# The general practitioner's use and expectations of an accident and emergency department

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## Summary

In an attempt to establish what the general practitioner expects from an accident and emergency department, and how closely the service provided correlates with that view, a 12-point questionnaire was sent to the general practitioners in the Glasgow Royal Infirmary catchment area.

Out of the 61.2% of general practitioners who replied, the majority wish to have responsibility for their own patients for conditions which are neither accidents nor emergencies. There is less agreement as to how much should be done within an accident and emergency department and on the appropriate modes of referral and communication between the general practitioner and the hospital service. Further consultation and cooperation are necessary to interpret and resolve these differences.

## Introduction

It has long been appreciated that there is common ground between the specialty of general practice and the hospital accident and emergency service[1]. One of the main reasons that has led to the difficulty in drawing a clear distinction between the two, is the policy in most accident and emergency departments of maintaining 24-h open access and of the medical staff examining any patient who presents[2,3]. This has resulted in an encroachment on traditional general practice territory by the hospital specialty. Several studies have investigated this problem, and while these are necessarily subjective, the universal conclusion is that a proportion of those patients presenting to the accident and emergency department could have been treated by a general practitioner. The extent of the problem is in question, and while an early study in Birmingham[4] estimated that as many as 64-89% fell into this category, more recent investigations have suggested figures of 54.2%[5] and 39.6%[6].

Whatever the reasons may be for patients attending hospital for 'primary care' there is very little known of how the general practitioner views this trend or indeed of what services he expects from an accident and emergency department.

The aim of the study was to find out from the general practitioners in our catchment area to what extend and in what way they used the department, and to see how their expectations compared with the services offered.

## Methods

A 12-point questionnaire was devised which was sent to 165 general practitioners in the catchment area of Glasgow Royal Infirmary. Stamped addressed envelopes were enclosed for replies. The general practitioners were not asked to identify themselves and the questionnaires were unnumbered and unmarked. No attempt was made to compare different groups of general practitioners.

The questionnaire can be divided into three main areas. The first part asked the general practitioners to estimate to what extent they used the accident and emergency department and by what method referrals were made. The next section concentrated on what services the general practitioners expected and how they wished us to deal with their patients presenting with non-urgent conditions. The final part dealt with communication from the accident and emergency department to general practitioners and the possibilities for future cooperation and discussion. One question was included which allowed the practitioners to comment and suggest improvements. The format of the questionnaire is shown in Figure 1.

1. How many patients would you expect to refer to the accident and emergency department each week?
2. What proportion have urgent medical, surgical, trauma, or 'other' conditions?
3. When referring patients to the department, do you refer your patient to the relevant receiving team rather than the accident and emergency doctor?
4. Do you refer patients mostly by letter, telephone, both or neither?
   Would a more efficient answering service increase your use of the phone?
5. Are the patients you refer directly to the accident and emergency team suffering from conditions which can be dealt with purely within the accident and emergency department, or do you refer patients with other conditions e.g. medical or surgical, for 'sorting out' and onward referral?
6. Do you regard the accident and emergency service as providing a second opinion service for matters which are neither accidents nor emergencies?
7. Is it your opinion that patients who come to the accident and emergency department with 'non urgent' conditions, should be referred back to their general practitioner?
8. Is it your opinion that patients who have already seen their general practitioner and subsequently come to the department with the same complaint, should be referred back to their general practitioner?
9. Please grade the standard of communication received from this department on a scale of 0-10. (worst = 0, best = 10).
10. Would you be interested in receiving feedback as to whether your referral of a patient to the department was appropriate, or might have been better directed elsewhere?
11. Would you be interested in attending joint meetings with accident and emergency staff to discuss such matters further?
12. Please indicate how you think the hospital and accident and emergency service could be improved?

*Figure 1. Questionnaire*

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## Results

One hundred and sixty-five questionnaires were sent out. One hundred and one replies were received representing a 61.2% return. Out of the questionnaires returned, not all individual questions were answered and this accounts for any discrepancies in the totals given below.

*Table 1. Number of patients referred per week*

| None | 1 | 2-5 | 6-10 | 11-20 | >20 |
|---|---|---|---|---|---|
| 8 (8.2%) | 27 (27.5%) | 53 (54.1%) | 10 (10.2%) | 0 | 0 |

In the replies to question 1 more than half the general practitioners referred two to five patients each week (Table 1), while none referred more than 10. Practitioners vary in the types of patients they refer (Table 2), the most common referrals being for medical conditions, while most of those who responded did make some attempt to send their patients to the appropriate receiving team (Table 3). The majority (52.5%) of those who replied use both a letter and telephone to refer their patients. The remainder used either a letter (36%) or telephone (10%), while 75% stated that they would increase their use of the phone if there were a more efficient service.

*Table 2. Categories of urgent conditions*

| | *Medical* | *Surgical* | *Trauma* | *Other* |
|---|---|---|---|---|
| Range | 0-90% | 0-100% | 0-30% | |
| Mean | 41% | 26% | 28% | 5% |

The majority of responders (77.4%) referred cases to the accident and emergency team only if the treatment they required could be carried out in the accident and emergency department. The remainder felt there was a 'sorting out' role for the accident and emergency doctor.

*Table 3. Referral to relevant team rather than A&E doctor*

| *Always* | *Most often* | *Sometimes* | *Rarely* | *Never* |
|---|---|---|---|---|
| 46 (46.4%) | 40 (40.4%) | 10 (10.1%) | 1 (1%) | 2 (2%) |

The replies to questions 6, 7 and 8 regarding services and general practitioner expectations are displayed in Table 4. The vast majority of those who replied wish to look after their own patients whenever possible.

Communication from the department (question 9) received a mean grading of 5.6 with a range of 0-10.

*Table 4. Services and GP expectations*

| *Question* | *Yes* | *No* |
|---|---|---|
| 6. Role of A&E as a second opinion service | 8 (8.3%) | 88 (91.7%) |
| 7. Role of A&E in non urgent conditions | 11 (11.2%) | 87 (88.8%) |
| 8. Role of A&E in patients request for second opinion | 26 (26.8%) | 71 (73.2%) |

*Table 5. Comments and improvements*

| *Comments* | *No. of GPs* |
|---|---|
| Improved hospital telephone service | 22 |
| Improved communication from hospital to GP | 9 |
| Do not see patients with non A&E conditions | 6 |
| Reduce waiting times in A&E department | 5 |
| Send letters by post not via patient | 3 |
| Separate A&E from admissions unit for other specialties | 3 |
| Easier access to senior members of staff/ consultants | 3 |
| Greater mutual respect/trust | 2 |

The answers received for questions 10 and 11 show that 82% of responders wish feedback on their referrals, while 70% are interested in attending joint meetings. Comments and suggestions for improvement of the service are listed in Table 5 and mainly relate to improved communications.

## Discussion

This survey provided an insight into the interface between general practice and the work of the accident and emergency department. While it was to be expected that general practitioners would perceive and use the service to a differing extent and in a different manner, there were recurring themes in the replies which should lead us to question aspects of our practice. It had been hoped that the anonymity of the study would encourage practitioners to reply and to allay any fears of an audit of an individual's practice. It is of interest that despite being supplied with a stamped addressed envelope, only 61.2% of our sample returned the questionnaire. This must be borne in mind when analysing the results and we can give no insight into the practice of the other 38.8%.

General practitioners vary in their interests, abilities and time they have available. The view that individual practitioners faced with similar problems have their own personal referral threshold[7] is supported by the answers to questions 1 and 2 (Tables 1 and 2). Less understandable is the variation in the way general practitioners refer their patients with urgent conditions to hospital. Less than half (46.4%) those who replied always referred to the relevant receiving team rather than the accident and emergency staff, although only two never made any attempt to do so. The reasons for this are not immediately obvious and deserve further investigation. When referring their patients, the majority (52.5%) used both the telephone and a letter, while of the remainder most preferred to use a letter rather than the phone. It is interesting to note that 62% of the practitioners who referred between 2 and 10 patients each week use both letter and telephone as opposed to 42% in the groups who refer none or one patient. This would tend to indicate that the mode of communication used does not depend on how busy a practitioner is. It became apparent from some of the replies to question 4 that not all general practitioners were aware that the way their patients were referred would affect the patients handling within our department. If the patient is 'phoned in' to the appropriate receiving team, eg medical or surgical, then that team is

notified on the patients arrival and seen only by them. These patients are seen within the accident and emergency department but have little contact with the accident and emergency medical staff. If the patient is sent in with a letter but there has been no preceding phone call, then that patient is seen by an accident and emergency doctor before referral to the appropriate receiving team - this can lead to delays within the department. We must take responsibility for some local practitioners being unaware of the admissions procedure and make every effort to advise them of departmental policy and any changes which affect them. However there are other problems in the area of communication. Despite the availability of 'GP priority' telephone numbers there would still appear to be unacceptable delays at the hospital switchboard and with medical staff answering their pages. The fact that 22 practitioners chose to mention this specifically in question 12 (Table 5) must prompt a re-examination of the present system. There may be a case for the introduction of a direct line to the receiving teams. This could prevent the patient experiencing unnecessary delays in the accident and emergency department and from seeing successive teams of doctors before definitive care is undertaken.

As has already been stated, the general practitioners varied in their perceptions of what duties the accident and emergency service should perform. Of those who replied 22.6% thought that the accident and emergency staff had a role in sorting out general practitioner's referrals and passing them on to the appropriate receiving team. Perhaps the term 'sorting out' was not specific enough but in general this is not a role that should be encouraged. It is likely that this would result in avoidable delays in the patients reaching their ultimate destination. A further study has been undertaken to investigate such delays and will be reported in due course. A separation of the accident and emergency department from the receiving area for other specialities as suggested by three general practitioners may discourage this practice. However there is a strong argument in favour of a combined unit in terms of resources, staffing and finance.

In the replies to question 6 (Table 4) only 8.3% regarded the accident and emergency department as providing a second opinion service. Whether this is a realistic expectation of a busy accident and emergency department is debatable and with the present trend towards group practices and vocationally trained GPs it would seem far more appropriate to consult ones partners rather than refer to someone who may be a very junior SHO.

Questions 7 and 8 provided perhaps the most interesting answers in our survey (Table 4). Clearly the vast majority (88.8%) of GPs who answered do not wish us to see their patients who present with non-urgent conditions. This raises the problem of how we define 'non urgent' or 'minor condition' and who should apply the definition. Attempts have been made to classify this category by a series of questions[8] applied by reception staff. Cohen[9] has pointed out that the senior house officers who operate most departments cannot always decide what is 'minor' but his assertion that 'they are anxious to see and deal with all the problems that come', can surely be challenged. Perhaps the answer lies in an efficient nurse triage system working with agreed guidelines and with access to senior medical staff. It would of course be desirable that such an exercise was combined with some attempt at patient education[8]. There is also a clear majority (73.2%) in favour of referring back patients who attend the accident and emergency department for a second opinion. This is a more contentious issue and the possibility of turning away serious pathology in this way has been illustrated in a recent paper[10].

We must also re-examine our policy on informing general practitioners of any attendance by their patients. At present a tear-off stylized letter from the front of the 'accident and emergency card' is filled in by the attending doctor. This raises issues of poor detail and legibility but a full typewritten letter for every patient would necessitate a large increase in our secretarial staff. The advent of computerization of records should incorporate a general practitioner letter facility.

The letter is usually given to the patient to deliver to their general practitioner. This can be notoriously unreliable[11]. There is also the option of sending the letter by post and this may become the favoured method. Despite a wide range of views in the effectiveness of our communication an average of 5.6 leaves much room for improvement.

In question 10, 82.1% of those who answered showed an interest in receiving some feedback on how appropriate their referrals were. We did anticipate that general practitioners might be wary of this but we do envisage that this would be carried out as an exercise with general practitioner input.

The ground between general practice and accident and emergency has become common due to usage and habit. A recent editorial[12] has stressed that it is important to define exactly what an emergency service is, particularly in light of the Government document 'Working for Patients'[13], which if implemented would mean greater individual responsibility for budgeting. Such a definition cannot and should not be made by the accident and emergency service alone. This point is illustrated in a paper by Reilly[14] who found that the more urgent task was not to inform GPs about accident and emergency services, but the converse. The fact that most trainees undergoing vocational training spend some time working in the accident and emergency department and accident and emergency senior registrars are required to gain experience of general practice can only assist with this task. Reilly also states that any significant reduction in the work of the accident and emergency department would require a change in attitude of the public at large. How we go about this is less clear, and if such a significant reduction were to be achieved, the implications of the extra work load on general practitioners must be examined[12]. Cohen[9] believes that general practitioners 'must show a greater willingness and organisation to be more readily available to their own patients' and an extension of opening hours has been suggested[12]. The trends evident in 'Working For Patients'[13] would indicate that this is unlikely to be encouraged by improving GP incentive and decreasing list sizes as had previously been proposed[4]. There may be a case for providing primary care units in accident and emergency departments[16] and it has been suggested that departments should have a section staffed by local general practitioners on a rota basis[17]. Alternatively, greatly improved methods of communication with easier access to senior medical staff in the accident and emergency department as suggested by

three general practitioners, may result in the practitioner being able to receive appropriate advice and save the patient an unnecessary, perhaps time consuming attendance at the hospital. This may well be an argument for the presence of more senior doctors in the accident and emergency department on a 24-h basis.

As early as 1962, Blackwell[1] suggested improved patient education and better hospital - general practitioner relationships as ways of making accident and emergency departments more efficient. With 70.2% of the general practitioners who answered expressing a willingness to attend joint meetings, perhaps, with the other changes occurring in the profession at the moment, now is the time to act upon that suggestion.

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