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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Inappropriate use of casualty departments

Sir,
A survey of 100 attenders was undertaken at a north London casualty department which was experiencing problems owing to increasing numbers of attenders. Nineteen per cent of the patients had no knowledge of their doctor's surgery hours and 32% had no understanding of the emergency cover provided by the practice. Fifty per cent of the patients had made no prior attempt to contact their general practitioner and 14% were not registered. Half of the presenting complaints were considered to be inappropriate for a casualty department. The main reasons given by these patients for coming first to casualty were that it was 'easier' and 'quicker' and (sometimes) 'better'. But the results indicate that lack of knowledge about practice arrangements or difficulty in contacting the doctor may also be a deterrent.

In order to provide attenders with more information and improve the department's inadequate knowledge about local practices, a questionnaire asking about surgery hours and emergency arrangements was sent out to all the 89 practices in the catchment area; 139 general practitioners from 58 practices responded.

Surgery hours ranged from 10 to 35 per week and most premises were closed outside these hours. Only a minority had reception staff available all day for appointments and messages, and only a minority were open on Saturday mornings for emergencies. Most practices operated appointment systems but said that they would give priority to emergencies. Out-of-hours cover was provided by a variety of systems, ranging from personal availability, cover by a group of doctors, answering services and deputizing services.

Opening hours and telephone numbers are displayed both inside and outside surgeries, and some practices have information cards as well. Information about general practitioners is also available from the family practitioner committee lists in post offices and public libraries. The casualty department survey raises the question why people are not making use of this information. Is the information clear enough? Is it explicit enough? Has it been given out in a way that makes sufficient impact? Has it been understood? Is more detailed advice needed about which types of case should go to the emergency department and which are best discussed with a general practitioner? Do patients need to know more about the services offered by the practices and their policy about, for example, the treatment of minor accidents and injuries, or stitching and injections? Are patients entitled to know in more detail what response they will get during the night or at weekends, and whether they will be able to contact the doctor they know or whether a deputy will attend them? Should they know whether they will have direct contact with their first telephone call, or whether they will be required to ring a special emergency number? And if so, what will happen then?

Although it may be impossible for general practice to be as easily accessible as a casualty department with its 24 hour open door system, more thought could perhaps be given to the genuine difficulties that some patients have in contacting their general practitioner. These may range from appointment delays to inconvenient surgery hours, or when surgeries are closed, to problems with the telephone.

A recent survey has shown that when surgeries are closed, accident and emergency attendances increase.[1] But it has also been said that when patients have confidence in the ready availability of their general practitioner, emergency calls tend to be reduced.

It seems to be a universal complaint that casualty departments are overloaded, and that many of the patients going there would be more appropriately and better looked after by general practitioners. But this might mean more work for general practitioners. Are they willing to accept it? Are they willing to supply more information about their practices to their patients and are they willing to try to inform their patients about the proper use of the emergency services? Can casualty departments play their part in this, and can a better working relationship between them and the surrounding practices be developed?

These are all difficult but important questions.

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References

1. Bowling A, Isaacs D, Armston J, *et al.* Patient use of a paediatric casualty department in the East End. *Fam Pract* 1987; **4:** 85-90.

A joint approach to smoking cessation clinics

Sir,
General practice is being increasingly considered as the most appropriate and effective area in which to practise preventive medicine.[1] The government in its recent white paper outlined incentives to stimulate primary care teams to undertake these new tasks.[2] Various studies have looked at the efficacy of general practitioners as health educators, and more recently attention has centred on the practice nurse.[3] We decided to advance this concept one step further by training the practice nurse as a counsellor as well as health educator. She was taught how to establish and run a smoking cessation clinic within the context of her own general practice. There were five stages in setting up the service.

1. Initial consultation with the local medical committee and family practitioner committee.

2. Identification of the general practitioners and practice nurses interested in such a scheme. The project was introduced to the local general practitioners at