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PRACTICE OBSERVED

Practice Research

Accident department or general practice?

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Abstract

Ninety two patients, who were registered with one general practice partnership that has a tradition of providing minor trauma services and who had attended a hospital accident and emergency department, completed a questionnaire giving their reasons for not first attending their general practitioners with their ailments. Most had not tried to contact their general practitioner, and of these, only a few were unsuitable for treatment first by the general practitioner. More than half had attended the accident and emergency department because they did not want to bother their own general practitioner or thought that their problem was unsuitable for his attention. A higher proportion had attended for reasons of perceived speed or convenience.

In the light of the need to cut costs in the hospital service and of government interest in promoting a wider range of services in general practice further study of such problems is needed. Patients' perceptions of the role of the accident department need to be changed if present behaviour is to be altered.

Introduction

The use of accident and emergency departments by patients whose ailments are neither accidents nor emergencies has been deprecated for years.[1] It is well known that many of the accidents that are attracted to hospital are minor ones which general practitioners can deal with. The results of previous studies show that the misuse of accident departments may occur because patients have mistaken beliefs that their condition requires the services of a hospital accident department and mistaken beliefs about the urgency of their condition and because patients are not registered with a general practitioner. It has also been suggested that general practitioners no longer have the skills or interest to deal with accident and emergency work.[2,3]

This study considered the attitudes of patients to their general practitioners' ability to treat accidents and emergencies and their reasons for choosing to attend the accident department rather than their own general practitioners.

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Methods

Patients who attended the accident and emergency department at this hospital were asked to complete a simple questionnaire if they said that they were registered with doctors in one group practice. This questionnaire was handed to them by the receptionist before they saw medical or nursing staff. Parents were asked to complete a questionnaire for their children.

The practice has eight partners (four of whom have been vocationally trained and two of whom are trainers), roughly 17 500 patients registered, and surgeries in two locations in Berkshire. An appointments system is run but patients with urgent problems are always seen on the same day in the time required for the complaint. The doctors carry out all out of hours work themselves. The practice has its own nursing staff in attendance, two partners carry air call bleeps at all times, and both of the purpose built surgeries have their own treatment rooms where several minor operations and casualties are managed each day. The practice owns two portable electrocardiographs and portable nebulisers and maintains equipment for intravenous cannulation and for administration of fluids. One partner is also an anaesthetist so that the practice can carry out first aid treatment for all except serious accidents. The hospital is located three miles from the practice area, and no part of the practice area is nearer to or more convenient for the hospital than for the two surgeries. The hospital is a "best buy" district general hospital with an accident department which dealt with over 40 000 patients in 1984-5.

One hundred questionnaires were meant to be distributed, but in the event 92 were successfully completed and collected during the survey period of 3 October 1984 to 3 February 1985. Two forms were lost during the period and six were not distributed in error. The survey depended on the good will and concentration of all receptionists in the accident department. Some patients were inevitably missed because they did not know the name of their general practitioner or because they were unable or unwilling to give it or because of other reasons. When the accident department was busy the receptionists occasionally forgot or were unable to hand out questionnaires to patients. It was not possible to identify accurately the numbers of missed patients, but this should not have introduced any systematic bias into the replies to the questionnaire, though it may have affected the numbers of questionnaires collected during the different time periods of the day or night.

The accident and emergency records of all the patients in the survey sample were inspected and the information that was gleaned and the results of the survey questionnaire were entered in a computer database for further analysis. I made a judgment from my knowledge of the ability of the practice to cope with accident and emergency cases on whether or not the patient concerned merited urgent referral to the accident department or whether the patient could have been dealt with first by the general practice. I had spent three months as a trainee in the practice and my judgments were subsequently verified by a senior partner. Any patient who had a fracture or was admitted to hospital—whatever the nature or circumstances—was considered to have had a sufficiently serious condition to merit hospital attendance, even though most such patients would probably have been adequately diagnosed first by their general practitioner.

Results

Of the 92 patients, 53 were male and 39 female. Table I gives the numbers of patients who attended the accident and emergency department in different time periods and whether or not these attendances took place when the general practice surgeries were open. Forty seven had attended during those times—that is, between 8 30 and 18 30, Monday to Friday, excluding bank holidays. (One surgery is also open for emergencies on Saturday mornings, but no account has been taken of this in the analysis.)

TABLE I—*Time periods during which patients in the survey population attended the accident and emergency department*

	No of patients
All days (hours):	
0831-1300	31
1301-1830	29
1831-2300	25
2301-0830	7
Weekends	33
Outside surgery hours (evenings, nights, weekends, and bank holidays)	55

TABLE II—*Analysis of the 92 patients in the survey population*

13 patients referred by general practitioner
12 patients not referred, who had urgent or serious complaints (see text)
5 patients not referred, but claiming to have contacted general practitioner
62 patients who completed the questions on reasons for not contacting general practitioner

Table II shows how the sample of patients was analysed. Thirteen of those who attended had been referred by their general practitioners. Of the remaining 79 patients, 12 fell within the "urgent" category, as defined, and table III gives the diagnosis and treatment of these patients. The remaining non-urgent complaints (67 patients) were judged by me and a senior partner in the practice to be well within the capacity of the general practitioners to deal with first and were not untypical of work handled in the practice surgeries.

Of these 67 patients, five claimed that they had tried to contact their general practitioner before they attended the hospital; two of these claimed that they had been referred by the general practitioner: one was possibly genuine, and the other patient told the hospital staff that her doctor had recommended her to attend, whereas she later confessed to her general practitioner that she had actually gone for a "second opinion" without his knowledge. These two questionnaires were therefore discarded, leaving 65 patients who had neither claimed referral by their general practitioner nor had conditions that required urgent attendance at hospital. Table IV summarises the responses of these 65 patients. Of the 62 patients who had not contacted their doctor, 18 quoted some other reason for not contacting him (table V). Where appropriate, responses to the questionnaire were reclassified in the light of the replies in table V: thus "more attention for little ones" and "wanted x ray examination" were interpreted as "problem not suitable for general practitioner." Table IV gives the numbers of responses for each item, the reclassifications, and the overall percentage of the 62 patients who responded to each item in the questionnaire.

TABLE III—*Urgent problems (defined in text), excluding referrals by general practitioner*

Problem	Treatment
Dislocated patella	Reduced
Vitreous detachment	Referred to eye clinic
Lacerated/dislocated finger	Reduced Steri-Strip
Ear haematoma	Aspirated
Lacerated/bruised knee	Sutured
Lacerated thumb	Sutured as inpatient
Fractured shoulder	Referred to fracture clinic
Penetrating eye injury	Admitted
Lacerated mouth	Referred to oral surgeon
Colles fracture	Reduced, fracture clinic
Radial fracture	Fracture clinic
Fractured fibular head	Bandage

TABLE IV—*Responses to questionnaire of 65 patients, whose problems were not urgent and who had not been referred by their general practitioners (plus number of answers reclassified—see table V)*

(1) Did you contact your own doctor before coming to casualty?
Yes 3 (see text)
No 62
(2) If you did not contact your doctor:

	No	No reclassified	Total No	%
(a) I did not want to bother my own general practitioner	16		16	25·8
(b) My problem was not suitable for my general practitioner	27	5	32	51·6
Either (a) or (b)	35	4	39	62·9
(c) It was more convenient for me to attend casualty	22	2	24	38·7
(d) It was quicker for me to go to casualty in an emergency	28	1	29	46·7
Either (c) or (d)	41	3	44	70·9
(e) I could not get through to my general practitioner on the telephone	3		3	4·8
(f) Some other reason (see table V)	18		18	29·1

Note: Reclassifications shown in table V were ignored in table IV if a positive response for that category had already been registered by the patient.

TABLE V—*Other reasons given by patients for not contacting general practitioner before attending accident and emergency department, reallocated to categories in table IV*

Other reason	Reclassification
Saw yesterday—no help	None
More attention for little ones	Suitable (b)
On duty at hospital	Convenient (c)
Surgery closed, needed x ray examination	Suitable, quicker (b, d)
Ailment not serious	Suitable (b)
Doctor might have referred me	Suitable (b)
No phone	None
Wanted x ray examination	Suitable (b)
Sent from school	None
Surgery closed	Quicker (d)
Accident at work	None
"Accident"	None
Boxing Day—surgery closed	Convenient (c)
No Boxing Day surgery	Convenient (c)
Seeing consultant already	None
Car accident	None
Needed stitch	Suitable (b)
Caught finger in door	Suitable (b)

Discussion

The workload of accident departments has been studied by others to see whether or not some of it could have been dealt with by general practitioners. The government is said to favour general practice undertaking more of the work that is now carried out in hospital, including minor surgical procedures.[4] Various explanations have been suggested for the increasing attendance at accident

and emergency departments and for the high proportion of "misusers" among those who attend. After analysing the records of 587 patients who attended the London Hospital during one week and administering a questionnaire to those who had had neither accidents nor emergencies Davison and colleagues thought that part of the answer to misuse lay with better patient education and increased registration with general practitioners.[5] In analysing 1000 consecutive attendances at hospital Myers found that only 45·8% were "justified."[6] Of 150 patients who completed a questionnaire and attended an accident and emergency department during "surgery hours," 47% said that they had needed hospital tests or treatment, and 21% said that their condition had been urgent, requiring immediate self referral to hospital. The results of Myers's study also indicated that many general practitioners felt unhappy performing casualty procedures such as suturing, which Cartwright and Anderson and Honigsbaum have also noted.[2,3] Myers concluded that the management of minor medical problems and trauma in general practice was inhibited by a failure of patient perceptions concerning general practitioners' ability, on the one hand, and unwillingness, on the other.

The patients in this study, however, were registered with general practitioners whose practice carries out most of the procedures for minor trauma, and therefore some of the reservations and conclusions of both previous studies do not apply. It is notable that many of the patients who had not been referred by their general practitioner believed that their condition was not suitable for his attention or that they ought not to bother him. A larger proportion believed that they would obtain speedier or more convenient treatment from the accident department than they would have done from their own general practitioner. The reality is likely to be different from these beliefs, for the patients from this practice who attend their general practitioner for such conditions would usually wait for a shorter time, travel less far, and be seen by a more experienced doctor if they attended the surgery first. Furthermore, the economic implications of staffing costs and paperwork generated by attendances at the accident department should be taken into account: direct treatment services and supplies cost £10·17 per district attendance at an accident and emergency department in 1984-5.[7]

The results of this study support the idea that the perceptions of patients are at the root of their preferences for treatment in hospital as against treatment in general practice for minor trauma and other emergencies. Such perceptions are erroneous for this particular, well run practice but none the less are clearly prevalent. Perhaps patient care would be improved and the expenditure on accident and emergency services reduced by attempting to change such perceptions.

Methods of changing perceptions might include charging a fee for attending the accident department (as is statutorily the case for drivers in road traffic accidents, where the cause for attendance may be more apparent), advertising by general practitioners who are interested in managing minor trauma, and more strenuous attempts by hospital managers and health officials to discourage patients from attending with other than severe injuries.

If the National Health Service were a business enterprise more sophisticated market research than this small study might provide a rational basis for policy making. Larger and more comprehensive studies are needed of patients' attitudes to this and other aspects of care where hospital and general practice overlap, and these might compare individual practices and the use that their patients make of hospital facilities. There is no evidence from this study that the Health Service needs a dual system for primary health care, for which provision is already made in the general practitioner's terms of service.

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Essays on Practice

Do general practitioner hospitals extend primary care?

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There are 350 general practitioner hospitals in England and Wales, which contain 8720 medical beds and discharge roughly 195 000 patients each year. There are also 54 maternity units and several general hospitals with general practitioner wards or designated beds. In Scotland and Northern Ireland there are a further 75 general practitioner hospitals. Sixteen per cent of general practitioners and 22% of hospital consultants help to staff these hospitals and provide outpatient services.[1,2] Small peripheral hospitals are sometimes called community hospitals, cottage hospitals, or local hospitals, but the term general practitioner hospital is preferable because it emphasises the responsibility of general practitioners for admission and day to day management of patients.

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General practitioner hospitals have evolved in response to local needs so that each one is unique in some ways; they have never been included in overall planning strategy for primary or secondary care. A personal review of the strategic plans for the next five to 10 years published by the health regions in England showed an uneven awareness of the contribution and potential of general practitioner hospitals, although these have been emphasised in earlier publications from the Department of Health and Social Security.[3,4] Because

of their small size and administrative and geographical isolation general practitioner hospitals have always been vulnerable to closure or change of use, usually to long stay geriatric units.[5,6]

The Association of General Practitioner Hospitals was established in 1969 to protect general practitioner hospitals from closure and to increase the awareness of the contribution that they make, although now the association has initiated research studies and also acts as an adviser. A working party appointed by the Royal College of General Practitioners reported on general practitioner hospitals in 1983,[7] and in 1984 a liaison group between the association and the college was established. This year the association published a directory of general practitioner hospitals in England and Wales.[2]

In the past two years some 50 general practitioner hospitals have approached the association because of threats of closure or the loss or change of use of beds; the association can help by sending an Action Pack, containing advice and information from the experience of individuals and other hospitals that have faced threats of inappropriate closure. Paradoxically, in the past year the annual representative meeting of the BMA, the annual general meeting of the Royal College of General Practitioners, and the conference of local medical committees passed resolutions that general practitioners should have facilities to look after their patients in hospital. Also, in the past two years two urban general practitioner hospitals, Chepstow Lodge in north London and the Lambeth Community Care Centre have been established. General practitioner hospitals are being built or extended in Mold, Blandford Forum, Ilkeston, and Andover, and there are plans for new units in Leamington Spa, Stratford upon Avon, Dawlish, and Leighton Buzzard.

No policy

This confusion emphasises the absence of any policy for the use or development of general practitioner hospitals. Such a policy would be based on the clinical contribution being made by these hospitals and on an analysis of their costs and benefits, and, using this information, on a clear view of the way in which they may contribute to overall planning for health care. We do not yet have all this information, but, it must be said, the role of the district general hospital has never been similarly scrutinised, its central importance in district strategy being taken for granted.

Cavenagh was the first to survey the clinical contribution made by general practitioner hospitals,[1] although earlier studies by Loudon and Berkeley had examined this in smaller areas in Oxfordshire and Scotland respectively.[8,9] The results of Cavenagh's survey showed that large numbers of acute medical admissions were taken by general practitioner hospitals, that 70 000 cases of elective surgery were handled each year, and that there were over 2 million attendances in the casualty departments of these hospitals a year. Over the past decade other reports have added details to this survey, emphasising the role of the general practitioner hospital in, for example, acute medical care, care of the elderly, and terminal care.[10-12] At the last summer symposium of the association of general practitioner hospitals the role of the general practitioner hospital in organising anticoagulant control and the provision of open access endoscopy was described. The Royal College of Surgeons has produced a discussion document on surgery in general practitioner hospitals which supports carrying out surgical procedures on appropriately selected patients[13] and the Association of Anaesthetists has produced guidelines on anaesthetic services for isolated units.[14]

In 1972 Rickard attempted to study the cost effectiveness of the Oxford community hospitals, which showed how difficult such an exercise is.[15] He suggested that a unit of at least 35 beds is probably most cost effective, although he was unable to confirm that care in general practitioner hospitals was "cheaper." One difficulty that will always be encountered in such a study is the possible disagreement on desirable outcomes between clinicians—apart from the inadequacy of routinely collected data on costing. Furthermore, carefully designed studies are required to answer questions about cost effectiveness.

Cheaper beds

Experience in Finland, for example, shows how general practitioner hospitals might contribute to planning for health care. General practitioners almost always have beds attached to their health centres, and Kekki's findings suggest that providing these low technology beds leads to a reduction in the use of more expensive centralised hospital beds.[16] It has been suggested that up to 40% of patients who are admitted with acute medical problems to district general hospitals in the United Kingdom could have been cared for in general practitioner hospitals had the facilities been available.[17,18] Providing more low technology inpatient facilities could be an alternative to the increasing centralisation of beds in expensive district hospitals.

Among the arguments in support of general practitioner hospitals is that the ability of general practitioners to care for patients in small hospitals contributes greatly to continuity of care, and this may be particularly important for patients who are elderly or terminally ill. Many general practitioner hospitals have associated outpatient departments where visiting consultants are available for advice; contact between doctors who work in primary and secondary care is important for the continuing education of both. Cartwright and Anderson presented evidence that the range of services offered in general practice may be contracting[19]: in general practitioner hospitals the clinical skills that are learnt during vocational training can be maintained and extended. The liaison group is agreeing standards for general practitioner hospitals related to vocational training practices, and general practitioner hospitals are an almost untapped educational resource. Many facilities associated with a general practitioner hospital, such as physiotherapy, radiology, and pathology, are also of benefit to the local community. These are likely also to be cost effective.

In a recent discussion of the balance between primary and secondary care Horder included providing more community hospitals among his proposals.[20] There is no reason to regard primary care as synonymous with ambulatory care; the activity of the general practitioners who staff general practitioner hospitals testifies to this. They do not work there for for the financial rewards, which are almost derisory.

General practitioner hospitals are a precious resource that are cherished by local communities and harness the enthusiasms of thousands of general practitioners. In the search for an efficient and effective health service their contribution should not be overlooked.

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