LETTERS TO THE EDITOR

Accident and emergency medicine or emergency medicine?

EDITOR,—In 1990, after debate and a vote at the Annual General Meeting, the name of our organisation was changed from the Casualty Surgeons' Association to the British Association for Accident and Emergency Medicine. I submitted an amendment to the effect that the words "Accident and" should be dropped from the new name, making it simply the British Association for Emergency Medicine. I did this because I believed the word Accident was unnecessary and indeed something of a tautology. I felt that, if we were going to make such a significant change, we should do so in a bold and imaginative way, to conform with sister organisations throughout the English speaking world. My amendment was defeated and I can understand the reasons for this.

I now feel it is time to reopen this debate. I believe, given the changes which are happening within the specialty of general medicine, there is a risk that we may lose the right to the title "Emergency Medicine". I believe it is very important that this does not happen, especially because we appear to be assuming the role of emergency physician to an ever increasing extent. I feel that the letters' page of our journal is an appropriate place in which to have such a debate and I look forward with interest to hearing what other practitioners of "emergency medicine" have to say on this subject.

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Planning cannot rely on emergencies arriving by ambulance

EDITOR,—Snooks *et al* have recently reviewed the literature on the appropriateness of emergency ambulance usage.¹ We agree that it is important for ambulance services to understand the factors that influence the public in their decision to phone 999. It is hoped that in the future non-emergency ambulance calls may be able to be dealt with by other means, for example telephone advice. Studies of inappropriateness of use do have downsides in helping with future strategies. We must also study the other side of the coin—the inappropriate failure to use an emergency ambulance. Triage categories 1 and 2 in the national scale represent those who the triage nurse believes need urgent care. Therefore we believe it is reasonable to presume that an emergency ambulance is appropriate for these cases. The converse is not, however, true as immediacy of treatment on arrival is only one criterion. For example, the paramedic may have undertaken treatment that means accident and emergency (A&E) treatment is less urgent.

We recently undertook a pilot study to determine the possible extent of this effect. A sample of consecutive records was retrieved from the computerised records of a large inner city A&E department. Information was obtained relating to mode of arrival of the patient and triage category on arrival. Triageing was undertaken according to the Manchester

guidelines and the national consensus on target times is utilised (that is category 2 has a target time of 10 minutes and category 1 needs immediate attention).²

In 10 079 cases, 885 were triaged as category 1 or 2 in a one month period. Altogether 2310 cases were transported to hospital by ambulance; 3265 had an unspecified means of transport. At least 23.4% of triage category 1 and 2 patients presented to the A&E department by routes other than the ambulance service (details are shown in table 1).

Those not arriving by ambulance will be unannounced. They demonstrate the need for advanced skills to be immediately necessary. All staff, medical and nursing, should be trained to care for the first few minutes of an emergency. To this end nursing staff as well as junior doctors need to become providers on the various life support courses.

Advice lines (for example NHS Direct) may increase the workload for the emergency ambulance service. Although those using the ambulance service inappropriately may decrease, by diverting them to other sources of care or transport there are others who would be appropriate for ambulance service care who do not utilise it. It may also engender an attitude of 24 hour care whatever the severity.³ Using the figures of Snooks *et al* of 30–52% of ambulance cases being inappropriate, this would extrapolate to 693–1201 cases in our study population of 10 079 A&E attendances. But if all category 1 and 2 used an ambulance this would give an extra 207–453 triage category 1 and 2 cases (depending on how many of the "unspecified" were actually ambulance cases). This analysis cannot determine how many extra category 3 patients may result by more appropriate use of an ambulance rather than public transport.

In planning, it is vitally important to consider those who fail to utilise the emergency system when it would have been appropriate, as well as those who use it inappropriately. In A&E we are oblivious of those who could have appropriately used A&E services but either sought treatment elsewhere or treated themselves. Education may therefore increase workload rather than decrease it.

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1 Snooks H, Wrigley H, George S, *et al*. Appropriateness of use of emergency ambulances. *J Accid Emerg Med* 1998;15:212–18.

2 Manchester Triage Group. *Emergency triage*. Mackway-Jones K, ed. London: BMJ Publishing Group, 1997.

3 McKee L. Telephone advice scheme criticised. *BMJ* 1998;317:429.

Table 1 Mode of arrival by triage category

Mode of arrival	Triage category 1+2 (%)
Ambulance	431 (48.7)
Car	183 (20.7)
Other	10 (1.1)
Police	1 (0.1)
Public transport	7 (0.8)
Walking	6 (0.7)
Not specified	247 (27.9)
Total	885 (100)

The authors reply

Cooke and Jinks refer to an issue not explored in any of the papers reviewed in our article: that of patients who do not use the 999 service when it would have been appropriate to do so. In searching the literature for this review paper, we found only one paper that addressed this issue,¹ although there are papers that have analysed sources of delay in arriving at definitive care in certain conditions such as myocardial infarction and stroke (in the US)^{2,4} and have concluded that calling an emergency ambulance is the most appropriate action to take.

Like Cooke and Jinks, Schuman *et al* examined a sample of patients attending an emergency room, divided them into (three) categories of urgency, and determined whether they had arrived by ambulance or not.¹ The study was much smaller than that of Cooke and Jinks, but a similar proportion of patients in a life threatening condition (12 out of 220) had not arrived by ambulance.

Turning again to the figures quoted by Cooke and Jinks, it is possible to construct a 2 × 2 table showing the distribution of all patients in their study according to level of urgency and ambulance transport. This table is reproduced here for clarity (table 2).

Although 454 patients in triage categories 1 and 2 did not use the ambulance when it might have been appropriate for them to do so, 1879 patients *did* use it when it might *not* have been appropriate for them to do so. We acknowledge, as Cooke and Jinks suggest, that the condition of patients at triage in A&E might be substantially different from how they presented to the ambulance crew on arrival at scene, particularly in some cases such as hypoglycaemia or asthma, but we doubt that this condition applies to over 80% of ambulance transports (1879/2310). With a rate of between 30–52% of 999 call-outs assessed as inappropriate, and the development of alternative emergency routes such as NHS Direct, it is difficult to see that, overall, the appropriateness of usage of the 999 service cannot be improved.

Cooke and Jinks' second point relates to the possibility that advice lines might increase the workload for the emergency ambulance service. A recently published study may give some insights into this.⁵ In a year long randomised controlled trial of a nurse telephone consultation service in an out of hours general practitioner (GP) cooperative, 50% of calls were managed by nurses without reference to a GP. The number of cases who had called the service and who attended A&E within the next three days was equivalent in both arms of the trial. Because of its blinded nature, however, this study was not able to examine the rise in demand over time engendered by the new service, and demand management remains a subject for research.

We thank Cooke and Jinks for drawing attention to the "other side of the coin", a relatively neglected issue in the debate about appropriateness of use of the emergency ambulance service. We have yet to see how much planned developments can influence the practice of patients, carers, and GPs. It is clear, however, that we need to understand our current workload and factors that influence demand

Table 2 Distribution of patients in study of Cooke and Jinks

	Ambulance	No ambulance	Total
Triage 1 and 2	431	454	885
Triage <1 or 2	1879	7315	9194
Total	2310	7769	10079