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Doing Ethnography In An Urban Hospital Emergency Department Setting: Understanding How Culture Was Related To Emergency Physician Habitus

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**ETHNOGRAPHY OF THE HABITUS OF THE EMERGENCY
PHYSICIAN**

by

RENADY HIGHTOWER

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

2010

MAJOR: ANTHROPOLOGY

Approved by

_____	_____
Advisor	Date

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DEDICATION

This research is dedicated to anyone who has ever sought or will seek the advice and treatment of the physician, who has been entrusted with the health and well being of us all, through their ability to deliver quality care to anyone, anytime, and anywhere.

I am humbled to have had the opportunity to study a topic such as this that can potentially affect and influence a person's life in a profound fashion. I am grateful for the chance to learn from those who have been privileged to provide care to those who seek them.

Finally, I am thankful for my church family whose love and support sustained me during the process

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I would like to take this opportunity to thank those who assisted in the process of completing this dissertation work. First, I would like to thank my field research sponsors who allowed me to enter into their emergency departments to observe them work. I would like to thank my committee chair and committee members for the amount of work and time they put into seeing this work come to fruition. Most important, I would like to thank the emergency physicians who took the time to allow me to enter into their world of medicine and patient care as a means of understanding what it means to be a physician in these modern times.

PREFACE

My interest in this research topic began several years ago with my desire to answer the question why African American patients experience poor health status and poor health care outcomes. At that time, I was unfamiliar with the term “health disparities’ and what exactly it entailed regarding understanding the issues and problems associated with African American health.

I chose to pursue doctoral work as a means to study and better understand the meaning and impact of health disparities. My journey through the doctoral program introduced me to the concept of health disparities and the issues related to this unfortunate health care phenomenon. Although my understanding is not complete, other aspect of the physician patient relationship emerged. As a result, I hope the work completed in this dissertation can inspire further work in this area.

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Chapter 1 “Introduction”

This dissertation started out as a study focused on examining the nature of the relationship between culture and the existence of health disparities. The research goal was to contribute to the understanding of health disparities by examining the physician-patient interaction and its relationship to patient care choices. The physician-patient interaction was examined in the context of African American health disparities to see how non-medical factors, such as physician ethnicity, influenced clinical decision-making. The research question asked how the characteristic of physician ethnicity played a role in the decision-making process regarding patient care choices thereby influencing the presence of health care disparities (Weaver & Sklar, 1980).

Sandra Wallman’s (1979) “Ethnicity at Work” helped to structure how to define, observe and identify ethnicity in this dissertation context. Wallman defined ethnicity as the general perception held by members of a cultural group used to distinguish the social boundaries between the group and other sections of the population (Wallman, 1979). The term ethnicity was not a reflection of race or culture: it was the sense of difference that each member experienced as they interacted with persons from other racial or cultural groups (Wallman, 1979). In this dissertation context, the social interaction was the physician-patient interaction that regularly occurred in the hospital emergency department. According to Wallman (1979), observing and measuring ethnicity in action posed a challenge. Therefore, it was prudent to place and analyze ethnicity in a scheme that could be delimited (Wallman, 1979).

Wallman’s (1979) findings dictated that the appropriate research context for observing ethnicity was the work environment or work encounter. In this dissertation

field study the work environment was defined as the hospital emergency department. The work encounter was defined as the physician-patient interaction. Thus, the differences produced by emergency physician ethnicity were based upon how they performed their decision-making process in regards to patient care choices during the physician-patient interaction. Hence, the research question asked and explored was whether or not a connection existed between physician ethnicity and patient care choices; and if so, was this related to the presence of health disparities (Todd et al., 1993).

Through rigorous research methodologies and data analysis no relationship was found between physician ethnicity and health disparities. Instead what emerged from the data analysis was a new focus and direction for further anthropological study. The emergency medicine physician became the new focus of the dissertation study. The aim of the research was to identify and describe the habitus of doing emergency medicine, which included the role of being an emergency physician in the hospital emergency department. The purpose for studying the habitus of emergency physicians as a reflection of their role as a physician is to gain a better understanding of what it means to be an emergency physician in the modern urban hospital emergency department.

The term habitus when used by the emergency physician informants referred to the physical and constitutional characteristics of an individual, especially the tendency to develop certain diseases. Habitus in the context of Pierre Bourdieu's (2005) practice theory was defined for this dissertation in the following manner: all actions, behaviors, and responses performed by the emergency physician as a part of their day-to-day routines. The habitus of the emergency physician was the routine, patterned forms of behaviors practiced daily as an emergency physician seeing and treating patients in the

emergency department. Finally, the habitus of the emergency physician was the essence of doing emergency medicine and being an emergency medicine physician. Habitus incorporated every routine, and practice that reinforced and reproduced the regularities in the system which helped to maintain the structure of the hospital emergency department and the physician-patient interaction. Habitus is the overall gestalt of being an emergency medicine physician and reflected the practices required to practice emergency medicine in the hospital emergency department. Identifying and studying the habitus of the emergency medicine physician provided a clear and distinct framework for understanding what emergency physicians do in their role as a physician and how they performed their duties as an emergency physician in the hospital emergency department.

The use of practice theory is essential to the cultural analysis of emergency medicine and emergency physician habitus because it placed the focus on the social relationships inherent within emergency medicine including the processes and mechanisms used by the emergency physicians in navigating and creating meaning in their role as physicians in the emergency department. Anthropologists have called this particular approach the interpretive paradigm because the social world of the emergency physician was not viewed or understood as an entity unto itself. Instead the social world of the emergency physician was understood as being temporal, historically situated, context-specific, embodying fluidity, while being shaped in conjunction with the researcher. Using the interpretive paradigm permitted the researcher to argue that the social realities of the emergency physician and the emergency department were constructed and derived through the meaning and understanding drawn from the social interactions and experiences generated among the members within the social setting. In

this research context, the research field also included the researcher as well. The most notable and significant anthropologist often associated with this particular paradigm was Clifford Geertz.

Clifford Geertz used the interpretive paradigm to study the meaning of culture (Geertz, 1973). As an anthropologist, Geertz argued that the concept of culture was semiotic in that it was made up of signs and symbols (Geertz, 1973). Members of the culture spun these signs and symbols together in a web of significance during the course of social interactions (Geertz, 1973, Shankman, 1984). Therefore the analysis of culture entailed the sorting out of meaning according to the native's point of view (Shankman, 1984). In anthropological research and according to practice theory, the native point of view was identified as being the research subject or actor's point of view (Bourdieu, 2005, Geertz, 1973). These attributes of the interpretive paradigm meshed perfectly and justified the applicability of Pierre Bourdieu's practice theory in this ethnographic study of emergency medicine and emergency physician habitus.

Practice theory represented the culmination of Bourdieu's intellectual's life work devoted to establishing a social science methodology for studying social life and human behavior in its natural form. Pierre Bourdieu, who wore several hats as philosopher, sociologist, and anthropologist, believed that the true study of social life entailed a detachment from the objectivist-subjectivist dualism associated with sociological and anthropological studies (Jenkins, 1992). One of the reasons Bourdieu found this dualism so unacceptable because the researcher effect it produced upon the object under study (Swartz, 1997). One such effect produced by the researcher is the projection of subjective criteria onto the objective reality observed (Bourdieu, 2005, Swartz, 1997).

Bourdieu was also concerned about the perspective of understanding that was generated by the researcher as an observer in the field of study. According to Bourdieu, many times the researcher generated their understanding of the social phenomenon through their verbal communication with the actors under observation (Jenkins, 1992). In Bourdieu's eyes, this perspective of understanding was lacking in integrity because it made sense of the social life based on the rules received from the value-oriented statements about what it is believed *ought* to happen, as opposed to the valid *description* of what really happened (Jenkins, 1992). In other words, when questioned by the researcher the informants usually responded based on what they thought the researcher wanted to hear (Jenkins, 1992).

Bourdieu saw this event as not only distorting the view and understanding of the true nature of the social life and social action, but it over emphasized the values, beliefs, and models associated with the actors and the social action. Bourdieu refuted this by defining and stating that social life was in fact, "...in its very nature, fluid, diachronic and mobile" (Jenkins, 1992, p. 49). Thus, the ability of practice theory to bypass the objectivist-subjectivist dualism often associated with sociological and anthropological research allowed sociology and anthropology to become the forensic science of the autopsy of social life and human behavior (Jenkins, 1992). This element of practice theory made it the most appropriate tool for studying emergency medicine and emergency physician habitus.

The anthropological study of emergency medicine and emergency physician habitus was undertaken for the following reasons. First, the hospital and the emergency department are not known to be traditional field sites for ethnographic study. Gaining

entry into the hospital and the emergency department was generally off limits due to the general defensiveness of the hospital administrators (van der Geest & Finkler, 2004).

Second, hospital ethnographies were scarce in anthropological literature because of the universal appeal of hospitals as being deceptively familiar in their scope and organization (van der Geest & Finkler, 2004). In general, hospitals differ in terms of scope and function: some are mission driven others are for profit. In their explanation for the lack of hospital ethnographies, the researchers Sjaak van der Geest and Kaja Finkler (2004) pointed to the fact that the attributes of a bureaucratic nature, division of labor, and medical nomenclature conspired to make all hospitals appear similar in appearance and in function. Like western biomedicine, these outward adorning characteristics imputed to hospitals the characteristic of being inherent with the universal principles of biomedicine; thereby disguising them as having uniformed structures and functions across cultures (van der Geest & Finkler, 2004).

Third, examining the cultural characteristics of the hospital and its emergency departments fell within the scope of anthropological study. After taking into account the variations in nature of the hospital environments, it became easier to appreciate the plurality of western biomedicine. The rationale for this assumption was grounded in the perception of the hospital institution as being the premier institution and extension of biomedicine cross-culturally (van der Geest & Finkler, 2004). Seeing the hospital in this context provided the needed opportunity for social science researchers to recognize that broader social and cultural processes were occurring in the hospital, including the emergency department (van der Geest & Finkler, 2004).

The premises stated above dispelled the assumption of the hospital and the emergency department being uniform cultural entities. Instead the hospital ethnographies of van der Geest & Finkler (2004) and Sjaak van der Geest and Samuel Sarklodie (1998) expanded the cultural and social image of the hospital and emergency department in the following two ways. First, the hospital and emergency department was not viewed as a place of universal practice, but as a place capable of reflecting the surrounding cultural and social environments. Second, the hospital was understood as representing the domain where core cultural values and beliefs came into existence through the practice of its participants.

The Problem Statement

To properly examine the meaning associated with being an emergency medicine physician, an ethnographic field study was performed in a hospital emergency department setting. The purpose of the ethnography was to explore how culture was related to emergency medicine, the hospital emergency department, and the habitus of the emergency physician. The goal of the study was to identify the habitus associated with being an emergency medicine physician in the emergency department; and to identify what emergency physicians experienced during the physician-patient interaction. Specifically, this study had the following two specific goals:

1. To describe how popular culture reproduces emergency physician habitus;
2. To describe how emergency physician habitus is related to the structure and function of the emergency department, and the physician-patient interaction

This study is significant because it used the physician-patient interaction as a means to discover and describe the cultural values, and beliefs internalized within the

emergency medicine physician. This study also emphasized the non-biomedical aspects of medical care and medical training. This research is also significant because it contributed to anthropological literature on hospital ethnographies by addressing the social and cultural domains of the hospital and the emergency department. Most importantly, the study was meaningful because the results could be valuable to emergency physicians and their hospital administrators.

The methodology followed in this study was rigorous and reflected a research process that used triangulation as a means to ensure the validity of data collection and analysis. Triangulation was the process of using more than one method of collecting data. The methodologies used to collect data included ethnography, in-depth interviews, and a content analysis of a cultural text. Collecting data via triangulation allowed the researcher to approach the study of emergency physicians from a different angle and to verify the internal validity of the data collection process.

Delimitation of the Study

The following factors contributed to the delimitation of the research in terms of generalizability. First, the true value of participant observation was not attained because I was not licensed or trained in emergency medicine. Therefore I was the non-participant observer in the field setting. Second, the sample size of the study was small, 17 informants was recruited. In-depth interviews along with observations of the informants in the natural field setting of the emergency department was used to produce a more complete image and understanding of what emergency physicians do and how they function in the hospital emergency department.

Finally, this dissertation study did not pay particular attention to the relationship between culture and social class. Sociologists and anthropologists acknowledge that class is a central part of American culture and an essential element in American social life (Ortner, 1991, 165). In American culture it is considered a taboo to speak of our society or to refer to persons using the term or concept of class. Yet, the existing complex dynamics between culture and class were responsible for producing the inherent social class structure in American society (Ortner, 1991). In American culture, class can be expressed by ethnicity, race, or language (Ortner, 1991). Bourdieu (1991) saw class as reflecting groups of actors occupying similar positions in a social space. Unfortunately, anthropological research has often failed bringing the study of social class into an analytical focus (Ortner, 1991). In this regard, this dissertation followed the way anthropologists have done research in the past in using the term ethnicity as the object of research focus.

Outline of Chapters

The second chapter, Literature Review, presented the particular aspects of past research believed to be important and necessary in studying the relationship between emergency medicine and culture. Traditional anthropological empirical research from W. H. R. Rivers, Arthur Kleinman and Robert Hahn provided the background for placing medicine, and therefore emergency medicine, in the context of culture. Anthropologist Deborah Gordon's work on the cultural aspects of biomedicine-helped lay the theoretical argument that justified biomedicine and therefore emergency medicine as cultural entities. Following the conceptualization of medicine and emergency medicine as

culture, Bourdieu's (2005) practice theory was used to frame the study of being an emergency physician and the behavior of the emergency physician as a form of habitus.

The next chapter, A Cultural History of Emergency Medicine was the beginning point for considering how culture influenced the development of emergency medicine. The sources used to describe the history and development of this medical specialty gave indication of how culture, in terms of social and cultural issues, can impact and influence the practice of emergency medicine, and emergency physician habitus.

The Methodology chapter embodied several goals. First, the chapter presented the pilot research project that served as the foundation of this dissertation. Second, the chapter presented the research methods used and data analysis involved in the ethnographic study of emergency physician habitus and culture. The objective of this chapter is to give an exhaustive account of the field research process, and the cumulative effect of the knowledge and insight gained from each step of the research study. The most important attribute about the methodology used was that it reflected an evolving research approach that assumed a more definitive shape over the course of the study.

In chapter five, The Relationship between Culture and Emergency Physician Habitus, practice theory was used to identify and explain the connection between popular culture and emergency physician habitus. The application of practice theory not only allowed for the acknowledgement of the reciprocal relationship between culture and the individual; but also permitted the opportunity to understand how culture shaped the experiences and behavior of the physicians to external events. The focus of this chapter centered on answering the following questions: 1) how popular culture reproduced

emergency physician habitus; and 2) how popular culture created emergency physician habitus.

The sixth chapter, *The Habitus of an Emergency Department* covered how emergency physician habitus influenced the system structure of the emergency department and the physician-patient interaction. The goal of the analysis is to answer the following questions: 1) how does physician habitus shape or influence the system of the hospital emergency department and the physician-patient interaction; and 2) how does emergency physician habitus alter the structure of the emergency department and physician-patient interaction.

The final chapter, *Summary and Discussion*, discussed what was learned during the process of this dissertation study. Next the chapter covered how this research is beneficial to future ethnographic studies of the hospital and emergency department environments. Finally, the chapter addressed the implications of this research approach regarding the future study of health disparities in emergency medicine.

The Research Setting

The urban area in Michigan that set the stage for this research was Detroit, Michigan. Two field sites were chosen for the research study as a means of comparing various hospital emergency department settings and environments. The first site was located in the urban setting of Detroit Michigan and was the main campus of the health system. This site was categorized as a Level I trauma center within a teaching hospital and research institution. Level I trauma means that the most serious, life threatening trauma cases are seen and treated in this hospital emergency department field setting.

Finally, the patient population typically seen and treated in this field setting is predominately African-American.

The second field site was a much smaller satellite location in suburban Dearborn Michigan. The satellite site was not categorized as a Level I trauma center. The trauma cases seen at this location were initially received, stabilized, and later transferred to the main campus location for advanced care and treatment. The site was neither a teaching nor research institution. Residents that rotated through the satellite setting were primarily in pediatrics. The field site had a mixed patient population: African-American, White (Indo-European), Chaldean, and Arab.

Finally, Laura Nader's (1982) perspective of studying up was applied during the research process. The traditional focus of anthropological research has always been placed on the observation and study of the cultural values, beliefs, and practices of persons occupying the subordinate position of the dominant-subordinate relationship (i.e. studying down). In these classical anthropology studies, the unit of analysis is identified as being the tribe, or indigenous people of a particular society, culture, or community. In medical anthropology, the less powerful position in the dominant-subordinate relationship is always identified as being the patient. In anthropological literature, research studies have produced a wealth of knowledge and understanding pertaining to the values, beliefs, and practices of patients.

Nader (1982) defined the perspective of studying up as studying the values, beliefs, and practices of those who occupied positions of power in society. In the context of this field research, studying up provided a means and opportunity to observe those directly involved in the provision of care to patients. According to Nader (1982),

Chapman and Berggren (2005), studying up not only gives access to the physician, but also presents the opportunity to expand and contribute to our understanding of social processes in medicine by focusing on those who *provide* the care (Chapman & Berggren, 2005; Nader, 1982).

The perspective of studying up shifted the focus from being one-dimensional to incorporating the study of those in position of power. Nader recognized the importance of both studying up and down in terms of the consequences that resulted when the perspective of studying up is ignored. Incorporating the perspective of studying up did not allow the researcher to occupy the position of dominance in field setting. As a result, the fieldwork and data generated was not skewed in favor of the anthropologist and was not lacking in the degree of understanding regarding informant's involvement in social interactions.

Second, the perspective of studying up enhanced the researcher's ability to ask the questions that could inspire and alter our way of viewing and understanding the social dynamics occurring in the physician-patient interaction. As a result, the researcher had a better chance of recognizing the true value and meaning of the relationship between emergency physicians and patients in the research design. As Nader (1982) pointed out in her essay addressing the perspective of studying up, people are not isolated in society they exist in relations to others in society. Hence, studying up created an avenue for generating a wealth of knowledge and understanding regarding the values, beliefs and practices associated with being an emergency physician, the habitus of an emergency medicine physician, and the profession of emergency medicine.

Definition of Terms

- **Habitus:** a term used in practice theory to denote the generalized behavior, action, response of participants in a cultural system or environment
- **Practice:** a term used to describe the smaller units of behavior, responses, and actions that make up the habitus
- **Culture:** an anthropological term used to describe the characteristic values, beliefs, and norms that are learned and associated with a particular cultural entity, or organization system
- **Studying Up:** an anthropological perspective that focuses on those that are in the position of power
- **Primary Care:** the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community (IOM, 1996)
- **Informant (i.e. research subject):** the subject of the dissertation study who provided the views, beliefs, ideas, and perceptions associated with their experiences of being an emergency physician
- **Non-Emergent Care:** defined in the context of the expanded role of emergency physicians; the provision of care to patients presenting to the emergency department with non-injured, non-critical, and non-trauma conditions

- Emergency Physician: a specialist trained to immediately recognize, evaluate, and respond to life threatening, limb threatening, acute illness, and disease

Chapter 2 “Literature Review”

Introduction

At the present time, there are only three models of emergency care systems in existence: 1) the European model, 2) the Anglo-American model, and 3) the neglect model. In the European model the resuscitation and triage of critically ill patients are delivered to the patient away from the hospital setting. Once they are stabilized, the patients are transported to the appropriate area for care. Unlike the Anglo-American model, there aren't specially trained emergency medicine physicians at the hospital facility. Unfortunately, the third model prevails in societies where emergency care services are not considered to be a national priority (Rainer, 2000). Lastly, the Anglo-American model of emergency medicine is the focus of this dissertation.

The Anglo-American emergency medicine system was defined by the following three criteria. First, the model consisted of highly trained, specialized physicians trained in emergency medicine. Second, the emergency medicine physicians were hospital-based and trained to evaluate all patients presenting to the hospital emergency department. Third, the training in emergency medicine focused on the prevention of untimely death and life-threatening or limb-threatening disease and illness with the ability to sustain life through the use of resuscitation techniques (Rainer, 2000).

To adequately study how culture was significant to emergency medicine required that emergency medicine be viewed as culture, and placed in the context of culture. Taking this approach provided the foundation for this dissertation study. Anthropologists, in the past and present, have observed and studied human action and interaction, as each of these areas represented patterns of human behavior that reflected the learned cultural values, norms and beliefs found within the society or culture. In

medical anthropology, researchers have expanded their studies to include the investigation into the relationship between disease, illness, and culture. For example, medical anthropologists would investigate the causes for high rates of disease within a culture as an indicator of how its own health care system was addressing or failing to address the needs of the patient population (Bailey, 2000).

Placing emergency medicine in the context of culture highlighted the following cultural model characteristics: 1) emergency medicine was a distinctive domain and system of ideas; 2) emergency medicine had a clear division of labor; 3) emergency medicine had clear practice roles, rules, and regulations; 4) emergency medicine had an intrinsic socialization process that characterized it as a system; and 5) emergency medicine encompassed its own enterprise of knowledge construction (Kleinman & Hahn, 1988). The sixth and most important criterion used to place emergency medicine in the context of culture was the fact that the Anglo-American model of emergency medicine has become *the cultural model* to developing countries and nations outside the United States (Millard, 2008).

Studying emergency medicine as a cultural model increased our understanding of this medical subspecialty and the role it plays in the delivery of health care services. Studying emergency medicine in the context of culture revealed how culture was influential in the development of this medical specialty. Most importantly, studying the connection between emergency medicine and culture contributed to our knowledge and understanding of how emergency physicians view and understand their role as healthcare providers.

The Study of Medicine as Culture

The study of medicine as a reflection of culture is known as medical anthropology. In their discussion detailing the history of medical anthropology, Merrill Singer and Hans Baer acknowledged that the father of medical anthropology, W. H. R. Rivers disputed, "...biomedicine is grounded in natural laws and scientific principles" (Singer & Baer, 2007, p. 14). As the debate regarding the legitimacy of biomedicine distinctiveness continued, more and more anthropologists and social scientists recognized how the influence of culture can be observed in the practices of biomedicine (Singer & Baer, 2007). Thus, the corollary of this argument is that many of the ideas and practices within biomedicine are not based solely on scientific principles (Singer & Baer, 2007).

Deborah Gordon's essay "Tenacious Assumptions" (1988) gave insight and clarity into understanding the cultural nature of biomedicine's ideas and practices. In her essay, Gordon (1983) critiqued biomedicine for its continued insistence on being separate, neutral, universal, and scientifically driven. She pointed out early in her essay that although biomedicine was characterized as being biological reductionism, studies proved that biomedicine constitutes and was constituted by culture and society (Gordon, 1988). Gordon acknowledged how these studies have also shown that biomedicine was not the universal against which all other medical systems aligned themselves. In fact, Gordon, Rivers, Singer and Baer and others have acknowledged that biomedicine was one of many systems of medicine existing in anyone particular cultural environment (Gordon, 1988; Rivers, 1927; Singer & Baer, 2007).

This perception of biomedicine was understood as representing a paradigm shift. In this view, culture and society influenced the knowledge, ideas, and practices within

biomedicine, which were perceived as “eminently and irreducibly social and cultural” in nature (Gordon, 1988, p. 20). To support her argument Gordon relied on the works of several noted anthropologists such as Howard Becker, Robert Hahn, and Arthur Kleinman among others (Becker et. al, 1961; Hahn & Gaines, 1985; Hahn & Kleinman, 1983). What was revealing and pertinent in regards to the nature of this dissertation was how Gordon illustrated the evolution of biomedicine as a product of western culture and society (Gordon, 1988). For example, Gordon pointed out how in its evolution, biomedicine became its own object of study in that researchers were able to identify, describe, and explain the hidden cultural attributes along with the social processes that shaped the practices and knowledge within biomedicine (Gordon, 1988).

The hidden cultural attributes that Gordon identified in her essay fell under the title of ‘tenacious assumptions’, which was the title of her essay (Gordon, 1988). Gordon used the word tenacious as a way to describe the origins of many of biomedicine’s assumptions and practices. The two cultural sources identified in her essay and chosen for discussion regarding the nature of biomedicine were the two major western traditions of naturalism and individualism (Gordon, 1988). Gordon used the tradition of naturalism to refer to science; and used the term individualism to refer to a complex system of values and assumptions, which asserted the primacy of the individual and individual freedom. Based on these distinctions, Gordon addressed the claim of biomedicine as being autonomous from such influences as social, culture, and religion. Gordon was able to accomplish this by challenging biomedicine’s tenacious assumption of being autonomous from society and culture. For example, Gordon showed how biomedicine sustains the idea of the modern identity by advocating independence from society and culture while

becoming the central stage in the promotion of patient rights and autonomy (Gordon, 1983). In this example society was using the social space of biomedicine to assert the values of autonomy, and individualism (Gordon, 1988). Gordon's discourse on the hidden cultural assumptions of biomedicine was important to this dissertation in that it supported this study's hypothesis of an existing relationship between culture and medicine.

Deborah Lupton (1994) introduced the idea of medicine as culture by recognizing how current social pressures and issues regarding the delivery of adequate health care produced a paradigm shift in the study of health care, illness, and the social role of medicine. Anthropologists responded to this shift by studying health and illness through challenging biomedicine's claim that their medical knowledge reflected truth and was politically neutral (Lupton, 1994). In other words, current social problems and issues surrounding the delivery of health care demonstrated that medicine is not independent of social and cultural influences. The social factors influencing medicine are expressed in terms of the economic conflicts known to influence the development of medicine by creating new hierarchies of power and authority (Starr, 1984). Even in the health disparities literature anthropologists believe that disease is an embodiment of culture and is displayed as a form of violence upon the human body; and measured or reflected in terms of differential disease rates (Nguyen & Peschard, 2003).

Lupton's (1994) argument for viewing medicine as culture derived from her examination and discussion of the sociocultural dimensions of medicine in western societies. Drawing upon the interdisciplinary scholarship and research from the sub-disciplines of medical sociology (sociology of health and illness), the history of medicine,

and medical anthropology, Lupton (1994) was able to link together the different theoretical perspectives she felt that reflected an informed understanding of medicine's sociocultural dimensions at the close of the 20th century. Lupton viewed medical knowledge as the inevitable product of social relations, emphasizing that essentially disease and illnesses were experiences, which should be interpreted by social activity (Lupton, 1994). Therefore, in our multicultural society physicians must be cognizant of their patient's sociocultural background in order to deliver quality health care services (Carrillo et al., 1999).

Lupton's work was considered important to this dissertation study because it showed that a paradigmatic shift had occurred in our understanding of medicine. This paradigmatic shift helped to free medical anthropology from its close link with biomedical practice, which permitted anthropologists to become more institutionally useful (Lupton, 1994). In this aspect, the anthropologist no longer categorized the patient as a constellation of unknown meaning; nor continued to uphold the assumption and belief that biology and therefore biomedicine was a universal constant; nor continued to view culture as external to disease, and illness (Lupton, 1994). In this paradigmatic shift, the medical anthropologist is now able to study and examine how culture and society impinged upon, altered, and changed the health status of the patient (Lupton, 1994).

Lupton's (1994) theoretical perspective on medicine as culture acknowledged the importance and relevancy of cultural studies and how such studies were able to produce invaluable insight regarding the sociocultural aspect of medicine. Lupton advocated in her discussion how the interdisciplinary nature of cultural studies could be used to reveal

the structures through which people, and society assigned meaning to experiences, and practices of a social institution such as western biomedicine (Lupton, 1994).

Most scholars and researchers in medicine and health tended do not view medicine as a product or an aspect of culture. A cultural studies framework offers an avenue for studying, and analyzing the characteristic of western biomedicine as a reflection of culture (Lupton, 1994). Finally, Lupton's cultural studies discussion provided the framework and support for cultural studies analysis on biomedicine.

Hahn and Kleinman's (1983) work entitled "Biomedical Practice and Anthropological Theory" supported the belief that biomedicine was in fact a sociocultural system. The purpose behind the essay was to promote and highlight the call for a theoretical development of an anthropological cultural study of medicine (Hahn & Kleinman, 1983). According to Hahn and Kleinman (1983), biomedicine was an artifact of human society for several reasons. First, biomedicine was a reflection of the cultural framework of values, premises, and problems taught and experienced through the social interaction between the physician and the patient. Second, the cultural nature of biomedicine was demonstrated at the institutional level through the social division of labor (Hahn & Kleinman, 1983).

When Hahn and Kleinman (1983) called biomedicine a sociocultural system, they avowed that they were not denying its physical and materialistic reality. But rather, they were promoting the exploration of its sociocultural dimension. According to Hahn and Kleinman (1983) the following five features supported the sociocultural status of biomedicine: 1) biomedicine was its own distinctive domain; 2) biomedicine had a clear division of labor; 3) the social relations in biomedicine were defined by roles, rules etc;

4) biomedicine was reproduced through a socialization process; and 5) biomedicine produced its own knowledge (Hahn & Kleinman, 1983). These five characteristics of biomedicine were important because they provided a framework for an anthropological theory in the study of medicine as culture.

Hahn and Kleinman (1983) considered the distinctive domain of biomedicine as the indicator of its sociological properties even though its participants (physicians) emphatically insisted on distinguishing medicine from society, and all other institutions such as religion, politics, and art. Hahn and Kleinman referred to those few practitioners who uncharacteristically supported their claim by proclaiming that the foundation of biomedical theory and practice rests upon art as well (Hahn & Kleinman, 1983). In their discussion of this point, Hahn and Kleinman admitted to seeing the art expressed in medicine in many ways. For example, art was expressed in the way physicians intuitively applied biomedical science to a patient's conditions in the non-medical expression of bedside manner in patient care (Hahn & Kleinman, 1983).

Finally, Hahn and Kleinman (1983) reminded us that biomedicine, like any other sociocultural system, continually remade nature; while, nature continually remade biomedicine. In this aspect, biomedicine was viewed as a product of the dialectic relationship between culture and nature, operating at both the individual and society levels. Society and the individual worked collaboratively to construct their cultural realities and understanding of illness and disease; including the rules governing their response to and their theories about the origins of disease and illness (Hahn & Kleinman, 1983). Their collaborative efforts produced a socially constructed ethno medical cultural guide that they each used and relied upon in making their responses to events.

Byron Good's (1994) work with the medical students at Harvard University illustrated the cultural significance of biomedicine's systems of meanings in his book "Medicine, Rationality, and Experience". Good unveiled in his book how physicians were taught a new way of seeing, speaking, and writing. Moreover, learning this new way represented how physicians produced knowledge and gave meaning in their world of medicine that eventually became their new reality when interacting with patients during the medical encounter. In other words, physician practice derived from the culture of medicine learned in medical produced structure, defined reality, and gave meaning to their work as doctors when interacting with patients during the physician-patient interaction.

What was relevant about Good's work with the Harvard Medical School was that it reflected an ethnographic account that described how medical practice was embedded in culture (Good, 1994). Good's ethnographic work is important because it supports the argument that medicine is indeed embedded in culture (Good, 1994). Second, Good's research at the Harvard Medical School presents empirical evidence demonstrating how an aspect of medical practice, what he termed the 'formative processes', actually shapes illness into a personal and social reality (Good, 1994).

In summary, the greatest contribution that anthropology made regarding twentieth-century knowledge is the insistence and belief that human knowledge is culturally shaped, and constituted in relation to distinctive forms of life and social organization (Good, 1994). Culture, when defined as patterns of organized clusters of significant symbols, represents what people use to give meaning to events in their lives (Geertz, 1973). Anthropologists, specifically medical anthropologists in their study of

biomedicine (contemporary medicine) have been careful to demonstrate how local medical knowledge is not arbitrary, but grounded in a 'seamless web' of local culture (Gordon & Lock, 1988). Studying medicine as a symbol of culture entailed examining the meanings and values implicit in its knowledge, practices, and social processes (Gordon & Lock, 1988). In our society, western medicine represents the core of our soteriological vision (Good, 1994). Medical anthropologists recognize that health care is a culture that is integrated and interrelated to others aspects of society such as, economics, politics, social issues, and cultural perceptions of health care (Bailey, 2000). Therefore, medical anthropologists are the most equipped to study and examine how cultures formulate their medical knowledge and reality in distinctive ways (Good, 1994). Based on the preceding discussion, medicine was viewed and defined in this dissertation as an example of its own cultural system. As a subset of medicine, emergency medicine was therefore viewed and understood to be its own cultural system.

The Research Framework

Pierre Bourdieu's (2005) practice theory provided the theoretical framework to study and understand the connection between culture and physician practice. Practice theory was the most appropriate theory for this dissertation study because the center of attention and focus was on the human action and interaction of the actor's within the cultural system. The choice to use this theory also rested upon the knowledge that practice theory possessed the ability to remove the likelihood of researcher bias that often obscures the ability to observe the purity of social actions. To overcome this, the researcher must be placed in the center of action in the field of study. When this occurs, the researcher is presented with the opportunity to ask some important questions such as,

how does culture work? Or how does culture influence, or shape physician practice? Based on this scenario, practice theory presented the best explanatory model for determining if a relationship existed between culture and physician practice: and for explaining what brought such a relationship into existence.

In anthropological field study, practice theory is often used as a model to help explain the meaning of social practices in the context of culture (Ortner, 1984). Practice theory defines social practices as being all patterns of social life, with particular attention paid to what people do in daily living (Jenkins, 1993). In the application of practice theory to emergency medicine, social practice was defined as human actions, practices, and behaviors that are performed both intentionally and unintentionally by the emergency physician (Ortner, 1984). Practice theory considers culture to be the mediator that unifies mankind by presenting the opportunity to walk in the shoes of others in order to understand how things are learned and done in practice (Jenkins, 1993). Clarity of this assumption was taken from the work of Richard Jenkins (1992) who expounded upon the thought, ideas, and writings of Pierre Bourdieu in relation to practice theory.

In his introduction to Bourdieu, Jenkins shows how Bourdieu believed in the commonality that exists among people in the way they related to culture (Jenkins, 1993). Jenkins used Bourdieu's term "psychic unity" to express the commonality between people: "cultures may divide the people of the earth, but in their relation to culture—how they learn it, handle it, modify it, draw upon it as a resource—they have more in common than not" (Jenkins, 1993, p. 50). Thus, practice theory and the focus it places on how things are done presented the opportunity to observe from the standpoint of the emergency physician how their practice was related to culture.

Practice theory provided the necessary framework for shifting the paradigm for exploring and understanding how we view physician behavior and its relationship to culture in the clinical setting. The purpose of using practice theory was to identify and explain the relationship between physician practice and culture (Ortner, 1984). As a participant observer, I was able to see how culture functioned in the hospital emergency department. In contrast, the understanding that the emergency physician informants had of how the hospital emergency department operated was different because it did not take into account the element of culture. In her discussion of practice theory, anthropologist Sherry Ortner (1984) saw practice as representing those things that people did as actions that are not only highly patterned and routine and systematically reproduced but became culture over time (Ortner, 1984). Therefore, to accommodate the discrepancy the goal of this dissertation research was to use anthropological theory and method to observe and understand how culture played a role in the hospital emergency department.

In her analysis, Ortner highlighted another important aspect of Bourdieu's practice theory in how the actions and behaviors inherent in practice were in fact structured by the cultural orientations and principles of the institutions, and organizations found within the cultural system (Ortner, 1984). The system structures found within a culture can shape and are shaped by practices as well. This reciprocal relationship between practice and system structures resonated of the existing relationship between practice and culture. In other words, the governing principles of the corresponding institutions and organizations known as culture influenced the everyday social practices of people, including the practice of emergency physicians (Ortner, 1984). In the final analysis, the paradigm of practice theory viewed the elements of social life as constituting

practices and individual experiences derived from the interactions of practice with culture through social structures. The outcome of this process produced a characteristic orientation that results in what Bourdieu calls the habitus (Ortner, 1984).

Habitus

In practice theory an asymmetrical relationship exists between the system and human action, and between practice and culture (Ortner, 1984). The outcome of this asymmetrical relationship is the creation of habitus. This term habitus was used to represent the capacity of people to exercise mastery over their social situation, and interactions (Ortner, 1984). Viewing physician practice and even behavior in this manner was appropriate for this analysis because physicians were culturally perceived as professionals, always in control and having the ability to master not only their profession but the lives and health status of their patients as well. Specifically, habitus represented the actor's ability to improvise in the enactment of a routine behavior that was continuously shaped by the underlying principles of the system; while continuing to being reshaped by those same principles through their world of public observation and discourse (Ortner, 1984). Based on this element of practice theory, habitus was the perfect description of how physicians were perfected and how they routinely performed in their day-to-day interactions with patients in the hospital emergency department.

In this dissertation study, human action and practice were defined as representing the actions of the emergency physician, such as decision-making and pragmatic choice, which they routinely performed in the emergency department. The system was defined as representing culture and was operationalized at three levels: global, macro, and micro. At the global level, the system was defined as representing the cultural institution of

emergency medicine including the formal doctrine, education, and training in medicine the physicians received. This cultural institution is responsible for administering the knowledge and required practices expected of all physicians. For example, during training socialization process takes place in which the physicians learn the behaviors and actions necessary for reproducing the principles of biomedicine and in becoming a doctor (Becker et al., 2007). This theoretical framework was supported by Byron Good's work at the Harvard Medical School in which he described the training process of becoming a physician as incorporating learning a new way of seeing, writing, and speaking (Good, 1994).

At the macro level, the hospital emergency department represented the system. As a facility, the emergency department represented the cultural norm that served to reinforce and influence the practices and behaviors learned during the socialization process called medical school. The emphasis in this cultural system was on reinforcement because this was the place where the emergency medicine resident (i.e. novice) began to *practice* their behavior, skills, knowledge, and abilities learned in the cultural socialization process in medical school. Once residency training was completed, the emergency medicine resident assumed the position of staff physician and began to practice the full role and responsibility of emergency physician that is communicated through the display of habitus in the delivery of health care services. At this level, the emergency department shaped and was shaped by the principles and practice of emergency medicine. Hence, the emergency department shaped and was shaped by physician habitus.

At the micro level the system was identified as being the physician-patient interaction. In the emergency department, the emergency physician resident demonstrated and practiced what they learned in medical school training during the physician-patient interaction. The practices performed by the emergency physician during the physician-patient interaction demonstrated their mastery and control over the patient, the environment, time, and space. Observing the physician-patient interaction was the perfect research field to witness how physician practice became habitus in the hospital emergency department. Observing the process of practice intersecting with culture illustrated the ability of habitus to capture and reflect the *practical* mastery that emergency physicians exercised in the social situation of the physician-patient interaction. For example, during the physician-patient interaction the emergency physician at some point improvised their practices in response to both clinical and non-clinical stimuli based on culture and social cues such as the patient's reason for visit, the incoming trauma or resuscitation case, or treating non-emergent cases. In this scenario, the habitus of the physician represented the intersection between culture and practice.

At other times, the habitus of the physician represented the intersection between practice and society. For example, there are times when the physician must be cognizant of the patient's social situation and how this may affect their medical condition. In this case, the habitus of the physician improvised to adjust for such social indicators as patient living alone, whether they engaged in self-destructive behaviors such as substance abuse, smoking, and if they had insurance. When encountering patients with the aforementioned social indicators, the habitus of the emergency physician changed to meet the needs of the patient and in some cases could affect the course of treatment.

In general, the system (albeit emergency medicine, the medical school training process, the emergency department, or the physician-patient interaction) shaped habitus by the way in which it defined the physician's world, limited or constrained the use of their conceptual tools, or restricted their emotional repertoires (Ortner, 1984). Habitus shaped the system by the way it reproduced the enactment of rituals that reflected cultural values, and norms. Most importantly, practice theory enabled the researcher to study habitus as a way to understand how the system was produced, reproduced, and how the system changed in the past or may be changed in the future (Ortner, 1984). Instead of studying physician habitus as unidirectional, the paradigm of culture was used to measure the product or outcome of patterned human relations that was capable of shaping our behavior and experiences within the cultural system.

The benefit of using practice theory was that it enabled the researcher to overcome the dichotomy between theoretical knowledge and expert knowledge. Bourdieu defined theoretical knowledge as being "...knowledge of the social world as constructed by outside observers" (Calhoun et. al., 1993, p. 3). For example, the knowledge that the researcher brought to the field setting would be defined as theoretical knowledge. Whereas, expert knowledge was defined in the following manner: "...knowledge used by those who possess a practical mastery of their world" (Calhoun et al., 1993, p. 3). This particular knowledge referred to that knowledge base that the informants learned, and practiced from day-to-day. This aspect of the theory was crucial because it ascribed validity to the informants' conceptions of their world without simply "...taking those conceptions at face value" (Calhoun et al., 1993, p. 3). Finally, overcoming this opposition was important because it placed the science and the researcher on the same

level in that both were perceived as being part and product of their social universe (Calhoun et al., 1993). Based on this reasoning the scientific field could lay no claim or invoke special privilege because it too was "...structured by forces in terms of which agents struggle to improve their position" (Calhoun et al., 1993, p. 3).

Certain characteristics about anthropology made it the most appropriate discipline for studying the relation between physician habitus, and culture. First, anthropology had strong methods, theory, and practice, which contributed to its ability to increase our understanding of the social processes involved health. These qualities also helped to identify opportunities for interrupting those social processes. Anthropological methods provided a framework for avoiding "...the pitfalls of methodological individualism ...", universalism, and "...unidirectional causation" (Nguyen & Peschard, 2003, p. 447).

Second, the trend within anthropology has been the movement away from studying poverty and the impoverished and to actively look at the ways in which cultural, social, and economic hierarchies affected communities (Chapman & Bergreen, 2005, p. 149). This movement in anthropology influenced this dissertation in the following manner. First, this anthropology movement produced a shift in research focus that helped define other aspects involved in the delivery of patient care. For example, focusing on the emergency physician revealed how culture through individual experiences influenced not only the physician-patient interaction, but the hospital emergency department as well. Second, this movement in anthropology in conjunction with practice theory helped formulate the research questions used to examine the dynamics between non-medical factors such as culture and the physician-patient interaction. For example, one question asked during one-on-one interviews with the research informants was "What non-medical

factors do you typically use in making a decision?” Third, practice theory along with the shift in anthropological focus influenced the approach taken in this dissertation because it placed the focus on examining the relations between the individual and society. For example, observing the dynamics between the individual and society suggested that the two entities were not independent of one another. Instead, the individual was understood as being an extension of society expressed through the decision making process (Swartz, 1997).

Third, the anthropologist used fine-grained ethnographic studies as a tool to thickly describe the manner in which people lived and interacted in their environment. The thick descriptions produced represented powerful and pertinent records of how social process was created (Chapman & Bergreen, 2005, p. 149). Finally, in the context of this dissertation, anthropologists were the ethnographers capable of not only documenting how institutions disrupt people’s lives; but also, how those who were disenfranchised interacted within the institutions that disrupted their lives (Chapman & Bergreen, 2005, p. 149). The ethnography afforded the anthropologist the opportunity to become submersed in the field setting while permitting the accurate observation and recording of the informants’ life. In doing so, the anthropologist was able to maximize the validity of the research data in ways that “...questions generated in laboratories, or by persons unfamiliar with cultural realities, simply cannot” (Chapman & Berggren, 2005, p. 151).

A Cultural Study of Emergency Medicine

Lupton’s (1994) cultural studies discussion provided the background and support for the cultural studies analysis done in this dissertation study. To understand how culture influenced or shaped physician habitus, I studied one of the major cultural sources for

explicit values, meanings, and beliefs associated with emergency medicine and emergency physicians, the TV program “ER”. I identified this program from both popular texts (O’Connor, 1998; Brodie et al. 2001; Jacobs, 2001) that described its centrality in forming public attitudes and beliefs about medicine, and from interviews with the physician informants themselves. The cultural studies discussion was especially relevant to this dissertation study in that it touched on how mass media (TV) could be used to support the position, and belief practices of a powerful social group such as western physicians and the social institution of western medicine (Lupton, 1994, p. 17).

The purpose for examining the TV drama “ER” was to determine the cultural perception of the emergency physician’s role in the delivery of health care. Because so many patients who were poor, indigent, uninsured or African American receive their health care through the emergency department, I selected the emergency department as a place of research. The mission of the emergency department was to see and treat patients experiencing a medical crisis. Treating patients in the emergency department experiencing other forms of medical crisis was a potential source of role conflict. To understand the goal conflicts that this created for the emergency physician and to get a sense of their values and beliefs, a cultural analysis of the television drama ER was completed.

The cultural studies frameworks for the TV show “ER” fit appropriately within the context of Pierre Bourdieu’s work and theory regarding the relationship between TV media and cultural production (Hesmondhalgh, 2006). Bourdieu’s theory on TV and cultural production was limited in that: 1) he never addressed what happened to cultural production since the middle of the 20th century; and 2) his study was primarily on the

relationship between television journalism and journalism and other fields of cultural production (Hesmondhalgh, 2006, p. 212). Critics based their critique of Bourdieu in this area on the idea of his lack of attention to this form of cultural production. In response to this critique of Bourdieu's work, it was noted that he did look at other forms of cultural production. In spite of such criticism, media scholars (Couldry, 2003; Hallin & Mancini, 2004) have continued to refer to his work and theory as a means of assisting them in the development of their theory and work on cultural production (Hesmondhalgh, 2006). Furthermore, Bourdieu's theory on the relations between TV media and cultural production was still considered a scholarly source in the study of contemporary television (Hesmondhalgh, 2006).

Bourdieu's study and theory on the connection between culture and TV media supported this contemporary cultural analysis of ER in the following manner. First, in performing any type of cultural analysis practice theory cautioned against the principle obstacle of "charismatic ideology of creation" (Hesmondhalgh, 2006, p. 211). Because according to Bourdieu, this obstructed the natural gaze (i.e. view) by redirecting the gaze towards "the apparent producer" of the TV show (Hesmondhalgh, 2006, p. 211). Thus, the focus of the cultural analysis was not on who created the TV drama; but, how did the TV drama culturally reflect or reproduce what we have come to know, accept and understand as being emergency medicine and the role of emergency physicians.

Second, Bourdieu's theory went against the natural inherent tendency to observe and view the TV drama ER as a reflection of our social context (Hesmondhalgh, 2006). Instead, Bourdieu used his theory of cultural production as a means to demonstrate an alternate way of doing a cultural analysis of TV by using his distinctive and unique

concepts, habitus, field, and capital (Hesmondhalgh, 2006). This dissertation focused on the concept habitus. Bourdieu's theory of cultural production in TV media created the opportunity to observe and study how the thinkable and un-thinkable, the do-able and impossible were created based upon how the categories of perception structured habitus as a function or product of possible course of action and intervention (Hesmondhalgh, 2006, p. 216).

Finally, the TV drama ER contributed to the genre of medical dramas (O'Connor, 1988). Although the TV drama appeared to glamorize the work of emergency physicians the show was able to accomplish several cultural outcomes. First, the TV show ER was both a reflection of and cultural influence on the medical specialty. For example, according to the Key Informant the emergency medicine community was able to use the TV drama ER as a podium to assist in creating an image of emergency medicine and as a vehicle for patient education about new emergency treatments available to the public.

Second, the TV show ER influenced how medical students formulated their cultural perception of what constituted appropriate physician behavior. For example, the physician characters on the show can be perceived as being a mirror that provided validation of desired qualities such as hero; or a cultural reflection of less desirable qualities and traits such as controlling, arrogant, and discriminating (O'Connor, 1988, p. 854). Furthermore, the TV show ER reproduced and reflected qualities that can be reinforced or contradict the cultural influences on real life physicians.

Finally, research in the TV media analysis literature indicated that an increase in the number of interns enrolled in emergency medicine residency programs was observed when the show premiered (O'Connor, 1988). For example, during the first season the

nation saw a 4% increase in applicants to emergency medicine programs nationwide (O'Connor, 1988, p. 854). However, according to the Key Informant caution had to be taken not to assume that the TV show ER was the anchor that defined the specialty of emergency medicine. Based on the research in the literature and Key Informant response, a complex cultural and social relationship was observed between the TV show ER and the development of the medical specialty emergency medicine.

Conclusion

The goal of this dissertation was to uncover and understand how culture reflected, shaped, reproduced, influenced or created the habitus of physicians who practiced emergency medicine. Studying the relation between culture and physician habitus was the key to accomplishing this goal. Pierre Bourdieu's practice theory was essential to this research in that it placed the researcher in the center of action, without bias and pre-suppositions due to prior subjective experience of the observer. Placing medicine in the context of culture opened up the profession to be examined and studied as a cultural model, which will enhance our understanding of the cultural values, norms and behaviors associated with physician practice and behavior. In addition, the cultural analysis of the TV drama ER was crucial and necessary as a means for understanding the relationship between culture and emergency medicine and emergency physician habitus.

Chapter 3 “A Cultural History of Emergency Medicine”

Introduction

To better understand how culture is related to emergency medicine and emergency physician habitus, the history of emergency medicine was examined in the context of culture. Performing this analysis was important to this dissertation for the following reasons. First, this analysis showed how culture was involved in the development of this medical subspecialty. Second, these analyses showed how culture has continued to influence and shape the practice of emergency medicine and emergency physician habitus.

In the previous chapter, emergency medicine was placed in the context of culture in order to address how culture was related to the practice of emergency medicine and emergency physician habitus. Laying this cultural foundation of emergency medicine facilitated the understanding of how culture influenced the development of emergency medicine and how culture reproduced, and created emergency physician habitus.

The purpose of this chapter is two-fold. First, this chapter shows how culture is involved in the development of emergency medicine. Second, this chapter gives historical background and pertinent facts surrounding the development of emergency medicine as it evolved in the United States.

A review of the literature focused on three important milestones involved in the history and development of emergency medicine. The first milestone encompassed the actual clinical and scientific development of the medical specialty. The second embraced the relationship between societal and cultural changes, and reflected back to the role of culture in the development of emergency medicine. And the third milestone involved our legal system. Each dimension was vital and critical to understanding and appreciating the

depth to which this medical subspecialty arose from and its continued success today. Most important, each milestone included some characteristic of culture.

This chapter is important because it addressed the questions of why and how this medical subspecialty came into existence. The involvement of culture in this chapter was related to a process of cultural change. From an anthropological perspective, the process of cultural change was looked at as a means of understanding the causes and consequences of change in relation to the social institution of medicine, and our integrated health care system (Fertig, 1996, p.165). By applying an anthropological perspective it was possible to examine the history of emergency medicine while considering the following conditions: 1) determining what motivated the initiation of change in physician attitude toward sudden death, 2) determining how changes in the norms and values lead to the change in the traditional practice of medical intervention, especially relating to sudden death, and 3) determining how technological advances and changes in physician attitude lead to changes in traditional medical behavior. The aforementioned conditions laid the foundation for understanding and appreciating the role and place of emergency medicine within our nation's fragmented health care system. Finally, this chapter painted a picture of how this young medical subspecialty answered the call for help from those without access to care as they assumed the role of 'safety-net' provider to this vulnerable patient population.

The Clinical Science of Emergency Medicine

The history of emergency medicine contained many life-changing events in medicine along with technological advances. Visionaries who believed that reviving a person from the onset of sudden death was possible brought these life-changing events

and technological advances together. For example, today resuscitation is the process of reviving someone back from sudden death caused by emergent conditions and trauma. The process of resuscitation has been developed and refined to the point that it has become a routine and standard practice used by all emergency medicine physicians in any given emergency department (Mitchell & Medzon, 2005; Eisenberg, 1997).

During the 1700's, sudden death was just that—death which happened suddenly. Historical accounts indicated that most sudden deaths occurred due to accidents and drowning (Eisenberg, 1977, p.14). In 1774, the “Humane Society” was founded to perform reanimation, the term used at that time to describe the process used to revive people who were victims of a trauma, accident or drowning (Eisenberg, 1977, p. 14). Equivalent to our present day emergency medical services, the society outlined for physicians steps to take, termed “Methods of Treatment of Drowned Persons” to resuscitate a drowned person (Eisenberg, 1977, p.14). For example, this historical account narrated the steps taken to revive a drowning victim:

First, the drowning baby was undressed and warmed by a fire. Eventually, on the advice of his father, Dr. Mantill proceeded to blow into the baby's mouth. Although the exact technique is not described, one can only assume that the nose was pinched closed and sufficient air exhaled into the mouth to cause the baby's chest to rise—concrete evidence that mouth-to-mouth artificial breathing was a lifesaving technique used in the eighteenth century (Eisenberg, 1977, p. 14).

Unfortunately, this method of mouth-to-mouth breathing was abandoned. But, eventually found its way back into use in 1954 (Eisenberg, 1977). According to Mickey S. Eisenberg (1977) an historian in emergency medicine the first priority should have been restoration of the circulatory system because physicians are taught in medical school that the blood carries oxygen throughout the body. Although the process was backwards

and was based upon their limited knowledge and understanding of human anatomy, their efforts were similar to ours today—to revive or resuscitate the person by retrieving life back into the victim (Zink, 2006; Eisenberg, 1997).

This was an important point in this chapter analysis because it illustrated a connection between culture and physician habitus of reanimation. For example, when applying practice theory to this scenario the humane society represented the cultural institution created to bridge the relationship between traditional medical behavior and 18th century medical beliefs. In this aspect, culture created the physician habitus of reanimation through the establishment of the humane society. In turn, the humane society helped to reshape society's views regarding death and traditional medical intervention into the physiology of death.

Reading Eisenberg's (1997) historical accounts of emergency medicine also revealed that the pursuit to reverse the onset of sudden death was not a steady endeavor. As was stated previously, Eisenberg's (1997) historical account showed that several of the steps now seen in our modern day resuscitation efforts were practiced several centuries prior (i.e. mouth-to-mouth respiration and electrical shocks to the chest). The problem with these techniques was that they were not always successful, which was mainly due to the lack of technological development and understanding regarding the physiology of death. In other words, they had the principles backwards (Eisenberg, 1997).

Because 18th century medicine was empirically based, physicians believed at that time that warming the body would bring back the circulation of blood flowing through the body. Unfortunately that empirical understanding was not correct. Knowledge

regarding circulation in the body was developed and corrected over time. For example, it took two hundred years for the re-discovery of several life changing techniques in resuscitation (Eisenberg, 1977, p. 19). The re-discovery of life-changing techniques in resuscitation coupled with advances in technology equipped emergency medicine physicians with the knowledge and ability to go into any situation performing their ‘ABC’s’: Airway, Breathing, and Circulation.

When did the first resuscitation occur? Based on historical accounts, no single date can be determined. It may have taken place with the use of the first defibrillation in 1947 or it could have been with the rediscovery and use of chest compressions in 1959 (Eisenberg, 1977, p.32). No single event led up to the development of the modern day procedure of resuscitation. Instead, several discoveries had to take place initially regarding the principles of circulation and the physiology of death before resuscitation made it on the scene. However, one thing was for certain, the discoveries had to precede resuscitation because resuscitation is a very complex process that involves several steps and procedures. It was the advances in technology, knowledge, and devices used in resuscitation that made the intervention into death possible. Our culture had come to accept and pursue the thought and possibility that man was able to intervene in death and could bring a person back from the dead. Culturally, our society had come to accept the idea that death was reversible (Eisenberg, 1977).

The social acceptance of reversing death helped to bring forward and into existence the process of resuscitation. The shift in the cultural paradigm for viewing and understanding the physiology of death played a major role in the development of the resuscitation process. Each of these elements helped prove that culture influenced

emergency medicine and produced a change in physician habitus. All of these events occurred in response to society and the needs of the patient.

The foundation regarding the evolution of resuscitation and reversing death began with the ancient Greek physician Aelius (or Claudius) Galenus (129-217 A.D.). As a practicing physician, while pursuing an understanding of human anatomy, Galen became the final authority on medical knowledge during the second-century (Eisenberg, 1977). Unfortunately, his understanding about human physiology and anatomy was incorrect. As a result, Galen pursued the theory that the furnace of life resided in the heart and produced innate heat that animated the body. Animate was defined as keeping the body warm. Further, Galen believed that this furnace of life was turned on at birth, and was permanently put out upon the death of the person, and could never be lit again! Thus, his strong belief in this principle was taught and passed on to other physicians and scientists for centuries, in effect dispelling the idea that death could be reversed (Eisenberg, 1997).

During Galen's lifetime, people believed that man could not and should not attempt to reverse death. Culturally, the premise was that the body and soul were intertwined and were essentially one. The soul resided in the heart, and represented the essence of life and human character. Therefore, under no circumstances could death ever be reversed, after all, where would the soul go? During that period of time, the human body was considered to be sacred. In terms of culture, society believed in the resurrection, which did not allow for the dissection of the human body. As a result, knowledge and understanding regarding human anatomy was hindered (Eisenberg, 1977). The idea of resuscitation would be abandoned and never re-visited again until the 1400s or during The Renaissance Period (Eisenberg, 1977).

The Renaissance Period (1400-1700) re-kindled man's desire to pursue the techniques of resuscitation. During this time of enlightenment, the people in society started to challenge the church and its doctrine about life and the stoic belief held that death was final and that man was not supposed to interfere in its divine course. The sanctity of the human body and the belief in the resurrection of the dead was also challenged. Each of these church doctrines and Galen's misunderstanding regarding the anatomy and physiology of the human body worked together to prevent anyone from seeking to explore the possibilities of reviving someone from death (Eisenberg, 1977). Galen's failed efforts at resuscitation provided the fuel to keep the church doctrine in force regarding death and resuscitation.

In the context of culture, the people looked for new knowledge along with the power of being in control of one's own life. The conflict between church doctrine and the people fueled the fire necessary to propel forward man's quest for knowledge and understanding about life and about death. Universities sprang up as a means to teach and pass on the wealth of knowledge as well as put it into print.

Galen's beliefs and doctrine on the physiology of how life exists in the human body remained influential until the discoveries made by the renaissance anatomists Andreas Vesalius (1514-1564) and William Harvey (1578-1657). Both anatomists are credited with the discovery of a newfound truth and understanding of the human body. First, Vesalius in 1543 was able to refute Galen's truth regarding the anatomy of the human body through his work and research on human cadavers. For Vesalius, anatomy was to be learned through observation and dissection on human cadavers. His

understanding went against Galen's view that anatomy should be studied and taught from textbooks (Eisenberg, 1977).

Fortunately, Vesalius was able to spend a great deal of time observing and dissecting human cadavers in order to get an understanding of how the human body functioned. Based upon his knowledge from the observation and dissection of human cadavers, Vesalius practiced resuscitation on animals, using pigs and dogs. Vesalius used various instruments in his attempt to simulate the natural respiration process. Sometimes he was successful sometimes he was not. He did not publish his efforts because he feared the wrath of God, and the wrath of the church, which did not advocate or support human meddling into God's business of death.

In 1628, the anatomist's William Harvey soon followed and was the first to correctly describe the circulatory system. Laying the foundation for future experimental research, Harvey discovered how the blood truly flows through the human body. Harvey also discovered and described how the heart functioned. Using Vesalius technique of observation and dissection of human cadavers, Harvey learned what he termed the fabric of nature herself, the circulatory system (Eisenberg, 1977).

Despite the cultural unleashing of intellectual knowledge, people living during the renaissance were not rebellious. Time was needed in order for this newfound knowledge to settle in the minds and hearts of society. For the most part, people went along with the orthodox doctoring of the Christian church. Scholars continued to pursue knowledge and understanding about man's existence, while researching how to revive someone from the dead within the confines of the church doctrine (Eisenberg, 1977).

As society gained more knowledge and a better understanding of the human anatomy and the circulatory system, our cultural views and thoughts about death shifted. The cultural change in belief regarding death took place based upon two events: 1) the secularization of society and 2) the principles of science being accepted within intellectual thought. Both events were necessary and played a significant role in how society changed its views regarding the acceptance of resuscitation principles as a method for saving lives and reviving from the dead (Eisenberg, 1977). This foundation caused the paradigm shift in viewing and understanding the physiology of death.

Briefly, secularization is the term used to define and describe how the principles of scientific thought permeated the thought processes of society. As the church's grip on the lives of the people relaxed, people began to understand and accept why resuscitation was useful and possible. This produced a change in the cultural dynamics of society. For example, the people began to take on the responsibility for their own lives, which became conduit for the principles of scientific inquiry to be incorporated into intellectual thought. As a result, the new religious doctrine became "...God helps anyone who helps themselves" (Eisenberg, 1977, p. 52). Medicine soon followed suit and took on the belief that "anyone could and should be saved" (Eisenberg, 1977, p. 52). In essence, this change in the cultural dynamics caused a change in the traditional principles and practice of medicine. Eventually, belief in resuscitation caught on, but the will to develop the process had not emerged (Eisenberg, 1977).

Mouth-to-mouth resuscitation is a part of the resuscitation process. According to history, the first mouth-to-mouth resuscitation occurred in 1732, but appeared in 1744 (Eisenberg, 1977, p. 55). Impressed with this method, the leading London physician Dr.

John Fothergill wrote: “the blast of a man’s mouth was simple, inexpensive, harmless, and could be administered by unskilled bystanders directly at the scene. ...may possibly do great good, but cannot do harm” (Eisenberg, 1977, p. 56). In their analysis of the mouth-to-mouth resuscitation method, physicians at that time conceded and agreed that this method was all together consistent with the view of the human body as a mechanical system, which was not fully understood (Eisenberg, 1977, p. 57). This method of resuscitation along with several other techniques devised at that time to revive sudden drowning victims was carried out and practiced by the many Rescue Societies. Likened to our modern day EMS (Emergency Medical System), rescue societies were charged with the task of responding to victims of sudden death with resuscitation (Eisenberg, 1977, p. 59).

It took several decades to perfect the mouth-to-mouth resuscitation technique. Culturally, laypersons and the medical profession viewed the mouth-to-mouth resuscitation technique as a vulgar act-taking place between two strangers (Eisenberg, 1977). Even though the method of mouth-to-mouth was beneficial and was logical, the method drew criticism and was considered vulgar because of the intimacy that occurred between strangers (Eisenberg, 1977). In response, Marshall Hall, founder and editor of the prestigious medical journal “The Lancet” in 1857 proposed the following: 1) shifting the person on their side as a means to cause the inspiration of air, 2) applying expiratory pressure to the person’s back while they were prone (Eisenberg, 1977, p. 75). Hall’s method did not involve mouth-to-mouth, instead he relied upon the mechanical expansion and compression of the chest wall. Resuscitation in this manner would result in an air exchange volume of 70 to 240 milliliters. Hall named his technique as the “ready

method”, for the following reasons: 1) no equipment was needed, 2) training was not complicated, 3) and you did not have to move the person to another location (Eisenberg, 1977). In the context of medicine and human physiology, Hall’s method recognized two important principles of resuscitation: 1) always address airway obstruction, and 2) the need to intervene immediately (Eisenberg, 1977). Eventually, in 1906 Irish surgeon Robert Woods rejected all forms of mechanical resuscitation and re-instituted the method of mouth-to-mouth resuscitation (Eisenberg, 1977).

The sanctioning of the mouth-to-mouth method of resuscitation required the participation of several key persons. The first person to sanction this procedure was physician Dr. Jim Elam. He believed that the most effective and logical maneuver was the mouth-to-nose method of ventilation. He based his knowledge and assumption upon his past experiences in the successful use of the mouth-to-nose method in reviving people who had stopped breathing (Eisenberg, 1977).

Dr. Elam proved his theory regarding the usefulness and success of the mouth-to-nose method in 1946 when he tried and successfully used the technique on patients with acute poliomyelitis paralysis (Eisenberg, 1977). Dr. Elam’s training prepared him to perform the work that he did in demonstrating the technique of mouth-to-nose resuscitation. The supporting data regarding the technique of mouth-to-nose (or mouth-to-mouth) resuscitation came from having the resident draw blood gas measurements from the artery located in the patient’s wrist (Eisenberg, 1977). These readings were important because they indicated that expired air was sufficient for oxygenation, providing the supporting validity of the mouth-to-nose (or mouth-to-mouth) resuscitation

(Eisenberg, 1977). Soon Dr. Elam would meet the second person vital to the reinstatement of the mouth-to-mouth method of resuscitation, Dr. Peter Safar.

Peter Safar's efforts at confirming the effectiveness of mouth-to-mouth method of resuscitation was considered to be the most daring and perilous because it literally engaged in taking a healthy person to the brink of death as a means to demonstrate the use of the method in bringing them back from the edge of death (Eisenberg, 1977). As Safar remarked, "resuscitation implies a commitment on the side of life. To devote one's energies to the restoration of lives cut short before fulfillment is to declare that life is intrinsically valuable, that it is worth saving" (Eisenberg, 1977, p. 94). In Safar's actual experimentations, life was not suddenly cut short because as the researcher he took them to the brinks of death in hopes of rescuing them and bringing them back to life.

The historical account of Safar's experimental studies in the use of mouth-to-mouth resuscitation revealed that he recruited 31 physicians and medical students and one nurse at Baltimore City Hospital in January 1957. Once recruited, the volunteers agreed to allow Safar to heavily sedate them and then totally, but temporarily paralyzed them to simulate the unconscious state of a person who has stopped breathing. Once they were paralyzed, various techniques of ventilation were done and compared as to which method of resuscitation was successful and efficient. The paralysis state lasted for no more than three hours, as devices were used to monitor their breathing and the oxygen and carbon dioxide content of their blood. They were not allowed to be in a non-breathing state for more than 90 seconds (Eisenberg, 1977). Safar was aware of the life threatening risks and took great action to prevent the loss of life and even acknowledged that he had tried the analgesics and muscle relaxants on himself, just short of going through the actual

experiment himself. The seriousness of his experimentation was to the degree that the Lloyds of London refused to insure it, but the U.S. Army supported him financially. Safar took this risk because he was convinced that "...it was the only way to get at the truth" and "I was confident that I could make it safe" (Eisenberg, 1977, p. 97).

The outcome of Safar's efforts was overwhelmingly positive. He proved his theory that mouth-to-mouth resuscitation was effective in restoring life to the victim (Eisenberg, 1977, p. 97). However, the most important finding was that the method of mouth-to-mouth resuscitation could be taught to anyone, at any age and could be performed immediately on the victim with a greater chance of success (Eisenberg, 1977).

The third and last person to be credited with the reinstitution of the mouth-to-mouth was Martin McMahon, a fire captain from Baltimore, Maryland. Captain McMahon met Safar in December 1956 when soliciting his help in improving the newly developed mouth-to-mouth resuscitation method. Once McMahon witnessed the success of the mouth-to-mouth method, he enlisted his commitment to developing it further (Eisenberg, 1977). In particular, McMahon saw the difficulty in keeping the airway of the victim open while seeing how quickly the new method could be learned. Further, McMahon remarked, "once you started to see the chest rise ...then you knew damn well that you were making an exchange of air" (Eisenberg, 1977, p. 99). Although he was sold on the application and success of the mouth-to-mouth resuscitation method, he knew that it would take a lot for the American Red Cross to accept this change. In response, McMahon taught the mouth-to-mouth method to his fire fighters, and then branched out to teach it to local civic groups, women and children (Eisenberg, 1977).

In May 1958 the American Medical Association “...unequivocally endorsed mouth-to-mouth artificial respiration in adults and urged that information about expired air breathing should be disseminated as widely as possible” (Eisenberg, 1977, p. 101). Finally, mouth-to-mouth became the official and sanctioned method of resuscitation in November 1958 (Eisenberg, 1977). By 1961 mouth-to-mouth respiration and chest compression was combined as a process of resuscitation (Eisenberg, 1977). In 1963 Cardiopulmonary Resuscitation (CPR) became the term used to describe the combination of mouth-to-mouth and chest compressions and in 1966, The National Research Council and National Academy of Sciences endorsed “CPR” (Eisenberg, 1977).

Study of the clinical science of emergency medicine indicated that a change in the social and cultural environment, experienced through the renaissance period, caused a change in the norms and values regarding life and man’s responsibility for his life. The pursuit of knowledge altered the course of how people began to live, including the development of medical science. It took time, but eventually the expansions of knowledge led to a change in how people and physicians viewed and accepted death, in particular, sudden death.

The Social and Cultural Impact on Emergency Medicine

The next important milestone in the history of emergency medicine was the evolution of this medical discipline seen through the efforts made to respond to societal and cultural changes while addressing the needs of the patients. In this dissertation research, social change was defined in several ways. First, social change referred to those changes that reflected and met the social needs of the people. Second, social change also meant those changes that reflected the expectations and demands of the

people. For example, a long-standing historical and social need in our system of health care has been how to provide adequate and available care to the poor, indigent, uninsured or African-American patient populations (Zink, 2006; Smedley et al., 2003; Jaynes & Williams, 1989).

In general, people in society adapt to their surrounding physical and social environments through the expression of culture (Fertig, 1996, p. 165). A cultural change was defined as being an alteration in an acceptable, learned, and practiced form of behavior. Cultural change was expressed through the ideas and norms that were characteristic to and practiced by the members in society. An example of a cultural change was seen during the early clinical and scientific development of emergency medicine. As the physical environment became less constraining, people started to pursue knowledge about life and the human anatomy. In time, this newfound knowledge prompted people to alter their views about death, especially death that was brought on suddenly. The altered idea and belief about the physiology of death created a new system of medicine and ultimately, a new physician habitus. This new system of medicine was emergency medicine and the new physician habitus was the process of resuscitation.

Each aspect of change was significant and played an important role in the development of emergency medicine. The social and cultural side of emergency medicine can also be viewed through the efforts of this subspecialty to address the needs of a population that had become disenfranchised through poverty from the health care system. Brian Zink (2006) began his narrative of emergency medicine with this thought in mind. The rationale for his choice was revealed in this revelation concerning the history of this medical specialty, "To me, the most fascinating aspect of the post-World War II history

of emergency medicine relate to the strong link between societal changes and the development of this new profession” (Zink, 2006, p. xi).

The social problem that continues to plague our health care system and society is how to provide care to the poor (Zink, 2006, p. 1). In American society many people have not been able to overcome poverty. This segment of the population created a class of patients who lacked access to the necessary resources required to address their condition and health status (Smedley et al., 2003, Zink, 2006). According to Zink (2006), with no obligation from private physicians to see and treat such patients who lacked health insurance, many of these patients sought their care through the hospital emergency department (Zink, 2006, p. 1).

The pioneers in emergency medicine encountered this social problem that has still remained with us today, “How to take care of very sick patients who seek their care through the emergency department” (Zink, 2006, p. ix). Hence many of these visionaries believed that the history of emergency medicine was special and important because it revealed how the problems of the past, are really nothing new (Zink, 2006, p. ix). In fact, it was the past accomplishments, failures, and solutions, which helped shape this medical specialty (Zink, 2006, p. ix). As one of the founders of emergency medicine noted: “I don’t believe we thought of ourselves as making history, but rather simply living our lives and solving our problems” (Zink, 2006, p. ix).

Emergency medicine was not considered a viable medical specialty and it definitely was not on the radar screen of academic medicine in its early stages (Zink, 2006, p. 18). As the numbers of emergency room (ER) visits continued grow, the concept of “emergency hospital” began to catch on across urban cities during the 1950s and 1960s

(Zink, 2006). In the same breadth, urban city hospitals became the default health care centers for the poor and especially for the African-American patients (Zink, 2006). The image of the urban hospital emergency department serving and caring for the poor and large numbers of patients seeking care produced the unwanted status of "...forgotten step child of medical academia" (Zink, 2006, p. 18). The stepchild status of academia was unfortunately due to the presence of poorly trained physician staffing, poor patient outcomes, and poor quality of care in the emergency department.

Upon closer examination, the historical account of the development and acceptance of emergency medicine illustrated how much the emergency physician and the emergency medicine patient had in common. For example, both were disenfranchised, lacked a voice, and were largely ignored by the authorities (Zink, 2006, p. 23). Even though the number of patients seen in the emergency department continued to increase, the general perception of emergency medicine and the emergency department was that it was an annoyance, and provided no opportunity for success as a physician (Zink, 2006).

Culturally speaking, the general practitioner (GP) was considered to be the ancestor to the emergency physician (Zink, 2006). The similarities between each was seen and expressed through the characteristics that the GP possessed at that time, and seen and required in emergency physicians today. Those characteristics included the following: 1) the ability to handle almost any medical problem in any patient, 2) the ability to provide minor surgical, obstetrical, and pediatric care, 3) being readily accessible to patients, and 4) the first and often only point of care (Zink, 2006, p. 3).

Over time, the role of the general practitioner changed for the following reasons:
1) advances in technology of clinical medicine with regards to diagnosis and treatment of

disease, 2) the public demand for and movement towards specialty training, 3) the necessity to be affiliated with a hospital to be successful, and 4) a decline in the number of house calls. For example, at one time general practitioners believed in making house calls to visit their sick patients. But this practice ceased because they no longer feared that the hospital would steal their patients when they instructed their patient to go to the hospital. Further, as the number of physician referrals to the hospital increased the demands of being available at all times took a toll on the general physician practitioner and their time with their families.

As society became more mobile, the demand for more medical services increased. Emergency physicians provided many of these services in the erratic setting of the emergency room (Society, 2010). By 1970, ER visits had more than doubled since 1955. The attitude of the private practice physicians soon changed towards the hospital and emergency department. Physicians in private practice no longer feared referring their patients to the hospital, and viewed the emergency department as providing better care to their patients that was not available in their offices. Technological advances in diagnosis and treatment and the development of antibiotics changed the atmosphere and characteristic of the hospital as well. No longer viewed as a place to die the image of the hospital changed to one where the facility was viewed as a place for cure and treatment of disease (Zink, 2006). This shift reflected a change in the cultural perception and understanding regarding the function and purpose of the hospital, the emergency department, emergency medicine and the emergency physician (Zink, 2006).

The change in emergency department functioning was also reflected through the change in patient pattern utilization of the emergency department. Researchers suggested

several reasons for the change including but not limited to: 1) a lack of available ambulatory medical services, and 2) a creation of government health insurance programs (Davidson, 1978; Beland et al., 1998). For example, Beland and colleagues (1998) chose to use the ecological perspective in anthropology to examine the relationship between the environment and the organization. In their research study the hospital was defined as representing the organization, and the environment was defined as the social environment. The ecological perspective was based upon the following three assumptions: 1) emergency department function was the result of an interaction between all medical units in a given area and the population, 2) emergency department function directly depended on the availability of other medical care resources, and 3) emergency department function depended on its hospital resources (Beland et al., 1998, p. 166). The scope of their research was considered anthropological in nature because their rationale was that an emergency department represented an organizational unit within a health care system. In addition, as a unit of health care within “a system”, the emergency department interacted with the population and its surrounding environment (Beland et al., 1998, p. 166). Thus, within this perspective, the function of the emergency department was defined “... by the interaction of the organizational unit and population characteristics in their environment” (Beland et al., 1998, p. 166). Therefore, the function of the emergency department depended on how the facility was used by the population it served (Beland et al., 1998, p. 166). Once again illustrating that emergency medicine and emergency physician habitus was affected by social pressures expressed through non-medical factors such as the cultural attribute of patient utilization.

Beland et al. (1998) research perspective was very important and set the groundwork for this dissertation research by examining how the emergency department interacted with patients. Thus, the basic premise of the ecological perspective was that a system of relationships exists between the ecosystem variable, defined as the hospital emergency department, the patient population, and individual (Beland et al., 1998).

Another cultural change in emergency department function had to do with its new image as “health care safety-net”. Since the 19th century, the following premise existed “...we should maintain a health care safety net for persons who are uninsured, difficult to serve, discriminated against, or who cannot get care elsewhere” (Baxter & Mechanic, 1997, p. 8). Briefly, the term health care safety net refers to any community, institution, provider or professional that devotes a great deal of its resources and time, while assuming the responsibility for providing health care to the uninsured and socially disadvantaged (IOM, 2003; Baxter & Mechanic, 1997). The other defining characteristic of a health care safety net provider is based on a legal mandate or an explicitly adopted mission, to maintain a 24-hour open door policy and serve all patients that enter their facilities for care (Hock et al., 2005). Based upon the two aforementioned defining characteristics, the hospital emergency department clearly falls within the confines of being one of our nations ‘health care safety net’ providers.

In the role of health care safety net provider, the emergency department extends a civil right to health care for all United States citizens by keeping its doors open 24 hours and by not refusing to see or treat anyone (Hock et al., 2005). However, being accessible on a 24-hour basis contributed to the increase seen in patient utilization over time (Hock et al., 2005). For example, Beland et al. (1998) found that the mean age of the patients

that visited the emergency department was about 36.7 years. In addition, approximately 67% of the patients that visited the emergency department were between the ages of 15 and 60 years of age. Based on this assessment, the researchers concluded that most of the patients seen and treated in the emergency department were adults. The researchers also found at that time that more men visited the emergency department than women at 52.7% compared to 47.3% respectively. Twenty percent of the patients had been hospitalized at least once prior to their emergency department visit. The most frequent diagnosis in the emergency department was chronic illnesses (23.9%); while injuries and poisonings accounted for 27.8% of emergency room visits.

In some aspect, the results of Beland et al. (1998) research was supported in the current numbers that reflected the changing nature of patient utilization of the emergency department (McCaig & Burt, 2005; Beland et al., 1998). For example, the results from the Centers for Disease Control (CDC) National Hospital Ambulatory Medical Care Survey in 2003 revealed the following. Emergency department utilization increased from 29.9 visits per 100 patients in 1993 to 35.5 visits per 100 patients in 2003 (McCaig & Burt, 2005). The CDC attributed the change to an increase in adult usage of the emergency department (McCaig & Burt, 2005). This coincides with the earlier trend found in the study by Beland et al. (1998). The CDC also saw an increase in the number of emergency department visits in the age groups 22-49 (up 19%) and 50-64 (15%) (McCaig & Burt, 2005).

While Beland and colleagues found a difference in gender, the CDC study found no difference in gender. Emergency department visits for injuries and poisonings accounted for 25.6% of emergency department visits, which was not very different from

what Beland et al. (1998) found earlier on. Finally, the current researchers found that 2.8 percent of the emergency department patients had been seen in the emergency department within the last 72 hours compared to the 27.2 percent who had been hospitalized at least once before their emergency department visit in the Beland et al. (1998) study.

Although Beland et al. (1998) approached their study of hospital emergency department function and utilization from an ecological perspective the authors discovered that the function of the emergency department was partially determined by patient usage. In their approach, Beland et al. (1998) looked at the function of the emergency department with regards to the following: 1) the interaction between the all medical care units in an area and the population, 2) the availability of other sources of medical care in the community, and 3) the availability of hospital resources. The outcome of patient usage coupled with the 24-hour accessibility of the hospital made the hospital emergency department the entry point into the health care system for most patients, especially those with non-acute, primary care medical conditions (Beland et al., 1998). These observations lead to the conclusion that patient usage of the hospital emergency department also changed the function of the emergency department.

Finally, changes in the function of the hospital emergency department eventually led to an alteration in the role of emergency physicians. Many of the patients that visited the hospital emergency department viewed their emergency physician as their primary care provider. Due to the ever-increasing numbers of persons remaining without health care insurance and no opportunity to access care; emergency physicians have been increasingly called upon to "...provide more than just urgent care for trauma and medical emergencies" (Lancet, 2006, p. 2033). Many of the services emergency physicians

provide include those "...that in the past were provided by personal physicians" (Lancet, 2006, p. 2033). Most importantly, even those patients with insurance have often sought help with their primary care issues in the hospital emergency department (Lancet, 2006).

Taking on parts of the role of primary care provider expanded the clinical responsibilities of the emergency physician. In their efforts to provide care, especially to those with primary care conditions, emergency physicians must now be prepared to deliver care for such conditions as minor illnesses and injuries, chronic conditions, and preventive care (IOM, 2007). Taking care of primary care patients required the emergency physician to perform specialized responsibilities such as administrative work involved in securing approval and payment for services, wound management, and pediatrics (IOM, 2007). As a result, the habitus of the emergency physician was also expanded to compensate for the added clinical responsibilities of caring for non-emergency patients in the emergency room.

The paradigm shift in the role of the hospital emergency department and emergency physician habitus emphasized the need to expand the scope of training in emergency medicine (Society, 2010). As a result, the nation soon recognized that our emergency departments were lacking in the progress of treating trauma. Junior residents or interns usually staffed emergency rooms in the 1960's and 1970's. These individuals were literally tossed into the environment with no supervision and without adequate backup (Society, 2010). In many cases, physicians who did staff the nation's emergency rooms did not have the requisite broad scope of knowledge in the provision of emergency care (Society, 2010). To meet this challenge congress passed legislation as a means of establishing standards for emergency medical care and services (Society, 2010).

By 1970, emergency medicine took on an academic nature, which gave the specialty credibility and the ability to improve and grow (Society, 2010). The first national meeting of emergency physicians was held in Arlington, VA 1968. A subcommittee of the American College of Emergency Physicians (ACEP) developed a residency-training program for emergency physicians in 1970. The first two academic emergency departments at our nation's medical schools were founded at the University of Southern California and the University of Louisville in 1971. The first formal residency program in emergency medicine was at the University of Cincinnati in 1972. The development and presentation of formal educational programs at the American Medical Association led to the establishment of a formal section on emergency medicine in 1976 (Society, 2010).

Soon after, many practicing emergency physicians began a lobbying campaign to make emergency medicine a recognized specialty under the American Board of Medical Specialties (ABMS). This move was important and vital because the ABMS was in charge of setting criteria and standards for member boards and was tied to the Accreditation Council for Graduate Medical Education (ACGME) for accredited training. The academic nature of emergency medicine continued to develop in identity and matured as the number of residency programs increased. The creation of academic departments in emergency medicine at medical schools significantly enhanced the education and training of emergency physicians and advanced the knowledge, skills, and abilities in basic medical science and clinical research (Society, 2010).

The social and cultural impact on emergency medicine was wide reaching. Changes that occurred in the discipline touched on several areas. Evidence of social

influences started with the concern for addressing the needs of the patient. The challenge faced was how to overcome society's perception of death. In time, norms and values previously held in society gave way to new norms and values that expressed an appreciation of life and death. Culturally, society accepted the fact that man could intervene in the process of dying thus conceding that life was worth saving. Another cultural impact on emergency medicine was seen in the discipline's efforts at becoming academic in nature. Taking on the role of academia in emergency medicine helped establish the credibility of this medical specialty. It also solidified emergency medicine as a legitimate branch of medicine.

The Legality of Emergency Medicine

While the profession of emergency medicine was taking shape and coming into its own, socially, culturally and professionally, another phenomenon was taking place, namely the legality behind the practice of emergency medicine. From a public health policy perspective, attorney William Curran examined the historical law regarding the practice of emergency medicine (Curran, 1997). At the outset of his discourse and examination of the legality behind emergency medicine, Curran informed his audience that his search of the medical and legal literature did not produce a comprehensive historical review of the laws surrounding emergency medicine. Curran explained this by referring to the fact that, at the time of his research emergency medicine was a relatively young medical and academic subspecialty. Thus, his work in this arena was of an exploratory nature, focusing on the development of the legal duties of emergency physicians in providing care to patients in an emergency (Curran, 1997, p. 658).

The laws regarding emergency medicine prior to WW II were drawn from English Medieval Common Law (Curran, 1997). English Law contributed two important principles to our understanding behind the legality regarding the practice of emergency medicine. First, English Law clearly indicated that physicians had no legal obligation to answer emergency calls or to stop at the scene of an emergency. Second, English Law also stipulated that due to the then growing body of medical negligence case law, "...if a doctor chose to answer an emergency call, no separate (or lower) standard of care was to be applied for emergency situations " (Curran, 1997, p. 659). The first principle was known as no obligation of rescue; and the second principle was known as the rule of ordinary care (ibid). Both rules were considered universal and applied to everyone. The rule of ordinary care was applied to emergency situations especially when there was no time to form an agreement about payment, and even more so, when the patient was in distress, and was unable to render payment for services (Curran, 1997, p. 659). Over time, these two principles were translated to the present practice of emergency medicine of seeing and treating all patients presenting to the hospital emergency department, regardless of their inability to pay.

There was much confusion over what standard of care meant and how it was supposed to be applied in gratuitous undertakings (Curran, 1997, p. 660). In 1866, the Illinois Supreme Court removed the confusion and ruled "...ordinary care was required in emergencies, even those where the service was rendered gratuitously" (Curran, 1997, p. 660). Later on in a different case, the same court clarified their position on ordinary care by ruling that the standard of ordinary care was more stringent in that the physician

“...was to perform according to the generally accepted professional concept of accepted practice, ... not at a minimum level of barely acceptable conduct” (Curran, 1997, p. 660).

The first Illinois Supreme Court ruling was viewed as representing a cultural practice of emergency medicine that set the stage for emergency department policy that is followed today, providing reasonable care in an emergency to all who come through the door, regardless of their inability to pay. The second Illinois Supreme Court ruling was defined as reflecting a negative social ideology that opened the door for the later practice of ‘patient dumping’. Patient dumping was a term used for an acceptable professional practice of transferring patients who were poor, minority, or African-American, if deemed necessary by the treating physician and emergency department facility without proper evaluation.

Treating patients without compensation eventually caused physicians to back away from rendering services in medical emergencies. At the same time, the American legal principles governing physician volunteering changed from the point of only assisting to stabilizing the patient to requiring the physician to accompany the patient to the hospital after they have been stabilized. Further, if the physician failed to do so, they risked being sued for patient abandonment (Curran, 1997, p. 661).

The fallout from this ruling caused the physicians to demonstrate reluctance in offering their medical services to patients in need (Curran, 1997). The threat of malpractice suits caused many physicians to express skepticism in rendering their time and services in hospital emergency rooms as well (Curran, 1997). In the end, Curran (1997) summed it up with this statement: “the waste of valuable professional ... time in unnecessary attendance, riding in an ambulance, or sitting about in an emergency service

for indefinite periods, appealed very little to few doctors” (Curran, 1997, p. 661). When the physician refused to accompany the patient to the emergency department, they could be accused of patient abandonment and such an accusation produced “...further aggravation, twisting the knife in the wound” (Curran, 1997, p. 662).

As the country and the medical profession continued to grapple with these issues, the modern era began to unfold around the mid 1960s and carried through the 1970s. Many important developments happened during this time. For example, a law was passed that expanded the requirements charity hospitals needed to satisfy in order to keep their tax-exempt status. This new IRS ruling stipulated that, “...community general hospitals establish and operate a 24 hour emergency service open to the ...community regardless of ability to pay” (Curran, 1997, p. 664).

The onset of the 1980s brought with it an increase in Congressional attention to the terms used in the discipline of emergency medicine. In 1985, the 99th Congress House of Representatives amended the deficit reduction bill (HR 3128) to include language regarding emergency services and treatment. In this amendment, the term ‘emergency medical condition’ was defined as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (a) Placing the patient’s health in serious jeopardy, (b) Serious impairment to bodily functions, or (c) Serious dysfunction of any bodily organ or part.

The amended deficit reduction bill also addressed the following emergency medical terms, stabilize and transfer. The term ‘stabilize’ was defined as follows: “with respect to a medical condition, to provide such medical treatment of the condition as may be necessary to assure that no material deterioration of the condition is likely to result

from the transfer of the individual from a facility” (HR 3128). The term ‘transfer’ meant “the movement (including discharge) of a patient outside a hospital’s facilities at the direction of any person employed by ...with the hospital, but does not include such movement of a patient who has been declared dead or leaves the hospital without permission ...” (HR 3128). Congress’s purpose for addressing each of these terms represented their attempt at addressing growing public concern and outcry regarding the inadequate treatment of patients in the emergency department.

During that period of Congressional attention, 22 states had enacted statutes requiring the provision of limited medical treatment in emergency situations (HR 3128). Moreover, many state court rulings had imposed a common law duty on physicians and hospitals to provide necessary emergency medical care (HR 3128). Many patients were unduly transferred or dumped onto other emergency room facilities without the proper evaluation. Unfortunately, the victims of this fallout were those who were poor, indigent, uninsured or African-American. Congress answered this public backlash with the passage of the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1985. This law is also known and referred to as the ‘patient anti-dumping’ law (Curran, 1997).

The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1985 a significant piece of federal legislature, dealt directly with the provision of emergency medical care. No other medical specialty was ever placed under federal mandate and regulation regarding the provision of patient care. The purpose of EMTALA was to prevent and deter hospitals from dumping those who were poor, indigent, uninsured or African-American because of race or their inability to pay for their health care services (Curran, 1997). Patient dumping defined by the law was: 1) refusing to provide care to a

patient because they cannot afford to pay, and 2) transferring a patient to a nearby public facility before their emergency medical condition had been stabilized (Curran, 1997).

Patient dumping was a negative form of hospital behavior that became culturally accepted by those hospital facilities committing the act of patient dumping. This acceptable form of negative hospital behavior created a social dysfunction in patient care. The hospitals receiving those patients that were dumped were not supportive of the sending hospital behavior. Many of the patients who suffered from this form of medical behavior lost their lives while seeking emergency medical care. For example, in the Congressional Record of the 99th Congress (First Session), a case of patient dumping was reported. The case was printed in the St. Louis Post-Dispatch, and dated November 18, 1985. According to the news report and Congressional Record, St. Louis Regional Medical Center officials investigated the death of a 20 year-old man who waited for 90 minutes before being seen and treated in the emergency department. The cause of his death was a ruptured appendix. Public outcry and backlash against this hospital practice produced a change in the practice of emergency medicine. In fact, not wanting to violate EMTALA was the motivation behind the change in the physician habitus.

The specialty of emergency medicine began with the purpose of saving lives and bringing the patient back from the brink of death (Zink, 2006; Eisenberg, 1997). But the needs of the African-American patient population, as well as those who were poor, indigent, and had no access to health care became too great. This exerted social and cultural pressure on both the emergency departments and the emergency physicians. Patients with non-emergent conditions and those seeking care for routine medical conditions began to flood the hospital emergency departments (Kershaw, 2008;

Haughton, 2005). The social needs of this particular patient population became so great that it eventually caused a change in the habitus of the emergency physician. Instead of performing the habitus of seeing and treating all patients presenting to the emergency department the habitus of patient dumping arose as a means to alleviate the pressures and financial burden of providing care to this patient population.

Patient dumping eventually caused a strain on the health care system. In an effort to address and meet the needs of a vulnerable population, the practice of emergency medicine underwent a shift in purpose. Congressional passage of the Emergency Medical Treatment and Active Labor Act in 1986 in a real sense helped bring about this shift in paradigm in emergency medicine. In essence, Congress helped reshape and redefine the role of emergency medicine and emergency physicians. In addition to the resuscitation of human life, emergency physicians were now mandated to provide primary health care services and treatment to patients who were poor, indigent, underinsured, or African-American. Thus, this medical discipline not only sees those patients on the brink of death, or those suffering from traumatic injuries, but also treats those who find themselves outside the health care system (Kershaw, 2008; Haughton, 2005).

The legal forces coupled with society and cultural pressures produced a change in not only emergency physician habitus, but also in the hospital emergency department as well. The impact from each of these milestones expanded the function of each of these entities that uncovered characteristics not previously seen such as primary care provider and safety-net provider. The final impact produced from the influences of the three milestones helped to solidify the cultural image of emergency physicians as modern day

heroes as they took on the role and clinical responsibilities associated with providing care to non-emergency cases that present to the hospital emergency department.

Conclusion

Emergency medicine was understood to be the product of an interaction between culture and biomedicine. Viewing the hospital as an extension of biomedical practice made it possible to explore the relationship between culture and biomedicine. The examination of this relationship proved that culture influenced emergency medicine and emergency physician habitus. The influence culture had on the development of emergency medicine was captured as an outcome of three interrelated milestones: the clinical science phase, social and cultural phase, and the legal phase (Fertig, 1996). The clinical science phase was shaped by society's desire for knowledge in understanding the human anatomy and the physiology of death. As knowledge of man increased, it brought about new levels of technology, which at that time influenced the behavior of physicians (Fertig, 1996). The development of knowledge and technology regarding death went against the behavior norms and values at that time, which was not to interfere with the divine order of death.

As knowledge progressed, the mental guidelines that people followed unconsciously in not interfering with the death process changed. This process of change signaled the onset of the social and cultural phase. During this period society began to accept the idea that sudden death was reversible, thus creating the possibility of preventing the loss of life. Societal pressures continued to impact the practice of emergency medicine through its efforts at meeting the needs of the patient.

Cultural and social forces eventually brought about a change in function of the hospital emergency department. The cultural and social impact on the hospital emergency department culminated into assuming the role of health care of safety-net provider. People questioned whether the hospital emergency department should be used or referred to as a safety-net (Haughton, 2005). But the harsh reality of living in the U.S. revealed that as of 2005, "...more than 45 million people living in the U.S. have no health insurance and therefore no guaranteed access to necessary health care" (Haughton, 2005). In light of such statistics, how else would one propose to provide a means of care for those who are in need? Haughton (2005) provided an answer to this question in his commentary when he remarked, "our political leaders in the United States have not yet come to terms with the notion that the right of access to timely and appropriate medical care is a human right" (Haughton, 2005, p. 282).

The legal culture of emergency medicine was the last milestone covered in the development of emergency medicine. From English Law to Congressional passage of the EMTALA law in 1985, the nature of emergency medicine changed. No other precedent had been imposed on any other medical specialty. In conclusion, EMTALA was not the solution for caring for the poor, indigent, uninsured or African-American patient. Reports indicated that the crisis in American hospital emergency departments were getting worse as more and more patients continued to present to the emergency department for treatment and care (O'Shea, 2007). In a sense, EMTALA may have represented "...another example of federal legislation that hurts the very people that it was meant to protect: low income patients in need of emergency services" (O'Shea, 2007).

Chapter 4 “The Methodology”

Introduction

Previous chapters introduced the concept of a relationship between culture and biomedicine. Closer examination produced the assumption that culture influenced the habitus of emergency physicians and emergency departments. Further research and study of the literature pertaining to culture and emergency medicine revealed that culture actually played a role in the development of this medical subspecialty. Thus, culture was important and significant in the development of emergency physician habitus.

This chapter covers the theory and methodology used to examine the relationship between culture and emergency medicine. The goal of the dissertation was to produce an ethnography that described the behavior of emergency physicians as they performed in the role of doctor in the hospital emergency department. Over time, how emergency physicians performed their routine and every-day tasks in delivering patient care represented the habitus of being an emergency physician.

The dissertation study focused on the emergency physician habitus for various reasons. First, focusing on the habitus of the emergency physician was surmised to be a means to gain insight and understanding into what it means to be an emergency physician treating patients in the hospital emergency department. Second, focusing on the habitus of the emergency physician represented a way to capture how these physicians functioned in the chaotic and stressful environment of the hospital emergency department. Third, focusing on emergency physician habitus was a way of identifying its relationship with culture: did culture create habitus, or did habitus reproduce culture.

The chapter is organized in the following manner. The chapter begins with a discussion of the theoretical framework. The discussion also covers the rationale for

choosing practice theory in studying the relationship between culture and emergency medicine. Next, the chapter presented the three phases of research in chronological order: phase I was the pilot study, phase II, then phase III. The pilot study represented the foundation of the dissertation study. The basic premise was to gain entry into the field site, establish a rapport and ongoing relationship with the inhabitants of the setting. The goal in the pilot study was to observe how the emergency physicians interacted with their patients.

Phase II involved a more in-depth observation and study of emergency physicians as they made decisions and interacted with their patients during the physician-patient interaction. The research goal in phase II was to determine if emergency physician ethnicity was related to health disparities. Several methodologies were used to collect data such as unstructured interviewing, and observation. The research in phase III focused on assessing how culture influenced emergency physician habitus through residency and training. Interviewing professors of emergency medicine at a local medical school measured this. The research goal in phase III was to evaluate how culture influenced emergency residency training.

Each research phase included a description of the methodology used to collect data, how the data was coded and prepared for analysis. The different data types included but were not limited to observation data of the physician-patient interaction, unstructured interviewing data, field notes, and narrative interviews data. The purpose for using multiple methods for data collection, known as triangulation, was to ensure the quality of the field study and to increase the validity and credibility of the results. Researchers for several reasons often criticized this process of data collection. First,

many believed that using triangulation implied that a single account of the social world existed. A second criticism of triangulation was that it implied that different data collection methods yielded unambiguous results that could not be compared across different methodologies. However, the richness that triangulation brought to the anthropological study of the relationship between culture and emergency medicine outweighed the criticisms for using such a research strategy.

Theoretical Framework

Anthropological theory is the framework anthropologists' use for explaining and interpreting behaviors, relationships, and social phenomenon based on the assumptions generated and used to understand the values, and norms associated with a particular empirical reality. The theory framework that was the most appropriate and applicable to this dissertation study was Pierre Bourdieu's (2005) practice theory. Bourdieu was a very well known French intellectual who was a sociologist, anthropologist, and philosopher (Calhoun et al., 1993; Swartz, 1997, Bourdieu, 2005). Arguably, one of the most influential and well respected scholars of his time, Bourdieu's research stretched across several disciplines including but not limited to education, literature, science, and religion (Calhoun et al., 1993). However, what Bourdieu was most known for was his theoretical framework practice theory.

Practice theory was the culmination of Bourdieu's life's work at redefining the prerequisites for a true scientific discourse about human behavior (Swartz, 1997, Bourdieu, 2005). As a social scientist, Bourdieu believed the true form of study of human behavior was hindered and burdened by the dualities of objectivism-subjectivism (Calhoun et al., 1993, Swartz, 1997). Bourdieu's persistent and relentless attacks on the

social science dualism form of objectivism-subjectivism echoed his efforts at maintaining the thought and belief "...social reality exists both inside and outside the individual ..."

(Swartz, p. 96, 1997). In his eyes, the duality of objectivism-subjectivism caused the research space in social science research of human action to be exclusively associated with various academic disciplines (Calhoun et al., 1993). Neglecting to free the social space of research inadvertently also produced an exclusive association with either subjectivism or objectivism (Calhoun et al., 1993). In this case the viewpoints of the subjectivist centered on the beliefs, desires, and judgments of the agents. In contrast, the objectivist viewpoints were centered on economic conditions, social structures, and cultural logic as the explanation for social action (Calhoun et al., 1993).

For example, in his own words, Bourdieu gave an example of why anthropologists should have cause for concern: "the anthropologist's particular relation to the object of his study contains the makings of a theoretical distortion ...as an observer ..."

(Bourdieu, p. 1, 2005). Bourdieu explained his position based on the following points: 1) as an observer, the anthropologist was excluded from the real play of the social action because he had no place (role) in the system, and 2) as a result, the anthropologist had no real motivation to make a place there (Bourdieu, 2005). Therefore, as an observer and researcher, the anthropologist became inclined to a hermeneutic representation of the social action and practices under study. Hermeneutic was a form of interpretive analysis in which meaning was gathered by searching for the connections between culture and practices (Bourdieu, 2005). In opposition, Bourdieu argued that all social action and life "...must be understood in terms that do justice both to the objective material, social, and cultural structures and to the constituting practices and experiences of individuals and

groups” (Calhoun et al., p. 3, 1993). This belief made practice theory the most appropriate and relevant theoretical framework to study the relationship culture had with emergency medicine, and with emergency physician habitus.

Certain assumptions were made in order to apply practice theory to the study of emergency medicine, and emergency physician habitus. First, society was viewed as a cultural system. Within that society were other existing sub-cultural systems that were interconnected and interrelated to each other. Based on this assumption, emergency medicine was defined as a cultural system within the larger social cultural system. Thus, the goal of this research was to study the relationship between society, as a representation of culture, and emergency medicine.

The second assumption made was that all cultural systems existed and functioned based on the manner in which the participants performed within that cultural system. The participants’ performance was defined as being the way they manipulated, interpreted, legitimized, and reproduced patterns of behavior that ordered their social world. The outcome of their behavior was defined as being social action. Therefore, studying social action represented the study of routines and patterns of behaviors that were performed by the participants as a part of their participation in the cultural system. In the context of this dissertation, social action represented the behaviors, and routines performed by emergency physicians as part of being a physician and treating patients in the hospital emergency department.

The third assumption made had to do with the nature of the relationships between the interconnected and interrelated systems and actors. At the heart of any cultural system was the existence of relationships characterized by asymmetry, inequality, and

dominance. Bourdieu believed in order to fully understand how a system operated one must observe and study the social asymmetry within. Studying the nature of the social asymmetry required the focus to be placed on either the actors or the nature of the interaction between the actors. If the focus was placed on the actors, then the researcher studied the roles and statuses the actors derived from their involvement in the asymmetrical relationship. If the focus was placed on the interaction then the researcher studied how the participants interacted with each other. Based on this assumption, the focus of the study was placed on the physician-patient interaction, which represented an example of asymmetrical relations between the physician and the patient. This relationship was a standard interaction in the hospital emergency department and a part of the practice of emergency medicine. Therefore, studying the physician-patient interaction in the hospital emergency department represented the best means to understand emergency medicine, the hospital emergency department, and the habitus of emergency medicine physicians.

Finally, Bourdieu's concept of culture in practice theory was far more restrictive than that found in anthropological research, where culture was believed to be a socially and historically specific, internalized symbolic system (Calhoun et al., 14, 1993). In anthropological research culture has taken on several meanings and concepts as a means to describe the meaning of human action. In the context of this dissertation, the anthropological concept of culture that was applied to this study was taken from the work of social scientist Robert Lawless (1979). Culture was defined by Lawless (1979) as representing and reflecting a way of life that people followed, specifically, culture represented specific ways of living (Lawless, 1979). The usefulness of Lawless's

definition of culture was seen in the way that he acknowledged how culture reflected the learned, rational, shared patterns of behaviors and beliefs that were adaptive and dependent upon human social interaction for continued existence (Lawless, 1979). Thus, the concept of culture, based on the work of Lawless (1979), was used as a tool to increase our understanding of how people lived and adapted to their social and cultural environment.

However, the narrow nature of Bourdieu's definition of culture was seen in a positive aspect based on how practice theory used culture to study human social actions and behaviors. In Bourdieu's eyes, culture was functionalism because he saw culture as being the totality of meaning ascribed by the participants to the practices, which constituted the way of life within the system (Calhoun et al., 1993). Bourdieu conceded that at times, the meaning attached to the practices of the participants were not always objectively correct, nevertheless, the meaning was functional. Bourdieu made this judgment because the meaning ascribed to the practices of the participants represented the best that had been said and done by the dominant classes within the cultural system (Sulkunen, p. 104, 1982). Over time, the practices of the participants became known as habitus because of the meaning it gave to being in the role of participant within the cultural system.

Bourdieu also saw culture as being relational in nature. He viewed culture in this way because he thought culture expressed, reproduced, and legitimized the social structural relationships within the cultural system (Calhoun et al., 1993). Bourdieu did not use the concept of culture to build a model for predicting human behavior. Instead, the concept of culture to Bourdieu represented an ever changing phenomenon in which

the participants ascribed meaning to practices at that particular time and space (Sulkunen, p. 104, 1982).

Both ways of viewing and understanding culture was important to this dissertation. In particular, Bourdieu's (1993) concept of culture was necessary because it helped to define the focus of the research, which was the habitus of the emergency physician. His concept of culture also helped to identify the habitus of the emergency physician. The habitus of the emergency physician was defined as representing the manner in which they performed during the physician-patient interaction in the hospital emergency department. The concept of culture used by Lawless (1979) was important to this dissertation in that it helped to explain any discrepancies that might have occurred in the habitus of the emergency physicians. This aspect was important for the following reasons.

According to Lawless (1979), all members of a cultural system possess notions about what behaviors and beliefs are acceptable. These behaviors and beliefs represents what people believe *ought* to happen or take place within the cultural system. Such behaviors and beliefs represented the ideal, which was defined as being the totality of rules, ideas, and values that people consistently claimed to be the best way of doing things (Lawless, 1979). In this case, the rules and ideas were the norms of that cultural system. Hence, real culture reflected the patterns of behaviors, beliefs, and values developed based on the way people *really* did things.

The Pilot Study

The pilot study represented the completed groundwork necessary for undertaking this research. During this initial phase of the research the field site was identified along

with two point persons for gaining entry into the field setting. One point person assisted in securing entry into the hospital setting as a whole. She in turned introduced me to the point person who assisted with the entry into the hospital emergency department. Both point persons were vital to and played a role in the success of the field study in the following manner. First, each of the point persons had a rapport and established relationship with each other. Second, each of the point persons supported the research and the researcher being at the hospital institution, including the emergency department.

After securing entry into the field site, it was important to have an established relationship with each of the point persons. This was important and crucial for several reasons. First, maintaining a rapport with the field site point person gave legitimacy and credibility to the researcher being an observer and participant in the hospital emergency department setting. Second, the field site point person was a practicing emergency medicine staff physician whose support, insight, and participation helped to provide a more complete understanding of emergency physicians and the hospital emergency department. Third, I was relieved to hear the positive response and support from each of the point persons because it alleviated much fear and stress in performing the field study.

The field site was a Level I Trauma Center in an urban teaching hospital emergency department. The goal of the pilot study was twofold: 1) to gain entry into the hospital emergency department, and 2) to observe and investigate how emergency physicians produced medical knowledge. Eleven subjects were recruited for the study (see Table 1). In anthropological studies, which are qualitative in nature, subjects are called informants. The study sample included informants who were third year residents in emergency medicine, senior staff emergency medicine physicians, an emergency

department pharmacist, patient advocates, and a clinical nurse specialist. Residents in emergency medicine are physicians completing their training in emergency medicine and are not yet board certified in emergency medicine. Senior staff emergency physicians are doctors who have successfully completed their residency training in emergency medicine and are board certified to practice emergency medicine. The sample population was also diverse and included males and females, and Europeans (white), and African-Americans.

Informant	Gender	Position	Ethnicity
1	Male	Third Year Resident	Black
2	Male	Third Year Resident	Black
3	Female	Patient Advocate	White
4	Male	ED Pharmacist	White
5	Male	Senior Staff Physician	Black
6	Female	Patient Advocate	Black
7	Male	Clinical Nurse Specialist	White
8	Male	Senior Staff Physician	White
9	Male	Senior Staff Physician	White
10	Female	Patient Advocate	Black
11	Male	Senior Staff Physician	White

Interviewing other emergency department staff was important because it revealed the nature of the relations and interactions between the actors in that setting. The mixture of emergency department staff involvement and participation in the study sample produced a representation of the social relations inherent in cultural systems that are characterized by asymmetry, inequality, and dominance. Producing such a sample population in this manner replicated the axiom in practice theory that the best way to know and understand how the cultural system functioned was to study the asymmetrical relations within.

Contribution of the Pilot Study to Phase II and Phase III

The research design of the pilot study provided many methodological design insights that were important and implemented in the design of phase II and phase III of the study. First, knowledge and understanding from the pilot study suggested how to observe the physician-patient interaction in greater detail. This awareness helped to train the research gaze on how to study and observe how the informants (i.e. emergency medicine physicians) interacted with their patients in the hospital emergency department. For example, observation of the informant began at the moment they picked up the patients chart and ended when they determined the final disposition of the patient.

Second, the pilot study also provided insight on how to conduct the dissertation study with regards to time, number, and length of observations. For example, based on the experience of the pilot study the observation period of the informant in phase II was defined as being an episode that was equivalent to one shift in the emergency department. The time of observation during the shift was at least three hours, no more than four hours. Each informant was observed for at least one shift, no more than two shifts at a time.

Third, the types of questions asked during phase II and phase III was based on the design and results from the pilot study. For example, based on the informants responses during the pilot study informants in phase II and phase III were asked questions relating to their perception and understanding about their role as an emergency medicine physician. The topic of primary care and health disparities was also addressed during both research phases.

The pilot study was instrumental and used as a guide in the development of the research design used in phase II and phase III. The knowledge, insight, and experiences gained from the pilot study helped to generate the narrative interview questions used

during the one-on-one interview of the informants, and the coding schemes used to collect and analyze the research data. Finally, the pilot study helped to define the physician-patient interaction as a social interaction. This was important because this allowed the interaction to be viewed and examined for social and cultural influences. A limitation of the pilot study was that the focus was only on the dominant side of the physician-patient interaction, namely the emergency physician. The decision to limit the scope and focus to the emergency physician was based on the original motivation of the researcher, which was to discover and understand how emergency physicians functioned in the hospital emergency department and how they interacted with their patients.

Phase II

The focus in phase II was still placed on the physician-patient interaction. However, a more in-depth analysis on how the physician interacted with their patient was completed. The purpose for the in-depth analysis was to learn if there was a connection between physician characteristics such as ethnicity and patient health disparities. The question asked was, is there a relationship between physician ethnicity and patient care choices as a measure of patient health disparities? In order to answer this research question, the researcher observed and studied the behavior of the emergency medicine physician as they interacted with the patient during the physician-patient interaction. This narrow focus produced a limitation regarding a true interpretation of the social interaction between the physician and the patient. Interviewing only the physician produced a limited understanding of the physician-patient interaction. The initial analysis of the data failed to confirm the existence of a relationship between emergency physician ethnicity and patient care choices as an indicator of possible health disparities. At this

juncture, a reassessment of the dissertation was made and a new direction was taken in exploring the nature of emergency medicine and the role of the emergency medicine physician. The focus was now on identifying the habitus of the emergency medicine physician and its relationship to culture.

Two field sites were chosen for the research study as a means of comparing various hospital emergency department settings and environments. The purpose for the comparisons was to determine if emergency department behavior differed in different emergency department settings. For confidentiality purposes, each site was identified as site one and site two respectively. The first site was a large public hospital emergency department. This site was categorized as a Level I trauma center within a teaching hospital and research institution. Level I trauma meant that the most serious, life threatening trauma cases were seen and treated at this hospital emergency department field setting. The highest form of emergency care was delivered to patients seen and treated at this emergency department because it was a teaching and research institution. Thus, the most advanced and aggressive forms of treatment and resuscitation were seen during field observation in this emergency department setting. Finally, the patient population seen and cared for in this field setting was predominately African-American.

The second field site was a much smaller satellite suburban location. The satellite site was not categorized as a Level I trauma center. The trauma cases seen at this location were initially received, stabilized, and later transferred to the main campus location for advanced care and treatment. The site was neither a teaching nor research institution. Residents that rotated through the satellite setting were primarily in pediatrics. The

patient population seen through these sites were mixed: African-American, White (Indo-European), Chaldean, and Arab.

Phase II Study Sample

The goal for phase II sample size was twenty informants (i.e. emergency physicians), ten informants from each field setting. However, only seventeen informants were recruited: ten from site one the public hospital and seven from site two the suburban satellite location. The sample population at the public hospital included both second and third year residents and senior staff emergency physicians. The informants who were self identified as being residents in emergency medicine were observed interacting with their patients. At the satellite location, all seven informants were self identified as senior staff physicians and were observed interacting with their patients. The observation period of the informants interacting with their patients at each of the field site locations began the moment the informants picked up the patients chart and ended when a discharge disposition was assigned. Each of the informants at both sites was interviewed one-on-one. In both research sites, informants were enrolled sequentially until sample size was reached. Each informant self identified their ethnicity, and included male and females. See table below.

Table 2.

Study Population Demographics – Phase II

Informant	Gender	Position	Ethnicity
1	Male	Third Year Resident	White
2	Male	Third Year Resident	Other
3	Female	Third Year Resident	Black
4	Male	Second Year Resident	White
5	Male	Second Year Resident	White
6	Female	Third Year Resident	White
7	Male	Third Year Resident	White
8	Male	Third Year Resident	White
9	Male	Second Year Resident	Other
10	Female	Senior Staff Physician	White
11	Female	Senior Staff Physician	Black
12	Female	Senior Staff Physician	Black
13	Female	Senior Staff Physician	White
14	Male	Senior Staff Physician	White
15	Male	Senior Staff Physician	White
16	Male	Senior Staff Physician	White
17	Male	Senior Staff Physician	White

Informant participation and inclusion in the study was based upon meeting the following conditions: 1) self identification as an emergency physician or resident in emergency medicine 2) are twenty-one years or older, and 3) are currently practicing emergency medicine in an established emergency department. Exclusion from the study was individual's that: 1) were patients seen in the emergency department, and 2) those that were not certified to practice emergency medicine.

Types of Data Collected

From this point and forward, discussion of the methodology proceeded from the new direction taken regarding the study of emergency physician habitus and the relation it had to culture. Different methods were used to collect data in phase II and will be discussed individually based on their occurrence in the phase II process. The different methods of data collection included the following: audio taping of the physician-patient

interaction in the natural setting of the emergency department (based on physician and patient informed consent), field notes of the physician-patient interaction while audio taping, informal interviews of each informant, and field notes while in the natural setting of the hospital emergency department. A cultural text analysis was also done on the TV drama ER, which generated data that revealed popular values, beliefs, and stereotypes associated with emergency medicine, emergency physician habitus, and the hospital emergency department. The following instruments were created by the researcher and used to collect data in this phase of the study: 1) The Physician-Patient Interaction Observation Check List (see Appendix A), 2), The ER Episodes Check List (see Appendix B) and 3) The Unstructured Interview Question Survey (see Appendix C). See the section Developing the Research Instruments for an explanation of how each instrument was developed.

Using multiple methods to collect data, known as triangulation, was essential and provided a means to establish consistent internal validity. Triangulation, defined as the use of multiple methods to collect qualitative data, was a necessary requirement for this dissertation study. For example, the triangulation data collection process was carried out by audio taping the informants interacting with their patients, while taking field notes of what was seen during the physician-patient interaction. The audio taping of the informants recorded how they interacted with the patient during the physician-patient interaction (the informant was recorded greeting the patient by name). The field notes recorded what the informant was observed doing when interacting with the patient (they greeted the patient by name), the ethnicity of the physician and the patient, and the gender of the physician and the patient. Next, the data points were compared and

examined to identify discrepancies and check for the validity of what was observed and heard. Performing this data collection process was important and served as a tool for verifying what the informant said as opposed to what they did. In addition, this assisted the researcher in not becoming bias or narrow in their view and interpretation of the situation. In other words, these two forms of data collection complemented each other and served as a rudimentary “checks and balances” and established credibility in the analysis of the research data.

Observation of the physician-patient interaction by audio taping and field notes also provided a means to identify those routine, patterned forms of behaviors and practices associated with the delivery of patient care in the hospital emergency department. For example, variations in the presentation of symptoms, illness, and diseases during the physician-patient interaction reflected some degree of variation in such routine, pattern behaviors such as decision-making, taking the patients history, and performing the physical exam. The ability to identify these routine, patterned forms of behaviors and practices was important because over time, they produced the habitus of being an emergency physician. Further, triangulation of the data collection process was also beneficial because it captured the variations in habitus, which reflected a key notion that Bourdieu had about habitus. He realized that habitus was not deterministic but a framework for understanding human actions and behaviors within the cultural system (Sulkunen, 1982). In other words, social life within the cultural system was the embodiment of habitus, which reflected the practices of improvisation, and the actor’s ability to play the social game of interaction (Calhoun et al., 1993).

The informants at both field sites determined which physician-patient interactions were selected based upon their knowledge, expertise and experience, the severity of the patient's condition and the patient's ability to give informed consent. Once the informant selected the case, the researcher was invited along, introduced by the physician to the patient, after which, the patient gave their informed consent to the researcher and the physician. The Physician-Patient Interaction Observation Check List was used to record what the researcher saw the informant doing while interacting with the patient. The researcher did not observe patients who could not give informed consent, and those patients who were critically ill or injured and those going through resuscitation.

This approach to observing medical encounters allowed the researcher to maintain a presence in the emergency department and acknowledge the urgency and time constraint of the emergency physicians, while not hindering or interfering with the flow of patient care. This was most important because this method of selecting the physician-patient interaction really gave the researcher an opportunity to gain an awareness and understanding of what emergency physicians consider being routine in a critical care environment. For example, it was routine to see, evaluate, and treat patients in the emergency department complaining of pain in the abdomen or with symptoms of asthma.

After completing the physician-patient observation period, each informant was interviewed once using the Unstructured Interview Question Survey developed by the researcher. The one-on-one interviews of the informants took place in the natural field setting of the hospital emergency department. Interviewing the informants in the emergency department helped to maintain the flow of the research experience of being in the emergency department. This also promoted an atmosphere of comfort and familiarity

for the informants. Informed consent was secured from the physician. Confidentiality was continuously stressed and assured to all informants interviewed.

Field notes were recorded while in the field setting and revealed examples of physician behavior while in the hospital emergency department. This was important because these examples of physician behavior revealed possible instances of how physicians may positively or negatively perceive the patients that they see and treat in the emergency department. These field notes were not taken or recorded during observation of the physician-patient interaction. Instead, these field notes were recorded as the researcher sat in the medical office and waited for the informant, or occurred in between observations of the physician-patient interaction. During this period of data collection, the researcher observed and heard some of the senior staff physicians and residents making fun or ridiculing the patients while conversing among themselves in the medical office. The researcher was able to record at least three incidents in which this behavior occurred. For example, one senior staff psychiatrist, following their case consult, announced as they walked into the medical office that the patient was on their way to their circle of life. The circle of life in this scenario meant that the patient was being transferred to the psychiatric facility. This display of behavior reflected other aspects of physician habitus that was non-medical in nature. In this case, the field note data revealed how the informants might perceive their patient while interacting with them in the emergency department.

Cultural Text Analysis of ER

This form of data collection occurred throughout the phase II process. Several episodes of the TV show ER was used to form the cultural text data. The purpose of

collecting this data was to produce some form of a cultural representation to determine how popular cultural values, beliefs, and stereotypes associated with emergency medicine, the emergency department, and emergency physician habitus were expressed. The assumption made in order to produce the cultural text data was that the TV show ER was a cultural depiction of American values, beliefs, and stereotypes associated with the practice of emergency medicine, the hospital emergency department, and with emergency physicians. Based on this assumption, the researcher believed that the cultural text data generated by the TV show ER produced the insight and meaning necessary to understand the habitus of emergency medicine physicians. The cultural text data also provided an added source of culturally rich data that was informative, especially with regards to the culturally perceived roles of emergency medicine, the hospital emergency department, and emergency medicine physicians within society.

Cultural Text Sample

The ER episodes were selected from the first season, and included the pilot show. A total of six episodes of the TV show ER were used to collect the cultural text data. Each episode was one hour in length; which translated into six hours of viewing time by the researcher. The pilot show was included because it expressed the show's creator idea of the urban hospital emergency department. The remaining five episodes were selected as they appeared in sequence during the first season. New episodes were analyzed until no new plots, or characters were introduced. The ER Episodes Check List instrument was used as a tool to collect the cultural text data. As the researcher viewed each episode, the ER Episodes Check List was used to record cultural text data.

The following data were recorded using the ER Episodes Check List: 1) how physicians talked about and referred to their patients during the episodes, 2) recording of basic demographic data of the patient and the physician, such as gender, race, and socioeconomic status of the patient, and 3) the type of medical condition of the patient. Physician perception of the patient was also recorded as a means of determining the presence of discrimination, stereotypes and bias, and incidents of racism. For example, the researcher recorded whether the physician blamed an African-American patient for their medical condition, or failed to acknowledge the patient as being responsible for their medical condition. The data collected represented the cultural image of what physicians actually did when they encountered their patient and how the physicians perceived their patient while seeing them in the emergency department. The researcher also used the ER Episodes Check List instrument to observe and record what types of medical cases were typically portrayed in the show's depiction of an urban emergency department as well, such as high blood pressure, chest pain etc. Each of the episodes, including the pilot, represented the initial appearance of the show on network TV and reflected a fresh look and image at how society through popular culture defined and characterized what emergency medicine was all about.

These episodes represented the cultural initial image of how the entertainment media understood emergency medicine, the hospital emergency department, and viewed emergency physicians. Examining various episodes and observing how the popular media portrayed emergency medicine, emergency physicians and the emergency department in the show produced the cultural text data. The cultural text data generated provided a glimpse of how society characterized the roles of emergency medicine,

emergency physicians, and the emergency department. Most importantly, the cultural text data from the show also gave an ideal of the practices associated with emergency medicine, along with the habitus of the emergency physician.

Data Analysis for Phase II and Cultural Text Analysis

Several methods were available to analyze the qualitative data. The method used in phase II data analysis was grounded theory. During data analysis the researcher placed emphasis on the identification of concepts from the close reading of the text. The qualitative data used for analysis in phase II was the interview data, and the ER cultural text data. The interview data was prepared for data analysis in the following manner. First, the audio taped interview with each informant was transcribed into a written text. Each of the transcribed texts were put into a word document file and labeled by informant and interview date. After transcription, the word file was coded using the coding scheme created by the researcher. This coding scheme produced a codebook that was used to interpret the transcribed interview data.

The techniques used in grounded theory to develop the codebook for the interview data proceeded as follows. First, the text is closely read and evaluated for categories, and concepts embedded within the text. The categories and concepts, which emerged from within the text, represented reoccurring values, beliefs, and ideas that were expressed by the informant during the interview process. This process of coding text translated the free flowing text (i.e. spoken speech of the informant) into a nominal variable called theme. The themes identified from within the text communicated cultural values, beliefs, and ideas of the informants. For example, one theme coded from the interview data had to do with the role of the informant as an emergency physician, and as a physician in the

emergency department. Eleven individual themes emerged from within the interview data. The codes identified were as follows: 1) roles, 2) health disparities, 3) physician perception of patients and their behavior(s), 4) physician training, 5) objective and goals in emergency medicine, 6) rationale for selecting emergency medicine, 7) history, 8) challenges, 9) cultural models, 10) presentation of self, and 11) emergency department setting. After reaching code saturation, the point where no new codes emerged, the researcher analyzed how each code was linked to one another. This was the second step in the process of the development of the coding scheme.

Analysis of how the eleven codes were related involved looking at the relations between codes to see if there was overlap or consistencies. If there was an overlap between the codes, then those codes were collapsed into one larger code or chunk of data. Those codes that had little relations were left as they were. This step in the analysis produced the following five dominant themes from within the interview data: 1) perception of the patient, 2) patient challenges, 3) presentation of self, 4) roles, and 5) cultural models. The quality and credibility of the data analysis process was enhanced by the third step termed memoing.

Memoing was the method of taking field notes on observations about interview text data. It entailed a continuous process of recording thoughts about what was read in the interview text data, meaning, and how themes related to each other. The researcher with assistance and guidance did this process continuously over the course of the data analysis process. In the final analysis, the five dominant themes were found to be the most representative of the values, beliefs, and ideas regarding emergency medicine, the hospital emergency department, and emergency medicine physicians that emerged from

within the interview text data. The interview codebook was comprised of the following. Eleven general codes from within the interview text and five dominant codes based on the relations between the eleven general codes. See table below for a summary of the five dominant codes within the Interview Codebook. The Interview Codebook can be found in Appendix D.

Code	Inclusion	Exclusion	Example
Perception of the patient	Statements made that addressed some aspect of the patient	Any statement that did not address some aspect of the patient	Some of them have good access to healthcare and they just don't take care of themselves
Challenges	Statements made that pointed out challenges and difficulties faced when interacting with patients	Any statement that was made that reflected broad issues in the healthcare system	I think the most important challenge is that while we handle illness everyday and you become somewhat desensitized to it
Presentation of self	Any phrase or statement used to describe how the informant felt or thought when interacting with patients	Any statement that was not related to emotion or described emotions	I think it's my demeanor or I'm frustrated more at myself for not identifying what they need
Roles	Statements made that defined the role of the emergency physician	Statements that did not address the role of the emergency physician	The role of the ER physician is multiple
Cultural models	Statements used to describe how the informant believed popular culture defined their role	Any statement not related to the cultural image of emergency physicians	I don't know if it sounds a bit elitist but we're probably one of the last few remaining real doctors

The data analysis for the cultural text data was performed in a similar fashion. Using the ER Episodes Check List, cultural text data was generated by recording the various medical problems that patients experienced during the one-hour episode. For example, the researcher recorded the nature of the patient's medical condition, the age of

the patient that was recited from the script of the show, and some dialogue that occurred between the physician and the patient. The gender and ethnicity of the physician and patient was also recorded as well.

After the recording of the ER cultural text data, a coding scheme was created to help analyze the cultural text data. Following the same process implemented in the data analysis of the interview text data, an ER coding scheme was produced. The dominant codes that emerged from the cultural text data were as follows: 1) medical condition of the patient, 2) physician attitude and perception of the patient, 3) life stage of the patient, race and ethnicity of the patient, 4) patient's socioeconomic status, and 5) patient's gender. All five dominant codes were placed in the ER Episodes Codebook (see Appendix E).

Developing the Research Instruments for Phase II and Cultural Text Data

Several instruments and recording procedures were used to collect research data. Several months were invested in the creation of the Physician-Patient Interaction Observation Checklist, which involved several important sources of input. The sources that were relied upon in developing this instrument were: 1) input from both research site sponsors, 2) input and direction from my dissertation committee chair, 3) reference to the Emergency Medicine Core Competencies requirements taken from the "Outcome Project" (<http://www.acgme.org/outcome/comp/>), and 4) reference to the unstructured interview questions used in this research. Each of the aforementioned sources helped shape and develop the instrument.

Each source was vital and unique in its contribution to the development of the Physician-Patient Interaction Observation Checklist. The contributions made included

unique expert knowledge and experience needed in order to devise an effective observation-measuring tool. Finally, the input from each source provided the necessary input and patience in perfecting the checklist, thereby creating an instrument that was capable of focusing on what the researcher was trying to capture and measure. After each correction, the instrument was pilot tested prior to final approval and implementation.

The next data instrument created was the Unstructured Interview Questionnaire. The questions in this instrument were open-ended and were constructed to inspire the informants to talk openly and feely about being an emergency physician. This instrument took some time to develop and finalize. The sources used to create the instrument included input and direction from the dissertation committee chair and the insight gained from the pilot study. For example, insight from the pilot study pointed me in the direction of asking the informants to explain their role in the emergency department and as an emergency medicine physician. The purpose of creating and using this instrument to collect data was to capture and explore the informants' experiences in emergency medicine and their thoughts about being a physician in the emergency department.

The ER Episodes Check List was developed to collect cultural text data from the TV show ER. The procedure for developing this checklist was similar to the one followed in the development of the Physician-Patient Interaction Observation Checklist. However, the difference pertained to the sources used to develop the instrument. The ER Episodes Check List required input from my dissertation committee chair to complete the task. After several revisions, a finalized version was approved for the recording of the cultural text data from the TV show ER.

Phase III

A third phase of research was undertaken that examined the meaning of emergency medicine habitus that emerged from the data collected and analyzed in phase II. For example, emergency physician habitus in phase II was the practices of stabilizing and treating patients experiencing a life threatening medical crisis and saving or prolonging life through resuscitation. However, the findings also suggested that the habitus of emergency medicine became sensitized to the cultural and social characteristics of the patient population seen and treated in the hospital emergency medicine department. The outcome of the sensitization was an expansion in the habitus of emergency medicine physician. Thus, to examine the relations between culture and habitus, and the influence cultural and social characteristics had on the habitus of emergency physicians, a third phase of research was added to the dissertation study.

The focus of the phase III study was on emergency medicine training as an outcome and indicator of the sensitivity of emergency physician habitus to cultural and social characteristics of the patient population treated in the hospital emergency department. The objective in this phase of study was to determine if the sensitivity of emergency physician habitus influenced or altered emergency medicine training. To better understand how the emergency physician functioned in the space of the expanded habitus, an assessment of their experiences as emergency physicians seeing and treating patients in the hospital emergency department was made. The perceived expansion in the emergency physician habitus emerged from within phase II data and was reflected in the informant's references to the delivery of primary care in the emergency department.

Phase III Study Sample

A third research field site was selected to carry out the phase III study. The third site selected was a public medical school and emergency medicine training program, which was affiliated with a public teaching hospital emergency department. The hospital emergency department was a Level I trauma center, a teaching hospital and a research institution. This site also provides and delivers the highest form of emergency care including the most advanced and aggressive forms of resuscitation and treatment. The patient population serviced in the hospital emergency department was predominately African-American.

The desired goal for the sample size was at least two no more than ten. The research informants were to be enrolled sequentially, depending on availability and until the sample size was reached, if possible. However, the sample size was small. Three informants were successfully recruited as participants in phase III with informed consent. Inclusion in this study was based upon the following criteria: 1) self identify as an emergency physician, 2) self identify as a professor of emergency medicine at the field site location, 3) are twenty-one years or older, and 4) are currently practicing emergency medicine in an established emergency department. The sample population consisted of two white male professors of emergency medicine and one white female professor of emergency medicine. Exclusion from the study were those who did not self identify as a professor of emergency medicine and who were not certified to practice emergency medicine. The informants that participated at this site were staff emergency physicians and had practiced emergency medicine more than three years beyond their residency program in emergency medicine, and were now professors of emergency medicine.

Types of Data Collected in Phase III

The purpose for phase III data collection was to explore how emergency physician habitus was sensitive to the social and cultural characteristics of patients seen and treated in the hospital emergency department. For example, examining how culture expressed through patient characteristics altered the habitus of emergency physicians could help explain how emergency physicians functioned in the emergency department. A single method was used to collect data during phase III. The data collection process lasted for several months and was based on the availability of the informants.

The researcher completed an one-on-one interview with each informant using the newly developed protocol instrument, The Narrative Interview Questionnaire (see Appendix F). The one-on-one informant interviews were audio taped and carried out at the third field site. Interviewing phase III informants at the third field site promoted continuity and familiarity for the informants. After completion of the one-on-one interviews, each audio tape recording was transcribed and placed in a word document file then labeled and identified by informant and date of interview.

The attributes measured by the Narrative Interview Questionnaire touched on the areas of training and experiences in emergency medicine. Specifically, the attributes measured were as follows: 1) residency training in emergency medicine, 2) professional experiences practicing emergency medicine, and 3) professional experience as a professor teaching emergency medicine. Collecting this type of narrative data provided a means to discover the similarities in the informant's experiences in being an emergency medicine physician. Uncovering the similarities in the experience of being an emergency physician revealed in a greater fashion how physicians functioned in the hospital emergency department. Identifying similarities also revealed how habitus of the

emergency physician was formed over time, and possibly what brought it into existence especially with regards to training. Even more important, the narrative interview data gave the researcher a better understanding of the meaning, purpose, and function of emergency medicine in the care of the poor and the uninsured. It produced a better picture of what emergency physicians experience in their day-to-day practice of emergency medicine.

Data Analysis for Phase III

The data analysis procedures used in phase II was used in phase III. After transcription of the narrative interview data into written text, it was placed in a word document file. The file was then logged according to the informant interviewed and the date of the interview. The narrative analysis consisted of reading the text and looking for similarities in how each informant told their stories about their experiences in emergency medicine. The codebook developed and used in phase II was used to identify the similarities in the text file generated in phase III. The major codes identified for similarities were 1) training, 2) professional experience, and 3) teaching experience.

Developing the Research Instrument for Phase III

The interview question protocol, The Narrative Interview Questionnaire was created during phase III of the study. The process of developing the instrument was similar to that which took place during phase II. Input was crucial and was mainly from the chair of the dissertation committee. The researcher and committee chair worked together and was guided by the insight received from the data collected and analyzed in phase II. Several revisions were completed prior to finalization. The questionnaire had three parts and addressed a specific aspect of the informants experience in emergency

medicine. The first part addressed the informants experience in teaching emergency medicine. The second part of the questionnaire addressed the informants experience with emergency medicine training. The third part of the questionnaire addressed their professional experience as practitioners in emergency medicine.

Each area was measured by asking questions that touched on that specific area. As a professor of emergency medicine, the informants were asked questions pertaining to residency training. For example, one question asked of the informants was “Are emergency physicians trained to work with non-emergency problems?” Also training in emergency medicine was assessed by asking the informant if training goals and content has changed in emergency medicine, and if so, how. In order to assess their professional experiences as staff physicians in the emergency department, the informants were asked questions relating to their role in delivery of patient care. For example, the informants were asked: “In what way is emergency medicine similar and or different from primary care medicine?”

Asking phase III informants to tell the story of their experiences thus far in emergency medicine measured the similarities in the narration of the informants. Professional experiences and anecdotes were measured and recorded by allowing the informants to tell their story of being an emergency physician. They could start anywhere, and end anywhere they wanted. Approaching their experiences in emergency medicine in this fashion ensured that the experience of being an emergency physician, good or bad, would be in their own words without any prejudicial persuasion or bias from the researcher.

Conclusion

This chapter described the foundation of this dissertation study along with the methodologies used in the data collection process. There were three phases of study: the pilot study, phase II, and phase III. Each phase had a distinct purpose and distinct methodology. The pilot study laid the foundation of the dissertation study. The primary purpose for the pilot study was to successfully gain entry into the field site and maintain a rapport within the research setting.

Phase II started out with a focus placed on the ethnicity of the emergency physician and its relationship to patient care choices as an indicator of a possible form of health disparities. No such relationship or connection was found. This finding prompted a reassessment of the dissertation study and generated a new direction and purpose for the field study. The new study led to further study of emergency physician habitus and its relations to culture. Several methodologies were used to collect the data as a means for creating credibility of the qualitative data. Phase III followed up on the findings that emerged during data analysis in phase II. At that point, the researcher was interested in discovering how habitus was related to patient social and cultural characteristics. Finally, in each phase of the dissertation data analysis was rigorous. Overall the chapter was detailed and provided a narrative of what took place and how data was evaluated for meaning.

Chapter 5 “The Relationship between Culture and Emergency Physician Habitus”

Introduction

The habitus of emergency physicians was the subject and focus of this study. Emergency physician habitus was exemplified during the physician-patient interaction: and was defined as social practices, which reflected the routines performed every day. For example, observations of the physician-patient interaction produced the following typical scenario:

Informant: Hi Mr./Mrs. Patient X, I’m Doctor Smith; what brings you to the ER today?

Patient X: explains what is bothering them and the symptoms they are experiencing.

Informant: restates the symptoms that the patient reported having

The dialogue between the informant and the patient continued until the physician completed their clinical decision-making process. The research site was the urban hospital emergency department. The research questions asked how culture was related to emergency medicine and how culture was related to emergency physician habitus. In other words, the study sought to understand how culture influences emergency medicine and how did culture creates, or reproduces emergency physician habitus.

Results from the data analysis in phase II and phase III produced several important findings explaining the relationship between culture and emergency medicine and between culture and emergency physician habitus. This chapter addresses two aspects of the findings found in phase II: the ER cultural text findings and the interview data findings. The phase II ER cultural text findings discussed pertain to the following dominant themes identified in phase II: 1) roles, and 2) cultural models. The interview findings were discussed as they related to the ER cultural text findings. The remaining

three dominant themes identified in phase II (perception of the patient, patient challenges, and presentation of self) and phase III analysis is discussed in chapter six.

ER Cultural Text Analysis

A relationship between emergency medicine and culture was established in order to determine if culture creates and reproduces emergency physician habitus. Examining this relationship is important because it increases our understanding of the association between popular culture and emergency medicine. This was accomplished by examining the TV show ER. Based on observations of ER episodes, the researcher identified the role of emergency medicine in popular culture; and conversely, the influence of ER on emergency physicians. Using the ER episodes as examples of the way US culture depicted, defined and understood emergency medicine, the cultural text provided an avenue for revealing the cultural values associated with emergency medicine, the emergency department, and the emergency physician. The core values, which emerged during data analysis, supported the assumption of an existing relationship between culture and emergency medicine. The core values that emerge and are discussed in this chapter are: 1) preservation of human life, 2) decisiveness in clinical decision-making, and 3) empathy. Each of these core values were found to be related in some aspect to the two dominant themes, 1) roles, and 2) cultural models.

The first cultural core value, preservation of human life, was observed and identified as being associated with the dominant theme roles. This cultural core value was reproduced by the act of resuscitation. In the cultural text of ER resuscitation was recognized as being one of the major activities that were performed in each of the episodes. For example, resuscitation was observed twice during the pilot episode. The

outcome of resuscitation was not always positive. However, it reflects a major core value in emergency medicine, the ability to preserve life by preventing the onset of sudden death. Resuscitation also reflects the value attached to life by the overcoming of death.

Resuscitation represents the emergency medicine physician's ability to save a life by intervening in life threatening crises. Resuscitation also exhibits the activities associated with the cultural core value of preservation of human life. Culturally, advances in resuscitation represent a catalyst in the development of this medical subspecialty. The cultural value implicit in the development of emergency medicine is the value of preserving human life. Observing the act of resuscitation helps to clarify how culture influenced the development and nature of emergency medicine. Culturally, resuscitation represents both an emergency medicine activity that was attached to the cultural core value preservation of human life and a specific process that is directly related to and reproduced the habitus of emergency physicians. In the context of practice theory, resuscitation reflects the practices that incorporated a specific set of mental structures and internalized schemes that guided the emergency physician's interpretation, understanding, and evaluation of the patient at a critical time and space.

In practice theory, resuscitation is part of the habitus and reproduced the habitus because it represents a specific set of abilities; routine patterned forms of behavior embodied within them the fundamental notion of time (temporal), space, and social ordering which underlined and helped organized the hospital emergency department as a cultural system (Bourdieu, 1990). Temporally, the habitus of resuscitation dictates that the patient was experiencing a critical emergency that required immediate medical attention. In the hospital emergency department, resuscitation dictated the spatial and

social ordering of the patient in terms of treatment and care. The resuscitation patient received priority medical attention and treatment ahead of other patients without delay. Again, resuscitation reflected an important aspect of the cultural core value preserving human life—specifically to acting quickly on behalf of the patient doing no harm and saving their life.

The practice of resuscitation helped to structure the hospital emergency department. Simultaneously, the hospital emergency department generated the appropriate spatial and temporal practice of resuscitation (Bourdieu, 2005). The practice of this habitus was viewed and interpreted as a process of cultural and social reproduction that is responsible for the continuity and regularity of the social structure in the hospital emergency department (Jenkins, 1992). The habitus of resuscitation was not viewed as the habitus of a collective homogenous phenomenon (Jenkins, 1992). Instead, this habitus was understood as being acquired through training and practice in residency. In practice theory, the experiences generated from each of these aspects, training and residency was manifested as a process of adjustments the emergency physician had to make between the habitus of resuscitation and the reality of seeing and treating patients in the hospital emergency department (Jenkins, 1992). Finally, from the perspective of practice theory, we can see resuscitation as representing the answer to society's quest to conquer death. Resuscitation expressed the core value of emergency medicine—to preserve human life. Further, advances in resuscitation science along with the cultural popularity and interest in the TV show ER led to the spread of the medical specialty of emergency medicine.

The cultural core value preservation of human life expressed through the act of resuscitation is related to the dominant theme roles. Observation of the ER episodes showed how the emergency physician functioned in the urban hospital emergency department. They provided care to every patient that entered the hospital emergency department. One major part of their duties observed during observation of the ER episodes was resuscitating patients. This conclusion was based on each episode that portrayed a resuscitation of a patient in the emergency department. The process of resuscitation was a highly specialized, technically advanced medical intervention and procedure involved in the care of critically ill patients. The observations of the episodes that involved resuscitation produced images of the emergency physicians as being trained and equipped to handle medical emergencies that entered into the urban hospital emergency department. In practice theory, the steps involved in the process of resuscitation represented the specific routines, highly specialized patterns of behavior, which revealed the mastery the characters exhibited and exercised over the care of the patient. Therefore, resuscitation was a part of their role in being an emergency physician in the hospital emergency department.

The actions of the characters performing resuscitation expressed the internalized core value of the emergency physician—to preserve human life. The core value became a part of the emergency physician by enculturation during the socialization process in medical school and residency training. The act of resuscitation was also a demonstration of their mastery over the procedure because it reflected the motivation behind their efforts to prevent death of the patient. According to Ortner's (1984) interpretation of practice theory, the asymmetrical relationship between the patient and the emergency

physician allowed for the emergency physician to assume the intrinsic perspective of solving the medical crisis. The gains sought from this interaction and process was the reversal of sudden death and prevention of critical injury to the patient. The ultimate gain was to preserve the patient's life. One of the foci of practice theory is to understand what constituted goodness in people, relationships, and in conditions of life (Ortner, p. 152, 1984). In the case of emergency medicine, goodness would constitute doing no harm. This goodness reflects the cultural core value of emergency medicine and was expressed by the act of resuscitation.

The second cultural core value addressed was clinical decisiveness in decision-making. This core value was demonstrated on the TV show by the various emergencies encountered by the hospital emergency department staff. For example, on ER, every patient that presented to the emergency department experienced the decisive clinical decision-making ability of the emergency physician characters. The fact that any patient, regardless of the medical condition, was seen and treated on the show in this manner is a testament to the validity that decisiveness in clinical decision-making is an important core value. The ability to carry out decisive clinical decision-making in the practice of emergency medicine was recognized and treated as a core value because it highlights an inherently unique characteristic of emergency medicine. That unique characteristic was referenced as a part of the mission and definition of emergency medicine: "...the evaluation, diagnosis, treatment, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care" (American, 2010). This type of action was illustrated through each of the episodes observed. At no time was a patient turned away, or denied care.

The cultural text from the ER episodes manifested this core value by producing episodes, which showed various types of medical conditions as routinely being seen and treated in the hospital emergency department. For example, the various types of medical conditions observed and recorded during observation included gunshot wounds (GSW), cardiac arrests, trauma and or injury to body, motor vehicle accidents (MVA), lacerations, asthma attacks, ulcers, psychosis, and drug overdose. The word routinely was used to describe the regularity of appearance of these medical conditions within the show's episodes. Each episode observed portrayed at least one of the aforementioned types of medical conditions. Thus, any patient that presented to the emergency department experiencing any type of medical conditions set off a sequence of events. These events were routinely carried out in the process of delivering care to the patient. The outcome of this process, decisiveness in clinical decision-making, was identified and termed the habitus of the emergency physician.

Going back to the meaning of habitus for emergency physicians, the application of practice theory would argue that this cultural core value helped them to perform the mission of emergency medicine, which is to see and treat any patient presenting to the hospital emergency department. Through socialization, training, and experience, this cultural core value eventually became an internalized structure and approach to practicing emergency medicine. In practice theory, socialization is the condition associated with seeing and treating patients in the hospital emergency department. One example is learning when to correctly apply the principles of resuscitation. Practice theory views training as the development of the emergency physician's appropriate disposition and response to the objective conditions encountered while functioning in the emergency

department. Practice theory defines the experience of the emergency physician as the sum of the socialization and training process. As time continued, this process produced and became the habitus of the emergency physician.

Finally, the cultural core value, decisiveness in clinical decision-making, was related to the dominant theme roles. The relationship between each of these elements was mediated by the cultural core value associated with the role of the emergency medicine physician, which is to be non-judgmental in the delivery of patient care. Decisiveness in clinical decision-making was expressed through the emergency physician's ability to treat any and all patients presenting to the emergency department. The practice of seeing and treating any patient presenting to the emergency department reflects the core value of being non-judgmental in the delivery of patient care. The ability to be non-judgmental in the delivery of patient care is a requirement and helps to fulfill part of the mission and role of emergency medicine. Thus, the ability to see and treat any and all patients presenting to the emergency department not only demonstrates the cultural core value of decisiveness in clinical decision-making; but also reflects a core value associated with the role of the emergency medicine physician, which is to be non-judgmental in the delivery of patient care.

Decisiveness in clinical decision-making and being non-judgmental in the delivery of patient care was clearly seen throughout each of the ER episodes observed. The character DR. Greene in the pilot episode expressed this aspect of the role of the emergency physician: "People come in here and they're sick, dying, bleeding and they need our help." The cultural core value, decisiveness in clinical decision-making, was

not only related to culture, but over time also reproduced the habitus of the emergency physician in the hospital emergency department.

The interaction of the cultural core values of preservation of human life with decisiveness in clinical decision-making produced the following effect: a cultural image of the emergency physician as hero. In other words, the emergency physician who exemplified both cultural core values was perceived as the hero. This interaction effect was portrayed in the cultural text data as the image of the emergency medicine physician intervening in the medical crisis of any patient presenting to the hospital emergency department in a non-judgmental fashion. The life saving intervention of the emergency physician character was displayed by their performance of certain activities such as CPR (cardio pulmonary resuscitation), and going above and beyond the duty of an emergency physician. In one episode, one of the main emergency physician characters, Dr. Greene, successfully revived an unresponsive child back to life from the brink of death via resuscitation. The reaction of both parents to Dr. Greene was marked by elation, and thankfulness, because their child lived instead of died. In this scene, Dr. Greene was perceived as the hero because he saved the life of the young child. In another ER episode, the emergency physician character assisted the mother of an asthmatic child in obtaining the necessary medications to treat her child.

The cultural image of the emergency physician character as hero also emerged from within the cultural text data in terms of portraying the hospital emergency department as a health care safety-net. In this context, the hospital as safety net was defined in terms of the patient population seen and treated through the emergency department. In the ER episodes observed, every patient who entered into the hospital

emergency department was evaluated and treated. The safety-net status was applied to the hospital based on the types of patients seen in its facility: African-American, poor, or uninsured. The patients in this category represented those who typically are seen in the hospital emergency department and are without some form of health insurance and or access to primary care providers. This category was a good representation of the patients appearing in the ER episodes observed.

The connection between the cultural perception of the emergency physician as hero and the cultural model of the emergency physician was made in the following manner. The cultural perception of the emergency physician as hero was viewed as reflecting the emergency physician habitus. The concept of ideal type was used to describe how the ER episodes observed helped to create a cultural model for understanding the habitus of emergency medicine physicians, and the function of the hospital emergency department (Lawless, 1979). The concept of ideal type was treated as a cultural concept because the model it produced represents the American values, ideas, and beliefs ascribed to the role of emergency physicians and the hospital emergency department. According to practice theory, culture is understood as having a powerfully influencing effect upon emergency medicine physician habitus and the hospital emergency department. To better understand this effect, practice theory was used as a tool to uncover how the ER episodes became influential in constituting the reality of emergency physicians, the hospital emergency department and subsequently, emergency medicine (Ortner, 1984).

Throughout the ER episodes the emergency physician was portrayed as saving the life of patients (i.e. preservation of human life) in medical crisis or distress. Saving the

life of a patient or addressing the patient's medical crisis invoked the image of hero. In essence, the emergency physician was the rescuer whose primary mission was to preserve the patient's life, and not to necessarily ask how. The image of the emergency physician as rescuer was acted out in several ways. For example, in one episode the emergency physician came to the rescue of a mother who could not afford to buy the asthma medication for her daughter. The doctor rescued the patient in that he filled the prescription and took it to her home. In another episode, the emergency physician assisted the parent of a cocaine-addicted child to getting them into drug treatment program. Based on the ER episodes observed, the cultural image of hero was acknowledged as being a part of the emergency physician habitus.

The place where the heroic action took place was the hospital emergency department. In each of the ER episodes observed the emergency department was portrayed as being the place where patients were saved and treated without asking why or how (i.e. rendering non-judgmental patient care). The image of the emergency department on the show reflects a hospital space characterized as being clinically diverse in terms of patients seen and treated, challenging for the physicians and staff, and a facility where care was provided for a breadth of patients and their health care needs. Further, the image of the hospital emergency department also reflects the current societal issues at the time of its premiere such as patient crowding in the emergency department, the uninsured patients, and insufficient resources.

America's perception and understanding regarding emergency physicians and the hospital emergency department is acted out in each of the episodes. The behaviors and responses of the actors who portrayed emergency physicians not only reflected American

culture, but were in turn controlled by the way the culture defined the meaning and reality of emergency physicians and the hospital emergency department. The behaviors and responses of the characters were an expression of the cultural norms, those values, and beliefs which society consistently claimed to be the best way to do things. In this case, they represented the best way to treat and address patient's needs in the hospital emergency department. Their behaviors and responses were consistent because they were themes performed repeatedly within the ER episodes over time.

This process produced the ideal type of emergency physicians and ideal type of the hospital emergency department. Ortner's (1984) interpretation of this outcome argued that the culture of emergency medicine had become a part of the self, which was the cumulative effect of the collective self, produced through process of socialization. It was the collective self that was articulated in the cultural norms displayed in the ER episodes each week (Ortner, 1984). Thus, the ideal type concept of emergency physician habitus, and the hospital emergency department became and is the cultural model.

The third cultural core value addressed was empathy, which is defined as the show's ability to communicate concern by imaginatively entering into the reality of its audience. ER successfully achieved this based on the various social and cultural issues presented in each of the episodes. HIV and Aids, breast cancer, domestic violence, mental illness, and drug abuse, were issues that were important and salient in our culture during its fifteen season run. Choosing to address the various social and cultural issues was an empathetic act. Therefore, ER's ability to tackle such issues demonstrated and proved the show's expression of societal empathy.

The cultural core value of empathy in ER also illustrates how culture influenced the show and how the show impacts American culture. The impact of culture on the show ER was demonstrated by airing episodes covering various social and cultural issues. For example, the ER episodes observed addressed such social issues as gang violence, binge drinking, and drug abuse. The cultural issues regarding mental health was addressed in the ER episodes observed as well. Over the course of its fifteen season run, the show aired episodes dealing with racism and discrimination, human rights, poverty, and the health issues related to the uninsured and homeless.

Societal pressure also originated from within the medical community, specifically those in the field of emergency medicine. For example, search of the literature regarding this topic revealed that after the airing of the first episode in which an ER nurse attempted suicide, a grassroots campaign was started as a means of changing the show's attitude towards nurses in the hospital emergency department (ED Management, 1998). The outcome of these efforts resulted in the depiction of emergency medicine nurses in a more realistic light (ED Management, 1998). Emergency physicians not only worked on the show as technical writers, but most of the storylines and anecdotes came exclusively from emergency medicine physicians and nurses in the field (ED Management, 1998). Finally, the Gates Foundation, known for funding global health projects also helped shape various story lines on the show (NYtimes.com).

ER influences American culture by calling attention to current issues through the show's episodes. Although the episodes focus on the activities that occur within the emergency department, the show is able to draw attention to social and cultural issues that occur outside the emergency department. For example, the show called attention to

binge drinking and hazing, an activity that regularly occurs on college campus across the nation. Critics of the show acknowledges the ability of ER to educate the public regarding such issues as drug seeking patients, the problems of managed care, and potential errors that staff can make in a busy, chaotic emergency department environment (ED Management, 1998). For example, one episode in season nine addressed the international crises in the Democratic Republic of the Congo and Darfur.

The last influential effect and connection with emergency medicine physician habitus that emerged from the phase II data centered on career choice for those choosing to pursue emergency medicine. Research indicated that the show ER positively influenced the profession of emergency medicine by increasing public awareness about the subspecialty of emergency medicine (ED Management, 1998). The cultural text analysis of ER illustrates how the habitus of American culture influences the choice and performance of these physicians. Research studies in the literature along with the responses from several informants indicated how the show influenced physician choice and performance (O'Connor, 1998; Turow, 1996). For example, some considered a sharp rise in the number of applicants to emergency medicine residency programs as an association between career choice and the premiere of the TV show ER (ED Management, 1998; O'Connor, 1998). In a 1998 interview with the chair of the department of emergency medicine at the University Of Southern California School Of Medicine, the chair reported that in discussions with applicants to the residency program regarding their motivation to pursue this specialty of medicine, the applicants uniformly expressed positive thoughts about emergency medicine based on the show ER.

The ER cultural text data produced findings that suggested the existence of a relationship between culture and emergency medicine physician habitus. Observation of the ER episodes expressed the existence of such relations through the cultural values that arose from within the ER cultural text. These cultural values help explain how emergency physician habitus is created and reproduced. The cultural values identified also touched on some aspect of emergency medicine and to some degree the hospital emergency department. This connection was illustrated by the connection between the cultural values and the two dominant themes of roles and cultural models. The outcome of this connection is the understanding of how culture influences emergency medicine and how emergency medicine influences culture.

Practice theory was used to explain how the cultural values were related to emergency medicine. The cultural concept of ideal type was used to explain how the cultural values produced the habitus of emergency medicine physician (Lawless, 1979). Finally, an evaluation of the literature regarding the impact ER had on the profession of emergency medicine revealed several positive effects. First, the premier of the show ER was associated with a steady increase in the number of applicants applying to the emergency medicine residency programs across the country (ED Management, 1998; O'Connor, 1998). Second, the show ER indirectly influenced emergency physician habitus by inspiring many medical students to pursue a career in emergency medicine.

Interview Findings

In this section, results from the informant one-on-one interview data are presented in the following manner. First, the findings from the one-on-one informant interview data are presented and discussed. Discussion includes how the informants define and perceive

their role as physicians in emergency medicine. Second, a comparison between the one-on-one informant interview and the ER cultural text findings was completed revealing the degrees of similarities and differences. The comparison illustrated the relationship between culture and habitus. Findings from the one-on-one informant interview data were important because it touched on several aspects of the informant's experience of being an emergency medicine physician. The informants' experiences of being a physician in the hospital emergency department produced three major findings: 1) an image of how the informants defined and understood their role as emergency physicians in the hospital emergency department, 2) the identification of how the informants habitus was reproduced, and 3) an indication of how the informants cultural experiences from interacting with patients during the physician-patient interaction created habitus. Each of these findings helped demonstrate the relationship between culture and habitus.

The interview data revealed how the informants defined and understood their role as emergency physicians. When the informants were asked about their role as physicians in the emergency department and their main objective when interacting with patients, the responses given touched on several aspects of being an emergency medicine physician. Each informant was asked the following questions: 1) what is your role as an emergency medicine physician? 2) What is your role as an emergency medicine physician in this setting? The informant's responses to the questions about his or her role were directly related to the profession of emergency medicine. The most frequently cited responses by the informants had to do with saving lives, taking care of life threatening emergencies, and treating trauma. This aspect of being an emergency physician was directly related to the mission and purpose of emergency medicine, to treat any patient presenting to the

emergency department and to prevent life threatening disease and illness. Therefore, the primary role of the emergency medicine physician was to treat patients experiencing a medical or trauma crisis.

However, several of the informants touched on another facet to their role as emergency physicians when answering the question what is your role as emergency physician. The other images associated with being an emergency physician included: safety-net provider, primary care doctor, front-line provider, and gatekeeper. For example, Informant L3 defined his role as an emergency physician as being multiple: “the role of the ER physician is multiple: first to take care of life threatening emergencies; second to deal with trauma, three to help people who are not able to see their doctor, and four to function as safety net”. Two informants touched on the role of primary care doctor. One of the two informants defined his role as an emergency physician in the following manner: “my role as an emergency physician was to provide primary care for patients in this acute setting and being a primary care doctor for society” (Informant O3). The second informant defined his role by recognizing the impact of providing primary care as an emergency physician: “in this urban setting we have to realize that sometimes we are the primary care physician, even though we can’t be the primary care physician” (Informant D2). Another informant reported that her role as emergency physician included being a front-line provider: “my role as emergency physician is sort of like front-line health care provider. We’re the first in line to see the patients with their cardiac disease, accidents” (Informant SSH). Still another informant defined her role as emergency physician as being a gatekeeper: “my role as emergency

physician is that I'm kind of the gatekeeper. I either let them in or keep em out" (Informant SSL).

Each of the informants who reported other facets to their role as emergency physicians described their main objective when interacting with the patient in terms of their primary role as emergency physicians. For example, each of them stated that his or her first and primary objective was to figure out what was wrong with the patient and why they came to the emergency department. While the informants' description of their role as emergency physicians touched on many facets, they each described their objective in seeing patients in the context of the mission and purpose of emergency medicine. The findings suggested that the informants defined his or her role as emergency physicians in a different context from that use to understand and communicate their role as emergency physicians.

Each of the seventeen informants used the mission of emergency medicine as the context to define his or her role as an emergency medicine physician: to see, treat, and stabilize any patient presenting to the emergency department; and to treat and rule out life threatening, limb threatening illness and disease in patients. Using the mission of emergency medicine as the context to define the role of an emergency physician in this fashion not only helped to establish the informants as physicians but also, reflected the education, training and discipline associated with this medical subspecialty. Using the context of emergency medicine in this manner also reflected the cultural core values found during the cultural text analysis of the TV show ER. For example, each of the informants answered the question "how do you define your role as an emergency medicine physician?" by describing the activities associated with decisive clinical

decision-making and the preservation of human life: seeing, treating and stabilizing all patients presenting to the emergency department; and ruling out life threatening, limb threatening disease and illness in patients.

The informants used a different context to understand and communicate his or her role as an emergency medicine physician. When the informants were asked the question “what is your role as an emergency medicine physician in this setting?” the informants used a context that reflected the cultural experiences associated with being an emergency medicine physician particular to that hospital emergency department environment. This context was unique in that it reflected and integrated two aspects: 1) the informant’s individual cultural experiences gained from interacting with and treating patients in the setting, and 2) the cultural environment of the hospital emergency department. Each of these two aspects acted together and produced the cultural image of how the informants perceived themselves and understood their role as emergency medicine physicians in that hospital emergency department setting. The outcome of this interaction produced the following cultural roles the informants ascribed to his or her role as an emergency medicine physician: safety-net provider, front-line provider, primary care provider, and gatekeeper. As already noted in the aforementioned interview analysis, each of the ascribed cultural roles mirrored the informant’s individual cultural experiences of providing care and interacting with patients in that particular hospital emergency department. Most importantly, the ascribed cultural roles also pointed back to the cultural values associated with the hospital emergency department identified in the ER cultural text data, such as primary care provider: “in this setting in the urban setting (we) have to realize sometimes we are a primary physician ...” (Informant D2).

The significance of this finding was in how the informants approached his or her role as emergency physicians. The finding suggested that the informants regularly used two distinct cultural schemas to define themselves as emergency physicians functioning in the hospital emergency department. The first schema the informants used to define themselves as emergency physicians was directly related to the mission and purpose of the profession of emergency medicine. The informant's use of this schema was straightforward and in alignment with the nature and meaning of emergency medicine. The practices associated with this image of the emergency physician reflected the education and training required to assume the role of an emergency physician and demonstrated the practical mastery required to perform as a physician in the hospital emergency department.

The second schema revealed a relationship between culture and informant experience. In this schema, the informant's role as emergency physician was culturally bound and originated out of individual cultural experiences from interacting with patients in the hospital emergency department. The cultural values associated with the role of emergency physicians were the same terms used to describe how they viewed themselves as emergency physicians: gatekeeper, safety-net provider, and primary care provider. Each of these terms is cultural laden with values borne out of our fragmented health care system and current health care crisis.

The ability to see and understand this practice the informants used to define and give meaning to their role was based on how practice theory approached the study of social interaction within a system. Practice theory can be used to explain the relationship between practice (i.e. human action) and the system. In this case, the relationship

explained was between the informant and the hospital emergency department. The system was identified as the hospital emergency department, and the social interaction was the physician-patient interaction. For example, one informant defined her role as an emergency physician in that particular setting in the following manner: “Well, I mean just the acuity and the types of patients you see and the problems. I mean you see more gunshot wounds, stab wounds, and things like that: more traumas. (But), you also see because of the indigent population, people that haven’t sought medical care early on and have more severe disease than you might see in the suburban setting, where people maybe, have access to medical care. You see people who probably don’t have primary care doctors here who come in for both severe and you know less severe disease” (Informant N3).

In this example one can see how the patient population, a cultural characteristic of that hospital emergency department, helped to define how this informant defined her role as an emergency medicine physician in that setting. The indigent patient population presenting to that hospital emergency department shaped that hospital emergency department environment into accommodating patients presenting with both severe trauma and non-emergent (primary care) needs. This process occurred when the cultural experiences of the informant encountering indigent patients in the emergency department enabled the informant to see that indigent patients are included in the patient population typically presenting to the hospital emergency department. In the language of practice theory, culture allowed and enabled the actors within the system (i.e. emergency physician informants) to see and respond with the appropriate behavior within the system (i.e. hospital emergency department). In other words, the informant’s individual cultural

experiences of seeing and treating indigent patients during the physician-patient interaction in that hospital emergency department setting helped to defined her role as a physician who saw and treated patients with primary care needs (i.e. primary care doctor).

In another example, the informant identified as a professor of emergency medicine described the training, discipline and criteria used in selecting an emergency physician to work in the hospital emergency department: “One thing we do is to try and keep people from being very judgmental. We try to do this by screening those people out from training so that we don’t even hire them. So for instance, if we were to interview a resident and you pick up the concept that they think that the only people that really need to be in the emergency department are people who are very, very sick; you don’t want to hire them. The reason for it is because they’re going to be too judgmental and minimize illness” (Informant SK).

In this example, the interaction between the hospital emergency department and patient population provided the context used to select the emergency medicine physician staff. The cultural core value non-judgmental was associated with being selected as an emergency medicine physician employed by that hospital emergency department. In this example, culture has an inhibiting or restricting effect on the actors and how they responded in the system. Specifically, the cultural environment of the hospital emergency department inhibited the display and practice that only very sick people should be seen and treated in the hospital emergency department. Thus, if the informant’s individual cultural experiences produced the concept that only very sick patients should be seen in the emergency department, they were not selected to be on

staff at that particular hospital emergency department. Each of these examples represents how the hospital emergency department (i.e. the system) through the individual cultural experiences of the informants (i.e. the actors) interacting with patients during the physician-patient interaction can help define his or her role as emergency physicians in the hospital emergency department.

Practice theory stipulated that the best way to understand the practice of the informants was to observe them functioning in the center of the research field, in this case the hospital emergency department. This allowed the observer (researcher) the ability to witness the fluidity of the informants practice (human actions) as they occur in the natural setting of the hospital emergency department. In other words, practice theory uncovered the informant's actions and their associated meanings, which were formally concealed to the informants' and observer alike, but were revealed through the anthropological study. This was accomplished because the scientist and the studied were both a part and product of the research field. The two schemas used by the informants when viewed outside of practice theory would give indication of an apparent conflict within. However, when viewed in the language of practice theory, the two schemas reflected the reflexive nature inherent in the use of practice theory when studying social interactions (Bourdieu, 2005).

As biomedical scientists, the informants sought to construct their reality by and through the patients they interacted with in the emergency department. This reality also included how they responded to the needs of the patients. While at the same time, the informants acknowledged the meaning of their work as emergency physicians through the cultural values ascribed to their status and tasks performed as emergency physicians. Each day, each shift in the hospital emergency department, the informants engaged in this

process. In practice theory, this process would be called a generative schema because it describes how the informants structure and organized their performance and behavior in the emergency department. Thus, the two schemas used by the informants each day in defining their roles in the physician-patient interaction and the hospital emergency department was the generative process referred to in practice theory (Bourdieu, 2005). This process not only generated the informants' practice, but also organized and structured their behavior in the hospital emergency department. Over time, the practices became a part of the habitus of being an emergency physician for each individual informant. This was the process by which the informant's practice was created, and how the overall habitus of being an emergency physician was reproduced in the emergency department.

Once the informants identified and understood their role as emergency physicians, the practices they utilized in emergency medicine began to emerge. In practice theory all forms of human action was seen as form of practice. The following interview question yielded results associated with the informant practice, which became a part of the habitus over time: "can you walk me through the decision-making process you follow in a typical physician-patient interaction?" The informant interview data revealed several forms of practice used by the informants.

Seventeen informants answered this question based on their individual experiences interacting with patients in the emergency department. For example, all seventeen informants acknowledged as a part of their practice the following: taking the history of the patient, performing the physical exam, and listening to the patient tell their story. Performing these tasks were a part of the routines carried out in seeing and

interacting with patients in the emergency department and a required element included in the overall habitus of being an emergency physician. However, the informants' sequence in describing their decision-making process varied and reflected their understanding of how the physician-patient interaction unfolded in terms of them evaluating, and treating the patient. In other words, the practices were the same and routine for each informant. However the pattern of how they each performed the tasks varied according to the individual informant perception and understanding of how the physician-patient interaction unfolded.

For example, some of the informants began their description sequence of their decision-making process by stating they had questions to answer or consider prior to beginning the physician-patient interaction. For example, one informant gave the following: "Well, let's see. There's the question of what's wrong with the patient in terms of medically that I have to deal with; And then—the next decision is where do they go from here" (Informant G3). Another informant gave the following scenario: "You know everyone has his or her own little algorithms. Here in the emergency room, the first little branch of my algorithm is, is this patient going to be admitted to the hospital: that is one of my first thoughts ..." (Informant SV). The Informant SSH described her decision-making process in this manner: "we ask certain, pointed questions about their particular medical problem, and history: what helps it, what worsens it: and what have they done for it recently".

Some of the informants reported that their decision-making process began with taking the patient history and doing a physical exam, this was illustrated by the following three informants. The first informant described his decision-making process in the

following manner: “Well, I mean, you always go by getting the history first, and what I found is that the history tells you the most. Eighty to ninety percent of the time, you get your answer from the history. Eighty to ninety percent of the time, you get your answer from the history. Then you go to the physical exam for confirmatory findings ...” (Informant O3). The second informant described her decision-making process in this manner: “Well, you know you do a through history and physical. And then based upon that you kind of proceed with ordering tests ...” (Informant N3). The third informant gave this description: “I always come and want to take their history. Not only their history, their past medical history, their medications I kind of do it systematically on everyone” (Informant SSC).

One informant began his decision-making process by visually viewing the patient: “You walk in and you see the patient: a lot of times you can decide by the way they look, by the way they’re breathing ...” (Informant D2). One informant began the description of her decision-making sequence with the necessity for talking and listening to the patient’s story: “Well you know, you listen to the story that’s ninety percent of your diagnosis ...” (Informant D3). One informant described his decision-making process with picking up the patient’s chart and triage notes: “First and foremost when we walk in we already have the print out from the nurses that have the vital signs, past medical histories, medications and their chief complaint. Then you start out with the history ...” (Informant SS). The remaining informants started their decision-making sequence with the necessity for performing the tasks of taking the patient history and physical exam. Variations reported by the informants in their decision-making process sequence reflected an important attribute of practice theory the improvisation nature of the actor’s, in this

case the informants. As a result, the informant decision-making process sequence also revealed elements identified by Bourdieu as being a part of practice, pragmatic choice. In this context pragmatic choice was defined as calculating and strategizing decision-making (Ortner, 1984).

The informants' practice also had components that reflected cultural orientation as well. Those cultural orientations were generated from and by the informants' experience in interacting with patients in the hospital emergency department. A clear example was seen in the response from the following three informants J3, D2 and D3. When the Informant J3 was asked, "Why do you think health disparities exist, especially among African-American patients? The informant responded by defining the condition of health disparities in terms of his experience interacting with African-American patients, particularly the elderly in the emergency department: "Seems to me that, I found out that I think a lot of African-Americans kind of wait a little bit too long. Especially the older people, they're a little bit more stubborn. They always wait till the end: they always come in three days later saying, "This started three days ago." "Well why didn't you come in then?" So, I think that's one thing I've noticed, that they just wait a little bit too long".

When the informant was asked to elaborate on their perception of the elderly African-American patient and give an example of the term stubborn he stated the following: "Well, like I said they wait to the last minute. So something's going on for three days. Why did they wait three days to come in? "Well, I thought it was just going to get better." Well, you know, it didn't get better after the first day. It didn't get better

after the second day, so. I just think that you know, I just found that a lot, especially with the older people, they kind of just wait”.

In this scenario the informant’s cultural experiences of interacting with elderly African-American patients produced the following stereotype towards patients in this population: they tend to be slow and stubborn. The term slow in this example referred to the length of time it took the patients to respond by seeking medical attention. The perception of elderly African-American patients was derived from the experiences gained through interacting with them during the physician-patient interaction. In the language of practice theory, the social interaction with the elderly African-American patient produced the informant’s cultural orientation response and the human action of patient perception. Each of these informant behaviors became practice and was used by him to make sense or give meaning to the behavior of the elderly African-American patient they encountered and observed during the physician-patient interaction.

In another example, the Informant D2 was asked the question can you share with me some steps you take in establishing a rapport with your patients? He gave the following response: “I think it really depends, I probably do different things for people of different ages: I think sometimes there’s people that’s maybe older individuals that are here that are a little bit lonely. So, maybe if you take a couple extra minutes and just talk to them: I ask them where they stay at; ask them other things like that, that can just work wonders in terms of opening up the communication with them. Then young people, sometimes we’ll talk about something you see them wearing, a sports jersey’s you can mention something along those lines to try and break the ice so to speak”.

In this scenario, the cultural orientation of the informant was developed during the physician-patient interaction as well. The experiences of interacting with different age groups informed the informant towards choices of specific techniques for establishing a rapport with the patient in a particular age range. For example, for young patients the informant used dialogue around cultural symbols such as team sports jersey to engage the patient into dialogue with the physician. For older or elderly patients, the informant used the techniques of listening and patience, or what they defined as taking time with them, as a means to engage the elderly patient in dialogue with the physician.

In the language of practice theory, this scenario reflected how the social interaction with different age groups unfolded to the informant. For analysis purposes, the acting unit in this case was the informant's practice of utilizing specific techniques for establishing rapport with age specific-patients. The informant's practice was generated by his cultural experiences gained from interacting with patients in different age groups. During the physician-patient interaction process, the informant learned to make adjustments to his general habitus by using specific techniques of establishing a rapport with patients in specific age groups. The unfolding of the social interaction event was the process of going through and experiencing the effects of establishing rapport with patients in different age groups during the physician-patient interaction. This cultural experience and process created a new practice for the informant that was used to establish rapport with patients in different age groups.

According to practice theory, the motivation for the informant's actions and therefore practice was justified as a form of expression of goodness in relationships. One of the foci of practice theory is to understand what constitutes goodness in relationships.

In the case of emergency medicine, goodness would constitute doing no harm. In this case the relationship, which was asymmetric in nature, was the interaction between the physician and the patient. The potential goodness was found within the informant's response and expressed in the following manner: "...it can work wonders in terms of opening up the communication with them" (Informant D2). Again, this 'goodness' is the same term used by Ortner when she addressed the intrinsic nature of practice theory in describing how the action of the actors within the system are shaped by "...the images, ideas of what constitutes goodness in people, in relationships, and in conditions of life" (Ortner, 1984, p. 152). Thus, establishing a rapport with the patient is a part of the habitus of doing emergency medicine and at times, could be influenced by the informant's cultural experiences gained from interacting with patients in the physician-patient interaction.

When the Informant D3 was asked could you share with me a technique or some techniques that you do or use to get a patient involved with you, if they're not dialoguing with you? She gave the following scenario: "I think laughter, I tend to joke a lot. Or I'll tell 'them a story you know, about someone else and try and not make it so personal; that's usually what I do. Or religion, a lot of times you know, some patients you can tell they came straight from church or older people I might talk to them about their faith. And I'll try and incorporate that". When the informant was asked how receptive are the patients when you do that? She stated the following: "Most patients are receptive. I haven't had anyone tell me to not talk about that or whatever: I mean, it's sincere".

Again, the same process of analysis used for explaining the Informant D2 practice was utilized to explain the Informant D3 practice of establishing rapport with patients.

The Informant D3 cultural experience gained from interacting with patients during the physician-patient interaction produced the practice of using and incorporating humor as a part of the techniques used to establish rapport with patients. The informant found and expressed the potential goodness in this practice in the following manner: “Most patients are receptive. I haven’t had anyone tell me to not talk about that or whatever: I mean, it’s sincere” (Informant D3).

The actions identified in the interview data represented a clear example of practice. Each informant practice revealed the process of how practice was generated for each of the informants within the social system. Each of these informant’s behaviors was considered a form of practice because they reflected the improvisational nature of social interaction described in practice theory. The practices identified and associated with each of the informants became a part of the overall habitus of being an emergency physician and reflected an aspect of doing emergency medicine in the emergency department. Consistent with practice theory, the informant’s practice of establishing a rapport with the patient was adjusted based on the daily interactions which took place and was reproduced during the typical physician-patient interaction.

The finale milestone and finding revealed regarding the nature of practice and its connection to the informant’s habitus had to do with their experiences in the hospital emergency department. Specifically, the informant interview data illustrated how experiences of interacting with patients during the physician-patient interaction could in some cases create a new habitus by alteration or an adjustment in practice. A clear example of this was seen in the response from the Informant L3. This example was

based on the informant's cultural experiences of interacting with patients in the hospital emergency department.

During the one-on-one interview process the informant (L3) opened up and shared how a background in search and rescue was instrumental in his assessment of the patient and the physician-patient interaction: "before I step into the area one of the things they teach you in air search and rescue is scene safety and to look at what's going on. I'm always aware of my surroundings and what's going on in the background" (Informant L3). The informant then proceeded to explain the significance of using such an approach prior to engaging in the physician-patient interaction, and its importance for interacting with patients: "I'm generally always looking around to keep my mind open and to keep my eyes open and my ears open. Like you can be sitting there dealing with your patient and you hear somebody scream down the hallway, I'll take a look and see if there's anything I need to be dealing with; that's being continuously aware and assessing your situation" (Informant L3). The informant's reason for using this practice was based on the following: "I've had and dealt with a couple of violent patients: uhmm I had a patient in our psych room that actually assaulted me. He actually clawed at my neck ...it's that kind of thing that you have to keep aware" (Informant L3). The informant defined this process of using the background of air search and rescue to establish scene safety as being clue conscious.

This example from the Informant L3 was considered atypical, unique and unlike the previous informant scenarios because the informant's new practice was viewed as being outside the scope of being an emergency physician. This particular practice, termed 'clue conscious' by the informant, was a behavior that was learned outside and

prior to entering into the profession of emergency medicine. The cultural experience of interacting with violent and psychiatric patients in the emergency department brought this learned behavior to the forefront and influenced the dynamics of how the informant responded to all physician-patient interactions occurring in the hospital emergency department.

The nature of the informant's experience, of being assaulted by a psychiatric patient during the physician-patient interaction, created a new habitus for the informant. Clue consciousness started out as an adjustment in practice meant to ensure that the scene of the physician-patient interaction was secure. This practice became a habitus for the informant in that it was the informant's norm for approaching all physician-patient interactions occurring in the hospital emergency department. What was interesting and significant about the new habitus was that it was in alignment with the overall habitus of being an emergency physician and habitus of doing emergency medicine in the hospital emergency department. The significance of this finding was that it clearly showed how culture could create and be created. Second, the finding suggested that the individual's life (cultural experiences) prior to becoming an emergency physician could alter, change, or create not only a new practice, but also a new habitus as well.

Finally, the last question asked was how were each of these two data sets related? Each of the data sets, the cultural text of ER and the informant interview data, illustrated how culture influenced the habitus of the emergency physician. For example, in the cultural text data, the influence of culture was expressed through cultural values found to be associated with the habitus of being an emergency physician in the hospital emergency department. In the informant interview data, the impact of culture on habitus was seen

through the informant's cultural experiences of interacting with patients in the physician-patient interaction.

Another similarity between the two data sets was that each of the data sets showed how habitus was the dynamic interaction between culture (i.e. the system) and human action. In the ER cultural text data, the interaction between culture and human action was expressed through the cultural values found within American culture and expressed through the actions of the emergency physician characters. In the informant interview data the interaction was between the physician-patient interaction (i.e. the system) and the action of the informant. This interaction was demonstrated through the informant practice.

The two data sets were different in that they each revealed separate cultural values associated with the habitus of the emergency physician and doing emergency medicine in the hospital emergency department. For example, the values revealed in the ER cultural text data were associated with the mission and purpose of emergency medicine profession and the cultural model of being an emergency physician. The cultural values in the interview data were generated through individual experiences of interacting with patients. Both sets of data showed how culture created habitus.

Conclusion

Bourdieu's (2005) practice theory was used to perform the analysis in this chapter and for making certain assumptions (Ortner, 1984). The first assumption made was that the entity under study was a system itself and reflected patterns of relations between people (Ortner, 1984). In this study the hospital emergency department and the physician-patient interaction were defined as representing a system made up of patterns

of relations between people, in this case, relations between the emergency physician and the patients (Ortner, 1984). Second, the patterns of relations in which people interacted were asymmetrical in nature, which according to Bourdieu were the most important human interactions to study within any system (Ortner, 1984).

The cultural text of ER represented a popular cultural example of how American society defined and understood the role of emergency medicine, emergency physicians and the function of the urban hospital emergency department. The underlying assumption was that culture defined as a reflection of American values, models, beliefs, and behaviors, can shape individual behavior and experiences including the role of emergency physicians, emergency medicine, and the urban hospital emergency department. Emergency physician habitus was defined through the character development and portrayal of how the emergency physicians interacted with the patients and through the portrayal of their attitude towards the patient. The observation and cultural analysis produced a culturally enriched data set. The topics chosen for discussion in this section having to do with emergency physician habitus were: American hero, and safety-net to the poor, and uninsured. The cultural image of safety-net was observed through the manner in which patients were seen and treated in the urban hospital emergency department. In each of the episodes observed and studied, the emergency department was the one place where the poor, indigent, uninsured or African-American patient could be seen and treated regardless of their economic and social condition.

Most importantly, practice theory recognized how social practice encompassed routines and scenarios that were established and had embodied "...within themselves the

fundamental notions of temporal, spatial, and social ordering that underlie and organize the system as a whole” (Ortner, 1984, p. 154). In essence then, the habitus that derived from the social practices of emergency physicians over time carried with it the attributes of time, space and social ordering. The ability of practice theory to take notice of these three distinct attributes inherent within the subspecialty of emergency medicine, the hospital emergency department and associated with emergency medicine physicians clearly spoke to the relevancy of this theory to this dissertation study.

Based on the one-on-one interview data, I found that the individual cultural experiences gained from interacting with patients influenced emergency physician practice, which eventually created a new form of habitus. According to practice theory, when the physician-patient interaction was considered as a type of cultural system, at some point in time the cultural system could be changed or adjusted to meet the needs of the patient population. The change in the system would occur through a change in the practice of the informants. Over time, the change in practice becomes a new habitus. This process illustrated, with clarity, what Bourdieu meant by ‘structured improvisation’ as it related to habitus. In this context, habitus represented a general system of generative schemes, an unconscious effort, operating in a structured space of possibilities (Calhoun et al., 1993, p. 4). The education and training the informants received in medical school provided the general system of generative schemes from which to improvise their responses (Good, 1994; Becker et al., 2007). As the informants’ continued to encounter patients whose behavior fell outside the norm over time, a newly formed perspective became an established part of the way they interacted with patients in the emergency department. This was how the informants’ action, based upon the perception of the

patient's behavior in the emergency department and the frequency for which such actions occur, became habitus over time.

The relationship between the ER content data analysis and the one-on-one interview data from the informants was investigated by comparing the degree of similarity and differences. In terms of similarities, both data sets produced an image of the emergency physician as American hero with the inherent habitus of saving life and preventing life threatening and limb threatening illness and disease. Based on the data response set from the one on one interview data along with the ER observation data set one can see how the cultural image of the emergency medicine physician as American hero is consistent with both the popular culture and with the image of what the informants held of themselves and their profession. In addition, the cultural experience of treating patients with various types of medical conditions produced the emergency physician habitus of heroically prolonging life and preventing life threatening and limb threatening disease and illness.

In conclusion, when the informants were faced with challenging physician-patient interactions (i.e. "is something else going on with this patient"—Informant B3) a new perspective was generated. In situations such as this, the informant's individual prior cultural experiences in the emergency department allowed him or her to make a choice. At which time the informants can do only one thing, adjust their practice to meet the needs of the patient. But when the individual informant is called upon to act and the range of choices was not constrained, he or she developed a new perspective. As the range of their cultural experiences in the emergency department continued to increase and as certain kinds of situations continued to occur, the perspectives generated eventually

became an established part of the each informants practice, and their way of dealing with the world (Becker et al., 2007, p. 35).

Chapter 6 “The Habitus of an Emergency Department”

Introduction

In the previous chapter Bourdieu's (2005) practice theory was used to explore the relationship between culture and the habitus of emergency physicians functioning in the hospital emergency department. The relationship between culture and the habitus of an emergency physician was expressed through the cultural values identified during the ER cultural text analysis. For example, one of the cultural core values uncovered in the ER cultural text data and discussed was American hero. This cultural core value was found to be associated with the image of the emergency physician and the emergency department. The image of the emergency department as hero was expressed through its role as safety-net provider because heroic efforts of the emergency physicians were played out in saving the lives of those who were poor and without health care insurance. We also learned in that chapter how culture through the informant's experiences of interacting with patients during the physician-patient interaction helped shape how the informants defined and perceived their role as an emergency physician.

The focus of this chapter was on the relationship between the informants practice as emergency physicians and the system. The system was defined exclusively as representing the physician-patient interaction, the emergency department, and the profession of emergency medicine. The research question asked how did the practice of the informants reproduce or bring about a change in the structure of the physician-patient interaction. Based on the framework of practice theory each aspect of the question was answered from the following perspectives: 1) how habitus reproduced the system, and 2) how habitus brought about change to the system. The data used to answer the research question were taken from phase II and phase III of the research design. The specific

findings discussed in this chapter were related to the three dominant themes revealed in the informant interview data: perception of the patient, patient challenges, and presentation of self. Data analysis from phase III informant interviews was also discussed

The following scholarly works anchored the presentation of the data in this chapter: Sherry Ortner's (1984) essay on anthropological theory, and Joan Emerson's (1972) essay on the gynecological exam, and Pearl Katz's (1981) work "Ritual in the Operating Room". Each of these scholarly works served as a model presenting and discussing the meaning of the data presented in the chapter. Ortner's (1984) work was relevant because it provided an important foundation for setting up data analysis for this chapter. In order to examine the relationship between practice and the system properly, Ortner's interpretation of practice theory suggested that two aspects be evaluated: 1) how practice reproduced the system, and 2) how practice could change the system (Ortner, 1984, p.154). She argued in favor of the modern view and version of practice theory because she believed practice theory defined the system as being powerfully constraining, while being subjected to being created and structured by human action (Ortner, 1984, p. 159). The application of this belief was applied to the data in the following manner. Emergency medicine as a cultural system was understood to be powerfully constraining on the practice of its practitioners through training and residency. Yet, it remained open to change based on the characteristics and needs of the patient population. For example, in the language of practice theory the human action of the actors was represented by the informants practice. In this study, the informants interfaced with the needs of the patient and symbiotically produced change in the structure—specifically, the roles of the

emergency physician, hospital emergency department, and emergency medicine. The change manifested itself through the performance of such tasks as the treatment and delivery of primary care services during the physician-patient interaction.

Emerson's (1972) work was important because of how she approached the study of the gynecological exam as an example of an intimate social interaction. Based on her observations and study of the gynecological exam, Emerson discovered how reality was embodied in the routines performed and reaffirmed by the physician and medical staff through the social interaction process. Further, Emerson concluded in her study that the ritual process of constructing reality in the gynecological examination was similar in any medical procedure and carried out by the physicians during the physician-patient interaction. Applying practice theory to Emerson's model was highlighted in the following manner.

The construction of reality was the ritual process by which the informants reproduced the system of the physician-patient interaction. For example, Emerson defined this ritual and process as the medical definition. The nurse has a definition of what is to take place and how the patient should respond. The physician has a definition of what the exam process will entail and how it should proceed. The tools used to reconstruct the reality for the physician was represented by the schemes, norms, and values that were associated with the enactment of rituals, routines that underlined the organizational principles governing the physician-patient interaction, the emergency department, and emergency medicine. For example, the physician ritually guided the patient through the exam in a particular constrained manner, while keeping the patient in line and defining the exam situation by his response. The underlining principle

governing the gynecological exam was the medical definition this is a medical situation. The norm associated with this governing principle was no one is embarrassed or thinking in sexual terms (Emerson, 1972). More importantly, these principles are continuously re-endorsed in the world of public observation and discourse. In other words, these are the actions and behaviors ritually practiced and observed performed by the physician during the gynecological exam.

Katz's (1981) work was important because it demonstrated how medicine was at times full of rituals in day-to-day practices. For example, Katz (1981) examined the relation between ritual and science in the context of the modern day hospital operating room. Distinctively, the article addressed the efficacy and function of the physician practice of sterility and the ritual procedures they followed as they related to the structure and function of the hospital operating room (Katz, 1981). The elaborate ritual procedures were followed and enacted by the surgeons and operating staff as a means of eliminating contaminations and postoperative infections (Katz, 1981, p. 336). What was important and significant about this article was that the author pointed out how these elaborate rituals and scientific procedures performed by the surgeons and staff essentially functioned as a means of maintaining the functioning and structure of the hospital operating room (Katz, 1981, p. 336). The procedures and ritual governing sterility of the operating room (i.e. OR) also gave clarity and meaning to the OR staff in relation to their occupational roles, which was validated by the color of their scrubs.

Presentation of the data in this chapter began with examining how the informants' practice as emergency physicians reproduced the system. Next, the chapter presented data revealing how practice changed the system. Data from the second phase of research were

used to support and strengthened the above hypothesizes. The system was defined as being the structured practices during the physician-patient interaction, in the emergency department, and in doing emergency medicine. The practice of the informants reflected what emergency physicians did while interacting with their patients in the hospital emergency department.

How Physician Practice Reproduced the System

The dominant theme identified in phase II, presentation of self, was the data point used to illustrate the relationship between informant practice and the system. Again, the system was defined as the physician-patient interaction, the emergency department, and emergency medicine. The practice of reproducing the system began for the informants through the socialization process of medical school training where the informants learned the governing principles, knowledge, and practices required in doing emergency medicine, interacting with patients, and for functioning in the emergency department. There are many aspects to emergency medicine that occur during the physician-patient interaction that might be characterized as being ritual in scope such as, decision-making (differential diagnosis), patient interviewing, and physical examinations. The role of the emergency physician entailed performing each one of these ritual processes daily, and involved some form of the presentation of self.

While in the emergency department, the informants spent a great deal of time interacting with patients during the physician-patient interaction. The initial moment of the physician-patient interaction reflected the social aspect of a medical encounter and required the informant to begin with the initial introduction of himself or herself to the patient. This social ritual behavior, the practice of introducing one-self to the patient was

how the informant gained entry into the physician-patient interaction. This ritualistic practice emerged when each of the informants was asked the question “can you share with me the steps you take in establishing rapport with a patient?” Based on the data, 15 out of seventeen informants responded to the question by stating that they introduce themselves to the patient prior to beginning the physician-patient interaction process. Several informant responses were used to illustrate the importance and significance of this ritual practice.

One informant explained that a failure to make introduction to the patient can hinder the conversation tone of the physician-patient interaction: “I mean, you always got to make sure they know who you are ... you try and meet them eye level and try to facilitate the conversation ...” (Informant O3). Another informant revealed that a failure to perform this ritualistic practice could also be perceived by the patient as being threatening: “a doctor can approach a patient in threatening way by not introducing himself, I think it’s definitely not as friendly and you don’t really build rapport as you go in they don’t know who they’re talking to” (Informant G3). Therefore, proper entrance into the physician-patient interaction was secured by the informant’s ability to perform the ritual practice of the social etiquette of introducing one-self, which set the tone for the physician-patient interaction.

At other times, informants introducing themselves to the patient helped the informants get a sense of why the patient was presenting to the emergency department: “... you always introduce yourself and try and just let them talk and figure out where they’re coming from. And try and sense what kind of person they are. And you know, if they need a lot of attention, you give them that” (Informant D3). For others, introducing

himself or herself to the patient provided a means to strike up a conversation with the patient and facilitated their assessment of the patient's expectation for their visit. For example, for the Informant SSH the following was revealed: "I try to introduce myself initially, and find out why they're here, you can also get an understanding of what their expectations are in terms of their visit". For the Informant SSL, her response was as follows: "I introduce myself to them, if I got a minute in comment on something like, are you missing work, or if they have kids I'll say I bet it's hard being sick and taking care of them: just something to get them talking".

According to Ortner (1984), the reproduction of the system, which in this case was the physician-patient interaction, should be looked at in relation to how the norms and values associated with this practice were reproduced by the enactment of the ritual (Ortner, 1984, p. 154). This brief social aspect of the physician-patient interaction, the introduction of the doctor to the patient, was defined as being a ritual practice because it was required and a learned behavior that was acquired during the socialization process of medical school training. The researcher observed the social practice of introducing oneself to the patient in the public discourse that occurred between the physician and the patient during the physician-patient interaction. This social practice reflected the importance of learning how to communicate with the patient. The importance of this brief social ritual practice was demonstrated and supported when the researcher was told by the informants that each emergency physician was evaluated on this aspect of behavior during the physician-patient interaction.

Further, this ritual practice was a part of the core competencies, which were established and set by the American College of Emergency Medicine and are expected of

all practicing emergency physicians. These core competencies help shape and structure the expected behavior of emergency medicine physicians. The brief ritual social practice of presentation of self (i.e. the emergency physician introducing himself or herself to the patient) once learned, became a daily routine practice. This social behavior reflected a human action that was carried out in an unconscious, and un-intentional manner that helped to perfect the informant's ability to interact and communicate with the patient in the emergency department setting. According to practice theory, this ritual practice of the informants was considered to be unconscious and un-intentional because it captured the practical mastery that the informants' had in the physician-patient interaction, the ability to gain entry, and establish a rapport with the patient.

Based upon the informant data responses, the researcher learned that the presentation of self was very important to the emergency physician because it set the parameters for the medical encounter, such as not being confrontational and being aware of the patients needs. Also, this aspect of presentation of self had various implications for how the physician-patient interaction preceded. For example, Informant B3 gave this explanation when sharing the steps taken in establishing rapport with patients: "You need to smile and say hello, introduce yourself, ...give them your hand and shake their hand introduce them and give them the respect...Most patients will be receptive towards that" (Informant B3). The data response from this informant indicated that a brief introduction to the patient was essential because it demonstrated the capacity to show respect and show empathy towards the patient: "you need to give them some empathy ... let them know that you understand that they're frustrated" (Informant B3). The informant defined giving respect to the patient to mean, "they deserve the same type of care as somebody

who has a regular doctor ... so I will be their regular doctor. I think that is what I mean by respect” (Informant B3).

Based on the responses from these informants, the ritual practice of introducing oneself to the patient touched upon several aspects of doing emergency medicine and performing as an emergency physician during the physician-patient interaction. The ritual practice of introducing oneself to the patient was directly associated with how the informants presented themselves to the patient. This ritual practice was associated with the value and norms responsible for directing and structuring the physician-patient interaction. When practiced by the informants, the ritual helped to define the social interaction between the physician and the patient as a non-threatening medical encounter. The ritual practice also directed the actions and behavior of the informants by opening up the lines of communication between the physician and the patient. This allowed the informant to properly assess the patient’s needs and expectations regarding their visit to the hospital emergency department. Finally, the ritual of introducing oneself to the patient represented a tool that could measure the informant’s ability to communicate with patients, a cultural core value and competency identified by the American College of Emergency Medicine.

The importance of being able to effectively communicate with patients was supported by the phase III Informant S, a professor of emergency medicine. Once again, the purpose of the phase III research was to make an assessment of how social and cultural characteristics influenced the habitus of an emergency physician. Findings from the phase III research proved that the habitus of the emergency physician became sensitized through training, to both the cultural and social characteristics within the

physician-patient interaction. This effect was identified in the phase III response data when Informant S was asked the question “what is the goal of emergency medicine training?” The informant gave the following response that revealed importance of having communication skills: “They (the informants) need to be great communicators because they have new patients every twenty minutes...Every patient is new—so, they have to be able to communicate well with their patients; well with their consultants; well with the nursing staff; well with everybody. Communication is very is very important. So we need to work on that as well” (Informant S).

When the ritual practice of introducing oneself to the patient was viewed as an example of little scenarios of social etiquette that play out again and again during the initial phase of each physician-patient interaction, one can observe how this practice was a part of the habitus while exerting some influence on the habitus. The ritual social practice of introducing oneself to the patient at the beginning of the physician-patient interaction demonstrated the following values associated with the practice of doing emergency medicine: showing empathy, showing respect to the patient, and not being threatening to the patient. Each of these values helped to set the parameters of the physician-patient interaction. Namely, the space and opportunity to properly make patient assessments gather information and address the concerns, needs, and expectations of the patient.

Another aspect of the theme presentation of self had to do with the cultural norms of multitasking and the ability to adapt to the emergency department environment. Each of these cultural norms was related to the practice of doing emergency medicine in the hospital emergency department. Together, each of these cultural norms through the

practice of the informant reproduced and helped maintain the structure and function of the emergency department. Failure to carry out or meet these cultural norms and expectations could have a direct impact on the structure and function of the emergency department. For example, the cultural experiences of interacting with patients during the physician-patient interaction could cause the informant difficulty in adhering to the cultural norm of multitasking and meeting the expectation of adapting to the changing and unpredictable environment of the hospital emergency department. The difficulties arise because as Howard Becker (2007) found in his study of medical school education and training “people carry culture around with them ...they don’t shed their cultural premises” (Becker, 2007, p. 143). Becker interpreted this finding to mean that members of a group, which in this case was the emergency physician informants, derived their meaning and understanding about the physician-patient interaction “... from cultures other than that of the group they are participating in at the moment” (Becker, 2007, p. 143). As a result, the informants would be unable to practice the cultural norm of multitasking and adaptation because their meaning of the physician-patient interaction was based on their prior cultural premises instead of the cultural norms acquired in medical education and training.

Several informants in phase II and phase III discussed the cultural norm and practice of multitasking. In phase II the Informant RS was asked to elaborate on what she meant by using the term personality trait when answering the question: “what encouraged you or motivated you to choose this path of medicine?” The informant defined the meaning of this term by describing her basic profile of an emergency medicine physician: “we’re self-starters, self motivated, very busy people. We’re multi-

taskers. We tend to do a lot of things all at once throughout our life both in emergency medicine and personally. We all tend to do a lot of things all at once” (Informant RS). For this informant the ability to multi-task or the practice of multi-tasking reproduced not only the meaning and purpose of emergency medicine, but also structured and described how she performed emergency medicine in the hospital emergency department.

For the Informant L3 the practice of multi-tasking and the ability to adapt to change were inter-related. The informant described each of them when he spoke about the adjustments made in coming to the Detroit area, and in his individual cultural experiences practicing emergency medicine. For example, the informant gave a detailed description involving the ability to multi-task in the context of being able to adapt to change. When the informant was asked “how does the ability to adapt to change directly impact what you do?” he gave this scenario: “one of the ways it directly impact you is because you never know what’s going to come in the doors. I can have seven gunshot wounds show up simultaneously and then still have the person with the chest pain that comes in still have the person with septic comes in still have the cardiac arrest come in; all of this in a matter of minutes ...you have to flip from trauma mode to resuscitation mode to dealing with the chest pain to dealing with I cut my finger. You have to be able to flip between modes very quickly” (Informant L3). The informant defined flip modes in the following manner: “that’s where you have to switch from being in the mind set of trauma to cardiac arrest to medical patients to regular patients” (Informant L3). In this detailed analogy given by the informant, the ability to multi-task with different degrees of patient acuity was a measure of their ability to adapt to the un-predictable nature of doing emergency medicine and seeing and treating patients in the emergency department. The

ability to practice this cultural norm helped the informant to uphold and maintain the function of the chaotic and un-predictable nature of the hospital emergency department.

The informant explained the practice of being able to adapt in the context of their experience doing emergency medicine: “I found one of the things I am able to do is adapt to change pretty easily so, it’s kind of you just go with it: one of the most important things in emergency medicine is being able to say, Ok, this really isn’t a problem we can take care of it. You have to be able to react but interact in different settings. You don’t know what you’re going to get that’s one of the interesting things about being in the emergency department I never know what’s going to come in any given night” (Informant L3). In this scenario the informant acknowledged the presence of individual cultural experiences; but his ability to adapt helped him to practice the cultural norm of being able to adapt to change. In this case, the individual cultural experiences did not hinder or interfere with the informant’s ability to meet the demands of the changing environment of the emergency department and nature of seeing and treating various medical conditions in the emergency department.

Finally, informants from phase III echoed the importance and necessity for possessing this cultural characteristic as an emergency medicine physician. When each of the informants was asked the question, “what is the goal of emergency medicine training?” they each touched on the importance of this cultural norm. For example, the Informant SS remarked that the goal of emergency medicine training was to: “develop, prepare and train young physicians to be able to deal with multitude of medical and surgical, acute surgical traumatic events that people might present with. They need to know how to multi-task, which is something they pick up, which you’ve probably seen in

your observations—they have multiple patients at once” (Informant SS). For the Informant KS the response to the question was that the training in emergency medicine involved: “caring for patients during the first hour or two of illness ... another emphasis is on what has been called multi-tasking and that’s really the ability to see multiple patients at a time” (Informant KS). Training in emergency medicine prepared the informants to practice the cultural norm of multi-tasking and adapting to change. Thus, phase III data supported the assumption that training in emergency medicine sensitized the informants practice to the demands of the emergency department, and emergency medicine by reproducing the cultural norms of multi-tasking and adapting to change.

How Physician Practice Changed the System

This section addressed how the practice of the informant produced change in the system. Again, the system was defined as the physician-patient interaction, the emergency department, or the practice of emergency medicine. Once again, the researcher relied upon Ortner’s (1984) interpretation of practice theory to explain how change occurred in the system. According to Ortner, change in the system occurred when a change in the practice of the informant occurred. A change in the practice of the informant usually occurred when a novel phenomenon took place that caused a change in the relations between the informant and the system. For example, when the informant encountered an event or occurrence outside the norm of the physician-patient interaction, a change in practice was introduced. This event or process took place because the traditional strategies and routine forms of behavior no longer applied to the new phenomenon. This change in the strategies reflected a change in the relations between the informant and the system. The change in the relations produced a change in the

context of the system. Thus, as the context of the system changed, the practice also changed to accommodate the new relations between the system and the informant.

The two remaining phase II dominant themes, patient challenges and perception of the patient, were used to illustrate this process of system change. The habitus of doing emergency medicine at times presented a challenge to the informants. Such experiences were reported on by each of the informants in various ways. The most frequently reported patient challenge experienced by the informants had to do with seeing and treating patients with primary care needs while doing emergency medicine in the emergency department.

Seeing and treating patients in this particular medical category was defined by the informants in phase II as an example of a patient challenged for several reasons. First, it produced a novel experience for the informants. Second, this novel experience was in conflict with their primary purpose and task, which was to save lives and prevent untimely death. According to the informants in phase II, seeing and treating patients in this medical category was a novel experience because it called for a change or alteration in their practice of doing emergency medicine. In this case, the traditional strategies and routine patterned forms of behavior were not appropriate for dealing with the patient demands and needs of this medical population. In response to the patient challenge and the needs and demands of this particular patient population, the role of the informant had to be slightly altered. As a result, the physician-patient interaction had to be expanded along with the capacity of the hospital emergency department to meet and accommodate the patient with primary care and non-emergent needs. The Informant W from phase III a professor of emergency medicine supported this assumption by stating the following

when describing the connection between emergency medicine training and primary care delivery in the emergency department: “our specialty is a unique specialty where we are more than willingly to undertake roles and responsibilities that will help improve patient care” (Informant W).

Several informants from phase II connected their practice of seeing and treating patients with primary care and non-emergent needs with the image and role of emergency physicians. For the Informant O3 the experience of seeing and treating primary care patients meant the following: “being the primary care docs for society”. The informant defined primary care needs in the following manner: “generally the alcoholic intoxicated and stuff that really don’t need to be here” (Informant O3). The Informant L3 reported that seeing and treating primary care patients in the emergency department meant: “functioning as the safety-net”. Based on the responses from each of the informants the practice of seeing and treating patients with primary care and non-emergency needs was not only a patient challenge but meant that their relation with the patient and function in the physician-patient interaction had changed. The outcome of this patient challenge transformed the physician-patient interaction, changed the dynamics of the emergency department, and slightly altered their role as physicians. In this case the change that occurred in the system was positive because the needs of the patient population were met.

The positive aspect of this change in the system was subsequently explored in phase III research. The researcher found evidence to support the necessity and existence of change to the system to meet the needs and demands of the patient population. The relation between informant practice and the system, meaning that practice was able to change the system, was validated through the response data collected during phase III.

Results in this phase revealed how training emergency medicine physicians to see and treat patient with primary care and non-emergency needs was crucial in emergency medicine.

The perspective of the phase III informants was different from those informants in phase II. The difference was mainly due to the fact that most of the informants in phase II were residents and still in training for emergency medicine. In contrast, the informants in phase III were clinical professors in emergency medicine. As each informant was asked questions regarding their understanding of the relationship between primary care and emergency medicine, they each touched on some aspect of primary care and non-emergency conditions appearing in the emergency department. Results from phase III research supported the perception of the phase II informants regarding their perception of providing care to patients with primary care and non-emergent needs. Based on the perception of the phase II informants and beliefs of the informants in phase III, learning how to treat patients with primary care and non-emergency needs was crucial and a part of emergency medicine training.

The following informants demonstrated this important finding regarding the training received in emergency medicine. When the Informant S from phase III was asked if the training in emergency medicine had changed in the last ten years, he gave the following response: "I think both emergency medicine and emergency medicine training has changed...as things change you have to change the training" (Informant S). Later on in the interview the Informant S expressed that he believed that emergency physicians should be trained to work with primary care and non-emergent patients as well: "it's the physician's duty to know how to treat common medical illnesses. I think it's a part of it

because we always have provided that role” (Informant S). The informant explained this by giving a personal testimony of his experience seeing and treating patients in this particular medical category: “I have twenty-seven years as an attending physician, and you always have people that come to the emergency department for that, non-emergent problems for two reasons one, they have no where else to go and two, because in their minds it’s an emergency ...so we’re always going to do those things” (Informant S). This finding was considered to be important because it proved how seeing and treating patient with primary care and non-emergent conditions had become a part of the habitus of doing emergency medicine and being an emergency physician. This finding also demonstrated that the system had changed. In order for this event to have taken place, changes in the informant’s practice had to occur. In addition the change in the system validated and showed how the role, purpose, and mission of emergency medicine had changed by supporting the cultural value and norm identified in the previous chapter, “decisiveness in clinical decision-making”.

The Informant W from phase III believed that the goal of emergency medicine had not changed: “emergency physicians are trained to deal with really any situation that is going to present to the emergency department setting. Certainly in our population here an urban city many of our patients will have difficulty for whatever reason ...so it’s not uncommon at all that we have non-emergent situations that our residents have to learn how to deal with” (Informant W). However, the informant believed that certain aspects to emergency training had changed which was reflected in the informant’s response above. The change in emergency training that the informant referred to was how

residents in emergency medicine are expected to learn how to deal with patients presenting to the emergency department with non-emergency and primary care needs.

Finally, when the Informant K from phase III was asked if the goal of emergency training had changed in the last ten years, her response was no. However, later on during the interview process the informant informed the researcher that while the goal in emergency training was the same, the patient population presenting to the emergency department had changed. The informant gave a personal testimony of her professional experience as an attending and professor of emergency medicine: “when I first started practicing medicine, it was rare to see a middle aged person with diabetes. Now, we see elderly people with diabetes, high blood pressure ...” (Informant K). The informant justified the changed she witnessed as being driven by the demands and needs of the patient population and the breakdown in the primary care: “what has changed in the past ten years is that the relationship with a primary care physician has broken down. A lot of people don’t have their own doctors, and they used too. The population has been aging and we have kept alive patients with severe disease who would have died before” (Informant K). This informant’s response showed how the change in the patient population brought about a change in the practice of the informant. This over time, led to an eventual change in the informant’s experience and practice of doing emergency medicine and being an emergency physician.

Each of the three informants from phase III agreed that some aspect of emergency training had changed in the last ten years. But the goal of emergency training had remained the same and consistent with the purpose and meaning of emergency medicine. The findings from phase II and phase III data proved that certain aspects to emergency

physician practice had changed and for several reasons. First, a change in practice occurred due to a change in the relations between the patient and the physician during the physician-patient interaction. For example, more patients presented to the emergency department because they required primary care and non-emergent services. Second, more patients in this medical category sought care and medical services because of the breakdown in the relations between the primary care provider and the patient. As a result of these two factors, physician practice was changed to meet the demands and needs of this new patient population. This change ultimately impacted and changed the dynamics of the physician-patient interaction and eventually the emergency department over time.

Finally, several of the informants in phase III elaborated on the significance of training and preparing residents to see and treat patients with primary care and non-emergent needs. As professors of emergency medicine, the informants expressed the necessity for training residents in being non-judgmental especially when attending to patients in this particular medical category: “what we try to train our residents to do is to be more open minded and non-judgmental and to approach everyone as a human being and as an individual such that they can address the issues that are of importance regarding their visit to the emergency department” (Informant W). The Informant K followed up on this idea and presented the argument further in regards to hiring residents once they have completed their residency training: “well one thing we do is try to keep people from being judgmental ...we try and screen those people out from training so that we don’t even hire them. So for instance, if we were to interview a resident and you pick up the concept that they believe the only people that really need to be in the emergency department are people who are very, very, sick; you don’t want to hire them. And the

reason being is because they're doing to be to judgmental. Another thing we try to do is really train residents not to minimize illness" (the Informant K).

The responses from both the informants were significant and important because they clearly spoke to the reality of doing emergency medicine inside the emergency department. Based on Emerson's (1972) method for the construction of reality during the physician-patient interaction, the informant practiced two forms of reality construction while interacting with the patient. If the patient presented to the emergency department with medical symptoms or conditions requiring emergent services, the informant responded with the practice of the routine patterned form of behaviors. If the patient's condition was of a primary care or non-emergency nature, the informant practice was altered to meet the demands and needs of the patient. Therefore, the informants responses from phase III indicated that a change in the system occurred if the patient presented to the emergency department with a non-emergent or primary care need, which brought about the change in the practice of the informant.

The Informant W summed it up in this manner: "we recognize that in an urban environment, such as the metropolitan area where we work that many of our patients don't have primary care physicians or don't have access to being able to see them with regularity. So, it doesn't matter much if they have a doctor if they can't see them. So we recognize that's a role that we play. So we do emphasize that and try to get our residents to be tuned to that and to address these kinds of issues. You realize that any potential problem can present to the emergency department, this is not very focused in terms of narrowly focused specialty where you can concentrate on isolated issues ..." (Informant W).

The experience of patient challenges represented a way that the practice of the informants changed the system. Patient challenges was experienced and defined by many of the informants as seeing and treating patients presenting to the emergency department with primary care and non-emergency needs. When seeing and treating patients in this medical category the traditional practices and routine patterned forms of behaviors were no longer applicable during the physician-patient encounter. In this type of physician-patient interaction the informant must adjust the definition of the medical reality while altering his or her practice of emergency medicine to meet the patient's needs. Encountering patients in this category eventually became a part of the training in emergency medicine. As a result, the professors of emergency medicine help train the residents to recognize his or her role as physicians in providing care to this patient population. In the end, the practice of the informants changed the system in emergency medicine by seeing and treating patients with primary care and non-emergency needs.

Another means by which the practice of the informants could change the system was through the phase II dominant theme of perception of the patient. Perception of the patient was the phase II theme that most characterized how the informants perceived and viewed their patients during the physician-patient interaction in the emergency department. This theme was of particular importance because it represented two facets of physician practice: 1) how the informants interacted with their patients during the physician-patient interaction, and 2) how the informants practiced emergency medicine in the emergency department. First, the informant's perception of the patient reflected the clinical nature, education and training of how the informants were taught to see and view the patient. Michel Foucault (1994) termed this the medical gaze and Byron Good

defined this as the informants learned new way of seeing. In this aspect the informant's perception of the patient represented the cultural element of medicine because it reflected the clinical reconstruction of the patient as the object of the medical gaze (Becker, 2007; Good, 1994; Lupton, 1994). This form of perception of the patient reproduced the system or habitus of doing emergency medicine and practice of being an emergency physician.

The second facet of the theme perception of the patient reflected the cultural dimension of how the informants perceived their patients. This form of perception of the patient was derived from how the informants defined the medical reality that eventually shaped their perception of both the physician-patient interaction and the patient. The informant's definition of the medical reality was influenced by his or her cultural experiences gained from interacting with patients in the emergency department. Although this perspective could produce variations in the cultural perception of the patient across individuals, undoubtedly the informant's previous cultural experiences in interacting with patients was the basis for how each viewed and perceived the patient. Most notably in the analysis of the data majority of the informants' perception of the patient was based on and generated by the patient's behavior in the emergency department and during the physician-patient interaction.

The following questions were created to explore and measure how the informants formed their perception of the patient in the emergency department and during the physician-patient interaction: 1) What determines your perception of the patient during the physician-patient interaction? 2) What non-medical factors do you typically use in making a decision? and 3) What stands out most to you during the time you're interacting

with the patient? Each of these questions generated a clinical perception of the patient. This aspect of the informant's perception of the patient reproduced the system and practice of emergency medicine. However, the cultural aspect of the informants' perception of the patient emerged from within the interview context as they spoke about their experiences interacting with patients in the emergency department.

The cultural aspect of how the informants formed their perception of the patient was connected to how practice was change, thereby leading to change in the system. Upon closer examination of the data, majority of the informant's responses clustered around the following patient characteristics: 1) behavior of the patient in the emergency department and during the physician-patient interaction, 2) patient appearances including personnel hygiene such as smell and body odors, and 3) patient social issues including socioeconomic status, level of education and social support. A few of the informants' referenced patient eye contact made with them and the patients knowledge of their medical condition as influencing their perception of the patient as well. Based on the clustering of the informants' responses, the experiences of interacting with patients that presented to the emergency department in conjunction with the associated patient characteristics produced a culturally driven perception of the patient in the emergency department and during the physician-patient interaction. At times, the outcome of the informant's perception of the patient produced an emotional response and practice that deviated from the routine patterned forms of behaviors learned in medical school and residency training. This new form of practice represented how the system was changed. The altered practices identified in the data were: 1) hardened, 2) cynical, and 3) jaded. In some cases the practice of patient monitoring was created as a means to increase the

efficiency in the delivery of patient care and services. Each of these outcomes caused the system to change or adjust to the informants experience and practice while interacting with the patient in the emergency department.



When the informants spoke about their experiences with patients in the emergency department, they spoke about their emotions and often referred to them as becoming “hardened”. Hardened was the emotional state where the informants clearly did not want to be, but they acknowledged that it would happen over time. For example, the Informant D3 described what it meant to become hardened based on her experiences of interacting with patients during the physician-patient interaction: “...sometimes we kind of, you know ...not try as hard. You’ll see ‘em time and time again: and you’re just kind of not, you’re not as willingly to always just step out on a limb and go the extra mile and say, let’s talk about this” (Informant D3). The informant gave an illustration of feeling this emotion in her description of interacting with patients who were combative and in denial. When asked the question “what do you do when you have a patient that you tell them, this is for your health, you should lose weight And they become combative, what do you do in that situation?” The informant gave her response: “most people live in denial, it’s so much easier you just kind of feel like you know, most days I think we kind of get hardened to it; and when we do get someone who wants to change; we’re kind of liked shocked and even sometimes, you’re kind of leery believing them and we’re like, ok, we’ll see” (the Informant D3).

Another informant spoke about and gave several examples of his experiences with interacting with patients in the emergency department in the context of becoming cynical at times. For example, the informant used the word cynical in explaining what was in the back of his mind, and what he was paying attention to while interacting with the patient: “It’s different for any patient that you know, comes in. Sometimes I feel that this patient’s not being forthcoming to me; is he not telling me the truth? Is he here for another reason? That’s always in the back of my mind. It’s hard not to be, it’s hard to not to be cynical here, but, you know sometimes we have to be”(Informant G3). The informant then gave another example and reason for becoming cynical during the physician-patient interaction: “the most cynical I’ve ever been, it’s usually where these patients that come here, what we call frequent flyers” (Informant G3). The informant defined frequent flyers as: “patients that come here on a regular basis for what seem to be trivial, trivial complaints or similar complaints that they’ve come in for in the past” (Informant G3).

Both informants rationalized their experiences with becoming hardened and cynical in an individual perspective. For the Informant D3, the business of becoming hardened had nothing to do with the capacity to perform as an emergency physician: “It doesn’t make me feel any less as an ER doctor. I feel like, you know all I can do is provide people with a service. And it’s up to them to be responsible for their own lives” (Informant D3). Yet, becoming hardened threatened the cultural image of the emergency physician as hero because the patient was provided with a service and left with being responsible for his or her own life. Encountering patients who were resistant to change and combative towards the informant altered the practice of the informant where they no

longer felt responsible for the health of the patient. In this instance, the altered practice of the informant failed to reproduce the system of emergency medicine.

For the Informant G3 encountering patients who frequently visited the emergency department for the same or trivial complaints produced a perception of the patient that they, the patient, were abusing the system. The informant was asked the question “how often do you find yourself having to be cynical when you don’t want to be?” In answering the question, the informant explained how his perception of the patient was generated and how it produced the emotion and practice of being cynical: “there’s a different pressure from senior staff here that have more experience. They always say don’t get pushed around by the patients. Because you know, sometimes people are here to take advantage of the system. And no one likes to be taken advantaged of” (Informant G3).

In following up on the informant’s experience with becoming cynical when interacting with frequent flyer patients, the informant gave an example of a personal history with interacting with this category of patients in the emergency department: “you really just want to quickly get those patients out of the department with as little fuss as possible, but that is not always possible” (Informant G3). For this informant interacting with patients who frequented the emergency department on a regular basis complaining of trivial complaints produced the cynical cultural perception of the patient as being difficult to deal with. The connotation for being a frequent flyer was that the patient was perceived as abusing the system and difficult to deal with. The outcome of this perception of the patient was the cynical practice of trying to get the patient out of the emergency department with as little fuss as possible. The system change produced in this

situation was that the physician-patient interaction projected the nature and practice of suspicion. In such a case, the patient's visit to the emergency department was defined as being trivial which was directly opposite to the cultural norm and valued identified in the previous chapter, "decisiveness in clinical decision-making".

In another example, the informant's perception of the patient produced the practice and emotion of being jaded. The Informant SSV initially used the term jaded in describing his experiences with patients in the emergency department setting: "in this setting I say you have certain a group of people here let's say for instance a lot of people with chronic disease like sickle cell a pretty terrible disease that needs a lot of medications which leads to some addiction problems and other kinds of negative behaviors also develop. You have to always keep an open mind that these are sick people and you don't want to become so jaded to that ..." (Informant SSV).

When the informant was asked to explain what jaded meant, he gave the following response based on his experiences with patients in the emergency department: "when you can become hardened. Certain things don't hit like they should, like a trauma "Oh another trauma" or "Oh another gunshot wound" I mean it can happen if you don't give yourself that mental break If you don't take a step back and say You know this really impacts somebody's life. You really need to be aware of that" (Informant SSV).

When the informant was asked the question "what determines your perception of the patient during the time you're interacting with them?" the informant addressed the practice of having preconceived notions: "I think it's very dangerous grounds because in many ways first and foremost you don't want to go into a room with a preconceived notion" (Informant SSV). The informant defined having a preconceived notion as a

practice where the emergency physician approached the physician-patient interaction in a manner that hindered the informant in performing his or her job as an emergency physician in the emergency department. The details of this practice were explained in the informant's personal experience with the emotion and practice of having preconceived notion: "let's say as we were talking about before, I picked up a chart and it say's sickle cell crisis. A lot of times that means someone looking for pain medication. But a lot of times that's a sick person and you don't ever want to just walk in and say they just need some pain medication and I'll be able to discharge them. Because you'll fall into the trap where this is someone who is really ill and you've already gone in with a preconceived notion about what their illness is that can get you in a lot of trouble and the patient in a lot of trouble. I've got to make sure it's nothing harmful or detrimental. If I've missed the big bleed then I've failed" (Informant SSV).

Another informant reported a different type of experience with patients in the emergency department and while interacting with them during the physician-patient interaction. The Informant SSL remarked that her perception of the patient was influenced by the patient's behavior and by watching them from the ER nurses desk. The informant gave the following personal testimony of how she formed her perception of the patient: "voice tone, how they look at me. Sometimes I see them in the parking lot, if I see them jogging in the parking lot, when they come in and then say ohh my back, and I'm kind of going huh? Or if I lose them and they're "gone to the mall for a snack I'm like okay what are they doing at the mall? (Informant SSL). The informant was able to watch the patients in that manner because of her appearance: "people don't think I'm a doctor because I dress" (Informant SSL). The informant explained her monitoring of the

patient behavior in the emergency department and during the physician-patient interaction is this manner: “I hate being in the back of the ER, my favorite ER is a square ER, I want to sit and see everybody. I want to see them eat the smuggled in food from McDonald’s. Because if they’re sick, if they’re coming in with belly pain and the family bring them in food, then they’re a little healthier than not” (Informant SSL).

In the dominant theme, the perception of the patient, there are moments when the behavior of the patient in the emergency department changed the practice of the informant and produced the behavior of patient monitoring. This was the case for this informant. The purpose for the adjustment in the informant’s practice was to increase her ability to perform her role as an emergency physician in the emergency department. In some aspect the emergency department became an observation bubble in which the patient became the center of attention through surveillance. Of particular importance here was that the practice of patient monitoring was utilized prior to and during the physician-patient interaction. This practice was an extension of the physician-patient interaction and was generated by the social cues used to evaluate the sincerity of the patient’s reason for their visit to the emergency department. This was a significant finding because it demonstrated how an event outside the physician-patient interaction could impact the system by changing the practice of the informant and the system, producing a new practice of patient monitoring and making the emergency department an observation bubble.

This section of this chapter illustrated how the practice of the informant had an impact on the system. Results in this section showed how the perception of the patient altered and changed the practice of the informant and the system. The informant’s

perception of the patient was generated in two ways: education and training, and by his or her cultural experiences from interacting with patients in the emergency department and during the physician-patient interaction. Perception of the patient was found to be an aspect of the informant's learned behavior acquired in medical school education and training. Perception of the patient in this context was an essential practice that was used to formulate the clinical perspective when treating patients in the emergency department (Becker et al., 2007). When each of the informants were asked questions on how they formed their perception of the patient, they each gave a description narrating the importance of identifying the clinical symptoms associated with the patient at that time.

However, when the behavior of the patient was outside the institutional norms of medicine the informant had to develop and maintain an altered perspective that called for a change in practice to accommodate the novelty of the situation at hand. In other words the perception of the patient came about when the informant faced a novel experience or patient behavior (i.e. something else is going on with this patient). In many physician-patient interactions, the prior perspectives generated by the cultural experiences of learning how to construct the medical gaze presented no other option but to form a perception of the patient. As the informant was called upon to act and as their choices remained unconstrained, they began to develop a perspective. As the range of their cultural experiences with patients in the emergency department and during the physician-patient interaction continued to increase, the perspectives generated eventually became their perception of the patient. Over time, this became the established practice and a part of the habitus of doing emergency medicine and being an emergency physician (Becker et al., 2007; Bourdieu, 2005; Swartz, 1997)

Conclusion

Encountering patient challenges altered the habitus of doing emergency medicine. This event produced a failure to reproduce the system, and changed the way the informant interacted with the patient during the physician-patient interaction. For example, while doing emergency medicine, the informant must be careful not to treat the patient's complaints as trivia. Treating a patient's complaint as trivial could easily happen especially if the patient made frequent visits to the emergency department.

Another way patient challenges influenced and or changed the practice of emergency medicine and the emergency department had to do with the informant's perception of the patient. The informant's perception of the patient was based on his or her cultural experiences functioning in the emergency department and influenced how they each approached the physician-patient interaction. Each of the informant's experiences of interacting with patients during the physician-patient interaction provided a different form of practice behavior and emotion. The outcome of each of the informant's cultural experiences with patients in the emergency department influenced his or her perception of the patient. Each of the informant's methods of perception of the patient captured and reflected how the informants practice was changed to meet the demands of the physician-patient interaction at that particular moment. The different forms of practice identified by the data were hardened, cynical, and jaded. In addition, there were moments when the behavior of the patient while in the emergency department produced a change in the informant's practice such as patient monitoring.

The informant's practice of patient monitoring was used to increase the informant's efficiency and effectiveness in delivering care to the patient. In other words, the cultural experiences of the informant had the capacity to alter the practice of the

informant. For example, the patient's behavior caused a deviation in doing emergency medicine and how the informant functioned in the emergency department. Patient challenges and perception of the patient altered the informant's practice of doing emergency medicine and ultimately influenced the culture and structure of the emergency department environment.

Referring back to practice theory, in Bourdieu's eyes, social life was defined as being composed of mutual interactions between social structures and human actions. Each of these came together and produced an enduring orientation to practices that structured the emergency department environment. Reflecting back on the data, perception of the patient represented the practice (i.e. human action), patient challenges were the dispositions, and the physician-patient interaction and the emergency department was the social structures. For example, the mutually constituting interaction of these elements came together and produced the enduring orientation action of patient monitoring, while structuring the patient as the object of surveillance, and structuring the physician-patient interaction and hospital emergency department as a place of surveillance monitoring.

According to practice theory, this scenario was very significant for this study because it demonstrated how at any given time the informant could be called upon to 'improvise' their practice to meet the needs of the medical encounter. This action of improvisation occurred without script and altered the informants' practice of doing emergency medicine by invoking the response of patient monitoring. The ability of the informant to respond in this manner clearly illustrated the informant's mastery over their task and their control over their environment. The ability to improvise in this manner

replicated the action and response of thinking on ones feet thereby causing the informant to assume the added role of patient monitor when performing in the emergency department and seeing patients during the physician-patient interaction.

Second, the practice of patient monitoring slightly altered the structure of the emergency department in that it became a type of surveillance. In this case, the mission was slightly expanded to include the habitus of monitoring a patient's behavior in the context of the physician-patient interaction and hospital emergency department. In either case, the orientation to patient monitoring, simply put, demonstrated the informant's ability to play the game of social interaction drawing from his or her cultural experiences, and using their embodied knowledge of the function of the hospital emergency department, and of emergency medicine. Based on the informant data one can conclude that the practice of the informant was capable of influencing and in some cases, even changing the system of emergency medicine.

Chapter 7 “Summary and Discussion”

The relationship between culture and emergency medicine was examined through a cultural analysis as a means to draw attention to the broader social and cultural processes, which operated within the hospital emergency department, and within the physician-patient interaction. The initial assumption made was that culture, expressed through physician ethnicity was somehow related to the existence of health disparities (Todd, et al., 1993). In the process of examining this relationship, no such correlation was found. Instead, other aspects of the relationship between culture and emergency medicine emerged and were found to be important for understanding how the emergency physician functioned within the physician-patient interaction and within the emergency department. The relationship explored was that which pertained to the connection between culture and emergency physician habitus. The question asked was how was culture related to the habitus of the emergency medicine physician?

The research revealed that a relationship existed between culture and the habitus of emergency physician. The habitus of the emergency physician was viewed as the practice of emergency medicine and expression of doing emergency medicine in the hospital emergency department. In this same aspect, culture was also related to each of these aspects as well. These findings were important because it produced a better understanding of what it means to be an emergency physician in the emergency department, and while interacting with patients during the physician-patient interaction. Most importantly, due to the immense gap in the literature regarding hospital ethnographies, this research provides significant and relevant knowledge that can

enhance our understanding of the relationship between culture and emergency medicine, and emergency physician habitus.

The research study was completed in three phases. Each phase touched on some aspect of the culture and emergency medicine relationship. The first phase was the pilot study, which initiated the entry into the hospital emergency department, established relations with key informants and provided the opportunity to maintain relations with the host research study site. Observations of the informants interacting with patients during the physician-patient interaction were also made during this phase. Phase II was the stage where the relationship between culture and emergency physician habitus was examined. The questions asked during this phase included: “how did culture influence emergency physician habitus?” And “how did culture reproduce emergency physician habitus?” During Phase III the relationship between culture and emergency physician habitus was examined further by looking at how culture influenced emergency medicine training.

In general, discovering that culture was related to both emergency physician habitus and emergency medicine was significant for several reasons. First, the relationship that was found to exist proved how emergency medicine was not detached from culture or unaffected by the influence of culture. Understanding this relationship helped to understand how emergency physician habitus was also a product of sociocultural processes. When emergency medicine was viewed and understood as a subset of biomedicine, then the relationship between culture and emergency physician habitus and emergency medicine supported Gordon’s (1988) claim that biomedicine was not autonomous or separated from culture.

Second, understanding that biomedicine and emergency medicine were not independent of culture touched on another aspect of Gordon's (1988) argument concerning biomedicine and culture—specifically, how hidden cultural values shaped the practice of biomedicine. In this study, American core values were found to influence and create aspects of emergency physician habitus. The aspects of emergency physician habitus created were expressed through the practices of the research informants. For example, the American core value of preservation of human life was not only the foundation upon which the habitus of emergency physician was created, but it was repeatedly reproduced as an emergency physician practice in the ER cultural text data.

Third, the relationship between culture and emergency physician habitus was also significant because it touched on the work of Lupton (1994) regarding the sociocultural dimension of emergency medicine. The interview data from Phase II suggested how emergency physician habitus had a sociocultural nature that was expressed by the practice of the informants during the physician-patient interaction. For example, when the informants described the process of establishing a rapport with the patient, identified as a part of the habitus of doing emergency medicine, their practice of engaging in this activity often reflected their cultural experiences gained from interacting with patients in the emergency department. This was significant for several reasons. First, medical knowledge was determined to be a product of social relations. Second, the informant's practice of doing emergency medicine in the emergency department and within the physician-patient interaction also produced medical knowledge. Most importantly, the sociocultural dimension of the emergency physician habitus, along with the sociocultural

dimension of emergency medicine proved how important and relevant culture was to the discipline of emergency medicine.

Fourth, this cultural studies framework of emergency medicine is also important because it facilitates our understanding of how to properly view and understand how medicine is indeed cultural in nature. Again, this ethnographic study of emergency medicine and the hospital emergency department provides invaluable insight into how to approach the study of emergency medicine and the emergency department. Because of the gap in the literature regarding hospital ethnographies, this dissertation study also provides an additional method for approaching anthropological study in a hospital emergency department setting.

Finally, this cultural studies framework on emergency physician habitus and on emergency medicine was timely because this specialty of medicine over time emerged as a major source of medical care for a large proportion of the American population (Weaver & Sklar, 1980). As a result, most emergency departments in our nation continue to provide non-emergency care to patients characterized as being low income groups, newly arrived immigrants, members of minority and ethnic groups, working-class and lower-class whites, and persons marginal to society, such as the homeless and mentally ill (Weaver & Sklar, 1980). Using Bourdieu's practice theory and his concept of habitus provided a means to capture and explain the new meaning of emergency physician behavior and practice in the current environment of the emergency department and within the physician-patient interaction. Taking care of the medical needs of such a diverse social and cultural population reflected how Howard Stein began his book entitled, "American Medicine as Culture". In his book Stein stated that he situated

“...biomedicine within American culture ...” while arguing, “...the very organization and practice of medicine are themselves cultural” (Stein, 1990, p. xiii).

Taking the above discussion further, medicine as we have come to know and experience today has been described as being its own culture (Kleinman & Hahn, 1983; Stein, 1990; Good, 1997). In their work on biomedical practice, Kleinman and Hahn (1983) defined medicine as a cultural system. The authors acknowledged further how this socio-cultural feature of medicine enabled the profession to be open to investigations concerning its material power, and socio-ideological sides and attributes (Kleinman & Hahn, 1983). One attribute that has been studied by social scientist is the value free, logical activity of medicine rooted and grounded in the principles of sciences (Kleinman & Hahn, 1983; Good, 1997).

The importance of being value free was often discussed and referred to by the informants in the research study. They made their reference to this cultural attribute by citing and relying on the federal mandate EMTALA, which according to the informants was the cornerstone of doing emergency medicine in the emergency department. According to the responses of the informants, EMTALA was the bulwark against any appearance of discrimination, racism, and involvement in the existence of health disparities for the emergency physician and the emergency department. In western medicine, the roots of being value free was associated with the Hippocratic oath, and presumed to be a reflection to some degree of western society and culture. In other words, the development of medicine rested on its ability to respond to the broader cultural paradigms and various social pressures over time. In doing so, western medicine

maintained its tenacious assumptions while it became a force to be reckoned with regarding cultural and social change (Kleinman & Hahn 1983).

Although the informants reported that they were un-biased in their perception of their patients, the data showed there were times when the informants blamed the patients in some aspect. The blaming of the patients was seen especially when dealing with chronic disease patients routinely seen and treated in the emergency department. For example, blaming the patient was indicated when Informant G3 was addressing how emergency physicians become cynical. When the informant was asked the question what's the most cynical you've ever been, the following response was given: "the most cynical I've ever been; it's usually when these patients that come here, what we call frequent flyers, that's patients that come here on a regular basis for what seems to be trivial complaints or similar complaints that they've come in for in the past...; they've already have a lot of documentation in, you know, in our ER dictation notes that I can review. And so you're like what is it today (Informant G3). Repeated visits to the emergency department led this informant to blame the patient based on the informant's perception that the patient was behaving irresponsibly in regards to their health condition.

From this dissertation research I learned that despite the historical framework of emergency medicine being centered on the practice of critical life saving techniques such as resuscitation, and the care for trauma patients, this field of specialty medicine has taken on a new and challenging role in the provision of primary care. Taking on this role exemplified how medicine was not politically neutral based on the eventual passage of the federal law EMTALA. This role was not one that was initially sought after by those in this particular medical profession. This role in the provision of primary care was

handed down through federal law EMTALA, which mandated that all emergency departments see, stabilize, and treat all patients presenting to their health care facility (HR 3128).

Most importantly, this law came about due to the unfair treatment that African American patients received, along with the poor and uninsured patients because of their inability to pay for services (Lee, 2004). Enacted in 1986, the purpose of EMTALA was to address and solve the problem of patient dumping that had become characteristic among many of our nations emergency departments (Lee, 2004). What brought about this unfortunate occurrence was the state of poverty that many of our citizens found themselves in. Citizens suffering in this poverty condition suffered heightened public indignity and perennial danger to the point where it manifested itself in a practice that endangered many of their lives (Lee, 2004). Unfortunately, this event in our health care history produced the practice of patient dumping, that over time had become a popular and acceptable practice in the culture of American medicine (Lee, 2004). Once again, this fact pointed to how society influences, issues, and problems can directly change and altered the cultural practice of American medicine. Most importantly, the failure of our nation's health care and public policy to address the national crisis of the poor and uninsured has placed a population of individuals at risk and at times even death (Lee, 2004).

One of the consequences produced by the enactment and enforcement of EMTALA was the uncertainty felt by our nation's emergency departments and emergency physicians regarding the extent of services that must be rendered to all patients seen and treated through the emergency department (GAO, 2001). According to

the Congressional Report, “more than 40 percent of emergency physicians and 60 percent of emergency department directors responding to ...OIG survey reported that some parts of the EMTALA law or regulations were unclear” (GAO, 2001, p. 15). The ambiguity of the law raised questions about the amount and type of care that is required to administer to patients seen through the emergency department (GAO, 2001, p. 15). For example, emergency physicians, and emergency departments were unsure about what medical screening exams were required to be administered to patients seen in the emergency department (GAO, 2001, p. 15). Based upon the literature and the responses from the informants in this field research, it was this uncertainty that opened the “flood gates” for providing primary care services and assuming the provider role of primary care physician.

Taking the perspective of medicine as culture enlightened my understanding and appreciation regarding the significance and impact that culture had on emergency medicine. The application of medicine as culture transcended the traditional American ideology of activism and individualism by using Bourdieu’s practice theory as a means of focusing on the relation between culture and human action, which in this case was culture and emergency physician habitus. The habitus of emergency physicians and emergency medicine was not fixed but was subject to change. The habitus of the emergency physician was not independent of reality, but was part of the construction of that reality (Lupton, 199; Emerson, 1972).

What I am saying is that practice theory allowed me to bypass the traditional dichotomies of social science research by placing me, the researcher at the center of observations of everyday life or practices of the hospital emergency department involving

the interaction of the emergency physician with their patient. This was significant and important because it revealed the meaning and aesthetics of being an emergency physician interacting with patients in the hospital emergency department. This ultimately led me back to my original theme, discovering what emergency physicians do; why they do what they do; and how they do what they do.

Implications for Understanding Health Disparities

This dissertation study can be utilized as a springboard to help facilitate our understanding of health disparities in several ways. First, utilization of practice theory eliminated the presence of objective subjective schism associated with social science research. This opened the door to opportunities to observe and study the actions and behaviors of actors within a cultural system. Second, practice theory reminds us that the most significant and important actions and behaviors that should be studied are those that occur within asymmetrical or dominant relations (Ortner, 1984). This is true because these forms of actions and behaviors can best explain the function and shape of any cultural system at any given time (Ortner, 1984). Also, these forms of behaviors and actions occur and function within the context of inequality. Thus, the asymmetrical relationship between the physician and the patient offers the best explanation for understanding how the physician-patient interaction functions and its relationship to the production of inequalities and health disparities. Examining the physician-patient interaction in this manner allows the researcher to ask such questions as: 1) how are the conditions of inequality produced?, 2) what are the conditions associated with the production of health disparities?, and 3) how are the actors involved in the production of inequality?, and 4) what actions are related to the existence of health disparities?

Third, shifting the research focus in this direction will help bring to light and define the element of (social) class in American culture (Bourdieu, 1991, Ortner, 1991). This is an important point because using practice theory gives the researcher the ability to uncover the hidden truths of how people are also shaped by culture through the conditions of inequalities (Bourdieu, 1991). In practice theory, inequalities are the product of distinctions in thought or ideologies brought about by the differences in class (Bourdieu, 1991). In this sense, Bourdieu (1991) defined class as a group of people who occupy similar positions with similar dispositions in a given social space within the cultural system. Bourdieu used his definition of class as a theoretical construct to analyze and explain behaviors and how people interact in any given social and cultural system.

For example, people occupying the same position in a social space are likely to constitute themselves as a distinct group. At the same time, as a group they produce a vision of how they view themselves and the social world around them. The group distinction and vision created by the group establishes them as a class and reflects the ideologies used to characterize them as being socially and culturally different from all others within the system (Bourdieu, 1991). Thus, in emergency medicine and within the physician-patient interaction the physicians and patients occupy different social positions with inherited ideologies, which distinguishes them as separate class entities within the system of medicine. Physicians occupy a position of authority based on the cultural capital associated with the profession of medicine. As a class, the physicians are distinct from the patient based on the cultural capital they possess and use: expert knowledge, technical language, symbolic symbols such as white coat and stethoscope. The patient's position is subordinate and dependent upon the physician. As a class, the patient is

seeking the expert knowledge, advice and service of the physician. This asymmetrical or dominant relationship between the physician and the patient based on social position and class is where inequalities and possibly health disparities are produced and experienced.

In the system, each group as a class (i.e. the physician and the patient) is relative to one another. Each of the groups is confined to their respective positions based on the distribution of power associated with the class and position they occupy (Bourdieu, 1993). Hence, the social space occupied by each class as a group is more than a group of people occupying similar space. The social space really consists of groups that are identified as a separate class based on the ideologies they use to make them economically, socially, and culturally distinct and different from other class/groups within the system. The perceived differences each group holds formulate the distinctions in thought that exists between each class (Bourdieu, 1993). Therefore, the relationship between culture and class is reduced to differences in thought reproduced and expressed in the form of inequalities and possibly in the form of health disparities (Bourdieu, 1993).

In the final analysis, using practice theory to study and improve our understanding regarding the nature of the relationship between culture and class will help avoid the pitfall often made by social science and anthropologist, misconstruing the questions asked regarding how people behave and represent themselves in social relations (Bourdieu, 1991). As a result, the scientific field and research focus will not struggle to capture how the agents interact and operate within a cultural system. Choosing rather to use Bourdieu's (1991) theoretical definition of class instead of the realist definition of class enables one to view and understand that class is not a clearly defined compact delimited group or entity (Bourdieu, 1990). As a result, we are led to reject the idea and

assumption that we have the knowledge to determine how each class will classify themselves and others; and how each member will determine their membership in a particular class (Bourdieu, 1990).

Appendix A. PHYSICIAN-PATIENT INTERACTION OBSERVATION CHECKLIST

Behavior	Yes	No
Physician introduces self to patient (Hello, my name is; Hi, I'm doctor...)		
Physician addresses the patient by name		
Physician establishes and maintains eye contact with patient		
Physician stands closer to patient's head than to the patient's feet (when appropriate)		
Touches patient in empathetic fashion (places hand on patient's shoulders or arm as they listen and/or speak to the patient)		
Listens to the patient without interrupting them (patient asks question or responds and physician doesn't interrupt)		
Physician shows agreement (By saying "I see," "That's right," "Okay," "Alright," "Oh, really.")		
Physician performs documentation during the medical encounter (physician filling out medical encounter template with little or no eye contact)		
Physician posture is oriented towards the patient (they face the patient when speaking)		
Physician uses words the patient can understand		
Physician talks patient through physical exam (establish rapport with patient)		
Physician shows approval to patient (doctor responds "Good" when patient responds correctly; e.g. "Take a deep breath.")		
Physician explains to the patient what to expect during the medical encounter (establishing rapport with patient)		
Physician acknowledges patient during encounter with head nod, or saying um-hum, ok, go-on. (active listening indicators)		
Physician asks patient if they have any questions		
Physician ignores patient's questions (patient asks question and physician fails to answer)		

Appendix B. ER EPISODES CHECKLIST

Type of problem		Yes	No
Emergency	Chest pain		
	Abdominal pain		
	Vomiting/bleeding		
	Fever		
	Toxicology		
	Trauma		
	Resuscitation		
Non-Emergency	Flu		
Primary care	Diabetes		
	Hypertension		
	Drug use		
	Alcoholism		
	Psychiatric		
Other			
Patient description	Gender	Male	Female
	Age		
	Race		
	SES		
	Education		

How do physician talk about or refer to the patient receiving primary care?

How is the patient depicted in the episode that is receiving primary care?

Who is associated with primary care?

Appendix C. UNSTRUCTURED INTERVIEW QUESTIONS

1. What encouraged or motivated you to become an emergency medicine physician?
2. What is your role as an emergency medicine physician?
3. What is your role as an emergency medicine physician in this setting?
4. Can you identify some challenges you've experienced or encountered when communicating with patients?
5. Can you share with me the steps you take in establishing rapport with a patient?
6. What are some techniques you use to get the patient involved (to dialogue) with you during the physician-patient interaction?
7. What determines your perception of a patient during the physician-patient interaction?
8. What are the main objectives you're trying to achieve during the physician-patient interaction?
9. Can you walk me through the decision-making process you follow in a typical physician-patient interaction in the ER?
10. What non-medical factors do you typically use in making a decision?
11. What stands out most to you during the time you're interacting with the patient?
12. Tell me about your training in medical school/residency?
13. During your medical school and residency training, was health disparities a part of the curriculum?
14. Do you believe health disparities exist?
15. In your own words, can you tell me what health disparities mean to you?
16. Do you think there is a difference in health of African Americans and whites, and other ethnic minorities?
17. Why do you think health disparities exist, especially among African American patients?
18. What is the role of emergency medicine?

Appendix D. INTERVIEW CODEBOOK

Codes	Definitions	Exclusion
Roles	Those statements that define or clarify the role of an ER physician by giving the characteristics, and ideal and qualities of an emergency physician. For example, my job is ..., “or “we function as ...” and “we are or we do”. These statements also touch on the role and delivery of primary care in emergency medicine. For example, “granted we all kind of get to knowing after awhile when you see the person that’s here for they’re basically, almost their routine care and we’re almost their primary care doctor”. “we try not to actually become the primary because actually that is not our true role”.	Statements that don’t speak or address the role of an emergency physician. These statements may instead address or speak on the role of other health care professionals or of patients.
Health Disparities	Statements that reflect the various problems and issues that are system wide in the health system: and reveal how the ER physician is aware that the larger context of life can/will affect the health status of a patient. For example, “...there’s increase in homelessness, alcoholism, unemployment is higher, ...”. Also, statements that reflect how the emergency physicians define or give meaning to the term/concept health disparities. These	Exclude those statements that point out the various problems and issues that the physician encounters when interacting with the patient. These statements would be more in line with the challenges faced by physicians when interacting with their patients.

	<p>statements may address or touch on the social or non-clinical aspect of the patient's health condition. For example, "I mean you have patients that fall through the crack, they don't have adequate primary care ..." Or these statements may blame the system. For example, "...I see that there are some weaknesses in our current health system ".</p>	
<p>Physician Perception of Patients and their Behavior(s)</p>	<p>Statements made by the emergency physician about their patient, when they talk about their patients. For example, "...because some of them have good access to healthcare, and they just don't take care of themselves. I mean, they don't take their medications". "But yeah, we have tried to we do try to refer discourage primary usage, you know, like the high users ..."; and "...well, because they say the wrong thing to get their pregnancy test ...".</p>	<p>Any statement that doesn't refer or point to the patient or is reflected of the patient seen in the ER.</p>
<p>Physician Training</p>	<p>Statements made about their experience during medical school and residency training.</p>	<p>Statements that are not about the emergency physicians training in medical school and residency</p>
<p>Objectives/Goals in Emergency Medicine</p>	<p>Statements made by emergency physicians that describe or state or begin with "the most important thing in emergency medicine is ...". These</p>	<p>Any statements that do not speak on goals of the physician during the physician-patient interaction.</p>

	statements also address those issues, concerns, or goals that are important to the physicians during the time they are interacting with their patients. For example, “I try to ...; I want to ...; we need to determine ...”.	
Rationale for selecting Emergency Medicine	Any statements that reveal why the informant choose to study or pursue emergency medicine. For example, “I don’t have a very long attention span. I need things to be changing to keep my interest”; “I guess for one thing we see a wide variety of patients ...”.	Any statement that doesn’t reflect why the physicians choose emergency medicine as a career.
History of Emergency Medicine	Any statements that give or address the history of emergency medicine as a medical specialty.	Those statements that don’t talk, discuss or elaborate on the history of emergency medicine.
Challenges	Statements made by the ER physicians that point out or describe the many challenges, difficulties, problems etc they experience, face or encounter when interacting with their patients. For example, “...I think the most important challenge ...is that while we handle illness everyday and you become somewhat desensitized to it ...”.	Those statements that point to the many broad problems and issues, which are present in the U.S. health system. These statements would speak to the system wide problems faced or encountered by emergency physicians in their delivery of patient care.
Cultural Modals	The emergency physicians description that reflect how they think, believe popular culture define their role or see them as emergency	Any statements that are not related to the modal for becoming an emergency physician.

	<p>physicians. For example, “what people, think of when uhmm, what regular non medical people think of when they think of what being a doctor does in general”. For example, “I don’t know if its sounds ahh, a bit, not necessarily elitist; but, ahh, we’re probably the last, one of the last few remaining real doctors, in terms of doctors that can handle any of the problems that come in”.</p>	
Presentation of Self	<p>Any statement or phrase that the emergency physician uses to describe how they think, how they feel or felt when interacting with their patients. for example, “Uhm—I ask them how they’re doing I think it’s my demeanor”; “Its hard to be, its hard to have to be cynical here; but, you know sometimes, we have to be”; “I’m frustrated”. But, uhm, not necessarily at the patient. But more at myself for you know not identifying that you know ...”.</p>	<p>Any statements that are not related to or show or describe emotions of the physician.</p>
Emergency Department Setting	<p>Any statement or phrase the emergency physician uses to describe or characterize the emergency department, especially the department in which they work. For example, “I think that in this setting, we see a lot of sick people although we don’t see a lot of trauma”.</p>	<p>Any statement that is not related to the emergency department or setting.</p>

Appendix E. ER EPISODES CODEBOOK

Code for:	Definition	Exclusion
Medical condition:		
a) Unstable/emergency	Chief complaint is chest pain; difficulty breathing; trauma; respiratory or cardiac arrest; resuscitation	Those conditions which are chronic/primary care; accident/violence; social/environment; and other
b) Accident/violence	Chief complaint is involvement in MVA; gunshot wound; stabbing wound	Those conditions which are life/limb threatening or chronic/primary; social/environment or other
c) Chronic/primary care	Chief complaint is high blood pressure; diabetes; CHF; flu	Those conditions which are unstable/emergent; accident/violence; social/environment or other
d) Social/environment	Chief complaint is alcohol abuse; drug abuse; substance abuse	Those conditions which are unstable/emergent; accident/violence; chronic/primary care and other
e) Other	Chief complaint is not taking medications; or psychiatric	Those conditions which are chronic/primary care; accident/violence; unstable/emergent; and social
Physician perception of patient (physician attitude)		
a) Worthy/responsible	Patient is not responsible for their disease; it occurs as a natural progression in life	Those conditions which are caused by reckless, irresponsible behavior
b) Guilty	Personal behavior/actions cause the disease and/or illness	Those conditions which are caused by irresponsible/immoral behavior; or not a part of the natural course of life; or not within the control of the patient

c) Irresponsible/immoral	Patient brings on their illness/disease because of their non-compliant, risky behavior	Those conditions is brought on by guilty behavior/actions; or not under the control of the patient; or due to the natural course of life
d) Other/Social	The illness or condition is a manifestation of their social condition and/or is not under their control	Those conditions which are due to the natural progression of life; caused by guilty behavior; or due to irresponsible and risky behavior
Life Stage (Age)		
a) Child/Adolescent	Patient between ages of 6 and 17	Patients who are 18 years old and above
b) Adult	Patients between ages of 18 and 55	Patients who are 17 and younger; and older than 55
c) Elderly	Patients older than 55	Patients 55 years old and younger
Race/Ethnicity		
White	Patients who reflect the physical characteristics and skin marker for "white"	Patients who reflect the skin marker and physical characteristic for non-white
African American	Patients who reflect the physical characteristics and skin marker for "African American" or "Black"	Patients who reflect the skin marker and physical characteristic for non-African American/Black
Other	Those patients who don't possess the skin marker or reflect the physical characteristics for white or Black (African American)	Those patients who reflect the skin marker and physical characteristic for white or Black (African American)
Social Class (SES)		
Poor		
Homeless		
Middle/working class		
Professional		

Appendix F. NARRATIVE INTERVIEW QUESTIONNAIRE (PHASE III)

Narrative Questions for Attending Physicians:

1. Tell me the history of you being an emergency physician: start anywhere you want, end anywhere you want.
2. Tell me your story of being an emergency physician as a book: what would be the title of the book? What would be in each chapter of the book? What would be the next chapter of the book? And what would be the last chapter of the book?
3. If I painted your career as a mural, what would each scene be? What would be the title of each scene? And what would be the title of the whole mural?
4. What TV show or movie exemplifies what you thought emergency medicine would be? And what TV show or movie exemplifies what emergency medicine is really like?

Narrative Questions for Professor of Emergency Medicine:

1. What is the goal of emergency medicine training?
2. Has that changed in the last ten (10) years?
3. Are emergency physicians trained to work with non-emergency problems, such as:
 - a. Adherence to medications
 - b. Sexual identity
 - c. Substance abuse
 - d. Weight (obesity)
 - e. Smoking
 - f. Chronic disease (diabetes, congestive heart failure, hypertension, renal failure)
 If so, how are they trained?
4. How does the training for non-emergent problems differ from emergency problems?
5. Given the changing nature of emergency medicine, do you see training goals and content changing and if so, how?
6. What is the role of death in emergency medicine and how is it taught and discussed?

Narrative Questions for both (Attending and Emergency Medicine Professors):

1. In what way is emergency medicine similar and/or different from primary care medicine?
2. What are the main challenges for emergency medicine today, and how are they being addressed?

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ABSTRACT

ETHNOGRAPHY OF THE HABITUS OF THE EMERGENCY PHYSICIAN

by

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Advisor: Dr. Andrea P. Sankar

Major: Anthropology

Degree: Doctor of Philosophy

This hospital ethnography focused on the relationship between culture and emergency physician habitus. The habitus of these physicians was defined as those routine, patterned forms of behaviors and practices performed by the physicians while in the emergency department and while interacting with the patient during the interaction. Pierre Bourdieu's practice theory was used to address how culture was related to the habitus of the emergency physician. The researcher found that culture was not only related to the habitus of these physicians, but it reproduced, and at times created, aspects of the habitus through the practices performed while in the emergency department and while interacting with patients.

AUTOBIOGRAPHICAL STATEMENT

Renady Hightower was born in Chicago, Illinois and received her bachelor's degree from the University of Illinois at Urbana-Champaign. Subsequently, moved to Detroit, Michigan where she received her master's degree from Wayne State University.