THE ABUSE OF THE ACCIDENT & EMERGENCY DEPARTMENT

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In 1956 11.5% of the population attended as new patients to the Casualty Departments of the U.K. Since then there has been a constant increase in attendances and now it is twice that figure. Why is this so? Are we witnessing an epidemic in accident and emergencies?

The Road Traffic Accident mortality figures at around 5,000 p.a. compare very favourably with those of other E.E.C. countries, indeed the death rate is now the lowest it has been since the mid-fifties despite the increase in traffic on the roads.

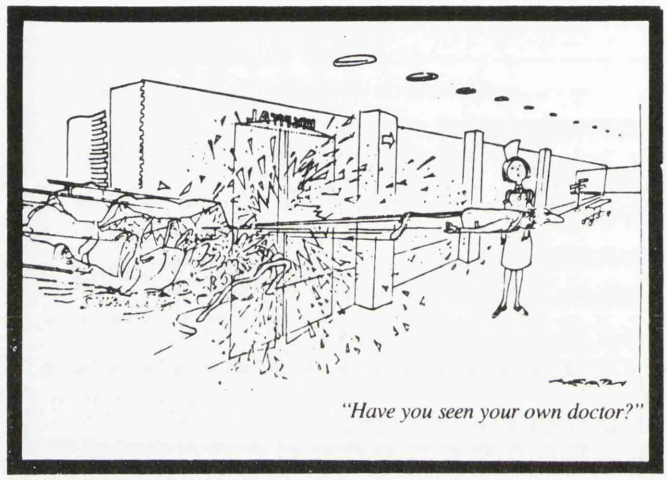
The increase in attendances is due to a change in the type of patient attending. Since 1956 there has been a change in the nature of general practice but an even more profound change in the expectations of the general public. General practitioners as well as A&E departments have seen a steady increase in attendances, yet the population has never been so healthy!

The A&E department's function, however, is to care for patients with accident and emergencies and A&E consultants are seeing a noticeable deterioration in the service they are providing because of the increase in inappropriate attenders. What is the solution?

In 1962 the Platt report dwelt at length on the organisation and administration of emergency services. Among the forty-five specific recommendations was that the word 'casualty' be dropped as it encouraged casual attendance. To give the service a new image, the phrase 'accident and emergency department' would replace it. This was duly done and large signs were erected outside these 'new' departments informing patients only to attend if they had an accident or emergency. However an emergency can be a rather subjective feeling. I remember seeing a young man at 6a.m. who had just finished his night shift. He had an ingrowing toenail which had developed over three weeks. When I drew his attention to the very large sign outside the department he stated quite emphatically that this was indeed an emergency for **HIM.**

So the solution would appear not to be a governmental decree!

Another approach to the problem is to accept this inappropriate use but to divert finance from the primary care budget in order to staff the department appropriately. Temporary registration fees, night visiting fees and emergency treatment fees are all within the remit of the FPC. It would not be difficult to justify the reimbursement of some of these fees to A&E departments who are providing general medical services in addition to their primary role. The Casualty Surgeons Association proposed this in response to the Government Green Paper. The government acknowledged that 3% of the population were not registered with a GP, but did not agree that such people might attend A&E departments. I would add that the above patients represent a saving of nearly 10 million pounds in capitation fees for the government.



"Have you seen your own doctor?"

We now have the White Paper and with the introduction of general practitioner budgets it has been suggested that the GPs be billed for these patients who use the A&E department for primary care. Of course we can't bill for emergency treatment but these are not emergencies. As most of the patients attend without consulting their GPs it seems a little unfair to penalise the GP. In these circumstances effective control of the budget is being given to the patient, an untenable situation. However one large teaching hospital is considering the introduction of this scheme.

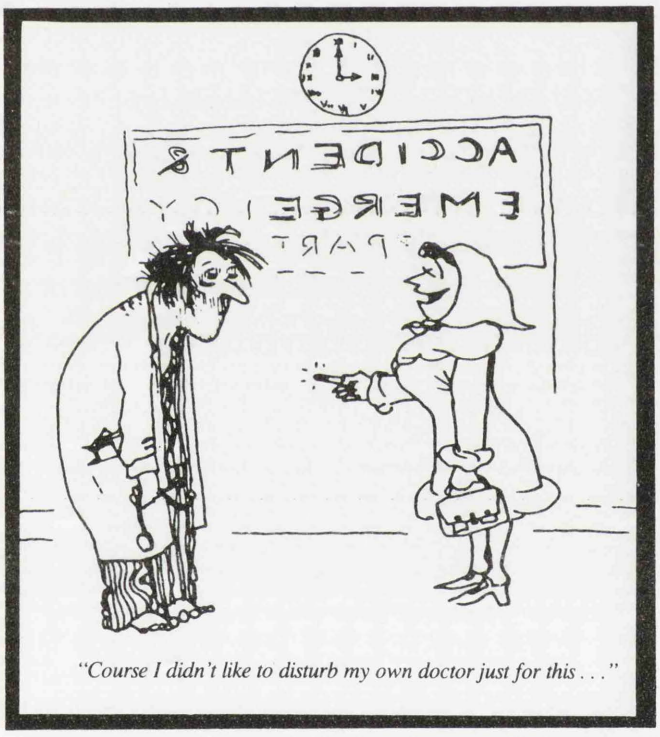
The percentage of inappropriate new attenders varies between studies: however at best it is 7% and at worse 40%[1]. The latter figures comes from University Hospital where the patients mix (20% not registered with a GP) presents predictable problems. Lancaster has its own problem in that being a tourist area there is approximately a 40% increase in patients during the summer months.

A local GP study [2] estimated that Lancaster A&E department had an inappropriate attendance rate of approximately 8% of people **registered with a local GP.** This compares very favourably with the national figures but there is an obvious danger that this rate will rise unless preventative action is taken. But what action?

The option of expanding the service to provide a GP service as an adjunct to the A&E department's main role would appear to be unacceptable to the government. That service is already funded in the community. To coin a White Paper phrase if 'money doesn't follow the patient', A&E departments will have no option but to turn patients

away in order to deal effectively with the appropriate attenders.

An educational campaign by the DHSS had no effect on the number of inappropriate attenders. If one considers that over 20% of the population attend the A&E department each year perhaps the best place to start re-educating the public is in the department itself. The fundamental problem is that these patients are satisfied with the treatment they receive in the A&E department and are, therefore, encouraged to return[3]. The A&E doctor is obliged to see a patient attending the department; he is not, however, obliged to treat that patient. My colleagues in A&E are quick to criticise general practitioners but it is we who encourage the abuse of the service by treating these patients! The usual reason for the GP not being involved is that the patient makes no attempt to contact him. Reception staff in G.P.s' surgeries, when under pressure, can fail to communicate to the patient the service provided and some can on occasion be obstructive. One patient in the local study[2] thought the reception staff were trained by Mussolini. He was in a minority of one so I suspect the staff had had a particularly bad day.



"Course I didn't like to disturb my own doctor just for this . . ."

The inappropriate attender can be of either sex but there is a relationship to age. Our local study showed that the commonest age range was 20-35 with an average age of 28 years. Perhaps this age group has the highest expectations of the Health Service.

A&E departments are starting to circularise the local community with guidelines for appropriate attendances. Once these guidelines are known it is inevitable that some patients will try and 'work the system'. One patient presented to a department with a 48hr time limit over which injuries would not be seen. She had tenderness in the anatomical snuff-box following a fall 'that day', so a scaphoid plaster was applied when the X-ray showed no fracture. It was in the clinic two weeks later that she admitted that the injury had occurred three weeks prior to the initial visit but had told a 'white lie' in order to be seen. She had indeed been seen but had had her wrist immobilised needlessly! Such guidelines can work, however, and the table lists the suggested categories.

Appropriate attendance at the A&E department

1. Injuries of less than 48 hours duration.
2. Epistaxis.
3. All eye injuries or sudden loss of vision.
4. Medical/Surgical EMERGENCIES.
5. Patients referred by their general practitioner.

Table

In order that the department is seen to be consistent with the public our current practice will have to be reviewed. For example, at the moment patients with chronic neck pain are sent by some general practitioners to the A&E department for cervical collars. The message we appear to be giving the public here is that the department is an applicances store!

Some A&E departments act as the receiving, diagnostic or assessment centre for other specialities taking in accepted cases from GPs. Fortunately this is not the case in Lancaster because with such systems the department becomes clogged by patients waiting to go to a ward, placing a burden on staff, space and the patients themselves. During the recent ambulance dispute we have had this experience with patients waiting up to seven hours for a bed. The hospital trolley was not designed with comfort in mind.

The primary reason for discouraging inappropriate attendance in the A&E department is to improve the service provided to the true A&E patient who deserves prompt and efficient treatment.

REFERENCES

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2. Ballard T.H. How appropriate is the use of Casualty. Syntex Award Winner 1988.

3. Bradbury Y. and Lewis B. North Western Regional Study of Accident and Emergency Services, Dept of Management Sciences, UMIST. March 1982.