



“Me First, Others Later” A focused ethnography of ongoing cultural features of waiting in an Iranian emergency department

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ABSTRACT

Background: Waiting is an inevitable experience in all emergency departments (EDs). This waiting time may negatively influence the patients and their relatives' satisfaction, healthcare professionals' (HCPs) performance, and the quality of care provided.

This study aims to explore, gain understanding of and describe what it is like to wait in an Iranian emergency department (ED) with particular focus on cultural features.

Method: A focused ethnographic approach based on Spradley's (1980) developmental research sequence was conducted in the ED of a tertiary academic medical center in northwest Iran over a 9-month study period from July 2017 to March 2018. Participant observation, ethnographic interviews and examination of related documents and artefacts were used to collect data. All the data were recorded in either field notes or verbatim transcripts and were analysed using Spradley's ethnographic data analysis method concurrently.

Results: The overarching theme of “Me first, others later” emerged. Within this overarching theme there were seven sub-themes as follows: human-related factors, system-related factors, patients and their relatives' beliefs and behaviors, HCPs' beliefs and behaviors, consequences for patients and their relatives, consequences for HCPs, and consequences for ED environment and care process.

Conclusion: The mentality ‘me first, others later’ as the main cultural barrier to emergency care, strenuously undermined our positive practice environment. An accountable patient/relative support liaison, a clearly-delimited process of ED care delivery, guidelines for providing culturally competent ED care, and public awareness programs are needed to address the concerns and conflicts which establish a mutual trust and rapport.

1. Introduction

Waiting in emergency departments (EDs) is a frightening experience for many people, both psychologically and physiologically. It is inconvenient and frustrating for patients who must wait due to lack of available beds particularly if they do not have life threatening conditions and waiting can be potentially dangerous [1]. Waiting times are characteristic of EDs and often inevitable for the majority of patients and their relatives. With this in mind, many efforts have been made to improve ED waiting times, while the problem has remained largely unsolved [2]. In the United States, 88.8% of patients waited longer than

1 h from ED arrival to discharge [3] and patients in the U.K spent an average of 3 h in the ED with 9.2% waiting more than four hours [4]. Similarly in Canada, 9 out of 10 left the EDs within 7.8 h and 10% waited even longer [5]. In Iran, compared with developed countries, the average ED waiting times are much longer [6,7] leading to and reinforcing specific beliefs and behaviors [8].

Likewise, EDs are under pressure to manage not only the technical elements (such as diagnosis and treatment) but also the personal elements of care (such as patient/staff interaction and psychosocial needs) [9]. This is challenging to HCPs since the qualitative aspects of care, such as the patient's emotional needs and staff attitudes and needs, are

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sometimes given less priority [1].

2. Background

Although it is of crucial importance to understand what it is like to wait in an ED [10] and use that information to innovate major changes in EDs' structure, processes, people, and culture [11] with the intent of more closely matching services to patient needs and preferences [12], there is little evidence on the cultural features of waiting in the ED [13]. Any prior studies have been quantitative in nature, primarily investigating time as the most important aspect of ED waiting [2,4,6,7,14,15]. There has been little research into the experiences of patients and their relatives, interactions among patients, relatives, and HCPs, and the overall culture of waiting in ED [13]. A qualitative approach could address these challenges providing context-specific evidence for practice and enabling the provision of patient, family, and staff-centered care using a holistic approach [1].

This study aims to explore, gain understanding of and describe what it is like to wait in an Iranian emergency department (ED) with particular focus on cultural features. Ultimately, the results would contribute knowledge that would potentially impact the provision of emergency care and improvement of patient outcomes.

3. Methods

3.1. Study design and procedure

A focused ethnographic study was conducted based on Spradley's (1980) developmental research sequence (DRS) for ethnographic data generation, treatment, analysis, and interpretation. This qualitative ethnographic study is couched within the interpretive paradigm which is concerned with understanding the world as it is from subjective experiences and perceptions of individuals and the meanings people assign to them [16]. The following steps of DRS were used: conducting participant observation; keeping an ethnographic record; making descriptive observations; creating a domain analysis; making a focused observation; generating a taxonomic analysis; making selective observations; producing a componential analysis; discovering cultural themes; making a cultural inventory; and writing an ethnography.

3.2. Setting

The study was carried out in the ED of a selected academic medical center (AMC) located in a large city in the northwest of Iran. The selected AMC is one of the largest and most well-equipped hospital in the region with 111,542 ED presentations in 2017. This was a 3% increase compared with the previous year. The ED is staffed by faculty emergency medicine (EM) attending physicians 24 h a day, together with EM-residents, residents from other specialties, senior medical students (Interns), nurses and nursing students. Routine challenges include prolonged throughput times and length of stay, overcrowding, boarding and some ambulance diversion. Different areas of our ED and its staffing and equipment are summarized in Table 1.

3.3. Participants and data collection

Purposive sampling was used to identify eligible participants from patients, their relatives, and the HCPs of this ED. Inclusion criteria was as follows; consent for study participation, staff who had worked in the ED as a HCP for a minimum of six months, ability to communicate in Azerbaijani or Persian.

The study was part of a nursing Ph.D. dissertation approved by the institutional review board (IRB) and the research ethics committee (ethics code: IR.TBZMED.REC.1396.260) of Tabriz University of Medical Sciences. The principal investigator (PI) was an emergency nurse who had practiced within the study setting for over five years,

both as a clinician and a clinical instructor. This enabled him to be familiar with the culture and layout of the setting and the staff involved as participants. The PI provided hospital officials, ED managers and potential participants with a brief explanation of the aims and procedures of the study and permission was obtained from hospital officials prior to collecting data. At the start of fieldwork, access negotiations commenced on an individual basis with identified gatekeepers by responding to their concerns honestly and remaining receptive to their suggestions for the study. Also, on-site notices announced particular information about the study two weeks prior to the commencement of data collection. Data were collected using the following methods over a 9-month study period from July 2017 to March 2018:

1. *Participant observations: of the place (environment), actors (participants), and activities (behaviors) in a cluster of social situations (ED areas):* The PI moved from "grand-tour" to "mini-tour" observations. As the words imply, "grand tour" observations were meant to be general in nature, to get a sense of the big picture (included descriptive observations). "Mini tour" observations, on the other hand, were meant to be more specific in order to obtain more detailed information (included focused and selective observations). Initially, 6 descriptive observations were conducted by the PI to investigate the major features of the social situations using the descriptive questions matrix, for example, what kinds of activities are occurring in the medical room? Subsequently, 12 focused observations (moved from "surface" to "in-depth" investigations) were carried out to study the cultural domains in association with waiting in ED, interactions among patients, their relatives and HCPs and the relationship of these domains with the rest of the cultural scene using the structured questions. For example, what are the causes of the activities occurred in the medical room? Finally, 18 selective observations were undertaken to look for differences among specific cultural categories using dyadic and triadic contrast questions, for example, what differences are evident in the participants' behaviors while waiting in ED? Observations lasted between 30 min and 3 h and were carried out on different days of the week and at different shift times.
2. *Ethnographic interviews:* Thirty-four informal ethnographic interviews were conducted during the course of participant observations in the field (lasting 3–5 min) and recorded through field notes. Afterwards, 13 face-to-face, in-depth, unstructured, formal ethnographic interviews were conducted by the PI to explore and discover the cultural meaning from culturally sensitive informants (two patients, four relatives, four nurses, and three physicians) following selective observations (lasting 45–60 min). The interviews began with general questions, including, "would you please describe your experience of waiting in ED to receive healthcare services?" More focused questions were then asked, including "what causes you to seek higher than a real priority in ED? And what are the main consequences of these behaviors?" Based on the participants' responses, probing questions were asked to obtain a full understanding. A digital voice recorder was used to record each formal interview and a separate consent was obtained from participants to record their responses.
3. *Document reviews:* Patient medical records, ED regulations, standards, instructions, manuals, and executive reports associated with ED patient flow, waiting, length of stay, discharge destination, and bed management were reviewed as part of data collection.

The data collected from these three methods were triangulated to strengthen the validity of findings and gain a deeper and more complex understanding of the subject matter. Data collection continued until data saturation was achieved. This was evident when no new data was obtained from further participant observations, ethnographic interviews, and document reviews.

Table 1
Areas within the ED, staffing and equipment.

ED areas	Staffing & Equipment (No. per each shift)									
	EM resident	EM intern	Nurse	Nursing assistant	Orderly	Security guard	Clerk	Cardiac monitoring device	Oxygen supplier	Number of Beds
Triage	–	–	1	–	1	–	–	1	–	1
Resuscitation	2	1	2	1	1	1	–	8	8	8
Medical	3	2	6	1	1	1	–	3	18	18
Major Trauma	1	1	2	1	1	1	–	2	12	12
Operating Room	1	–	1	–	1	–	–	2	2	4
Fast-Track	1	–	1	–	–	1	–	–	–	3
24-hour Pharmacy	–	–	–	–	–	–	2	–	–	–
Reception & Discharge	–	–	–	–	–	–	2	–	–	–
Billing & Payments	–	–	–	–	–	–	1	–	–	–
Patient Waiting Area	–	–	–	–	–	–	–	–	–	–

3.4. Translation

Since all the participants had native fluency in both the Azerbaijani and Persian languages, the data were collected in Persian to ensure consistency of meaning and transcribed verbatim into a typed document by the PI. The original transcriptions were independently translated into English by two researchers fluent in Azerbaijani, Persian and English which led to two forward translations. Afterwards, a reconciliation meeting was held to audit the forward translations in terms of their conceptual equivalence, comprehensibility, and clarity of speech relative to the original version. The reconciled English transcriptions were then back translated by two independent bilingual native English speakers with university degrees in Persian who had no access to the original English version. Eventually, the final translation version was validated by means of reviewing the entire forward and backward translation process [17,18]. All translators signed confidentiality agreements.

3.5. Data analysis

Transcribed data were read and re-read to obtain an overall understanding of primary themes. Seven hundred and eighty-six initial codes were generated using the participant's own words to label the data. The analysis was carried out at the same time as data were collected using an iterative-inductive process of the four fundamental tasks: "domain analysis," "taxonomic analysis," "component analysis," and "cultural theme analysis" whereby the PI moved back and forwards between idea, data collection, data analysis, and findings. MAXQDA 12 software was used to organize and manage the qualitative data and descriptive statistics were applied to summarize the characteristics of the participants using IBM SPSS software (version 25; SPSS, Chicago, IL).

3.6. Rigor

The following quality-enhancement strategies were applied during each phase of this study to establish Lincoln and Guba's (1985) criteria for trustworthiness (dependability, credibility, transferability, and confirmability). (1) Prolonged engagement and persistent observation by investing sufficient time in the field and focusing deeply on the characteristics and aspects of ED waiting culture; (2) Triangulation of data through multiple methods of data collection (participant observation, ethnographic interview, and using ED documents or cultural artefacts); (3) A thick description of research method and a comprehensive and vivid recording of field notes; (4) The PI's complete immersion with the data; (5) An evaluation of the soundness of research materials and study findings by other research team members (peer review), three study participants (member checking), and two independent experts (external audit); (6) Keeping all of the original material, including verbatim draft, field notes and data analysis records

safe for future verification and reference; and (7) Searching for negative or disconfirming cases, rival explanations, and diverse perspectives.

3.7. Ethical consideration

Ethical approval was obtained prior to conducting the study and each participant provided informed written consent prior to the selective observations and interviews and the IRB waived the requirement for the investigator to obtain written informed consent prior to the descriptive observations done in fully public spaces of the ED because of the infeasibility of observing waiting culture in a large number of participants without a waiver. Moreover, the study in its entirety involved no more than minimal risk to participants and the waiver did not adversely affect the participants' rights and welfare. The study conforms to the provisions of American Anthropological Association statement on ethics (Principles of Professional Responsibility) and the Federal Policy for the Protection of Human Subjects (Common Rule). To protect the privacy of individually identifiable information, all field notes, recordings, memos, and/or other primary data were anonymous and the confidentiality of the participants was ensured through the use of pseudonyms (numerical values) which did not disclose the participants' names or any personal information at all stages of research and reporting. The data were kept in locked/password protected files/e-files to which only the PI had access.

3.8. Limitations of the study

While this study demonstrated important elements of an ongoing cultural feature of waiting in an ED with real patients, in real circumstances, it had several limitations. First, this focused ethnographic study was conducted in a single ED of a large-sized AMC in Iran, which limits the generalizability of the findings and thus generalizations should be made with caution. Second, the unoccupied time became occupied during the informal field interviews undertaken immediately following each observation, altering the participants' perceptions of ED waiting. Furthermore, these field interviews were sometimes cut off or interrupted by others, leading to disrupted interactions that impeded or negatively influenced the interview process. It was also challenging to access some patients' relatives due to their aggressiveness. To combat this, we optimized data quality and ensured maximum data diversity making participant observations on different days of the week and times of the day, including night shifts and using formal interviews with the different social actors which allowed a broader and deeper understanding of the culture of waiting in our ED. Another limitation was the PI's insider role which might affect the depth of the study findings. We tackled this challenge and reduced the potential concerns by disciplined bracketing and detailed reflection on the subjective research process, with a close awareness of our personal biases and perspectives. While all care was taken to ensure participants' meanings were adequately relayed and their quotes were written verbatim, the authors

Table 2
Participants' characteristics.

Variables		Participants							
		Patient (n = 9)		Relative (n = 13)		Physician (n = 10)		Nurse (n = 15)	
		Number	(%)	Number	(%)	Number	(%)	Number	(%)
Gender	Female	5	55.6	3	23.1	2	20	10	66.7
	Male	4	44.4	10	76.9	8	80	5	33.3
Age	≤ 30	3	33.4	2	15.4	2	20	3	20
	31–40	2	22.2	6	46.1	4	40	8	53.3
	41–50	2	22.2	2	15.4	3	30	4	26.7
	≥ 51	2	22.2	3	23.1	1	10	–	–
Number of years in profession	≤ 5	–	–	–	–	4	40	2	13.3
	6–10	–	–	–	–	1	10	4	26.7
	11–15	–	–	–	–	2	20	5	33.3
	16–20	–	–	–	–	2	20	4	26.7
	≥ 21	–	–	–	–	1	10	–	–

acknowledge that some meanings may be slightly altered as a result of the forward and backward translation process.

4. Findings

4.1. Characteristics of study participants

Given the qualitative nature of this ethnographic study, 36 observations, particularly participant observations, and 47 ethnographic interviews, mainly informal, were carried out. Since the demographics of the observed participants were not accessed, the characteristics of the interviewed ones were only reported. This study included 47 participants (9 patients, 13 relatives, 4 EM attending physicians, 6 EM residents, and 15 nurses) in the final data set. Almost half of the participants were male (53.3%) with ages ranging from 24 to 62 years and the number of years in the profession ranging from 1 to 26 years. Other characteristics of the participants are presented in Table 2.

4.2. Main results

“Me first, others later” emerged as an overarching theme. Observation of participants' behaviors during their ED wait time, and description of their experiences, thoughts, beliefs, and feelings described an ongoing cultural feature of waiting in an Iranian ED. Furthermore, the contextual data revealed seven sub-themes, including “human-related factors,” “system-related factors,” “patients and their relatives' beliefs and behaviors,” “HCPs' beliefs and behaviors,” “consequences for patients and their relatives,” “consequences for HCPs,” and “consequences for ED environment and care process.” Table 3 presents the main theme, sub-themes, and primary concepts.

4.2.1. Human-related factors

According to field observations, many participants were unaware of the nature of their disease and unfamiliar with HCPs' roles and responsibilities, and healthcare system laws and regulations that lead to specific waiting times. For example, one doctor describes the following: “It happens all the times that the patients and/or their relatives ask me something related to nursing roles and responsibilities ... I never say: ‘this is not my duty and I don't do this.’ However, when I tell them politely to ask their nurses about that, most go through the roof and shout at me. Even some do not ask their nurses, (do) it themselves, and leave ED offensively.” (EM resident 1)

Patients and family at times do not understand the need to wait for treatment. For example, another participant who is an ED nurse stated: “Daily, I argue with many relatives on their patients' non-critical, non-acute medical condition and the necessity of going to the fast-track area or even outpatient clinic to receive care, while they insist on higher priority and want

to go to the ED acute areas.” (Triage nurse 1)

Some participants described a negative, pessimistic attitude toward the healthcare system. One observation during the data collection period saw a patient's relative argue with the HCPs, throw his patient's record at one of the EM residents and leave the ED to go to a private hospital. The families' experience of this situation is described as follows: “Early in the morning, the son transported to this ED by EMS ambulance following a car accident. When my family and I came here, we found him neglected. We faced a delay longer than 24 h and now, still waiting for ED discharge. Once you take your patient to this system, you are in hot water. You yourself should take care of your patient because nobody will help him even if he dies...” (Patient's relative 1)

A number of participants were concerned only about getting what they wanted or needed and not caring about what happened to other people. This inability to see the needs of others was a strong theme and described as self-seeking behavior. For example, the following interaction takes place during the resuscitation of an unrelated patient in cardiac arrest:

Patient's relative (with a harsh tone): “Hey, where should we go to inject these medications?”

Senior nursing staff (in a hurry): “Go to fast-track”

Patient's relative: “I went, nobody was there.”

Senior nursing staff: “If so, you should wait about 15 min or more because we are carrying out resuscitation on a seriously ill patient”

Patient's relative (giving a loud shout-out): “I don't care how seriously sick he is. I'm here for an hour and my patient has a serious medical condition, too”

Senior nursing staff (After seeing the 27-year old female patient and checking the prescription): “Routine treatment for an acute pharyngitis! ... You said, your patient is seriously sick! Do you really think these symptoms need emergency attention?”

Many of priority-seeking expressions, vocalizations, postures and movements of the participants directly triggered similar emotions and related behaviors in others. This was verified by the PI as emotional contagion of priority-seeking behaviors. One of the ED nurses clarified: “Unfortunately, when a patient and/or a relative shouts violently at HCPs to receive higher priority, others started to act similarly.” (ED nurse 4)

Many of the participants talked about a feeling of uncertainty and impending crisis which connected to the completely unscheduled and unpredictable nature of Emergency Departments. One resident stated the following: “Sometimes, the delivery of several trauma patients by EMS at the same time led to a traffic jam of patients within ED and much longer waiting times ... meanwhile, some of the patients and their relatives believe if they don't catch the treatment timely, they have to wait for hours.” (EM resident 2)

Table 3
The main theme, sub-themes, and primary concepts.

Main Theme	Sub-themes	Primary concepts
Me first, others later	Human-related factors	Lack of awareness and familiarity Distrust and pessimistic attitudes toward a healthcare system Being overly self-seeking Emotional contagion of seeking priority Perceived uncertainty
	System-related factors	Failure in orienting patients Lack of responsiveness Inefficient patient flow system and overcrowding Insufficient medical equipment Shortages of HCPs
	Patients and their relatives' beliefs and behaviors	Poor quality of hoteling services Preference of personal values over other patients' Bogus symptoms, exaggeration and malingering to obtain urgent care Inconsiderate behaviors, inconsistent with the nature of the ED environment Proactive and reactive aggression and/or violence
	HCPs' beliefs and behaviors	Preference of personal values over others' Poor inter- and intra-professional collaboration Inter- and intra-professional task interference
	Consequences for patients and their relatives	Unmet actual expectations and appropriate requests Dissatisfaction, complaining, and violence Left without being seen and/or discharge against medical advice
	Consequences for HCPs	Abandoned supportless (helpless) in cases without any relatives A 'first come, first served' queuing Disrupted concentration Exhaustion
	Consequences for ED environment and care process	Verbal confrontation and reactive aggression Distrust toward legitimate requests of the really urgent patients Apathy toward insistent behaviors Imposed procrastination and clinical negligence Tumultuous atmosphere Fragile security situations Unfair distribution of medical equipment and welfare facilities A delayed recognition and response for the really urgent patients Reduced quality and safety of patient care

4.2.2. System-related factors

A majority of ED patients and their relatives experience a high level of anxiety and distress with regards to their medical condition and the unfamiliar environment. They also feel they are unheard as they request clinical information or express their frustration often without response. Moreover, the HCPs and ED officials also have a sense of an unfamiliar environment due to a lack of orientation programs: *"Here, I don't know what to do? Where to go? And from whom to seek medical assistance? ... It's challenging for me to find my way through ED treatment areas which resembled a confusing maze ... I've been asking them [the HCPs] for help many times since last night, but no one answered me as if they didn't hear me at all!"* (Patient 2)

The study site is challenged with an inefficient patient flow system, which appeared to contribute to the participants' frustration with waiting. Insufficient medical equipment and understaffing further escalated the problem especially during the peak hours and led to long and tedious waiting. For example, one of the hospital supervisors stated the following: *"Our ED is really understaffed. Last night, in our major trauma area, we had 28 patients while our team consisted of only 1 EM resident, 1 medical student, and 2 nurses ... Also, we do not have enough medical equipment for the majority of our patients."* (ED supervisor 1)

Other services were lacking and this contributed to patient and relative frustration. A patient's relative points this out: *"Just turn back and look around the ED to see many things make waiting difficult for us: a totally insufficient number of chairs for seating, the dirty and broken water cooler without any glasses, poor sanitary condition in toilets with their unpleasant smell felt inside treatment areas, unbearable heat, the loud and annoying sound of floor scrubber machine, and dull lighting ..."* (Patient's relative 4)

4.2.3. Patients and their relatives' beliefs and behaviors

Our field observations indicated that the majority of patients and their relatives, most of the time, preferred their personal needs and

desires over others'. Often, they would not tell the truth and exaggerate their symptoms. One of the EM residents shared her experience as follows: *"This patient with asthma exacerbation needs to receive oxygen, not by a mask connected to a portable O₂ cylinder, but via CPAP which is in the next patient room (PI observed the machine is free, but non-portable). When I asked for changing the rooms, the relative of non-urgent patient argued with me and told me, it is not my business* (EM resident 2)

A number of the participants stated that at times, they became annoyed and nervous with some of the rule breakers' inconsiderate behaviors, showing a lack of concern and respect for the rights and feelings of anyone else, which were totally inconsistent with the nature of the ED environment. *"It's hard to imagine, but they often go to the head of the line, walk around unnecessarily in the ED hallways, talking so loudly on their cell phone, takes up more space, step on others toes, and don't worry about hurting, embarrassing or inconveniencing anyone else, as if they are not in the hospital ED!"* (EM attending physician 2)

Some participants talked about experiencing both proactive (characterized by an absence of provocation) and reactive (defined as a defense mechanism against a perceived provocation or threat) aggression and/or violence. One described: *"Once I argued with one of the relatives. I told him about his patient's non-urgent condition and the necessity of going to the outpatient clinic. He suddenly shouted at me loudly and I was extremely scared. His voice was in my ear for several months."* (EM resident 3)

Also, a male ED nurse talked about his experiences as follows: *"Last year, when I asked the relative to stay out of the ED Resuscitation area, he pushed me away, hit me on my face and broke my nose."* (ED nurse 7)

4.2.4. HCPs' beliefs and behaviors

HCPs beliefs, behaviors and interactions shaped the ongoing culture of ED waiting. During our field observations, we observed HCPs choosing to act for themselves rather than the patients and their relatives or their colleagues and organizational expectations. As a nurse

and a relative stated: *"I'm sick and tired of calling my colleagues back to the ED treatment areas. They always invent a series of excuses (eating, praying, or any other thing) to walk out of the ED even at peak times, ... At times, the ED secretary also shirks from her duties and I have to enter medical orders into the computer electronically instead ..."* (ED nurse 5) *"Just look at that EM resident plays with her mobile phone. I have asked her 3 times to put her mobile phone away and visit my Mom, but she doesn't care about"* (Patient's relative 12)

Some HCPs had a strong sense of working with their own tasks and not performing a task outside of their own. Sometimes this disrupted the inter- and intra-professional interactions and collaborations and led to conflicts: *"... Sometimes when a nurse presents to the patient's bedside, finds the patient transferred to the imaging without his/her coordination or supervision ... ED housekeeper sweeps the floor and cleans the environment at the same time with the presence of patients and the provision of health care services ..."* (ED Supervisor 2).

"Yesterday, when my IV solution was over, I asked an EM Intern on my bedside to stop it. Neither had she closed the roller clamp on the IV infusion set, nor did she turn off the EID. 'Ask your nurse!' she said to me angrily." (Patient 7)

4.2.5. Consequences for patients and their relatives

The consequences of putting personal needs and desires first with a complete disregard for others' and acting accordingly, were common in the ED and could be traced to many of the behaviors the participants exhibited. Patients and their relatives' expectations may remain largely unmet for the sake of the beliefs and behaviors in conjunction with the study's main theme, "Me first, others later." Such conditions often led to the patients and their relatives' dissatisfaction, complaints, and even violent acts. In addition, many of the patients might leave the ED without being seen or be discharged against medical advice (a DAMA rate of 13%): *"Today, non-urgent patients impede timely care delivery for urgent patients ... The aggressive demand for taking precedence over others contribute inappropriate utilization of ED resources, extended workflows and long delays for patients with urgent conditions ... They might take out their dissatisfaction by lashing out at HCPs, ... Some made a dash out of the ED even without completing their treatment (EM attending physician 1)"*

Field observations shed light on difficulties patients experienced when they came to the ED alone, since the relatives' presence and drudgery at the bedside were a major part of patient care in many cases. A patient described his feeling of waiting alone in ED: *"Here, no one really cares about you. It's harsh, but true, I felt utterly abandoned and supportless."* (Patient 5)

4.2.6. Consequences for HCPs

Field observations indicated that the participants' beliefs and behaviors on how deserving they were of receiving higher priority over others led to some negative consequences for HCPs. The HCPs often provide emergency care based on a 'first-come, first-served' rule in each of the ED treatment areas regardless of the primary ESI triage, as confirmed by one of the EM residents: *"When a patient waits for a long time and finds other patients who came later, visited without considering how urgent their medical condition may be, he/she struggles to be visited immediately in any way and may commit violent acts due to their sense of injustice. To combat this, we often adopt a hassle-free 'first come, first served' approach in each of the ED treatment areas after the primary triage (EM resident 4)"*

The majority of HCPs expressed their concern that the self-seeking beliefs and insistent behaviors of the patients, their relatives, and colleagues disrupted their concentration and led them to feel exhausted emotionally and physically. At times HCPs engaged verbal confrontation and reactive aggression with one another as a means of venting this frustration and exhaustion. One ED nurse recounted her experience: *"One night, I got into a verbal confrontation with one of the relatives. I was so irritated and I had a hard time to focus on my job which led me to incorrectly triage a patient. I was lucky that my colleagues were alert enough*

to recognize that patient's possibly life-threatening condition (Triage nurse 2)"

ED staff also stated that such behaviors caused a general feeling of distrust and apathy toward even legitimate requests from urgent patients and might lead to clinical negligence and procrastination. For example: *"When I ask them to wait until I've finished my work with a patient, they still insist on their exaggerated demands unreasonably. To avoid any possible conflict and serious event, 'Okay, let's go,' I just say but do nothing (ED nurse 3)"*

4.2.7. Consequences for ED environment and care processes

A noisy, confusing and chaotic ED environment was one of the consequences which raised from all those contextual beliefs and behaviors demonstrated by the patients, their relatives and the HCPs. This tumultuous atmosphere might increase the potential for a fragile security situation, as expressed: *"Last night, we lived such an unstable and daunting shift leaving us no choice except calling the police. It wasn't easy even for the police officers to control that dicey situation. Further, one of them stayed at our ED patrolling the treatment areas until morning (ED Supervisor 1)"*

These challenging conditions might negatively influence the process and quality of healthcare provision and lead to prolonged ED time, delayed recognition and response for urgent patients, and unfair distribution of medical equipment. For example: *"How you expect the ED care to be quality and safe when these rough situations affect me physically, mentally and emotionally and make me feel disappointed, exhausted, and insecure at work ... After all, I'm a human being, not a robot (ED nurse 9)"*

5. Discussion

This focused ethnographic study provides valuable insight into the backstage of waiting culture within Iranian E.Ds. Seven sub-themes supported the overarching theme, the mentality 'Me first, others later.' In our context of practice, the majority of patients and/or their relatives lacked appropriate knowledge on the nature of ED services and emergency situations. They also perpetuated some misconception and misunderstanding about HCPs' roles and responsibilities. On the other hand, the ED failed to provide timely and adequate information for patients and their relatives. Similarly, a recent qualitative study in Australia showed that relatives perceived that providing adequate information was frequently absent within EDs, leaving both the patients and their relatives feeling lost and uncertain during their waiting, with no explanation as to why this was so [19]. In another study in Sweden, the majority of patients declared that they were given very limited and largely unsatisfactory information about the expected waiting time upon their ED arrival [20].

HCPs believed that their failure to respond to many of the questions and requests put to them by the patients and relatives stemmed from: ED overcrowding; understaffing; heavy workloads; employees' exhaustion; and the patients and/or their relatives' inconsistent behaviors [21]. Individually and collectively, these factors are challenging for HCPs and can interfere with the timeliness and quality of ED care, negatively impact all involved satisfaction, and lead to an increased error rate in ED setting [22]. As reported by an Australian study, HCPs want relatives to behave in an appropriate manner and to seek information, but also not to be too demanding so as the patient's rights are infringed upon [23].

Many patients and their relatives in the current study reported they felt that their previous negative experiences, unmet expectations, uncertainty about continuity of care, and distrust toward the responsiveness of HCPs and healthcare system impacted their behavior and feelings. Accordingly, our HCPs should provide care focusing on persons, not conditions [24] and develop a mutually beneficial partnership among patients, relatives, and HCPs [25].

Another problematic issue is the self-seeking behaviors of patients and their relatives in utilizing ED care and amenities with a seemingly disregard for other people's opinions, value, or presence and the self-

seeking behaviors of HCPs' in showing a lack of concern for the rights and feelings of their colleagues and/or patients and their relatives. Such behaviors are not conducive to the ongoing processes of ED care delivery and strenuously undermines our positive practice environment. A study conducted in Iran, found that the HCPs' relentless pursuit of self-seeking behaviors deemed incredibly annoying by their colleagues, lead to social disconnection and interpersonal hostility and aggression in ED [26]. To effectively shift the attitudes and behaviors away from self-seeking manner, special consideration should be given to the patients, their relatives, and HCPs' culture, race, religion, social background and ethnicity for it may affect their values and preferences [27,28]. Further to this, the healthcare facilities should proactively develop guidelines for addressing these cultural conflicts along with providing culturally competent ED care [29] and there must be an ability for all involved to adapt to 'the rules of the game' [30].

Moreover, more effort is required to reconcile these discrepancies and inconsistencies to pave the way forward in Iran and similar settings. Vital to this effort is to use a clearly-delineated process to establish transparency in ED care delivery and thereby dispel the atmosphere of distrust and misunderstanding by elucidating 'who received ED care earlier, and why?' [2]. For example, some EDs used computerized whiteboards to provide rapid access to more detailed information [22], as well as displaying online waiting times of the entire local EDs via billboards in the hospital entrance to publicly notify patients and their relatives of the long waiting times and offer an alternative ED nearby with a shorter waiting time, especially for lower acuity patients [31]. These solutions seem to be practical in our context of practice and may decompress our overburdened ED and smooth the 'peaks and valleys' in ED volume that occur throughout the day.

Another avenue to consider an accountable patient/relative support liaison and also a dedicated 'ask me' desk in the ED at all times, preferably one of the knowledgeable, experienced and senior team members, to meet the patients and relatives' needs, expectations and answer questions and concerns through respectful deliberation, negotiation, and compromise. This may help to de-escalate any potentially aggressive or confrontational events [32,33]. Furthermore, along with a need for an integrated multidisciplinary approach and adding culture outreach specialists to our current team, it is necessary to correct public attitude, misconception, and belief without credence about the nature of ED care to curb ED overuse. The ED awareness programs by the mass media and public 'where for care' campaigns should stress the importance of 'where the patients go for medical care can affect how much they pay, how long they wait and the type of treatment they receive,' while both our primary care and urgent care facilities are clearly underutilized by patients and their relatives.

We also observed a high rate of DAMA (13%) of which, most of them were non-urgent patients who failed to receive ED care sooner than others and their expectations remained largely unmet, despite their insistence, bogus symptoms, aggression and/or violence. This negative consequence puts them at increased risk of adverse clinical outcomes. Likewise, a prior study in Iran reported the overall DAMA rate of 8.8% [34]. A recent systematic review and meta-analysis estimated the rate of DAMA from the Iran hospital EDs at 11.8% [35]. In contrast, in an earlier study conducted in US hospital EDs, the rate of DAMA was reported about 0.1 to 2.7% [36]. Thus, available evidence suggests that DAMA rate in developing countries and in Iran, in particular, is much higher than in developed countries [34]. Although DAMA depends on the country and the culture of the patients, which makes it hard to compare rates cross-nationally [37], these cultural differences between Iran and Western countries should be taken into consideration in clinical practice and future research in the related areas of immigrant Iranians and their relatives in this situation.

6. Conclusion

In conclusion, the mentality 'Me first, others later' was the main

cultural barrier to timely emergency care both on macro and micro levels that may affect not only the patients and their relatives, but also the healthcare professionals, healthcare system and healthcare quality. Since what is driving the majority of patients and their relatives with low-acuity conditions, and even non-urgent ones, to insist on receiving higher priority and earlier emergency or urgency care regardless of the ED's set of priorities and other patients' much more urgent conditions, stem from their misconception and misunderstanding of the field of ED care and is mostly unconscious and out of their awareness, much needed to address and modify their beliefs and behaviors. Our findings provide valuable insight into the perceived benefits of an accountable patient/relative support liaison and also a dedicated 'ask me' desk in the ED at all times, a clearly-delineated process in ED care delivery, guidelines for providing culturally competent ED care, and the concerns, conflict, and unprofessional behaviors that need to be addressed through education and ED awareness programs. Also, further research is recommended to explore the other cultural aspect of the EDs.

Authors' contribution

HH, AS, SSV, FAM: original concept and study design; AS: data collection; AS: data analysis and interpretation; AS, HH, SSV, LAW, TW: manuscript preparation and final critique; HH, SSV: study supervision.

Declaration of Competing Interest

There is no conflict of interest in this study.

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