Shaped by Shock
Staff on the Emergency Department ‘Shop Floor’

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**Abstract:** In this article we consider the impact of shock in hospital emergency departments where people seek urgent medical care and access hospital services. We define shock as an unexpected event or set of circumstances, for although emergency departments plan for uncertainty, shock moments are when protocols and procedures fail to meet operational demands. We reveal how, depending on the professional experience and personality of staff, shocks are experienced and defined in a variety of ways. On some occasions shocks result in critical departmental failure, while at other times they generate new working practices. Shocks can empower individuals through celebrating teamwork and a sense of belonging, to take personal responsibility at a range of ‘shop-floor’ scales. These emotional and embodied engagements contribute to the operational resilience of the department.

**Keywords:** change, embodiment, emergency department, identity, learning, resilience, shock, transition

**Introduction**

The NHS Hospital emergency department is open twenty-four hours every day, seven days a week, all year long. It is designed to meet the needs of people who arrive without warning and require urgent, sometimes life-saving attention, although arguably some of these patients should be treated in local General Practitioner (G.P.) surgeries (Campbell 2013a). This article is based on semi-structured interviews with department staff and provides an insight into emergency department culture and the contextual framing of shock. Our research revealed how emergency department staff are exposed to uncertainty on a daily basis and regard this as an accepted and sometimes desired dimension of their work.1

‘Shock’ as a research term originated in our infrastructure research (Castán Broto et al. 2014) and we recognise that except for clinical purposes this term is not used day to day by emergency department staff. Indeed, one senior surgeon was surprised at our choice of focus, warning us that staff would assume our interest was in moments of panic and lost professionalism. We were grateful for his advice as this ensured we carefully explained our research and defined shock in ways that made sense locally.

Our use of the term shock can be traced to other elements of a larger EPSRC research project focused on infrastructure and our efforts to investigate the attributes of resilient systems. This research centred on defining shock as moments of organisational change and learning, when individuals are forced to be innovative and rethink their usual ways of working. In this article we confine our analysis of shock to the context of the emergency department, with comparative lessons for infrastructure to follow in future publications.

Shocks are not simply busy periods of activity but moments when usual working practices are regarded as no longer working. In these situations individuals may perceive certain resources, be it training, sup-

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plies, equipment or their professional experience, suddenly lacking and no longer equipping them for a set of circumstances. What results in these situations are various individual engagements and responses that merge at a departmental level and produce more or less successful outcomes.

Adopting an anthropological research approach enabled us to explore the impromptu and creative dimension of emergency medicine. Our focus, much like Wright’s (1994) and her interest in studying-up, was to reveal how shocks on the shop floor encourage change from the bottom up, as opposed to change from senior NHS managers. Our research positioned shock as framed by particular contexts and individual experiences (Rapport 1997). These can be particularly stressful and adrenaline laced moments, with individuals keyed through their emotions into new ways of knowing and engaging with the emergency department environment. At the same time, we draw a distinction between our interest in positive experiences of shock and other perhaps destructive experiences like trauma.

Finkel (2010: 186) and Messinger (2013) have described how soldiers with service in Iraq are frequent casualties of Post-traumatic Stress Disorder (PTSD). These ‘trauma victims’ suffer physically and mentally, finding it difficult to come to terms with some of their past experiences (Svasek 2005: 199). However, whereas PTSD is a ‘wounding experience’ (Caruth 1995: 184), we explore shock as a moment of emotional intensity but with a positive and creative outcome. We consider shock to be a learning experience, where individuals have an opportunity to work in new ways, perhaps with new people and solutions.

Definitions of shock relate to the professional expertise and personality of emergency department staff; these are situations where individuals can disagree on when the department is being shocked. Also, while these liminal periods are moments of transition (Turner 1964) and may stimulate change in how individuals engage with their environment, this may not be a shared experience. New working arrangements and collaborations can be confined to certain personnel and parts of the department. When shock has this effect, it stimulates change formally and informally at various scales, and we suggest contributes to the ‘materialised professionalism’ of emergency department staff (De Marrais et al. 1996: 16).

Research was carried out by the first named author in three emergency departments, in three NHS Trusts, and prior to the creation of new trauma centres (London Trauma Office 2010). Two emergency departments were researched as part of a Design Council project (2011) and this involved participant observation with staff and patients over three night shifts in December and early January 2009–2010. The second period of research, funded by the EPSRC, centred on thirty-seven in-depth, semi-structured staff interviews and provided a spread of viewpoints from those of senior consultant to junior nurse, departmental cleaner and porter. Interviews were organised around a set of common discussion themes, audio recorded, transcribed and used to complement insights gathered from ethnographic field notes. The interviews established how people ‘acquire direct knowledge of their environments in the course of their practical activities’ (Ingold 1992: 40; 2000: 186; 2011: 57). In our analysis we explored the emotional links between emergency department personnel and their environment and why shock might act as a catalyst for change.

In the next sections we describe the context of the emergency department and how staff train and prepare for uncertainty. We then refer to our interviews to illustrate how well-rehearsed plans can be disrupted but how the actions of motivated individuals, working in a range of professional levels, combine and contribute to departmental resilience. Our start point is to introduce shock as a personal, emotional and therefore embodied experience. We then describe how the emergency department is organised, and describe how drills and procedures are learned to the point where they become habit, but also how more flexible and adaptive responses emerge. Using examples from our interviews we reveal how shock situations are resolved in ways that reflect the qualities and character of staff on duty at the time, and through a combination of approaches.

Practical and Embodied Engagements

We contextualised research participants as connected to their work environment by a collection of emotional, embodied engagements. This positioning provided us with insights into the characteristics of shock and notions of resilience, and acknowledges the ongoing process of cultural creativity. Our approach was guided by the work of Tim Ingold (1992: 40) and Kay Milton (2005: 25) and their interest in ecological anthropology. This is an approach to understanding human–environment engagements that differs from cultural constructionism as it avoids creating a nature–culture dualism. Ingold discussed how ‘It is possible for persons to acquire direct knowledge of their environments in the course of their practical activities’
and similarly Milton noted that human emotions are ‘ecological rather than social phenomena … [and] mechanisms through which an individual human being is connected to and learns from their environment’ (2005: 31). Recognising the emotional connections of individuals reveals how ‘direct knowledge’ is acquired through practical engagement. This provides the framework for our research and our approach to analysing the impact of shock at both an individual and department scale.

In other relevant work, investigating links between the emotional arousal of individuals and new ways of remembering and thinking, Whitehouse (2005: 91) defined ‘procedural learning’ as situations where a range of ‘embodied skills … eventually becomes second nature to us, in the sense that we can carry them out without consciously representing the knowledge we have acquired’. This type of ‘second nature’ knowledge arises from repetitive forms of learning, much like riding a bicycle or knowing the words to the national anthem, and is a way of learning and knowing, with similarities to Pierre Bourdieu’s description of habitus. He described this as a collection of ‘dispositions’ or ‘permanent manners of being, seeing, acting and thinking, or a system of long-lasting (rather than permanent) schemes or schemata or structures of perception, conception and action’ (Bourdieu 2005: 43). In this way knowledge builds over time (De Marrais 2004: 13) as a collection of ‘inscribed practices’ (Connorton 1989: 74).

In a clinical context, learning by repetition is illustrated by protocols and procedures that guide staff during medical emergencies. One surgical team demonstrated this approach when they studied the handover procedures of a Formula 1 pit-stop team and sought to transfer these lessons to a hospital operating theatre (Sower et al. 2008). To assist in speedy and efficient patient handovers the surgical team even sought help from a professional dance instructor who choreographed their operating theatre movements.

However, orchestrating and pre-setting the professional behaviour of clinicians in this way has raised concerns. Moorthy et al. has suggested that medical staff can ‘overlearn’ to the extent that ‘responses become automated’ and ‘staff become so accustomed to responding automatically they become less capable of thinking in new ways’ (2006: 146). Wears et al. (2007: 612) noted that established protocols and procedures provide finite levels of dynamic and adaptive capacity and can lead to system failure, with resilience lost and the department entering a state of uncontrolled ‘free fall’. As we reveal in later sections, many experienced staff regard maintaining control and avoiding ‘freefall’ as key to achieving successful outcomes. As we discuss below, learning by rote contrasts with more dynamic and less formal responses that combine different staff experiences and training (Anders et al. 2006; Miller and Xiao 2007: 51; Rasmussen 1997). Our semi-structured interviews revealed that staff mix approaches so familiar routines and well-practiced procedures are complemented by more impromptu ways of dealing with uncertainty. Although procedures may become habit-like, they are adapted and changed during shocks and not usually applied as designed.

The Emergency Department

In general, the numbers of patients attending emergency departments in the U.K. is on the rise, attributed to restricted General Practitioner (GP) surgery opening hours, the closure of NHS Direct, and challenges faced by the 111-telephone advice service. The four-hour waiting time target in emergency departments has encouraged patients to ignore local GP surgeries and attend local emergency departments, which are open twenty-four hours a day and may provide a convenient drop-in service (Campbell 2013b). In April 2012, a rationalising of NHS budgets led to twenty-two emergency departments being upgraded to Major Trauma Centre status where clinical specialists and equipment is centralised (London Trauma Office 2010).

When the department is quiet, staff prepare for a range of possible shocks by checking and servicing equipment like trolleys, oxygen supplies, defibrillators and suction units (Moorthy et al. 2006). Staff continually re-familiarise themselves with procedures and specialist techniques, training at both the individual and team level. Patients arrive at the department and are allocated clinical care depending on the severity of their illness or injury and sent to the Minor or Major treatment area. Those with traumatic injuries are moved rapidly to the Resuscitation area (Resuc), where equipment and skilled staff are summoned from across the hospital to provide critical emergency care. A carefully organised shift pattern is designed to ensure sufficient numbers of trained staff are available to deal with medical emergencies but certain staff–patient ratios can be compromised during busy periods. One of our research participants, a senior consultant named Joe, explained how, ‘we run staffing levels for a busy day, but quite frequently a busy day can suddenly become a horrendous day, and one multi car pileup can result in a significant overload to the system … and that unfortunately usually happens out of hours’.
When the pre-planned system becomes overloaded new solutions have to be found. Joe admitted that sometimes ‘demand outstrips supply’ to the point where, ‘you have clinically very sick people requiring multiple staffing and equipment resources … [and] you end up prioritising according to need’. In this situation staff make ‘clinical judgments’ and decide which patients need what medical interventions most urgently. Rasmussen (1997) has detailed how dealing with unpredictability and striving to maintain a ‘safe operating envelope’ are central concerns in the emergency department, but as consultant Sally described, ‘the adapting quickly process, and changing what you do, is relatively common because … a huge amount of emergency department work is crisis management … of changing your pattern of what you’re doing … because what you’re doing is not working’.

Sally detailed how the arrival of multiple casualties mixed with low staffing levels means that staff ‘have to improvise [and] people’s roles change’. This is a similar situation to that described by Stein (1967), where junior doctors move into the roles of senior doctors, and nurses into those of junior doctors, and where staff task shift and assume new responsibilities to suit particular situations. In these moments, senior consultants continue to supervise the work of junior staff, while they also practice medical procedures on the ‘shop floor’. Joe excitedly recalled how they frequently take the lead on a range of medical procedures, ‘even as a consultant … you just roll your sleeves up … you’re seeing the patients the same as your registrar … you’re actually doing exactly the same job as your very junior colleague’. Engaging with patients in this way provides an opportunity for junior staff to watch, imitate and learn. Joe suggested these work practices act as a good ‘leveller’ and contribute to a ‘slightly different work ethic in A&E’. As we discuss below, the resilience of the department is heavily dependent on teamwork and esprit de corps. In addition, our interviews also suggested that departmental resilience is a quality that arises when staff have ‘familiarity’ with shock events.

Craft, Leadership and Shock Familiarity

Pye (1968) defined craftsmanship as activities that involve a degree of risk, where results are not predetermined but depend on the judgement and dexterity of the worker. Medical staff working in the emergency department can be likened to crafts people for they too need dexterity and to engage with risk in a context of uncertainty. Working in this context encourages a particular culture of resilience among emergency department staff, as Anne, a senior staff nurse noted, ‘They come here to do their training [doctors] … so they’ve maybe not worked in A&E for more than a few weeks … they’re sort of put in these situations, not necessarily to be in charge but seeing trauma, but they’re not familiar with [shock type situations] … and I think it’s quite stressful for them, same as new nurses, eventually they get used to it’.

This ‘getting used to it’ is an orientation that arises the more staff are exposed to shock situations, with staff ‘familiarity’ key to creating departmental resilience. Shock situations develop from a lack of resources (staff or equipment) but also involve incidents with unique or unusual characteristics. In one incident described by senior sister Joyce, a woman suffered heart failure as she arrived at the hospital for an emergency caesarean. ‘We were pre-alerted so we had time to alert the appropriate people … the consultant [in the emergency department] and the obstetrics people … to do the caesarean.’ Joyce explained how the priority was to save both mother and child, ‘so the adult team was trying to resuscitate mum, obstetric team was getting the baby out … at exactly the same time’. This was a shock situation for Joyce because,

[It was] such a rare thing, it doesn’t happen very often, so the nursing staff on [on-duty] with me, myself included, never seen it before … that sort of led to a big learning curve for everybody and changes [in] the way we do things … I didn’t flap [panic] because I knew we could get the team down, it’s a case of ‘Right …’ the first call I made … an obstetric cardiac arrest call … [and] got my senior doctor.

Joyce noted how this moment was made more difficult because it was not alerted as a trauma and staff attending ‘didn’t know what to expect’ or what was ‘required from a nursing or doctor point of view’. Joyce explained how they decided to deal with this as a trauma for lack of other guidance. The problem with this being classed as a medical emergency was that no single individual was designated in charge over all. Joyce noted that,

It’s so rare that kind of thing [requiring two teams] … in a medical emergency … it tends to be one patient if its cardiac arrest you deal with it … if it’s another kind of medical emergency you deal with that … It can be a bit like, it’s not very well organised … you should have a trauma lead … that stands back and does nothing, and says, ‘You do that! You get that, you sort that out, you do this, and let’s do this next …’

In these situations, staff from different parts of the hospital work closely with each other. Anne, a senior staff nurse described how:
some of these situations get a bit fraught because everybody’s sort of upset and wanting to do their best for everybody ... You can get emotionally involved, it’s very strange because you’ll have some incidents where you can deal with it ... and then there’s other incidents which totally get to you and there’s no explanation as to why.

The unpredictable and emotional aspect of emergency medicine described by Anne is difficult to replicate in training, but has huge implications for how a team functions outside a training environment. Unlike the highly structured context of a formula 1 pit-stop team, an emergency department team emerges from who is on duty at the time. In these situations, clear leadership is recognised as playing a crucial role in achieving successful outcomes.

Personnel are emotionally connected to their work environment and knowing how to act comes from a mix of training and cultural familiarity. Joyce, like many we interviewed, described having to control how she physically and emotionally engaged with situations, remaining detached as best she could:

If you get involved [emotionally + physically] in something, you can’t stand back and be objective and watch, and see what needs doing because you’re too involved. Having said that, the priority’s the patient, and if a nurse has gone off to get something, then I will get involved, I’m not going to stand back and say, ‘I’m sorry, I can’t do that because I’m in charge today!’ You know, you’ve got to do what needs doing at the time.

The experience and professionalism of this senior sister is elegantly illustrated here, for Joyce trusts her colleagues enough to stand back and take an overview of what is happening. At the same time, while not wanting to become over involved and risk losing control, she is prepared to be flexible and step in when required.

Leadership is not always assigned at the outset, as Anne acknowledged, ‘sometimes you have to sort of take [control] so that is quite stressful ... sometimes you want to smack them’ [other staff]. I’m sorry but you do! I think some of the younger staff do sometimes get very stressed at that, whereas it takes years to be able to say, ‘Just calm it!’

These moments Joyce explained, ‘can be chaotic ... because everybody’s a bit buzzing ... you can get doctors say, “Can I have this?” and “Can I have that?” “Can somebody get me this ... somebody get me that?” And they’re just saying it into thin air!’ Such pre-arranged partnerships need to work if patients are to receive the care they need. Joyce was adamant that success in a trauma situation came from people having a designated role and them having control over their emotions so they do not affect their clinical judgements. So, explained Joyce, ‘an anaesthetist doctor, for example, should have a nurse to deal with the airway ... the doctor and the nurse, they should be just speaking to each other ... and the doctor should be asking the nurse for whatever he needs, and that nurse should be just dealing with that doctor’. This is the ideal working arrangement but Joyce adds how ‘it depends very much on personalities’.

The emotional response of staff is important, especially whether they experience an incident as a professional shock or a personal trauma. Shock situations can also develop from instances when team alliances break down and procedures fail to deliver what is required. Responding in a flexible way to fit with an evolving situation is important when specialists are drawn into the team from other parts of the hospital.

Anne detailed how specialists sometimes have different priorities from one another:

There’s a lot of shall we say shouting around, because everybody’s trying to get in ... everybody wants to do their bit, you’ll have orthopaedics ... plastic ... your neurosurgeon ... your surgeon coming for abdo [abdominal] ... they’re all waiting for their bit of the patient, it can become quite stressful because there’s only usually a couple of nurses actually doing all the running around ... We [the nurses] have to sometimes say, ‘Right! Can you stop! We’re doing ABC,’ we’re going to see whether there’s breathing ...’

Anne and other experienced senior nurses are not only accustomed with this type of situation but have the confidence to manage incidents as they change and morph in different directions. They are happy to abide by certain protocols that are working but also willing to adapt and change when they are not:

We’re used to the situation ... so you’re used to sort of going through all the motions ... and you know what to do ... calmness ... we do have training and I think it’s just experience ... most of our training is the fact that we have them [incidents] so regularly. Familiarity is good. A&E is prioritising, you’ve got to prioritise.

The lessons learned through these team experiences can vary. Following the incident of the woman admitted for an emergency caesarean, Joyce described the multidisciplinary debrief held to discuss the incident’s response. ‘Obstetrics thought there were issues ... there were just little things ... [that] doesn’t occur to us in A&E.’ There were problems of noise with the team treating the mother finding it difficult to hear the baby’s heart beat and rate of breathing, and the team
complained of finding it difficult to concentrate with all the noise and confusion, the mother being out of sight but only behind a curtain in an adjacent cubicle. Joyce noted that this ‘wasn’t something that crossed our minds’.

The unfamiliarity of the obstetrics team with the emergency department also meant ‘they couldn’t put their hands on’ certain equipment and were constantly asking where it was stored. The ventilator used was unfamiliar and they had to ask for help in getting it to work. Finally, they requested in future to be contacted by telephone rather than crash call11 as this would provide detail of why they were required and who to send. ‘So, what we kind of learnt from it’, recalled Joyce, ‘was to check all this equipment on a daily basis, likewise they [obstetrics] have to come down and familiarise themselves with our equipment, and you know this number [telephone] will get used now’.

Building a Culture of Resilience

During the interview I asked Joyce what the impact of the incident had been; she replied, ‘so you know it kind of changed the way that we practice, just little things … the idea is to make it all a bit slicker next time’. I asked if she thought it would be ‘slicker’ next time, and she replied ‘No, not really!’ When I asked her why, she explained:

because again, it’ll probably be another five years before it happens [again], and the people that are on [duty] that shift will have never seen it happen before, they’ll have the same, ‘It isn’t going to be me’. And the obstetrics consultant that came down that night, and our registrar that was on that night, it’s going to be all different people and they’re going to go through the same experience we did.

Her account suggested that the intimate details of a shock are not necessarily remembered in the following months and years, but such experiences do have a positive effect of strengthening a departmental culture of resilience, encouraging a can-do attitude and a willingness to task shift and work extra hours. Joyce, much like Anne and others we interviewed, recognised that successful outcomes depend on staff being regularly exposed to situations of uncertainty and risk. ‘It’s all familiarity …’ said Joyce. ‘There’s nothing you can do about something that you’ve never seen before, that makes you go “shit!” You know.’

Regular exposure to shock, and the familiarity that results means staff acquire what Goodwin (1994: 626) described as ‘professional vision’. This helps staff that rotate through shift systems to focus, not necessarily on perfecting drills like the surgical team wanting to emulate a Formula One pit-stop crew, but on a type of resilience that depends on individuals being familiar and relaxed with confusion and uncertainty. Encouraging this mindset alongside access to hospital-wide resources raises the confidence of staff to deal with a wide range of incidents. Anne suggested, ‘all you can do is have all your policies and your protocols in place, and be familiar with them, and be familiar with your equipment, training and scenarios … and that kind of thing helps I think’. Likewise, Joyce recognised how, ‘because of the nature of the department, there will always be situations thrown up that … totally throw you and you can’t have a system … and a protocol … and a plan for everything … you have to be flexible … you have to adapt to whatever comes through the door’.

Teamwork

Seemingly minor acts like senior consultants referring to other staff, and being known by their own first names, encourage ancillary and junior staff to feel valued and supported. Teamwork and a sense of belonging are vital components of departmental resilience because they foster a positive work ethic and encourage staff to share tasks and responsibilities. Senior nurses, for example, are willing to mop floors when the cleaner is busy, and porters will step into the role of medical orderlies when needed (see also Clarke et al. 1984; Hindmarsh and Pilnick 2002). These perceptions encourage staff to endure shock, this positive behaviour acting to insulate the department from shock by creating ‘buffering capacity’ (Anders et al. 2006). George, another consultant, commented on the huge contribution of a good team and how difficult personalities only minimise the chance of a positive outcome, ‘We just really worked together well as a team, and we just cracked on and got it sorted, nobody had a break, nobody complained … I had good staff, doesn’t always work like that … it’s the human element that changes it all’.

The contribution of a teamwork ethic appeared in all of our interviews. During a winter ice event, for example, the department was inundated by the mass arrival of people suffering a similar range of minor injuries (fractured and sprained ankles and wrists). George, the lead consultant on the day, described how ‘you have to play to people’s strengths … It’s about knowing your team and working in the most efficient way’. George and Joyce recognised the likely impact
of mass casualties arriving, Joyce commenting on how there were ‘fourteen people at one point … waiting to see orthopaedics to get their wrists pulled, Minor Injuries was heaving!’ She described how extra staff were summoned from other parts of the hospital:

We got all the orthopaedic consultants down, and we identified rooms that they could use [in the emergency department] … it was like a conveyor belt, an orthopaedic consultant, a registrar, and a senior house officer, and I gave them a nurse and literally, one was going in and taking all the details, putting in the local anaesthetic in the wrist, the next one was going along pulling [manipulating] the wrist, then the plaster technician … it was ridiculous!

Incidents like this also impact on staff in non-clinical roles. Supplies are exhausted and need to be replenished by the ward clerk. Similarly the mass arrival of casualties requires ‘matron’ to find spaces on the general wards, to enable patients to be moved out of the emergency department to make space for new arrivals. George was adamant that having the ‘right people’ across a range of clinical and non-clinical roles was critical for securing a positive outcome, ‘You’re trying to do something different and think out of the box … and what you want is people who’ll go with you on that … rather than just stick to what they’ve always done for fifty years … if you had somebody inflexible, we might not have the same results’.

Moments of shock acclimatise staff with risk and uncertainty, and provide opportunities for them to become culturally attuned to working in this department. The mix of characters on a particular day, and the management style of those in charge, all impact on how a shock is resolved. Shock situations develop when a range of pre-planned strategies are compromised for whatever reasons. Departmental resilience depends on staff rethinking how to apply protocols, to address shocks in different ways, with varying degree of success, using a range of skills and competencies (Lindberg 2010).

Conclusion

In this article we have provided a shop-floor view of departmental resilience and revealed this to be a quality that originates in a complex collection of interpretations and responses of people working in different departmental positions. We explored a range of research participant worldviews and perceptions, with our specific definition of ‘shock’ providing an important focus to our work. This ensured we obtained insights that were comparable to research gathered from other non-clinical (infrastructural) contexts, and allowed us to pursue a comparative trans-disciplinary research approach. This was important to our research, which was designed not simply to identify a range of individual shock moments but to examine the insights from these and consider how resilient cultures develop in other (infrastructural) contexts.

Our research participants provided accounts of incidents where disruptive challenges led to moments of transition. These allowed us to frame resilience as an ongoing process rather than a fixed or static state. Our theoretical approach was informed by this observation and led to analysis that identified cultural complexity within the emergency department (see also Eriksen 2007). This fluidity is reflected through the two approaches we discussed above for dealing with uncertainty. In the first, drills and procedures are learned until they became habit, while in the second, staff engage and adopt a more bespoke approach to neutralising shock. What results are approaches that combine the two, so a degree of pre-planning coexists alongside response that are driven by particular staff personalities, competencies and emotional experiences. ABC drills, for example, remain important waymarkers as new solutions and ways of working are developed to deal with a particular shock.

A culture of resilience can arise among staff working at a range of professional scales when they are exposed to shock. This regular exposure hones the practical and emotional skills of staff and is an essential embodied experience for those working in the emergency department. These shake up the status quo and ensure staff remain motivated and engaged with their workspace. While staff may find these adrenaline-fuelled moments stressful, all those we interviewed enjoyed the ‘buzz’ of working here, although sometimes in hindsight.

The shop-floor team enlarges by developing links with other departments. This, alongside the building of a strong teamwork ethic, enhances the department’s capacity to deal with situations that stretch resource availability. Our anthropological insights have revealed staff willing to work longer hours and task shift for the benefit of colleagues and patients. Departmental resilience is revealed as a quality that originates from the shop floor as well as from policy decisions taken by more senior NHS managers. In applied terms, the insights of this article highlight the collective power of small-scale and individual staff-level interventions. Resilience at the shop-floor level appears intimately associated with people working in strong teams, sharing a sense of excitement and companionship, and motivated to explore new solutions to new challenges.
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Notes

1. Interview staff described enjoying the excitement of working on the shop floor and contrasted this with what they regarded as mundane work found on other general hospital wards.
2. A term used by research participants to describe the working area of the emergency department.
3. Design Council Research on how to reduce violence to staff and other patients in NHS emergency departments through rethinking the design of the built environment.
4. This EPSRC research project entitled ‘Shock not Horror’ focused on themes of resilience and sustainability. The project was designed to gain fresh perspectives on how infrastructures respond when challenged and damaged, by comparing these with similar situations in the emergency departments of NHS hospitals.
5. NHS Direct: a health and advice service replaced by 111.
6. 111: A health-advice service replacing NHS Direct.
7. The four-hour rule was introduced in 2004 and stipulated that 98 per cent of patients should be processed through NHS emergency departments within four hours of initial registration and was introduced to reduce the patient waiting times for hospital bed spaces. NHS Trusts that breach this rule are fined and identified in league tables. The four-hour rule links patient care to an economic model (Department of Health 2010) where funding follows the patient and NHS Trusts compete for business (Health and Social Care Act 2012; Ramesh 2012).
8. Pseudonyms are used throughout.
9. This was a throwaway comment and not meant seriously.
10. Airway: Breathing: Circulation.
11. An emergency call put out to summon staff from across the hospital.

References


Health and Social Care Act (2012), (London: Her Majesty’s Stationery Office).


