

A Generalized Description Of The Behavior Of
Forty Individuals Admitted To A Hospital
Emergency Room

by

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CHAPTER I

INTRODUCTION

The practice of nursing has historically focused on the problems faced by an individual when in a state of impaired health. The focus remains the same today, although methods of identifying and solving these problems are ever changing. The scope of nursing has increased rapidly in the past few decades. Much of a nurse's responsibility embraces the resolution of problems resulting from stress.

(22)

When Selye defined his concept of stress, new vistas were opened for nurses to explore the problems of impaired health. This word "stress" is not just an empty, descriptive term. It is becoming increasingly well defined in terms of a complex of physiological and psychological reactions which occur when harm, actual or impending, befalls an individual.

When an individual does experience stress, there is some degree of disruption of equilibrium; the routine of life is disturbed. It is in the awareness of this state of disequilibrium that nursing has found a specific purpose. Dorothy Johnson stated it this way: "The achievement and maintenance of a stable state is nursing's distinctive contribution to patient welfare, and the specific purpose for nursing care."

(15)

When we accept the premise that the "maintenance of a stable state is nursing's distinctive contribution to patient welfare", we also accept problems; namely that of being able to assess the degree of stress and of establishing means for its resolution. We must have a framework on which to base our judgments about the

(15)

stability or instability of the patient in a given setting. This framework may be established on the basis of information collected by nurses about the characteristic response(s) of individuals in a particular situation, or setting.

Nursing has many settings in which to observe patient behavior. Certainly any situation which involves nurses and patients could be ground for fruitful study. The setting chosen for this study is the hospital emergency room.

Statement of the Problem

The purpose of this study is to observe the behavior of individuals who have been admitted to a hospital emergency room. It is anticipated that the result of these observations will be a collection of typical responses, or behavior patterns, which will serve the purpose of providing a framework for the nurse who is working with a patient in this area.

Limitations

The study was limited to the direct observation of forty patients in a selected hospital emergency room. These observations were limited to the adult population. The minimal age for consideration as an adult was sixteen years. Observations were not done on unconscious, or obviously intoxicated patients. Patients whose condition did not indicate the need for emergency, or immediate treatment, were not included.

The observation tool (see Appendix A) utilized general guidelines for observing behavior. Representative examples of patient's verbalization were also recorded. Any conclusions drawn will necessarily be subject to the accuracy of the tool, the objectivity of the researcher, the situation, and the participants of the study.

Assumptions

It is assumed that direct observation is a reliable means of obtaining information, and that the presence of the writer as an observer did not significantly alter the situation observed.

It is also assumed that the practice of the members of the health team was enough of a constant that they did not differentially alter the behavior of the various individuals. Based on this assumption, the observer recorded only the behavior of the patient in the emergency room situation.

Justification

This study is significant because it attempts to make a step forward in the eventual fulfillment of a felt need in nursing today; that of a framework on which to judge behavior and deviations of behavior in specific situations. To paraphrase Pascal: We have no standards to judge deviations from the state of equilibrium, let alone significant deviations. Dorothy Johnson stated that idea more simply and concisely when she wrote, "Needed: a framework."⁽¹⁵⁾

There are many reasons for choosing the hospital emergency room as the site for behavioral observations. People are turning more and

more to the facilities offered through the emergency room. If we can accept the assumption that nurses are judged in part by the patients they nurse then we must not overlook the need for good patient care in the setting of this increasingly utilized hospital area.

Further, the emergency room is an ideal place to demonstrate the idea that, "The focal point in nursing is that nurses are intermediary (11) between a technical and a human approach." Nursing has well documented the technical approach, but the human approach is often less tangible. This area of departure from "solid" fact has led to uncertainty and/or anxiety in many nurses of today. This uncertainty often leads to a split, or depersonalization in the nurse-patient relationship. (1,16) However, "It is actually when confronted with the impersonal things (11) that the patient feels helpless." The nurse in the emergency room must maintain the balance between the "technical" and the "human" approach if she is to meet the needs of the patient, and further nursing itself.

Steps In Procedure

This study was organized and carried out in the following fashion:

1. The area of study was chosen, and a review of the literature done.
2. A hospital was chosen in which to carry out the observations.
3. Permission was obtained to pursue the study from the Director and Assistant Director of Nursing Service at the selected hospital.
4. The emergency room personnel were acquainted with the proposed plans for study.
5. A review of the records for the previous month was done to ascertain the number of observations that would typify activity in the emergency room for that period.
6. It was decided, for purpose of obtaining a sample, that approximately one half of the observations should be done on patients with orthopedic injury, since approximately 50 percent of the admissions were for orthopedic conditions.
7. Six observations were done and written in narrative form with much detail.
8. Items to describe behavior and speech were selected from the observations done.
9. The Diagnostic and Statistical Manual of the American
(2)
Psychiatric Association was reviewed for further

pertinent behavioral descriptions.

11. This tool was reviewed by twenty-three registered professional nurses, and suggestions for revision were made.
12. The tool was revised according to the suggestions.
13. A pilot study was done in the selected emergency room on ten patients, using the revised tool. No further revisions were found to be necessary.
14. A series of forty observations were done as planned.
15. The data were tabulated.
16. The study was summarized.
17. Conclusions were drawn.
18. Recommendations were made.

Overview

This study will be presented in four chapters.

Chapter I, the Introduction, presents and justifies the study, indicates its relationship to trends in nursing today, and presents a plan for procedure.

Chapter II, the Review of Literature, presents a survey of related writings and significant studies.

Chapter III, The Study, explains the methods involved in carrying out the study, and presents the findings.

Chapter IV, the Summary, Conclusions and Recommendations, summarizes the study and presents conclusions and recommendations based on the data obtained.

CHAPTER II

REVIEW OF LITERATURE

Since the public has come to expect prompt, effective care from hospitals at all hours, the importance of good emergency care cannot be overemphasized. The hospital with a modern, well operated emergency department makes an outstanding contribution to the community. New friends will be made for the hospital, and the medical and nursing profession will be recipients of the good will of the community served. (28)

In the studies done at the Hartford Hospital by Drs. Shortliffe, Hamilton and Noroian they revealed a definite increase in the use of hospital emergency room facilities. The rapid growth took place between 1945 and 1955. Out of these studies it was predicted the public would continue to use the facilities of the emergency department in their community, and that the emergency department should be staffed with professional personnel of adequate training and mature judgment. (22)

Harriet S. Bell, in describing the role of nursing in the emergency room of Harper Hospital, Detroit, Michigan, stated that, "Nursing the patient in the emergency room involves many facets of care, and is one of the most challenging and interesting jobs in the hospital." (7)

In the emergency unit "nursing the patient as a whole" is extremely important. We expect our staff to be able to recognize the acute emergency and to institute first aid measures quickly, as well as to recognize that the patients needs are real to him, even if they appear minor to us. This means projecting one's self into the patient situation, allaying the fear of the unknown and replacing the fear with a feeling of confidence and security...We feel that intelligent nursing administration, coupled with a genuine concern for human beings in need makes the emergency service one of the most effective in the hospital. (7)

The quality of nursing care described in the previous lines is an example of what Dr. Harold Frøshaug suggested when he said, "The focal point in nursing is that nurses are intermediary between a technical and a human approach." He added, "It is actually when confronted with the impersonal things, that the patient feels helpless."

However, this "dual role" is not easily fulfilled. Menzies and Aasterud both speak of the stress and anxiety felt by the nurse in the course of functioning as her position demands. It seems that the interpersonal relationships are among the first to suffer as anxiety mounts within the nurse. Margaret Aasterud describes a "split-up" nurse-patient relationship which sees the nurse performing only a few tasks for, and having restricted contact with, any one patient. There may be depersonalization, categorization, and denial of the significance of the individual. Menzies describes depersonalization in the nurse-patient relationship as one of the social defenses to stress. It is fortunate that these mechanisms do not serve to relieve anxiety in the nurse. "An individual whose psychic defenses are based on evasion remains a prey to emotional disturbances and is vulnerable to stress."

Dorothy Johnson offers a solution to the nurse caught up in the dilemma of combining a "technical and a human approach" as a part of expected nursing practice.

The achievement and maintenance of a stable state is nursing's distinctive contribution to patient welfare, and the specific purpose for nursing care...The nurse's specific responsibility is to re-establish equilibrium

when the individual is experiencing stress
which disrupts equilibrium. (15)

Johnson feels that a "framework" of descriptive behavioral incidents is needed before the nurse can consistently make accurate judgments as to the degree of disequilibrium being viewed. "This (15) suggests some possibilities for descriptive research."

Ida Orlando presents ideas which give direction on how to proceed with the creation of a "framework." She feels that the nurse must know how to use her powers of observation. It is through repeated observation that the nurse may become proficient in identifying the need of the individual for help, ministering the help needed, (17) and validating that help given was help needed.

A slightly different focus to justify the need for and use of a "framework", was suggested by Ernestine Wiedenbach.

If the nurse's goal is to help a particular patient then her thoughts and feelings will need to be directed to the complex process of deciding whether that patient needs help; what help he needs; and how she may provide it in a way that will be helpful to him... The prime focus of nursing is on the patient's perception of his condition...The condition may influence the capacity to function, but his perception of it influences his will to function. (26)

The preliminary report by the American Nurses' Foundation on "the role of the nurse in the outpatient department", points out that nurses working under the stress of role insecurity may become a stressor to the patient. Ninety to ninety-five professional nurses were interviewed in seven hospital outpatient departments. It was found that the typical interaction between the nurse and the patient,

in 65 percent of the cases, was related to organization matters; while only 35 percent pertained to information relevant to patient care. "In light of this it is interesting to note that so many of the covert responses (of the patient) indicated frustration, resentment or confusion on the part of the patient."⁽⁸⁾

The importance of "humanizing" nursing in the outpatient department was emphasized by Audrey Wendemuth. "In the outpatient department the nurse will soon recognize that she is dealing far more with people and their behavior in times of stress, than she is dealing with technical details of professional nursing."⁽²⁵⁾

The literature points out what nurses should be doing, what the nurse is doing, and what deficits in patient care are created by the gap between the real and the ideal in nursing practice. It should be helpful at this point to review the literature for references to the reactions of individuals to stress situations. This is done to provide groundwork for the eventual description of behavior specific to the emergency room studied in this thesis. A review of this kind can not be begun without first giving mention to the work of Hans Selye. Selye defined a "non-specifically caused state" which is termed "stress". The behavior which occurs when the individual is in a state of stress is thought to be the result of adaptation, or attempted adaptation to the stressor. He defines three stages through which the organism passes when in a state of stress. The first is alarm; the second, one of resistance; the third, exhaustion. Hopefully, of course, the stressor would either be overcome or removed before

(22)

the stage of exhaustion is reached.

Hamburg indicates that the behavior of the injured leads to the best opportunities for studying adaptive responses to conditions of stress. His study of the psychological adaptive processes in life threatening injuries resulted in the following classification

(4)

of psychological reaction to injury:

1. Denial - "There is nothing to worry about."
2. Unconcern - "I may die, but it does not disturb me." (This is more often seen with severe injury.)
3. Conditional acceptance - "I know I am sick, but I will get over it." (This is the most common reaction.)

(6)

Beecher categorizes reactions to noxious stimuli as:

1. Skeletal Muscle Response - This includes increased muscle tension, wincing, crying, motions of rejection and flight.
2. Autonomic Nervous System Response - This includes sweating, tachycardia, cardiac arrhythmias, increased or decreased blood pressure, dilated pupils, pallor, flushing, syncope, and prostration.
3. Central Nervous System Processing of Original Stimuli - This includes the intelligent processing of stimuli. The human ability included in this last category gives the individual the ability to substitute signs and symptoms in reaction to pain. Some of these substitute symptoms are burning, numbness, pressure, tingling, and paresthesias.

F.J.J. Buytendijk also describes the reactions of individuals

(9)

to injury. He states that those individuals with a "painful reaction"

will exhibit "dynamic movements"; while those with a "fright reaction" will exhibit "static movements".

The touching of one's injury is a "personal reaction" which increases the individuals "feeling of self".

Reaction to pain, such as restlessness, irritation, protest, rage, complaints are all psychological reactions, more or less obligatory. They do not mean anything, they are mere agents distracting from the pain, discharging, emphatic emotions and inducing flight from one's self...Reaction to pain occurs in relation to how man views his bodily existence.(9)

An extreme amount of pain may lead to unconsciousness, or a state of painlessness. To avoid this, the individual must be in possession of his "self". When contact is lost, there is no pain. Weeping is an act of inner surrender whereby part of the "self" possession is given up. However, the act of weeping also gives strength to the individual whose stress is great enough to lead to a loss of "self". Tears reveal to him that he is suffering, and, therefore, "he is". This "proof" may be needed to help the person to maintain his "self" under stress.

(12)

Another aspect of "self" is described by Erving Goffman.

If behavior is exhibited that does not potentiate the self image the individual does not remain passive. He will control the implications by explanation, apology, or righteous indignation.(12)

There are many kinds of stress situations. Certainly community disaster fits this category. J.S. Tyhurst defines the results of a study on individual reactions to community disaster.

This study was carried out by the Department of Psychiatry at McGill University. The data were obtained from on the spot observations by a psychiatrist and a sociologist during four disasters. The effects were defined in terms of periods through which the individuals studied passed. The first period, lasting from a few minutes to one hour after occurrence, is characterized by high stress. This is the period of "impact". The individual is centered on the present, and 75 percent of the group have a "stunned" reaction. These individuals are dependent and need to be cared for. The next period is that of "recoil". The time this lasts differs with the individual. It is characterized by diminishing stress. The persons involved are centered on the present and recent past. Seventy-five percent of these individuals are recovering and expressing emotions. The third phase is the "post-traumatic" period, which gradually tapered off in time with the individuals being centered on the present and the future. These people were mostly recovered. (24)

Stress and anxiety occur together. A study done by Basowitz, Persky, Karchen, and Grinker differentiated two types of anxiety. Experiments were done to study a group of young, healthy men as they underwent the stresses of paratroop training. The study was carried out at the Airborne Department of the Infantry School, U.S. Army, Fort Benning, Georgia. The 150 subjects involved were divided into four groups for purposes of various aspects of the total study.

The findings of the study indicated that:

The focus of anxiety in this situation was found to be allied with anticipation of failure rather than death and destruction...

Two types of anxiety could be distinguished... shame anxiety and harm anxiety... Shame and harm anxiety may differ in their effects on the adequacy of functioning, although the evidence is still insufficient... Disruption or traumatic anxiety is associated with utilization of mechanisms which are precursors of rage. Such disruption of equilibrium requires early, more rigid defenses to prevent disintegration from excessive stimulation... Shame anxiety is derived from straining to complete the task at hand... It results in less ego deformation, but more reaction formations and overcompensations. (5)

I.L. Janis used the concept of anxiety resulting from stress.

He analyzed the behavior of individuals as they reacted to a situation of stress. Some of the hypotheses he formulated are as follows:

(14)

1. Exposure to a threat of bodily damage tends to sensitize the individual to unacceptable hostile and destructive tendencies in his own aggressive behavior so that even actions, which are normally tolerated without effective involvement, are consciously or unconsciously felt to be violations of inner superego standards.
2. When a person faces an objective threat of bodily damage, he will spontaneously attempt to alleviate guilt and anxiety by thinking of compensatory gains.
3. The closer an anticipated threat of bodily damage is perceived to be, the greater will be the individual's motivation to ward off anticipatory fears by minimizing the potential danger that he will be seriously affected by it.
4. When a person attempts to minimize the danger after becoming aware of a potential threat, fear reactions are not extinguished, but rather, are temporarily held in check only so long as no clear-cut signs of danger are brought to his

focus of attention.

As has been suggested, stress does not result only from physical factors. It may be present as a result of anticipation of threat or bodily damage. Certainly a prime example of this is the patient who is facing surgery in the near future. Cassady and Altocchi made a study of some of the more common concerns about surgery expressed by 40 general surgical female patients at Duke University Medical Center. (10) It was reported that 34 of the 40 verbalized one or more concerns. The categories of concern identified were death, diagnosis, discomfort, helplessness, socio-economic status, disability, and the unknown.

Besides examining behavior reported as a result of various stress situations, the literature has been reviewed regarding various methods of recording the data observed. (18) Pascal and Jenkins suggested a method for systematic observation of gross human behavior in an interview situation. Their behavioral scales suggest a means of rating or grading degree of behavior as defined by categorical description. Some of the basic measures used for the observation of behavior are frequently, latency, rate, intensity, duration, amount, variety, condition, direction, and correctness. The actual content of the verbalization is ignored with this approach. The tool operates on the basis of the S-R (stimulus-response) event. If an S-R event occurs with increased frequency then it is assumed that the observed response, or movement toward, is related to the stimulus which can be defined. It was planned that from these formulations of behavior, the goals of behavioral change would

emerge.

A similar, but more "controlled" method of studying changes in behavior of an individual during an interview was described by Saslow and Matarazzo. It was felt that more could be learned from a comparative study of the responses of individuals if the stimulus conditions could be standardized. This was accomplished by means of a standardized interview. A study at the psychiatric clinic of the Washington University School of Medicine called for twenty patients to be interviewed independently by two interviewers. It was found that "interviewee reliability patterns are stable under identical stimulus conditions, unique for any given individual, and reliably measurable." (20)

Although the technique of interview can provide a stable setting for obtaining valuable information from an individual, it cannot be used in all situations in nursing. The nurse who wishes to study behavior in a given setting must observe the behavior as it occurs. The earliest studies of this nature involved the direct observation of the behavior of nurses themselves. Phoebe Gordon proposed the method of continuous observation in 1934 for a study of head nurse activities done at the University of Minnesota. The techniques of continuous observation requires that one observer shadow one person continuously during the period of observation. This gives a total picture of the situation as it unfolds, but does restrict the number of persons to be observed. It is costly if applied for general use. (13) (2)

Another, somewhat more practical method for observing a situation involves the taking of intermittent observations. This technique makes large scale investigations less time consuming and therefore, much

(2)
more usable.

"Nurses are trained to observe as a necessary part of caring
(19)
for patients." However, the nurse who plans to use her powers of
observation as a research tool often finds that "there is conflict
between inherent desire to act as nurses in certain situations in
which their duties as research observers require a different form of
(19)
action." Two solutions have been proposed to aid the nurse in over-
(19)
coming any conflict in this area:

1. Make it known to personnel that you are not there to perform nursing function.
2. Do not wear a uniform.

The most important thing for a nurse who sets out to do
research to remember is that she has to acquire a new concept of
(19)
herself, and help others acquire a similar view.

Nursing now is beginning to search for means to make practical
use of observations that have been collected by those engaged in
research. A research project conducted at the University of
(27)
Pittsburgh produced a tool called "the patient profile". This tool
was designed to "measure the nursing needs of patients". The patient's
physical ability and response are evaluated in terms of their ability
to fulfill seven basic needs of "nourishment, elimination, rest,
exercise, social interaction, safety and therapy".

Others, currently carrying out studies in nursing research, are
attempting to construct "profiles" that are specific to a group of
individuals in a particular situation. One such example is the study
of "nursing needs of chronically ill, ambulatory patients" being

carried out by Doris Schwartz at the New York Hospital general
(21)
medical clinic.

The review of the literature indicates that the role of the nurse in the emergency room is one of growing significance. There is also evidence that this role may be difficult to fill according to ideal expectations due to a lack of "framework" of knowledge about the behavior of the individuals admitted to the emergency room.

The actual information contributed by nurses regarding the behavior of hospitalized individuals is limited. However, the common denominator of stress makes it possible to review the literature of other disciplines and obtain general facts about the reactions of individuals to stress situations, whether actual or impending.

The methods of obtaining information vary according to the information desired. The interview setting seems appropriate in some situations; while in others, the setting of the work situation must be used. Observation and interview, used either separately, or in combination, constitute the most effective techniques. When the method of observation is used, the given setting may be observed continuously or in timed intervals. Either method will give satisfactory results.

Nursing is now going about the task of compiling "profiles" of the behavior of individuals. It is an arbitrary question as to whether one tool could be used over a series of different situations, or whether the behavior of individuals under various circumstances requires individualized description.

Summary

1. The role of the nurse in the emergency room is one of growing significance.
2. Nurses do not have a large body of knowledge regarding the behavior of the hospitalized patient in the emergency room.
3. Nursing is beginning to collect information, through research, about the behavior of individuals in various situations.
4. Systemic observation of behavior leads to suggestions for rating or grading the degree of behavior.
5. Direct observation, in continuous or timed intervals is a means of collecting descriptive data about behavior.

CHAPTER III

DESIGN OF STUDY

This study was conducted at a Portland hospital emergency room for the purpose of providing a generalized description of the behavior of individuals admitted to that emergency room. The selected hospital, of 300 beds, has an approved internship program for medical school graduates. The emergency room has around the clock coverage by either an intern, or a physician paid by the hospital. At least one registered nurse is on duty at all times. The staff physicians of this hospital share emergency room responsibilities on a rotating basis, and are called at the discretion of the attending intern or physician. As this is a private hospital, the patients are sometimes attended by their private physician. He may have been called by the patients in advance of their arrival in the emergency room. If he has not been called, he is notified by the attending doctor. He may or may not come in to see the patient, depending on the degree of severity of the case. The patient is referred back to his personal physician for all follow-up care. If the individual does not have a personal doctor, the staff physician on call will be assigned the follow-up care.

Once every six days, the hospital takes the responsibility for "city call". On this day, indigent persons, those in police custody, and those persons being transported by ambulance, who have no personal physician or hospital preference, come to this hospital.

This emergency room consists of an admitting office, a waiting room, a private consultation room, a nurse's desk, a doctor's room, a treatment room with two beds, a cast room with four beds, an emergency surgery room, and two emergency recovery rooms with three beds each.

The hospital admits an average of 25 to 30 patients per day to the emergency room. The regular process for those coming to the emergency room is first to go through the admitting procedure. In cases of extreme emergency this procedure is, of course, waived until it is expedient for the patient or the family to give the admitting information.

Permission was given for pursuit of this study by the director and assistant director of nursing service. The evening emergency room personnel were then advised of the intentions for the plan. Everyone accepted the idea with much interest. It is interesting to note that most of the personnel wanted to clarify whether their actions were to be observed along with the patient's.

The records of admission for the past month were made available. A review indicated that approximately 50 percent of the patients seen over that period had been treated for orthopedic injuries. For this reason, it was decided to design the sample to consist of 50 percent orthopedic injury victims. The review of records indicated, further, that the previously chosen number of forty observations, divided into twenty orthopedic and twenty other type patients, should give a sample characteristic of the total population adult patients. It was decided to limit the study to the adult population to substantiate better any generalizations drawn from the forty observations. It was felt that

the behavior of children and adults was so different that the number would need to be increased to describe both groups accurately.

As data were to be collected by direct observation, a method of recording was needed. Six patients were observed and their behavior and verbalization recorded in detailed narrative form. A review of these observations indicated general categories for the description of behavior and verbalization. It also indicated that behavior patterns differed before treatment, during treatment, and after treatment; although, the behavior patterns within each period were fairly constant. It was, then, decided that the behavior most typical of each period, or phase of emergency room stay, would be recorded; and, that this would be done in terms of general categories of behavior which might usually occur.

An observation guide was constructed and reviewed by 23 registered professional nurses, including three nurses from the emergency room. After revisions were suggested, the Diagnostic and (3) Statistical Manual of the American Psychiatric Association was reviewed for pertinent terms descriptive of behavior. Fifteen guidelines for observation were selected (See Appendix A). These were limited to those observations which could be made without the patient becoming unduly aware of the presence of the observer, and without physical contact. Each of the guidelines included terms descriptive of behavior.

Descriptive words such as "average" and "normal" were used with awareness that these are relative terms. In most cases the absence of observable behavior in the other stated words made the

patient eligible for the description of "normal" or "average".

A pilot study was done on ten patients in the emergency room using the revised tool (See Appendix A). It was found that the tool was usable, and that no further revisions were necessary. During the pilot study, four of the forms were filled out separately and simultaneously by a member of the emergency room staff; and, it was found that these did not differ significantly from those of the researcher. The results from the pilot study have not been included in the final results of this study.

Procedure

The data for this study were collected in nine days in March and April, 1964. (See Appendix B). The data regarding the description of the population of the study by age, sex, injury, have been tabulated for clarity of presentation (See Appendix B).

(18)

The recommendations of Poulos and McCabe concerning the role of the nurse as a research observer were considered. It was decided that a white uniform would be worn, with no cap or pin. This outfit was chosen for the purpose of being less conspicuous to the patient. Although this was found contrary to one of the recommendations, it was found that the advantage of wearing a uniform outweighed the possible disadvantage of being called upon for service by those in the emergency room. It was anticipated that service requests could be largely eliminated by following the second recommendation. "Make it known to personnel that you are not there to perform nursing function." This was done by informing the personnel who were most often there to the purpose for the presence of the researcher. As it was impossible to

(18)

anticipate which private physician would present themselves in the situation, some service requests were expected. These expectations were heightened by the fact that the researcher has been employed on a part time basis at the hospital, had worked in the emergency room on occasion, and was known to many of the nurses and physicians in the hospital.

The personnel of the emergency room gave full cooperation to the researcher by providing a friendly and accepting atmosphere. There was only one service request from the personnel during the nine days of observation; that was to turn off the autoclave. Since this did not interrupt the continuity of observations, it was done. There were few service requests from the physicians. It was found that the researcher would be more inobtrusive if she did not make an issue of not giving service to the physicians when requested. This point of view was made possible by the personnel who were careful to relieve the researcher of service at the earliest opportunity.

Probably the greatest problem in the situation was the uncomfortable feelings of the researcher herself. It was frustrating to be a non-participant observer rather than a functioning member of the situation. This was especially true in situations where the emergency room was busy, and more help was needed. This "conflict" had been predicted by Poulos and McCabe, but not genuinely appreciated until actually working in the real situation. This "conflict" was more acute when the emergency room was busy, and more help was needed. Only one incident occurred during which the researcher dropped her role as observer. This occurred when a patient brought in

suffering from a heart attack, had a cardiac arrest. As it happened, the researcher was not observing any patient at that time.

The patients themselves appeared to accept the presence of the researcher without question. The fact that the emergency room nurse has many records to keep, and is often writing, made the recording activities of the researcher seem similar to those of the other nurses in the situation.

It was not possible to make the observations from one spot, as no such ideal location existed. The researcher attempted to stay out of the immediate situation involving the patient, but had to move around to observe all aspects of the patient, and hear the content of verbalizations. It was decided not to use a clipboard to hold the observation guides, as tables were readily available and more inconspicuous freedom of movement was possible.

The limitations outlined before initiating the study were not difficult to follow. The division of the population into twenty persons with orthopedic injury and twenty persons with non-orthopedic injury seemed to create itself. This should further validate the selection of the sample along these criteria. The sample consisted entirely of individuals of the caucasian race. The only person seen by the observer who was not of this race was a Mexican. He was one of two individuals who were eliminated from the study because of being highly intoxicated.

Four individuals were eliminated from the study because they were in an unconscious or convulsive state during the time the observer was present.

An account of the number of children seen in the emergency room while the researcher was present was not kept. It is estimated, however, that approximately twenty to twenty-five children were omitted from the study in accordance with previously established limitations.

The hours chosen for study represent the hours of maximum patient load in the emergency room. Upon completion of data collection, it was found that almost forty hours, or one hour for every observation collected, was spent in the emergency room. The time for the observations ranged from 11 A.M. to 11 P.M. However, the majority of the observations were done between the hours of 2 p.m. and 9 p.m.

Findings

The findings have been tabulated and analyzed according to the observations made on the behavior of forty individuals before, during, and after treatment in the emergency room. The results have been presented in fifteen categories, corresponding to each numbered guideline in the observation guide. (See Appendix A) These results have been reported in percentages which are descriptive of the total group, but not necessarily descriptive of an individual within the group. For this reason, an attempt has been made, to include some individualized analysis before the group data reports, as indicated, to promote clarity. The patient numbers mentioned refer to Appendix B.

The order in which the data are presented corresponds to the order on the observation guide. (See Appendix A). This is not necessarily the sequence in which the behavioral observations were made. There may appear to be little transition or relationship from one category to the next. However, when considered as a composite, the data assume considerable meaning.

The behavioral terms used to report the results within each category correspond to those suggested under each observation guideline. (See Appendix A). The raw and percentage data have been tabulated for each category, one through fourteen. This was possible, since only one descriptive term was used to describe each individual within a given category.

The first category presents the observations made of the level of consciousness of the forty patients before, during and after treatment.

The descriptive words "dull", "alert", and "stimulated" were used as shown on Table I.

One individual (patient #1) was dull after treatment. This was thought to be due primarily to blood loss and sedation.

Three persons were in a stimulated state on admission. This was evidenced by much gross body movement, such as frequent change of position, restlessness, and pacing. This was accompanied by increased verbal activity. All three of these individuals were grossly upset about the carelessness they had shown in inflicting their own wounds. (patients #15, 24, 33) One person had hit a wall with his fist in a fit of rage, fracturing a metacarpal. The other two had cut themselves with a knife, by accident. Their wounds were not severe. However, their self indignation and explanations to the personnel indicated that they felt somehow inadequate because of having injured themselves.

(12)

The words of Erving Goffman seem to apply to these men:

If behavior is exhibited that does not potentiate the self image the individual does not remain passive. He will control the implications by explanation, apology, or righteous indignation. (12)

A lady who had been in a car accident (patient #5), became stimulated during examination of her injured shoulder. Her behavior (14) appeared to follow the hypothesis of Janis, which states that individuals may be "sensitized" by exposure to a threat of bodily damage to the extent that they become unable to tolerate actions which would not disturb them under other circumstances. After examination, it was found that this lady's injuries were minimal.

TABLE I
 NUMBER AND PERCENT OF FORTY PATIENTS
 EXHIBITING ONE OF THREE LEVELS OF CONSCIOUSNESS
 BEFORE, DURING AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

BEHAVIOR	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Dull	0	0	0	0	1	2.5
Alert	37	92.5	36	90	38	95
Stimulated	3	7.5	4	10	1	2.5
Totals	40	100	40	100	40	100

The second category reports the method of ambulation or transportation of the patients observed while in the emergency room. The data were presented in terms of those who ambulated with assistance, those who ambulated unassisted, and those who needed a transportation device such as a stretcher or a wheelchair. The number transported by wheelchair or stretcher appear in Table II, opposite from the term, "other".

The method of transportation on entering the emergency room remained the same for all but four patients on leaving.

All but five of the patients were treated or examined on a stretcher. These five remained in a chair.

TABLE II
 NUMBER AND PERCENT OF FORTY PATIENTS
 EXHIBITING ONE OF THREE METHODS OF AMBULATION OR TRANSPORTATION
 BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

METHOD	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Assisted	6	15	0	0	5	12.5
Unassisted	13	32.5	0	0	14	35
(wheelchair- Other stretcher)	21	52.5	40	100	21	52.5
Totals	40	100	40	100	40	100

The third category deals with observations of the spontaneous activity of the patients while in the emergency room. The terms used to describe this activity were "quiet", "restless", "shaking", and "tense", as shown in Table III. The activity of "vomiting" was suggested in the observation guide; but no adult patient of those observed was involved in this manner.

Fourteen (35 percent) of the individuals remained quiet throughout the entire sequence, while eight (20 percent) were continually restless. The other nineteen individuals (47.5 percent) varied in behavior over the different periods.

The one individual judged to be tense before treatment was a boy who suffered internal injuries from falling from a horse.
 (patient #32)

The one woman observed to be shaking during the examination had sprained her shoulder in an automobile accident. (patient #5)
 This shaking was also a part of the behavior which led the observer

to report her level of consciousness in category one as stimulated.

(9)

Buytendijk stated that variations in spontaneous activity, such as restlessness, are "mere agents distracting from the pain", and that they induce "flight from one's self".

TABLE III

NUMBER AND PERCENT OF FORTY PATIENTS

EXHIBITING ONE OF FIVE TYPES OF SPONTANEOUS ACTIVITY

BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

BEHAVIOR	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Quiet	21	52.5	19	47.5	26	65
Restless	18	45	20	50	14	35
Shaking	0	0	1	2.5	0	0
Tense	1	2.5	0	0	0	0
Vomiting	0	0	0	0	0	0
Totals	40	100	40	100	40	100

The fourth category reports the direction in which the forty patients observed moved their hands. The terms used for reference are anatomical. The patients were observed to determine whether the hand motion was to the injury, to the head, to the side, or to the abdomen.

There were two individuals who maintained the same direction of hand motion throughout the entire period in the emergency room. A large number of individuals, seventeen (67.5 percent) before and

thirty-three (82.5 percent) during and after treatment, kept their hands away from their injury; and either at their side, head or abdomen. The twenty patients with orthopedic injuries seemed to place their hand (s) on their injury more than those with non-orthopedic injuries. Nine (45 percent) of the twenty with orthopedic problems directed their hand motion toward their injury, compared with four (20 percent) of those with non-orthopedic problems who did so. The comparative incidence of those with orthopedic problems who put their hands to their injury remained higher during and after treatment, although the number decreased. During and after treatment, six (30 percent) of the twenty with orthopedic injury put their hands to their injury, but one (5 percent) of the twenty with non-orthopedic injuries did so.

(9)

Buytendijk suggests that the touching of one's injury is a "personal reaction" which increases the individual's "feeling of self".

TABLE IV

NUMBER AND PERCENT OF FORTY PATIENTS

EXHIBITING ONE OF FIVE TYPES OF SPONTANEOUS ACTIVITY

BEFORE, DURING AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

DIRECTION OF MOTION	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
To Injury	13	32.5	7	17.5	7	17.5
To Head	15	37.5	14	35	11	27.5
To Side	10	25	15	37.5	19	47.5
To Abdomen	2	5	4	10	3	7.5
Totals	40	100	40	100	40	100

Category number five yields a description of the position of the patient's hands while in the emergency room. The terms used to describe this position are, "relaxed", "crossed", and "clenched", as shown in Table V.

TABLE V
NUMBER AND PERCENT OF FORTY PATIENTS
EXHIBITING ONE OF THREE HAND POSITIONS
BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

POSITION	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Relaxed	20	50	20	50	31	77.5
Crossed	11	27.5	8	20	5	12.5
Clenched	9	22.5	12	30	4	10
Totals	40	100	40	100	40	100

That part of the group with clenched hands seemed to include more individuals with orthopedic injury. Six (30 percent) of the twenty patients with orthopedic injury had their hands clenched before treatment. This increased to eight (40 percent) of that group. Of the twenty individuals with non-orthopedic injury, three (15 percent) clenched their hands before treatment. This number was raised to four (20 percent) during treatment. After treatment, three (15 percent) of the twenty patients with orthopedic injury clenched their hands; while one (5 percent) from the other group of twenty did so. This one individual with a non-orthopedic injury was one of those

who had entered the emergency room in anger from carelessness in inflicting his own wound.

The position of the patient's legs while in the emergency room is described in category six. The terms selected to describe this position were, "relaxed", "crossed", and "flexed", as shown in Table VI.

The patients were judged to have their legs flexed if one or both legs were in this position.

There were four persons whose legs were flexed for the duration of their stay in the emergency room. These represent the five patients listed in the after treatment column. They were: a woman with a fractured mandible (patient#35), a man with a fractured pelvis and femur (patient #1), a man with glass in his eyes (patient #38), and a boy with internal injuries (patient #32).

TABLE VI
NUMBER AND PERCENT OF FORTY PATIENTS
EXHIBITING ONE OF THREE LEG POSITIONS
BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

POSITION	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Relaxed	17	42.5	16	40	31	77.5
Crossed	17	42.5	17	42.5	6	12.5
Flexed	7	15	8	17.5	5	10
Totals	40	100	40	100	40	100

The seventh category presents observations made of how the

forty patients moved their injured body area. Table VII presents the data with reference to those who held their injured area quiet, those whose injured area was restrained by some physical means, those who moved their injured area freely, and those who hyperactively moved their injured area.

The individuals whose injuries were restrained were those with orthopedic problems. Those who moved their injured part freely had sustained non-orthopedic injury. Those with hyperactivity of the injured area were: a man with a sprained ankle (patient #14), and a man with lacerated lips, mouth and tongue. (patient #26)

TABLE VII
NUMBER AND PERCENT OF FORTY PATIENTS
EXHIBITING ONE OF FOUR INJURED AREA MOVEMENTS
BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

MOVEMENT	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Quiet	26	65	24	60	33	82.5
Restrained	7	17.5	12	30	3	7.5
Free	6	15	2	5	2	5
Hyperactive	1	2.5	2	5	2	5
Totals	40	100	40	100	40	100

Category eight gives a description of the facial expression of the forty patients observed. The terms which have been selected for description along this line are: "relaxed", "smiling", "pained", and

"sober", as shown in Table VIII.

Three individuals from the group whose expression was pained before treatment changed to a relaxed expression. They were: a man and a woman, each with a sprained ankle (patients #19, 21), and a man with an eye abrasion. (patient #33)

Four individuals from the total group smiled throughout their stay in the emergency room. They were: a man who had cut his knuckle (patient #29), a man who had sprained his shoulder (patient #30), a woman who had fractured her tibia (patient #12), and a boy who had lacerated his finger. (patient #33) The last patient mentioned was told repeatedly by the doctor repairing his finger that it was possible that the repair would not be successful, and that part of the finger might eventually be lost. His behavior seems to conform (12) to Goffman's ideas about the ways in which an individual may plea for "disqualification" of some of the features of the situation as applying to him.

The lady with a fractured mandible (patient #35) had an expression which was predominantly pained. However, when a member of the personnel approached her, she would attempt to smile. She seemed (24) to exhibit the "stunned reaction" described by Tyhurst as occurring during the period of impact, which may last to one hour after the accident. The emergency room personnel were possibly seeing her entering the period of "recoil" where emotions are expressed. The emotion expressed, however, was minimal in comparison to the seriousness of her injuries.

TABLE VIII
 NUMBER AND PERCENT OF FORTY PATIENTS
 EXHIBITING ONE OF FOUR FACIAL EXPRESSIONS
 BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

EXPRESSION	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Relaxed	7	17.5	9	22.5	20	50
Smiling	18	45	9	22.5	13	32.5
Pained	13	32.5	22	55	3	7.5
Sober	2	5	0	0	4	10
Totals	40	100	40	100	40	100

The ninth category described the action of the patient's eyes while in the emergency room. The terms used to describe this behavior were: "open", "closed", "darting", and "blinking", as shown in Table IX.

There was no one individual who has closed eyes for more than one phase of the emergency room stay. It is more descriptive to report, in this case, that eight (20 percent) of the group had their eyes closed at some period of time while in the emergency room.

Those observed as having darting eyes are essentially the same group of people in all three categories. They are: a man with a sprained ankle (patient #14), a man with a fracture of the first lumbar vertebra (patient #18), a man with a fractured metacarpal (patient #15), and a man with a lacerated hand (patient #24). The man with the vertebral fracture, and the man with the fractured pelvis are not represented in the after treatment column.

The individual reported blinking before treatment was a man who came in with lye in his eye (patient #4). He did not continue to exhibit this behavior during and after treatment. Those who were blinking during the treatment included five of the fourteen females in the sample (about 35 percent). The other two exhibiting this behavior were two sixteen year old boys, one with internal injuries, the other with a fractured arm (patients #32, 34).

TABLE IX
NUMBER AND PERCENT OF FORTY PATIENTS
EXHIBITING ONE OF FOUR EYE ACTIONS
BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

ACTION	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Open	31	77.5	25	62.5	33	82.5
Closed	3	7.5	3	7.5	2	5
Blinking	1	2.5	7	17.5	2	5
Darting	5	12.5	5	12.5	3	7.5
Totals	40	100	40	100	40	100

The tenth category gives information pertaining to the direction of the patient's eyes while in the emergency room. The terms used to describe this behavior are reference points. It was decided whether the patient's gaze was directed toward the injury or toward the doctor and nurse. If the eyes were not directed toward the injury or the doctor and nurse, they were considered to be directed "away".

Two of those whose eyes were directed away from either the injury or the doctor and nurses, exhibited this behavior throughout their stay in the emergency room. These were: a woman with a torn fingernail (patient #25), and a woman with an avulsion of the finger (patient #2).

There was no one individual who fixed a gaze on the injury. Three of the patients did not direct their eyes to the injury for two of the three periods defined. Two men, one with a cut knuckle, the other with a fractured metacarpal (patients #15, 29), looked at their injury before and after treatment. The other, a sixteen year old boy with a lacerated finger (patient #33) directed his gaze to his injury during and after treatment. These three individuals looked at the doctor and nurse when not looking at their injury.

TABLE X

NUMBER AND PERCENT OF FORTY PATIENTS
EXHIBITING ONE OF FOUR EYE DIRECTIONS
BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

DIRECTION	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Injury	7	17.5	7	17.5	3	7.5
Doctor-Nurse	30	75	30	75	32	80
Away	3	7.5	3	7.5	5	12.5
Totals	40	100	40	100	40	100

The eleventh category pertains to the observations made of the appearance of the skin of the patients in the emergency room. The

terms used to describe the skin were: "normal", "pale", "diaphoretic", and "flushed", as shown in Table XI. The term "cyanotic" had been suggested for observational reference, but none of the patients exhibited this appearance. Some of the patients exhibited more than one of the skin characteristics mentioned. These have been reported opposite the term "other".

Twelve (30 percent) of the group demonstrated variations in the appearance of their skin while in the emergency room.

Two of the patients were pale and diaphoretic throughout their stay in the emergency room. They were: a man with a fractured lumbar vertebra (patient #18), and a man with a fractured pelvis (patient #1).

One patient was diaphoretic throughout the entire period in the emergency room. This was a man with a knee laceration (patient #7). A man with glass in his eye (patient #38) was observed to be diaphoretic during and after treatment.

Pallor, flushing, and sweating and among the autonomic responses
(6)
listed by Beecher which may occur in reaction to noxious stimuli.

TABLE XI
 NUMBER AND PERCENT OF FORTY PATIENTS
 EXHIBITING ONE OF FIVE SKIN APPEARANCES
 BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

APPEARANCE	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Normal	27	67.5	25	62.5	25	62.5
Pale	3	7.5	5	12.5	4	10
Cyanotic	0	0	0	0	0	0
Diaphoretic	1	2.5	2	5	3	7.5
Flushed	7	17.5	6	15	6	15
Other (more than one above)	2	5	2	5	2	5
Totals	40	100	40	100	40	100

Category twelve describes the quality of verbalizations heard in the emergency room. The terms, in Table XII, used to describe this behavior are: "silent", "average", "groan", and "sigh". The terms "whine", "scream", and "cry" were also suggested in the observation guide, but no behavior of this type was observed.

Each patient reported under the category of sighing represents a different individual.

All of those having groaning vocalization before treatment continued to groan during treatment.

TABLE XII
 NUMBER AND PERCENT OF FORTY PATIENTS
 EXHIBITING ONE OF SEVEN VOCAL QUALITIES
 BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

QUALITY	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Silent	0	0	5	12.5	1	2.5
Average	33	82.5	22	55	36	90
Whine	0	0	0	0	0	0
Groan	6	15	12	30	2	5
Sigh	1	2.5	1	2.5	1	2.5
Scream	0	0	0	0	0	0
Cry	0	0	0	0	0	0
Totals	40	100	40	100	40	100

The thirteenth category describes the rate of vocalization with use of the terms, "rapid", "moderate", and "slow", as shown in Table XIII. Those who were silent have been included in the tabulation for clarity.

One individual spoke rapidly during the entire period in the emergency room. This was a butcher who had cut his finger (patient #24).

TABLE XIII
 NUMBER AND PERCENT OF FORTY PATIENTS
 EXHIBITING ONE OF FOUR VOCAL RATES
 BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

RATE	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Rapid	7	17.5	1	2.5	1	2.5
Moderate	31	77.5	31	77.5	36	90
Slow	2	5	3	7.5	2	5
Silent	0	0	5	12.5	1	2.5
Totals	40	100	40	100	40	100

The fourteenth, and final category which lends itself to tabulation, describes the intensity of verbalization of the patients in the emergency room. The terms used to describe the intensity are: "loud", "moderate", and "soft", as shown in Table XIV. Those who were silent have been included in the tabulation for clarity.

Most of the patients represented in the groups who spoke either loudly or softly, did have an average vocal intensity for some period of their emergency room stay. One individual spoke softly throughout the entire period: this was a lady with a fractured mandible (patient #35). Two patients exhibited both loud and soft vocal intensity at different times. A seventy-two year old lady with a fractured arm (patient #10) spoke loudly on admission, softly throughout treatment, and average after treatment. The other person was a woman with a fractured tibia who spoke with average intensity on

admission. This increased to loud intensity during treatment; and diminished to soft after treatment.

TABLE XIV
NUMBER AND PERCENT OF FORTY PATIENTS
EXHIBITING ONE OF FOUR VOCAL INTENSITIES
BEFORE, DURING, AND AFTER TREATMENT IN A HOSPITAL EMERGENCY ROOM

INTENSITY	BEFORE TREATMENT		DURING TREATMENT		AFTER TREATMENT	
	N	%	N	%	N	%
Loud	6	15	5	12.5	0	0
Moderate	31	77.5	23	57.5	35	87.5
Soft	3	7.5	7	17.5	4	10
Silent			5	12.5	1	2.5
Totals	40	100	40	100	40	100

The remaining data are observation on the content of verbalization of the forty patients seen in the emergency room. It is not possible to present these data in tabular form, as more than one response has been collected for each patient. The verbalizations will be described in terms of the general interpretive statements in the observation guide (see Appendix A, page 2). Examples of typical verbalization will be presented along with specific examples.

Seven patients (17.5 percent) answered questions only before treatment began. Fourteen patients (35 percent) spoke only to answer questions during the treatment. However, after treatment, there was no patient who did not make some sort of comment in addition to

answering questions.

Hamburg's classification of the "psychological reactions to injury"⁽⁴⁾ were pertinent to this group. There was no individual who exhibited an attitude of "unconcern". This is not too unusual, as the sample included few seriously injured patients, and this behavior is more often seen with severe injury. However, fifteen (37.5 percent) patients did deny their injury or its significance before treatment. None exhibited this behavior during and after treatment. Before treatment, four patients with fractures stated, "I don't think it's broken." Some typical comments from the group were:

"It's not much." (patient #3)

"I don't think it's hurt bad." (patient #40)

"This isn't really an emergency." (patient #22)

"I shouldn't have come. It's not that much."
(patient #7)

Hamburg's third classification was that of "conditional acceptance"⁽⁴⁾. One patient stated acceptance of the responsibility for the injury before treatment. None verbalized along this line during treatment. However, ten (25 percent) patients verbalized acceptance of the injury after treatment. Some examples were:

"Another cast! Oh, well!" (patient #28)

"I'll be okay." (patient #29)

"I don't mind." (patient #10)

"It's not so bad. I've had a cast before." (patient #8)

"I don't mind staying in the hospital." (patient #40)

There were only three patients who asked about their condition before the doctor volunteered a diagnosis. Two patients

with possible fractures asked, "Is it broken?" A third asked, "How bad is it?"

Some of the patients indicated their fear, or anxiety, about the treatment by asking many questions of the personnel. Seven patients (17.5 percent) asked questions before treatment:

"Is my doctor coming over?" (patient #11)

"What's he going to do?" (patient #17)

"What are you doing?" (patient #26)

"Are you going to give me a shot?" (patient #33)

Ten patients (25 percent) asked questions such as these during treatment:

"Does it have to be fixed now?" (patient #15)

"Are you cutting off the whole end?" (patient #2)

"What's that?" (reference to local anesthetic) (patient #37)

"What are you doing?" (patient #39)

"Is the needle dull?" (after doctor looks at needle)
(patient #7)

Twelve patients (30 percent) made statements before the treatment indicating their fear of the prognosis. Some examples are:

"It's beginning to get stiff." (patient #22)

"I'm afraid it's broken." (patient #21)

"I'm afraid I'll have a stiff elbow." (patient #10)

"I'm dizzy. I'm worried." (patient #16)

"I saw the bone when I cut it." (patient #33)

During treatment, two patients commented on their prognosis; and after treatment, seven patients (17.5 percent) did so. Five of these

asked, "Will I be all right?" One lady with a sprained ankle (patient #21) asked, "Can I ski next week?"

Eleven patients (27.5 percent) made some sort of apologetic statement before treatment. Three patients with an orthopedic injury incurred from ski accidents stated, "This makes me feel silly." (patients #9, 12, 21) A fourth patient with similar circumstances stated, "I'm too old for this sort of thing." (patient #8)

One seventy-two year old lady who had been in an automobile accident (patient #40) said, "Please excuse my breath. I had green onions for lunch."

Four patients (10 percent) apologized during treatment for the complaints they were making about the discomfort of the treatment.

Some samples of this are:

"I'm sorry. I'm just so nervous." (patient #28)

"I'm sorry. It's really not so bad." (patient #10)

There were no apologetic statements made after treatment.

(12)

These observations seem to follow Goffman's idea that the individual, when exhibiting behavior which does not potentiate his self image, tries to control the implications with explanation and apology.

(9)

Buytendijk states that complaints and statements of protest are merely agents used by an individual to detract from pain.

Seven patients (17.5 percent) made comments before treatment, such as:

"I'm so thirsty." (patient #35)

"I've got to have something for pain." (patient #36)

"Oh, no!" (patient #10 - when injured area was moved)

Thirteen patients (32.5 percent) made symptom-centered statements during treatment. Six individuals verbalized something similar to, "Oh, that hurts." A young girl with a fractured leg (patient #28) said, "I can't stand it. It's so cold.", when benzoin was poured over the stockinette on her leg which was to be casted.

A man with a fracture of the first lumbar vertebra who had asked for something for pain before treatment, (patient #18) commented, "I felt better before I got the shot."

After treatment, most of the symptom-centered verbalizations came from those who had a cast.

"It's hot." (patient #8)

"It's awfully warm." (patient #29)

"It's so heavy." (patient #9)

There were ten patients (25 percent) who made statements of resentment of the injury before treatment. Some of these comments were:

"I'll never ride a motorcycle again." (patient #28)

"That's what I get for being a good samaritan."
(patient #1 - he had been hit while helping a woman pack her car)

"I should have had more sense." (patient #15)

"I'll never drive a car again." (patient #17)

Five patients (12.5 percent) made resentful comments during treatment, and five made similar comments after treatment. Some of these examples are:

"I was supposed to go to a party tonight." (patient #28)

"How stupid, to fall off a horse." (patient #32)

"That fixes me for work." (patient #11)

"This wasn't my fault." (patient #26)

Nine members of the group were admitted to a hospital ward from the emergency room. The other thirty-one patients (77.5 percent) went home. Those discharged were given instruction and a plan for follow-up care by a staff physician or their doctor. Seventeen persons, of the thirty-one discharged, (about 55 percent), asked no questions during this period of instruction. Most of them indicated understanding by shaking their head and saying, "Yes", "Oh", "Uh-huh". Seven of the thirty-one (22.5 percent) centered their questions around the topic of when they should see their doctor, or what doctor they were to see.

The findings of this study were very similar to the findings on individual reactions to stress reviewed in the literature. The less severely injured patients did appear to conform to social role expectations, as described by Goffman. The incidence of quiet, smiling behavior exemplifies this. Many individuals who could not maintain this composed appearance, apologized for their behavior. Those whose behavior differed greatly from their own expectations became stimulated.

Many individuals who were severely injured, and appeared to be experiencing more pain, could not maintain a quiet appearance. They dealt with their pain by means of physical motion, although this was never excessive. They clenched their hands, flexed their legs, verbalized discomfort, groaned, and exhibited a facial expression suggestive of pain.

Buytendijk states that these actions distract from the pain and increase
 (9)
 the individual's "feeling of self."

Denial of injury was the prevalent reaction before treatment,
 while acceptance of injury was the prevalent reaction after treatment.
 (4)

Hamburg states that both of these reactions are significantly present
 in groups of persons who have been injured. This study contained few
 severely injured individuals, and Hamburg states that acceptance is
 the most common reaction to injuries which are not serious.

(6)
 The autonomic nervous system responses described by Beecher
 were evident in the individuals who did demonstrate a variation in the
 appearance of their skin.

Many of the individuals appeared to be centered on the present
 and the recent past. This was evidenced by a preoccupation of many
 with the immediate symptoms, by resentful comments which referred back
 to the time of injury, and by fear of treatment. This same behavior
 (24)
 was reported by Tyhurst as occurring during the phase of recoil after
 community disaster.

The findings of this study provide a generalized description
 of the behavior of forty patients admitted to a hospital emergency room.
 This information should provide the nurse in this particular area with
 (15)
 the "framework" which Dorothy Johnson felt was needed before nurses
 could help the patient "achieve and maintain a stable state."

The guided observations were essential for this collection of
 data (see Appendix A). Ida Orlando (17) tells how important purposeful
 observation is to the nurse. It is by means of observation that the
 nurse must identify the need of the individual for help. The data in

this study fulfill this initial step. It was not within the scope of the study to do more than construct the observational guidelines and observe the patient's behavior. Orlando states that this step of observation is only the beginning. The nurse must minister the help needed, and validate that help given was indeed help needed. (17)

Although this study does not answer the question, "What does the nurse do?", it does go into some detail to collect the initial observational data needed before the nurse can perform. Hopefully, this "separate" treatment will serve to emphasize the importance of a "framework" of information, specific to the setting, on which a nurse may base her purposeful action.

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study was undertaken to determine what kind of behavior is exhibited by individuals admitted to a hospital emergency room. It was decided that the direct observation of patients in an emergency room should yield this information.

A hospital from the Portland area was selected for the study. After permission was obtained from the nursing service administration to pursue the study, the records for the admissions of the past month were reviewed. It was determined that approximately 50 percent of the adult admissions were for orthopedic problems of some sort. It was then decided that, for purposes of the study, 50 percent of the population observed should consist of persons with orthopedic problems.

After a review of the related literature and the emergency room personnel had been acquainted with the plans for the study, six observations were done in the emergency room, and written in narrative form. Items were selected which would best describe the recorded behavior in brief words. The Diagnostic and Statistical Manual of the American
(2)
Psychiatric Association was reviewed for words which might be used to describe behavior. An observation tool was constructed from this complex of descriptive words and phrases.

This observation tool was reviewed by twenty-three professional nurses. It was then revised according to their suggestions. This revised tool was then taken back to the emergency room for a pilot study of the observation of the behavior of ten patients. It was found that no further revisions were needed.

A series of forty observations were collected over a period of about forty hours.

It was found that over 90 percent of the patients were alert, while in the emergency room. Three of the patients (7.5 percent) who were in a stimulated state on admission, were upset about their carelessness in inflicting their own wounds. They gave apologies and explanations for their presence in the situation and for their actions. Goffman (12) stated that this behavior might be typical of the individual whose appearance in a given situation did not comply with his self-concept.

One patient appeared dull after treatment. This was thought to be due to the effects of blood loss and sedation.

Over 50 percent of the patients entered and left the emergency room on a stretcher, or in a wheelchair. Thirty percent of the patients were able to enter and leave unassisted. Twelve to fifteen percent walked in and out of the emergency room with assistance.

Two major characteristics of spontaneous activity were that the patient was either quiet or restless. Before treatment, 52.5 percent of the group was quiet, and 45 percent were restless. These figures reversed during treatment to 47.5 percent quiet and 50 percent restless. After treatment, the incidence reversed again. Sixty-five percent of the group was quiet, while 35 percent was restless. Thirty-five percent of the sample remained quiet throughout the entire sequence, while 20 percent were continually restless.

Before treatment, 67.5 percent of the group kept their hands away from their injury before treatment, and either at their head, side or abdomen. During and after treatment, this number raised to 82.5 percent.

Forty-five percent of that part of the group with orthopedic injuries directed their hands toward their injury, compared with 20 percent from the other part of the sample who did this. During and after treatment, 30 percent of those with orthopedic injury put their hands to their injury, while 5 percent with non-orthopedic injuries did so. Buytendijk states that an individual may need to touch his injury to increase his "feeling of self".⁽⁹⁾

Before treatment, 77.5 percent of the patients relaxed or crossed their hands. This number decreased to 70 percent during treatment, and rose to 90 percent after treatment. Thirty percent of the part of the group with orthopedic problems had their hands clenched before treatment. This increased to 40 percent during treatment. Fifteen percent of those with non-orthopedic injury clenched their hands. This number rose to 20 percent during treatment. After treatment, 15 percent from the part of the group with orthopedic injury clenched their hands; while 5 percent from the other group of twenty did so.

Before treatment, 85 percent of the patients either relaxed or crossed their legs. This number lowered slightly to 82.5 percent during treatment, and then raised to 90 percent after treatment. Ten percent of the group maintained their legs in a flexed position at all times. Buytendijk states that bodily motions are agents to distract from pain.⁽⁹⁾

Before treatment, 82.5 percent of the group had their injured area either quiet or restrained. This increased to 90 percent during and after treatment. There were two individuals (5 percent) who had hyperactive movements of the injured area during and after treatment.

Before treatment, observation of the facial expressions of the group revealed that 17.5 percent were relaxed, 45 percent were smiling, 32.5 percent appeared pained, and 5 percent were sober. During treatment, the incidence of pained expressions rose to 55 percent, while smiling decreased to 22.5 percent. After treatment, 82.5 percent had a smiling or relaxed face, 10 percent were sober, and 7.5 percent had a pained expression. Buytendijk states that pained expressions may be a manner of dealing with pain.⁽⁹⁾

Before treatment, 77.5 percent of the group had their eyes open. During treatment, 62.5 percent of the patients had their eyes open; while 82.5 percent of the group exhibited this behavior after treatment. Twenty percent of the individuals had their eyes closed at some time during their stay in the emergency room. During treatment, 35 percent of the female population in the sample were observed to be blinking. The 12.5 percent of the group with darting eyes before treatment, remained the same during treatment. Two individuals dropped from this group to bring the total down to 7.5 percent after treatment.

Before and during treatment, 17.5 percent of the group directed their gaze toward their injury. There was no one individual who fixed his eyes on the injury for the entire period in the emergency room. After treatment, 7.5 percent of the group directed their eyes to the injury. Those who looked at the doctor and/or nurse while in the emergency room comprised 75 to 80 percent of the group. Those looking away from both the doctor and/or nurse, and the injury, constituted 7.5 percent of the group before and during treatment. This number raised to 12.5 percent after treatment.

Thirty percent of the group demonstrated variations in skin appearance while in the emergency room. Before treatment, 67.5 percent of the group had normal appearing skin, 17.5 percent were flushed, 2.5 percent were diaphoretic, 7.5 percent were pale. During treatment, 62.5 percent appeared normal, 12.5 percent appeared pale, 15 percent were flushed, 5 percent were diaphoretic. After treatment, 62.5 percent appeared normal, 10 percent appeared pale, 7.5 percent were diaphoretic and 15 percent were flushed. Two patients (5 percent) remained pale and diaphoretic throughout treatment.

Before treatment, 82.5 percent of the group spoke in an average voice, 15 percent groaned, and 2.5 percent sighed. During treatment, the number with average vocalization dropped to 55 percent, while the number groaning rose to 30 percent. Those silent and sighing were each 2.5 percent of the group. After treatment, the number groaning decreased to 5 percent; while the number with average vocal quality rose to 90 percent.

Before and during treatment, 77.5 percent of the individuals exhibited a moderate rate of vocalization before and during treatment. This number rose to 90 percent after treatment. Those speaking rapidly comprised 17.5 percent of the group before treatment, but this number fell to 2.5 percent during and after treatment. Five percent of the group spoke slowly before and after treatment, and 7.5 percent spoke slowly during treatment.

Before treatment, 77.5 percent of the group spoke with moderate intensity. This number dropped to 57.5 percent during treatment, and then it rose to 87.5 percent after treatment. Fifteen percent of the

group spoke loudly before treatment, 12.5 percent spoke loudly during treatment, and none exhibited this behavior after treatment. Before treatment, 7.5 percent of the group spoke softly. During treatment, 17.5 percent spoke softly; while 10 percent exhibited this behavior after treatment.

Before treatment, 2.5 percent of the group verbalized acceptance of their injury. No individual verbalized acceptance during treatment; but 25 percent of the group stated acceptance of the injury after treatment. This seems consistent with the findings of Hamburg, who states that acceptance is the most common reaction to non-severe (4) injury.

Very few asked a direct question about their injury. Before treatment, two individuals (5 percent) asked of their injury, and one (2.5 percent) asked during treatment. No member of the group asked of their injury after treatment.

Before treatment, 17.5 percent of the group responded in answer to question only. During treatment, 35 percent responded in this way. There was no individual who did not make some comment on his own initiative after treatment.

Before treatment, 17.5 percent of the group verbalized fear of that treatment. This number rose to 25 percent during treatment, and then fell to 2.5 percent after treatment.

Those whose comments centered on their injury comprised 17.5 percent of the group before treatment. This number rose to 32.5 percent during treatment, and then fell to 12.5 percent after treatment.

Before treatment, 27.5 percent of the group apologized for some

action on their part. During treatment, 10 percent behaved in this manner; while no individual apologized for his action after treatment.

Twenty-five percent of the group indicated resentment of their injury before treatment. This number dropped to 12.5 percent during and after treatment.

Thirty percent of the individuals indicated fear of the prognosis before treatment. This was indicated by 5 percent of the group during treatment, and 17.5 percent after treatment.

Before treatment, 37.5 percent of the individuals denied the significance of their injury. There was no incidence of denial during and after treatment.

The findings of this study were consistent with the literature reviewed. The importance of the social role, as described by Goffman, appeared evident in the quiet, smiling appearance and well modulated voice of many individuals in the group. It appeared that when the individual's behavior, and very presence in the situation, was not acceptable to him, "the individual did not remain passive". He reacted by apology, explanation, and in a few cases, stimulated behavior. (12)

Those individuals who were more severely injured also sought moderate behavior, although it was not possible for them to maintain the quiet, smiling appearance that some did. They dealt with their discomfort by flexing their legs and clenching their hands, placing their hands on their injury, telling of their discomfort in short, pointed phrases, and showing an expression of pain. Buytendijk states that these actions are methods of dealing with pain and increasing the feeling of self. (9)

The autonomic nervous system responses to noxious stimuli described by Beecher (6) were observable in the number of individuals who exhibited some variation in the appearance of their skin.

Although the emergency room situation was not one of disaster, and few severely wounded persons were included in the sample, many of the patients appeared to exhibit behavior similar to that described by Tyhurst as occurring during the phase of "recoil" after a community disaster. (24) They did appear to be centered on the present and recent past.

The purpose of this study was to provide a generalized description of the behavior of forty patients in a hospital emergency room. This was done to create a "framework" on which the nurse in the situation could base subsequent action. Dorothy Johnson felt that a "framework" of descriptive behavioral incidents was needed before the nurse could consistently make accurate judgments, about the degree of "disequilibrium" she was viewing. (15)

(17) Orlando states that after observing, the nurse must act. The suggestion of action was not within the scope of this study. It was anticipated that emphasis on the observations preliminary to nursing action, would point out the need for the nurse, in a specific situation, to have a framework of behavioral incidents as background for her judgments about patient care.

CONCLUSIONS

1. The findings of this study cannot be generalized to other populations of emergency room patients. Its value lies in reinforcement and suggestion of ideas to other nurses working in a similar situation.
2. Predetermined guidelines promote reliability of observations. Those established for this study were adequate for providing a generalized description of patient behavior in the emergency room.
3. It was possible to describe a portion of the patient's behavior before, during, and after treatment with single words.
4. Observations made before, during, and after treatment, were adequate to provide a generalized description of patient behavior.
5. Information on patient behavior collected by direct observation could create a "framework" on which a nurse may base subsequent nursing actions such as Dorothy Johnson indicated in the literature.

RECOMMENDATIONS FOR FURTHER STUDY

1. Carry out descriptive studies of patient behavior in nursing areas other than the emergency room, using predetermined guidelines for making observations.
2. Carry out a descriptive study of the behavior of children in the emergency room, using predetermined guidelines for making observations.
3. Do a follow-up study of patients treated in the emergency room, use interviews in home visits, or mail questionnaires to determine if instruction received in the emergency room was adequate.
4. Carry out a study to observe the actions of the nurse which occur in conjunction with the patient behavior presented in this study.

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APPENDIX A

OBSERVATION GUIDE

Sex _____
 Date _____
 Patient # _____
 Hour _____

Age _____
 Reason for Admission _____
 Treatment _____

B D A

B D A

1. Level of Consciousness

Dull
 Alert
 Stimulated
 Other

2. Ambulation

Assisted
 Unassisted
 Other

3. Spontaneous Activity

Quiet
 Restless
 Shaking
 Rigid
 Vomiting
 Other

4. Direction of Hand Motion

Injury
 Head
 Side
 Abdomen
 Other

5. Position of Hands

Relaxed
 Crossed
 Clenched
 Other

6. Position of Legs

Relaxed
 Crossed
 Flexed
 Other

7. Movement of Injured Area

Quiet
 Restrained
 Free
 Hyperactive
 Other

8. Expression of Face

Relaxed
 Smiling
 Pained
 Sober
 Other

9. Action of Eyes

Closed
 Open
 Darting
 Blinking
 Other

10. Direction of Eyes

Injury
 Doctor-Nurse
 Away
 Other

11. Appearance of Skin

Normal
 Pale
 Cyanotic
 Diaphoretic
 Flushed
 Other

12. Quality of Vocalization

Silent
 Average
 Whine
 Groan
 Sigh
 Scream
 Cry
 Other

13. Rate of Vocalization

Rapid
 Moderate
 Slow
 Other

14. Intensity of Vocalization

Loud
 Moderate
 Soft
 Other

BeforeDuringAfter15. Content of VerbalizationAnswer Questions Only

(example)

Denies Injury

(example)

Asks of Injury

(example)

Accepts Injury

(example)

Fears Treatment

(example)

Fears Rehab./Prognosis

(example)

Resents Injury

(example)

Centered on Injury

(example)

Other

(example)

APPENDIX B

DESCRIPTION OF SAMPLE

<u>Patient #</u>	<u>Condition</u>		<u>Cause</u>	<u>Age</u>	<u>Sex</u>	
<u>3-1-64, Mon.</u>						
1.	Fx., pelvis, femur	(ortho)	Hit by car	70	M	
2.	Avulsion, finger		Shut in car door	45	F	
3.	Lacerated palm		Fixing lawn mower	35	M	
4.	Lye in eye		Cleaning gun	42	M	
5.	Sprained shoulder	(ortho)	Auto accident	52	F	
<u>3-15-64, Sun.</u>						
6.	Laceration, head		Auto accident	17	F	
7.	Laceration, knee		Ski accident	24	M	
8.	Fx., ankle	(ortho)	Ski accident	38	M	
9.	Fx., ankle	(ortho)	Ski accident	22	F	
10.	Fx., radius	(ortho)	Fell in driveway	72	F	
<u>3-19-64, Thurs.</u>						
11.	Fx., clavicle	(ortho)	Fell down stairs	28	M	
12.	Fx., tibia	(ortho)	Ski accident	23	F	
13.	Infected arm		Gravel in wound	24	M	
<u>3-21-64, Sat.</u>						
14.	Sprain, ankle	(ortho)	Ski accident	22	M	
15.	Fx., metacarpal	(ortho)	Hit a wall	29	M	
16.	Contusion, head	(ortho)	Auto accident	32	F	
17.	Fx., ribs	(ortho)	Auto accident	54	M	
<u>3-22-64, Sun.</u>						
18.	Fx., L-1	(ortho)	Sled accident	37	M	
19.	Sprain, ankle	(ortho)	Ski accident	23	M	
20.	Ligament inj., knee		Ski accident	17	F	
21.	Sprain, ankle	(ortho)	Ski accident	37	F	
<u>4-10-64, Fri.</u>						
22.	Poss. neck & knee inj.		Auto accident	30	M	
23.	Foreign body, leg		Firecracker	25	F	
24.	Laceration, hand		Knife accident	32	M	
<u>4-12-64, Sun.</u>						
25.	Torn fingernail		Shut in car door	52	F	
26.	Lacerations, mouth		Auto accident	54	M	
27.	Laceration, thigh		Cutting a box	46	M	
<u>4-18-64, Sat.</u>						
28.	Fx., femoral condyle	(ortho)	Motorcycle accident	18	F	
29.	Cut knuckle	(ortho)	Machinery	56	M	
30.	Sprain, shoulder	(ortho)	Hit by a ball	30	M	
31.	Laceration, finger		Hit with steel	53	M	
32.	Internal injury		Fell from a horse	16	M	
33.	Laceration, finger		Knife accident	16	M	
<u>4-19-64, Sun.</u>						
34.	Fx., radius	(ortho)	Fell in yard	16	M	
35.	Fx., mandible	(ortho)	Auto accident	23	F	
36.	Fx., ankle	(ortho)	Ski accident	32	M	
37.	Foreign body, hand		Cleaning sink	30	M	
38.	Glass in eye		Glasses broken	50	M	
39.	Abrasion, eye		Hit with grass	50	M	
40.	Laceration, lip		Auto accident	72	F	
Total Patients					26	14

APPENDIX C

RAW DATA SHEET

	<u>B</u>	<u>D</u>	<u>A</u>		<u>B</u>	<u>D</u>	<u>A</u>
1. <u>Level of Consciousness</u>				8. <u>Expression of Face</u>			
Dull	0	0	1	Relaxed	7	9	20
Alert	37	36	38	Smiling	18	9	13
Stimulated	3	4	1	Pained	13	22	3
Other				Masked	2	0	4
2. <u>Ambulation</u>				Other			
Assisted	6	0	5	9. <u>Action of Eyes</u>			
Unassisted	13	0	14	Closed	3	3	2
Other	21	40	21	Darting	5	5	3
3. <u>Spontaneous Activity</u>				Blinking	1	7	2
Quiet	21	19	26	Open	31	25	33
Restless	18	20	14	10. <u>Direction of Eyes</u>			
Shaking	0	1	0	Injury	7	7	3
Tense	1	0	0	Doctor-Nurse	30	30	32
Vomiting	0	0	0	Away	3	3	5
Other				Other			
4. <u>Direction of Hand Motion</u>				11. <u>Appearance of Skin</u>			
Injury	13	7	7	Normal	27	25	25
Head	15	14	11	Pale	3	5	4
Side	10	15	19	Cyanotic	0	0	0
Abdomen	2	4	3	Diaphoretic	1	2	3
Other				Flushed	7	6	6
5. <u>Position of Hands</u>				More Than One	2	2	2
Relaxed	20	20	31	12. <u>Quality of Vocalization</u>			
Crossed	11	8	5	Silent	0	5	1
Clenched	9	12	4	Average	33	22	36
Other				Whine	0	0	0
6. <u>Position of Legs</u>				Groan	6	12	2
Relaxed	17	16	31	Sigh	1	1	1
Crossed	17	17	6	Scream	0	0	0
Flexed	7	8	5	Cry	0	0	0
Other				Other			
7. <u>Movement of Injured Area</u>				13. <u>Rate of Vocalization</u>			
Quiet	26	24	33	Rapid	7	1	1
Restrained	8	12	3	Moderate	31	31	36
Free	7	2	2	Slow	2	3	2
Hyperactive	1	2	2	Other			
Other				14. <u>Intensity of Vocalization</u>			
				Loud	6	5	0
				Moderate	31	23	35
				Soft	3	7	4
				Other			

	<u>Before</u>	<u>During</u>	<u>After</u>
<u>15. Content of Verbalization</u>			
<u>Answer Questions Only</u> (example)	7	14	0
<u>Denies Injury</u> (example)	15	0	0
<u>Asks of Injury</u> (example)	2	1	0
<u>Accepts Injury</u> (example)	1	0	10
<u>Fears Treatment</u> (example)	7	10	1
<u>Fears Rehab./Prognosis</u> (example)	12	2	7
<u>Resents Injury</u> (example)	10	5	5
<u>Centered on Injury</u> (example)	7	13	5
<u>Apology</u> (example)	11	4	0