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*Document Version*
Accepted author manuscript

*Published in:*
Sociology of Health and Illness

*DOI:*
10.1111/1467-9566.13258

*Publication date:*
2021

*License*
Unspecified

*Citation for published version (APA):*
Pedersen, A. R., Brehm Johansen, M., & Scheller, V. K. (2021). Challenging 'Colour Time': A Practice and Narrative Approach to Organising Waiting Time in Hospitals. *Sociology of Health and Illness*, *43*(4), 829-843. https://doi.org/10.1111/1467-9566.13258

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# Challenging 'colour time': A practice and narrative approach to organising waiting time in hospitals

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## Abstract

Waiting time in hospitals is often studied from one of two perspectives: a distributed resource in hospitals or a potential steering and measuring factor. In this article waiting time in an emergency department is examined from a practice and a narrative perspective, placing *time* at the core of our analysis. Our article explores patient waiting time as a local practice that builds on the temporal structuring that effects how waiting time is regulated by both normal clock time and event time – as interpretative time. We also consider how individual narratives in situated spaces allow for negotiations, but we also present isolated time experiences. The empirical data derive from an organisational ethnographic study of a newly introduced triage system for incoming patients at an emergency department in Denmark. The analysis shows how waiting time is organised in the formal visitation system as "colour time" based on the negotiations of the healthcare professional as at the "right time" and as the patient's individual illness experiences with "wasting time". The findings indicate the importance of the unequal relationship between clock time and event time and the different contextual situations affecting the possibilities of organising.

**Keywords** Waiting time, triage system, emergency care, practice, narratives, patients, health care professionals

## Introduction

Waiting time as a sociological phenomenon refers both to individual experiences of waiting and to time as a resource that can be measured. This article concerns waiting time in a hospital setting, a classic though currently relevant theme in sociological healthcare analysis. Schwartz's (1974) classic waiting time study indicated that waiting time generates distinct social and personal costs and is related to the clients' position in a power network and their willingness to wait. A more recent study demonstrated the steering potential of measuring and regulating waiting time in a healthcare context (Bevan and Hood 2006). Waiting time can also be defined as human experience, which is an understanding researchers have addressed from inside (Riessman 2015) and outside healthcare organisations (Harvey 2015; Johnsen *et al.* 2018). These studies illustrated how waiting time can be understood as a distributed resource or as human experience in hospital organising. The purpose of this study is to follow their lead by demonstrating how different versions of time are deployed by organisational members and patients to facilitate and describe their different purposes, priorities and experiences.

The empirical material stems from an organisational ethnographic study of reorganising patient prioritisation through formalised triage work processes in an emergency department in a regional hospital in Denmark. Triage, a popular organising mechanism in hospitals (Bjørn and Rødje 2008, Johannessen 2017, 2018), originates from military medicine, where quick action and prioritisation of

emergency care is imperative (Nakao *et al.* 2017). In the triage system in our study incoming patients were assigned a triage level based on their vital signs and on an emergency signs and symptoms algorithm. The fieldwork consisted of observations, interviews and shadowing at the department, which involved following everyday life surrounding the flow of incoming patients.

The research question is: *How do different interpretations of time create unequal conditions for organising waiting time?* This article is structured as follows. First, we present a theoretical framework for exploring waiting time from a practice and narrative perspective before describing our case and methods. Next, our analysis is divided into three parts and presents the findings: triage work as clock time based on 'colour time'; the negotiation of clock time by healthcare professionals using event time at the 'right time'; and lastly the coexistence of event time as individual patient narratives of 'wasting time'. Finally, the article concludes by considering how these findings demonstrate a dynamic relationship between different representations of time, and how further studies on waiting time in a healthcare setting can be carried out**.**

## Sociological perspectives on waiting time: time as practice and narratives

Studies of waiting time in hospitals often focus on the personal cost of waiting and on the difference between patients' time and time scales for healthcare professionals (Bevan and Hood 2006, Fetter and Thompson 1966, Gasparini 1995, Schwartz 1974). In their classic study of the relationship between patient waiting time and doctors' idle time, Fetter and Thompson (1966) concluded that a least seven variables affect the relationships: appointment interval, service time, patient arrival pattern, number of

no-shows, number of walk-ins, physicians' arrival patterns and interruption in patient services. Another study of waiting time in healthcare described the temporalities experienced in conflicts involving the slowness and frustration of waiting in juxtaposition to movement and the fast pace of everyday life (Ferrie and Wiseman 2016). Hauge (2016) showed how waiting time, as perceived time, appears in different life worlds, while a management study by Bevan and Hood (2006) demonstrated how waiting time in hospitals as distributed time has become part of a new public management steering paradigm.

Triage systems organise waiting time in hospitals. Accordingly, recent practice studies have demonstrated the consequences of triage by investigating the discretionary practices of nurses in face-to-face triage, where they have to navigate guidelines and the antagonistic relationship between nurses and patients that contradicts the ethical guidelines (Johannessen 2017, 2018). Another triage study described the negotiations that occurred during patient assessments in an emergency department and how patients and their relatives helped in determining their placement into categories (Hillman 2014). Our study builds on and supports these studies by examining how time is part of triage work and organising, both as part of the formal structuring and professional negotiations, but also by including an individual patient experience perspective.

**A practice perspective on time: temporal structuring**

Studies of medical practice from a temporal perspective is a classic field of interest (Glaser and Strauss 1968, McCoy 2009, Waterworth 2003, Zerubavel 1979). Many researchers have contributed theoretically to this tradition and attempted to describe the various time dimensions in organisational

life. From a practice-based position, Orlikowski and Yates (2002) defined the object-subject time dichotomy as the contrast between *clock time* and *event time* , where the former is associated with 'machine time' as an objective concept that can be measured in time scales as minutes and hours and the latter is conceived as experiences and subjective time understandings, for example Roy's (1959) classic study of workers talking about banana time as a specific break during their workday. Orlikowski and Yates (2002), who further argued that the concept of *temporal structuring* overcomes this dichotomy, defined temporal structures as deeply embedded in human action and as guiding ongoing activities. Drawing inspiration from Zerubavel (1979), Orlikowski and Yates (2002) described how temporal structures shape social life, i.e., project plans, deadlines and weekly meeting cycles. Temporal structure research in hospitals explains how time is socially constructed by actors as temporal frameworks and reference points.

Studies of temporal structuring have been criticised for focusing too much on socially defined structures and too little on the 'inner dynamic', e.g., how they become social structures through sensemaking and narratives that establish connections between events and expectations for the future (Hernes 2014). We take this critique into account by combining narrative and practice-based theories on time.

In summary, temporal structuring in organisations has the capacity to explain how participants use time to coordinate activities. Focusing on temporal practices enables the bridging of clock time and event time as both are part of temporal structuring. However, the perspective lacks explanatory power regarding how temporal structures become meaningful, which a narrative perspective on time can

provide.

**A narrative perspective on time: individual time narratives**

Sociological research in healthcare settings has a long tradition of studying narratives (Bury 2001, Charon 2008, Currie *et al.* 2009, Ezzy 2000, Hunter 1991, Hydén 2010, Mishler 1984, 2004, Riessman 2008, 2015, Williams 1984, Williams and Jones 2017). Studies by Williams (1984) and later Bury (2001) on illness narratives gave voice to patients' long-neglected interpretations. Other contemporary studies of illness narratives provided an overview of the extended sociological literature examining the relationship between narratives and illness experiences (Hydén 2010). The narratives of physicians (Hunter 1991) and of healthcare professionals on patient safety (Currie *et al.* 2009) have also unfolded how meanings are part of understanding regulations and healthcare practices. Individual *time narratives* represent examples of event time, where time emerges in the (storytelling) events, and events are defined (and narrated) by all organisational members (Clark 1985) with the goal of making sense (Bruner 1990). We also included space in our definition as events are told in a specific spatial context (Bakthin 1981). The initial idea was to emphasise that time cannot be understood without a spatial dimension, in other words as a chronotope, where time and space are intertwined (Pedersen 2009).

In their search for diverse meanings, some researchers take a critical stance towards narrative studies because they do not discuss their power relationships and effects (Boje 2011, Jackson 2002, Mumby *et al.* 2017). Mumby *et al.* (2017) described how both collective public protests and hidden, everyday individual micro resistance are examples of opportunities for societal resistance and represent

a dynamic understanding of power as the possibility to resist. In a study on the politics of storytelling by refugees, Jackson (2002) described the contested spaces under which stories are told and stressed the power relations between private and public realms, highlighting that storytelling can re-constitute events in a story, which allows the teller to no longer relive these events passively and to actively rework them into their dialogue with others and in their own imagination. As a result, storytelling and narratives become empowerment, which can re-balance the public and private realms if the narratives have an audience.

In summary, narratives have the capacity to represent human experience and awake sense making, which means that narratives are an example of event time, where individually told narratives relate to events and space. Narratives can also affect other narratives if they have an audience and the opportunity to negotiate their viewpoints in concrete spaces. Combining a practice and narrative approach makes it possible to investigate the triage system as a work practice but also to listen to the individual narratives of the people the triage system affects.

## Research setting

The emergency department is a suitable empirical setting for studying waiting time as the triage system regulates the amount of time each patient has to wait. At the time of the fieldwork, the emergency department under study had recently introduced a structured triage system to determine and classify how to clinically prioritise patients. Inspired by a Swedish scheme, the system had been locally adapted to Danish medical guidelines. Nurses, secretaries and a few emergency chief physicians were employed by

the emergency department, but the last-mentioned group mainly comprised physicians from other hospital units who took shifts there as a part of their overall schedule. Patients arrived by ambulance, upon referral by their general practitioner or came in on their own initiative. After being registered by the secretary, patients stayed in the waiting room until greeted by a nurse who did the initial triage assessment. The activities observed included a triage nurse taking the patient's temperature, blood pressure, oxygen saturation, pulse and respiratory rate, and assessing them using the Glasgow coma scale, which determines the level of consciousness. Then the nurse related the symptoms described by the patient to a predefined emergency signs and symptoms algorithm to assign the patient a colour code. A triage colour code is established by an algorithm based on the patient's vitals and symptoms. The colour code becomes the patient's overall categorisation and is then registered on the patient's observation chart and given to the coordinating nurse. Each colour code has predefined rules for how much time can pass before the patient has to be reassessed. Most of the incoming patients were assigned as green, yellow or orange to correspond with the level of urgency, with red representing the most urgent and green the least. When the fieldwork ended, it became clear that the triage practice looked different depending on the vantage point of the system itself, the professionals and the patients.

## Methods and analysis

The empirical foundation of our study is an ethnographic fieldwork-based study (Ybema *et al.* 2013) carried out in an emergency department in a Danish hospital. The fieldwork lasted three months, and data consisted of both semi-structured qualitative interviews and fieldnotes from place- and person-

oriented observations, i.e., shadowing (Czarniawska-Joerges 2007). In this case, a researcher followed employees in their daily work and focused especially on triage-related activities. We interviewed various people in the emergency department to gain a broad representation of the variety of the people working there and patients. Twenty-six semi-structured individual interviews were conducted primarily with nurses (n=15), but also with doctors (n=3), managers (n=3) and patients (n=5). All interviews were conducted using thematically arranged interview guides, where topics and issues to be covered were specified, though there was room for other relevant topics to surface and be explored during the interviews. The interviews, which lasted 20-90 minutes, were audio-recorded, with the exception of the patient interviews because they took place in the emergency department and the circumstances did not allow doing audio recordings, e.g., if an interview took place in a shared patient TV room, but extensive fieldnotes were taken. The data were collected before COVID-19. The interviews were done in-situ, which means they were not rationalised after the event and do not represent structured accounts.

Doing fieldwork in the emergency department, which consisted mainly of shadowing the nurses (and to a lesser extent doctors) as they worked, brought several ethical issues to the fore. After the shadowing was completed, follow-up interviews were carried out with the nurses and physicians. Nurses were asked individually to agree to participate on a day-to-day basis. During shadowing, the patients the nurses interacted with were told why the fieldworker was present and given the opportunity to decline to participate. During acute situations with red patients, such as the arrival of trauma patients, the fieldworker withdrew from the situation, which means that no red patients were observed or

interviewed. The fieldwork was thus highly dependent on a situational ethics approach (Goodwin *et al.* 2003).

We became acquainted with the various ways in which individual narratives on waiting time developed among patients due to the triage system, and we found inspiration in the literature on practices (everyday activities, temporal structures based on clock time and event time) and individual narratives (as examples of event time). One example of an everyday activity was that the coordinating nurses had to list patients on the whiteboard in the visitation room (observed), which we then talked about in the interviews. The following overall thematic codes were used to analyse the material: everyday activities, clock time and event time based on individual narratives. The narratives in the analysis are representative individual narratives from the empirical material and were selected to illustrate diverse sensemaking in the material. Using an inductive approach to our data, we identified a three-fold pattern in the material. Table 1 lists the content in each of the three parts.

**Table 1.** Summary of the three-fold analysis

| ***Time findings*** | **'Colour time'** | '**Right time'** | **'Wasting time'** |
|---|---|---|---|
| *Everyday activity:* | Triage system | Using the triage board | Waiting in waiting areas |
| *Clock/event time:* | Clock time | Negotiating clock/event time | Event time |
| *Spaces:* | Abstract space | Concrete space | Private and public spaces |

The initial analysis presents the everyday activities of the triage system. We identified individual narratives in the material and divided them into sections concerning (clock) time and space. We then analysed the practice of adjusting the triage system at the triage boards in the assessment room, where we collected individual narratives about the interaction of clock time and event time. We went beyond a practice perspective, which means the analysis did not end here because we applied a narrative approach, allowing a third analysis of the time narratives coexisting with clock time. This part of the analysis presents the patient narratives of their illness experiences related to their personal waiting time.

## 'Colour time': the ideal encounter in clock time and in abstract space

The triage system, which establishes a framework for the healthcare professionals' activities, is a central part of organising waiting time in the emergency department. One everyday activity is that the professionals use the whiteboard with the names of incoming patients and assign them colour codes. In a small office in the emergency department, the coordinating nurse lists the patients' names on a whiteboard, their room number assigned upon registration, arrival time, reason for contact and the nurse assigned to the patient.

> *The coordinating nurse is standing in front of the whiteboard examining the row designated for placing the coloured magnets indicating the patient's triage level. "Anne, why doesn't the lady in room four have a colour? She arrived an hour ago?" asks the coordinating nurse. Anne, standing behind her, replies, "Oh, I forgot; she's yellow." The coordinating nurse places a yellow magnet on the whiteboard. A porter comes by the triage room and says, "Room 8.1 is*

*leaving now." The coordinating nurse erases this patient's information on the whiteboard and the porter pushes the bed down the hallway in the direction of the observation unit. A member of the ambulance crew is standing in the doorway with a stretcher carrying an elderly woman and asks, "Where should I put Mrs. Jensen?" The coordinating nurse answers, "Room 5, by the window", picks up the referral sheet from the holder on the wall and starts noting the name, time and reason for contact on the whiteboard on the line labelled 5.1 (room 5, bed by the window). The member of the ambulance crew heads off down the hallway with another crewmember with the newly arrived patient lying on the stretcher.*

This observation illustrates how the colour system is used to create a central temporal structure in the emergency department. It creates a background that guides the allocation of patients and tasks, setting expectations for time frames and professional action. As such, the colour system is an example of how the social life of the emergency department is based on a structured pattern that puts everything in order, i.e., with patients in the right beds and doctors in the right places.

**Clock time: distributing patients based on ideal time scales**

When incoming patients are registered based on their arrival and formally entered into a system that coordinates visits for the physician, clock time scales are a part of organising the system:

*A doctor comes into the assessment room, looks at the whiteboard and writes his name in the space indicating that a physician has seen (marked as an x) or is seeing (half an x) the patient.*

*There is a yellow magnet indicating the triage category by the patient where he writes his name. The coordinating nurse sees it and says, "Please see the man in [room x] first because he is actually orange and has already been waiting for half an hour [i.e. longer than the rules allow for orange patients]". The doctor replies that he would rather attend to the heart patient since this is his specialty, but the coordinating nurse explains that the man is orange, which means he needs to be seen before the yellow heart patient. The doctor hesitantly erases his name, rewrites it by the patient in room 3.1 instead and leaves the room.*

This system of colour codes assists in providing incoming patients with a predefined time frame for re-evaluation. For example, according to the rules, green patients must be re-evaluated after 120 minutes and orange ones, every ten minutes. These re-evaluation time frames provide a benchmark for the acceptable amount of waiting time for each patient category, but they also presuppose that the needed resources in terms of nurses and patient rooms are available and sufficient. This shows that time frames characterised by ideal clock time are an important part of the triage system.

**Abstract space: always a perfect fit between space and time**

Patients in waiting areas or the patient rooms eagerly wait to be seen by a physician. To treat them in a timely and correct manner, the doctors follow the colour codes in the triage system. However, there is often a discrepancy between what happens in reality and the built-in expectation that the re-evaluation time frames in the standardised triage system are always adhered to. In a busy everyday emergency

setting this expectation is not always fulfilled due to the availability of resources, as many of the patients with the same colour are in the patient rooms:

> *When I had the role of coordinating nurse last week, I had seven orange patients on the board at the same time. That means I would have to had seven nurses in seven patient rooms observing their respective patient every ten minutes (…) It's tempting to say that today we go strictly according to the colours, just to show what would happen if we followed the triage strictly.*

This quote demonstrates that the optimal use of the triage system occurs in an abstract space, but that the process is complicated by the fact that it does not take the availability or scarcity of the contextual resources on hand into account, leading to the creation of problems that the healthcare professionals must solve in practice.

In summary, the triage system provides a backdrop for temporal structuring in the emergency department, and the colours establish temporal frameworks for providing patients with treatment. 'colour time', as described in the narratives of the healthcare professionals on the use of the triage algorithm, points to an imaginary abstract space with ideal encounters between the algorithm and the patient. The triage system is thus placed at the top of a discretionary hierarchy by providing directions for an ideal clock time and flow of patients. However, as the next section will show, the perfect balance is not always easy for the professionals to achieve.

## Struggling with ‘colour time’ by negotiating the ‘right time’ in concrete spaces

For the healthcare professionals the preadmission assessment room is an important place in their workday where they interpret the patients’ level of urgency according to their colour codes. As the first analysis demonstrated, ‘colour time’ directs the healthcare professionals’ work by establishing a central guiding structure for ordering patients, professionals and beds. The underlying idea of ‘colour time’’ shows how the sociality of waiting time is translated into a structural time pattern, while the colour system displays how waiting time can be understood as clock time in an abstract space. However, even though ‘colour time’ establishes the central structuring of waiting time, this understanding lacks focus on the inner dynamic, i.e. how waiting time becomes meaningful to professionals.

In an interview a nurse talks about waiting time in accordance with the triage assessment: “*You respect the colour codes, and you respect that a red patient will take all your time. And if you have a red patient, then it’s completely legitimate not to attend to your other patients; then, someone else takes over*.” The nurse describes how waiting time, in her understanding, is in accordance with the colour-coded triage system and that ‘colour time’ is a legitimate way of organising waiting time for the healthcare professionals. However, the healthcare professionals often have to negotiate ‘colour time’ since assigning patients to the right spot becomes difficult in an everyday context.

**Event time: negotiating to achieve the 'right time'**

When the healthcare professionals negotiate 'colour time', they introduce event time by including other events (e.g. encounters with nervous patients) in their decision making. The following excerpt from the researcher's observation fieldnotes describes a dialogue that occurred at the whiteboard used to place the colour codes:

> *A nurse comes into the room and places a green magnet on the whiteboard, "Well, I couldn't get her to be more than green". The coordinating nurse replies, "But we need to have her seen by a doctor so she can go to GYN [gynaecological department]. The nurse replies that the patient is also extremely nervous, making it really difficult for her to wait the amount of time it would normally take a green patient to be seen by a doctor. The coordinating nurse picks up the telephone and calls one of the doctors, who then arrives shortly afterwards. She was in the adjacent room dictating a file. The nurse tells the doctor about the patient and the doctor says she will see the patient immediately, adding, "Oh, I just need to check if there are other patients who need to be seen first". The doctor looks at the whiteboard, and since the yellow and orange patients are all marked with the names of other doctors, she notes her name on the whiteboard, exits into the hallway, picks up the case sheet and heads for the patient's room.*

This description demonstrates how nurses and physicians make minor decisions about the patient flow and structure a 'right time' by taking other events into account in their practices and not just by following the codes as endless, mindless routines. The colour-coded time and standardisation of patients

is questioned and negotiated by the healthcare professionals based on their own interpretation of the patients' wellbeing. This interpretation does not always align with what the colour code indicates. 'colour time' can be interpreted as incorrect, causing the healthcare professionals to make new decisions based on the individual patient's circumstances. The professionals fit the patient into what they perceive as an appropriate triage category, leading to a 'correct amount' of waiting time. As a result, the 'colour time' provides a direction for decision making but also gives healthcare professionals an opportunity to disagree and construct other ways of making the patients fit into the 'correct' interpretation.

**Concrete spaces as shared patient rooms**

A nurse describes some of the unforeseen consequences of the triage system and the introduction of 'colour time', with an abstract understanding of space:

> *Cancer patients can lie here for hours before they are going on to the oncology unit, which I think is wrong. They might not have signs and symptoms that make them acutely ill here and now, but haven't they been through enough already, so that it's fair to speed up the process a bit? It's not okay that patients with a terminal disease have to spend their precious time in a place like this.*

This nurse talks about how the colour-coded system does not benefit cancer patients or the chronically ill as the emergency department is not responsible for the time, they spend in shared patient rooms, as their time would be better spent elsewhere, i.e. in other departments. She illustrates the unforeseen

negative space consequences of using the triage system as temporal structuring, which is not designed to take ethical dilemmas into account but focuses mainly on objective time scales.

In summary, when physicians and nurses talk about a space dilemma, they draw on differing situational interpretations of the correct (and incorrect) designation for a patient that are not in accordance with the standardised categories of the triage model. Their assessment becomes the specific reason why a placement is right, which is then negotiated if patients are seen as urgent or not. This is one example of how temporal structures become meaningful for professionals in practice. Accordingly, this section described the professionals' narratives concerning ongoing negotiations that involve balancing the ideal patient flow with professional discretion, i.e. they conduct invisible work to support systems and plans that have a higher power status in the organisation. As a result, their understanding of waiting time differs from the triage system's but also from the patients' narratives.

## Co-existing times: waiting time as 'wasting time'

During busy periods, not all patients in the emergency department can be placed in separate rooms when they arrive. The patients arriving by ambulance are taken to a patient room, but non-acute patients typically sit in the waiting room before being called into triage, or they wait in in the hallway if they are triaged green or yellow and no vacant rooms are available. While waiting, the patients do not interact with the colour code system or the healthcare professionals, only if they briefly ask to hear where their names are on the waiting list, i.e. when can they expect to be seen by a doctor. Their interpretation of waiting time is based on their individual experiences and illness trajectories.

**Event time: experience and feelings of 'wasting time'**

The patients use event time (as the healthcare professionals do) to understand waiting time. In contrast to the healthcare professionals, they have no opportunities to interact with the triage system. Instead, they are the 'object' of prioritisation. The following fieldnotes concern Mary, a patient in the observation unit who described her interpretations of waiting time:

> *Mary explains that she did not go to her general practitioner until she felt sick, tired and had no energy. The general practitioner referred her to the hospital and arranged for transportation because she was deemed unable to drive on her own. She arrived at the hospital in the afternoon and was dropped off just outside the entrance. She then walked to the counter, where she was registered by a nurse and told to take a seat and wait to be called in. At dinner time, she had blood samples taken and, in the evening, she was told that the tests showed elevated values and that she had to wait for a doctor. When the doctor finally arrived, he told her that it was too late in the evening to do a scan, so he gave her an anticoagulant injection and told her to go home and come back the next day for an ultrasound.*

Unlike physicians and nurses, Mary does not spend every day at the emergency department, which means that she represents the constant flow of patients entering and exiting the unit daily. The patients understand waiting time in relation to their own individual illness narrative, i.e. what happened in the past and what will happen in the future. They focus on the next event in their treatment schedule. The

events in their illness trajectory are thus closely relate to their feelings of being a nobody, an invisible guest in the emergency department:

> *When Mary had asked about the waiting time, she was told that she was second on the list, but acute patients kept on arriving and had to be treated first. Mary states, "I felt like I waited forever, especially because I was concerned about my condition and not feeling well". She adds, "When you're in the emergency department, you expect things to happen". The time went slowly, which Mary emphasised by pointing out that the nurses started recognising her when they passed her in the hallway, asking, "Are you still sitting here?". Mary also talked about how she went to the office at one point to ask if she could go home but was informed that they had to examine the blood test results first. When Mary was finally told that she could go home but had to come back the next day for further tests, it was almost midnight. She had hoped that she would find out what was wrong, so that she could look forward to the right treatment. Because it was so late, the free patient transportation service was no longer running, and she had to call and wake up her daughter to bring her home. In the end, Mary returned home shortly after midnight.*

This means that patients' experience of waiting time is conditioned by event time, which is related to their biographical narrative of their medical histories. Mary described how she observed what was going on around her and that she continually had a feeling of not knowing what was happening while in the waiting room or hallway at the hospital. Whether they wait 10 minutes, 1 hour or 15 hours, patients feel

they are wasting time if any time spent does not aid their quest to recover; their purpose is to see a doctor, not to wait.

The interpretation of waiting time as a waste of time can also lead to strong feelings of confusion and anxiety. Another patient, John, describes how he becomes confused by the long waiting time:

> *My journey started when my GP referred me to the hospital for an acute X-ray and to the emergency ward. She had warned me about the lengthy wait, so I knew, but it was such an incredibly long wait. Well, the X-ray went quickly, I was received and immediately had a chest X-ray taken. I got back to the emergency unit in the morning. I had a blood sample taken at around noon, so at least something was happening, but then I was not seen by a doctor until after dinner time in the evening which is a terribly long time to wait. In the afternoon, I was given a bed, but before that I had sat on a chair in the hallway. I had been sitting on that chair for so many hours, but all of the sudden the nurse told me that an orderly would be coming with a bed for me and that he would take me to a ward. I thought it was somewhere in the emergency unit, because I thought that a doctor would then come to see me there. But then the orderly came – without a bed – and I had to go with him to find a bed. Then we went to the observation unit. I got a bit confused "what am I doing here, is there something completely different wrong with me?" I got quite anxious about why I had to go there. I had thought something else entirely. The orderly then said, "I see you have pneumonia. Why aren't you going to the pulmonary medical unit?", which made me even more confused.*

John's story describes his medical journey and his experiences with symptoms in relation to his expectations. He highlights how he was hospitalised and became confused and nervous. Even though John's narrative contrasts with Mary's, their narratives share some common features of wasting time. They feel that waiting is a waste of their time, even if the reason for waiting is a test result. None of the patients resist the long waiting hours as they respect that other people are worse off than they are and need to come first. However, they become nervous and tired after sitting for long hours observing life at the department.

**Entering public spaces with private concerns**

Mary, who spent the entire day watching how other patients were attended to, explains how waiting time at the emergency department passes slowly:

> *Mary also talks about how she was sitting across from two rooms where patients came in and out, but that she did not see anyone tidying up or doing any cleaning during the many hours she waited just outside. Quite upset, she repeats that even though several patients were treated in the room, no one did any cleaning for the entire eight hours she waited. I asked her if she experienced other issues besides the long wait and she replied, "Well, no, except for the fact that I was starving. There was water available and we finally got a cup of coffee, but no food".*

Mary describes how she observes everyday life in the waiting areas and how she relates the space to her need for food and her concerns about the lack of cleaning. Unlike the healthcare professionals, patients do not have many decisions to make; instead they spend their waiting time observing the hospital's busy everyday life and reflecting on the meaning of their own waiting time. They are unable to interact or share their understanding of the waiting time with the busy healthcare professionals or directly affect the triage system.

In summary, these patient narratives remain in the mind of the patient unless somebody (such as a researcher) asks them about their experience. The patients do not have an audience in the hospital for sharing their experience of waiting time, making their stories silent and untold. In the next section, we discuss the implications of our findings, i.e. what a time perspective offers in terms of explaining the coexistence of different waiting time narratives.

## Discussion: organising waiting time by entering or not entering into other narratives

Our analysis saw wating time as a diverse time concept, dividing it into 'colour time', 'right time' and 'wasting time'. Inspired by Knights' (2006) thinking, we understand waiting time as a diverse everyday concept by combining a temporal practice perspective with subjective narrative time. Knights (2006) described how linear time (clock time) is often taken for granted as an overarching structure defined as an objective conceptualisation of time as an ordered phenomenon existing externally to the individual in fixed immutable units. However, Knights further asserts that researchers should accept that various

conceptions of time coexist, arguing that, in everyday practice, time is diverse and incorporates relational, cyclical, processual, individual and linear aspects. Thus, different time understandings need to be included in the analysis of waiting time in an everyday practice perspective.

These time understandings, however, do not each play an equal role. De Certeau (1984) argued that narratives and spaces are not isolated from each other, but that some of them will possess comparably more power than others. ‘colour time’ is the formal, legitimate way of organising waiting time, which means the triage system functions as a temporal structure that prioritises clock time in an abstract space, based on the underlying ideal that all patients will fit into predefined colour codes. ‘right time’ become the bridge between this ideal and what is possible in concrete spaces, where the healthcare professionals negotiate by using event time, where they interpret what the ethical, professional and practical right time is for the patients. Consequently, ‘colour time’ is met with resistance, as the healthcare professionals are conducting ‘hidden’, everyday micro resistance (Mumby *et al.* 2017). The healthcare professionals’ narratives thus reveal the invisible sensemaking work required to make ‘colour time’ fit with the ‘right time’. This specific kind of temporal structuring involved constantly discussing with each other to impose meaning into a ‘meaningless’ system.

Using an organisational ethnography approach allowed us to hear and document the assorted waiting time narratives in the busy life at the emergency department. For the patients, we became the audience when they recounted their experience of illness (Jackson 2002). The patient narratives reveal that patients are unfamiliar with ‘colour time’ and ‘right time’ but relate waiting time to their individual illness trajectory. In these trajectories, all waiting time is annoying and feels like a waste of time in light

of the overall illness progression. waiting time becomes incomprehensible and an empty set of actions, despite medical reasons for delays. Patient narratives lack an audience because they are private, but the realms of private and public spaces meet in public waiting areas.

A combined practice and narrative approach highlight the collision of clock time and event time and reveals the possibilities available for sensemaking and resistance among patients and healthcare professionals (Currie *et al.* 2009, McCoy 2009, Mumby 2017, Waterworth 2003). Researchers such as Waterworth (2003) argued that temporal structures in hospitals sometimes collide as they establish various frameworks – accessible separately to different professional groups and to patients and professionals. McCoy (2009) demonstrated how patients construct temporal frameworks to cope with their illnesses and to provide alignment between the inner experience of time and standard clock time. The common denominator of these concepts is that they reveal how social life is translated into structural time patterns by professionals in their everyday practice and used to communicate social messages between actors. Our study emphasises the thoughts and feelings associated with temporal structuring and how temporal structures become meaningful through narratives of waiting time. Contemporary management studies (Bevan and Hood 2006) refer to how waiting time, as linear clock time, becomes an imperative managerial concept. They criticise how a reduction in waiting time easily becomes a target for managers that does not take into account unseen effects on day-to-day organising. In accordance with this assertion, our analysis points to the further unseen ethical effects of formalising waiting time as 'colour time' when scarce resources, professional judgements and individual illness trajectories and experiences are not taken into consideration.

## Conclusion

Our analysis, which demonstrated how waiting time emerged as ‘colour time’, ‘right time’ and ‘wasting time’ in an emergency department, showed how waiting time cannot be understood as a unified temporal phenomenon as it never becomes universal or standardised. From a practice perspective, the findings revealed the unequal relationship between organising based on clock time versus event time. From a narrative approach, our findings imply the importance of making sense of events in negotiated situations and including narratives in different spaces.

Introducing a central steering concept like a triage system that focuses solely on clock time creates many coordination problems that require engaging in event time in an everyday context. This study calls for looking more closely at the value of event time in temporal organising in healthcare and the ability to see the potential of fragmented everyday time (Knights 2006). The narrative approach provides the space to include many voices (Boje 2011), while incorporating a space element shows that the situated nature of narratives underlines the various contextual conditions of interacting with other narratives (Boje 2011, Jackson 2002), In our study, patients in waiting areas are decoupled from the assessment room and the healthcare professionals’ negotiations. This article further opens new avenues for examining the narrative construct of everyday (waiting) time as event time. One of the implications is that the path towards patient-centred care becomes transparent but remains, in the light of organisation, untraveled because patient illness narratives are not included in the standardised triage system or in the professionals’ day-to-day practices.

Research on how time conditions organising from a practice and narrative perspective is in its early stages, which means that there is a need for further theoretical and micro-analytical developments to gain a greater understanding of the organising implications of diverse time understandings. The combined practice and narrative approach offers a way of understanding various practices based on individual narratives, not only in the emergency setting but also in other healthcare settings, where time and space become interpretative elements. Finally, a study of waiting time adds to sociological studies of health and illness by addressing the unequal positioning of clock time and event time, shedding light on the unseen organising consequences of introducing new temporal structures.

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