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Emergency department encounters' impacts on First Nations members, families and communities: Results of a thematic analysis of sharing circles in three treaty areas

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ABSTRACT

First Nations are subject to ongoing colonialism in Canada, including within healthcare. Emergency departments serve a gatekeeping function in healthcare as patients are assessed for immediate assistance, admission to further care or discharge from acute care. They are also among the care settings where racism is most reported. This study draws on accounts of emergency care provided by 41 First Nations community members, 2 non-Indigenous providers invited to participate by their communities, and 4 First Nations health directors. Theoretically informed thematic analysis reveals First Nations members' experiences of being treated as illegitimate patients, discredited, and excluded from care. First Nations participants discussed their awareness that interactions with providers would be shaped by providers' perceptions of their race. They disclosed the ways emergency care encounters caused lasting personal suffering and negatively impacted their families and communities. We argue that emergency care must be assessed in terms of long-term impacts of emergency care encounters. Findings and conclusions may be useful to providers and health system leaders interested in healthcare equity. Additionally, the work will be of interest to scholars of racism and social exclusion, insofar as the emergency department provides stark insights into everyday practices by which racial hierarchies and harms are enacted.

1. Introduction

This paper reports on one aspect of a larger multi-disciplinary project which examines hospital-based emergency healthcare. We are situated and conduct our work in the Canadian province of Alberta, which has been superimposed by Canada on the territories of the Anishnabé, Blackfoot, Cree, Dene suliné, Dené Tha', Dunne-za, Nakoda, Saulteaux and Tsuut'ina First Nations. We recognize colonialism as a major determinant of Indigenous health(Czyzewski, 2011), and as ongoing in Canada as Indigenous peoples' assertions of their sovereignty continue (Lawrence and Dua, 2005). Our intent in this paper is twofold. We aim to document how emergency care impacts First Nations patients, families

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and communities from the perspective of First Nations community members and co-authors. We also intend to contribute to sociological accounts of how emergency care reinforces social hierarchies. In the discussion and conclusion, we argue that understanding emergency departments as colonial social institutions, with impacts that go beyond biomedical outcomes, could improve the role of emergency care in our communities.

Our research team began our work together in 2016. We were aware that anti-Indigenous racism is prevalent in Canadian society(Truth and Reconciliation Commission of Canada, 2015) and that healthcare institutions are not an exception to this (Allan and Smylie, 2015; Cameron et al., 2014a; Lux, 2016; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Furthermore, we are aware that colonial institutions operated by the Canadian state often do harm to First Nations people under the guise of benevolence and care (Kolopenuk, 2024; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Razack, 2011). This paper relates to an initial research objective to "explore First Nations Emergency Department experiences of seeking and receiving care, racism and reconciliation, and healing, from First Nations patient and emergency department clinician perspectives." Our results and analysis here focus mostly on seeking and receiving care, and racism, from First Nations perspectives. Discussion of the complicated notion of "reconciliation"(Kolopenuk, 2024) remains for a future work, and clinician perspectives have been reported elsewhere (McLane et al., 2022b).

We understand racism in Jones' terms as the "structures, policies, practices, and norms resulting in differential access to goods, services, and opportunities of society by 'race'"(Jones, 2002). From the beginning of our project, we have agreed with Jones that there is no need to question *whether* racism exists in particular institutions or settings but to understand *how racism operates* in those settings (Jones, 2002). We recognize colonialism as "the processes by which Indigenous Peoples were [and are] dispossessed of their lands and resources, subjected to external control, and targeted for assimilation and, in some cases, extermination"(National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Racism has been a key strategy and support of colonialism in Canada (Lawrence and Dua, 2005; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Razack, 2011).

To understand the operation of racism in emergency care, we draw on sociological research into emergency care. Such literature shows that emergency providers rely on socially organized considerations about patients' worth as people, and deservingness of care. By doing so, providers determine how they will allocate their time and resources among patients (Glaser and Strauss, 1964; Hillman, 2014; Mannon, 1976; Roth, 1972; Timmermans, 1998; Vassy, 2001; Wamsiedel, 2018, 2020; White et al., 2012). This may lead providers to discipline (Foucault, 1977) patients who they perceive as inappropriate candidates for their care (e.g. by more or less direct comments to this effect, through holding back their empathy and effort, by having patients endure long waits) or to expend additional efforts to aid patients who they see as especially deserving of their care (Hillman, 2014; Vassy, 2001; Wamsiedel, 2018). In the process, emergency departments reproduce social hierarchies through practices of discipline and assistance, admission to further care or exclusion from care settings and systems (White et al., 2012). Yet existing sociological literature that considers emergency care practice in relation to power, and the way expressions of power shape subjects, largely examines provider perspectives and practices. Moreover, this literature has given little explicit attention to issues of colonialism and racism.

A separate body of research considers Indigenous patients' healthcare experiences in Canada and internationally, but this literature is largely informed by everyday or clinical perspectives. There is a need for sociological and theoretically informed studies which report on how Indigenous people accessing emergency care are impacted and that relate this literature to issues of racism and colonialism. In prior publications we have reported that racism is an ever-present and stress-inducing threat for First Nations patients presenting for emergency care – as patients cannot generally tell whether a negative encounter in an emergency department is related to racism or other factors (McLane et al., 2021b). We have also shown that First Nations patients are triaged as less urgent than comparable non-First Nations patients, which will impact the course of their emergency care (McLane et al., 2022a). After interviewing nurses and physicians, we found they reported that "First Nations patients are exposed to disrespect through tone and body language, experience overt racism, and may be neglected or not taken seriously" (McLane et al., 2022b).

Providers further described that racism impacts care, with one reporting that a patient with potential appendicitis left the emergency department on overhearing racist remarks by a physician. Another described that providers ignore "intoxicated" First Nations patients and that these patients will "usually disappear … they leave". Other providers described cases where serious conditions were initially mistaken for intoxication due to stereotypes related to Indigenous substance use (McLane et al., 2022b).

1.1. Study context

In Alberta, treaties between Indigenous peoples and the Crown in right of Canada set out the nature of the relationship between settlers and Indigenous peoples (Maskwacis Cree Foundation,), with different treaties covering distinct geographic areas. Three numbered treaties (Treaties 6, 7 and 8) include First Nations whose traditional territories lie within what is now Alberta. These treaties provide for a treaty right to health that entails First Nations achieving a high standard of health and well-being (Craft and Lebihan, 2021). From First Nations perspectives, this right requires the full implementation of the treaties with respect to First Nations maintaining their sovereignty, ways of life, and medical practices while sharing their territory with settlers in return for support and services in a range of areas including healthcare (Craft and Lebihan, 2021). Indigenous oral traditions report that this right to health was promised broadly across numbered treaty negotiations (but only written down in Treaty 6 by agents of the Crown) (Craft and Lebihan, 2021).

The commitments made to First Nations within treaties have been historically viewed as a matter for the Canadian Federal government (Craft and Lebihan, 2021), which today disputes the nature and extent of these obligations, but provides some health services through Indigenous Services Canada. The *Constitution Act* makes health care generally the responsibility of the provinces of Canada(Lavoie et al., 2010). Lack of integration between services, and disputes between Federal and Provincial governments over which services each is obligated to provide, have contributed to poor health outcomes for First Nations (Lavoie et al., 2010). The *Treaty 6, 7 and 8 Elders' Declaration* on health calls on both the Federal and Provincial governments to fully implement the treaties to address these poor health outcomes (Elders Declaration, 2016). The Elders furthermore cite UNDRIP article 23 which notes that "indigenous peoples have the right to be actively involved in developing and determining health, housing, and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions" (UN General Assembly, 2007).

Yet emergency care is not administered by First Nations. Instead, emergency department and urgent care services in Alberta are provided by about 110 facilities (varying slightly over time) funded by and operated under the direction of the provincial government (McLane et al., 2021). All of these are located outside Indigenous communities, even where Indigenous population numbers have been the basis for the presence (or size) of hospitals in relatively small settler communities (Personal communication between Patrick McLane and First Nations health organization). In previous work, we have documented that First Nations members must travel further on average to reach their nearest emergency department (McLane et al., 2021a). 21.4% of First Nations emergency visits are by patients who live more than 200 km from the

metropolitan and urban centres that contain the largest hospitals, offering the most services, compared to 4.5% of non-First Nations visits (McLane et al., 2021a).

1.2. Audiences for this study

Canadian Federal commissions and inquiries document inequities faced by Indigenous peoples and mandate action to address these (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Royal Commission on Aboriginal Peoples, 1996; Truth and Reconciliation Commission of Canada, 2015). A tremendous body of literature also sets out Indigenous community-led approaches to health and wellness, which may inform health system transformation (Nightingale et al., 2026). Findings of our study may be useful to First Nations in holding Federal and Provincial agencies to account, to providers and health system leaders interested in improving the role emergency departments play in communities, and for all partners in working to fulfill the First Nations treaty right to health. Additionally, the work will be of interest to scholars of racism and social exclusion, insofar as the emergency department provides stark examples of everyday practices by which racial hierarchies and harms are enacted.

2. Methods

Informed by Indigenous research paradigms (Kovach, 2010; Wilson, 2001), our project highlights the importance of collaboration and respectful community engagement. Our work adheres to traditional protocols and practices led and facilitated by Knowledge Holders for assurance of ethical space(Ermine, 2007). We collected data predominantly through sharing circles, an Indigenous method that involves creating a space for openness through ceremony (Lavallée, 2009). In our circles, unlike in Western focus group methods, participants spoke in turn (with the option to pass to the next speaker) and did not interrupt or question one another. The relatively unstructured nature of sharing circles (Lavallée, 2009) allowed participants to share their stories and helped build a relationship with those who participated (Wilson, 2001). As Kovach puts it, participants engaged in "a deep purpose of sharing story as a means to assist others" (Kovach, 2010).

PM and LB facilitated the sharing circles. LB is a Cree Traditional Practitioner/Knowledge Keeper, a registered nurse, and the Executive Director of Alberta First Nations Information Governance Center (AFNIGC). She is experienced in Indigenous health program development, delivery, and practice as well as policy and research at community, national and international levels. PM is a PhD sociologist trained in social constructionist and critical Western research perspectives. Other team members include First Nations health system staff (TB, EL, KJ). BH is a Kainai RN with emergency department experience. BRH is an emergency physician and senior leader. CB is a Métis specialist physician with expertise in rheumatology and Indigenous healthcare research. KR is a settler mental health researcher. DN is a first-generation immigrant from the Philippines. She holds a master's degree in anthropology and is currently doing her PhD in Interdisciplinary Graduate Studies, exploring Indigenous-immigrant relations in the healthcare system.

2.1. Setting

Members of our research team live in the cities of Edmonton in Treaty 6, the city of Calgary in Treaty 7, and rural and First Nations communities. We conducted three sharing circles to ensure one was conducted in each Treaty area. The Treaty 7 circle was held in a First Nation near Calgary. Participants traveled from other parts of Treaty 7 territory to attend. The Treaty 6 circle was conducted in a mid-sized settler town, which derives economic benefits from nearby First Nations reserves and which includes a larger hospital than its population might otherwise warrant due to the presence of these First Nations (Personal Communication between Patrick McLane and First Nations Health Organization. Re: Historical Documents Shared in Confidence., n.d.). The Treaty 8 circle was conducted in a remote settler community which acts as a service hub for many First Nations. This community is more than 200 km from any larger urban or metropolitan centre, and some participants had traveled from more remote communities to attend. Health director interviews were conducted by telephone.

2.2. Community engagement and ethical data ownership

This work is partnered with First Nations organizations and adheres to the principles of Ownership, Control, Access to and Possession of First Nations data (OCAP®) (Schnarch, 2004). The Alberta FNIGC is the custodian of the qualitative data in this study (Alberta First Nations Information Governance Centre, n.d.). The Organization of Treaty 8 First Nations of Alberta, Kee Tas Kee Now Tribal Council, Paul First Nations Health Services, Yellowhead Tribal Council, Blackfoot Confederacy Tribal Council, Stoney Nakoda Tsuu T'ina Tribal Council and Maskwacis Health Services participated in this study.

Through a series of meetings held over the course of a year leading up to our grant application to fund this project, including two in-person engagements with Elders, First Nations research partners co-designed the study objectives and research plan. They emphasized the need to identify racism as a significant factor in addressing Indigenous health disparities. The project research team met frequently throughout the course of the study, both as a whole and as smaller working groups that included both First Nations and non-First Nations team members. To ensure continuous and respectful engagement with our partner communities, we invited Elders from each of the three treaty areas to provide guidance throughout the project. The Elder Advisory met in-person five times over the course of the project to review methods and co-interpret findings. An overview of key dates in the project has been previously published as an appendix to another manuscript(McLane et al., 2024).

2.3. Data collection

In each treaty area, First Nation partners organized a sharing circle (Lavallée, 2009) with the support of Alberta FNIGC and University staff. Elders were present during the sharing circles and provided opening and closing prayers. A four-page visual guide developed by LB and validated by First Nations Elder Advisors was used to facilitate sharing circle discussions (see Appendix 1). Participants were invited to relate their experiences with emergency treatment to any part of the visual, and rounds of discussion were held about each page of the visual. This provided an opportunity for the participants and facilitators to engage in an unstructured dialogue that aligns with Indigenous "values of respect, relevancy, reciprocity, and responsibility" (Kovach, 2010). Each sharing circle lasted for about 6 hours, including time taken to review the study, present study quantitative findings for discussion and share a meal together with participants.

Health directors were invited to participate in interviews either as individuals or together with their colleagues. A semi-structured question guide developed by PM and LB was utilized with health directors. PM and a non-author research assistant conducted interviews. All participants were invited to complete a demographic questionnaire.

2.4. Sampling

First Nations partners recruited participants who would be able to speak to First Nations emergency care experiences. We sought participants from rural, remote, and urban areas of Treaty areas 6, 7, and 8 as well as a balance of men and women. We aimed to have youth, caregivers and parents in each sharing circle. Inclusion criteria for sharing circles were community members age 15 years or older and who had visited an emergency department in the last five years. Based on published sample size guidance (Creswell, 1998; Green and Thorogood, 2009), we believed that a sample of about 30 participants would allow

us to understand enough about First Nations emergency department experiences to make a contribution to the literature. Health director interviews and focus group participation was open to any participant with a health director role with a First Nation. Our inclusion of health directors was suggested by team members during the course of the project, and was not initially planned, but we have found their perspectives very valuable. Each partner organization received a call to invite their health directors to participate.

2.5. Ethics

Participants received study information letters, and were given the opportunity to ask questions prior to giving their written consent. Honoraria were provided at values determined by First Nations partners in accordance with their protocols. In some settings, mileage and hotel rooms were provided. Ethics approval was obtained from the Health Research Ethics Board (HREB) at the University of Alberta (no. Pro00082440).

2.6. Analysis

Sharing circles were audio-recorded and transcribed verbatim. Direct quotations are labeled according to which sharing circle the quotation was taken from and a participant number (e.g SC#_#). Health director quotations are marked HD and participant number. We conducted thematic data analysis (Vaismoradi et al., 2013).

Research team members (DN, PM and three non-author research assistants) coded the transcripts informed by research on Indigenous patient emergency care experiences (Browne et al., 2011, 2016; Ford-Gilboe et al., 2018; McLane et al., 2021b;McLane et al., 2021a), stages of emergency care (Asplin et al., 2003), definitions of terms related to systemic racism (e.g., Jones, 2000), and using the topics discussed during the sharing circles as initial codes. Coders also created additional codes inductively. Nvivo software (QSR International Pty Ltd,) was used for early coding, but the analysis was primarily conducted using word documents (to bring coded data together to form themes), visual depictions of the themes, and tables (such as the much shortened one that appears in this paper). Qualitative data were initially analyzed under three broad headings relating to barriers to care before, during, and after going to the emergency department. A "patient journey map" reflecting this analysis was created as a knowledge translation product and utilized by the project team as such (McLane et al., 2023). While this descriptive presentation of First Nations emergency department care remains valuable, further reflection upon the data in context of sociological theory (Hillman, 2014; Mannon, 1976; Roth, 1972; Timmermans, 1998; Vassy, 2001; Wamsiedel, 2018, 2020; White et al., 2012) (and Cassel's work on "suffering" (Cassel, 1982)), led to the richer analysis presented here. PM developed the final themes, based on literature related to emergency care and discussions of the data with LB.

The multidisciplinary background of our team enhances the credibility of our findings (Shenton, 2004). First Nations team members provided cultural context on the analysis and confirmed that our findings reflect the realities of First Nations members. Early qualitative analysis was presented to Elders in September 2022. In February 2024, Elder advisors validated our current interpretations as culturally appropriate and aligned with their community's priorities to promote more equitable emergency care for First Nations communities. While much of the time-consuming analytic work was conducted by non-First Nations team members (PM and DN), we would stress that these team members were shaped in our thinking by our ongoing relationships and regular interactions with First Nations team members, and discussions with the Elder Advisory, in the context of this co-designed project. The analysis would not have been what it is if it were conducted by non-First Nations authors working alone, nor would it have been ethical.

3. Results

Sharing circles were held in October 2020, July 2021, and April 2022 as COVID-19 pandemic precautions permitted. The three circles had between nine and 17 participants each. Forty-one First Nations community members from 10 Nations participated in the sharing circles along with two non-First Nations care providers (Table 1). Two persons who participated as First Nations community members (by describing their care experiences in relation to others' accounts) responded "no" to the question "Do you identify as First Nations?" on the demographic form. It is possible that they were of First Nations identity, but not recognized as having this "status" by Federal law, or had personal or political reasons to prefer a different ethnonym than First Nations.

Four Health directors (HD) participated in interview discussions in 2019 and 2020. Two were interviewed as individuals and two were interviewed together. Three identified as First Nations. One health director worked on-reserve, while three worked off-reserve. One served in metropolitan areas, while three worked in rural communities.

Themes arising from qualitative data were delegitimization, racially shaped interaction, exclusion, suffering and impacts on community. Definitions of themes and example quotations are offered in Table 2. Across themes, participants described cases when provider actions were directly harmful, when needed care was delayed or care was not received.

Table 1
Sharing circle participants' demographics.

	N = 43	%
Age		
20-30	3	7.0%
31-40	10	23.3%
41-50	8	18.6%
51-60	6	14.0%
61-70	14	32.6%
71 or older	2	4.7%
Gender		
Man	10	23.3%
Woman	30	69.8%
Two Spirit	1	2.3%
Prefer not to say	2	4.7%
Area of Residence		
Urban/Metro	5	11.6%
Rural	33	76.7%
Remote	5	11.6%
On-reserve	30	69.8%
Off-reserve	13	30.2%
Do you identify as First Nations?		
Yes	39	95.3%
No	4	4.5%
Do you have experience taking a child or other dependent to ED?		
Yes	41	95.3%
No	2	4.7%
Do you have experience accompanying older relatives to ED?		
Yes	30	69.8%
No	13	30.2%
How many times have you gone to emergency department in last year (for yourself or another)?		
0	0	0%
1	5	11.6%
2	8	18.6%
3	3	7.0%
4	7	16.3%
5	4	9.3%
6	2	4.7%
10-15	3	6.9%
20	1	2.3%
Missing	6	14.0%
Last time you went to ED, did you go by ambulance?		
Yes	10	23.3%
No	33	76.7%

Table 2
Themes and example quotations.

Theme	Description of Theme	Supporting Quotes
Delegitimization	The patient is defined by providers as an illegitimate candidate for care. In the process, patients' accounts of themselves and their needs may be disregarded and their status as credible persons undermined.	Following a car accident. "He [an emergency doctor] said, 'I checked all your records and everything,' he said 'there's absolutely nothing wrong with you.' I said 'what?' 'There's nothing wrong with you.' That's very strange because I'm hurting, and I'm supposed to be the one knowing that there's nothing wrong with me. Then he just turned and walked away. So, I was hurting the next day." The patient discloses that on seeking care elsewhere it was discovered they had a "bleeding kidney." (SC3_P2) "And I remember when I got my diagnosis. And still, they keep on telling me, you know, you're coming here [to emergency] for opioids. And, you know, due to my condition, I'm prescribed them. But I use them as the doctor tells me. So I always have to have proof. And it's difficult." (SC2_P17)
Racial Differences in Interactions and Treatment	First Nations participants noted that anti-Indigenous prejudice and negative stereotypical ideas about First Nations people impacted interactions and treatment in ED.	"soon as you come in and depending on how you look-if you're First Nation here and you look First Nation, you get treated differently. And then there's a lot of First Nation people that don't look First Nation, and they get treated properly. And then you hear remarks about- you guys get stuff for free. Like 'oh it must be nice to be Indian because you guys get a lot of stuff for free.'" (HD_19) "And everyone, everywhere, every hospital you go to, there's an experience of racism. It's bad … that's why we always say, when you go to the hospital, try [to] bring someone with you." (SC2_08) In deciding which family members should go to the hospital, a participant relayed "my dad was there. We decided he should stay home just because I'm passably white. People don't automatically assume I'm Indigenous when they see me. So I often get treated better than when I'm with my darker family members." (SC2_07) "the [white] kid didn't look sick, wasn't coughing severely … This little girl was still up, and playing
Exclusion	As patients are framed as illegitimate emergency department patients, and their accounts are discredited, they report exclusion from care.	and doing whatever. And the nurse came in to talk with them and she's like 'Oh you're not feeling good sweetie?' Just a completely different approach with her versus how she treated me and my child who was like lying in bed, having a difficult time with his breathing and stuff. Like no, there was not that type of compassion. And I hated to compare, but it was so obvious …" (HD_18) "There's no faith or hope in, even our local healthcare system … There have been times where people have gone to the hospital and are constantly turned away without being properly assessed. "(SC3_P15) "we were rejected in the hospital. They didn't even check us. We were sent out …" (SC3_P2) "We have community members who there are some mental health concerns and when they do go into the emergency, whether it's addictions, drug induced, any kind of slightly off behavior, they're either ushered out or just give them something to calm down, which is not fair." (SC3_P6) "We have a lot of concern for our elders because …, they speak Cree or very little English … they get sent home. … we had to keep sending this elder to the hospital just about every day to get assessed, get that treatment that he needed. But they kept sending him home. 'There's nothing they can do, they won't take me back,' he said. Two days after he passed because he didn't want to go back to the hospital. He was not taken care of because nobody listens." (SC3_P14) "In the ER … the doctor … looks at [my daughter's] arm and it had the wrapping that I did at home. 'Well, now you can go home.' And I was like, 'What? This is an open PICC [peripherally inserted central catheter] line. Like, how are we supposed to go home?' … he didn't check for fever and check, like for anything. It's this little Indian girl to his, to his eyes, I found and I thought, 'okay, well, all right … I guess I'll go home.' But I was so close to my, uh, her

(*continued on next page*)

Table 2 (*continued*)

Theme	Description of Theme	Supporting Quotes
		medical team at the children's hospital … I told them, 'Hey, this is what happened.' And they were livid … She went to surgery like within 5 h and then went into a room." (SC2_09) "if they get taken in by ambulance … a lot of times, it's an emergency call. They don't have the proper footwear or clothing to leave with. And they're not provided like even the disposable footwear. And they're sometimes they'rejust being asked to wait outside and not there … They are being asked to leave the premises." (SC1_03)
Suffering	Patients suffer insofar as their personhood is threatened, not only due to illness, but as a result of medical care. First Nations patients suffer when their identity as a First Nations patient is perceived to be devalued and a reason they or their family members are treated poorly.	"Well, I think the impact's really, you know, major mental health impacts. Major setbacks. You know, you might be feeling, you may have really developed yourself on the Nation, you're really feeling that you know the system, that you understand yourself … So when they step off the reserve and are treated disrespectfully, everything that they've built up, that confidence and that knowledge that we've built up is dismissed." (HD_20). See further examples in text below.
Impacts on Community	What happens to patients in the emergency department resonates more widely as stories of suffering that become part of family histories and circulate within communities.	"She [my sister] called the ambulance and she went to [rural hospital 1] and the doctor told her 'are you here to get some pills?' And she said, 'no, I'm sick … I need to know what's wrong.' And the doctor told her, 'why did you call an ambulance just to come and get your pills?' … And he was mad because she took the ambulance there … When my mom got there [she] said, 'Can't you tell? Look at her face. There's something wrong with her.' So my mom had to raise hell with the doctors so that they checked her. She'd had a stroke." (SC2_04) "I see it all the time, I hear it all the time. In [rural town], people tell each other on Facebook posts, don't go there [to the local hospital] …." (SC3_P6)

3.1. Delegitimization

Participants repeatedly described cases where they were told, or made to feel, that they were not a legitimate emergency case. A health director described their own experience,

> "I don't go for just nothing. And that's how they've made me feel, like I'm just there for nothing. … And a couple of times they had actually mentioned that 'you know, with these viruses, it happens, and it's a lot of resources that are being used here.' Just this kind of like I was wasting, wasting their time, being there." (HD_18)

As described by Wamsiedel, patients are subtly or overtly disciplined through "sequences of talk that are clinically and bureaucratically irrelevant [but which] socialise patients with regard to the organisation of functioning of health care, and sanction suspected transgressions from the mission of the ED" (Wamsiedel, 2018).

A paramedic participant described an interaction in which a nurse directly questioned why a patient was brought to their hospital.

> "[It's] not an uncommon thing to hear when we bring someone to the hospital is 'why didn't you go to a different hospital?' … this particular incidence I said, 'we do go to other hospitals,' right? And this nurse at the time said, 'not with this shit you don't.' And he said that standing right next to the patient … most of the time they are around the corner when they say it, sometimes in ear shot still. And again, that's not a, an outlier of an event. It's just the one that comes to mind." (SC1_08)

In this quote, it is not clear if the patient or their medical condition is referred to as "this shit". The nurse's comments illustrate a broader ambiguity between denigration of the patient and disregard for their condition as out of place within the emergency department. In common discourse within the emergency department, seeing the patient themselves as a problem, and seeing their medical concerns as inappropriate for the ED, are not rigorously distinguished.

As Hillman (2014) has written, patients must convince providers that they are legitimate emergency cases or else find it "increasingly difficult for them to be treated as full persons … who are present as a moral demand … Thus the onus switches from the hospital to the vulnerable patients to 'sort' themselves out and fend for themselves."

The delegitimization of the patient then impacts their ability to give an account of themselves and their needs. A young two spirit person describes,

> "[The physician] proceeded to ask me like straight up, he was like, 'have you been sleeping around?' And I said, 'no, I've had the same partner for the last four years.' And he says, 'I don't believe you.' And this was in a room full of other patients. And I started crying … he forced me into getting an ultrasound and doing a pregnancy test. And after I already said my partner is not male; I am transitioning. I disclosed all of these things to him …" (SC1_01)

Suffering occurs for the patient when the physician calls their account of themselves and their health into question (Cassel, 1982). Yet participants described this as a common occurrence in presenting for emergency care.

> "It's like we'redisregarded and not heard, even though we'retelling them what's wrong with us and explaining that this is what I need you to do because this is what is wrong with me. Still things don't get done, or things don't get resolved, or treated, or cared for." (SC3_P15)

According to participants, this lack of care is particularly likely to occur where suspicions of substance use are on the healthcare providers' minds or the distinction between a medical condition and morally denigrated behavior is blurred. The paramedic participant described a general moralization of mental health and addictions issues, leading to a "punitive, flippant, cavalier approach to people" and "disproportionately" impacting "Indigenous communities".

Participants also expressed a knowledge that they must meet provider expectations for acceptable patient behavior (Sointu, 2017). One advised that in the emergency department "don't even ask questions, because if you do, like you confuse them, because we're not supposed to ask questions."(SC1_03) Another described waiting with their ill father

and family members to be called from the waiting room and says,

> "we all, weren't argumentative or belligerent or anything like that. And just hoping that our dad was going to get attention. And then every now and then it'd be like, there are other people in the waiting area, and they all got treated and every now and then it would be like, okay, you go ask, you go ask the nurse." (SC1_06)

This participant shows an awareness that they are reliant on the triage nurse to process them through to further care, and feeling that they must balance the need not to frustrate the nurse with a desire to ensure they have not been forgotten about.

3.2. Racially shaped interactions

Participants expressed that as First Nations persons they are forced to navigate the difference that their race and ethnicity makes in interactions with largely non-Indigenous providers.

> "I think a lot of it has roots in colour and everything … People, non-Natives, Natives walking through. It's just the treatment alone is different. They're so happy to see you [non-Natives]. They're smiling and chatting and everything. A Native comes through it. It's, you, you can see the facial changes, right?" (SC2_P16)

Participants further described being met with questions that reflect stereotypes about Indigenous people "you smoke marijuana or street drugs? Do you abuse alcohol? Is there violence in your home? Is your place a safe home?" (SC3_P09). Participants also noted that their symptoms may be assumed to be related to substance use, impacting the treatment they receive.

> "I went to the emergency department. And they, I told them my symptoms, how much pain I was in. It woke me up in the middle of the night. It was so painful. And I was just told that I was just depressed and that they wouldn't test me for anything … And I had pancreatitis, which I could have died from if they had sent me home that night. And they asked me, they started interrogating me, 'were you drinking, were you drinking?' And I was like, 'no, I wasn't drinking. I drank two weeks ago, but that's beside the point.' … they put me in the room with all the detoxing alcoholics and, it was terrifying. Like they were all screaming … And I was in so much pain still and I asked for painkillers to help. And they said I was drug seeking." (SC 1_01)

Another participant described unnecessary administration of an opioid poisoning reversal medication,

> "So I was in there with her and the nurse came in. She didn't say anything to me, didn't say anything to my loved one and just came in and jabbed her with the Narcan and then she kind of moaned in pain and she [the nurse] was like, 'oh, you felt that, did ya?' Kind of chuckled to herself … [It wasn't] opioids. It was, um, things were off with her blood chemistry. So they ended up getting that figured out after."(SC2_07)

3.3. Exclusion

Participants described times when they or their loved ones did not receive needed care. This was often framed in terms of physical exclusion from the care setting. Persons used terms of participants being "sent home," told "you have to leave," "constantly turned away", and "ushered out" (Table 2). This resulted in repeat efforts to seek care, and medical consequences of delayed care were repeatedly described, including death in more than one case.

A young First Nations woman describes her ill partner being sent home, until his death during their third attempt to access emergency care. She further describes her exclusion from the care encounter as she attempted to advocate for him. Our sharing circle was paused after this as those present took time after hearing this story, and so that LB could provide one on one support to the participant as an Elder, in a separate room.

> "I have a hard time sharing … my boyfriend was sick. I kept taking him in a lot of times. Maybe three times, they just kept sending him home. Sent him home with some medication and a hot pack; that was the second time. And the third time I don't know, they didn't …. just … he was already delusional. He wasn't himself. The infection was already living everywhere in his body. I don't know how they couldn't have caught that. Or even like seeing it in the x-rays [pause] anything. The night I took him in … he was delusional and everything … He was having a really hard time breathing, they said he had a possible staph infection. They just kept sending home, sending him home, because he was young and he had tattoos on his face, like maybe it's [pause] He was Native. What they were thinking or what [pause] yeah, I don't know what. They just kept sending him home and then the last night we went I was standing beside him, I was telling the doctors, check his records, like his x-rays, you guys must have taken x-rays when he came in, these past couple times. Nothing, they didn't listen to me. They gave him [pause] they took him because he was having a hard time breathing, he wasn't himself, he was really delusional and they just kind of were like, 'here.' They gave him two Ativan, as if they thought that was going to help. I said no, he has an infection in his body. He needs antibiotics, he needs to be put on IV, and he needs something for his fever. So, he [pause] there is something wrong, I said. And they gave him two shots of [pause] epinephrine? Whatever you call it, in the thighs. They didn't get there in time. As I'm trying to get off the bed, I was leaving the room because they sent me out. You know. The nurses weren't, they weren't actually helpful. I don't know what. They are not compassionate. They are not compassionate about their work at all. They meet with me, then I didn't even know; I was asked to leave. They made me, the cops came down and made me [pause] yeah. I didn't know why they made me give a statement. I didn't even know he was already gone. And they said there was nothing they could do. And then they came and told me. And uh [pause] just [pause] it was weird. Like, I [pause] they just, I don't know. They could have done; they should have done a lot more. They could have sent him out [to another hospital], they could have listened to him. Because he died! … I could have been there. But I remember, I remember everything when I close my eyes." (SC3_P13)

She describes a number of possible non-medical reasons her partner did not receive lifesaving care. It may be that he was young, had tattoos on his face, or was "Native". She notes she does not have enough information about provider mindsets to tell if some or all of these factors were at play. She notes her distress that she was excluded from him and the care setting during his death when she says "I could have been there", and that this distress is ongoing as she repeats "I remember." As in the quotes given above around patient legitimacy, she locates the root of the problem not only in providers' failure to detect the severity of her partner's illness through tests, but in that they did not listen to him or to her. One has the impression from the ordering of her story that she was perhaps "asked to leave" because of her attempts to advocate for her partner.

A health director told a similar story, where a patients' wife was advocating for her husband and was told by a physician "'you're being rude' and 'I could kick you out of the hospital.'" She eventually "had to leave because she wouldn't quit arguing with him to see her husband" (HD_19). "[H]e got flown out within the hour to [regional hospital 2] … So when he got there it was emergency surgery … If he would have just gave up and went home, he wouldn't even be here anymore. His kids would have no dad." (HD_19)

As we've reported in previous research (McLane et al., 2021b), numerous participants also described that patients will not present for care or do so as a last resort (SC2_07, SC2_08, SC3_P15). Some described

avoiding specific emergency departments where they or others had bad experiences (SC1_06, SC3_03, SC3_P15, HD18). In this way, exclusion becomes a broader phenomenon than individual cases, but involves First Nations people coming to perceive that particular sites, or the emergency care system as a whole, are not safe for members of their community.

3.4. Suffering

In our interpretation of accounts participants shared, our attention was repeatedly drawn to the lasting negative impacts of care encounters. We draw on Cassel's definition of suffering for this theme. Cassel writes that suffering goes beyond physical pain, that "suffering is experienced by persons" and that for each of us our personhood is a complex whole involving such things as our past, our relationships, our inner lives, our connection to our culture and society, our plans for our future (Cassel, 1982).

Participants described suffering from attacks on their personhood when they were treated as not credible or not worthy of care. This was particularly so when being First Nations appeared to be the cause of their negative encounters with care providers.

> "I was on a gurney in the hallway … And then, they asked for my information and stuff. Then they went away, and I could hear them making fun of me, making fun of my [Indigenous] name. And if I hadn't been sick … they would have heard from me … these were the people that were supposed to be taking care of me. I regret to this day, not speaking up …" (SC1_06)

This story shows how a negative encounter stays with a person. Even though the patient should never have found themselves in this situation they came to "regret" their own conduct when they were mistreated.

Another participant described providers not treating her infant son fully following a dog bite and that it seemed to her that assumptions about Indigenous parenting and relations to domestic dogs were made by providers.

> And the doctor just looked at me and looked at my son and he didn't say a word to me or to my son. He didn't say anything about his wound at all, actually. And just said to the other doctor, 'um, can you send me his demographic information?' He's just wondering about him being Native and the dog bite … (SC2_07)

She concluded "I never told this story to his [my son's] dad because I was ashamed that I wasn't stronger in the situation, didn't speak up when that doctor was not really treating us like people at all."(SC2_07) At another point she noted "I carry a lot of shame because I felt like I should have been stronger." (SC2_07)

Participants further described how care relations within families were negatively impacted. Choices about which family members would accompany an ill person to hospital were shaped by consideration of which family members were apt to be recognized by providers' as Indigenous. For instance, a participant described their experience seeking medical care for their daughter who was eventually diagnosed with cyclical vomiting.

> "My daughter suffered from a debilitating thing for months. She would have frequent, uncontrolled vomiting episodes. My husband took her in, and they have the same last name. They both look First Nation. I was hesitant of him taking her to the hospital. The first thing they said is, 'is she on any kind of street drugs?' She was 14. Not that that means like at 14 you don't do street drugs, but she's like, 'no I don't do street drugs.' … This happened for four months straight, every three to four weeks. When I happened to be home she got amazing care, top notch care … so I made sure that I was the only one that took her, because every single time she went in without me they blamed it on drugs … [and it was because her father is] noticeably First Nation." (SC3_ P10)

3.5. Impacts on community

Negative care impacted on others' sense of themselves and their options in the world – including their options for where and whether to seek care. Indeed, our sharing circles were organized around First Nations members' sharing consequential stories of emergency department encounters with one another, and so in this way each of the quotations exemplifies the way care encounter stories are shared and made relevant in community settings.

Participants frequently told stories about family members, which they were not personally present for, as in the following example.

> "[M]y cousin's daughter. She was really sick and she, she went to [rural hospital 7] and she just put in a hallway and given a different kind of antibiotics, something like that. So just give it to them, the doctor gave … the antibiotics and she leave it, then nobody checked on her. She died on that hallway …. I mean, for me, it's been murder. But there's nothing I can do. I know, but there's nothin I can do. It's not for me to judge them. I'll leave it to Creator." (SC2_06)

This is a consequential story of death in the emergency department that is circulating within community and continuing to cause suffering for the teller. The participant indicates that she does not feel this situation is over, but is an unresolved wrong that ultimately Creator must deal with.

Another participant told the story of lack of care for their grandchild, who was sent home from two care settings, and who nearly died as a result.

> "… my youngest grandchild. She was, she got really sick and we brought her to the hospital in [rural hospital 2]. They laughed at her mom and dad, threw them a piece of paper on the common cold. The next day, my granddaughter was really struggling to breathe. I told them to take her to her family doctor in [a small town]. They said she had croup. Next day we went and brought her to [regional hospital 1]. Her, her oxygen level was at 78. She was having a really hard time breathing. That doctor in [regional hospital 1] told her that … my granddaughter wouldn't have survived if she went another day, if she listened to the doctors. That one was really hurtful."(SC2_17)

These cases are similar to the cases of patients who described continuing to suffer from regret over how they responded to poor treatment they or their family member received. In each case, the care encounter continues to have importance for participants' relationship to the healthcare system long after the care encounter occurred.

Another participant explains the way stories circulate within First Nations communities and impact on care seeking decisions.

> "people say don't go to the [urban hospital 3] in [urban area]. Things like that. I think it's almost every hospital that people have gone to that they've had a negative experience over the years. It might not have been the same people, but it was the same community members that talk amongst themselves, that somebody had mentioned. You hear the stories on Facebook, social media. Well, we just talk and it's not like they're not true stories. They're facts." (SC3_ P15)

They noted at another point that "… people are dying, people are hurt, and people don't want to access care, because of the treatment that other people have had." (SC3_P15)

4. Discussion

Study participants describe the negative consequences that follow from being perceived as illegitimate, or not credible in their accounts of themselves and their needs, and excluded from care. Negative emergency care interactions are sources of suffering which impact patients, families and communities long after the encounter. This is particularly so where encounters are perceived to be shaped by racial prejudice and stereotyping. In this way, the emergency care system can be an actively

harmful site of social exclusion.

Participants' reports of their treatment mirror reports in numerous healthcare settings from around Canada (Cooke and Shields, 2024). A review study "reported Indigenous people feeling that they were generally not treated well by healthcare providers [and] feeling ignored, feeling treated differently from other patients, feeling as though they had been treated more slowly, or not being listened to or believed by clinicians." Scoping review authors grouped these findings under the heading of patients feeling "lessened as a person." (Cooke and Shields, 2024)

4.1. Suffering in emergency departments

Our finding reflect a limited body of other studies which show emergency care as a cause of suffering (Body et al., 2015). A review study has found feelings of being depersonalized or forgotten in emergency departments as significant sources of patient suffering (Graham et al., 2019). Authors found that across a number of studies "Patients longed to be viewed as 'sensible' … in their decision to attend the ED" (Graham et al., 2019). In a study of patients presenting to emergency departments for mental health concerns, "Patients … stated that they wanted to be perceived as worthy people who were suffering and legitimately seeking assistance" (Clarke et al., 2007). What First Nations patients expressed in terms of deficits in their care in our study is thus similar to what patients generally express when they describe sources of suffering in emergency departments. Yet, First Nations patients' experiences of racism in emergency departments compound suffering, through injury to their personhood, when they or their loved ones are de-legitimized, stereotyped or dismissed on the basis of their Indigenous identity.

4.2. Alignment with findings on Indigenous patients' emergency care

Our results are aligned with other studies on Indigenous patients having negative experiences in emergency care (Browne et al., 2011; Cameron et al., 2014b; Goodman et al., 2017). Goodman has documented Indigenous patients' accounts of being dismissed by providers and physically excluded from care sites (Goodman et al., 2017). As noted in the introduction, our prior work demonstrates system effects that are observable across First Nations members' emergency care (e.g. less urgent triage levels, proportions of patients leaving without completing care) McLane et al., 2022a;McLane et al., 2024). Provider perspectives that we documented show how stereotypes about Indigenous people are widely held across providers and impact quality of care(McLane et al., 2022b). These provider perspectives mirror participants' reports of encountering racism, being stereotyped and often not receiving needed help in emergency departments.

4.3. Alignment with findings on how healthcare reinforces racial and colonial hierarchy

Findings align with studies on health care's role in reinforcing social hierarchies (Hillman, 2014; Roth, 1972; Sointu, 2017; Timmermans, 1998; Vassy, 2001; Wamsiedel, 2020). As Andaya has written, the medical setting works to produce patients as racialized "subjects who, through their perception of an institutionalized lack of care for them … experienced their lower position in broader social hierarchies" (Andaya, 2019). Furthermore, insofar as participants found themselves reflecting on how their appearances, skin tones, circumstances and behaviour would be interpreted by non-Indigenous providers they demonstrate the way colonized groups are forced to internalize the perspective of the white colonizers, who regard them negatively (Fanon, 1986)(Coulthard, 2007). That is, First Nations patients are pushed to consider themselves through the eyes of colonial worldviews when interacting with overwhelmingly non-Indigenous providers, and non-Indigenous institutions. When a participant comments that a First Nations persons' "confidence" is dismissed by disrespect "off reserve" they evidence the way Indigenous personhood is undermined by the internalization of colonial views.

4.4. Emergency care's power to make live and let die

When considering the way power is exercised, we should recognize not only the power of state institutions to directly do violence to bodies (e.g. through armed forces), but also the life-saving powers of state institutions like healthcare and the harm that is done when life-saving powers are made less available to populations the state does not value (Foucault, 2003). As sociological studies of healthcare practitioners record, the efforts providers make on behalf of patients are informed by providers' assessments of the patient as a person. This applies even to life saving interventions. As Timmermans (1998) has written, reporting an ethnographic study of resuscitation efforts, "people who are able to establish some kind of personhood … have the best chance for a full, aggressive resuscitative effort". Similarly, Glaser and Strauss have famously reported that healthcare professionals work tirelessly to build narratives around their patients (Glaser and Strauss, 1964). These stories centre on patients' value as members of the majority society and what a poor or beneficial care outcome will mean for the patients' family and community. Examining the "social loss stories" providers tell, Glaser and Strauss comment on the ways patient characteristics ranging from age to skin color, accomplishments to familial relationships, are utilized in judging the meaning of a death. "High social loss patients [i.e., those valued as persons] often re-ceive more than routine care. Extra "good will" efforts are made to talk with them, to keep up their spirits, to make them comfortable, and to watch for sudden changes in their condition" (Glaser and Strauss, 1964). When participants in our study described the deaths or near deaths of loved ones in emergency care, and linked outcomes to a lack of care on the part of providers related to their Indigenous identities, they show their awareness of a phenomenon that Western social scientists have had to painstakingly uncover and document.

4.5. Impacts on communities

Emergency department encounters have lasting impacts on patients, family members and wider communities as they become part of stories that circulate in these communities. Similarly, Goodman has noted that First Nations participants in their study "drew upon a seemingly collective narrative about how others before them have experienced adverse care, which informed personal understandings and experiences of healthcare"(Goodman et al., 2017). We believe it is important to note these broad impacts of emergency care on patients and communities. While Western conceptions of healthcare often focus on the individual patient and their experience at a given point in time, our results suggest that whole communities are impacted on a continuing basis by emergency care encounters. The everyday work of providers, which they may quickly forget (Glaser and Strauss, 1964), is not forgotten by patients, families and communities.

4.6. Implications

The perspectives of participants in our study show that emergency care (often considered a purely beneficial, life-saving institution) is part of the ongoing colonization of Indigenous peoples when care encounters undermine the well-being of Indigenous people at individual, family and community levels. Emergency departments could operate differently if leaders and providers were attentive to the fact that emergency department encounters are a source of suffering, that reinforce colonial racial hierarchies and harms, and worked to avoid occasioning this suffering. Indeed, our work suggests that when researchers, decision makers and the public assess emergency department performance, we should consider the hospital as a social institution which shapes patients and their communities through care encounters. Such efforts would

align broadly with Indigenous perspectives on health system evaluation (Nightingale et al., 2026). Indigenous perspectives open the possibility of thinking broadly about whether the emergency department is delivering help or harm to each of the communities it serves in the long term – and assessing this through community-led processes as we have done here. In turn, such thinking may drive allocation of resources to improving the role the emergency department plays in patient biographies, family histories and community-well-being.

At the provider level, we have previously reported on strategies providers undertake to attempt to address First Nations patients' prior negative experiences in healthcare (McLane et al., 2022b), which we believe remain aligned with findings in this article. At the organizational level, it is possible emergency department level interventions to improve equity in care for First Nations patients may be beneficial (McLane et al., 2022b), although there are few examples in the published literature (MacLean et al., 2024) and these showed limited success.

Efforts to bring non-Indigenous emergency providers together with First Nations members on an equal footing outside a healthcare delivery context may be beneficial in helping improve relations of non-Indigenous providers with First Nations members (McLane et al., 2021b). Similarly, First Nations leadership in care and care improvement would be valuable as First Nations leaders may present a powerful counterpoint to stereotypical ideas of First Nations members. Anti-racism education for providers may also be worthwhile (McLane et al., 2021b citing Burns et al., 2017; Stone and Moskowitz, 2011). However, given that so much of the way providers treat patients is about connecting with them as persons (Sointu, 2017), it may be that an increase in the proportion of First Nations emergency care providers is necessary to make change in First Nations patients' emergency care. Moreover, as Elders told us in meetings in February 2021 and October 2022, First Nations owned and operated care facilities may be warranted (Allen et al., 2020). In some areas, First Nations emergency care needs may be best achieved by reallocating more healthcare resources (e.g. funds, buildings, equipment, governance authority) to First Nations to manage directly and with support by treaty partners. Such thinking finds its foundations in the treaties. In February 2024, Elder Advisors told the research team that the concept of well-being was tied to treaty during the treaty signings, and non-First Nations people living here need to understand this connection between well-being and treaty. Similarly, the Elders of Treaties 6, 7 and 8 assert that "the Canadian and Alberta governments must be bound to fully implement the Treaties" respecting First Nations sovereignty and Crown obligations in order "to achieve the highest attainable standard of health for First Nations" (Elders Declaration, 2016).

5. Limitations

A limitation of this study is that few youths were included, despite the relatively young age of Indigenous populations. A large proportion of participants were women, and we have not considered the impacts of gender (or intersections of gender with First Nations identity) on emergency care in this report. Specifically raising issues of gender to solicit participant perspectives during data collection would have enhanced our study. Furthermore, we did not talk to persons who were unhoused or who disclosed experiencing substance use disorder, and patients with these characteristics may have had different experiences than those persons who participated in our study. We also did not explore the experiences of Métis or Inuit persons, as our study was partnered with First Nations organizations.

6. Conclusion

First Nations participants discussed their awareness that interactions with providers would be shaped by providers' perceptions of their identity, and the ways emergency care encounters caused lasting suffering and impacts on their communities. We suggest that emergency care should be assessed in terms of long-term impacts of emergency encounters on patients and communities. Community-led processes may evaluate hospitals as social institutions that deliver both help and harm to patients, families and communities. There is the potential for emergency departments and hospitals to play their role in communities differently. If patient suffering and the retrenchment of social hierarchies (including colonial racial hierarchies), are explicitly seen as common outcomes of care encounters, then efforts to avoid such suffering and hierarchization can be made. Through compassionate care for patients that validates their worth as persons, family members and community members (in families and communities that are also valued) emergency departments may come to offer positive encounters in patients' biographies, family histories and communities. For First Nations, such improvements to emergency care would occur within the framework of the treaty right to health.

Disclaimer

Parts of this publication are based on data and information from the Understanding and Defining Quality of Care in the Emergency Department with First Nations Members in Alberta project. The analyses, conclusions, opinions, and statements expressed herein, however, do not necessarily reflect the views of the Alberta First Nations Information Governance Centre and are solely those of the authors. Statistics reproduced from this document must be accompanied by a citation of this document, including a reference to the page on which the statistic in question appears.

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CRediT authorship contribution statement

Patrick McLane: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Writing – original draft, Writing – review & editing. **Lea Bill:** Conceptualization, Data curation, Methodology, Writing – review & editing. **Katherine Rittenbach:** Conceptualization, Funding acquisition, Writing – review & editing. **Cheryl Barnabe:** Conceptualization, Funding acquisition, Writing – review & editing. **Brian R. Holroyd:** Conceptualization, Funding acquisition, Writing – review & editing. **Tessy Big Plume:** Conceptualization, Investigation, Writing – review & editing. **Kris Janvier:** Conceptualization, Investigation, Writing – review & editing. **Eunice Louis:** Conceptualization, Funding acquisition, Investigation, Writing – review & editing. **Deanna Neri:** Investigation, Writing – original draft, Writing – review & editing. **Bonnie Healy:** Conceptualization, Funding acquisition, Methodology, Writing – review & editing.

Declaration of competing interest

Patrick McLane was an employee of Alberta Health Services when the research was conducted. Brian Holroyd was a contractor for Alberta Health Services. The views expressed in this document are solely those of the authors and do not represent those of their employers.

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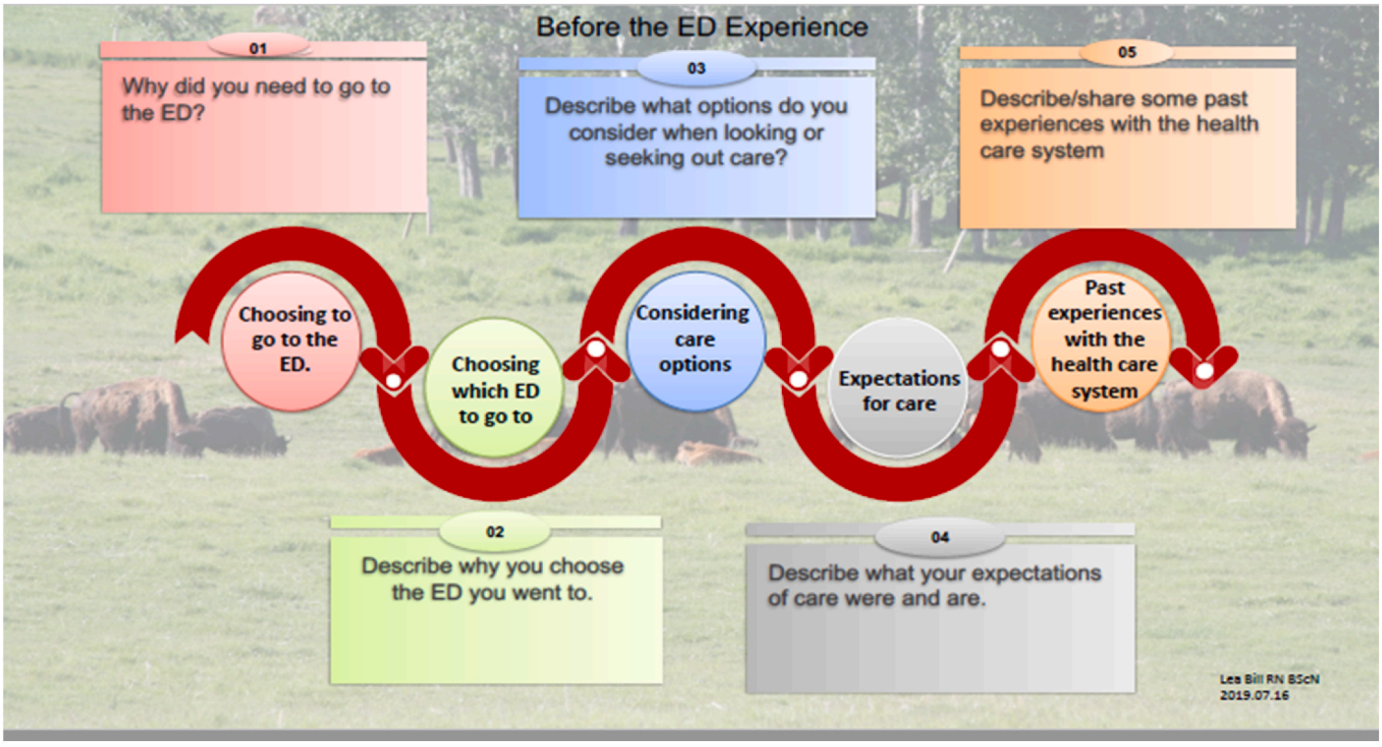
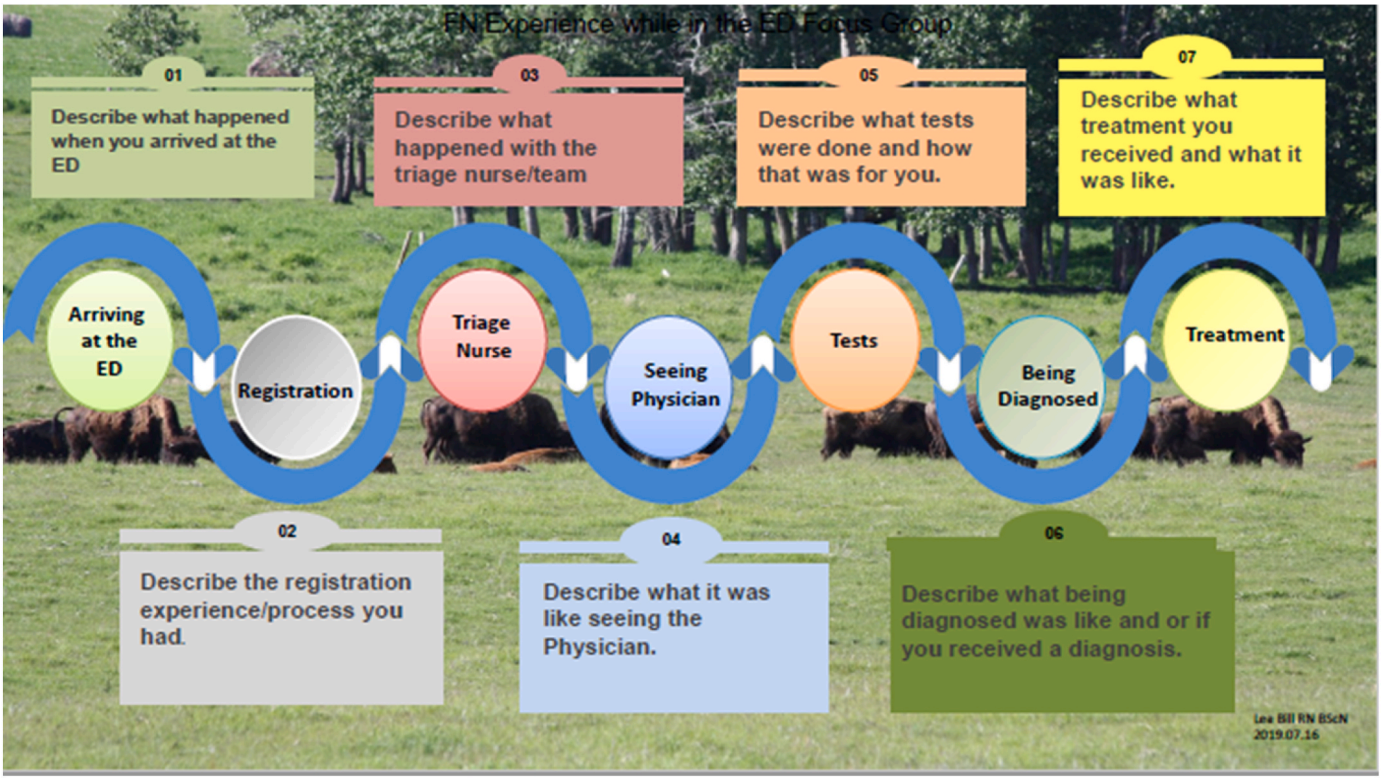
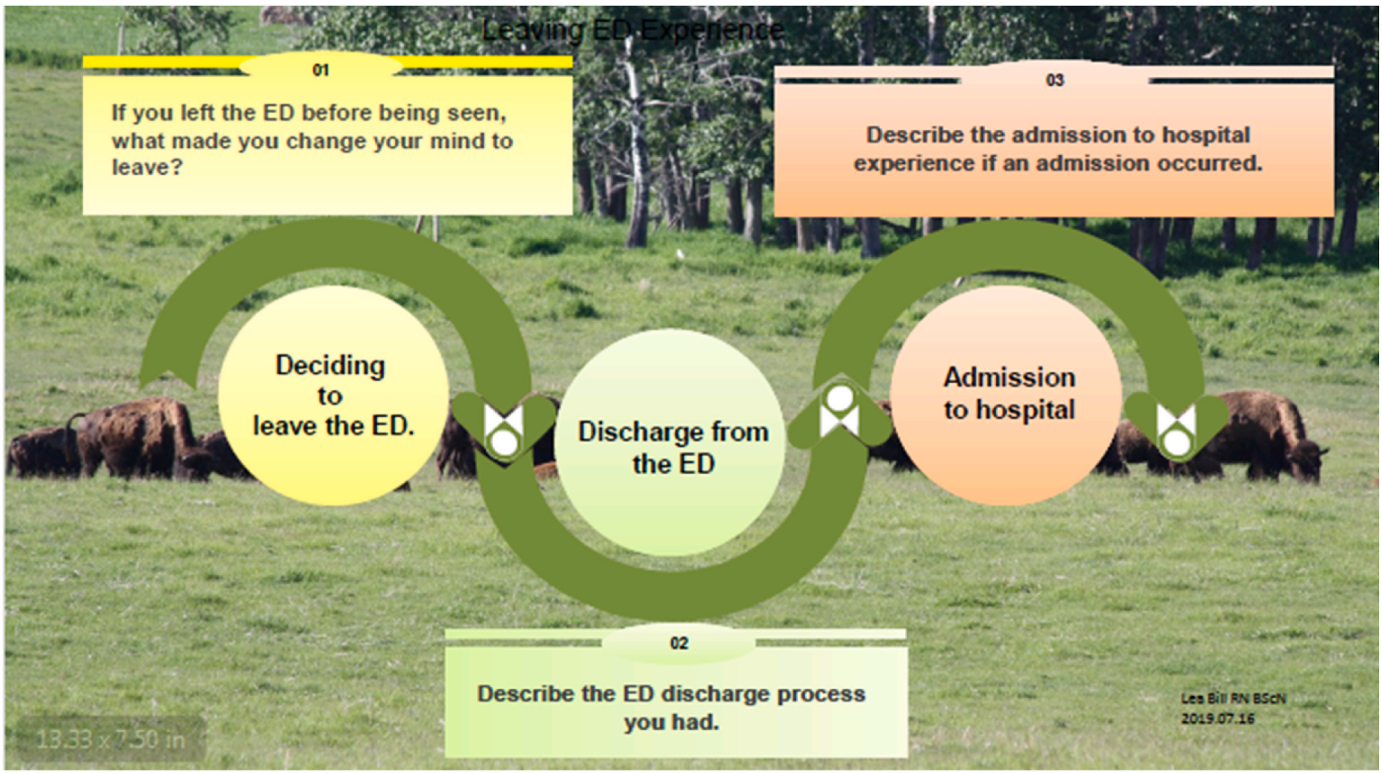
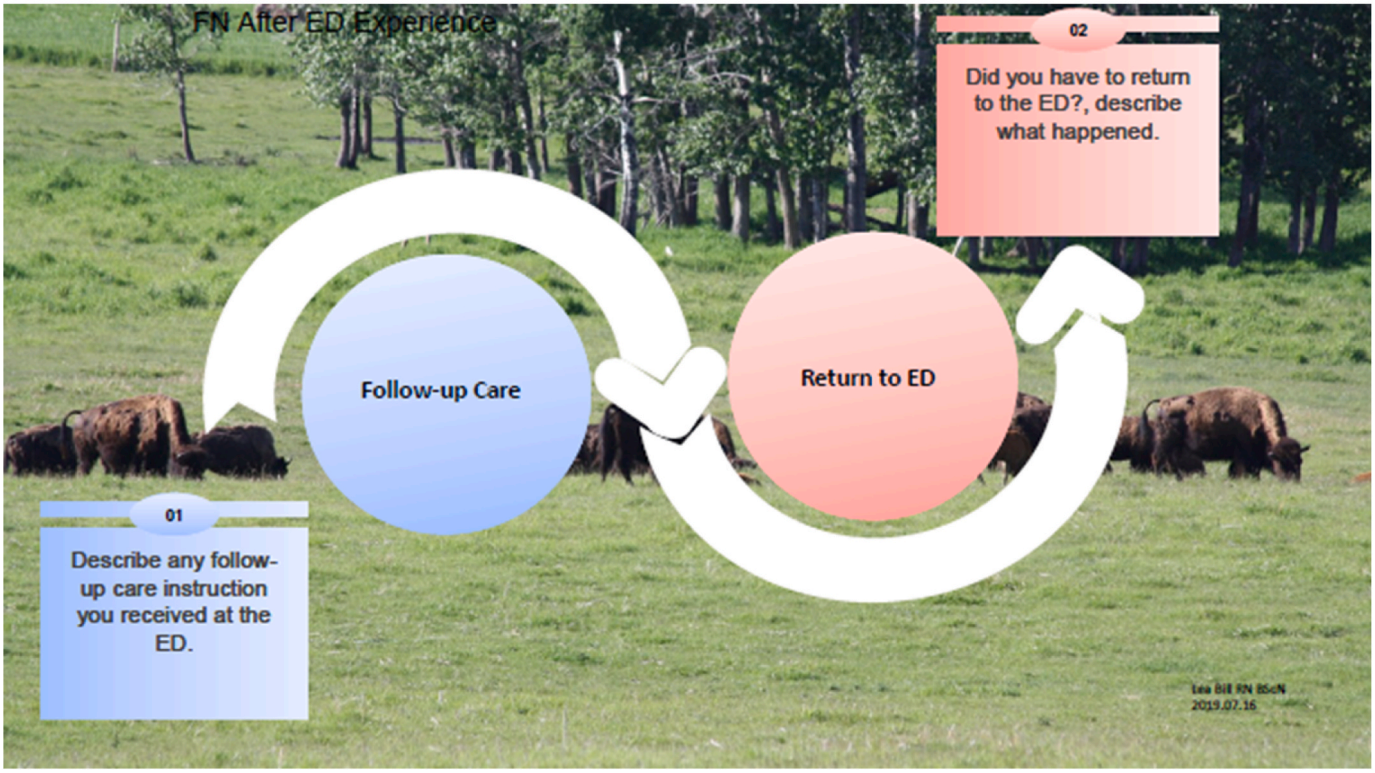
Appendix 1. Four-page visual guide for sharing circles






Leaving ED Experience
01
If you left the ED before being seen, what made you change your mind to leave?
03
Describe the admission to hospital experience if an admission occurred.
Deciding to leave the ED.
Discharge from the ED
Admission to hospital
02
Describe the ED discharge process you had.
Lea Bill RN BScN
2019.07.16
13.33 x 7.50 in


FN After ED Experience
02
Did you have to return to the ED?, describe what happened.
Follow-up Care
Return to ED
01
Describe any follow-up care instruction you received at the ED.
Lea Bill RN BScN
2019.07.16

Data availability

The authors do not have permission to share data.

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