*Accident and emergency services**

FROM THE COUNCIL OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

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The responsibility of general practitioners in England and Wales under Schedule 1 of the terms of service (National Health Service, 1972 revision)

(1) A general practitioner has an absolute responsibility for treating or obtaining treatment at all times for all the patients whom he has accepted on his list of patients, should they require it (paragraph 13 of the Schedule).

(2) He may, however, delegate this responsibility to another doctor whether or not he is a partner or assistant. In addition, if it is " . . . treatment which it is clinically reasonable in the circumstances to delegate . . . " then it may be given by a person " . . . whom the doctor has authorised and who is competent to carry out such treatment " (paragraph 16). This usually means a registered nurse.

(3) In this context a general practitioner must also consider to be his patients " . . . persons to whom he may be requested to give treatment which is immediately required owing to an accident or other emergency at any place in his practice area . . . ", provided that he is available to do so, has not legitimately delegated his work to a deputy (see above), and the person's own doctor is not available (paragraph 4).

The responsibility of the general practitioner is immediately reduced by referral of the patient to hospital for a second opinion or investigation.

Remuneration for treating accidents and emergencies

(1) For patients on his own list or that of a doctor for whom he is deputising (including ' temporary residents '), a general practitioner cannot claim a fee for emergency treatment unless it comes within the terms of a ' night visit '.

(2) For giving emergency treatment to casual attenders not on his list, a general practitioner can claim fees under the National Health Service. These range from £3.00 to £5.00 for various treatments relating to accidents and emergencies.

(3) For attending or treating any persons involved in a motor accident, whether his own patients or not, a general practitioner can claim a fee from the drivers of the vehicles under Section 213 of the Road Traffic Act 1960(b).

*Presented to the Employment and Social Services Subcommittee of the Expenditure Committee on 13 November 1973.

Distribution of the workload between general practitioners and hospitals

Very few figures are available and comparisons are difficult, but Dixon and Morris (1971) found that during a six-month period—in the same population of 11,500 people in Bristol—836 went ' casually ' to the Accident and Emergency Department, while 1,430 went to and were treated entirely at the health centre for similar minor conditions.

It is likely that general practitioners see and treat the majority of these cases all over the country, and that only a minority of people decide to go to a hospital first. Only one published study (Blackwell, 1962) has hypothesised about the factors contributing to this choice by the patient, which must reflect a wide range of social, psychological and medical dilemmas.

There is general agreement that about 30 per cent of attenders at accident and emergency departments are referred by their general practitioners, but of the remainder who refer themselves, only about ten per cent do so because they are unable to see their general practitioners.

There is also general agreement that about 60 per cent of the patients seen in accident and emergency departments could have been dealt with entirely by their own general practitioner.

Resources available to general practitioners in contributing to the management of accidents and emergencies

1. *Premises*

In 1969 Irvine and Jefferys reported that 71 per cent of general practitioners in health centres and 31 per cent of general practitioners in privately-owned group practice premises had access to a treatment room in the building. Of general practitioners not in group practice, only nine per cent had a treatment room.

The Royal College of General Practitioners strongly supports the provision of treatment rooms and related equipment in all kinds of premises. The siting, design and equipment have been the subject of several publications, exhibitions and symposia sponsored or published by the College. The Department of Health (1970) has also given detailed advice about their provision in health centres and in some rural areas the design, both of health centres and privately-owned premises, has been modified to allow the reception of stretchers for accidents and emergencies.

2. *Nurses*

Skilled nursing care is now considered to be indispensable in general practices, and particularly in the management of accidents and emergencies. A nurse can carry out a preliminary assessment either in the home or in the treatment room, and can interview casual attenders at the surgery. She can give first aid and, under the supervision of the general practitioner, more specific treatment. She can accept and manage cases referred back to the general practitioner from the hospital accident department.

Nurses are available to general practitioners by attachment from local health authorities, and about 80 per cent of practices now have attached nurses who work mainly in patients' homes. In addition, between 20 and 25 per cent of practices employ a nurse part-time, and these nurses work mainly in treatment rooms.

It is probable that neither group is adequately trained for accident work occurring in the community, although some of them may have had experience in accident departments in hospital. Dixon (1969) showed in a health centre in Bristol that the treatment room nurses there managed 77 per cent of the casual attenders entirely on their own initiative and responsibility.

Neither group of nurses does any night duty. It is, however, believed that some local health authorities are beginning to experiment with a night nursing system in patients' homes.

3. *Cottage and community hospitals*

The experimental ' community ' hospitals are not intended to provide an accident service (Oxford Regional Board, 1969) but general practitioners may share the facilities of a treatment room in the hospital as they do in many existing ' cottage ' hospitals, particularly in rural areas.

4. *Special emergency schemes for road accidents*

The Committee has received a memorandum from Dr Easton separately, and will be aware that similar schemes are being operated in Chester, Portsmouth, the Thames Valley and the South-west of England.

Training general practitioners for accidents and emergencies

The Royal College of General Practitioners has recognised some senior house officer posts in accident and emergency departments as suitable for training future general practitioners. The results of research, which will be available early in 1974, suggest that the level of supervision and teaching in a number of these posts fall below the required standard, and that their service component is too large for them to give proper training.

Reasons for the use of accident and emergency departments by general practitioners

(1) Referral of serious injuries and accidents.
(2) The need for special facilities e.g. x-rays, a general anaesthetic, or stomach washout.
(3) The need for observation of a patient e.g. head injuries or poisoning.
(4) The need for an urgent second opinion e.g. children with abdominal pain.

There should be no relaxation of the standards of communication and professional courtesies when a general practitioner refers patients in any of these situations.

The contribution of general practitioners to the work of the accident and emergency department

The Royal College of General Practitioners has produced a report jointly with the Royal College of Physicians (1972) which sets out their policy in relation to general practitioners working in hospitals.

A small proportion of the 25 per cent of general practitioners who hold part-time hospital appointments are working in accident and emergency departments. It is likely that most of them are simply providing a pair of hands but the Royal Colleges support the separation of accident work from the wide range of medical, social and psychological problems which are labelled with the term ' trivia ', and which also present in accident and emergency departments. General practitioners have special skills and knowledge for coping with these problems, and could make a major contribution both to this aspect of the work and to the ' triage ' function through suitable appointments, which might even include the full-time directorship of a department at consultant level.

Other than this, it should be remembered that there is a limit to the number of sessions which a general practitioner can give to hospital work and still remain an effective general practitioner for the patients in his practice.

If communications can be improved between accident and emergency departments and the local general practitioners, there is the possibility of general practitioners and practice nurses accepting early discharges of patients from the departments. There is even the possibility that this might reduce the duration of certified sickness following accidents.

Conclusion

There is much in common between general practices and accidents and emergency departments. In both the case-load is unpredictable and mainly unscreened and as well as major organic illness there are a large number of human problems and dilemmas which are at a loss for any other outlet.

The use of the word ' trivial ' should be replaced by a concerned attempt to look at the problems and perceptions of patients. More than any other section of the profession general practitioners can offer a rational approach to these problems, but the primary need is to define by appropriate research the issues in medical care which are hidden in the phenomenon of the casual attender at accident and emergency departments.

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