Factors Associated with Reluctance to Use an Emergency Department in a Multi-ethnic Community

Results of a Telephone Survey

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ABSTRACT

Background: Delays in seeking emergency care when experiencing serious symptoms may increase morbidity and mortality. Understanding the reasons for such delays may result in interventions to reduce them. We examined the relationship between ethnicity and the reluctance to use an emergency department (ED).

Methods: An exploratory multilingual telephone survey was completed in Greater Vancouver, British Columbia, with randomly selected men and women, aged 40 years and older, listed in the BC Ministry of Health Services Client Registry Database. Survey items included whether the respondents were "somewhat," "very" or "not" reluctant to use an ED. Reasons for reported degree of reluctance and potential correlates were explored including age, gender, income, education, anxiety, vulnerability, self-reported health status, life stress, and satisfaction with a previous ED visit. Multiple logistic regression analysis was conducted.

Results: Among 973 (56% response rate) participants (56.3% female) were 149 Chinese, 67 South Asian, 221 foreign-born (not Chinese or South Asian), and 536 Canadian-born participants (not Chinese or South Asian). Controlled for all potential confounders, Chinese (OR=0.30, 95% CI=0.19, 0.48) respondents were less likely than Canadian-born participants to report reluctance to use an ED. Anxiety (OR=1.05, 95% CI=1.02, 1.09) and dissatisfaction with a previous ED visit (OR=1.85, 95% CI=1.27, 2.68) were significant correlates.

Conclusions: Canadian-born participants may be at higher risk of delaying necessary treatment from EDs that have been publicized to have long waiting times. Further studies are needed to understand the role ethnicity plays in ED utilization.

MeSH terms: Ethnicity; emergency medical services; attitude to health

La traduction du résumé se trouve à la fin de l'article.

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There has been widespread media coverage of long waiting times and overcrowding in Canadian emergency departments (EDs). A public attitude survey found that 74% of Canadians were concerned about deteriorating ED service.¹ Such concerns may dissuade people from seeking ED care even in the face of urgent health care needs, and may vary on the basis of social status. The utilization of ED services has been associated with socio-demographic characteristics such as gender, age, income and education.² Little is known, however, about ethnic differences in ED utilization. American researchers have reported no ethnic differences³ or higher rates⁴ of use among non-white populations. These differences may disappear, however, once income and health insurance coverage are controlled.⁵ In Denmark, where universal health care insurance exists, Norredam et al.⁵ found inconsistent patterns of ED utilization between Danish-born individuals and immigrant groups. In Quebec, no differences were noted in the average number of ED visits of 'native' Quebecers and other ethnic groups.⁶

The role of ethnicity in treatment seeking for potentially serious symptoms is not well understood. An American survey revealed that white respondents were more likely to report having trust in physicians and hospitals than were non-white respondents.⁷ Therefore, not only utilization patterns but readiness to rely on ED services may differ among various ethnicities and may result in differences in treatment delays or avoidance of treatment seeking. Further, researchers have typically relied on the number of actual ED visits to explore differences in utilization. However, a substantial proportion of individuals who die suddenly or unexpectedly do not seek medical treatment immediately before death.⁸

As part of a larger study examining the public's ability to recognize symptoms of acute myocardial infarction (AMI), we examined the relationship between ethnicity and reluctance to use an ED.

METHODS

Setting

The setting for the study was Greater Vancouver, British Columbia. Of the 2 million residents of the city, 37% are 'for-

eign-born', 44% of whom immigrated within 10 years of the 2001 census. The largest visible minority groups are those who self-identify as Chinese and South Asian.⁹

Participants and recruitment

The data were obtained via a telephone survey. A list of 3,419 randomly selected people, aged 40 years and older, was obtained from the BC Ministry of Health Services' Client Registry Database, which contains all residents who have lived in BC for at least 3 months and applied for provincial health insurance. We assumed that many of the listed numbers would be dead numbers (i.e., not reach households), a 50% participation rate, and a small ineligibility rate (due to language barriers). We determined that about 800 respondents were necessary to ensure that estimates of binary splits of 50%-50% would result in $\pm 5\%$ margins of error 19 times out of 20 and that sufficient statistical power was available for all planned analyses.

A letter and a consent form were mailed to all selected people (translated into Chinese and Punjabi for those people whose names appeared to be Chinese or South Asian). If consent was given, interviews were conducted in English, Mandarin, Cantonese or Punjabi between September 2003 and July 2004. Details of the recruitment procedure were published elsewhere.¹⁰ Ethics approval was granted by the University of British Columbia's Behavioural Research Ethics Board.

Measures

The main purpose of the questionnaire was to assess the participants' ability to recognize AMI symptoms and to determine how they might respond to those symptoms. Certified translators translated the questionnaire into Punjabi, Mandarin and Cantonese, which was validated through back translation. The questionnaire was pilot tested with a randomly selected sample and assessed in terms of its length and comprehensibility.

A question about reluctance to attend an ED was posed: "Some people do not want to go to the emergency room, even though they think they should. How reluctant would you be to go to the emergency room?" Three response choices were provided ("not at all reluctant," "somewhat

TABLE 1
Sample and Population Characteristics

Characteristics	No. of Respondents (N=973)	Prevalence, % Survey Sample	Vancouver, CMA Census*
Ethnicity			
Born in Canada	536	55.1	49.8‡,§
Not born in Canada (other)	221	22.7	NA
South Asian	67	6.9	5.9‡,§
Chinese	149	15.3	16.3‡,§
Gender			
Women	548	56.3	52.4†
Men	425	43.7	47.6†
Age (years)			
40-49	369	37.9	37.1†
50-59	290	29.8	27.1†
60-69	180	18.5	16.4†
70+	134	13.8	19.3†
Education			
<High school	92	9.5	27.6‡
High school	243	25.0	12.4‡
College/diploma/certificate/incomplete university	341	35.0	40.1‡
Bachelor's or higher	292	30.0	19.9‡
Refused or missing	5	0.5	NA
Total household income, CAD\$			
<19,999	77	7.9	18.5‡,
20,000-39,999	150	15.4	21.2‡,
40,000-59,999	167	17.2	19.1‡,
60,000-79,999	116	11.9	14.5‡,
80,000-99,999	107	11.0	10.2‡,
100,000+	171	17.6	16.4‡,
Refused, do not know, or missing	185	19.0	NA
Marital status			
Married/Common law	692	71.1	64.3†
Separated	94	9.7	3.7†
Divorced	34	3.5	10.9†
Widowed	81	8.3	10.2†
Never married	72	7.4	11.0†

* 2001 Census data

† Population aged 40 years and older

‡ From a random sample of 20% of Census data

§ Population aged 45 years and older

|| Population aged 15 years and older

reluctant," or "very reluctant") followed by an open-ended question that sought an explanation for the response. The provided explanations were categorized thematically.

Questions regarding the participants' health status, stress level, and satisfaction with a previous ED visit, if any, were asked using 4- or 5-point Likert scales. Because psychological traits may be related to health care utilization, two scales of the Revised NEO Personality Inventory (NEO-PIR)¹¹ were included: anxiety and vulnerability. Each trait was measured with eight 5-point Likert scale items; (range from 8 to 40). Their internal consistency has been shown to be satisfactory (Cronbach's alpha >0.77). The NEO is provided in English and Chinese; certified translators developed a Punjabi version. The NEO has been used widely in cross-cultural research and various translations have been shown to replicate the measurement model observed in North American data.^{12,13} In our sample, Cronbach's alpha for the anxiety scale ranged from 0.71

(Punjabi-speaking respondents) to 0.80 (English-speaking Chinese respondents). For the vulnerability scale, one subgroup had Cronbach's alpha <0.70 (0.65 in English-speaking South Asian respondents), while the others ranged from 0.71 (English-speaking Chinese and other foreign-born respondents) to 0.80 in Punjabi-speaking respondents.

The concept of ethnicity is multidimensional and includes factors such as race, ancestry, identity, language and religion.¹⁴ In our project, ethnicity was measured in a manner similar to that used in the 2001 Canadian Census, defined as the ethnic group to which the respondents' ancestors belonged.¹⁵ The question posed was, "Most people in Canada describe themselves as Canadian first but also identify themselves based on their background or the nationality of their ancestors. What would you say is your main ethnic background? (e.g., First Nations, Punjabi, Scottish, etc.)." Multiple responses were accepted. Respondents also were asked:

TABLE II

Reported Reluctance to Use an ED by Demographic, Psychological and Health-related Characteristics

Characteristics	Reluctance		OR (95% CI) (unadjusted)	OR (95% CI) (adjusted)
	Reluctant (%) (n=525)	Not Reluctant (%) (n=448)		
Ethnicity				
Born in Canada	316 (59.0)	220 (41.0)	1.00	1.00
Other foreign-born	122 (55.2)	99 (44.8)	0.86 (0.63-1.18)	0.81 (0.58-1.15)
South Asian	29 (43.3)	38 (56.7)	0.53 (0.32-0.89)*	0.57 (0.30-1.08)
Chinese	58 (38.9)	91 (61.1)	0.44 (0.31-0.64)*	0.30 (0.19-0.48)*
Gender				
Male	215 (56.6)	210 (43.4)	1.00	1.00
Female	310 (50.6)	238 (49.4)	1.27 (0.99-1.64)	1.10 (0.82-1.48)
Age (years)				
40-44	95 (56.2)	74 (43.8)	1.00	1.00
45-49	119 (59.5)	81 (40.5)	1.14 (0.76-1.73)	1.10 (0.71-1.72)
50-54	84 (51.2)	80 (48.8)	0.82 (0.53-1.26)	0.87 (0.55-1.38)
55-59	68 (54.0)	58 (46.0)	0.91 (0.57-1.45)	0.95 (0.57-1.57)
60-64	47 (50.5)	46 (49.5)	0.80 (0.48-1.32)	0.93 (0.52-1.65)
65-69	44 (50.6)	43 (49.4)	0.80 (0.48-1.34)	1.01 (0.54-1.87)
70+	68 (50.7)	66 (49.3)	0.80 (0.51-1.27)	0.96 (0.55-1.67)
Education				
<High School	40 (43.5)	52 (56.5)	1.00	1.00
High School	129 (53.1)	114 (46.9)	1.47 (0.91-2.39)	1.11 (0.62-1.99)
College/diploma/certificate/incomplete university	187 (54.8)	154 (45.2)	1.58 (0.99-2.51)	1.15 (0.64-2.05)
Bachelor's or higher	165 (56.5)	127 (43.5)	1.69 (1.05-2.71)*	1.22 (0.67-2.21)
Income (CAD\$)				
<19,999	43 (55.8)	34 (44.2)	1.00	1.00
20,000-39,999	81 (54.0)	69 (46.0)	0.93 (0.53-1.61)	0.89 (0.50-1.61)
40,000-59,999	103 (61.7)	64 (38.3)	1.27 (0.74-2.20)	1.17 (0.67-2.06)
60,000-79,999	68 (58.6)	48 (41.4)	1.12 (0.63-2.01)	0.76 (0.40-1.42)
80,000-99,999	56 (52.3)	51 (47.7)	0.87 (0.48-1.41)	0.81 (0.40-1.65)
+100,000	87 (50.9)	84 (49.1)	0.82 (0.48-1.41)	0.70 (0.37-1.32)
Marital status				
Married/common law	368 (53.2)	324 (46.8)	1.00	1.00
Separated/divorced/widowed	105 (56.1)	82 (43.9)	1.13 (0.81-1.56)	0.88 (0.59-1.32)
Never married	52 (55.3)	42 (44.7)	1.09 (0.71-1.68)	0.84 (0.50-1.41)
Mean Anxiety Score (SD)	14.0 (5.2)	12.6 (5.0)	1.06 (1.03-1.09)*	1.05 (1.02-1.09)*
Mean Vulnerability Score (SD)	9.2 (4.1)	8.9 (3.8)	1.02 (0.99-1.05)	0.99 (0.95-1.04)
Health status				
Excellent	106 (57.6)	78 (42.4)	1.00	1.00
Very good	164 (53.8)	141 (46.2)	0.86 (0.59-1.24)	0.80 (0.54-1.19)
Good	159 (52.8)	133 (47.2)	0.82 (0.57-1.20)	0.85 (0.56-1.29)
Fair	84 (56.4)	65 (43.6)	0.95 (0.62-1.47)	1.00 (0.61-1.67)
Poor	22 (42.3)	30 (57.7)	0.54 (0.29-1.01)	0.49 (0.24-1.02)
Life Stress				
Not at all stressful	31 (39.2)	48 (60.8)	1.00	1.00
Not very stressful	100 (46.1)	117 (53.9)	1.32 (0.78-2.24)	1.16 (0.63-2.12)
Somewhat stressful	318 (57.9)	231 (42.1)	2.13 (1.32-3.45)*	1.61 (0.90-2.88)
Very stressful	75 (59.1)	52 (40.9)	2.23 (1.26-3.96)*	1.47 (0.74-2.90)
Satisfaction with previous ED visit				
Satisfied	363 (52.2)	332 (47.8)	1.00	1.00
Dissatisfied	122 (64.2)	68 (35.8)	1.65 (1.18-2.29)*	1.85 (1.27-2.68)*
Other (no opinion or no previous visit)	40 (45.5)	48 (54.5)	0.77 (0.49-1.19)	1.31 (0.76-2.26)

* p<0.05

whether they were born in Canada; if not, in which country they were born; how long they lived in Canada; their first language spoken and the language spoken most often at home. Based on an operationalized definition of ethnicity as self-reported ethnicity and country of birth, the participants were classified into four mutually exclusive groups: a) self-identified as East Indian, Gujarati, Hindi, Punjabi, or Sikh and 'foreign-born' (South Asian); b) self-identified as Chinese and foreign-born (Chinese); c) not identified as South Asian or Chinese and foreign-born; or d) not identified as South Asian or Chinese and Canadian-born. Three individuals who identified as Chinese and were born in Canada were excluded.

Data analysis

Bivariate analyses were performed using chi-square (χ^2), ANOVAs, and Mann-Whitney tests. Participants who were 'somewhat reluctant' or 'very reluctant' to use an ED were recategorized into one group because the variable did not conform to a linear gradient. Satisfaction with a previous ED visit was classified into those who were "satisfied", "not satisfied", and those who had never been to an ED or did not offer an opinion about their last visit. Multivariate logistic regression analysis was performed to examine the associations between ethnicity (adjusted for socio-demographics, health and stress status, satisfaction with a previous ED visit, anxiety, and vulnerability) and reluctance to use an

ED. Variables that were associated with the dependent variable at p<0.25 in bivariate analyses were entered into the multivariate model in accordance with Hosmer and Lemeshow's¹⁶ modelling strategy. Age, income and health status were entered for theoretical reasons. The independent variables were tested for multicollinearity and the model's goodness of fit was assessed. A p<0.05 was considered statistically significant. Multiple imputation, a widely demonstrated, valid and effective procedure, was used to handle the missing data.¹⁷

RESULTS

Of the 3,419 people sampled, 976 respondents completed the survey and 759

TABLE III
Frequencies and Percentages (with 95% Confidence Intervals) of Reasons for Reluctance to Use an ED by Ethnic Group and Degree of Reluctance

RELUCTANT Ethnicity	Long Waiting Times	Not Sure if Problem is Serious Enough	Prefer Talking with Own Doctor	Prefer Using a Walk-in Clinic	Don't Like EDs	"I Don't Like the Way People are Treated"	Let It Heal on its Own	Other
Born in Canada (n=316)	149 (47.2) (41.6%-52.7%)	110 (34.8) (29.6%-40.1%)	48 (15.2) (11.2%-19.1%)	28 (8.9) (5.7%-12.0%)	20 (6.3) (3.6%-9.0%)	13 (4.1) (1.9%-6.3%)	8 (2.5) (0.8%-4.3%)	89 (28.2) (23.2%-33.1%)
Other foreign-born (n=122)	59 (48.4) (39.5%-57.2%)	39 (32.0) (23.7%-40.2%)	18 (14.8) (8.5%-21.0%)	6 (4.9) (1.1%-8.8%)	14 (11.5) (5.8%-17.1%)	2 (1.6) (0.0%-3.9%)	7 (5.7) (1.6%-9.9%)	35 (28.7) (20.7%-36.7%)
South Asian (n=29)	12 (41.4) (23.5%-59.3%)	9 (31.0) (14.2%-47.9%)	8 (27.6) (11.3%-43.9%)	3 (10.3) (0.0%-21.4%)	1 (3.4) (0.0%-10.1%)	0 (0.0%)	0 (0.0%)	3 (10.3) (0.0%-21.4%)
Chinese (n=58)	32 (55.2) (42.4%-68.0%)	15 (25.9) (14.6%-37.1%)	7 (12.1) (3.7%-20.5%)	1 (1.7) (0.0%-5.1%)	2 (3.4) (0.0%-8.1%)	0 (0.0%)	0 (0.0%)	20 (34.5) (22.2%-46.7%)

refused to participate (a response rate of 56.3% among the people contacted). The remaining 1,684 were either ineligible (9% lived outside the area or spoke another language) or could not be contacted (91% had wrong numbers, could not be contacted, or had died). The respondents' ethnicity was classified *a priori* on the basis of their surnames¹⁸ and the resulting response rates were: Chinese = 46%, South Asian = 43.3%, and all others = 59.4%.

Table I presents the socio-demographic characteristics of the participants contrasted with Census data. Five hundred forty-eight (56.3%) of the participants were women. One hundred forty-nine respondents reported their ethnicity as Chinese and were born outside Canada and 67 participants were identified as South Asian and were born abroad. The majority of the third group of foreign-born participants were born in Europe (n = 198; 89.6%). Of the Chinese group, 112 (75.2%) participants responded in Mandarin or Cantonese, and 33 (49.3%) of the South Asian participants responded in Punjabi. The average time of residency in Canada was 21.0 years (SD = 10.8) for the South Asian group, 15.4 years (SD = 10.8) for the Chinese group, and 33.3 years (SD = 15.8) for the other foreign-born participants.

About one half (46.0%) of the respondents reported that they were "not reluctant" to access an ED while 36.6% reported being "somewhat reluctant" and 17.3% reported being "very reluctant." The bivariate relationships between reported reluctance and the socio-demographic, health-related and psychosocial characteristics are shown in Table II (unadjusted odds ratios). Reluctance to use an ED was related to ethnicity, education, satisfaction with previous ED visits, perceived life stress, and anxiety. There were no significant relationships found between reluctance to use an ED and vulnerability, health status, gender, age, and income.

Table II also provides the multiple logistic regression model for reluctance to use an ED on ethnicity and the other predictors (adjusted odds ratios). The model demonstrated satisfactory goodness of fit ($\chi^2 = 4.77$, df = 8, p = 0.78). Compared to Canadian-born participants, the Chinese participants were 70% less likely to report reluctance to use an ED. Participants who were dissatisfied with previous treatment in

an ED were 1.85 times more likely to report reluctance than were respondents who were satisfied with previous visits. Age, gender, income, and education were not related to reported reluctance to use an ED. For each one point increase in the anxiety score, respondents were about 5% more likely to report reluctance to use an ED. Vulnerability, health status and perceived life stress were not associated with the outcome variable.

Table III provides the reasons for the participants' reluctance to use an ED, stratified by ethnicity; the most common reasons for all ethnic groups included long waiting times, not being sure whether one's symptoms would be serious enough, and feeling better talking with a family physician.

DISCUSSION

The findings provide important insights into the public's potential reluctance to access ED services. Less than one half of the respondents reported no reluctance while the majority either reported being somewhat or very reluctant to use an ED. The Chinese respondents were less likely to report reluctance than were Canadian-born participants, even when key confounders such as health status were controlled. The association between South Asian ethnicity and reluctance was not significant once confounders were added to the multivariate model. Of those not reluctant to use an ED, the Chinese respondents were most likely to state, "When you need to go, you need to go."

The findings cannot be compared readily with other studies about ethnicity and ED utilization. For example, an American⁸ study that examined the treatment-seeking behaviour of individuals dying from heart disease found that white Americans were less likely to call 9-1-1 or to try to reach an ED than members of other groups, such as African-Americans. However, the African-American population is not comparable to Canadian immigrants. Also, previous studies have been based on patients actually accessing EDs, and the age groups and health problems addressed in other studies differ from our survey. The Chinese and South Asian groups in our study are not equivalent to disadvantaged groups of refugees or recent immigrants in uncertain health conditions. The

average time spent in Canada was greater than 15 years for both the Chinese and South Asian participants, and their diverse profiles (from poor to rich, from poor to excellent health status) increased the heterogeneity of the sample and thus reduced the effects of other confounding variables. On the other hand, we may have missed the important group of recent immigrants in our sampling design because of delays in obtaining provincial health insurance or reluctance to participate in research.

Researchers in the United States have observed that there are particular ethnic groups with relatively high ED utilization rates.⁴ This may occur because ED care is provided free of charge in the US, when other primary care services are provided for a fee. Because there are no financial barriers to ED or primary care services in Canada, it is not likely that the Chinese respondents, who reported less reluctance to use an ED than did Canadian-born participants, were motivated by financial concerns. Participants who were less satisfied with a previous ED visit were more likely to report reluctance to use an ED. According to the Canadian Health Community Survey,¹ about 20% of Canadians report being somewhat or very dissatisfied with ED treatment they have received, which is not associated with age, gender, income or education.

Some authors have hypothesized that language barriers, potential racial discrimination, or unfamiliarity with the health care system may account for ethnic minorities' avoidance of some health services.^{19,20} Neither language barriers nor aspects related to unfair treatment and discrimination were reported to any great extent by the Chinese and South Asian respondents. We assume that the majority of our sample of immigrants, who have resided for considerable time in Canada, are familiar with the health care system. Concerns about racial discrimination in an unknown hospital setting may be implicit in reports of preferring to see one's own family physician. However, in our study very few South Asian and Chinese participants offered this answer. The respondents were able to respond in their first language, with an interviewer of the same ethnic group, and thus should have felt comfortable to mention concerns about racial discrimination, if they were held.

Limitations

Our study examined reluctance to use the ED in general, although the other survey questions were predominantly about AMI symptoms. We cannot assess the extent to which this influenced participants' responses; nonetheless, the role culture plays in delays to ED presentation for other conditions should be examined. Our study included a broad range of potential confounders, such as health status and personality traits; other potential confounders such as health beliefs and social support were not included.

The response rate of our study was typical for this type of survey.²¹ However, lower educated participants and those with lower incomes were under-represented; thus we cannot rule out a selection bias. The number of South Asian participants was small, resulting in wide confidence intervals. Because we offered interviews in Mandarin, Cantonese, and Punjabi, we do not expect a systematic response bias resulting from language barriers, as often occurs in English-only studies.

CONCLUSIONS

Canadian-born residents may be at higher risk of delaying necessary treatment, especially for symptoms of acute myocardial infarction, than are other cultural groups.

RÉSUMÉ

Contexte : Le fait de tarder à se rendre à l'urgence lorsqu'on éprouve des symptômes graves peut accroître la morbidité et la mortalité. En connaissant les raisons de tels retards, il serait peut-être possible d'agir pour les réduire. Nous avons examiné la relation entre l'appartenance ethnique et la réticence à faire appel à un service d'urgence.

Méthode : Nous avons mené une enquête téléphonique préliminaire multilingue dans le Grand Vancouver (Colombie-Britannique) auprès d'hommes et de femmes de 40 ans et plus, sélectionnés au hasard, dont les noms figuraient dans le registre des usagers du ministère des Services de santé de la Colombie-Britannique. Nous avons demandé aux répondants s'ils étaient « un peu », « très » ou « pas du tout » réticents à faire appel à un service d'urgence. Nous avons analysé les raisons citées pour expliquer le niveau de réticence et les corrélats éventuels (l'âge, le sexe, le revenu, l'instruction, l'anxiété, la vulnérabilité, l'état de santé déclaré par l'intéressé, le stress dans la vie personnelle et la satisfaction par rapport à une visite antérieure à l'urgence). Nous avons ensuite procédé à une analyse de régression logistique multiple.

Résultats : Sur les 973 participants (taux de réponse = 56 %; proportion des femmes = 56,3 %), 149 étaient Chinois, 67 étaient Asiatiques du Sud, 221 étaient nés à l'étranger (sans être Chinois ni Asiatiques du Sud), et 536 étaient nés au Canada (sans être originaires de Chine ni d'Asie du Sud). Compte tenu de tous les facteurs confusionnels possibles, les répondants chinois (RC=0,30, IC de 95 % = 0,19-0,48) étaient moins susceptibles que les répondants nés au Canada d'éprouver de la réticence à utiliser un service d'urgence. L'anxiété (RC=1,05, IC de 95 % = 1,02-1,09) et l'insatisfaction par rapport à une visite antérieure à l'urgence (RC=1,85, IC de 95 % = 1,27-2,68) étaient des corrélats significatifs.

Conclusion : Les personnes nées au Canada pourraient courir un risque plus élevé de tarder à se faire soigner dans les urgences qui passent pour avoir de longs délais d'attente. Il faudrait mener d'autres études pour approfondir le rôle de l'appartenance ethnique dans l'utilisation des services d'urgence.

The role culture plays in delays to ED presentation for other serious conditions should be examined. Qualitative work is required to gain a deeper understanding of why respondents of various ethnic backgrounds report different levels of reluctance to use the ED. The higher rates of reporting "when you need to go, you need to go" among Chinese respondents may suggest directions for in-depth research.

Further studies are required to inform health care providers as to how patients of all ethnic groups can be encouraged to use ED services for acute health conditions. In the meantime, health professionals are advised to counsel all patients about the most appropriate course of action in the context of potentially serious symptoms.

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Coming Events / Activités à venir

To be assured of publication in the next issue, announcements should be received by **June 1, 2007** and valid as of **July 31, 2007**. Announcements received after **June 1, 2007** will be inserted as time and space permit.

Pour être publiés dans le prochain numéro, les avis doivent parvenir à la rédaction avant le **1 juin 2007** et être valables à compter du **31 juillet 2007**. Les avis reçus après le **1 juin 2007** seront insérés si le temps et l'espace le permettent.

Options for the Control of Influenza VI
17-23 June 2007 Toronto, ON
Largest international conference exclusively devoted to influenza, and covering every imaginable topic from basic science to health care policy.
Contact:
MediTech Media Conferencing, Inc.
www.optionsvconference.com

International Conference on Physical Activity & Obesity in Children: Science, Policy, Practice
Organized by the Canadian Fitness and Lifestyle Research Institute (CFLRI)
24-27 June 2007 Toronto, Ontario
Contact:
CFLRI
Tel: 613-233-5528
Fax: 613-233-5536
E-mail: mcosta@cflri.ca
www.phe.queensu.ca/epi/obesity/index.htm

2007 Annual CPHA Conference/2007 conférence annuelle de l'ACSP
Public Health in Canada: From Politics to the People / *La santé publique au Canada : des politiques aux êtres humains*
In partnership with / organisée en collaboration avec : CIHI-CPHI/ISPC-ICIS, CIHR-IPPH/IRSC-ISPP, PHAC/ASPC
In association with / en association avec : OPHA/ASPO
Jointly held with the first Canadian Public Health Geomatics Conference: GIS in Public Health/De concert avec la première Conférence de géomatique en santé publique : Les SIG et la santé publique
16-19 September/septembre 2007 Ottawa, ON
Contact/Contacter :
conference@cpha.ca
www.conference.cpha.ca

Forum 11
Equitable Access: Research Challenges for Health in Developing Countries
29 October-2 November 2007 Beijing, China
Global Forum for Health Research
The annual Forum brings together decision-makers, funders and leaders in research and development to focus on reducing the massive underinvestment in health research for the needs of developing countries.
Contact:
www.globalforumhealth.org

Symposium francophone de médecine
Une réalisation de l'Association des médecins de langue française du Canada
Du 31 octobre au 2 novembre 2007
Montréal, QC
Contacter :
Tél : 514-388-2228 ou 1 800 387-2228
www.amlfc.org

Politics, Policy & Public Health
135th Annual Meeting & Exposition of the American Public Health Association
November 3-7, 2007 Washington, DC
Contact:
APHA
www.apha.org

CALL FOR ABSTRACTS
International Nursing Research Conference
Facing the Challenge of Health Care Systems in Transition
29 June-3 July 2008 Jerusalem, Israel
Contact:
Diesenhaus Unitours – Convention Department
Tel: 972-3-5651313 Fax: 972-3-5610152
E-mail: meetings@diesenhaus.com
www.d-convention.com/israelnursing
Deadline for abstracts: 15 September 2007

Beyond the Horizon
74th Annual Educational Conference of the Canadian Institute of Public Health Inspectors (CIPHI)
20-23 July 2008 St. John's, NL
Contact:
www.ciphi.ca/events.htm

29th ICOH, International Congress on Occupational Health / 29^e CIST, Congrès International de la Santé au Travail
Occupational Health: A Basic Right at Work – An Asset to Society / Santé au travail : un droit fondamental au travail – un atout à la société
22-27 March/mars 2009 Cape Town, South Africa / Afrique du Sud
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