Satisfaction with the accident and emergency department – a postal survey of general practitioners' views

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Abstract

Objective—To survey general practitioners' opinions of the quality of care offered by an urban accident and emergency (A&E) department.

Methods—A postal questionnaire was used. The questionnaire addressed issues of patient treatment, communications between hospital and GPs, and the GPs' perceptions of patient satisfaction. Questions required graded responses. Response rate was 57% (91 of 160 GPs mailed).

Results—96% and 91% of responders respectively were satisfied with patient assessment and treatment, and 70% were satisfied with the explanation given to the patient. Problems were highlighted in communications between the department and GPs. 68% reported that adult patients always/usually gave their practice a hand written letter detailing their initial A&E attendance. Concerns were expressed about the content, illegibility, and inconvenience of this form. 42% of GPs reported never/rarely receiving a typed summary of patients discharged from the A&E review clinic. 28% of GPs would have appreciated a telephone call from the department on occasions. The areas of most patient dissatisfaction were perceived by GPs as: waiting time (67%), communication (19%), staff attitude (7%), and actual treatment (7%).

Conclusions—A postal survey of local GPs can give valuable information about the quality of care provided by a hospital department. Overall GP satisfaction with the service was high, but there are concerns about aspects of written and telephone communications between the department and GPs, which can be addressed.

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Key terms: accident and emergency department; general practitioner; quality of care assessment

Quality of care in medicine continues to grow in importance. For provider units in the new NHS, the expectations of patients – the consumers of care – must be met where practicable. As the contracting process becomes more sophisticated, so purchasers have increasing power and influence to specify the nature of secondary care provided, with a particular emphasis on audit and quality issues.

In accident and emergency (A&E) medicine there are several avenues open for studying quality of care: simple data on waiting times, analysis of complaints, patient satisfaction studies, and outcome data. All have their uses and limitations. While analysis of death and major trauma (for example, the major trauma outcome study) will measure a department's response and capability in the most challenging situations, the majority of cases are such that even suboptimal care is likely to lead to an acceptable outcome. By contrast patient satisfaction surveys tend to exclude the most serious cases. They consistently reveal high overall satisfaction while highlighting long waiting times and poor communication from nursing and medical staff as sources of dissatisfaction.^{1 2} Performing such surveys at the time of initial presentation means that the outcome for the respondents is not known, while retrospective surveys may suffer from recall bias and poorer response rates.

Historically, primary care has had limited influence over the nature of secondary care. General practitioners (GPs) in particular are underused in the evaluation of secondary care. They have traditionally been the patient's advocate and can maintain a healthy independence in their role as the link between primary care and hospital institutions. Furthermore, they see the after effects of good or poor hospital care once patients are discharged back to the community. Many GPs – not just fundholders – have expressed enthusiasm for having direct involvement in the commissioning of health services.³ Despite this, their opinions as a group have rarely been sought. A postal questionnaire has been shown to be an acceptable and accurate method of obtaining GPs' views about the quality of available secondary care.^{4 5} It was therefore decided to use this method to ascertain local GPs' views on the quality of service provided by the A&E department at the Royal Victoria Infirmary, one of the two major units in the city.

Methods

All 160 GPs registered with Newcastle upon Tyne family health services authority (FHSA) were sent a postal questionnaire. This addressed issues of patient treatment, communications between hospital and GPs, and the GPs' perceptions of patient satisfaction. Questions required graded responses which have subsequently been compressed for ease of interpretation and there was also scope for additional comments. A covering letter on the

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front of the questionnaire could be detached to allow for completion and return to be anonymous.

On initial A&E attendance, the notes made by the doctor are written on a green sheet with a white backing card. The green sheet is intended to reach the patient's GP by hand, while the white card is kept as the A&E record. In children and some adults this letter is forwarded by post instead. The 18% or so of patients who attend our A&E review clinic have a typed letter posted to their GP on discharge. Questions addressed the effectiveness of these procedures.

Statistical significance was measured using the χ^2 test.

Results

Replies were received from 91 out of 160 GPs (57%). The first four questions asked about the GPs' level of satisfaction with patient management in the department (table 1). This was generally high, but significantly lower for patient explanation and follow up than for assessment and treatment ($P < 0.01$). There were four adverse comments about inappropriate consultation with the GP following attendance at the A&E department, especially where dressings or sutures should be managed by the practice nurse.

In a series of questions about communication between A&E and GP practices, 68% of responders reported always/usually receiving their copy of the green form from their adult patients; 54% always/usually received those sent by post promptly; 31% always/usually received a typed discharge summary on those patients discharged from the A&E review clinic. Table 2 lists the opinions about the level of information in these letters. There were 15 unfavourable comments about the green form – illegibility (4), missing or inaccurate information (staff names, referral source, patient disposal) (5), lack of brevity (2), size (2), and late arrival (2).

In a separate question about telephone communication we asked if the A&E department had failed to contact the practice by telephone when this should have happened. Twenty out of 86 replies (23%) stated this had never been the case; 42 (48%) that this was a

Table 3 GP perception of patient satisfaction

A How often do patients express an opinion about the quality of service in our department? (n = 91)	
Always/usually	5 (6%)
Sometimes	52 (57%)
Rarely/never	34 (37%)
B Nature of patients' opinions (n = 87)	
Always/usually favourable	37 (42%)
Sometimes critical	40 (46%)
More often/always critical	10 (12%)
C Most likely source of patient dissatisfaction	
Waiting time	72 (67%)
Communication	20 (19%)
Staff attitude	8 (7%)
Actual treatment	7 (7%)

rare event; and 24 (28%) that this happened sometimes/often.

The final series of questions asked about the GPs' perceptions of patient satisfaction and these responses are summarised in table 3.

Discussion

PATIENT SATISFACTION BY PROXY

This study suggests that patients do comment to their GPs about their hospital experiences and that they may express criticism that stops short of a formal complaint. The GPs' perception of the causes of patient dissatisfaction tallies with results obtained from analysis of complaints and patient satisfaction surveys. Waiting time is strongly correlated with discontent and in our survey it was cited as the main problem 67% of the time.

Sometimes the delay is due to a series of waits for investigation, treatment, and finally discharge. Nurse practitioners and primary care doctors in A&E units may improve waiting time but are not widely used because of a lack of resources.

Evaluation of the impact of triage on patient satisfaction is mixed.⁷ It may give valuable information to patients on the likely delay involved in an A&E attendance at an early stage, or it may increase the overall visit time. By contrast, staff skills in communicating with patients (19% dissatisfaction) can always be improved by increasing awareness and training. The wider use of written patient information can increase patient recall and therefore compliance with advice given.

RESPONSE RATE

Interpretation of the results must be cautious in view of the response rate of 57%. This is well within the range expected from a postal survey and may in real terms be higher than this once local factors are considered. There is a second major A&E department situated in the West End of Newcastle upon Tyne, so a number of GP practices contacted would have only limited contact with the Royal Victoria Infirmary and thus little incentive or ability to comment constructively on its A&E service. This cannot be proved, as a high proportion of responders did reply anonymously; attempts to track down non-responders would have led to loss of this anonymity and presumably inhibited expression of criticism.

COMMUNICATION

Our results confirm that communication between hospitals and GPs is a highly relevant

Table 1 Details of GP responses about patient management

Satisfaction with	Number (%) satisfied	Number (%) not satisfied
(a) Clinical assessment	87 (96%)	4 (4%)
(b) Treatment	83 (91%)	8 (9%)
(c) Advice and explanation to patients	63 (70%)	27 (30%)*
(d) Instructions for follow up at the practice	63 (69%)	28 (31%)*

* $P < 0.01$ compared with (a) and with (b).

Table 2 Amount of information in written communication to GP

	Too much	About right	Not enough
(a) Green sheet	12 (15%)	69 (83%)	2 (2%)
(b) Typed letter	0 (0%)	68 (96%)	3 (4%)

issue. The precise format of the casualty record forwarded to the GP presents difficulties. The green form must contain more than just the essential summary details required by GPs as it is often the only basis from which to defend a complaint against the A&E department. The alternative of posting a computer generated letter to GPs also has drawbacks. Such letters are generated by diagnostic coding; the quality of the letter is only as good as that of the coding. GPs may receive letters that are inaccurate or late, and there may not be the facility for free text.

The department aims to send a short typed summary on the 18% or so of attenders that have been discharged from the follow up clinic. It is disappointing that only 28/90 (31%) of GPs reported always/usually receiving this communication but this may in part reflect the relative infrequency of an individual GP's patient attending the clinic. At least 96% of those able to comment indicated that these letters contained about the right amount of information.

CONCLUSION

We conclude that a postal survey of local GPs can give valuable information about the quality

of care provided by a hospital department. Overall GP satisfaction with the service was high, but there are concerns about aspects of written and telephone communications between the department and GPs, which can be addressed.

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