges of Nursing* 23 (4):226-234.

Mattingly, Cheryl. 1998. "In Search of the Good: Narrative Reasoning in Clinical Practice." *Medical Anthropology Quarterly* 12 (3):273-297. doi: 10.1525/maq.1998.12.3.273.

Mattingly, Cheryl. 2010. *The Paradox of Hope: Journeys through a Clincal Borderland.* Berkely University of California Press.

Mattingly, Cheryl. 2013. "Moral Selves and Moral Scenes: Narrative Experiments in Everyday Life." *Ethnos* 78 (3):301-327. doi: 10.1080/00141844.2012.691523.

Mattingly, Cheryl, Nancy C. Lutkehaus, and C. Jason Throop. 2008. "Bruner's Search for Meaning: A Conversation between Psychology and Anthropology." *Ethos* 36 (1):1-28.

Maxwell, Joseph A. 2005. *Qualitative Research Design: An Interactive Approach.* Vol. 41, *Applied Social Reserch Methods Series.* Thousand Oaks, California: Sage Publications, Inc.

McKay, Ryan T., and Daniel C. Dennett. 2009. "The evolution of misbelief." *Behavioral and Brain Sciences* 32 (6):493-561.

Medford-Davis, Laura N., Vidya Eswaran, Rohan M. Shah, and Cedric Dark. 2015. "The Patient Protection and Affordable Care Act's Effect on Emergency Medicine: A Synthesis of the Data." *Annals of Emergency Medicine* 66 (5):496-506. doi: http://dx.doi.org/10.1016/j.annemergmed.2015.04.007.

Medscape. 2016. "Medscape Physician Compensation Report 2016." Medscape Accessed September 2, 2016.

Merleau-Ponty, Maurice. 2002 [1958]. " Introduction: Traditional Prejudices and the Return to Phenomena." In *Phenomenology of Perception*, 26-29. New York: Routledge Classics.

Merton, Robert K. 1973. "Social and Cultural Contexts of Science." In *The Sociology of Science: Theoretical and Empirical Investigations*, 181-183. Chicago: Chicago University Press.

Mertz, Marcel, Julia Inthorn, Guenter Renz, Lillian Geza Rothenberger, Sabine Salloch, Jan Schildmann, Sabine Wohlke, and Silke Schicktanz. 2014. "Research across the disciplines: a road map for quality criteria in empirical ethics research." *BMC Medical Ethics* 15 (1):17. doi: 10.1503/cmaj.050698] http://dx.doi.org/10.1186/1472-6939-15-17.

Miles, Mathew B., and A. Michael Hubberman. 1994. *Qualitative Data Analysis: An Expanded Sourcebook.* Tousand Oaks, California: Sage Publications, Inc.

Mol, Annemarie. 2002. *The body Multiple: Ontology in Medical Practice*. First ed. Durham: Duke University Press.

Morton, Jennifer. 2013. "Unequal Classrooms: What Online Education Cannot Teach." *The Chrincle of Higher Education* July.

Nugus, Peter, Katherine Carroll, David G. Hewett, Alison Short, Roberto Forero, and Jeffrey Braithwaite. 2010. "Integrated care in the emergency department: A complex adaptive systems perspective." *Social Science and Medicine* 71:1997-2004.

NYSDOH. 2015. DSRIP Medicaid Redesign. edited by https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_faq.pdf. New York: New York State Department of Health.

NYSDOH. 2015(rev). "Patients' Bill of Rights." New York State Department of Health Accessed February 2, 2017.

O'Keefe-McCarthy, Sheila. 2009. "Technologically-Mediated Nursing Care: the Impact on Moral Agency." *Nursing Ethics* 16 (6):786-96. doi: http://dx.doi.org/10.1177/0969733009343249.

OED. 1961[1933]. Oxford English Dictionary, 2nd ed., s.v. "morality": Oxford University Press.

Oster, Ady, and Andrew Bindman. 2003. "Emergency Department Visits for Ambulatory Care Sensitive Conditions: Insights Into Preventable Hospitalization." *Medical Care* 41 (2):198-207.

Pavlish, Carol, Katherine Brown-Saltzman, Patricia Jakel, and Ann-Marie Rounkle. 2012. "Nurses' Responses to Ethical Challenges in Oncology Practice: An Ethnographic Study." *Clinical Journal of Oncology Nursing* 16 (6):592-600. doi: 10.1111/j.1547-5069.2010.01380.x.

Pellegrino, Edmund D. 2006. "Bioethics and Politics: "Doing Ethics" in the Public Square." *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy* 31 (6):569-584. doi: 10.1080/03605310601088756.

Pellegrino, Edmund D., and David C. Thomasma. 1993. *The Virtues in Medical Practice.* New York: Oxford University Press.

Pence, Gregory E. 2008. *Classic Cases in Medical Ethics: Accounts Of The Cases That Shaped And Define Medical Ethics.* 5th ed. New York: McGraw-Hill.

Pine, Adrienne. 2011. "From Healing to Witchcraft: On Ritual Speech and Roboticization in the Hospital." *Culture, Medicine, and Psychiatry* 35 (2):262-284.

Plato. 2015. The Republic. idph.net: Project Gutenberg Etext.

Powell, Alison E., and Huw T.O. Davies. 2012. "The Struggle to Imporve Patient Care in the Face of Professional Boundaries." *Social Science & Medicine* 75:8.

Rawls, Ann Warfield. 2008. "Harold Garfinkel, Ethnomethodology and Workplace Studies." *Organization Studies* 29 (5):33.

Richardson, Lynne D., and Ula Hwang. 2001. "Access to Care: A Review of the Emergency Medicine Literature." *Academic Emergency Medicine* 8 (11):7.

Rorty, Amélie. 2011. "Aristotle on the Virtues of Rhetoric." *The Review of Metaphysics* 64 (4):715-733.

Salhani, Daniel, and Ian Coulter. 2009. "The Politics of Interprofessional Working and the Struggle for Professional autonomy in Nursing." *Social Science and Medicine* 68 (2):8.

Sanders, Arthur B., Arthur R. Derse, Robert Knopp, Kathleen Malone, Joyce Mitchell, John C. Moskop, David Sklar, Jeffrey Smith, and E. Jackson Allison, Jr. 1991. "American College of Emergency Physicians Ethics Manual." *Annals of Emergency Medicine* 20 (10):1153-1162. doi: 10.1016/S0196-0644(05)81399-X.

Scheper-Hughes, Nancy, and Margaret M. Lock. 1987. "The Mindful Body: A PRolegomenon to Future Work in Medical Anthropology." *Medical Anthropology Quarterly* 1 (1):35.

Schubert, Cornelius. 2011. "Making sure. A comparative micro-analysis of diagnostic instruments in medical practice." *Social Science & Medicine* 73:6.

Shamoo, Adil E., and David B. Resnik. 2009. *Responsible Conduct of Research.* 2nd ed. New York: Oxford University Press.

Shim, Janet K. 2010. "Cultural Health Capital: A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment." *Journal of Health and Social Behavior* 51 (1):1-15.

Shweder, Richard. 1991. *Thinking through Cultures: Expeditions in Cultural Psychology.* Cambridge: Harvard University Press.

Simon, Robin W. 1997. "The Meanings Individuals Attach to Role Identities and Their Implications for Mental Health." *Journal of Health and Social Behavior* 38 (3):256-274. doi: 10.2307/2955370.

Smith, M.G. 1998. *The Study of Social Structure.* New York: CIFAS.

Starr, Paul. 1982. *The social transformation of American medicine.* New York: Basic Books.

States, United. 1979. The Belmont Report Ethical Principles and Guidelines for the protection of human subjects od research: The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. edited by Education Department of Health, and Welfare. Bethesda, Maryland: The Commission.

Stets, Jan E., and Peter J. Burke. 2000. "Identity theory and social identity theory." *Social Psychology Quarterly* 63 (3):224-237.

Strauss, Anselm, and Juliet Corbin. 1998. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* Second ed. Thousand Oaks, CA: Sage Publications.

Sullivan, Roger J. 1983. "The Kantian Model Of Moral-Practical Reason." *The Monist* 66 (1):83-105.

Sykes, Karen. 2005. *Arguing with Anthropology*. Abingdon: Routledge.

Tangherlini, Timothy R. 2000. "Heroes and Lies: Storytelling Tactics among Paramedics." *Folklore* 111 (1):43-66. doi: 10.2307/1260978.

Tannen, Deborah, and Cynthia Wallat. 1987. "Interactive Frames and Knowledge Schemas in Interaction: Examples from a Medical Examination/Interview." *Social Psychology Quarterly* 50 (2):205-216.

Tauber, Alfred I. 2008. "Medicine And The Call For A Moral Epistemology, Part II: constructing a synthesis of values." *Perspectives in Biology and Medicine* 51 (3):450-63.

Thomas, Keith. 1997. "Health and Morality in Modern England." In *Morality and Health*, edited by Alan M. Brandt and Paul Rozin, 15-34. New York: Routledge.

Thomas, Tessy A., and Laurence B. McCullough. 2015. "A Philosophical Taxonomy of Ethically Significant Moral Distress." *Journal of Medicine and Philosophy* 40 (1):102-120. doi: 10.1093/jmp/jhu048.

Throop, C. Jason. 2012. "Moral Sentiments." In *A Companion to Moral Anthropology*, edited by Didier Fassin, 157-161. Oxford: John Wiley and Sons.

Timmermans, Stefan. 1998. "Mutual Tuning of Multiple Trajectories." *Symbolic Interaction* 21 (4):425-440. doi: 10.1525/si.1998.21.4.425.

Timmermans, Stefan, and Emily S. Kolker. 2004. "Evidence-Based Medicine and the Reconfiguration of Medical Knowledge." *Journal of Health and Social Behavior* 45:177-193. doi: 10.2307/3653831.

Traynor, Michael, Maggie Boland, and Niels Buus. 2010. "Professional Autonomy in 21st Century Healthcare: Nurses' Accounts of Clinical Decision-Making." *Social Science and Medicine* 70:6.

Turner, Victor. 1975. "Symbolic Studies." *Annual Review of Anthropology* 4:145-161.

Veatch, Robert M. 2003. "Is There a Common Morality." *Kennedy Institute of Ethics Journal* 13 (3):189-192.

Verbeek, Peter-Paul. 2008. "Obstetric Ultrasound and the Technological Mediation of Morality: A Postphenomenological Analysis." *Human Studies* 31 (1):11-26. doi: 10.2307/40270638.

Vosk, Arno. 2002. The Sociology of Emergency Medicine. *Emergency Medicine News* 24 (2): 34-35. Accessed April 27, 2013.

Vuuren, Mark van, and François Cooren. 2010. ""My Attitude Made Me Do It": Considering the Agency of Attitudes." *Human Studies* 33 (1):85-101. doi: 10.2307/40981091.

Weber, Max. 2011 [1949]. *Methodology of Social Sciences*. New Brunswick, U.S.A.: Transaction Publishers.

Wikström, Ann-Charlott, Ann-Christin Cederborg, and Marita Johanson. 2007. "The Meaning of Technology in an Intensive Care Unit - An Interview Study." *Intensive and Critical Care Nursing* (23):187-195.

Wilce, James M. 2009. "Medical Discourse." *Annual Review of Anthropology* 38 (1):199-215. doi: doi:10.1146/annurev-anthro-091908-164450.

Wilkinson, Judith M. 1987. "Moral Distress in Nursing Practice: Experience and Effect." *Nursing Forum* 23 (1):16-29. doi: 10.1111/j.1744-6198.1987.tb00794.x.

Wilson, Michael, and David Cutler. 2014. "Emergency Department Profits Are Likely To Continue As The Affordable Care Act Expands Coverage." *Health Affairs (Milwood)* 33 (5):792-799.

Zafar, Waleed. 2014. "Moral experience and ethical challenges in an emergency department in Pakistan: emergency physicians' perspectives." *Emergency Medicine Journal.* doi: 10.1136/emermed-2014-204081.

Zigon, Jarett. 2007a. "Moral breakdown and the ethical demand: A theoretical framework for an anthropology of moralities." *Anthropological Theory* 7 (2):131-150.

Zigon, Jarrett. 2007b. "Moral Breakdown and the Ethical Demand: ATheoretical Framework for an Anthropology of Moralities." *Anthropological Theory* 7 (2):131-150.

Zigon, Jarrett. 2008. *Morality: An Anthropological Perspective*. New York: Berg.

Zigon, Jarrett. 2012. "Narratives." In *A Companion to Moral Anthropology*, edited by Didier Fassin, 204-220. West Sussex, UK: John Wiley and sons.

Appendix I

Glossary of Medical Terms

Hospital Positions/Personnel:

ALS. Advanced Life Support trained emergency medical technicians. ALS technicians are paramedics with training to do airway intervention and administer medication and start intravenous fluids. Also called paramedics.

Attending. Physician who is a medical doctor employed by the hospital as part of medical staff that supervises and trains residents.

BLS. Basic Life Support trained emergency medical technicians. BLS technicians have fewer training hours and cannot administer medications, start intravenous fluids or intubate patients.

EMS. Emergency Medical Service. These are prehospital care providers that include both ALS and BLS emergency care providers.

MD. Medical Doctor.

PA. Physician Assistant, Non-physician trained to support physicians, diagnose, take patient histories. Has prescribing authority

Paramedic. Advanced training emergency medical technician. Paramedics make up the ALS teams of Emergency Medical Service (EMS) and can give medication, start IVs and do intubations.

Patient Services. Patient Services representatives are support staff responsible for addressing issues of comfort for the patients and their families. Sometimes they assist in getting forms for patients, phones to dial out of the emergency room or assist other staff in dealing with patient family and friends.

Resident. Physician finishing specialized training.

RN. Registered Nurse

Service Associate. Title at UED given to their custodial staff

Tech. Nursing Assistant with 120-200 hours post high school practical patient care training.

Medical Terminology/Equipment/Products:

ACA. Affordable Care Act, also known as Obamacare

Albuterol. Medication that opens up medium and small passage ways in the lungs

Bag. Used in terms of to "bag" a patient. To manually ventilate a patient. Also bagging. The process of forcefully pressing air through the lungs using a large balloon like bag that delivers air through an intubation device. This is done in cardiovascular event until a mechanical vent can be put on a patient who has undergone cardiovascular arrest.

Bicarb. Sodium bicarbonate. Bicarb is a product used in resuscitation attempts to prevent lactic acidosis in heart attack victims.

BP. Blood Pressure

BiPAP. Bilevel positive airway pressure. Also called BPAP, is a non-invasive mechanical pressurized forced air that uses timed cycles to force air into the lungs using a face mask over the mouth and nose.

Bradycardia. Slow heartbeat - lower than normal limits.

CA. Cardiac Arrest, also known as a heart attack

Cardiac Catheterization. Insertion of a catheter into a chamber of vessel of the heart done for various procedures that are sometimes diagnostic and sometimes therapeutic.

Carotid. Carotid Artery. The carotid arteries are major blood vessels in the neck supplying blood to the head.

Cath Lab. Catheterization laboratory where cardiac catheterization occurs.

Code. A term used to indicate cardiopulmonary arrest.

CPAP. Continuous positive airway pressure. An artificial ventilation that provides continuous positive airway pressure to maintain airways and prevent lung collapse.

CT. CT is a computerized tomography, also known as a CAT scan or computerized axial tomography. CT/CAT is a type of imaging that uses x-Rays to provide three dimensional imaging and can provide greater detail of soft tissue physiology.

Dilaudid. Hydromorphone, highly addictive controlled narcotic used to treat severe pain.

DKA. Diabetic Ketoacidosis which is acidosis causes by accumulation of ketones in the blood and tissue.

DNI. Do Not Intubate. A written order that a patient can request prior to succumbing to medical illness.

DNR. Do Not Resuscitate. A specific pre-written order in a patient chart, which allows patients to refuse resuscitative efforts in the event of cardiac failure.

Dopamine. Naturally occurring catecholamine in the body that can be used in healthcare to treat symptoms of shock by improving blood flow.

Echo. Echocardiogram. A type of ultrasound imaging to observe heart movement

EHR. Electronic Health Record. EHRs are patient charts that are now access electronically. Some institutions refer to electronic records as an EMR, or electronic medical record.

EKG. Electrocardiogram. A measurement of electrical activity of the heart

EMTALA. Emergency Medical Treatment and Labor Act. Federal law enacted in 1986 that requires emergency rooms to treat and stabilize any patient coming into the emergency department.

Encephalopathy. Disease of the brain.

Ensure. A type or brand of liquid meal.

Epi. Epinephrine. A drug used in resuscitation event which increases blood pressure and stimulates heart muscle, increases heart rate and the amount of blood pumped by the heart.

ET. Endotracheal tube. Used for intubating a patient to open the airway so that oxygen can be forced mechanically or with a bag into the patient.

Femoral Artery. Main artery that runs through the leg

Frequent Flier. A term used to describe a patient known to the emergency department and repeat patient to a particular hospital or emergency department.

Haldol. Haloperidol. An antipsychotic drug used to treat schizophrenia, manic episodes in bipolar disorder.

Heparin. Blood thinner used to prevent deep vein thrombosis (DVT) and other potential clots in the body.

Hypoxia. Reduced oxygen levels in tissue

ICU. Intensive Care Unit

Intubate/Intubation. Insertion of a tube through the mouth and into the trachea. The procedure is done so that air can be ventilated into the lungs.

IO. Intraosseous infusion. The process of injecting directly into the marrow of the bone.

IO Gun. Intraosseous Gun used to directly access the marrow allowing for immediate intravenous access. Generally used when vascular access is difficult due to collapse.

Ischemia. When blood is lacking in part of the body due to constriction or obstruction of blood vessels.

Ipatropium. Drug used to open up medium and large airways in the lungs

IV. Intravenous means into a vein. A medical IV uses a syringe or intravenous catheter to administer medications or solution directly into the venous circulation.

Lasix. Diuretic (furosemide) is a diuretic that prevents your body from absorbing too much salt. Lasix is used to treat water retention.

LVAD: Left Ventricular Assist Device – these are people with end stage of heart

MI. Myocardial infarction. Dead heart tissue from blockage of blood vessels.

MRI. Magnetic Resonance Imaging. A type of diagnostic imaging used to provide detailed images of human anatomy. MRI's do not use radiation, but take longer and cannot be used on individuals with non-removable metal implants.

NG. Nasogastric tube.

Pneumothorax. Collapsed lung

Pulsox. Pulse oximetry is a device that measures a persons oxygen saturation.

ROSC. Return of Spontaneous Circulation, ROSC is a major determinant in the potential survival of a patient undergoing a resuscitation attempt after cardiac arrest.

POTS disease. Postural Orthostatic Tachycardia Syndrome is a disease where the change from supine (lying down) to upright causes an abnormally large increase in heart rate.

Resus. Resuscitation area of the hospital with a higher ration of nurses and physicians available to attend to critically ill patients.

SLOCO. Slow Code. A purposely slow response or incomplete response to a medical resuscitation.

SOP. Standard Operating Procedure, SOP is usually used to describe processes that are documented and recorded using a specific guideline that can be referenced and followed.

STEMI. ST-elevation Myocardial Infarction is a heart attack where there is a complete blockage of a heart artery.

Tachy. Tachycardia is a fast heart rate faster than normal when person is at rest.

Troponin. A protein that can be measured in the blood. Troponins are released into the blood when myocardial (heart muscle) tissue is damaged.

Appendix II

Patients' Bill of Rights

As a patient in a hospital in New York State, you have the right, consistent with law, to:

1. (1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.
2. (2) Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age.
3. (3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. (4) Receive emergency care if you need it.
5. (5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.
6. (6) Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
7. (7) A no smoking room.
8. (8) Receive complete information about your diagnosis, treatment and prognosis.
9. (9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and bene ts [sic] of the procedure or treatment.
10. (10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care — A Guide for Patients and Families."
11. (11) Refuse treatment and be told what effect this may have on your health.
12. (12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
13. (13) Privacy while in the hospital and con dentiality [sic] of all information and records regarding your care.
14. (14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.
15. (15) Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
16. (16) Receive an itemized bill and explanation of all charges.
17. (17) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satis ed [sic]with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.
18. (18) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.

19. (19) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.
Public Health Law(PHL)2803 (1)(g)Patient's Rights, 10NYCRR, 405.7,405.7(a)(1),405.7(c)

Appendix III

Methods of Study

The work produced in this research is from observation in the emergency department. This manuscript is written in the tradition of anthropology relying on methods that include traditional ethnography where for purposes of this manuscript, I also describe the sociocultural position of medicine and those working in it to situate the work I describe in the field. The process of research in the field includes taking daily notes and time in the field, making daily transcriptions into field notes and then using that research to guide a concept map of interrelated events and theoretical issues emerging from the data. This research relies on knowledge gained from observing the overall workflow and how the various healthcare workers as EMS, nurses and doctors in the emergency department work alongside each other as individuals who professionally are part of a pedagogical hierarchy of various levels of professionals in this urban high-volume emergency medical department.

Participant observation in the emergency department allowed for sustained contact in this research setting within the unfamiliar setting of a large urban emergency care center. Narratives derived from observation and interviews with care providers in the emergency department are the primary data sources for this study. Embedded as an observer allowed me to observe the everyday experience and how EMS, nurses and physicians in critical care negotiated their role as individuals, professionals, and in relation to the patients they cared for during their daily work. The observation was over a fifteen month period doing consecutive hours of observation from early morning to early afternoon in the *resus* area of

the emergency department. Consecutive hours of observation were essential to being able to observe complete interactions of patient care by nurses and physicians in their practice and observe their interactions as clinicians and also individuals. UED is located within a large urban teaching hospital with an emergency department that sees over 100,000 patients in the emergency department each year.

I analyzed data by reviewing of daily logs of observations. The logs were detailed notes of each day of observation and transcripts from interviews. I recorded daily interactions in the *resus* and then rewrote detailed logs based on the daily notes. The qualitative interviews were not scripted and were of various lengths based on availability and time allowance of the healthcare workers being interviewed. In the interviews, I had informal conversations with healthcare workers about what was most important to them personally and professionally. The open dialog allowed me to make further inquiry with healthcare workers to ask if they reflect on their role and how it has changed in the time they have been working in the emergency department. Interviewees were invited to freely express any views they had on their work, environment and how they related to production of care in emergency medicine.

Following the suggestions of Miles and Hubberman, I developed a concept map that informed not only the conceptual framework, but also worked to help focus what was most important in the data (Miles and Hubberman 1994). The conceptual framework helps guide the diverse theory involved in this analysis, which involves understanding the theoretical framework on anthropological perspective in moral positions in daily life. Understanding the perspective that is discussed by Laidlaw that individuals within a culture make reflective choices (Laidlaw 2002) informs the use of how individuals within their professional role are

part of a local moral world as noted and discussed by Kleinman (1999a:358) . The conversation and direct observations of the healthcare workers involves interactions, object use that takes the form of technology, instruments and even people. While the analysis was not a conversation analysis study, analyzing the conversations and actions was part of a framework that helped inform my understanding of how the individual, as a professional, places themselves in their work both professionally and personally.

The Teachers College Institutional Review Board (IRB) provided oversight for human subjects protection. The IRB also approved all study procedures and the qualitative interview format and process. The IRB at UED was notified of the Teachers College IRB oversight and given the opportunity to require additional review for the project. The UED IRB considered that review sufficient and required no secondary review of the fieldwork. All names have been changed and the dates coded to protect the identity of the individuals and the institutions involved in this study. All individuals discussed in this study are real and reflect their ongoing lives as they live and work in the often chaotic world of emergency medicine.

Analysis

The methods and analysis used in this study rely on grounded theory. Grounded theory was first described as a method for identifying concepts and theories that emerge from the text and allow the researcher to link these themes to theory (Strauss and Corbin 1998, Glaser and Strauss 1967). While this research is based on generating theory from systematic analysis of fieldwork notes, this research and subsequent analysis was not completely restricted to themes emerging from the notes and includes a broader analytical

framework that allows me to access fields and analysis as diverse as bioethics, medical anthropology, frame analysis, and includes newer developments in moral anthropology. Consequently, and as noted in methods of study, the analysis is informed by both the day to day observations as well as influence of other writings and disciplines.