Narratives and gatekeeping: Making sense of triage nurses' practice

Abstract

It is well documented that emergency service staff consider some patients to be 'inappropriate attenders'. A central example is 'trivia', denoting patients with medical problems considered too 'trivial' to warrant attention. Although research has repeatedly shown that frontline staff violate guidelines in turning away 'trivial' patients, existing research has paid insufficient attention to why staff are willing to engage in guideline-violating gatekeeping, which may put both themselves and 'trivial' patients at risk. To address this issue, the present paper explores nurses' narratives about 'trivial' patients—referred to in this context as 'GP patients'—drawing on fieldwork data from a Norwegian emergency service. The paper reconstructs three narrative clusters, showing that nurses' gatekeeping is motivated by concerns for the patient being turned away, for nurses and more critically ill patients, and for the service they work for. Some of the issues embedded in these narratives have been underanalysed in previous research—most importantly, the role of identity and emotion in nurses' gatekeeping, and how patient narratives can function as 'social prognoses' in nurses' assessments. Analysis of these narratives also reveals an antagonistic relationship between nurses and 'trivial' patients that contradicts nurses' ethical guidelines and indicates a need for healthcare reform.

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Introduction

Walk-in emergency medical services (EMS) are open to anyone seeking medical attention. This openness attracts people with a wide range of complaints and motivations, many of whom are deemed 'inappropriate' by EMS workers. Staff notions of inappropriateness have been thoroughly investigated in sociological research, particularly in studies relating to informal patient categorisation in EMS settings (Dingwall and Murray 1983; Dodier and Camus 1998; Edwards and Sines 2008; Edwards 2007; Guttman *et al.* 2001; Hillman 2007, 2014, 2016; Hughes 1988, 1989, 1977, 1980; Jeffery 1979; Kelly and May 1982; Latimer 1997, 1998; Mannon 1976; Roth and Douglas 1983; Roth 1971, 1972; Vassy 2001; Wamsiedel 2016).

A key category explored in this research is 'trivia', which denotes patients presenting with medical problems deemed too 'trivial' to warrant emergency attention. On the surface, 'trivia' might seem a purely clinical category, but existing studies have shown that these patients are judged by an amalgam of clinical and extra-clinical criteria. Such patients are seen to exploit EMS organisations for reasons of convenience (Vassy 2001: 625), and to present with 'routine' conditions that do not allow staff to utilise their professional skills (Dingwall and Murray 1983: 141; Dodier and Camus 1998: 423; Palmer 1983; Roth 1972: 845). They are further seen to lower the status of EMS organisations to that of GP services (Jeffery 1979: 96) and to deviate from the norm that patients 'should be restricted in their reasonable activities by the illnesses they report with' (Jeffery 1979: 101).

Staff have also been shown to turn 'trivial' patients away altogether from the EMS. Vassy (2001) refers to such gatekeeping as 'the micro-rationing of care', defined as 'when the staff refuse to provide a service which they could competently provide, and when the re-directed person does not obtain the equivalent service elsewhere' (p. 619). In most of the described settings, turning away patients with medical complaints contravenes organisational guidelines and/or national legislation (cf. Vassy 2001). As those turned away might prove to be sicker than assumed by staff, this is a potentially risky practice for both patient and provider.

Although existing research has highlighted how EMS staff perceive and sanction these patients, the category of 'trivial' patients remains underanalysed in sociological research. Previous studies have largely treated 'trivia' as one among several categories of inappropriate attenders, giving only brief and general remarks about why staff view these patients in this way. Existing research has also neglected why EMS staff are willing to overrule guidelines to

turn such patients away. We therefore lack important insight into the logics of their gatekeeping practice.

This paper seeks to uncover EMS staffs' subjectively convincing reasons for turning 'trivial' patients away. It does so by analysing the *narratives* underlying such gatekeeping. As cultural structures of key importance for human cognition and communication (Abbott 2008), narratives have been shown to structure healthcare providers' clinical reasoning (Hunter 1991), and, more importantly, to serve as core heuristics for evaluating the value of patients and their conditions (Johannessen 2014). Narrative analysis is therefore a useful means of untangling staff notions about 'trivial' patients.

Specifically, the paper draws its data from a fieldwork study of triage nurses in a Norwegian walk-in EMS organisation. Working in the frontline of the EMS, triage nurses were responsible for assessing the urgency of patients' complaints. Although officially they had very limited authority to deny patients access, they frequently contravened guidelines to turn away 'trivial' attenders, referred to in this context as 'GP patients' (i.e. *general practitioner* patients). Underpinning their gatekeeping was a series of narratives about GP patients and related elements of their work, all of which reveal salient reasons for engaging in this guideline-violating practice.

In what follows, I elaborate the narrative framework and provide an overview of the study's data and methods. In the analysis, I reconstruct three clusters of narratives, framing gatekeeping as motivated by concerns for (1) the individual patient, (2) nurses and more critically ill patients, and (3) the EMS as an emergency institution. In conclusion, I discuss the broader implications of these narratives for nurses' gatekeeping practice.

Narratives

According to Barthes (1975: 237), 'there has never been anywhere, any people without narrative'. His message resonates within the sociology of health and illness, where studies have demonstrated the relevance of narrative in a range of topics related to health and healthcare, including patients' experience of their illness (cf. Frank 1997) and professionals' interpretation of patients (cf. Hunter 1991).

In the present context, *narrative* refers to a representation of a series of events (Abbott 2008: 13), chained together by a plot and involving characters acting out or being exposed to these events (Polletta *et al.* 2011: 111). As representations, narratives simplify characters and events, emphasising some aspects while minimising others. Attending to what and how

something is represented therefore serves to highlight 'how social actors frame and make sense of particular sets of experiences' (Coffey and Atkinson 1996: 67).

Some remarks in previous research on 'inappropriate attenders' hint at the relevance of narrative for understanding patient categorisation and gatekeeping. For instance, Roth (1972: 846) remarked that staff told 'atrocity stories' about patients, but he did not elaborate on content and structure of these stories. Similarly, Jeffery (1979: 95) commented on how the informal categorisation of a patient entailed that 'staff felt able to predict a whole range of features related not only to his medical condition but also to his past life, to his likely behaviour inside the casualty department, and to his future behaviour'. However, like Roth, Jeffery ventured no deeper into this narrative landscape.

The present paper explores narratives in an organisational setting, where storytelling 'hardly follows the traditional pattern of a narrator telling a story from the beginning to the end in front of an enchanted and attentive audience' (Czarniawska 2007: 386). As narratives often function on a *connotative* level (Thwaites *et al.* 2002: 120), alluded to only in actors' brief remarks, the analysis seeks to reconstruct hermeneutically the narratives underlying nurses' fragmented accounts—teasing out their notions about themselves, GP patients and others as characters with certain motivations and dispositions, embedded in trajectories with positive or negative outcomes. In so doing, we can hope to understand how nurses conceive of GP patients, and why they believe it is warranted to turn them away from the EPCC.

Data and methods

The paper is based on an ethnographic study of a Norwegian emergency primary care clinic (EPCC; '*legevakt'* in Norwegian). EPCCs are heterogeneous institutions ranging from a single physician on call in rural areas to large-scale organisations employing hundreds of workers. Similar to emergency departments (EDs) in other countries (Vassy 2014)[1], the latter organisations allow patients to walk in at their own discretion. Data in this paper are drawn from one of these large-scale organisations, an urban, public EPCC that performed more than 50,000 consultations per year; employed more than 100 nurses and physicians and was open for 24 hours on every day of the week. It was intended for patients with medical rather than surgical complaints and served patients along the whole spectrum of criticality.

A basic overview of the EPCC's patient flow provides useful context for the analysis section. The first to meet patients were the receptionists, who registered patients' bureaucratic details and made brief clinical assessments to identify and move the most urgent patients in front of

the line to see the triage nurse. Triage was performed in two booths next to the reception, where nurses called on patients individually. A triage assessment typically lasted 4–8 minutes, during which the nurse would gather a brief medical history, collect vital parameters, perform simple examinations and settle on an urgency level. Triage assessments were regulated using the *Manchester Triage System* (MTS)—a paper-based system of flowcharts in which relevant symptoms and signs are ranked at five levels of urgency.[2] After triage, patients deemed eligible were sent to another waiting area 'inside' the clinic, where they were to wait to be called on by a nurse for testing or a physician for a consultation. Each shift also had coordinating nurses and physicians to monitor patient flow.

I conducted 47 fieldwork sessions at this EPCC between April and December 2015. These were stratified according to shifts, weekdays and roles, and had an average duration of six hours. Twenty sessions were spent shadowing nurses in triage and asking them about their assessments, which enabled me to learn about their gatekeeping in close proximity to actual patients. The other sessions were spent following nurses in other roles, as well as physicians and auxiliary staff. For the purpose of analytical contrast, I conducted a further nine fieldwork sessions at two other emergency institutions.

Important parts of the fieldwork were conducted in non-patient settings, notably in break rooms and at the working station shared by nurses and physicians, which were key places for sharing remarks about GP patients. When several nurses were present, I would mostly listen to their conversations, occasionally asking about topics of interest. When alone with nurses, I would engage them in conversation; on quiet days, these interactions took the form of informal interviews.

I also conducted semi-structured interviews with seven nurses, two physicians and two managers, all recruited towards the end of fieldwork. The interviews with nurses lasted on average 100 minutes (ranging from 40 minutes to three hours). Using an interview guide with seven batteries of questions, I inquired about topics such as 'inappropriate attenders' and gatekeeping in the EPCC.

The interviews were transcribed verbatim. During fieldwork, I scribbled keywords and near-verbatim quotes on a notepad or laptop, for later use in writing more elaborate, low-inference field notes (totalling approximately 1,270 single-spaced pages). All notes were written in Norwegian; I have translated the extracts included in this paper, making minor grammatical and aesthetic adjustments.

The study was approved by the Norwegian Social Scientific Data Services. Pseudonyms are used to secure informants' internal and external confidentiality (Tolich 2004), and no other identifying information is disclosed. I signed non-disclosure agreements with the participating EPCCs and secured participants' informed consent by distributing an information letter and delivering several short presentations on the project.

Analysis began immediately on entering the research setting. As nurses were particularly concerned with GP patients, teasing out their notions about this category became a key occupation during fieldwork and in writing field notes. For this paper, the relevant data were inductively differentiated and iteratively reviewed to explore nurses' notions about GP patients. I did not begin by analysing narratives but became aware of the narrative character of nurses' perceptions through long-term engagement with the data. As there are no firm boundaries between the reconstructed narratives, I refer to each section in the analysis as a 'narrative cluster', ordered around certain thematic and structural similarities.

In selecting data, I have been careful to emphasise those accounts that were consistent with nurses' gatekeeping practice. Because I was not allowed to record nurses' conversations in the field, most of the quoted excerpts are drawn from the interview data, which are richer in detail and reveal more about how nurses viewed GP patients. However, it is important to note that the analysis builds on all the data collected about GP patients, and that the interviewees' accounts are largely consistent with remarks made in backstage settings. A likely reason for this consistency is that I interviewed nurses towards the end of the fieldwork, after ensuring that they saw me more as 'one of them' than as a potentially dangerous 'outsider'. As Nurse Nina told me in her interview, 'Now that you've been working with us for so long, […] you've seen it yourself; you know what we're talking about, and you don't respond by raising your eyebrows thinking 'Oh my gosh! Are *you* a nurse?'

Analysis

To begin, it is useful to look at the category 'GP patients' itself, as this was used by the nurses. A first defining feature is that GP patients are those with problems deemed to have a medical (i.e. somatic or psychiatric) rather than a social basis. This is a central distinction within the category of 'illegitimate attenders', separating GP patients from, for instance, the 'tramps' and 'drunks' described by Jeffery (1979). Second, GP patients present with problems that are deemed 'non-urgent'—in other words, they are considered unlikely to be at risk of serious harm if referred to a lower level of care (usually their GP service). Prototypical

members of this category included young patients presenting with mild ear pains or a sore throat. However, congruent with other studies (cf. Vassy 2014: 624–5), the boundary separating urgent from non-urgent was seen to vary according to such factors as number of attenders, time of day, patients' impression management, and the nurse making the assessment.

GP patients were also referred to as 'green' patients, referring to the second lowest level of urgency among the MTS' five triage codes. 'Blue' is the least urgent category, but less than one percent of patients were assigned to this category, making 'green' the lowest priority de facto. In broad terms, 'green' encompassed all patients who (1) had experienced changes in their medical condition during the last seven days but (2) had no symptoms or signs indicating a need for medical attention within the next sixty minutes (the target waiting time for the third least urgent code, 'yellow').

Many nurses expressed frustration that management generally considered 'green' patients to be eligible for EPCC treatment.[3] In both their words and actions, nurses instead insisted on drawing a distinction within the green category. On the one hand were the legitimate 'green' patients who, although having no symptoms suggesting urgency, could benefit from further inquiry (e.g. because of having a somewhat 'diffuse' condition). On the other were the mere 'GP cases', who nurses frequently attempted to turn away from the EPCC.[4]

Of the 342 triage assessments I observed, 120 resulted in a green code while 62 ended in an attempt to turn the patient away.[5] Fearing sanctions, nurses rarely *denied* GP patients access; instead, they relied on a series of strategies to *convince* the patient to go home or to seek help elsewhere. To 'turn a patient away', then, meant trying to convince them to go home and rest, to visit their GP or to visit the other (allegedly 'simpler') EPCC in the city. Approximately 75 percent of the observed attempts were successful. Although this form of gatekeeping was often 'softer' than the 'micro-rationing' described by Vassy (2001), it was nonetheless at odds with the guidelines. Nurses' reasons for engaging in this practice are explored in the narratives below.

Helping the patient

A first cluster of narratives framed gatekeeping as a way of helping the patient. These accounts typically related to patients who attended at busy times and who, because of their low-priority triage code, would have to wait several hours before receiving medical attention. Nurse Olivia exemplified this concern as follows.

> Sometimes, they get complete sympathy and empathy from me, even if they get a green priority. I mean, I *often* say it to help the patient, especially when I'm working nights or evenings; then I say 'Perhaps it will be better for you to go home and sleep and contact your GP tomorrow instead, or come back here during the daytime, when there's a shorter line'—because I know they're going to be sitting here all night. (Interview)

This account emphasises Nurse Olivia's concern for the patient's wellbeing. She knows that green patients may have to wait all night and therefore advises them to seek help the following day when there are more available staff. Other nurses offered similar reasons for turning away patients they were certain would receive no effective treatment in the EPCC, or whose condition they believed would benefit from thorough follow-up by their GP.

On occasion, nurses framed this 'helpful' gatekeeping as opposing management's economic interests, as in Nurse Christine's account:

> Nursing management wants as many patients as possible in the clinic because this is about money—the more patients we get, the more money we get. And there's a deficit, so they want all the patients they can get. But street-level nurses tend to disagree with that if we can offer them help elsewhere, where the patients may be seen sooner. So, [we're] focusing on the patient, not on the economic aspects.

She went on to recount an example of these differing orientations.

> This one time, the head of my division visited the booth where I triaged patients, and then I said [to several patients] 'Go to [the other clinic in the city] because here you have to wait six hours'—we're talking simple stuff, like ear infections, a simple sore throat, some stuffy noses—things like that. And then the head of my division told me 'You can't do that, Christine; they are making us really easy money because they're so quick [to treat]'. And then I tried to say 'But … you have to consider the patient'; but 'No, that's nothing to be concerned about' [laughs in a resigned manner]. (Interview)

In these accounts, Nurse Christine casts herself in the role of patient's advocate, fighting for the patient's interests against the economic interests of management. Because management's concerns are depicted as extra-clinical, Christine is framed as justified in her clinically grounded 'defiance'.

A central underlying theme in these narratives is nurses' clinical competence. Nurses considered themselves capable of determining patients' eligibility for the EPCC, and of predicting the outcome of the physician's consultation (at least in assessing 'simple' cases). This reveals one salient reason for overruling guidelines: that one considers oneself competent to do so. In this regard, many nurses considered the MTS too risk-averse, arguing that it

needed some professional adjustment.[6] Accordingly, nurses often deemed it necessary to apply stricter criteria than the MTS when guarding the gates to clinic.

Finally, it is worth noting that these stories portray nurses and GP patients as having shared interests. In contrast, the next two sections reveal a more antagonistic relationship between the two groups.

Helping themselves and more critically ill patients

The second cluster of narratives centred on how admission of GP patients might negatively affect EPCC work. These narratives can be divided into two main types. The first emphasised how GP patients, by their sheer number, impact negatively on nurses' everyday work. This narrative was set against the backdrop of resource scarcity, as the EPCC was much-visited, and nurses often complained about being understaffed and overworked. GP patients were in part blamed for this because they were seen to attend in large numbers with problems that did not warrant nurses' time and attention—in other words, they added *unnecessarily* to an already challenging workload. A related complaint was that admitting a large number of GP patients could result in loss of oversight and control, potentially placing other patients at risk. Nurse Nina explained this when I asked her about the problems of admitting GP patients to the clinic.

> When we have a lot of patients, it's easy to lose control—especially of the waiting area. Patients have a responsibility to tell us if they get worse, but this is where things can slip through the cracks. When we're overseeing a lot of patients, the waiting list is long, and a lot of time passes between each check on patients. They may be assigned a low priority [in triage], but that can change during their wait. They could develop criteria for sepsis [blood poisoning], and when there's a lot of patients, we might miss that. (Interview)

Nina's account depicts a possible trajectory where a patient deteriorates in the waiting room while nurses are too busy attending to other (and, implicitly, more trivial) concerns. Her account highlights the fear that certain patients in the lower urgency categories—typically, the 'green' and 'yellow' patients with somewhat 'diffuse' conditions—could be at risk of swift deterioration after leaving triage. The influx of GP patients adds to this concern because their sheer numbers make it more difficult to keep track of each individual patient in the waiting room.

A second type of narrative within this cluster concerned patients' behaviour while waiting—especially when the EPCC was overcrowded, as was frequently said to be the case. Crucially, in these stories, GP patients were described as tending to complain or 'nag' during their wait.

Nurses often conveyed their irritation with such ‘nagging’ in brief moments of backstage ‘ventilation’. A much-repeated juxtaposition was that ‘most complaints come from patients who really don’t have to be here’ (Nurse Ella). Nurses also expressed frustration with the content of patients’ complaints, as in the following declaration by Nurse Olivia.

> It would have been different if someone had stopped me saying ‘Could you have a look at him, he’s experienced a rapid decline’, and it actually turned out to be true—right? Instead, they stop you and claim that they’ve been waiting for five hours when they’ve really only been waiting one hour. On top of that, they were warned about the wait when they were first registered. (Interview)

Olivia’s account highlights an important distinction between asking for a new assessment and complaining about a long wait. The latter was poorly regarded as clinically unwarranted and devoid of any useful information for the nurses, and because it signalled a lack of trust in nurses’ assessments (and in the functioning of the EPCC more generally). Her account also emphasises how patients are likely to exaggerate, and how they complain despite having been warned by the triage nurse about the waiting time. Olivia’s description is typical of how nurses viewed ‘the nagging patient’. In this regard, several nurses confessed to having developed an aversion to the waiting room; one even referred to a colleague who considered quitting the EPCC principally because of constantly having to deal with patients’ non-clinical questions.

Beyond being merely irritating, nagging was also said to delay patient treatment. As evidence of this, several nurses referred to the ‘vicious cycle’ of the waiting room, which Nurse Nina described as follows.

> No one gets rejected[7] here. That means, unfortunately, that there’s a long wait for things that aren’t critical and that could, in theory, be seen by a GP. A long wait makes the patients frustrated; they become irritated, and then they start complaining about having to wait, and then we spend a lot of *our* time explaining to them ‘This can wait, it’s not critical, we have to prioritise the sickest patients first’. They’re stealing attention from our real work, and after a while, that makes you really resigned. (Interview)

Nina depicts a process in which GP patients become frustrated while waiting, leading to complaints that take up nurses’ time and further delay treatment. Additionally, other nurses claimed that ‘nagging’ in the waiting room was contagious; when one patient begins to complain, others soon follow. Although Nurse Nina attributed this behaviour to GP patients having to wait longer than others, she emphasised the frustration of having to deal constantly

with such complaints. Implicit in her account is the belief that *all* patients are *prone* to nagging (some more so than others), highlighting one reason for wanting to turn away any patient presenting with GP problems on busy days.

GP patients were also seen to lack respect for the EPCC's functioning. This was exemplified when I asked Nurse Nora about the problems of admitting these patients to the clinic. She first referred to the 'vicious cycle' mentioned above and then recounted the following story.

> Nora: I had a patient in Room 5 who was *really* ill, and then a green one came into the room, asking 'When is it my turn?' That's *incredibly* rude. Then you don't give a shit about how polite you're supposed to be; it's like, 'Get out! Get out, go to the waiting room and wait until you're called!'
>
> I: So, that has happened to you?
>
> Nora: Yeah, and that pissed me off.
>
> I: What happened?
>
> Nora: I think I saw to someone who wasn't breathing properly, or who was unconscious, and we were working on him in Room 5, and then this person came in and started to *nag* about having to wait. And when they see the patient in front of them, then you'd expect them to have a basic understanding of 'Okay, they're actually *that* bad, then I *understand* why I have to wait'. But when they don't, then … then you've had it. Sometimes, it's just too much. I've never said anything impolite to patients; I've never called someone an idiot or told them to shut up, but I'm like, 'You have to get out because you have *no* reason being here! Go out, sit down and behave properly'. We kind of have to resort to adult education sometimes. (Interview)

Nora's story establishes a contrast between the triviality of this 'nagging' patient's complaint and the importance of treating critically ill patients. She emphasised that the patient, even when personally witnessing a life and death drama, failed to recognise why he had to wait. Within this narrative framing, his actions reveal a lack of appreciation for the priorities of EPCC staff. For Nurse Nora, this was particularly evident in how the patient physically entered Room 5 to complain. This room is dedicated to the treatment of the most critically ill patients, and as such represents 'real' emergency medicine to clinic staff. By entering this room, the GP patient disrespected this valued symbol, causing Nora to feel a strong need to sanction his transgression.[8] It is also worth noting how Nora shifts between describing this particular patient and a more general 'type'—in other words, the patient is treated as a

metonym for the moral transgressions of this patient group, as evidence of how 'they' selfishly prioritise their own problems without concern for those in greater need.

In contrast to the previous section, then, these narratives depict the interests of nurses and GP patients as conflicting rather than shared. 'Green' patients complicate EPCC work, both by their sheer presence and by their tendency to complain and disregard highly valued aspects of emergency medicine. These narratives also include concerns for a third party, the sicker and more deserving patients, which serves to heighten the triviality of GP patients' complaints.

On busy days, the leap to rationing seems clear. Knowing that GP patients will fill up the waiting room—and that they will have to wait for several hours, leading to 'nagging', interfering with nurses' work and potentially putting sicker patients at risk—nurses see good reason to turn GP patients away from the EPCC.

Helping the EPCC

The two narrative clusters above concern gatekeeping in an overcrowded setting, where nurses discern a series of reasons for turning GP patients away. On slower days, the threshold for admitting patients was claimed (and observed) to be lower, meaning that more patients were accepted. However, several nurses emphasised the importance of turning away certain patients, regardless of capacity, as in the following assertion by Nurse Olivia.

> Sometimes we turn them away because we think they're abusing the clinic—like, they're constantly presenting with a stuffy nose and the like.[9] So, even when there's a short line, we're sort of doing it on principle.

Later in the interview, she stated the following.

> Olivia: Even if there's a short line, if someone presents with a 'green' problem, then I usually try to advise them to seek help from their general practitioner. To … discourage them from them spreading a rumour, so to speak, that 'if you come to the EPCC, then things move swiftly, without problems'.
>
> I: Do you think people are spreading that kind of rumour now?
>
> Olivia: Yeah, at least within certain groups.
>
> I: What do you think that rumour consists of?
>
> Olivia: Well, say, if you're … if two friends are chatting, and one of them complains that she has some pain, but that she doesn't want to bother with calling her GP, for instance,

> then the other might say 'But just go to the EPCC; that's what I did, and it was really efficient, they saw me right away, and …' I think that's how it often works. (Interview)

Nurse Olivia highlights how nurses may be motivated to turn GP patients away even on slow days, either to sanction repeated presentations with inappropriate complaints or to combat the spread of rumours about the EPCC as convenient. Both motivations are grounded in her belief that many 'green' patients 'abuse' the EPCC—a term that reveals both the negative experience of seeing patients taking advantage of the EPCC and her moral reproach of such actions.

Accusations of 'abuse' were common among the nurses, who often exchanged stories about patients exploiting the constant availability of the EPCC. Nurse Nina gave the following examples of 'abusive' reasons for attendance.

> A lot of the patients are honest, or they give themselves away, if I may put it like that, when they come here saying 'My GP's too far away'; they happened to be in the area; they couldn't get an appointment [with their GP] today; they have so much else to do this week, or they don't feel they can take time off work to go to their GP during working hours—excuses like that. (Interview)

Nina's account suggests that many patients are perceived as using the EPCC primarily for convenience, violating the norm of attending only when you cannot wait to receive help elsewhere. Several nurses argued that this defeated the purpose of the EPCC, as in the following field note excerpt.

> 'It's not EPCC work to do infection tests on people with sore throats, just because they won't bother going to their general practitioner', Nurse Nora says, frustrated. 'Everything about the clinic loses its meaning when people can come here for whatever'. She insists that the EPCC is intended for people with critical illness. 'So the EPCC should be an EPCC?' I probe. She confirms, adding 'But [this EPCC] isn't that—we're the whole city's GP office'. (Lunchroom conversation)

Nora's account reveals how GP patients blur the line between EPCCs and GP services. She articulates this as 'everything EPCC' losing its meaning, which highlights GP patients' status as 'matter out of place' (Douglas 1966: 44) in the EPCC, threatening to break down institutional boundaries. Because EPCCs outrank GP services in the nurses' hierarchy of healthcare organisations, this potential breakdown was considered particularly problematic. EPCCs are seen to have at least the potential for lifesaving and drama, which is generally considered prestigious in healthcare settings (cf. Album *et al.* 2017). In contrast, nursing in

GP services is associated with administrative and routine clinical tasks, often performed by less qualified healthcare assistants. The influx of GP patients therefore risks reducing the EPCC to a 'mere' GP service. A similar notion was implicit in Nurse Nina's criticism of patients using the EPCC as a 'hairdresser with drop-in hours'. While cutting hair is not typically considered a matter of life and death, EPCC work should, in the opinion of many nurses, be exactly this.

Nurses' concerns for the EPCC's institutional identity can be further understood by exploring the connection with narratives referencing 'real' EPCC work—that is, treatment of critically ill patients. In contrast to GP patients, nurses referred to the treatment of critically ill patients as 'exciting' and even 'fun'. Nurse Maya explained this as follows.

> With critical cases, we typically get to make quick and major changes. If, say, we're treating someone with acute respiratory problems, in a few minutes, we have kind of saved that life, right? (Interview)

Critically ill patients afford nurses an opportunity to be lifesavers, bringing a patient from certain death to certain survival—a binary reversal that is highly valued in healthcare. These 'quick and major changes' are exactly the opposite of what GP patients offer staff, as GP patients typically require time-consuming examinations in triage (to ensure that there are no signs of urgency) and the triviality of their complaints precludes any intervention of significance. Further contrasts were established in the following account by Nurse William.

> The *critical* – that's high tempo. It's quick decisions with significant consequences for the outcome. It's more risky. If you're wrong then it *might* have serious consequences. So, you have to have some ambition when it comes to mastering the trade. And I think that's motivating for those who apply here. You *have* to know your stuff—you'll quickly be exposed if you don't. When you're working with less critical cases, like fiddling in the lab with some green patients, then you might get away with being at a lower professional level—it won't have any grave consequences. But if it's critical, it will, and then you'll quickly be exposed. Moreover, it's about action—ambulances, sirens, stretchers carried in haste through the corridors. On good days, you might get a sense of life and death, if that's what you want. And you have relatives in despair, and it's a lot of emotions in the swing of things. (Interview)

Nurse William echoes Nurse Maya's notion of 'life and death', adding the narrative elements of risk, action, rapid pace and emotional investment—evoking, perhaps, images from TV medical dramas like ER or House. He also emphasises the need for the specialised skills required of characters in such dramas, in explicit contrast to 'green' patients, who are framed

in much more mundane terms, affording staff fewer possibilities for professional affirmation. Accordingly, another nurse, Emil, confided, ‘Every day, we’re hoping it’s something *real*, so we get to do the things we’re trained to do rather than just doing trivial routine stuff all the time’.

In this overarching narrative, then, GP patients are depicted first as ‘abusing’ the EPCC’s openness, and second as threatening to break down the institutional boundary between EPCC and GP services. Both were seen as reasons for turning away patients, even on slow days. Regarding ‘abuse’, it should be noted that there was some disagreement about its prevalence; while some nurses believed that a majority of GP patients were ‘abusers’, others saw these as a small minority. Nevertheless, most agreed that certain patients abused the clinic, and that these were more deserving of sanction. Accordingly, there was an observed tendency that the more ‘abusive’ a patient was perceived to be, the more time and energy was invested in guarding the gateway to the clinic.

Discussion and concluding remarks

Using narrative analysis to untangle nurses’ reasons for turning away GP patients, the present analysis has reconstructed three clusters of narratives, which show nurses’ guideline-violating gatekeeping to be motivated by concerns for the individual patient turned away, for nurses and more critically ill patients, and for the emergency service in which they work. Nurses were most vocal about the antagonistic narratives in latter two clusters, but all were compatible with observed gatekeeping practice.

As well as resonating with and extending previous findings, the analysis has also highlighted aspects of gatekeeping that have previously received little attention—for example, how turning patients away may be motivated by concern for the patients themselves.[10] Three additional contributions, intimately linked with the study’s narrative perspective, deserve particular mention. First, in focusing on characterisation, the narrative perspective highlights the importance of identity in nurses’ gatekeeping practice.[11] For example, we have seen how the concern for organisational identity was important for nurses seeking to protect the EPCC’s role as a place for critically ill patients. Issues of identity were also evident on a personal level, as for instance in nurses’ regard for the lifesaving and dramatic aspects of working with critically ill patients. While this potentially cast nurses as heroic figures in a drama of life and death, GP patients were associated with far more mundane imagery. Put simply, their presence was considered a threat to nurses’ prestigious identity as lifesavers, augmenting the

importance of turning such patients away from the EPCC. Although similar concerns have been documented in research on EDs (cf. Hillman's (2007, 2014) discussion of 'real' emergency medicine), this might be a particularly pressing concern for EPCC nurses because of their institutional position between the 'trivia' of GP services and the 'emergencies' of EDs.

Second, the reconstructed narratives illustrate the affective sides of nurses' gatekeeping, echoing Czarniawska's (2007: 390) view that 'stories permit access to the emotional life of organizations'. Among other things, GP patients were seen to evoke feelings of frustration and anger. Considering how people typically want to avoid situations of low 'emotional energy' (Collins 2004), this seems likely to reinforce nurses' motivation for turning away GP patients. And as emotions tend to intermesh with notions of patients' social worth (cf. Sointu 2017), this might be a problematic source of social inequality in healthcare delivery.

Third, in addressing temporality, the narrative perspective also helps us see how the reconstructed narratives can serve as *social prognoses* in nurses' triage assessments. While clinical prognoses are confined to predicting the trajectory of a patient's medical condition, social prognoses entail a broader set of predictions, encompassing the possible consequences not only for the particular patient but also for nurses, for other patients, and for the EPCC more generally. The abovementioned 'vicious cycle' of the waiting room is a key example of such prognoses. In patient assessments, these broader prognoses can serve as hypotheses to be tested against the available data, for instance by considering whether patients' behaviour suggests that they are likely to cause trouble while waiting. In this respect, social prognoses align with Schutz' (1967) work on *typification*, which demonstrates our general reliance on common-sense constructs of typical motives, personalities and actions in making sense of our social worlds. Although beyond the scope of this article, further research into this connection between prognostication and typification is highly encouraged (for inspiration, cf. Veltkamp and Brown 2017).

In adopting a narrative perspective, this paper does not mean to trivialise nurses' concrete experiences with GP patients (who on occasion were observed to behave in accordance with the antagonistic narratives as described above). However, it is important to maintain an analytical distinction between experiences and narratives; the latter are *representations*, and this has several important implications for interpreting the present findings. First, patients might have been represented differently. For instance, what nurses framed as 'nagging' might instead be seen as a consequence of having to wait while experiencing discomfort and pain.

Second, some experiences were emphasised more than others—in particular, atypical or 'extreme' cases attracted greater attention, indicating a bias in nurses' cognition and communication (cf. Kahneman 2011). Third, because nurses shared stories with each other (and often also retold stories heard from others), they prolonged the sense of the original encounters. As this storytelling diffused and cemented beliefs about GP patients, a nurse could have reasons for turning away these patients regardless of whether s/he had had direct personal experience with them. Moreover, the shared nature of these beliefs added significantly to their normative force; as Ridgeway (2014: 5) notes, 'individuals expect others to judge them according to [shared] beliefs' and therefore 'take [them] into account in their own behavior, whether or not they personally endorse them'.[12] Finally, these shared narratives inevitably informed nurses' experiences with patients in the EPCC, serving as *general* schema for interpreting *individual* patients' behaviour (cf. Zerubavel 1997). These are important reasons for highlighting the role of narratives in gatekeeping.

Lastly, the present findings reveal some troubling features of patient-provider relations in EMS organisations, as nurses' antagonistic narratives reveal assumptions, expectations and generalisations that can negatively affect how they receive and treat those identified as GP patients.[13] However, because the reviewed EMS research has found some degree of antipathy towards 'trivial' patients across time, space and occupational groups, it is important to recognise the structural foundations of this antagonism, rather than simply attributing it to the moral shortcomings of nurses. Relevant structural factors include the tension between openness and emergency-centeredness in walk-in EMS organisations (Dodier and Camus 1998) — and how this is often resolved in favour of the latter, to the potential detriment of EPCCs and other EMS being open, low-threshold institutions. Furthermore, Hillman (2016) shows how antipathy can be linked to institutional concerns of rationalisation and efficiency, which engender a 'combative' relationship between EMS staff and patients. More—and preferably comparative—research is needed to flesh out the structural determinants of this 'combative' relationship. However, one thing is evidently clear: If the 'respect for the life and the inherent dignity of the individual shall characterize all practice' (Norwegian Nurses' Organisation 2011: 15), then EMS staff, managers and policy makers must work to reduce this antipathy towards 'trivial' patients.

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Endnotes

[1] In contrast to EPCCs, most Norwegian EDs do *not* allow patients to walk in at their own discretion.
[2] The MTS system is detailed in Mackway-Jones et al. (2014).
[3] It should be noted that management permitted nurses to 'advise' the least urgent 'green' patients to seek help elsewhere when higher-ranked coordinators deemed the clinic overcrowded. However, most nurses turned patients away without regard to this centralised coordination.
[4] Although staff attempted to turn patients away at several points in the clinic, triage nurses were its main gatekeepers because they were the frontline personnel making the most thorough clinical assessments.
[5] I also observed five 'blue' and two 'yellow' patients being turned away (the latter two were allegedly 'overtriaged' by the MTS).
[6] Arguably, the triage nurses had good reasons for 'adjusting' the MTS; see Johannessen (2017, 2018) for a more thorough discussion.
[7] 'Rejection' denoted outright denial and was seen as a harder and less legitimate form of gatekeeping.
[8] Entering the room of another patient was also considered problematic for other reasons—in particular, because it violated the patient's right to privacy. However, in Nurse Nora's account, the disregard for Room 5 seems the most serious transgression.
[9] Nurses had access to the clinic's electronic patient record system and used it regularly to reference patients' EPCC history.
10 Buchbinder (2017) makes a similar argument.
[11] As Hillman (2007: 170) suggested, 'Perhaps patient's appropriateness remains to a large extent related to staff identities'.
[12] The data suggests that these narratives were shared by many physicians as well as by nurses. Furthermore, some nurses claimed that physicians expected them to be strict gatekeepers. Although I never observed physicians explicitly conveying such expectations, these claims suggest that physicians at least influenced nurses in a Meadian sense, acting as a 'generalised other' (Mead 1934) who was assumed to expect such gatekeeping.
[13] Theoretically, it is possible that nurses' antagonistic narratives serve as 'blinders' on their assessments, making them overlook relevant data and turn patients in need of emergency attention away (cf. Kahneman 2011). My data do not suggest such conclusions, but this could be explored in future research.

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