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OnlineFirst Version of Record - Nov 12, 2010

What is This?

Access to Primary Care From the Perspective of Aboriginal Patients at an Urban Emergency Department

Annette J. Browne,[1] Victoria L. Smye,[1] Patricia Rodney,[1] Sannie Y. Tang,[2] Bill Mussell,[3] and John O'Neil[4]

Abstract

In this article, we discuss findings from an ethnographic study in which we explored experiences of access to primary care services from the perspective of Aboriginal people seeking care at an emergency department (ED) located in a large Canadian city. Data were collected over 20 months of immersion in the ED, and included participant observation and in-depth interviews with 44 patients triaged as stable and nonurgent, most of whom were living in poverty and residing in the inner city. Three themes in the findings are discussed: (a) anticipating providers' assumptions; (b) seeking help for chronic pain; and (c) use of the ED as a reflection of social suffering. Implications of these findings are discussed in relation to the role of the ED as well as the broader primary care sector in responding to the needs of patients affected by poverty, racialization, and other forms of disadvantage.

Keywords

Aboriginal people, North America; emergency care; health care disparities; health care, access to; health care, primary; health care, users' experiences; postcolonial theory; vulnerable populations

Despite the commitment to provide universal access to high quality primary care,[1] access inequities remain a pressing national concern in Canada. Research continues to demonstrate that people who experience particular clusters of vulnerabilities are more likely than others to become ill, and are less likely to receive appropriate health care services; for example, significant proportions of the Aboriginal population,[2] people living in poverty, women experiencing abuse, and people with mental illness or addictions, among others (Adelson, 2005; Raphael, 2007). In Canada, persistent inequities in health status and access to primary care for Aboriginal people represent serious concerns (Adelson; Canadian Institute for Health Information, 2004; Frohlich, Ross, & Richmond, 2006; Health Council of Canada, 2008; O'Neil, 1989).

Access to primary care in urban centers is of particular concern given the increasing number of Aboriginal people living in Canadian cities (Newhouse & Peters, 2003; Statistics Canada, 2008). In 2006, 60% of people identifying as First Nations on the Canadian census reported living off-reserve, and among those, 76% resided in urban settings (Statistics Canada, 2008). For many, moving from rural communities to large urban centers represents the possibility of increased educational or economic opportunities (Peters, 2004). However, in cities, as in other parts of Canada, many Aboriginal people continue to experience poverty, lack of employment, racialization,[3] discrimination, and social exclusion (Browne, McDonald, & Elliott, 2009; Newhouse & Peters). As a result, Aboriginal people are often more likely to live in low income and inner city neighborhoods. These social dynamics and economic realities have significant effects on health status. For example, in 2006, Winnipeg, Manitoba had the largest proportion of Aboriginal people (10% of the total city population) among all of the major Canadian cities. Data from 1995 to 1999, however, showed that life expectancy at birth for registered First Nations people residing in Winnipeg compared to all other Manitobans was 10.2 years less for women and 9.6 years less for men (Martens, Sanderson, & Jebamani, 2005). In Vancouver, the site of one of Canada's poorest neighborhoods, the average life

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expectancy for status First Nations people compared with other residents was 13.3 years less for women and 11.7 years less for men between 1992 and 2002 (Cardinal & Adin, 2005). Rates of homelessness among Aboriginal people in several major cities are increasing dramatically because of growing levels of poverty, cutbacks to social assistance and programs, "deinstitutionalization" of people living with serious mental health issues, and the lack of affordable housing (Canadian Institute for Health Information, 2007). HIV rates among Aboriginal people in urban centers have also risen dramatically, with Aboriginal women experiencing the highest rates of infection (McCall, Browne, & Reimer Kirkham, 2009; Pearce et al., 2008). Inequities in health and social status stem from long-standing, historically mediated disadvantages such as systemic racism and discrimination, the intergenerational effects of residential schools, welfare colonialism, and economic marginalization (Adelson, 2005; Frohlich et al., 2006; Warry, 2007).

Research shows that residential schools have had particularly deleterious effects on the health and mental health of large numbers of Aboriginal people (Brant Castellano, 2006; Haskell & Randall, 2009; Waldram, Herring, & Young, 2006). Between the 1800s and 1990s, more than 130 government-funded, church-run industrial schools, boarding schools, and northern hostels operated in Canada with the explicit mandate to indoctrinate Aboriginal children into the dominant culture. Aboriginal leaders, community members, and researchers concur that the collective and intergenerational exposure of Aboriginal people to forced assimilation policies and systemic discrimination are among the root causes of poor health, mental health, and social outcomes (Kirmayer et al., 2007). Historical trauma in concert with high rates of poverty and dislocation from one's family and community have also been linked to higher rates of substance use, addictions, mental health problems, HIV and AIDS, interpersonal violence, and an overall pattern of social suffering (Brant Castellano; Pearce et al., 2008). Social suffering was conceptualized by Kleinman, Das, and Lock as resulting from the ways that social, economic, and political power and related inequities shape human experiences, and how these forms of power shape responses to social suffering. For example, "trauma, pain and disorders . . . are health conditions; yet they are also political and cultural matters" (1997, p. ix).

In this article, the term *marginalized* is used to emphasize that marginalization is entrenched in the history of relations between Aboriginal people and the nation–state, and has resulted in social and structural inequities, and a disproportionate burden of ill health and social suffering. These inequities cannot be glossed over as lifestyle, behavioral, or cultural issues; rather, they are manifestations of the complex interplay of social, political,

and economic determinants that influence health status and access to health care. Health status for Aboriginal people is also shaped by long-standing inequities in access to health care (Peiris, Brown, & Cass, 2008). Research continues to show that tacit and sometimes overt discriminatory practices and policies in health care create barriers to accessing services (Adelson, 2005; Bourassa, McKay-McNabb, & Hampton, 2004; Browne, 2007; McCall et al., 2009). Therefore, when analyzing access to primary care services for Aboriginal people, it is important to examine the intersections between micro-level interactions operating at the level of clinical practice, and wider social and historical contexts that shape health care relations and access to services. In this article, we discuss findings from an ethnographic study in which we explored experiences of access to primary care services from the perspective of Aboriginal people seeking help for health issues triaged as "stable and nonurgent" at an emergency department (ED) located in a large city in Western Canada.

Use of the Emergency Department for Primary Care Issues

Although EDs are not typically designed as primary care access sites, an increasing number of people in Canada are using EDs for primary care issues triaged as stable and nonurgent (Canadian Institute for Health Information, 2005a, 2005b, 2005c; Han, Ospina, Blitz, Strome, & Rowe, 2007). In part, this is because of health care reforms that have resulted in a diminishing number of general practice physicians (Health Council of Canada, 2008). Nonurgent use of the ED for primary care issues that could, ostensibly, be treated in community or walk-in clinics accounts for an estimated 33% to 55% of all ED visits (Canadian Institute for Health Information, 2005b). From a health systems perspective, nonurgent use of the ED is often constructed as a misuse of a specialized set of services; however, for vulnerable and socially disadvantaged populations, EDs can serve as an important safety net (Bernstein, 2006; Ionescu-Ittu et al., 2007; Malone, 1998; Ragin et al., 2005; Richardson & Hwang, 2001). Studies continue to show that factors associated with nonurgent use of the ED include poverty, homelessness, transience, lack of a regular primary care provider, and social factors related to lack of support, marginalization, loneliness, and extreme social and psychological distress (Bernstein; Dunlop, Coyte, & McIsaac, 2000; Geller, Janson, McGovern, & Valdini, 1999; Koziol-McLain, Price, Weiss, Quinn, & Honigman, 2000; Lowe et al., 2005; Mandelberg, Kuhn, & Kohn, 2000; Padgett & Brodsky, 1992). Nonurgent use of the

ED is also understood to be a function of patients' prior and ongoing health care experiences in other settings (Bernstein; Malone). Patients who are unsatisfied or feel uncomfortable with community-based services, or who perceive barriers to health care elsewhere, are more likely to seek help at the ED for nonurgent concerns (Mustard, Kozyrskyj, Barer, & Sheps, 1998; Sarver, Cydulka, & Baker, 2002). Because the ED often serves as a safety net for patients receiving inadequate primary care, exploring the perspective of patients who seek help at the ED can provide important insights about access to primary care services (Ionescu-Ittu et al.).

Access Inequities for Aboriginal People

In Canada, inequities in access to health care and outcomes for Aboriginal people are well documented at a population health level (Canadian Institute for Health Information, 2004; Peiris et al., 2008). For example, population level data show that status First Nations people in urban areas use fewer community-based primary care services and have consistently higher "preventable hospital admissions" (if patients had access to quality primary care in the community) compared to other resident populations (British Columbia Provincial Health Officer, 2009). In British Columbia, for example, the age-standardized mortality rate (ASMR) for "medically treatable diseases" (meaning those for which mortality could potentially have been avoided through appropriate and timely health care intervention) has fluctuated between 2 and 5 times higher for the status First Nations population compared to other residents—rates that "more than likely reflect gaps in access to primary care services" (p. 108). These proxy measures signal challenges with access to primary care services; however, there remains a gap in knowledge concerning the social and contextual factors influencing access, particularly from the perspective of Aboriginal people living in urban areas. As Peiris et al. (2008) argued, "Indigenous perspectives on access barriers are poorly represented and undervalued in the scientific literature" (p. 985). We sought to address this gap by exploring the perspectives of Aboriginal people seeking services at an urban ED for health issues triaged as stable and nonurgent, which could, theoretically, be addressed in other community-based primary care settings. Our analysis is not intended to imply that Aboriginal people are inappropriately using the ED, or that it is only Aboriginal people seeking primary care services in the ED. Rather, as we discuss, the factors that shape people's access to primary care services, and their use of the ED, cannot be separated from the social contexts of their lives; these have implications for how primary care services are used and structured.

Overview of the Study

The decision to focus on access to primary care from the perspective of patients coming to an urban ED was generated through a series of dialogues with Aboriginal health care leaders and health care providers working at the ED and in local primary care clinics. An Aboriginal community advisory committee comprised of people who represented patients, primary care service providers, members of Aboriginal health organizations, and interested community members also provided guidance throughout the study. The study presented here therefore represents a collaborative research endeavor among university researchers and community-based leaders in Aboriginal health, which was guided by guidelines for ethical research with Aboriginal people (Canadian Institutes of Health Research, 2007; Schnarch, 2004).

Theoretical Perspectives Informing the Study

This research was informed by postcolonial theoretical perspectives. Postcolonial theories can be defined as an interdisciplinary family of theories that share a common concern about the legacy of colonialism, and how this continues to shape people's lives, experiences, and life opportunities (Young, 2001). Recently, postcolonial theories have been introduced into the realm of health research as a framework for understanding how various forms of inequities are organized along axes of race, class, and gender, and how people's individual and collective histories shape present-day experiences and new forms of inequities (Anderson et al., 2003; Browne, Smye, & Varcoe, 2005, 2007; Reimer Kirkham & Anderson, 2002).

Postcolonial perspectives are particularly applicable to research addressing health and health care involving Aboriginal people because they help to explain how and why colonialism continues to influence the social and economic contexts of people's lives, access to resources for health, and everyday social experiences (Browne et al., 2005; McConaghy, 2000). Aboriginal scholars and researchers who draw on postcolonial perspectives emphasize the need to reclaim and reposition indigenous voices, knowledge, and analyses, and the importance of including the perspectives of people who have been marginalized as a result of social, historical, and structural inequities (Battiste, 2000; LaRocque, 1996). Given the extent to which health and access to health care for Aboriginal people has been shaped by social relations rooted in Canada's colonial history (O'Neil, 1989), these perspectives are particularly relevant to the research discussed in this article.

Integral to postcolonial theorizing as applied in our programs of research is the notion of intersectional analyses.

From an intersectional perspective, social phenomena and categories such as racial status, poverty, gender, or substance use are understood as mutually constructed and interdependent (Varcoe, Hankivsky, & Morrow, 2007). For example, experiences of racialization or poverty are not merely "added" forms of oppression for Aboriginal people. Rather, being subject to racism compounds poverty and experiences of social exclusion—processes by which individuals are denied opportunities to participate in aspects of social, economic, cultural, or political life (Galabuzi, 2004). Social exclusion, poverty, and discrimination intersect to create risks for substance use and other risks to health (Reid, 2007). From a postcolonial perspective, these various forms of inequity and oppression cannot be analyzed as purely separate entities; rather, they are mutually reinforcing and interacting.

Setting and Participants

The setting for this study was an ED located in a large teaching hospital in a Western Canadian city.[4] At this ED, patients triaged as stable and nonurgent (according to standardized triage protocols) were cared for in the nonurgent division within the larger ED. As described below, the patients invited to participate in this study were those who attended the nonurgent division of the ED. Although the study was conducted in the ED, the patients we interviewed discussed their experiences accessing health care at the ED and other primary care sites, including other EDs, walk-in clinics, community clinics, and physicians' offices. The interviews with patients therefore informed an analysis of access to primary care in the context of patients' wider health care experiences.

This ED was located in close proximity to an inner city neighborhood characterized by very high levels of poverty and unemployment; lack of affordable housing; people living in poorly maintained, single-room occupancy hotels; and high rates of homelessness. As an outcome of these social conditions, there were also high rates of substance use and addictions, mental health problems, violence and trauma, and related health problems; many of the people residing in this neighborhood experienced social and economic marginalization. One salient demographic feature was the high proportion of Aboriginal people who lived in this neighborhood, often because other areas of the city were unaffordable. Reflecting this demographic, the majority of participants in this study were living in poverty, with many residing in single-room occupancy hotels, social housing, or shelters. Most lived on meager social welfare or disability payments, or had no income, and many struggled with substance use problems. What was particularly striking was the extent to which the Aboriginal participants' lives and health issues were shaped by intersecting issues of trauma, violence, and disconnection from their families and communities.

The most common health issues that both Aboriginal and non-Aboriginal participants sought help for included chronic pain symptoms, musculoskeletal injuries (mostly soft tissue injuries such as sprains, vs. fractures), and treatment for abscesses and cellulitis. Examples of other reasons for seeking care among the Aboriginal participants included postoperative abdominal pain, treatment for post-HIV exposure, and headache. Proportionally more non-Aboriginal people were in the ED for intravenous antibiotic treatment. Although these were the presenting medical diagnoses, during the course of the research interviews, participants typically discussed their health concerns in relation to their personal and social circumstances. The health issues that people sought help for, and their experiences accessing health care, were thus inextricably tied to their social, economic, and historical circumstances.

The patients who participated in this study (*n* = 44) included 25 men, 18 women, and one transgendered person (age range 20 to 62 years). Of the 44 patients, 34 self-identified as Aboriginal (62% were status First Nations, 26% nonstatus, and 12% Métis), and 10 self-identified as Euro-Canadian. The inclusion of a theoretical sample of non-Aboriginal patients reflected the emerging and flexible nature of ethnographic studies. Originally, the study was designed to include only Aboriginal patients. As data collection and analysis proceeded, however, the members of our research team and the Aboriginal community advisory committee realized that there was a need to explore how health care experiences are variously shaped by people's differing ethnocultural and social locations. Thus, a sample of non-Aboriginal participants who were from the inner city neighborhood and had similar socioeconomic profiles to the Aboriginal participants were recruited. For example, there were equal proportions of men and women in both groups of participants, and both groups were of the same average age (42 years). Among the Aboriginal participants, 32% reported completing high school, compared to 30% among the non-Aboriginal participants. People in both groups experienced high rates of unemployment: 74% among the Aboriginal participants and 70% among the non-Aboriginal participants.

Data Collection

Using an ethnographic design, data were collected over a 20-month period of immersion in the ED and involved (a) individual in-depth interviews with 44 patients triaged as stable and nonurgent; (b) individual in-depth interviews with 38 ED staff, including nurses, doctors,

social workers, and admitting clerks; and (c) participant observation in the ED to observe clinical encounters between patients and staff, and the general ED environment, which provided important contextual information. To limit the scope of this article, the analysis we discuss draws primarily on interviews with patients who identified as Aboriginal. We reported on other aspects of the findings elsewhere (Tang & Browne, 2008).

Purposive sampling was used to recruit patients who were triaged in the ED as stable and nonurgent, and data were collected in the nonurgent division during daytime and evening hours. The majority of interviews with patients were conducted by three First Nations researchers who were experienced at in-depth interviewing. Patients were interviewed in unoccupied clinic rooms in the nonurgent division of the ED either while waiting to be seen by a health care provider or immediately after. In all cases, written informed consent was obtained prior to interviews or observations. To understand the patients' experiences of accessing health care within the particular contexts of their lives, interviews lasting 30 to 60 minutes were focused on the patients' current and past experiences at the ED; their experiences seeking primary care elsewhere; and their decision to seek help at the ED. An open-ended interview guide was developed and refined with input from the Aboriginal advisory committee members, and further refinements were made after pilot testing the guide with several patients. Broad, open-ended questions were posed, followed by more specific open-ended queries to explore issues raised by participants in more depth. Examples of questions and probes included: Tell me what brought you here today? Where do you usually go for health care? Have you come to this ED before? How has it been for you to get the care you feel you need? Six patients also participated in second interviews, which provided an opportunity to clarify and expand on discussion points. Second interviews were challenging to organize, however, because many of the participants lived in temporary or transitional housing, and people moved frequently.

Data Analysis

An interpretive thematic analysis was conducted using procedures for qualitatively derived data (Thorne, 2008). Interview transcripts and observational notes were repeatedly read by the members of the investigative team to identify recurring and contradictory patterns in the data, and possible linkages to theoretical perspectives. NVivo, a qualitative computer software package (QSR International, 2002), was used to organize and code the narrative data. As more data were collected and analyzed, coding categories were refined, and in the final stages, the analysis shifted to a more abstract and conceptual representation of the ideas and themes expressed through the data.

Credibility of the analysis was continually evaluated and discussed with the members of our research team, which included leaders and experts in Aboriginal health, ED clinicians, and health care administrators in primary care, as well as university-based researchers. Triangulation of patient, staff, and observational data contributed to the rigor and trustworthiness of the analysis (Thorne, 2008). To validate credibility of the analytical insights derived through the particular interpretive lens of the research team, the researchers regularly discussed the emerging themes with different groups of stakeholders, including the Aboriginal community advisory committee, clinical practice leaders in the participating ED, and Aboriginal and non-Aboriginal staff and patients at primary care access clinics in the inner city. These stakeholders concurred that the themes reflected in the data resonated with their experiences and their interpretations of those experiences. Throughout, an audit trail of analytical insights and decisions was maintained.

Findings and Discussion

Drawing on illustrative excerpts from the interview data, three themes are discussed. Consistent with interpretive inquiry, literature is interwoven in the discussion of findings as a way of forming linkages between the empirical data, related literature, and relevant theoretical perspectives.

Anticipating Providers' Assumptions

An overriding theme in the interviews reflected the extent to which patients were concerned with how health care providers might be responding to them on the basis of their appearance as people living in poverty, as residents of the inner city neighborhood, or as people affected by substance use and addictions. Patients' concerns centered on the potential dismissal or diminishment of their health issues because of how they would be "read" by providers. One 48-year-old Métis woman described it in this way:

> Well it seems like when my husband and I [were renting] in a well-to-do neighborhood . . . you're accepted as being normal class, everyday citizens. But as soon as you're known to have come from the [inner city], the first thing that's thought about you is that you're a drug addict or a drunk. . . . Like as soon as I tell them that I did interferon treatment for hepatitis C, the first thing they ask me is, when was the last time I used."

For many of the patients who self-identified as Aboriginal, anticipating how they would be read extended to questioning whether they were going to be treated differentially on the basis of their visibility as an Aboriginal person. A 41-year-old man who self-identified as First Nations, an "ex-alcoholic," and "ex-street person," explained: "I don't really like coming to the [ED], but where's a guy supposed to go, you know? And again, is it because I maybe look like a street person? Maybe it's because I'm Native. I don't know." Other patients who identified as Aboriginal expressed similar concerns about the intersecting assumptions that could shape providers' interactions with them. For example, on the day of her interview, a 39-year-old First Nations woman who described herself as an "addict" currently on methadone, explained how pleased she was to be treated "really well" in the ED on this occasion. However, she also described how concerned she was that the health care staff at this ED and at other primary care agencies would form what she perceived to be unwarranted assumptions about her on the basis of her visibility as a First Nations woman and person who actively used drugs, and how that often inhibited her from seeking help: "They have attitude, especially the admitting clerks. . . . I don't know, maybe because I'm a drug addict . . . maybe because I'm Native. . . . Today they're nice. . . . But I avoid coming here in a big way."

Although non-Aboriginal patients also expressed concern about providers judging them in negative ways because of their appearance as impoverished and from the inner city, none questioned whether those judgments were based on assumptions about their ethnocultural identity. In contrast, the concern described by a First Nations man, that he "should walk in with a three-piece suit or something . . . and maybe they'll do something," was echoed by other patients who wondered if the combination of appearing to be poor and Aboriginal would affect their credibility as medical subjects, or would influence their chances of receiving help. As we and others have argued, such perceptions and concerns cannot be analyzed as purely individual or idiosyncratic points of view; the social dynamics that racialized people experience on an everyday basis create the backdrop against which they evaluate their current health care experiences (Fiske & Browne, 2006; Smedley, Stith, & Nelson, 2002). In Canada, wider social discourses, often referred to as "moral underclass discourses," are pervasive (Levitas, 2005; Raphael, 2007; Reutter et al., 2009). These discourses construct people who are living in poverty, homeless, or substance users as relatively undeserving or unworthy members of society. From this perspective, poverty is often understood to be a reflection of the motivational and moral failings of those who are poor. In the Canadian context, such discourses intersect in powerful ways with enduring colonial myths and assumptions about Aboriginal people as dependent on "the system," or as undeserving recipients of special benefits or entitlements (Warry, 2007). These contribute to the ideological contexts in which many Aboriginal people experience discrimination, or anticipate and perceive discrimination within wider social relations and in health care encounters.

Across many of the interviews, the patients who identified as Aboriginal described how attuned they were to providers' verbal and nonverbal gestures, facial expressions, body posture, and the "vibes" that providers conveyed. One woman who used the ED frequently for primary care issues said, "I can feel the negative, you know. Like, 'Why are you here again?'" This sensitivity to providers' nonverbal communication has been well documented by other researchers who have discussed how readily patients from racialized groups tune in to their providers' interpersonal mannerisms (Dovidio et al., 2008; O'Neil, 1989; Smedley et al., 2002; Stuber, Meyer, & Link, 2008; Varcoe, Browne, Wong, & Smye, 2009). In contrast, patients described how significant it was when providers in the ED conveyed concern about their general well-being, or acknowledged their presence in some way; for example, when they were asked if they wanted a drink or a snack; when they felt listened to attentively for a few moments; or when providers stopped very briefly to ask how they were feeling as they were waiting to be seen. A 40-year-old First Nations woman residing in a shelter, who described a long history of sexual abuse, suicide attempts, and intravenous drug use, explained how meaningful it was to be treated "like a regular person" at the ED, particularly because she came so frequently for injuries sustained by an abusive ex-partner, and because of HIV and hepatitis C symptoms:

> It's the treatment, how you're treated as a human being. Because I know when I'm not treated very well, I will not go back there and my health will slide. So, I mean as far as accessing goes, I was seeing—not here, but [in another ED]—that they treat Aboriginal people a little bit differently, especially if they're coming in and they're HIV [-positive], because people assume you're still using drugs. They assume that's how you got it, so it's assumptions, assumptions. I know, because I usually get treated very well here. That's why I came back here. . . . I'm stubborn a bit [about coming in], but I know that when I come here, I'm going to get treated like a human being—not Native, not HIV, not this, not that. I'm not categorized, I'm just another person who's sick and needs help, that's all.

This woman's account highlights the impact that brief supportive interactions can have on patients' overall perceptions, and the significance of such interactions for people who often experience dismissal, racialization, and marginalization.

For health care providers who are working in highly pressured health care environments, it can be challenging to address the range of intersecting health and social issues that shape the lives and health of many patients from the inner city, both non-Aboriginal and Aboriginal. The experiences of health care providers in this study reflected the extent to which their practices were shaped by widespread pressures for efficiencies, staffing shortages, and cost constraints in the ED (Tang & Browne, 2008). Many of the health care providers we interviewed reiterated that the lack of resources in the ED (for example, the lack of meal services for patients who have to remain in the ED for an extended time, inadequate staffing levels, and the lack of immediately available social services) for patients who are obviously socially disadvantaged is distressing for themselves as well as their patients. In some cases, providers responded to these pressured practice environments by distancing themselves from their patients. One ED staff member described it as follows:

> Few health care providers have the patience and resources to deal with these people adequately. . . . They are often difficult to deal with. . . . They don't get exactly what they want or they feel more marginalized. They don't feel that they're being taken seriously, whether they are or not. . . . And they can get defensive. . . . There are a lot of patient issues, and there are system issues, and the two don't mesh well together.

As we continue to discuss, the consequences of "not meshing well" contributed to the frustration, and often anxiety that many patients expressed about the inability to receive help for primary care issues they felt were legitimate.

Seeking Help for Chronic Pain

Among patients in this study, the most common reason for seeking help at the ED was for chronic pain symptoms. Patients' interpretations of their experiences seeking help for chronic pain were illustrative of how the manifestation and management of a common issue in primary care (pain management) can be enmeshed with experiences of social suffering. Heavily imbued with social meanings and ambiguity concerning its legitimacy, chronic pain without a clear physiological basis is particularly challenging to address. This is especially the case in ED settings, where the emphasis is on managing acute manifestations of pain (Burgess et al., 2008; Pletcher, Kertesz, Kohn, & Gonzales, 2008).

In this study, the proximity of the ED to the inner city neighborhood where there were high numbers of people living with the long-term effects of trauma, substance use, chronic pain, and addictions meant that staff sometimes encountered patients seeking pain medications or other prescription drugs. Attuned to the realities and visibility of illicit-drug-related activities prevalent in the inner city, patients made frequent reference to the legitimacy of some providers' reluctance to prescribe narcotics or other pain medications. A 33-year-old Métis man, who was seeking help for wrist pain so that he could return to work as a temporary laborer, explained:

> He just told me that I couldn't get any other medication here [at the ED]; that I had to go to my other doctor. Well, my other doctor prescribed acetaminophen and that's not cutting it. I could just go and get something, you know, do everything illegitimate. I could just go out to the [inner city] streets and buy something. . . . Something stupid like that. I won't do that. I choose to go about it the right way and come to the ED, and then they don't give me anything. . . . This city is rampant with drug use, so I don't blame them. They wonder [if] . . . "maybe he's a drug user."

Although patients who identified as Aboriginal recognized these dynamics, they repeatedly expressed concerns about being viewed by providers as "drug seeking," even when, from the patients' perspectives, they were seeking relief for legitimate pain issues. Research shows that key determinants of providers' decisions to prescribe opioids are (a) assumptions about which patients are most likely to be honest about their pain, and (b) fear of abuse or diversion of narcotics (Burgess et al., 2008). Access to treatment for chronic pain can therefore be colored, even if unwittingly, by prevailing attitudes in health care toward people who are poor, reside in neighborhoods where there are high rates of substance use, live with addictions, or who might be from racialized groups (Burgess et al.; Pletcher et al., 2008). In our study, a 41-year-old First Nations man from a rural reserve community in a neighboring province, who traveled frequently to the inner city to visit his daughter, described the challenges he experienced in obtaining treatment for chronic back pain incurred during his prior work as a plumber. At the time of the interview he lived on disability payments (a form of social welfare) because of his inability to work. Given his travels across provincial

borders, and because his own doctor was often unavailable, he described the consequences of running out of his regular pain medication:

> They don't really understand. My health problems, they're not serious but they bother me. My back bothers me and I have to have my medication because it's been miserable, you know, in pain. I can't sleep, and this and that. If you don't see the one doctor that will help you, then you go to other doctors that don't want to help you. . . . When it comes to giving medications for pain and stuff like that, they kind of take it that you don't need it. . . . It's how they look at it [repeated requests for pain medications]. They say, "You're abusing it." And I mean, that's a good call in some situations. But I don't think it's right for them to make an assumption when someone really does need it and you're forced to go to an emergency department.

This participant's concerns about being mistaken for "those people who are abusing it" also intersected with his concern about being judged negatively on the basis of his identifiable Aboriginal status: "It's kind of stigmatizing, I think. They look at your status card and they know you don't have to pay for it. So, 'Why give it to the Indians?' You know, I mean that's kind of a problem, too." In Canada, First Nations people who are registered as "status Indians" with the federal government receive certain legal recognition and entitlements (e.g., coverage for limited pharmaceuticals, dental care, and other limited, noninsured health benefits). These entitlements are often a source of resentment toward Aboriginal people among the non-Aboriginal population (Newhouse, 2004). Such resentments can be conveyed in health care situations, for example, through negative glances or nonverbal responses by cashiers or pharmacists when people show their status cards as they attempt to fill prescriptions at pharmacies (Fiske & Browne, 2006). In this man's case, concerns about how he would be "read" fed into his overall anxiety about having to explain his situation to different providers. Given his experiences and concerns about being viewed as "one of them"—meaning other Aboriginal patients who might be drug seeking—he saw few options for seeking help elsewhere. He therefore expressed relief when at this ED, the doctor conducted a computer pharmaceutical search, and after a series of faxes were sent across provinces, confirmed his usual pain medication regime and he was given a new medication to try. He went on to explain: "With my situation here, the anxiety and what it involves, I wanted to get another medication that will help. And they say this one will help." In this context, the ED represented the most viable option for obtaining help for the management of chronic pain.

Disjunctures between patients' needs and ED responses. Another First Nations man similarly described his inability to get relief from chronic hand pain, which prevented him from working at the temporary construction job he previously held. In this case, he described not knowing what to do for relief, and so he took his wife's pain medication, and then came to the ED because he subsequently became ill. He expressed ambivalence about seeking help at the ED, but also described his sense of not being able to deal with the pain on his own. He was aware that "complaining and complaining" would do very little; however, he expressed frustration at being told at the ED that he would "have to 'live with it [the pain] for the rest of your life,'" and asked that the providers "at least tell me a little bit more." Although the source of his physical pain (a chipped bone) was diagnosed at the ED, he remained frustrated about not knowing how to manage with chronic pain:

> To me it's something that hurts like a bugger; that stops me from doing things I normally do. So there's definitely got to be a problem there, and how do you get people [providers] to understand that there's a problem? . . . I don't really want to keep saying to them how much it hurts, because they're going to put me in a nut ward or something. I can't just keep coming here because it's going to be, again, "You're just coming in for pain meds [medications]," the addiction thing, "This is an emergency ward."

Repeatedly, there was a mismatch between what many of the patients were seeking (management of chronic pain symptoms) and what the ED, as it was then structured, could reasonably provide. Exacerbating the situation was the lack of other available resources or primary care services designed to help people deal with chronic pain. For the man quoted above, these realities reinforced his sense that, "I guess it's just . . . go to the hospital [ED]. . . . If you've got to wait, you've got to wait. There's nowhere [else to go]."

We are not denying the issue of drug seeking among some patients, and the challenges that health care providers and administrators face in balancing their ethical obligations in responding to substance use or misuse. Nor is it possible to definitively determine whether patients' pain symptoms are part of their addiction issues or not. Regardless of whether pain has an identifiable physiological basis or stems from emotional trauma and experiences of social suffering, people's presenting issues are best understood (and responded to) within their particular life and material circumstances. The social contexts and relations within which patients experience their symptoms and interpret how they are treated are the same contexts and set of relations against which their symptoms

are interpreted and responded to in health care encounters. Patients' descriptions of their attempts to seek help for what they perceived as chronic pain thus provided important examples of how access to primary care services were enmeshed within wider social relations.

Physicians who participated in this study also expressed concern about institutional policies at the ED that prevented refills for narcotic prescriptions from being issued to patients who came to the nonurgent division, and policies in nearby walk-in clinics that precluded any narcotic prescriptions from being issued. These policies were designed to curtail requests for narcotic prescriptions by people presumed to be misusing or diverting opiates for illicit purposes. Clinical policies thus intersected with patients' experiences to create concern and often anxiety for patients about the prospect of receiving help. As the Aboriginal patients in this study described, their overriding concerns reflected the extent to which they would be judged (not only within the ED, but in other areas of the primary care system), and their pain issues dismissed, on the basis of an interrelated group of assumptions: that because they were indigent and visibly identifiable as Aboriginal, they would be more likely to be viewed as drug seeking. This created further anxieties about the likelihood of receiving help for chronic pain issues at other primary care settings such as walk-in clinics or physicians' offices. For many patients, coming to the ED therefore represented their "best chance" for obtaining relief from chronic pain, although the ED visits did little to alleviate their ongoing concerns.

Use of the ED for Primary Care as a Reflection of Social Suffering

Although the ED is not currently designed to respond fully to the complex health and social issues that patients in this study presented with, our data show that the ED continues to be used by people whose health is shaped by experiences of social suffering. In part, use of the ED by the patients in this study who were socially disadvantaged can be explained by the proximity of the ED to the inner city neighborhood, and referral patterns by local clinics that often refer people to this particular ED. A Métis woman who lived in social housing in the inner city explained, "This is the only place they [other providers] send me to, so I'm stuck with what I've been given." However, participants' past health care experiences and everyday social experiences also shaped their judgments about where they would be most likely to receive help, and where it would be acceptable, as the woman quoted above explained, for people "like us . . . from the inner city" to go.

Reflected in many of the Aboriginal and non-Aboriginal patients' interviews was the sense that it might not be acceptable to seek health care elsewhere, that is, outside of the inner city. In part, this was influenced by some people's need to be able to walk to the closest ED (having no money for a bus or taxi). However, patients made numerous references to neighborhood boundaries that existed between the inner city and the gentrified neighborhoods located in close proximity. For example, another ED was located near the inner city; however, it was perceived by many patients to be in an entirely different neighborhood. Several of the Aboriginal patients were unaware of its existence entirely, reporting, "This is the ED I usually come to." This points to a taken-for-granted awareness of social and class boundaries shaping where patients from the inner city perceived themselves as belonging. As such, certain health care settings, places, and spaces, although physically proximate to the inner city, were viewed by both Aboriginal and non-Aboriginal patients as socially distant (Conradson, 2003; Parr & Philo, 2003). A 39-year-old First Nations woman who was staying at a women's shelter said the following:

> This [the ED study site] is convenient because it is close to where I am [in the inner city]. At least if I have to take a bus home, I know how to get home. You know, if I was to go to [the other ED nearby], I'd be lost, and I've lived in [the inner city] for 16 years. So I mean, that's how far I'd go and how far I don't go. I don't really go on that side; I just mainly stay on this side.

The above excerpt also highlights the social dichotomy of "us and them," whereby people from the inner city might tend to keep themselves and their activities, including accessing health services, on "this side," without going beyond the boundaries of their social and geographic belongingness. In these ways, social boundaries were reproduced by geographic boundaries between adjacent middle-class neighborhoods and the poorer inner city. These findings also raise questions about where people presume that it is socially acceptable for them to go, because of their socioeconomic status, addiction issues, and in the case of the Aboriginal participants, their identity as Aboriginal people, among other factors. One consequence is that social suffering is potentially intensified as people are continuously exposed to a high concentration of social stressors and health risks encountered in many low income inner cities (Williams & Mohammed, 2009). The implications for Aboriginal people are particularly concerning given that inner cities are often sites of racism and discrimination, poverty, and social exclusion (Peters, 2004).

The ways that many primary care sites—including physicians' offices and walk-in clinics—operate are also to the disadvantage of those people who, in various ways,

are subject to social and economic marginalization. For example, several patients' experiences suggest that there is a process of screening that occurs, whereby some providers choose not to accept patients from the inner city who have complex mental health problems, addictions, or related health and social issues, thus excluding certain patients from accessing local community-based clinics.

Seeking care in the context of past traumas. Overall, for many of the Aboriginal patients in this study, the prospect of coming to the ED for help represented a paradox of sorts. Some patients described a level of reliance on the ED because of what they perceived to be limited options for going elsewhere. In large part, this arose because of concerns that their health issues would be dismissed if they were to seek help elsewhere. Conversely, they often described dissatisfying experiences at the ED because the services they received only partially met their needs. For instance, a 34-year-old man who identified as Métis was referred to the ED from a walk-in clinic for a sprained wrist. Further discussion revealed that he had just arrived in the city 6 days prior, having left a rural reserve community where, he noted, he was ostracized by his family. Over the course of the interview, he described his struggle with depression, attempted suicide, addictions, and recently, meningitis requiring hospitalization for 2 weeks. He also described how he had "straightened himself out, had a place to live, a job, a girlfriend," but that recently things had started to break down:

> I'm ashamed of myself, actually. . . . I came to [the city] because I needed a change. I lost my job because I fell and hurt my knee and I couldn't work. And here I am. My bag got stolen, so I have no clothes, no wallet, no ID [identification], no socks, even. . . . There's a little park there, and I go sleep on the benches every night. I work the karaoke place. I set up and tear down karaoke. I make twenty bucks a night, but that's just to survive with my cigarettes or my food. It's kind of rough starting out [this way in the city]. But I plan to get up and start doing well for myself.

Although this man's presenting issue (a sprained wrist) was appropriately triaged and dealt with, it was the wider context of his life that was of pressing concern. While waiting in the ED, a medical intern spoke with him about his lack of a provincial health insurance card. The following conversation was noted in fieldnotes:

> The intern asked the patient, "So you don't have any health [insurance] coverage?" The patient replied in a direct, clear manner, "No, I don't have any ID or anything. Everything was stolen." In

response, the intern quickly asked again, "You don't have a health card from another province?" The man replied, "No, I don't have a treaty card [similar to a status card], no coverage at all. Can I see the social worker?" The intern responded in an authoritative tone of voice, saying, "They can't help you with getting your cards or anything," to which the patient replied, in a matter-of-fact tone, "Oh, okay."

Although in the end the patient was referred by one of the nurses to a social worker in the ED, this excerpt highlights how patients can continue to fall through the gaps in the social safety net. Although the role of EDs is to respond to people on the basis of their triaged health condition, experiences of social suffering render some patients vulnerable to health issues that extend well beyond what EDs are designed to address—in this case, support with basic needs for shelter and food, and a way of recouping his lost identification. Seeking help for a stable and nonurgent issue therefore has markedly different implications for patients who are homeless, transient, or struggling with substance use or addictions than for those who are employed, have homes to return to, and the support of friends or family.

Throughout the interviews, the conditions of social suffering that shaped patients' lives drew attention to the linkages that existed between people's health care and access experiences, and their material, social, and historical contexts. The final example we draw on involved a 58-year-old First Nations woman who described a long history of abuse and trauma at a residential school, which she attended as a child. Echoing the experiences of many of the children who were subject to traumas from emotional, physical, or sexual abuse at residential schools (Brant Castellano, 2006; Haskell & Randall, 2009), this woman described a persistent feeling of anxiousness when talking to people in positions of authority or power, such as health care providers. She described coming to the ED frequently for a variety of chronic health and mental health concerns including anxiety, joint stiffness, chronic pain, asthma, and allergies. She recalled a recent experience at one of the EDs where she sought help:

> I had one nurse who said, "You know how many times you've been here?" I said, "No." She said, "Thirty-three times." And I said, "Well, this is a hospital, right?" I didn't really need to hear that because I was really having a lot of problems with myself and I didn't understand it, because of being raised in the residential school. You know, you're always told to shut up and we didn't have any opinion about anything. So it was really hard for me to

try to converse with doctors or anything. . . . And then I said [to the nurse], "Well, I can't help it." I said, "I don't know who to talk to about what's going on with me."

What this excerpt helps to illuminate is how providers and patients can each become caught in frustrating interactions. Whereas this woman's distress stemmed from her concern that she would be repeatedly dismissed, providers can also become frustrated when they fail to see the wider sociohistorical circumstances that give rise to some patients' repeated visits. Exacerbating the issue was this woman's concern that providers would perceive her as "one of them," meaning Aboriginal people in the ED who might be viewed as drug seeking, drunk, or addicted. As she explained,

> The way they talk sharp—I saw that it wasn't just me they were talking to like that. It was people that were either drunk or had been drinking. . . . Like, "Oh you've been drinking." And I said to myself, "I wonder if they're going to come over and say that to me."

As she continued to seek help at the ED, the responses she received were incommensurate with her lived experiences. As she described, "They would just lift up my blouse, use a stethoscope, and say, 'Go home and take your medicine.' But I was in tears, I was crying all the time . . . but they were busy." Her fears about not being listened to were borne out when she went to one ED after several futile visits to another ED and was diagnosed with a medical condition requiring immediate surgery. The admonishment she encountered from providers for "not coming in earlier," and the questions asked of her, such as, "Why didn't you come here right away?" compounded her sense of uncertainty about seeking help.

ED staff tend to see patients only at particular points in time, and not in relation to the larger contexts of patients' lives that might be contributing to delays in seeking care. The expectation that patients ought to have sought help earlier (to avoid complications and further burden on the system) points to two issues. First, admonishing patients for not coming in early enough reinforces the prevailing ideology of individualism in health care that places responsibility on patients for obtaining timely health care. Second, it shifts the responsibility away from the practices and inadequacies in health care that contribute to people delaying seeking care, and away from the structural issues that often underlie people's repeated visits. Thus, patients can be constructed as the source of the problem for failing to seek help for their own health care needs early enough,

or for repeatedly seeking help. Yet, for many people— such as those living in poverty or with significant mental health or addiction issues—the timing of when to seek help is not solely determined by the urgency of their physical needs. Rather, decisions about when, where, and even whether to access primary care (at the ED or elsewhere) are mediated by a range of complex circumstances, including past experiences with health care, geographic and social boundaries, and people's lived experiences of racialization and marginalization.

Implications and Conclusions

Access to appropriate, responsive primary health care services has been identified as critical to achieving overall improvements in health status among Aboriginal populations (Adelson, 2005; Canadian Institute for Health Information, 2004; Frohlich et al., 2006). The findings of this study highlight the significance of personal, social, and historical contexts, and prior health care experiences in influencing Aboriginal people's access to primary care services in urban settings. These contexts and experiences are particularly pertinent to understand given the health disparities and inequities in access to health care that many Aboriginal people in Canada continue to experience. Postcolonial theoretical perspectives are particularly useful in informing such analyses because they draw attention to the ways that socioeconomic, political, and historical relations intersect to shape the contexts in which health care is experienced, received, and delivered.

In the case of this study, one of the most striking findings was the extent to which many of the Aboriginal participants felt they were being judged (a) on the basis of their identity as Aboriginal people who were living in poverty, (b) as patients who could potentially be viewed as having illegitimate pain issues, and (c) in some cases, as people who might be coming to the ED for inappropriate reasons. Although several of the non-Aboriginal patients in this study described their experiences of poverty stigma—referring to the dismissal, disrespect, and social exclusion often experienced by people who are poor (Reutter et al., 2009, p. 298)—none linked those experiences to their ethnocultural identity. Regardless of whether the Aboriginal patients in this study were or were not treated differentially on the basis of these intersecting sets of assumptions, such concerns warrant attention.

Although providers, health care planners, and administrators do not intentionally respond differentially to patients on the basis of their ethnocultural, class, gender, or social position (van Ryn & Fu, 2003), data from this and other studies demonstrate that strategies are needed to address and mitigate people's experiences of inequitable treatment in health care contexts. Such strategies are

needed to counter the harms that can arise from (a) actual and perceived experiences of discrimination, (b) the stress of anticipating negative treatment, (c) the potential for health care encounters to become strained as a result, and (d) the effects that these dynamics can have on inhibiting people from seeking primary care (Dovidio et al., 2008; Stuber et al., 2008). This has particular salience for Aboriginal people in Canada, given the high proportion of people who continue to experience barriers to accessing health care in urban settings (Browne et al., 2009).

Findings from this study also highlight the need to redress the gap in services for Aboriginal and non-Aboriginal people who are living with the overlapping issues of chronic pain, addictions, mental health concerns, and poverty. For example, when patients feel that they cannot get help with what they perceive to be chronic pain—regardless of whether the pain has an identifiable organic cause or is secondary to emotional pain, mental anguish, or addictions issues—social suffering is potentially intensified. The issue of how to respond appropriately to requests for pain relief from patients triaged as stable and nonurgent in the ED setting is challenging. Research continues to show that clinical uncertainty about how to address chronic pain in primary care contexts, particularly for patients perceived to be at risk of diverting or misusing medications, increases the probability that prescribers' decisions will be influenced by stereotypes, including stereotypes based on people's ethnocultural or social background (Burgess et al., 2008; Pletcher et al., 2008; van Ryn & Fu, 2003). This is not to suggest that EDs can or should be able to comprehensively address the complex range of issues that underlie people's experiences of chronic pain, addictions, and related health and social problems. However, in the absence of community-level primary care services that can better respond to these intersecting issues—particularly for people who experience racialization and marginalization, such as Aboriginal people—EDs will be left to bridge the gap.

Given the issues presented here, and the context of ongoing primary care reform in Canada, we ask: To what extent can EDs be responsive to the complex social contexts of (ill) health for Aboriginal and non-Aboriginal people who continue to experience marginalization? Whereas in the past in some jurisdictions, the ED functioned as a social safety net for indigent patients (Malone, 1998), the current context of health care reform in Canada is characterized by a decrease in the number of family physicians; a decrease in community-based health and social services; an increase in the number of people who fall through the cracks; and growing pressure for EDs to off-load nonurgent "traffic" onto overburdened community-based services (Canadian Institute for Health

Information, 2005a, 2005b, 2007; Health Council of Canada, 2008). Despite these realities, EDs in some Canadian jurisdictions are being provided with incentives that reward the processing of patients triaged as stable and nonurgent in the minimal time possible. Although efficiency incentives might be appropriate in some cases, for many EDs, such incentives have the effect of relegating the sociopolitical and economic contexts of people's health to the sidelines and further threatening their access to primary care. Aboriginal and non-Aboriginal patients whose needs are impacted by chronic pain, mental illness, or addictions, and whose health is at risk because of poverty, historical trauma, or violence, are likely to require multiple forms of intervention and referral.

Although EDs are typically intended as "patches" in the primary care system, the ability to respond more fully to the interconnected health and social needs of patients who are most significantly affected by structural, social, and historical inequities could have significant benefits. Malone (1998) suggested the idea of a "slow track," staffed by an interdisciplinary team of clinicians, nurse practitioners, and social workers, to better address the root causes of some patients' primary care needs—particularly for health and social conditions that are not amenable to the rapid responses that EDs are designed to provide. Developing the capacity, resources, and time to directly and immediately refer patients in the ED to social workers, chronic pain specialists, or outreach mental health and addictions services could be framed as aligning with efficiency goals related to responsiveness. This is occurring in some EDs (Bernstein, 2006; Lowe et al., 2005; Ragin et al., 2005), and the impact of these responses requires further study to understand their effects on health outcomes and cost effectiveness (Bernstein). However, the extra resources and time that might be required to support such responses are at significant risk of not being considered or implemented if they are viewed as running counter to efficiency incentives. Questions requiring ongoing consideration will be: Which groups of patients are likely to be negatively affected by ED efficiency incentives? What are the specific implications for the increasing number of Aboriginal people who are living in urban contexts? What are the health consequences of off-loading nonurgent services for patients who are dealing with multiple social disadvantages without adequate primary care services available in the community? What might be the role of primary care services in responding to the health effects of social suffering? Reflecting on these issues will be critical to understanding the role of the ED, and the wider primary care sector, in responding to the needs of Aboriginal as well as non-Aboriginal patients affected by poverty, racialization, marginalization, and other forms of disadvantage.

Acknowledgments

Declaration of Conflicting Interests

Funding

Notes

1. Primary care refers generally to the first level of contact that people have with the health system, and the first element of a continuing health care process that might include the provision of secondary and tertiary levels of care (Hogg, Rowan, Russell, Geneau, & Muldoon, 2008).
2. In Canada, the term *Aboriginal* refers to indigenous people from three unique groups: First Nations, Inuit, and Métis people (Royal Commission on Aboriginal Peoples, 1996). In 2006, 3.8% of the population self-identified as Aboriginal (Statistics Canada, 2008). The federal *Indian Act* (Indian Act, 1985) classifies First Nations people into registered "status Indians" (referred to in this article as status First Nations) or "non-status Indians," to distinguish those people who receive certain legal recognition and entitlements from those who do not. In this article, the term *Aboriginal people* is used to refer generally to the diverse groups within Canada. First Nations or Métis are used more specifically to refer to research participants who self-identified as such.
3. Racialization refers to the social processes by which people are labeled according to particular physical characteristics or arbitrary ethnic or racial categories in ways that stigmatize and marginalize them as "others," and lead to negative social, economic, and political consequences (Galabuzi, 2001; Henry & Tator, 2005).
4. At the outset of our study, our clinical partners in the hospital, the Aboriginal community advisory committee, and the

investigative team agreed that the study site and city would remain anonymous.

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