Providing primary care in the accident and emergency department

The end of the inappropriate attender

Out of hours calls to general practitioners have doubled in the last three years,[1] while emergency admissions to hospitals have increased by 16% from 1988-9 to 1993-4, with some hospitals seeing a doubling since 1993.[2 3] Yet accident and emergency departments—a major gateway to the hospital—treat a mixed group of patients, and only a small proportion of the 15 million people who visit Britain's 227 accident and emergency departments each year[4] are critically ill or injured. What drives the increasing demands on accident and emergency services and out of hours calls to general practitioners is not yet understood, but attempts are being made to manage the workload in a way more appropriate to the problems it presents.

Until recently the accident and emergency community blamed many of its problems on "inappropriate attenders." That attitude is changing, with the recognition that many attenders need primary care. Lack of an agreed British national triage system makes valid comparisons difficult, but the British Association of Accident and Emergency Medicine considers that 10-40% of accident and emergency patients need primary care, while the Black Country review suggested a figure of 12-38%, and international figures suggest 7-70%.[5-8]

Dale and his coworkers at King's College School of Medicine and Dentistry have been researching the demand for "emergency" primary care since 1988. In a prospective study of 5658 patients attending one accident and emergency department in 1995 they used a triage system to divide patients into "primary care attenders" and "accident and emergency attenders."[9] They concluded that triage by nurses within the accident and emergency department could be developed to identify patients with problems that were more likely to be of a primary care type; these patients were less likely to receive an investigation, minor surgical procedure, or referral. Of the 5658 patients studied 40.9% were classified at triage as presenting with primary care problems. Nevertheless, there were limitations in the sensitivity of triage practice and in the clinical approach of junior medical staff—who had a propensity to intervene.

Using their definition of primary care, Dale and his team carried out a prospective controlled intervention study of 4681 patients classified as primary care attenders.[10] This showed that employing general practitioners in accident and emergency departments to manage patients with primary care needs reduced rates of investigation, prescription, and referral when compared with hospital doctors. A related study showed that primary care patients could be managed in this way at reduced cost and with no detrimental effect on outcome.[11]

In a study in Dublin, within a different health care system, Murphy et al performed a randomised controlled trial of 4684 patients.[12] This group represented 66% of all accident and emergency attenders and included "semi urgent" cases and those in whom a delay was considered acceptable. Their "delay acceptable" group was broadly similar to Dale et al's primary care attenders. This study also supported the success of triage systems and concluded that general practitioners working in accident and emergency departments managed "non-emergency" attenders safely and used fewer resources than did the usual accident and emergency staff.

These studies allow us to reach the following conclusions. Firstly, about 40% of new attenders in accident and emergency departments can be safely triaged by trained nurses to receive primary care. Secondly, general practitioners working in accident and emergency departments can safely and effectively treat these patients at less cost than hospital doctors. Both studies conclude that further research into patient outcome and satisfaction should be carried out.

So where do we go from here? The NHS is under pressure in both acute and community care, and accident and emergency departments represent the interface between the two. Although general practice is responding to the increasing demand for primary care out of hours through cooperatives and the development of out of hours primary care centres, accident and emergency departments also need to respond. Patients will continue to use accident and emergency departments for primary care problems as they have always done. So these departments need to be organised to provide care for the needs of their local community. Contracts for accident and emergency and general practitioner services need to be reworked for 2000 and beyond, to accommodate the need to integrate all out of hours emergency healthcare services. In addition, a national triage scale incorporating a recognised primary care attender category should be agreed as a matter of urgency. The studies of Dale and Murphy identify the primary care population and offer cost effective solutions. Whether there are enough general practitioners available or whether nurse practitioners are part of the solution to treating primary care attenders are unanswered questions. As an article in the *BMJ* concluded,[13] the fact that the current staffing crisis in accident and emergency departments is occurring at the same time as general practitioners are looking at better ways of organising their out of hours commitments offers both groups a unique opportunity to restructure their services and improve them.

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Rationing health care

A logical solution to an inconsistent triad

The basic principle of the NHS is simply that comprehensive, high quality medical care should be available to all citizens on the basis of professionally judged medical need without financial barriers to access. In seeking to enact this principle, the NHS is not alone. The same aspiration is to be found in nearly all economically developed societies outside the United States. Yet, in the face of increasing healthcare costs this basic principle threatens to become what logicians call an inconsistent triad; a collection of propositions, any two of which are compatible with each another but which, when viewed together in a threesome, form a contradiction. Perhaps we can have only a comprehensive service of high quality, but not one available to all. Or a comprehensive service freely available to all, but not of high quality. Or a high quality service freely available to all, but not comprehensive. Each of these three possibilities defines a characteristic position in the modern debate about healthcare costs and organisation.

High quality comprehensive care that is not freely available to all is, of course, the solution to the dilemma adopted by the United States. This is a poor solution. It is not simply the uncivilised way in which the healthcare needs of citizens are ignored, with up to 20% of Americans uninsured or underinsured and with non-existent primary care services for the poor. It is also that, even for those who are insured, the consequence of the search for ever more prestigious health care is a mutually defeating game of spiralling costs and defensive medicine.

American analysts reply with their own arguments, asserting that the NHS buys its comprehensiveness and free availability at the cost of quality. This is the essence of what may be termed the "Brookings" characterisation of the NHS, after the famous Washington think tank. Its reports have argued that the NHS serves patients badly, with too few diagnostic tests, too much waiting, not enough screening, and an unwillingness to use expensive treatments.[1 2] All too often this argument conjures up wartime stereotypes of a phlegmatic island race bearing their misfortunes with fortitude. More seriously, it commits the fallacy of assuming that good medicine is always interventionist medicine. It is not, however, an argument that is easily dismissed, as any visit to a busy outpatient department or a reading of the King's Fund report on London's mental health services will testify.[3]

Move then to the third option: why not sacrifice comprehensiveness in order to achieve at least a core of high quality care freely available to all? Perhaps when drugs were few and treatments simple it was possible to be comprehensive, but now we know that, for many patients, there will be possible treatments that are disallowed on the grounds of cost, either implicitly or explicitly. Honesty about lack of comprehensiveness and the definition of a core range of services might go some way towards a solution. The trouble with this proposal is that, though many have tried, none has succeeded in defining a core range of services that can be made to work without severe qualifications. As Rudolf Klein has pointed out, the various committees around the world that have looked at the problem have simply come up with the same candidates for exclusion (vasectomies, sterilisation, tattoo removal, in vitro fertilisation, gender reassignment), all of which are marginal to the problems of allocating resources in health care.[4]

This conflict, implicit in the basic principle of modern health care, is not one that is best approached by treating it as logical puzzle to be resolved by dropping the least credible proposition. Such value conflicts are the essence of public policy: between economic growth and environmental protection; between individual freedom and social stability; between humanitarian intervention and recognising the right of national self determination; between comprehensiveness, quality, and availability in health care. As Sir Isaiah Berlin said, 30 years ago, we live in a world of conflicting values where clearcut solutions cannot in principle be found. To suppose that we can escape this conflict of values by retreating to an ideologically and organisationally simpler world casts a veil of deceit over the choices that must be made.[5]

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