“Unless you went in with your head under your arm”: Patient perceptions of emergency room visits

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Abstract

There is increasing concern in Canada regarding growing pressures on emergency room care. Frequent media reports call attention to overcrowding, lengthy waiting times and the re-routing of ambulances due to the closure of emergency rooms during periods of overcrowding. Much of this information, however, is anecdotal. As such, little is known about patients’ experiences in emergency rooms in Canada. The purpose of this study is to explore patients’ perceptions of their most recent emergency room visit. Semi-structured, in-depth interviews were conducted with 41 men and women from two socially distinct neighbourhoods in Hamilton, Ontario, Canada. Much of the previous work on experiences in emergency room care is international in scope and uses quantitative methods to examine patient satisfaction with emergency care. This study considers patient experiences more broadly and looks beyond satisfaction to examine reasons for seeking emergency room care and the factors that shape experiences. The findings show that most patients describe their experiences in negative terms. The aspects of emergency room care that were most often linked with negative experiences were waiting times, patient perceptions of the quality of care received and staff–patient interactions. The findings are discussed in the context of recent health care reforms in Canada, which we argue have not addressed adequately the ‘crisis’ in emergency rooms.

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Introduction

The emergency room (ER) is an important component of health care systems. It is the site where individuals receive care in emergency situations but also where primary care services are often provided when doctors’ offices and health clinics are closed. ERs may also be the first contact point for those without family physicians. In Canada, there has been increasing concern regarding the mounting pressures on ERs. Frequent media reports document increases in wait times, overcrowding and compromised quality of care in ERs. In September 2000, a newspaper story attributed the death of a young man living in Toronto, Ontario to the rerouting of his ambulance from a local hospital to one that was much further away due to overcrowding in the local hospital ER (Toronto Star, September 11, 2000). In another case, a Toronto, Ontario man was sent to Peterborough, Ontario, a 150 km distance from Toronto, because at the time all Toronto hospitals were closed to ambulance cases (Guelph Mercury, December 29, 1999). From these and similar stories, an ‘ER crisis’...
seems evident (see also Hamilton Spectator, January 13, 2000; Toronto Star, January 13, 2000; Toronto Star, June 8, 2001). While there is much anecdotal evidence of the existence of an ER crisis in across Canada, there have been few studies to examine the state of ER care in Canada and even fewer that explore patients' perspectives of care received in these settings.

Hospitals are an important part of the Canadian health care system and this is reflected in national and provincial health expenditures. In 2001, approximately 30% ($32 billion) of total health expenditures in Canada was spent on hospitals (CIHI, 2004). Similarly, in the province of Ontario, approximately 27% ($11.5 billion) of total health expenditures went to hospitals (CIHI, 2004). ERs are a critical component of the Canadian health care system in general and the hospital system in particular. In the year 2000, the total number of visits to ERs in the province of Ontario was 5,272,803, which represents approximately half of the total population of Ontario (Ehrlich, Chhetry, Emo, Nelligan, & King, 2002). The Hamilton Health Sciences Corporation, which governs four of the five hospitals located in the City of Hamilton, Ontario, has an annual budget of $553,571,024 of which 3% is allocated to ER services (Berti, 2004). Given the essential role that ERs play in providing urgent and primary care, the financial resources that are invested into hospitals each year, the high volume of care they receive each year, and the potential crisis in ER settings across the country, patient experiences represent an important but undocumented aspect of ERs. In fact, the evidence suggesting that ERs are facing increasing pressures is largely anecdotal and the research examining individuals’ perceptions and experiences in ER settings is limited. In light of the current situation, this study explores patient experiences in ER settings in Hamilton, Ontario, Canada to begin to understand both patients’ perceptions of the care received in ERs but also the factors that shape their ER experiences.

Background

Patient experiences in ER settings is an under researched area in Canada. Much of the research that examines user attitudes towards ER care has been conducted in other international settings, mainly the United States (US) and United Kingdom (UK). Further, the majority of research focuses on assessing patient satisfaction using quantitative methods and global measures of satisfaction. Despite the lack of focus on patient perceptions of and experiences in ER settings, the existing research is important for identifying aspects of ER care that shape overall levels of patient satisfaction.

Research has identified three main determinants of patient satisfaction with ER care: physician–patient interaction; information/communication between the physician and patient; and wait times (see Trout, Magnusson, & Hedges (2000) for a complete review). Of these three, interpersonal dimensions of the physician–patient relationship, which include how compassionate or sensitive physicians are to patients’ needs as well as their ‘bedside manner’, have been demonstrated to be the most important determinant of patient satisfaction (Avis, Bond, & Arthur, 1997; Bursch, Beezy, & Shaw, 1993; Cohen, 1996; Hall & Press, 1996; Hutchison et al., 2003; Krishel & Baraff, 1993; Lewis & Woodside, 1992; Mayer et al., 1998; Sun, Adams, & Burstin, 2001; Thompson, Yarnold, Williams, & Adams, 1996; Watson, Marshall, & Fosbinder, 1999; Yarnold, Miecehson, Thompson, & Adams, 1998). For example, Hall and Press (1996) using data from a national random sample of emergency departments in the US found that patients who feel physicians take them seriously and provide clear information have an increased likelihood of satisfaction. Similarly, Thompson et al. (1996) in a study of patient satisfaction with care received in a suburban hospital in the US found that patients who described their interactions with health care staff positively were more likely to be satisfied than those who did not. In general, this research has shown that when patients perceive a physician’s interpersonal skills to be high, they are more satisfied with their overall care.

Research has also demonstrated that patients who feel adequately informed about care and treatment processes tend to be more satisfied with care than those who are not informed (Bjorvell & Stieg, 1991; Bursch et al., 1993; Cohen, 1996; Hall & Press, 1996; Krishel & Baraff, 1993; Rhee & Bird, 1996; Sun et al., 2001, 2000; Thompson et al., 1996; Watson et al., 1999). For example, in their study of patient satisfaction at five urban, teaching hospital ERs in the US, Sun et al. (2001) showed that patients who felt they received poor explanations of causes of health problem and poor explanations of test results were associated with decreased levels of satisfaction.

Finally, perceived and actual wait times have been shown to be a significant determinant of patient satisfaction (Bursch et al., 1993; Hall & Press, 1996; Hutchison et al., 2003; Krishel & Baraff, 1993; McMillan, Younger, & DeWine, 1986; Spaite et al., 2002; Thompson et al., 1996; Watson et al., 1999). In general, research has shown that as wait times (either actual or perceived) increase, patient satisfaction decreases. In their study of patient satisfaction in an urban accident and emergency department in the UK, Maitra

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1The most common global measure uses a Likert scale and asks respondents ‘Overall, how satisfied are you with the care you received in the emergency department’ (Bursch et al., 1993).
and Chikhani (1992) found a significant inverse correlation between satisfaction and waiting time to see the doctor and total wait time in the ER. Thompson et al. (1996) also showed that when patients perceive waiting times to be less than expected overall satisfaction increases. In a study conducted at a University Medical Centre in Arizona, Spaite et al. (2002) found that when waiting times were reduced, satisfaction improved significantly not just for waiting times but for other measures included in their analysis (i.e. staff were perceived as more kind and compassionate and improvements in the care received).

Beyond characteristics of the care received, individual attributes such as socio-demographic factors have also been shown to influence patient satisfaction. For example, research has shown that as age increases satisfaction with health care increases (Cohen, 1996; Hansagi, Carlsson, & Brismar, 1992; Sun et al., 2001, 2000). In addition, individuals from lower income groups tend to be more dissatisfied with ER care than individuals from higher income groups (Cohen, 1996). Few studies have shown a significant link between gender and satisfaction (see Boudreaux et al., 2003; Cleary & McNeil, 1988; Cohen, 1996).

Much of the previous international research has found that most patients have high levels of satisfaction with ER care (i.e. Bjorvell & Stieg, 1991; Hansagi et al., 1992; Lewis & Woodside, 1992). In contrast, most Canadian research on ERs has examined overcrowding, wait times, and the use of ERs for non-urgent/emergency problems (see Béland, Lemay, & Boucher, 1998; Burnett & Grover, 1996; Harris, Bombin, Chi, deBortoli, & Long, 2004; Kelly & Birtwhistle, 1993; Lewis & Woodside, 1992). However, a more recent study conducted by Hutchison et al. (2003) examining differences in patient satisfaction among 433 patients using walk-in clinics, family practices and emergency departments in four urban locations in Ontario (Burlington, Hamilton, London, and Toronto) revealed higher levels of satisfaction among patients using family practices and walk-in clinics than those using emergency departments. This study thus puts perceptions of ER within a broader context, namely, attitudes towards and perceptions of the health care system itself. This is an important context for this study.

Recent opinion polls show that while Canadians are proud of their universal health care system, many are increasingly concerned with the apparent deterioration of the health system in the past decade (Mendelsohn, 2002). For example, a recent poll revealed that 30% of individuals strongly disagree with the statement that local hospital ERs provide services in a reasonable amount of time. Yet another poll showed that 51% of Canadians feel that the health system’s performance with respect to ER waiting times is poor or very poor (Mendelsohn, 2002). While there is ample research and media coverage on waiting times, overcrowding and the misuse of hospital emergency departments in Canada, we know little about other aspects of ER care that concern Canadians. Therefore an examination of patient perceptions of ER experiences may be relevant to understand how the ER relates to patient perceptions of the health care system (i.e., how changes in the latter may affect ER use).

**Research setting and methods**

The research was conducted in the city of Hamilton, Ontario, which is located on the western tip of Lake Ontario, about 60 km west of Toronto. The population at the time of the study was approximately 380,000. Hamilton has five hospitals, four of which have ERs that operate 24 h a day, 7 days a week, and one urgent care centre that is open daily from 8:00 a.m. to 10:00 p.m. each day. The St. Joseph’s Health Care System operates one emergency department and the urgent care centre. Combined, they see over 100,000 patients each year (McMaster, 2002). The Hamilton Health Sciences Corporation operates three emergency departments, which see a total of approximately 100,000 patients per year (McMaster, 2002).

To gain an understanding of patient perceptions of ER care in Hamilton, in-depth interviews were conducted with individuals living in two distinct neighbourhoods in Hamilton, Ontario. Past research has demonstrated that health status and use of health care services is linked to socioeconomic status (SES) (Guohua, Grabowski, McCarthy, & Kelen, 2003; Macintyre, McKay, Der, & Hiscock, 2003; Marmot & Wilkinson, 1999). Therefore the neighbourhoods selected for this study were chosen based on their differences in SES. This allowed us to examine if patient experiences in ER settings vary by socioeconomic environment. The Northeast Industrial neighbourhood is characterized by low levels of income and education and high levels of unemployment. In contrast, the Mountain neighbourhood is characterized by higher levels of income and education and lower levels of unemployment.

The research presented in the study is part of a much larger, interdisciplinary research project aimed at deconstructing determinants of health at local levels. The neighbourhoods were selected by analyzing socioeconomic and demographic data from the Census of Canada using local indicators of spatial association and geographical information systems. In-depth interviews were also conducted with key informants from local areas, which identified similar areas of interest for the study. The use of both quantitative and qualitative methods was necessary for validating the selection of neighbourhoods. The goal was to select neighbourhoods with a range of characteristics representing salient hypotheses from the population health literature.
To explore ER perceptions we aimed to conduct a total of 40 interviews with 10 men and 10 women in each neighbourhood. The participants were chosen randomly from a pool of randomly sampled respondents from both neighbourhoods who had previously participated in a telephone health survey conducted by the McMaster Institute for Environment and Health (see Luginaah et al., 2001). One hundred and twenty households were randomly drawn from the survey respondents and in late June 2002, a letter was dropped off to mailboxes explaining the purpose of the interviews and to inquire if survey respondents were interested in participating in an interview. Between 24 and 48 h after the letter was delivered, a follow up phone call was made and if respondents were interested an interview time was set up. Twenty-eight individuals could not be contacted because they were either unavailable or had moved since the survey was conducted. Of those contacted (n = 92), 41 agreed to participate in face-to-face interviews, which were conducted in July 2002. Since potential participants for the qualitative study were part of a double-random sample, one would not expect non-participants to differ from those who participated in the interviews. Ten interviews were conducted with men and women in each neighbourhood except in the Industrial neighbourhood where 11 interviews were completed with female respondents. Of the 41 respondents, 1 respondent did not have an ER experience, 2 did not state the reason for not participating and indicated they were under no obligation to answer any specific question, could stop the interview at any time and that all responses will be strictly confidential. All respondents agreed to have their interview tape-recorded so they could be subsequently transcribed. Tape recording is an accepted method for recording an interview and allows the development of a conversational interview style because the interviewer is not preoccupied with note-taking (Dunn, 2000). There is no prima facie reason to believe that tape recording had an impact in shaping participants’ responses as the recorder was always placed in a non-intimidating location.

During the interview, respondents were asked to talk about their most recent experience in an ER setting. This allowed individuals to discuss aspects of the ER that were most important to them and had the most significant impact on their overall experience. Factors potentially contributing to individual experiences, including hours of operation, services provided, waiting times in waiting rooms, waiting lists, quality of care, distance, and transportation were explored. Respondents were also asked if there were anything that would discourage them from going back again.

The interviews were transcribed and input into NVIVO, a qualitative software package for analysis. A coding scheme was developed based on the interview script and in conjunction with the responses from the participants. Factors identified by respondents during the interview that contributed to either a positive or negative ER experience were coded accordingly. Researchers assessed the importance of each factor by examining how often each was mentioned. A mention was counted each time a respondent brought up a particular aspect of their ER experience (e.g., wait times) that influenced whether their experience was positive or negative. Therefore there may be more than one mention per individual as an individual might have mentioned both positive and negative factors that resulted in either a positive or negative overall experience. The interview transcripts were read over numerous times and based on the interview text it was evident whether or not an individual had a positive or negative experience. In cases where no strongly negative or positive opinion was expressed as to the nature of the experience, the experience was considered neutral. Even though the idea of ‘counting’ is not often viewed as part of qualitative research, it provides a rough measure of significance or relative importance of different themes (Miles & Huberman, 1984). Further, as Baxter, Eyles, and Elliott (1999) note, counts give an indication of the relative importance of themes while quotations build on this data by indicating how the respondents talked about them to contextualize the themes. Thus, counts should be understood in relative terms rather than absolute (Baxter et al., 1999).

In the next section, the results are presented in three ways. First, the relationship between the urgency of the visit, as an indicator of how the ER is being used, and participants’ perceptions of their visit as positive or negative is considered. Second, the factors that contribute to individuals’ positive and negative experiences are analyzed and presented. Here, quotes from the respondents are used to add context and to illustrate
their experiences of ERs in Hamilton. The quotes chosen have been selected because they were well articulated and represent what many respondents have said about a particular subject. At the same time there is an attempt to ensure that as many voices as possible can be represented. Finally, the relationship between individuals’ perceptions of their experiences and sociodemographic and economic characteristics are presented.

Results

Most of the respondents discussed a previous visit for themselves. Of the 42 experiences discussed, 25 of them were presented by individuals describing their own experiences in the ER. The 17 other experiences were visits in which the participants accompanied someone else, most often another family member (i.e. spouse/partner, parent, child), to the ER. The reasons why people sought care from an ER varied from very serious to non-urgent. In classifying the reasons for visits, the triage categories used by McMillan et al. (1986) were applied. McMillan et al. (1986) classify urgency for ER visits according to three categories: immediate, urgent, and non-urgent (see also, Hansagi et al., 1992). ‘Immediate’ care refers to serious life or limb-threatening disorders. ‘Urgent’ cases include broken bones, sudden pain and lacerations. Finally, ‘non-urgent’ cases are those in which patients who could have been treated by their physician and whose treatment time was not particularly urgent from a medical perspective.

Applying these categories to the information provided by respondents reveals differences across the three categories. There were 4 experiences that can be classified as immediate (e.g., stroke, heart attack, motorcycle accident), 28 urgent cases (e.g., broken bones, severe lacerations, breathing problems) and only 10 cases that were classed as non-urgent (e.g., urinary tract infection, eye or ear infections). Further, of the 10 non-urgent cases, 4 participants reported seeking care from the ER because primary care was needed after hours. Therefore, using this classification, it is apparent that the majority of respondents in our sample sought care for an immediate or urgent condition. Few of the respondents sought care from the ER for non-urgent reasons.

When examining experiences in the context of the urgency of the visit some interesting findings were revealed. The most and the least serious triage categories (i.e. immediate and non-urgent) had an equal number of positive and negative experiences. There were 4 immediate experiences with 2 being positive and 2 negative, and there were 10 non-urgent experiences, 5 were positive, 4 negative and 1 was neutral (i.e. no opinion expressed either way). In contrast, individuals falling under the ‘urgent’ category reported more negative experiences than positive experiences (17 negative, 9 positive and 2 neutral experiences). These findings stand in contrast to previous studies that have found that the greater the need for emergency care the more satisfied individuals are with emergency care received (Boudreaux, Friedman, Chansky, & Baumann, 2003; Hansagi et al., 1992; McMillan et al., 1986; Sun et al., 2000).

Nature of emergency room experiences

For ease of interpretation, we have collapsed the three triage categories together to discuss in greater detail respondents’ experiences and the aspects of ER care that led to a positive or negative discussion of their encounter. When all experiences that respondents discussed are considered, 23 of the 42 experiences were negative, 16 were positive and 3 were neutral. While some participants may have mentioned 1 or more negative factors, this does not necessarily mean their entire experience was negative, or vice versa. A positive or negative rating was based on a count of the total positive and total negative mentions for each individual and then rated as positive if the positive mentions were greater than the negative mentions and similarly negative if the negative mentions outweigh the positive.Thirty-four of the 37 participants mentioned at least 1 negative aspect of their visit or something that would discourage them from going in the future. This paints a picture in contrast to previous quantitative studies that show high satisfaction with ER care in the US, the UK and elsewhere (Bjorvell & Stieg, 1991; Hansagi et al., 1992; Lewis & Woodside, 1992; Maitra & Chikhani, 1992; Watson et al., 1999).

Aspects of the emergency room encounter

Thirty-three of the 37 respondents indicated that a lengthy wait for care was a negative factor in their ER experience. While other research has shown that the interpersonal or expressive dimensions of the physician/patient relationship is the most important factor in shaping satisfaction (Avis et al., 1997; Cohen, 1996; Lewis & Woodside, 1992; Stewart et al., 2000; Sun et al., 2001, 2000; Yarnold et al., 1998), the interviews revealed that waiting times were mentioned by our respondents twice as often as any other aspect of ERs. The following quotes illustrate the frustration individuals experience with wait times in the ER:

It would have to be a real serious emergency because the wait would be...unless you went in with your head under your arm, you know. Please re-attach. Forget it. I’d rather wait and, if I had to, use a walk
in clinic. Wait until the next day. Anything but emergency. (Theresa, Industrial).

Well, the wait for one thing. I have been there with my wife and it has been awful. She had to wait seven hours and we had three doctors because they changed shifts twice so it was pretty awful. We just waited around and she was not gravely ill so every time someone came in that was more important than her, we were put off again further (Mark, Industrial).

That is probably my biggest beef with the healthcare system right now. The hours of waiting. You could be waiting for hours in the ER before being looked after and getting home. You might see someone and then you need X-rays and there is another long wait, and then they have to read them and there is another long wait and then you are back in the waiting room. You always seem to be waiting. The care is adequate, but the wait. Trying to get in...is way too long (Robert, Mountain).

You’re sitting there...I mean, you’ve sat there all day long. We were there from nine, ten in the morning, till eleven at night. And, you know, I’ve heard of people, the fellow next door who was in emergency for a couple days because they couldn’t get any beds (Debbie, Mountain).

Failure to receive care and/or receiving inappropriate care was the second most frequently mentioned negative aspect of ERs. Of the 37 respondents, 18 stated that they did not receive the care they required. For example, Marilyn, in describing her experience of having a miscarriage, shares her disappointment with the care she received and the attitudes of healthcare workers:

It was very cold in there. It was very cold in the emergency rooms. That’s probably for a reason. They probably see a lot of terrible things, but you’re not thinking about that at the time. All you are thinking about is yourself. I remember being in pain and thinking I wished somebody would come in and tell me what is going on. Am I losing this baby or not and they were out there, standing there, joking and making fun of some of the patients. I thought, “You bastards!” you know. It’s terrible. They’re human in there (Marilyn, Industrial).

Other respondents discussed what they perceived to be poor quality of care provided by ER staff:

He continued to have strokes while we were in the hospital. It’s very difficult to sit by and watch your family when you know something is going wrong, and it’s hard to get somebody to come in and look after them (Debbie, Mountain).

The quality of care was pretty pitiful. I understand where they are coming from and they see me as wasting their time because these sorts of situations should be dealt with by a general practitioner, but when you are sick and you don’t have a doctor, you need to be cared for by somebody (Mark, Industrial).

That whole thing on a scale of 1–10, I’d give them maybe...in a really generous mood...a 2. I thought it was horrible. I thought the care was horrible. I thought everything was horrible. I thought the attitude was horrible. It was a really bad experience and that went on for 6 days and nobody could give me any answers, none of the doctors. The doctor had an attitude. He definitely had an attitude (Shelly, Mountain).

At one time, they used to come and actually clean the area themselves. Now they throw a bucket at you and some sterile stuff and tell you to do that and they will be along someday to give you your shot. I mean, you’re not a priority at that rate. Myself, emergency is not great, but I thank God I don’t have to use that either (Theresa, Industrial).

Previous research that indicates patient/physician interaction plays a key role in ER satisfaction (Avis et al., 1997; Cohen, 1996; Lewis & Woodside, 1992; Stewart et al., 2000; Sun et al., 2001, 2000; Yarnold et al., 1998), however, only 3 individuals in our study discussed physician–patient interaction:

I wish that the people at [name of hospital] hadn’t been so gosh darn lazy. They were just horrible...you are sitting there and you watch the 16 nurses walking up. You watch a group of nurses discuss their weekend plans...the whole thing took maybe one half hour from beginning to end, but there wasn’t one nurse in the entire place who gave a darn. The doctor that came up to me and looked at my arm and said, “The last guy I saw like that, died within three hours.” They were rude, they inconsiderate, they were horrible. They were horrible. It was awful (Shelly, Mountain).

I remember being really upset by that experience because, first of all, like I said, I was upset about losing the baby and they left me there for so long. They didn’t treat me very well. They were like...a slap on the back kind of thing. You know, like ‘buck up’. You’re pretty distraught in there and you ask a lot of questions and they don’t really have the answer, but they have got to understand that you are emotionally falling apart. There was no sympathy at all. Yeah, they weren’t very kind in there at all (Marilyn, Industrial).
The care was impersonal, I guess. The doctor seemed to be rushed. The treatment you got when you were going through the process was very impersonal and rushed...he had so many other people to attend to (Helen, Industrial).

While there is much media attention in Canada regarding the apparent misuse of ERs for non-urgent/emergency health reasons, only 3 individuals identified this issue as a problem:

I am a very, very strong believer in not abusing the service...very strong believer. If my daughter were to get sick tonight, and I knew she had to see a doctor, but it wasn’t critical, I would wait until I could get her in to see one tomorrow kind of thing. Rather than spend the time at emergency room (Carolyn, Mountain).

The only thing that would discourage me from going is the fact that it is an emergency service. I don’t go there unless I feel it’s really necessary and I know there is something wrong and I can’t get my hands on a doctor or a walk in clinic because I am aware that the emergency services are not designed for non life threatening emergencies, unless it is something like a broken bone or something like that. So it is very seldom that I would go to emerg (Shirley, Industrial).

I’ve seen people in emergency. They ought to kick their ass out of there and chase them down the street because they have no business using the service. No business whatsoever. That too ties up.... They could be doing something more important (Theresa, Industrial).

Further, despite recent media reports about the misuse of ERs, most of the individuals interviewed sought care at the ER for immediate or urgent reasons.

Dimensions of experiences

Differences in how participants perceived their ER experiences were noted across different age groups. In general, individuals 65 and older had significantly fewer negative experiences than did individuals who were under 65 years. To uncover the differences between the age groups, the average number of negative experiences per person was examined. The results demonstrated that individuals under the age of 65 had an average of 2 negative experiences while individuals over 65 had 1. This finding is consistent with previous studies that have found older individuals to be more satisfied with ER care (Boudreaux et al., 2003; Cohen, 1996; Hansagi et al., 1992; Sun et al., 2001, 2000). No differences were noted in the types of negative experiences discussed between individuals from these age groups.

Socioeconomic characteristics appear to play a role in the nature and number of negative experiences. The neighbourhoods selected for this study can be used as a proxy for SES, where individuals from the Mountain neighbourhood generally have higher SES (including household income, education level, and employment status) than residents from the Industrial neighbourhood. An examination of experiences in the context of neighbourhood reveals a higher number of total negative mentions among residents from the Industrial neighbourhood compared to those from the Mountain. Further, of the total number of negative mentions across both neighbourhoods, two-thirds were from Industrial residents and one-third were from Mountain residents. Previous studies that examined the relationship between SES and satisfaction are inconclusive. Some show higher satisfaction is linked with high income (Becker & Newsom, 2003; Campbell, Ramsay, & Green, 2001; O’Malley & Forrest, 2002; Yancy et al., 2001), while others show an inverse relationship (Katic et al., 2001; Maitra & Chikhani, 1992). There were no apparent differences in the types of negative experiences between residents of the Mountain and Industrial neighbourhoods.4

In summary, in this qualitative study, we note some differences in ER experience by socio-demographic status. Respondents who were younger rather than older and who lived in the poorer rather than more affluent neighbourhood reported negative experiences. In fact, overall, negative rather than positive experiences were presented by our respondents with wait times and appropriateness and kindliness of care being mentioned most often. Few mentioned that their experiences were negatively impacted by other users, especially those perceived to be there for inappropriate reasons. Thus our results suggesting some anecdotal evidence on ER problems may be incorrect. So what are the implications of our exploratory study?

Discussion and conclusion

In contrast with the mainly quantitative research in this field of study, the results of this qualitative study demonstrate how some individuals perceive the care received in ER settings as negative. Waiting times, perceptions of the quality of care received, and staff-patient interactions were factors that shaped individual experiences of ERs in Hamilton, Ontario. Furthermore, the results of this study demonstrate that individuals perceive the care received in ER settings as

4We also analyzed the data by health care provider. However, no differences emerged in the total number or type of negative experiences mentioned by respondents visiting the 4 emergency departments and the urgent care centre.
negative. These findings make important contributions to our understanding of ER care.

First, despite a focus in Canada on the use of ERs for non-emergency reasons (see Gray, 2000; Gutkin, 2000), our exploratory study indicates that a majority of respondents visited the ER out of necessity. Further, contrary to previous research which has shown high levels of patient satisfaction with ER care, our study revealed mainly negative ER experiences among our respondents. In addition, while international research has shown that high levels of urgency are associated with high overall levels of satisfaction, for some users this is apparently not the case as the majority of individuals in our study presenting themselves for urgent care had a negative ER experience.

Second, previous quantitative research has shown that physician–patient interaction is the main predictor of patient satisfaction. While it is difficult to make comparisons between quantitative and qualitative research, it is interesting to note that respondents in our study most often discussed lengthy waiting times as being the main contributor to their negative ER experience.

Third, these findings appear to show that users of ERs in Hamilton are experiencing the effects of serious strain on this part of the Canadian health care system. The results show that respondents are not satisfied with ER care and identify lengthy waiting times, poor physician–patient interaction and a lack of quality of care as the main factors shaping negative experiences. The identification of these factors may be related in part to increasing levels of concern across Canada about the current state of the health care system (see Mendelsohn, 2002). In fact, many of our respondents indicated that their most recent ER experience was of lower quality than in the past. This suggests the need for ER reform and the research findings highlight some potential avenues for restructuring ERs. We, however, recognize that our results are limited by the study design and await further research to confirm or reject them.

The Federal government of Canada recognizes the increasing pressure that the health care system is currently experiencing and has spent over $15 million on 2 recent health care commissions: the Romanow Report and the Kirby Commission (Kirby, 2002; Romanow, 2002). These commissions examined the current state of the health care system in Canada and suggested potential recommendations for reform. Despite the almost exhaustive list of recommendations supplied by both reports, neither commission made concrete suggestions for reforming ER care. Instead, the final reports from both commissions state that pressures on ERs can be alleviated by restructuring other parts of the health care system (i.e. primary and secondary care). For example, the commissions recommend increasing the number of family doctors and decreasing wait times for diagnostic machines in order to alleviate pressure on ERs. While improving access to primary care might decrease the number of Canadians using ERs for non-emergency health reasons, few of the individuals in our study used the ER for non-urgent reasons. Lack of access to family physicians is an important issue across Canada and those individuals without family physicians may rely more heavily on ERs for primary care than those with a regular family doctor. In addition, a recent poll showed that most individuals seek emergency care between 6:00 p.m.–midnight, when walk-in clinics and family physician offices are closed (Mendelsohn, 2002). As a result, ensuring access to 24h/7 days per week primary care for all Canadians is one way of preventing non-urgent/emergency use of ERs (see Romanow, 2002). However, the number of Canadians without a regular family physician represents a small percentage of the total population. Data from the recent Canadian Community Health Survey reveal that 84 percent of Canadians have a regular medical doctor (Canada, 2001). Hence, this strategy, while ensuring access to family physicians, will have only a small impact on reducing ER pressures.

While our study is based on a small sample of 37 individuals from one city, the results show that the majority of our respondents visited the ER for urgent/emergency reasons. This suggests that changes beyond the primary care system need to be made in order to improve the delivery of care within ERs. In support of this finding, recent reports from both the Canadian Association of Emergency Physicians (CAEP) and the National Emergency Nurses Affiliation (NENA) indicate that non-urgent patients consume only a small proportion of ER resources, contribute very little to overcrowding, and do not displace patients who need urgent/emergency care (CAEP & NENA, 2001, 2003). Further, in a recent study by Schull, Slaughter, and Redelmeier (2002), a panel comprised of clinical and administrative experts from ERs and hospitals was organized to identify key determinants of urban ER overcrowding. According to the expert panel, in health care systems with universal coverage, a lack of access to primary care is not believed to be a key determinant of overcrowding.

The Romanow and Kirby reports suggest that overhauling the primary care system will influence ERs in a positive way. However, as noted above, non-urgent/emergency users of ERs are not the key determinant of overcrowding and increased waiting times. Further, our research reveals overwhelmingly negative experiences among individuals visiting ERs for urgent problems. According to our respondents, ERs are barely meeting their needs. Therefore, while reforming primary care is a valid and important suggestion for improving access to health care in Canada, some focus needs to be directed towards emergency care.
The main factor contributing to a negative experience in our study was waiting times. International research has revealed that when ER patients are given an expected wait time, they are much more satisfied with their ER experience than those who are not provided with an approximate wait time (Bursch et al., 1993; Hall & Press, 1996; Lewis & Woodside, 1992; McMillan et al., 1986; Sun et al., 2001, 2000; Thompson et al., 1996; Watson et al., 1999). Therefore informing patients of their estimated waiting time to receive care might improve overall levels of satisfaction and decrease frustration among ER users.

Respondents also mentioned perceived poor physician-patient interaction and a lack of quality of care as contributing to negative experiences. In their submission to the Romanow Commission, the CAEP argued that ER crowding has a destructive and demoralizing impact on health care professionals (CAEP, 2001). Improvements in ER staffing are key to reducing stress among ER care providers. There are approximately 1100 emergency physicians in Canada and about 300 emergency surgeons (CAEP, 2001). In Ontario there were 5.3 million visits to ERs in 2000 (Ehrlich et al., 2002). According to the CAEP, 1 full-time emergency physician is required for every 5000 visits. This means that the province of Ontario alone requires over 1000 emergency physicians. There is no reason to believe that the ratio of emergency medicine physicians to patient visits will improve in the near future. Further, over the past few years, there has been a significant reduction in hospital staff and a corresponding increase in staff workloads (Hamilton Spectator, August 6, 2003). This indicates a strong need to consider alternative health care providers within ERs. For example, physician assistants and nurse practitioners have practiced successfully in US ERs (CAEP, 2001) and nurse practitioners are common in emergency departments in the UK (Drummond & Bingley, 2003). The integration of other health care providers within ERs may alleviate current pressures on ER staff and reduce stress levels, thereby improving physician-patient interactions.

In summary, there are important avenues of ER reform that have the potential to improve patient care and experiences but have yet to be acknowledged within the recent wave of health care commissions in Canada. This study provides a picture of individual experiences of access to emergency care and in doing so contributes insight into an under researched aspect of the health care system. The findings demonstrate the need for further evaluations of ER care and highlight the importance of implementing emergency-room specific recommendations to improve patient experiences with the Canadian health care system.

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**Further reading**


