

Primary care: the old bugbear of accident and emergency services

APPROXIMATELY half of the patients attending accident and emergency departments in cities and urban areas present problems that could have been treated in general practice.¹ This workload has long been referred to as inappropriate. But with the National Health Service now emphasizing aims which include developing locally responsive services, using available expertise and resources efficiently, and achieving continuity of care across acute and primary care sectors,^{2,3} is this view still acceptable? What are the implications for general practice?

Traditionally, hospital staff have been unwilling to recognize accident and emergency services as a legitimate provider of primary care. The predominant view has been that primary care presentations are 'trivial', and cause prolonged waiting times, inefficiency, avoidable costs, and staff stress.⁴⁻⁶ However, labelling the use of accident and emergency services for primary care as inappropriate has done little to stem the demand.

Since the inception of the NHS, general practitioners have also been concerned about the use of accident and emergency services for primary care.⁷ This use throws into question the degree to which general practice services are responsive and comprehensive, and challenges the general practitioner's key role as gatekeeper to secondary care. A recent survey found that almost 90% of general practitioners preferred accident and emergency departments to redirect patients with non-urgent problems back to general practice without treatment.⁸ However, is this a practical, or indeed a desirable, policy?

There is no clearcut boundary between problems that belong in accident and emergency departments and those of general practice. As reports of triage and accident and emergency nurse practitioner schemes confirm,^{9,10} even experienced accident and emergency staff have difficulty in deciding which patients can be safely discharged without first being assessed by a doctor. Severity can only be confidently determined with hindsight. In addition, the accident and emergency department serves an important 'safety net' function, especially for vulnerable groups like the homeless, socially deprived, and psychologically distressed who may have difficulty negotiating the registration formalities, surgery hours and appointment systems of general practice.¹¹ Herein lies the conundrum: deciding which patients should be referred back to general practice requires clinical assessment, but in the patient's eyes this process alone may provide sufficient reassurance and reinforcement to vindicate their decision to attend an accident and emergency department.

In line with the new health service principles, the Royal College of General Practitioners has recently accepted a policy document that contains a more consumerist view of accident and emergency services than might previously have received recognition (RCGP council minutes, 7 December 1991). It discounts the view that patients are misdirected in using accident and emergency departments rather than general practice, but argues that accident and emergency's primary care function should be appropriately planned and provided for.

By legitimizing the provision of primary care in accident and emergency departments, however, a number of issues of relevance to general practice are exposed. Why do patients refer themselves to accident and emergency departments rather than attending their general practitioner? To what extent is the demand for accident and emergency primary care a proxy for consumer dissatisfaction with general practice?

The perceived availability, accessibility, competence, and convenience of general practitioner services are all likely to influence the use of accident and emergency services, but patient surveys indicate that the perceived need for urgent care is probably more influential than dissatisfaction with general practice *per se*.^{11,12} Improved communication between accident and emergency departments and general practice will facilitate the identification of strategies to increase the availability and accessibility of services. Developing aspects of general practice, such as increased provision of drop-in surgeries, practice nurses, and minor trauma care, may enhance the quality of primary care in the community, but their impact on the overall demand for accident and emergency primary care is less obvious. The demand for such care is influenced by a broad range of experiential, cultural, economic and other social factors.^{13,14} Developments in general practice alone, therefore, are unlikely to achieve a sizeable reduction in demand for accident and emergency primary care. On the other hand, the time consuming workload of routine activity imposed by the general practice contract discourages flexibility and responsiveness in practice organization, and so may indirectly result in an increase in demand for accident and emergency care.

The accident and emergency department is not an ideal place for practising primary care. The anonymous, stressful and hectic environment discourages patient-centred management. Accident and emergency medical staff tend to focus on excluding 'the serious' which, although appropriate for more life-threatening presentations, may lead to unnecessary investigations, referrals and treatments for patients with primary care needs.^{14,15} Inadvertently, this may result in patients believing that the knowledge and technology available in accident and emergency departments are superior to those in general practice, and so contribute to reinforcing future demand for accident and emergency services.¹⁶ Effective primary care requires psychosocial and community understanding, but accident and emergency staff generally lack postgraduate training in these areas. They have little knowledge or awareness of primary care capabilities in the community,^{17,18} and so are unlikely to encourage patients to make more effective use of them.

What part could general practitioners be playing in the development of accident and emergency primary care? One innovative model which may have wide applicability involves the sessional employment of general practitioners to see patients attending accident and emergency departments whom triage nurses identify as presenting primary care problems. This system is being developed and evaluated in the accident and emergency department at King's College Hospital, London.¹⁴ Considerable benefits in the effectiveness and efficiency of care have been found. In addition, the positive relationships that resulted led to the implementation of a primary care training programme for accident and emergency staff, acknowledgement of the contribution general practice skills can make to hospital practice.

The health service reforms are creating an impetus for fresh consideration of the role of primary care in accident and emergency services. The new contracting process between purchasers and providers encourages recognition of the breadth and diversity of primary care. In addition, it creates opportunities for more imaginative responses than would have previously been possible. For example, Lambeth, Southwark and Lewisham

family health services authority, jointly with the South East London Commissioning Agency, are now commissioning accident and emergency services for 1992-93 which include the King's College Hospital model of accident and emergency primary care. A number of other districts are considering similar plans.

Primary care in accident and emergency departments is no longer the bugbear of old. It is becoming a legitimate part of a more integrated health service. The potential for developing accident and emergency primary care is considerable, and general practitioners should be playing a leading role.

JEREMY DALE

Lecturer in primary care, King's College School of Medicine and Dentistry, London

References

1. Cohen J. Accident and emergency services and general practice — conflict or cooperation? *Fam Pract* 1987; 4: 81-83.
2. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555)*. London: HMSO, 1989.
3. NHS Management Executive. *Integrating primary and secondary health care*. London: Department of Health, 1991.
4. Driscoll PA, Vincent CA, Wilkinson M. The use of the accident and emergency department. *Arch Emerg Med* 1987; 4: 77-82.
5. Skinner DV. Accident and emergency services — radical restructuring is needed. *BMJ* 1990; 301: 1292.
6. Faroughi D, Chadwick L. Accident and emergency abusers. *Practitioner* 1989; 233: 657-659.
7. Crombie DL. A casualty survey. *J R Coll Gen Pract* 1959; 2: 346-356.
8. Morrison WG, Pennycook AG, Makower RM, Swann IJ. The general practitioners use and expectations of an accident and emergency department. *J R Soc Med* 1990; 83: 237-240.
9. Green J, Dale J. Health education and the inappropriate use of accident and emergency departments: the views of accident and emergency nurses. *Health Educ J* 1990; 49: 157-161.
10. Morris F, Head S, Holkar V. The nurse practitioner: help in clarifying clinical and educational activities in accident and emergency departments. *Health Trends* 1989; 21: 124-126.
11. Morgan W, Walker JH, Holohan AM, Russell IT. Casual attenders: a socio-medical study of patients attending accident and emergency departments in the Newcastle-upon-Tyne area. *Hospital Health Services Review* 1974; 70: 189-194.
12. Wood TCA, Cliff S. Accident and emergency departments — why people attend with minor injuries and ailments. *Public Health* 1986; 100: 15-20.
13. Calnan M. The functions of the hospital emergency department: a study of patient demand. *J Emerg Med* 1984; 2: 57-63.
14. Dale J, Green J, Glucksman E, Higgs R. *Providing for primary care: progress in accident and emergency*. London: Department of General Practice and Primary Care, King's College School of Medicine and Dentistry, 1991.
15. Andersen NA, Gaundry PL. Patients attending an accident and emergency department for primary medical care. *Fam Pract* 1984; 1: 79-85.
16. Bliss HA. Primary care in the emergency room: high in cost and low in quality. *N Engl J Med* 1982; 306: 998.
17. Reilly PM. Primary care and accident and emergency departments in an urban area. *J R Coll Gen Pract* 1981; 31: 223-230.
18. Dale J, Green J. How do nurses working in accident and emergency departments perceive local general practitioners? A study in six English hospitals. *Arch Emerg Med* 1991; 8: 210-216.

Address for correspondence

Dr J Dale, Department of General Practice and Primary Care, King's College School of Medicine and Dentistry, Bessemer Road, London SE5 9PJ.

Meningococcal infections and the general practitioner

DURING the last decade 1238 deaths in England, Wales and Scotland have been attributed to meningococcal infections.¹⁻³ Since younger age groups are particularly afflicted,⁴ this represents an unwelcome loss of young life, and is accompanied by a burden of morbidity related to the disease itself, its complications and its sequelae.

From the perspective of an individual general practitioner, however, symptomatic infection with meningococci is uncommon. Bearing in mind that the delay between suspicion of a diagnosis of meningococcal infection and treatment affect morbidity and mortality, it has legitimately been described as a diagnosis not to be missed and doctors of first contact are expected to have a knowledge of this condition out of proportion with their experience.⁵ Clinical presentation is varied, particularly with respect to cutaneous manifestations, if present. In reality, therefore, diagnosis is not always straightforward; retrospective studies of the accuracy of the clinical diagnosis given by general practitioners before their patients were admitted to hospital tend to confirm this.^{6,7} Thus, diagnostic vigilance needs to be maintained, and awareness should be heightened during winter and spring,⁸ during the course of a known local outbreak of meningococcal infection, and during outbreaks of respiratory viral infections, including influenza A,⁹ and mycoplasma infections.¹⁰

In the absence of contraindications, and in spite of reports

of emerging resistance,^{11,12} benzylpenicillin remains the drug of first choice for the treatment of meningococcal infections.¹³ Evidence for the benefit of early treatment has recently been reviewed.¹⁴ It seems to be generally accepted that a life saved by early, ideally intravenous, injection of an antibiotic outweighs the occasional failure to demonstrate pathogens in the cerebrospinal fluid.¹⁵ Shortly after general practitioners received a letter from the chief medical officer in 1988 recommending early treatment of meningococcal infections, a postal survey of general practitioners revealed that only 49% of respondents carried parenteral penicillin in their emergency bags.¹⁶ Participation bias may have concealed an even more disappointing result.

Communication is a key element of almost any infection control strategy. Notification rates for meningococcal meningitis in England and Wales have varied from 50%¹⁷ to 67%.¹⁸ In an ideal world, all suspected cases of meningococcal infection should be notified promptly, by telephone, to the responsible consultant in public health medicine or consultant in communicable disease control. The rapid identification of relevant contacts and appropriate administration of chemoprophylaxis (usually rifampicin) can then be coordinated with a view to preventing further cases, if possible. In the interests of good practice and compliance, contacts should be forewarned of the potential side effects of the chosen chemoprophylactic