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ACCIDENT AND EMERGENCY SERVICES: USE, ABUSE AND MISUSE

A Report of a Conference held at the King's Fund Centre on 3 April 1979

King's Fund Centre
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INTRODUCTION

The Accident and Emergency service is a vital, yet frequently neglected, link between primary and secondary health care. Accident and Emergency departments in hospitals are frequently seen by the general public as alternatives to family practitioner services. At the same time, more general practitoners are organizing "immediate care" schemes to provide medical care at the scene of the emergency.

What is the proper role of the Accident and Emergency service? How should responsibility be divided? Is there a place for 'casualty' in small hospitals and health centres? These were some of the questions considered at this conference organized in conjunction with the North West Regional Association of Community Health Councils.

The Conference Chairman, Mr W Ashworth, Chairman of the North West Association of CHCs, said in his opening remarks that CHC members throughout the country were hearing complaints about the problems of travelling to Accident and Emergency, and Casualty Departments and unfavourable comparisons were being made with General Practitioner treatment of years gone by.

THE AREA PERSPECTIVE

The first speaker, Dr D S Parken, Area Medical Officer, Lancashire Area Health Authority, set the scene with a brief history of Accident and Emergency services since the introduction of the National Health Service in 1948. He then looked at the present service and considered some of the problems that exist, particularly those which relate to doctors.

During the 1950s there was much concern and discussion about casualty services, especially as the number of accidents was increasing. In 1961, The Accident Services Review Committee of Great Britain and Ireland, chaired by Sir Henry Osmond-Clarke[1], recommended the creation of a three tier system for the treatment of accidents and other emergencies:

- a peripheral service for minor injuries staffed by GPs
- an accident unit in what is now known as the District General Hospital
- a Regional Unit for complicated cases

There was some debate about the need for a Regional Unit. The Platt Report (1962) recommended a two-tier system [2]. However both these reports and the Scarth Report on Scotland [3] recommended the rationalization of services in 'Accident and Emergency Departments'. This policy began to be implemented during the 1960s.

The workload of these departments rose steadily and attendances virtually doubled between 1962 and 1972. Dr Parken suggested several reasons for this steady increase, although he pointed out that their significance varies between different types of community. In many parts of the country, GPs are now less accessible. In inner cities, GPs with lock-up surgeries often live some distance from their practice. Grouping of GPs into health centres can cause problems of access in more rural areas. The growth of deputising services or even vandalized public telephones can cause problems for a patient trying to reach the GP in an emergency. Similarly the growth of appointment systems in General Practice or the use of answering machines may act as a psychological barrier for the patient. Dr Parken stressed that such changes are often desirable for other reasons and many GPs try very hard to overcome the problems that arise. On the other hand, some GPs may have a deliberate policy of referring all trauma cases to Accident and Emergency Departments, either for medico-legal reasons or because the GPs surgery facilities are inadequate.

Dr Parken then considered the type of people who attend Accident and Emergency Departments and the needs they present, drawing upon a study carried out in Leeds between March 1976 and February 1977 [4]. In Leeds, the majority (62%) of cases were male and a high proportion (25%) were aged 15-24 years. There were 65,000 new cases in the study year and 73.8% of the new attenders were self or lay referrals. Dr Parken said that there was a wide range of cases presented and often the services of different specialists were required. The large District General Hospital should be able to provide multidisciplinary back-up services.

Nonetheless the largest increase in new patients came from those suffering from apparently minor conditions that many GPs would expect to attend themselves.

Dr Parken then looked at the various grades of doctor working in Accident and Emergency departments and discussed some current issues. There is considerable debate about the development of a new specialty in Accident and Emergency work. The protagonists believe that it is important and necessary for career satisfaction to have one consultant fully committed to the department and to training junior staff, dealing with local hazards and major disasters, liaising with the ambulance service and carrying out preventative work and research. Others argue that a consultant from another specialty, with adequate sessions allowed for Accident and Emergency, can provide a satisfactory service. Moreover, some say that Accident and Emergency work is too general to become a recognized specialty.

Traditionally, 'medical assistants' have played an important role in Accident and Emergency work and many smaller units have been kept going by them.

For several years now, GPs have been working in certain Accident and Emergency Departments in the hospital practitioner or clinical assistant grades. However there are still some areas where consultants will not agree to such appointments.

Accident and Emergency Departments are also staffed by doctors in training. Most junior doctors in Accident and Emergency Departments are Senior House Officers. Many are from overseas and often Accident and Emergency work is not their first preference. (Only the Royal College of Surgeons stipulates six month's experience in Accident and Emergency work for their higher diploma). The number of doctors in Accident and Emergency may be further restricted because of the recent introduction of 'limited registration' for many overseas doctors and the imposition of certain criteria on doctors in this category working in Accident and Emergency Departments.

In 1978, a working party of Area Medical Officers in the North West Region, (of which Dr Parken was a member) was formed to consider the danger of possible closure of major Accident and Emergency units. Their recommendations were very much in line with those of the Lewin Report [5], published around the same time. The Area Medical Officers found evidence of low morale amongst junior doctors in Accident and Emergency Departments, partly because of patients with fairly minor ailments and partly because of a lack of supervision and instruction in departments not having a consultant in Accident and Emergency services.

The Working Party thought that the public needed to be educated in the correct use of Accident and Emergency Departments. It also thought that Accident and Emergency jobs would be more attractive if there was more emphasis on the training element. It urged consultants from other specialities to provide a physical presence in Accident and Emergency Departments and to instruct junior staff in all aspects relevant to their own speciality. It also suggested that Accident and Emergency work should constitute required training experience in many other specialities (eg Paediatrics, psychiatry, ENT). The Area Medical Officers also recommended that sufficient registrar and senior registrar posts should be established to meet all consultant training needs. However they did not see a major role for the hospital practitioner grade or for clinical assistants in the Accident and Emergency Departments of District General Hospitals. It was felt that GPs had a major role in community hospitals and in health centres with specially designed treatment rooms.

In inner-city areas, there may be a need for a new type of primary health care centre, staffed by GPs, junior doctors and district nurses. Such a centre might be attached to an existing hospital.

Dr Parken summed up by stressing the need to build up a comprehensive, attractive and acceptable training programme in Accident and Emergency services for medical graduates.

THE CONSULTANTS VIEW

The second speaker, Dr V Dallos, Consultant Physician in charge of the Accident and Emergency Department at Whipps Cross Hospital, in the East End of London, described the work of her department.

She saw the Accident and Emergency Departments as the interface between the community and the District General Hospital. It must have an open-door policy and be open 24 hours a day, 7 days a week. A wide range of cases, requiring a variety of specialized treatment are seen.

Dr Dallos described the functions of the Accident and Emergency Department as - the reception of patients; diagnosis; resuscitation; initial treatment; and referral for definitive treatment either to a GP or another part of the hospital. The department has a major disaster plan, carries out training in Emergency Medicine and has research interests.

The Accident and Emergency Department at Whipps Cross is one in the DHSS Accident and Emergency Consultant pilot scheme. The medical staff includes the Consultant Physician in Charge, three Clinical Assistants, from surgical, orthopaedic and general medical backgrounds, who provide nine sessions, and eight Senior House Officers (including one GP Vocational Trainee). Training is provided in emergency medicine for Senior House Officer's, the GP Vocational Trainee, hospital staff in other specialties, and post-basic nursing course in Accident and Emergency work. A Programme for Senior Registrars is pending.

Dr Dallos described the physical plan of the department. One important feature is the segregation of stretcher cases and ambulant patients. Great attention was paid in the design of the department to the patterns of patient flow.

Dr Dallos discussed the workload analysis at Whipps Cross in 1976. 85,000 patients were treated in the Accident and Emergency Department in 1976; 63,000 of whom were new cases. Of these 48,000 were ambulant. Dr Dallos felt that about 10% should not have come to the Accident and Emergency Department but the rest required one or more of the skills available at the Accident and Emergency Department. She also pointed out that it was not always minor trauma cases which were wrongfully presented; some major trauma cases were inappropriate in an Accident and Emergency Department. In all, 15,000 cases were later admitted to hospital wards, 65% of which go to medical wards. The Accident and Emergency Department also had its own 24-hour observation ward, which took about 13% of the admissions. The number of attendances at Whipps Cross has risen steadily since the Department opened in 1971, but Dr Dallos said she was less pessimistic than Dr Parken because the same number of staff were now looking after a larger number of patients.

Dr Dallos then considered the factors that brought about misuse and abuse of the Accident and Emergency Department. She considered that there were three possible culprits-

1) Patients,
2) GPs and other primary care services,
3) Other Accident and Emergency Departments.

There are several reasons why patients use Accident and Emergency services rather than more appropriate GP services. In the East End traditional attitudes favour cutting out 'the middle man'. In a floating population people may not have a GP or even know where to find one. Other factors may be the site of the accident or panic which may prevent a patient from making the most rational choice. GPs and Primary Care Services may contribute to inappropriate use of Accident and Emergency Services, through rigid appointment systems, inadequate deputising services, lack of facilities or tests at the GP surgery. Other problems may be queue jumping, or the GP himself. Also home helps, district nurses and social workers in the East End tend to refer clients to Accident and Emergency Departments rather than a GP.

At Whipps Cross, the Accident and Emergency Department has also had to deal with patients from other catchment areas, because of a shortage of beds or staff shortages in neighbouring hospitals. The closure of centralized Accident and Emergency Departments through wildcat strikes can also cause problems.

Finally Dr Dallos considered possible future developments. She foresaw an increase in centralization of Accident and Emergency services and advocated the creation of new Accident and Emergency Consultant posts. There was a need to extend GP Vocational Training in Accident and Emergency and also Accident and Emergency Specialist Nurse Training. Better emergency care by GPs for their own patients in their own centres should be encouraged. However, except possibly in rural areas, she opposed the reappearance of small, unstable casualty departments which she felt would aggravate existing problems and were bound to be more expensive. Finally she thought the situation should be reviewed every three years.

The third speaker, Mr David Wilson, Consultant Surgeon in charge of the Accident and Emergency Department at Leeds General Infirmary, talked about the workload and conditions in his department at Leeds and compared these with more general trends in Accident and Emergency Services. In setting the scene Mr Wilson listed the necessary conditions for a successful Accident and Emergency Department. It needed to be in the centre of the catchment area and had to provide a wide range of x-ray, other diagnostic and resuscitation facilities. Like earlier speakers he stressed the importance of multi-disciplinary back-up services but from his experience at Leeds, he discounted tales of low morale.

Mr Wilson discussed the teaching responsibilities of the Accident and Emergency Department at Leeds. There is a full commitment to post-graduate and under-graduate teaching. He referred to a survey of doctors recently reported in the British Medical Journal (6) on what they felt to be the most important training experience Accident and Emergency experience was listed in the top five specialties. The teaching of nurses is also a very important feature of the Accident and Emergency Department. Mr Wilson said that he is personally involved in training Red Cross and St Johns Ambulance personnel.

He then described some of the research activities which have been carried out at Leeds. Three years ago a computerized record system was introduced. This allows doctors to identify more easily cases they wish to follow up. The computer has also been important in studying the nature of the case load. Sources of referral have been analyzed and the distribution of cases by age and sex, (which again shows a predominance of young men attending the department).

A study comparing the workload of the Accident and Emergency Department and five GP practices indicated that the degree of duplication of services was less than expected. A large part of the GPs workload was concerned with elderly patients. The distribution of work through the day and week is also different. The GPs tend to work a five-day week whereas the Accident and Emergency Department is open 24 hours a day. A study of waiting times has led to the adjustment of staffing patterns to reflect more closely the pattern of patient flow.

Unlike Whipps Cross, Mr Wilson's caseload has fallen from 74,000 cases in 1974 to 63,000 in 1978. One factor in this decrease may be the sign erected in the waiting room, with the cooperation of the CHC, which suggests who should be attending the Accident and Emergency Department and the current waiting time for non-urgent cases. Research has indicated that use of the Accident and Emergency Department also varies with the proximity to the hospital and GP attitudes. The distribution of the caseload between different diagnostic categories also appear to vary according to the time of year. Finally, Mr Wilson stressed that one factor which crucially influences the workload of the Accident and Emergency Services is accident prevention and he urged that much greater attention be paid to this.

THE GENERAL PRACTITIONER VIEW

The fourth speaker Dr F M Cottier, a General Practitioner from Preston, concentrated on ways in which the GP can help Accident and Emergency services. He listed four important services that the GP can provide.

Firstly, the GP acts as a casualty clearing station - for instance suturing minor lacerations. However there is a limit to what he/she can do, partly because of lack of facilities (such as x-ray) and partly because of patient expectations.

Secondly the GP has a vital role to play in teaching the general public immediate life saving techniques such as cardiac massage and mouth to mouth resuscitation. Dr Cottier stressed the importance of on-the-spot care in cases such as cardiac arrest.

Thirdly, the GP can train ambulance men, both formally, at the RHA ambulance training centre and informally, by dropping in at the local ambulance station and answering questions.

Fourthly, Dr Cottier described a relatively new development -'mobile immediate care schemes'. These are designed to fill the treatment gap between the occurance of the emergency and the point at which the victim can receive definitive care. Such schemes vary from one part of the country to another. The GP may carry the basic equipment in his/her own car or, with community support, it may be possible to equip a special vehicle carrying more sophisticated equipment. A GP may specialize in a particular type of emergency (road accidents, cardiac arrests or midwifery, for instance) or he/she may

be part of a general team covering a particular geographical area. The GP may work directly with the ambulance service or there may be a specially trained immediate care unit at the local general hospital.

The communication system is very important; such schemes depend upon radio links. The GP must also be well trained in the use of the various pieces of equipment.

Such schemes have several benefits. The response time in getting skilled care to the victim is quicker. The GP is usually easily available, because practices tend to cover fairly circumscribed areas. There can be considerable advantages in treating the patients 'in situ', bringing them round to a steady state, where they can either be allowed to stay at home, or else are better able to undertake the potentially hazardous journey to hospital. Other spin-offs are that one GP has better equipment available and that there are skilled teams readily available in case of a major disaster.

As for future developments, Dr Cottier felt that there was little room for small accident units which lacked back-up facilities and multi-diciplinary support. He believed that GPs could shoulder more of the minor trauma cases, while major trauma would be increasingly cared for in District General Hospital Accident and Emergency Departments. This would leave a gap however, which it would be up to mobile immediate care schemes to fill. He also saw a possibility of developing 'mobile immediate care transit' schemes, which could transport critically ill patients to the main Regional centres. This however would require considerable thought. Finally he believed that there was room for a new type of medical officer to work with the reorganized ambulance service.

In the afternoon, conference members were split into six discussion groups. Six questions were suggested for consideration by the discussion groups, and afterwards by a panel:

1. What principles should govern the development of A & E Services in the future?

2. What are the current deficiencies in the A & E Services and how might they be remedied?

3. What is the role of the General Practitioner and the primary care team in the provision of A & E Services? How should they relate to the Hospital-based Service.

4. Is there a place for 'Casualty' in Cottage or Community Hospitals or Health Centres?

5. What features are characteristic of an effective hospital-based department. How should the A & E Service relate to other hospital departments?

6. What is the role of the ambulance service? How should it respond to changing needs in the future?

The members of the panel were the speakers plus Mr J Eversfield (Principal DHSS), Mr W James (Chief Ambulance Adviser, DHSS), Dr W J Modle (Senior Medical Officer, DHSS) and Dr I Russell (Lecturer in Medical Statistics, University of Newcastle upon Tyne).

The first question from the floor was "Does the panel agree that medical personnel should be specially trained in Accident and Emergency work?" All the speakers expressed sympathy with need to develop a specialty in Accident and Emergency work. Mr Wilson stressed the importance of the senior registrar grade in Accident and Emergency, doctors who are committed to a career in this field and who will be available to become a consultant when the opportunity arises. Dr Parken pointed out that AHAs needed to recognize that it would be difficult getting educational approval for senior registrar posts if the training facilities were not good enough.

The second question from the floor concerned the desirability of centralizing Accident and Emergency Departments. Mr Eversfield said that the DHSS target was 24 hour, centralized departments. There was no evidence that these were not working in urban areas, although there may be problems in rural areas. Dr Dallos endorsed this view, but also advocated better primary care and the use of health centres. She conceded that this might not be feasible in rural areas, but foresaw problems staffing a secondary service. Dr Cottier felt that centralized departments were a medical desirability and an economic necessity, even in rural areas, but he would like to see a specialty in 'transport medicine' developed. This led on to a discussion on small casualty units in community hospitals or health centres. One speaker suggested this would be a good idea in coastal resorts where there are seasonal peaking problems. The DHSS view is that the provision of casualty services in health centres is a matter for AHAs and GPs to work out between them, although apparently there are difficulties because the AHA cannot pay doctors working from a health centre whereas they can if they work from a small hospital.

A questioner from the floor asked the panel if they thought that deputizing services sometimes sent patients to Accident and Emergency Departments rather than treating them themselves. Dr Russell said that in a study of the use of Accident and Emergency services in Newcastle, the use of deputizing services seemed to influence the patient's choice of care. Dr Dallos suggested that the idea of continuing patient care by one doctor was becoming a myth and the important thing was to ensure cooperation between agencies.

There was a lively discussion about the merits of a two-tier ambulance service. Mr James said this might be desirable in metropolitan areas but was a lot more difficult in rural areas, where flexibility was required. It was suggested that highly trained ambulance men who mostly supplied a taxi service became frustrated. However it seemed from the discussion that the state of morale in the ambulance service varied from one part of the country to another and it was suggested that selected advanced training programmes could improve the situation.

Finally there was a question about training the general public in first aid. It was suggested that highly trained ambulancemen might train children at secondary school. There was some debate about whether the compulsory setting of the class room was the most cost-effective forum for training the general public. Dr Russell found in the Newcastle study that there very few accident victims were sent unnecessarily to Accident and Emergency Departments from school. On the other hand, Dr Wilson said it should be

possible to identify factories with high accident rates and the educational effort should be focussed there.

The discussion ran out of time at 4.30 pm and Mr Ashworth closed the conference by thanking the participants for their contributions.

SUMMARY

The following themes emerged strongly during the conference:

1. Despite concern about the closure of casualty departments, all the speakers favoured the centralization of Accident and Emergency services in District General Hospitals where the proper facilities and back-up specialists are available. At the same time GPs have an important role to play dealing with minor casualties (either in rural community hospitals or health centres) and also participating mobile immediate care schemes.

2. The speakers all agreed on the need to build up a specialty in Accident and Emergency services and to get such consultants into post.

3. There is a need to provide adequate training opportunities in Accident and Emergency departments to improve morale amongst junior medical staff.

4. There is a need to educate the public -

   a) in the proper use of Accident and Emergency departments
   b) in first aid, so they can provide immediate care

5. There is a need to pay greater attention to measures to prevent accidents.

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Requests for further information about this conference or suggestions for further related activities should be directed either to individual speakers or to: David Hands, Assistant Director, King's Fund Centre, 126 Albert Street, London NW1 7NF

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