



Salud Pública de México

ISSN: 0036-3634

spm@insp.mx

Instituto Nacional de Salud Pública
México

Mondragón B, Liliana; Romero M, Martha; Borges, Guilherme
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Salud Pública de México, vol. 50, núm. 4, julio-agosto, 2008, pp. 308-315
Instituto Nacional de Salud Pública
Cuernavaca, México

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Ethnography in an emergency room: Evaluating patients with alcohol consumption

Liliana Mondragón B, MSc, ⁽¹⁾ Martha Romero M, PhD, ⁽¹⁾ Guilherme Borges, ScD. ^(1,2)

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Abstract

Objective. To present an ethnographic description of the treatment of patients with excessive alcohol consumption in an emergency room, how they are evaluated by doctors, and the various contextual aspects surrounding this condition. **Materials and Methods.** The ethnographic work was carried out over a period of two months, with researchers working 24 hours a day, seven days a week from January 9 to March 15, 2002 in the emergency room (ER) at General Hospital, Mexico City. **Results.** Patients that had consumed alcohol and were admitted to the ER had to wait longer than others to be treated for their intoxication to wear off and for their sometimes aggressive attitude to become calm. The rejection of the alcoholized patients was expressed through scolding to persuade alcohol-dependent patients or those that abused alcohol to reduce their consumption. **Conclusion.** The theoretical and methodological approach of the ethnographic observation enables reflection on the social and cultural mechanisms related to this health problem.

Key words: ethnography; emergency service, hospital; alcohol consumption

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la valoración de los pacientes con consumo alcohol.
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Resumen

Objetivo. Presentar una descripción etnográfica en un servicio de urgencias (SU) sobre la atención de los pacientes con consumo excesivo de alcohol, las formas de la valoración de los médicos y los diferentes aspectos contextuales que enmarcan esta condición. **Material y métodos.** El trabajo etnográfico se realizó durante dos meses, trabajando las 24 horas, los siete días de la semana, del 9 enero al 15 de marzo de 2002, en el servicio de urgencias de un Hospital General de la Ciudad de México. **Resultados.** Al paciente que había consumido alcohol y que ingresaba al SU se le hacía esperar más, para que se tranquilizara y a su vez disminuyera la intoxicación. A través de regaños se trató de sugerirle al paciente con dependencia o abuso de alcohol que redujera su consumo. **Conclusión.** El abordaje teórico y metodológico de la observación etnográfica permite hacer una reflexión sobre los mecanismos sociales y culturales, enmarcados en las problemáticas de salud.

Palabras clave: etnografía; servicio de urgencia en hospital; consumo de bebidas alcohol

(1) Instituto Nacional de Psiquiatría Ramón de la Fuente. México DF.

(2) Universidad Autónoma Metropolitana Xochimilco. México DF.

Fecha de recibido: 2 de mayo de 2007 • Fecha de aceptado: 4 de abril de 2008
Solicitud de sobretiros: Mtra. Liliana Mondragón Barrios. Instituto Nacional de Psiquiatría.
Calzada Mexico Xochimilco 101, Col. San Lorenzo Huipulco. 14370, México DF, México.
Correo electrónico: lilian@imp.edu.mx

According to a medical criterion of normality, excessive alcohol consumption is regarded as a disease and a lack of self-control. The medical model treats somatic factors as the only causes of the pathologies derived from alcohol, without considering socio-genetic, psychiatric, psychological, social, or cultural factors.¹ These conceptions, constructed by medical discourse, are endorsed by society. Thus, from the physician's point of view, curing the symptoms is the main goal, since biomedical thought is based on an etiological ideal according to symptoms and signs, in which the patient's manifestations become biological phenomena to be dealt with in a somatic dimension.² Thus it takes the symptom into account as an effect, yet ignores the cause, i.e. alcohol consumption; in other words, it is considered to be a biological issue when the reality of the problem is that it is also a social issue.^{2,3}

The problem, however, may not lie in the etiology of diseases but rather in the technical limitations of the control, diagnosis, cure, and prevention of certain ailments, which are usually "inaccurate" as in the case of alcohol consumption or alcoholism, as pointed out by Menéndez and Di Pardo.⁴ In this case, alcohol consumption is an imprecise problem due to its multi-causal network and the cultural, social, and economic aspects to which it is linked. The identification, diagnosis, and evaluation of the heavy drinker is perhaps an even more important limitation.

An important factor in addressing alcohol consumption problems is the evaluation of the problems related to that consumption. This evaluation may consist of three steps. The first is screening to identify the problem or disease through a test or other quickly administered procedure, without determining a diagnosis. The second is the evaluation of existing problems for patients that tested positive in screening. The third is specialized evaluation programs for specialized treatment. Another aspect closely related to the diagnosis and treatment of alcohol consumption is the doctor's role, particularly in the identification and treatment of persons with related problems. Some of the research from Spain^{5,6} has shown that the prevalence of problems associated with alcohol consumption differs enormously among doctors' reports on the frequency of these problems in their consults.

Meanwhile, some studies have shown that there is a significant increase in the number of patients detected or diagnosed with alcohol-related problems when doctors have adequate supervision or support to detect or diagnose the problem and when the doctor has knowledge of and experience with the issue.^{5,6} Other research^{5,6} has proven that the existence of positive or negative attitudes on the part of doctors towards working with this type of patients influences their capacity to diagnose them.

Despite their importance, the medical model has ignored issues such as the various ways in which the doctor-patient relationship is established and its role in evaluation, as well as the stereotypes and stigmas associated with problem drinkers.

For the anthropologist, sociologist, or social psychologist, there are different ways of seeing and understanding the phenomenon of alcohol consumption. The forms and functions of alcohol consumption are not "given" by the biological world but rather by the dialectic between the social structure and personal experience.⁷ Thus, anthropological literature shows that cultural aspects may be central to shaping the way in which people drink and the patterns of behavior associated with alcohol consumption, in addition to the way problem drinkers are seen, considered, and treated.

Thus, one can question the social and cultural implications, as well as other factors such as the dynamics of health systems, that could combine to influence the evaluation or diagnosis of alcoholized patients. In this respect, we present the results of an ethnographic observation designed to explore the ways doctors evaluated problems related to alcohol consumption, injuries caused by consumption, and attitudes towards alcoholic patients. The ethnographic observation was carried out in an emergency room (ER) since most of the consequences of alcoholic intoxication are usually treated in this type of service.

Material and Methods

This study is part of a project by the World Health Organization (WHO) that sought to determine the role of alcohol in accidents in the international context, provide data on monitoring systems in the countries studied, and test new epidemiological analysis techniques; details about the participating countries, methods, sample characteristics, and results can be consulted in other documents.^{8,9,10} The project also includes a qualitative approach, a phase called "key informants" to explore the forms of assessing and measuring alcohol consumption in the routine work of an emergency service (ES), including the use of clinical observation developed by members of the multicultural study group and WHO, on the basis of Code Y91 of the International Classification of Diseases (ICD-10).¹¹ In Mexico, the project was approved by the committee of ethics in research at the Ramón de la Fuente National Institute of Psychiatry. All the ethical safeguards were taken to assure the anonymity of the information.

The sample consisted of 705 first-time patients over the age of 18 admitted for injuries to an emergency service in Mexico City. The data were collected by in-

interviewers (male or female nurses and psychologists) trained by the research team to administer the structured questionnaire which was conducted after informed consent had been received. The collaboration and training of medical personnel was sought to fill out the clinical observation instrument.

An ethnographic observation was carried out, understood as a social research method in which a complete or partial description is made of a group of persons that have something in common and whose behavior is understood in a specific, everyday context over a long period of time.¹² The observation lasted six weeks between January and March 2002 and was undertaken by a key informant. The key informant was a female member of the research team, rather than from the community.

The structure of the ethnographic observation is given below:

1. Description of emergency services: structure, personnel, functioning, admission procedures, treatment alternatives, waiting and consultation time, patients, medical questioning or clinical history specifically related to routine data on alcohol consumption associated with accidents/injuries.
2. Description of the medical assessment of alcohol consumption: the impact of drunkenness on emergency services, ways that doctors detect alcohol consumption associated with accidents, barriers, interventions carried out, and health professionals' attitudes towards drinkers.

Results

Ethnographic observation

General description of emergency service

The study was conducted in the emergency services at a general hospital in the southern region of Mexico City. It is a public hospital, primarily for the population that does not belong to either of the two national health systems and has no private medical insurance. The health care provided is almost free, since the cost of consultations is sometimes symbolic as compared with other hospitals of the same level.

The emergency service setting includes three treatment areas: 1) pediatrics; 2) gynecology-obstetrics, and 3) medical and traumatic emergencies. In 2000, a total of 40 359 adult patients were treated in this hospital. For the treatment of injuries and traumatism, the service is regarded as being level II, with 12 beds and five surgery

units. This service operates with two traumatologists and three or four resident internists; there is no nursing staff. Adjacent to the main entrance are three x-ray rooms and an intensive care unit. Surgery and hospitalization are carried out within the hospital's main area. The facilities are small with a large number of patients being treated and others waiting to be seen.

The emergency service is 435 square meters inside the hospital and is located near the back. Access for emergency service patients is complicated; patients must cross the entire hospital, since most of them walk onto the premises; others arrive by private car and a fraction is driven there by ambulance.

The emergency services are painted white, inside and out; the walls, floor, sideboards, and some furniture such as and chairs are all white, except for the seats in the waiting room which are royal blue plastic; the uniforms are also white.

There is a reception module where there are generally two or three people who register patients. There is a social work cubicle near the entrance to the emergency services next to the reception module which is also used by the state prosecutor's office, when their presence is required. The state prosecutor's office is the legal department responsible for legal issues for admissions involving patients who are victims of crimes such as rape and sexual abuse, family violence, robbery, homicide, as well as suicide attempts. Next to this cubicle is a waiting room, which is the largest area in the emergency facility, for all the emergency service patients and their families. To the far right of this space is a window for patients to request x-rays and on the far left are special x-ray rooms.

There are five surgery units where patients are seen; three are located at the entrance to emergency services opposite the reception module and another two are behind the waiting room at the end of the area. On one occasion during the field work, the largest surgery unit with equipment for dealing with orthopedic emergencies (taps, special buckets for plasters, gloves, etc) was turned into an operating theater for operating on an exposed lower limb, while two consultations were carried out simultaneously in the same space.

In all the surgery units, there is a bed with light blue sheets, a writing desk with two drawers that are usually empty or contain a few sheets of scrap paper, a typewriter, a white plastic chair, and curtains instead of a door.

At the end of emergency services is an observation room where seriously ill patients are treated, with an entrance that is restricted to authorized personnel and a wooden door that is always kept closed. This room

has all the surgical medical equipment for dealing with any emergency. As in the waiting room, it covers a large area within emergency services.

The ES has a characteristic hospital smell of formalin, disinfectant, medicine, and dampness. Cleaning is divided into shifts: 1) to remove toxic waste such as small vials, urine samples, needles, syringes, and normal rubbish; 2) to clean the surgery units and change the sheets; and 3) to mop the floor and remove any blood stains.

Patients admitted to emergency services were largely men and youths; the average age was 35.4. Most of the patients were either single or married, with a low formal educational level. They were usually also people with low incomes that lacked the means to pay for private services.⁹ They lived near the hospital, located in a rural and urban sector. In the mornings and afternoons a similar percentage of men and women were admitted, whereas at night the percentage of men was higher.

One of the most common characteristics of those admitted to emergency services was their delay in seeking treatment for their injury/accident or illness; the injury had occurred two or more days before they requested a consultation. Sometimes this was due to the fact that they tried to "hang on until they couldn't bear it any longer," in the words of one patient.

Another significant characteristic was their low formal educational attainment, which constituted a barrier to their treatment since the doctors' technical and scientific language was poorly understood by the patients. This hampered the dynamics of the clinical interview since when the doctor asked the patient questions, the patient did not understand the question and gave an inappropriate answer, making the doctor impatient and turning the interview into an exchange yielding little useful information for either party.

The most common types of traumatism for which patients were admitted were falls, cuts, violence, and car and household accidents; the most common medical diagnoses were fractures, blows, contusions, and sprains.

Also admitted, albeit to a lesser extent, were patients that had attempted suicide and those with serious alcohol consumption problems such as withdrawal; patients that had been the victims of crimes such as attempted rape and sexual abuse or intra-familial violence were also admitted and these cases were referred to the state prosecutor's office, as required, and the patients were allowed to file a complaint if desired.

With regard to the treatment process, when the patient comes to the emergency service, he requests a consultation at the module. He then waits to be evaluated by a doctor or resident who determines whether the

injury is an emergency or not and whether the patient warrants emergency treatment. In the event that the patient is accepted, the doctor asks those in the module to take down the patient's details including name, address, age, and reason for the consultation; these data are provided by the patient or the relative accompanying him. Once the patient receives his treatment slip, he is given bills for both the consultation and the x-rays. Payment for a consultation was approximately \$58 pesos and the cost of x-rays varied from \$76 to \$111 pesos. If for some reason the patient did not have enough money to pay, for example, if he had been robbed or did not have enough money with him at the time, the patient was sent to the social work area where his situation was discussed until an agreement was reached, such as paying the next day or, in extreme cases, being exempted from payment.

Once the patient pays for his consultation and, if necessary, x-rays, he hands in the documentation at the emergency module where his treatment slip is kept and subsequently placed in a tray while the patient is in the x-ray department. The patient then remains in the waiting room for one to three hours. The doctors take the treatment slips from the trays and summon the patient from the waiting room to begin the consultation.

The role of doctors and other professionals within the service includes the resident doctors who generally worked 36 by 24 hour shifts in the hospital while affiliated doctors worked seven hours. Most of the medical team comprised medical students specializing in internal medicine who normally were the ones to attend to patients. Some of the affiliated doctors only supervised the correct treatment and diagnosis of the patients.

The waiting time for receiving medical attention varied according to the number of patients waiting for treatment and the severity of the injury. Thus, the approximate length of time a patient waited to be seen, if his injury was not serious, varied from three to nine hours; a patient with a moderately serious injury waited from two to three hours; and extremely serious patients were attended to almost immediately, with only 30 minutes elapsing between their time of arrival and medical treatment. Sometimes they were automatically admitted to the observation area, having to wait no more than five minutes to be seen. Patients were attended to in order of arrival.

Routine evaluation of alcohol consumption associated with injury was conducted by the doctor. During the consultation, the doctor would introduce himself to the patient, telling him his name and position. He began by taking the patient's medical history, during which he questioned the patient in detail about what had happened, how it had happened, his medical background such as previous ailments, hereditary medical problems,

the patient's habits, sexual relations, and whether or not he was allergic to any medication. When the doctor suspected or perceived that the injury was related to drug or alcohol consumption, he would ask questions such as the age at which the patient had begun consuming alcohol or drugs and his current consumption levels.

The doctor would write this down, either by hand or on a typewriter, on the patient's treatment slip, in addition to his diagnosis and treatment. At this point, the patient would be discharged or told what out-patient department he was being referred to, whether psychiatry or orthopedics, as appropriate.

The emergency services did not have many treatment options. The most common treatment was orthopedics, which was responsible for dealing with plasters, splints, or simply bandages, although sometimes the patient himself was asked to buy the bandages for his treatment since the hospital lacked sufficient material for the number of patients it had to treat.

Other treatments involved surgery and suturing injuries; major surgery, however, was only used in extreme cases such as an exposed fracture or wound to a vital organ.

The most common treatments consisted of administering muscle relaxants, analgesics, or simply first aid. The emergency services lacked alternative treatments for alcoholized patients such as detoxification or Alcoholics Anonymous (AA).

Description of medical assessment of alcohol consumption

Alcohol consumption had an impact on emergency services; it was an important factor in patients' admission to emergency services for traumatismos. Patients admitted to emergency services who had consumed alcohol in the six hours prior to the accident had injuries ranging from slight to serious. In addition, there were several patients who had traumatismos due to fights, attacks, or aggression and reported that their aggressor appeared to have been inebriated, to have been drinking, or had been in a place where people often drink. This was the case of a middle-aged woman who went to pick up her husband and daughter at her sister-in-law's house. The sister-in-law was drunk and attacked the patient for no reason, biting her finger. Days after the incident, the patient went to the emergency services because of the discomfort from the wounds caused by the bite and the doctors decided to amputate her finger, since she was diagnosed as having gangrene.

It is important to point out that very few of the patients admitted in an inebriated condition stated that alcohol consumption had caused the accident.

Moreover, people were always reluctant to admit any type of alcohol dependence unless it had previously been diagnosed by another doctor.

One problem involved in identifying alcohol consumption was that the only tool for detecting alcohol consumption available to doctors was the clinical interview. In addition, the questions doctors asked about the patient's consumption patterns (frequency and amount) were not standardized questions and their only purpose was to determine whether alcohol could have been the cause of the injury. In other words, they had no tools for the rapid detection of the presence of alcohol or any other substance.

When the patient appeared inebriated, the protocol consisted of making him wait longer for the consultation for two reasons: first, to give him time to calm down, since these patients were usually upset (shouting, swearing, or pawing the air) and, second, to allow their inebriation to wear off.

During the consultation, doctors did not inquire whether the patient had consumed alcohol before the accident and determined that by observation. Subsequently, when the doctor drew up the patient's clinical history he would ask the patient about his usual alcohol consumption in the past and present, exploring the various degrees of severity this may have had.

One of the main problems in exploring alcohol consumption was that doctors lacked appropriate material to be able to analyze previous alcohol consumption. Moreover, at the time of the exploration, they only took into account organic damage and physiological problems due to excessive alcohol consumption (such as shaking, impaired thought, language and motor coordination, and even convulsions) that the patient displayed, usually those with alcohol dependence or abuse.

Doctors tried to make patients with alcohol dependence or abuse problems aware of their alcohol consumption by suggesting and scolding them to stop drinking, and in the most severe cases would refer them to psychiatric services or other services available in the community such as AA or Al-Anon. They would also talk to the patients' relatives who had accompanied him, usually the spouse or parents. Relatives also sometimes hampered patients' treatment since they despaired at the length of time it took for their family member to be treated.

With regard to the detection of injuries, as in the registration and detection of alcohol consumption, the interview is the doctor's main tool for exploring the causes of a traumatism. If a person was traumatized, he was first asked what had happened, then submitted to a physical examination, and then an

x-ray was taken to determine the existence of a fracture or dislocation. The method used was sufficiently practical and accurate, since it ruled out any possibility of a fracture before a diagnosis was made.

In the case of injuries, the main barrier to treating the patient was slow service. This was more common at night when the doctors rotated so that some were on duty and some could sleep, and on weekends when more patients are admitted to emergency services.

Medical personnel's attitudes were involved in the assessment of alcohol consumption. The information for the assessment of alcohol consumption was based on the observation of what happened during the consultation and on the clinical observation instrument constructed in accordance with the ICD-10, codes Y91.

Researchers first trained the interviewers to administer the clinical observation instrument. They were given more thorough training than the doctors for reasons of time, space, and the needs of the research itself. Moreover, they were from different health areas (i.e. psychologists and nurses).

Subsequently, the medical personnel, director, assistant director of critical areas (emergencies), affiliated doctors, and residents were asked to collaborate in part of the research study, which would involve filling in the clinical observation sheet. A member of the research team explained to the doctors and residents on other shifts and doctors working on weekends and holidays the objective of the clinical observation sheet, how it should be filled in, and its importance to the study.

Most of the doctors completed the clinical observation instrument easily. In this respect, the doctors said that the clinical observation instrument was extremely useful in enabling them to explore alcohol consumption. Sometimes, however, they admitted that the consultation period was so short that they were unable to recall the signs and/or symptoms displayed by the alcoholized patient, meaning that they answered the instrument automatically. This, however, did not prevent them from participating in a quick and effective manner.

Some of the most common barriers observed in the implementation of the instrument were: forgetfulness on the part of the doctors; shift changes; placing the patient in another service, such as hospitalization, orthopedics, or surgery and whether the doctors that directly attended to the patients belonged to these services. In addition, due to the lengthy waiting times, several patients left without being attended to or evaluated by the doctor.

The interviewers also encountered a number of obstacles in implementing the instruments, such as having to pressure or track down the doctors to ensure that they filled in the clinical observation. They also mentioned

that the most complicated part of the research was the clinical observation, both because of the problems mentioned earlier and because of the superior attitude displayed by some of the doctors.

Likewise, throughout this ethnography we have observed the way alcohol consumption is evaluated during the consultation and that if this type of attitude occurs during consultations—in the clinical interview, which is the only instrument available to doctors to evaluate alcohol consumption—the situation rapidly degenerates into a poor doctor-patient relationship and, therefore, the assessment of alcohol consumption is incomplete. There is also a lack of information, orientation, and treatment for alcohol consumption.

Discussion

In the ethnographic observation undertaken in this study, it was possible to demonstrate the social responsibility and mandate for repairing the damage caused by excessive alcohol consumption; the clinical scenario, such as an emergency room, reveals the grave consequences of excessive consumption that not only involve the drinker himself but also third parties who become the victims of these effects.

In the ER context, excessive alcohol consumption is regarded as an agent related to harmful effects that translate into serious traumatism; this damage is caused by social problems such as violence, unemployment, poverty, family relations, etc.^{13,14}

We noticed that there are conditions that enable one to conceive of alcohol as a media vehicle in social problems, meaning that the ER context contains a social sphere determined by ambivalence towards alcohol consumption it is not only a disease caused by biological, somatic and pathological dimension, but also by the dialectics of the social, cultural and even personal structure. This can be clarified through the assessment of ethylic intoxication in the doctor-patient relationship, given that these connections shape a doctor's knowledge and practice¹⁵ as much as the patient's imaginary.

On the one hand, the doctor should regard excessive alcohol consumption as a disease, but on the other, his attitude towards alcoholized patients goes beyond that indicated by his profession. Thus, the doctor often treated the patient as a dissolute person whose alcoholism could be due to moral weakness, as people used to think. The cultural and social elements that emerged were expressed as intolerance in the ER through scolding as a way of making the patient aware of his drinking style. Medical personnel also expressed disgust and rejection of the patients they treated who were in an alcoholized state.

In addition, patients that had consumed alcohol and were admitted to the ER were made to wait longer than usual so that their intoxication would wear off and their sometimes aggressive attitude would become calm before being treated. In these cases, the patients' order of admission was not respected. Regardless of the traumatic emergency, these patients were always left until last, with priority being given to non-alcoholized patients.

Furthermore, the doctors' annoyance and impatience was due to the alcoholized patients' misunderstanding of their technical language. According to Kleinmann,⁷ poor communication in the doctor-patient relationship sometimes leads to patients misunderstanding the way they should look after their injuries or, worse still, to an uncertain diagnosis.

The social and cultural aspects surrounding the meanings of excessive alcohol consumption that permeate doctors' attitudes towards patients who are intoxicated during their evaluation can also influence the accuracy of the evaluation.

The instrument used by doctors to evaluate alcohol consumption in intoxicated patients was a non-standardized interview in which each doctor used different aspects to undertake a diagnosis of the patient in question. The indicators of organic damage or physiological problems were the only factors enabling doctors to analyze consumption prior to the accident. In other words, screening criteria did not provide sufficient suitable information for reliably making a determination and, therefore, the doctor failed to identify most of the people that came in for consultation due to excessive alcohol consumption or related problems.

Moreover, the doctor's role—colored by his lack of or scant supervision, support, knowledge, and experience related to this problem—as well as his attitude towards the alcoholized subject influences the way these patients were evaluated.^{5,6} Thus, evaluation is based on early detection, i.e. screening, and is not a specialized form of evaluation.^{5,6}

On the other hand, we noticed that the clinical observation instrument, which we evaluated in this study, contributed to a more efficient evaluation in several respects: it helped various doctors in their consultations, some of whom even mentioned the support provided by this instrument in their diagnoses; it is appropriate for the short time available for carrying out a diagnosis; however, the large number of patients a single doctor has to see sometimes leads to an unreliable response by the doctor in the use of this instrument. Paradoxically, some of the doctors felt questioned by the group of researchers and refused to answer the clinical observation; questioning knowledge is equivalent to question-

ing power. Conversely, other doctors openly asked the researcher about the results of the breath samples (as a reliable indicator of alcohol levels in the blood, which was also measured in the general study) in order to be able to answer the clinical observation correctly.

Another essential aspect of patient care in the ER was time. One of the main reasons why assessment was incomplete was the lack of time available for medical assistance and treatment in the ER. According to the 2004 Health Report, waiting time in an emergency room is 18.1 minutes.¹⁶ The medical team, comprising residents who attended to patients, perform their functions in the least possible amount of time, particularly with regard to finding out more about the patient's injury than about the way he drinks, although these events were related.

Inside the ER everything is an emergency and has to be prioritized. The way the process of care is structured effectively solves this dilemma and helps overcome the shortcomings of the service. While this exhausting practice, involving the mandate of being a good doctor, reflects the social and moral responsibility of saving lives, it is an undeniable fact that time becomes a barrier to attention, creating misunderstanding between doctor and patient and reflecting a deficiency in the hospital infrastructure.

Another factor related to time and apparently to additional cultural issues was the time that elapsed before medical assistance was sought. Patients that had consumed alcohol generally waited a long time before having their injury examined, despite its severity. The phrase ““wanting to hold on until they couldn't bear it any longer” stated by a patient referring to a delay in the request for medical care for an injury suggests a sort of invulnerability based on the idea that “nothing has happened,” or of risk as a cultural value, which interferes with self-care and the use of preventive health services.¹⁷ Once again, this reflects the idea that culture and society are factors that may shape patterns of behavior linked to alcohol consumption, including the way people drink, who can drink, how much, when and where.

Among the many barriers to estimating alcohol consumption is the setting of the emergency room itself and the lack of financial resources that is reflected in the lack of basic supplies (bandages, syringes, adhesive tape, etc.). Financial factors also hamper the treatment of addicted patients, although this problem is more noticeable in private practice.¹⁸

Other problems include the lack of resources and information. The ER did not have de-tox centers or groups such as AA and there was no directory of or basic information about treatment alternatives, such as leaflets; there was a lack of space, reflected in the shortage of

beds, doctor's offices, wheel chairs, etc and when two consultations were carried out simultaneously in the largest doctor's office; and only one out of every five consulting rooms had sufficient equipment to deal with any emergency or to be adapted as a surgery unit.

Finally, with this ethnography and the experience undergone in the ER, two basic needs emerged: first, the need for public policies that would reduce the economic, physical, and emotional cost of problems associated with alcohol consumption and, second, the need to sensitize medical personnel to the problem associated with consumption to enable them to engage in an empathic medical practice.

As regards to the first need, some measures include controls related to the availability of alcohol and driving while intoxicated, as well as preventive programs. As for creating a more empathic medical practice, it may perhaps not only benefit patients associated with alcohol consumption but also all those admitted to an ER.

Acknowledgements

We would particularly like to thank the authorities and health professionals at the M.G.G. Hospital for allowing us to carry out this research, and above all, the hospital patients that participated in the study.

This study was financed by the World Health Organization, the Ramón de la Fuente National Institute of Psychiatry (4275P) and the National Council of Science and Technology (CONACYT-39607-H).

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