General practice patients in the ED

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One of the mysteries of public policy is that at times the public discourse settles on a perspective that has either the flimsiest or indeed contradictory evidence. One such discussion relates to the factors that contribute to the congestion of hospital Emergency Departments (ED) in Australia.

Modern emergency medicine is a relatively recent phenomenon characterised by the reformation of 'Casualty' into ED, the emergence of new professions (Emergency Physician and Paramedic) and massive enhancements in the quality and quantity of staffing, resources and facilities. The net effect of these changes has been to concentrate acute medical care in EDs; both within the community and within the hospital. However despite these investments there remains both public and professional concern with the congestion of EDs and its clinical and organisational impacts.

There are many opinions as to the cause of that congestion but the evidence is clear. There are more people seeking care in EDs (increased demand) and EDs continue to experience difficulty obtaining access to ongoing care for their patients (Access Block). However despite the clarity of the evidence, many still believe that a major contributor is the "inappropriate" use of the ED by GP patients.

This edition of the Medical Journal of Australia (1) contains an article which compares four different methods of determining the proportion of GP patients attending EDs. One of these measures is used by the Australian Institute of Health and Welfare (AIHW), data from which is often cited in the public policy debate. The article finds that three of the methods derived from diagnostic and outcome criteria arrive at similar figures (approx 10%) while the AIHW approach relatively and grossly overestimates the proportion (>25%). This article again highlights the dichotomy between the tone of the public debate and the evidence.

In Australia, an average of 30 people in every hundred will attend an ED each year and that rate is growing across the country at 2% per annum (2). The reasons behind this growth in demand are unclear however demographic factors (including an ageing population), epidemiological factors (rising rates of chronic disease prevalence) and health system issues (including the scope and availability of primary care options) are likely contributing factors. The relative contribution of these factors is unclear as the growth in utilisation is across all age groups, amongst more urgent categories and highest for trauma (3).

However despite this evidence, the public and political discourse remains that the ED congestion is contributed to significantly by "inappropriate attendance" by "GP" type patients. Some imply this is a deliberate ploy by politicians and health bureaucrats to shift responsibility between tiers of government. However this perception is also contributed to by staff from within EDs who consistently tell the stories of the "bizarre" user. Thus any attempt to provide evidence to challenge this assumption may help refocus the debate onto the real causes.

This paper also challenges the very basis of the concept of 'GP patients' by demonstrating the diversity of measures. This study compares four different methods of estimating the "GP" load of

EDs. Each is potentially flawed. They are all statistical methods which do not (and cannot) take into consideration the particularities of each case. Additionally they are based on urgency, diagnosis or outcome, none of which is predicable by the patient when exercising their choice of where to obtain urgent medical advice. Extensive research around the world into the concept of inappropriate attendance or GP patients demonstrates not only a variable rate ranging from 4.8% to 90% but also demonstrates exceptional variability between clinicians (4).

Interviews with actual patients have shown that the vast majority genuinely perceive they have an urgent illness and need urgent advice (5-7). It is a 'big ask' to impose on the patient a quality of clinical judgement for which they do not have the expertise but in fact are seeking that expert judgement from health professionals. Put simply, it is unreasonable to say that a patient's choice of location of care is 'inappropriate' when after assessment by a health professional they are determined to require admission to hospital, a diagnosis of significance or an urgent rating; or not.

The authors of this article reach the correct conclusion that the AIHW method grossly overestimates the load of GP patients. We concur that the AIHW method is false and the least accurate and should not be used. The use of the ATS categories 4&5 as a surrogate indicator of "inappropriate" attendance represents a complete misunderstanding of the concept of urgency and its difference from complexity and from severity. These three concepts are different although complementary. Of particular note is that 38% of patients who die in hospital are ATS category 4 or 5 on arrival (8). These are often sick people if not necessarily urgent.

However, we contend they all four definitions are incorrect. The real definition of a GP patient must be crafted around the exercise of judgement of a reasonable lay person who in possession of a level of average intelligence and knowledge would reasonably have chosen to seek medical care from a GP.

The problem is complicated even further by the definition of a GP and therefore a GP patient. Reasonable patients may well seek attention from GPs if those services are available when required and the GP has the requisite skills, resources and facilities to meet the patient's needs. Many patients seen in EDs could be managed by an experienced GP with access to radiology and procedural facilities but could not be handled by inexperienced GPs required to see patients every 10-15 minutes in an isolated practice. Many GPs have narrowed their scope of practice and therefore lack the skills, confidence and facilities to provide even low complexity trauma care. Further, the nature of community care means that any necessary investigations require further appointments and travel. The "one stop shop" attraction of EDs could be matched by integrated health clinics.

It is also important to emphasise the point that notwithstanding the difficulty in defining GP patients, they are not a significant contributor to ED congestion accounting for less than 5% of ED length of stay (1,9).

We appeal for a more rational basis to this discussion and thank the authors for their contribution.

Firstly we contend that there are not GP patients or ED patients or outpatients or inpatients there are just patients and their needs for medical care. The challenge for our health systems is to

understand those needs and provide accessible and quality health services that meet those needs. Our failure to do so should not be excused by blaming the patients.

Secondly we need to understand that there is increasing demand for acute health care from a growing and ageing population with growing chronic disease prevalence. We should understand that need and attend to the capacity constraints that are the real cause of the current system wide congestion.

Finally we need to better compile the evidence to inform the public debate and identify ways in which that evidence can be made accessible to those responsible for policy making. Therefore counter the influence of the ill informed and the conspiratorial.

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