Why do patients choose the emergency department?

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Imagine the mother of a toddler with a cough and fever. With advice from a friend she manages to observe her precious patient over the weekend. However, as the week progresses her child doesn’t progress as well. Her friend encourages her to go to the hospital, and suggests her general practitioner (GP) would refer her there anyway.

She calls her GP but can’t get an appointment until Thursday. She thinks it is probably not serious but worries it possibly could be pneumonia. She appreciates the Emergency Department (ED) is a free, few questions asked, 24/7, accessible service. She is aware there are alternative clinics in the community but she’s not sure what the difference between them is, nor what are the conventions around their use, and they seem similarly removed from her usual GP as is the hospital.

So, she goes to the ED. There she reads a sign urging her to keep the Emergency Department for emergencies. She’s not quite sure what constitutes an emergency and whether hers is sufficiently worthy. After explaining that her toddler has had a cough for 4 days she is gently chastised and told that the relative nature of her emergency has earned her a long wait. Eventually her child is examined, medicated, and discharged with a prescription to complete over 7 days. She takes him home, happier, but none the wiser.

In this issue of the Journal, Jones and Thornton review the New Zealand literature about the reasons people go to the ED when they might have gone to a GP. They conclude that the cost of the GP is not among the main reasons for this choice. Rather, they conclude, patients go to the ED mostly because they believe the ED is the right place to go. My knowledge of the international literature and unpublished surveys done at some of our DHBs, is concordant with their findings—that a belief that the ED is the appropriate choice is the main reason people choose the ED. Of course, cost does feature among the reasons, as does an inability to access a GP, (particularly the patient’s own GP) in a timely fashion, but these are not the main drivers.

One evening on the television news there were two stories about health. One told a hospital story and the other one a story based in the community. In the first, the reporter spoke outside a public hospital and referred to the ‘A&E’ therein. In the second, the reporter spoke outside an Accident and Medical Clinic and referred to it as ‘A&E’. Neither was an ‘A&E’. Indeed, there has not been an A&E in New Zealand for over 20 years. However, we have a confusing plethora of EDs, A&Ms, After Hours Clinics, Urgent Care Clinics, Integrated Family Health Centres, GP Surgeries, and so on.

In 2006, in this Journal, Richardson and colleagues published a paper concluding that health professionals couldn’t agree about what constitutes an appropriate presentation to an ED. Richardson has gone on to complete a PhD thesis on this issue, reaching the same conclusion after very comprehensive consideration.
If educated and informed journalists don’t know that we don’t have A&Es in New Zealand, nor the difference between an ED and a community based primary care facility, then how might we expect our potential patients to know where to go when they have a need for care? If we, as health professionals, can’t agree what constitutes an emergency appropriate for an ED, how might we expect our potential patients to work this out from an evolving constellation of symptoms?

We expect our patients to navigate a complex health system we don’t understand ourselves and then, when we perceive they get it wrong, we blame them for being either insufficiently knowledgeable or inappropriately frugal. We should be better than this.

In June, 2011, the Ministry of Health’s Shorter Stays in the ED team, with input from the Primary Health Care Implementation team, the Ministry’s ED Services Advisory Group, the Australasian College for Emergency Medicine and the Royal New Zealand College of General Practitioners, and after wider consultation with the sector, published a document entitled; Guidance for New Zealand emergency departments regarding the interface with primary health care.\(^3\)

This document is unique and valuable, particularly exploring how the relationships between EDs and primary care influence the way we manage our patients. It states that ‘GP’ patients are not, as many imagine, a major contributor to ED overcrowding. However, it emphasises that primary health care is the principal provider of both routine and urgent health care to the New Zealand population, providing continuity and coordination of health care for individuals, and that EDs provide episodic ‘crisis’ care for people who perceive the need for acute or urgent care.

Those who present to an ED should not be ‘triaged away’ nor denied care in any other way. However, just as an ED will refer a patient with a perceived cardiac problem to a cardiology service, or a patient with possible appendicitis to a surgeon, so should it refer a patient to primary health care if, after adequate assessment, it is clear that the ongoing management of their condition can best be provided by primary health care. In doing so the ED is not providing primary/GP care—it is providing emergency medical care—just as referring a cardiac problem to a cardiologist is not doing cardiology, nor a surgical problem to a surgeon, is not doing surgery.

The document should be read to better understand how it addresses these, and other relevant issues but, suffice it to say, it encourages clarity around our relative roles and relationships. Finding such clarity among ourselves is an important step towards providing clarity to our patients, so that they might better access the most appropriate care for their needs.

**Competing interests:** Mike Ardagh is the National Clinical Director of Emergency Department Services with the Ministry of Health, a position also known as ‘Target Champion’ for the Shorter Stays in the Emergency Department Health Target.

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References:

