LETTERS

Patient satisfaction and healthcare providers

We read the article by Sandhu *et al*[1] with great interest. It is always encouraging to see good research addressing the changing contributions to better patient care made by different groups within the emergency department team. However, we were concerned with their conclusion that 'patients appeared to be more satisfied with Emergency Nurse Practitioner (ENP) consultations than with Senior House Officer (SHO) consultations', as we feel that the evidence presented does not support this.

The unadjusted patient satisfaction score was higher (9.3) for ENPs than for SHOs (8.8), but there are two large potentials for bias that were not addressed in the discussion. Both relate to the large difference in the proportion of patients with injuries seen by each group: 9.2% for SHOs and 80.4% for ENPs.

Firstly, this difference could be due to selection of patients. The paper does not describe how patients were allocated to different groups of healthcare providers (HCPs), and the figures would strongly suggest the allocation was not random. If ENPs were allowed to choose which patients they saw, then it is hardly surprising that their own satisfaction ratings were highest. Patients may also be likely to be more satisfied with a consultation with which the HCP is more confident and comfortable. It is also possible that HCPs could deliberately select patients they considered would be uncritical.[2]

Secondly, the proportion of patients with injuries could help to determine the satisfaction rating. It is plausible that patients with injuries will be more satisfied than those with non-injuries, as the latter might be more chronic, less easy to diagnose and less easy to treat in the emergency department setting. Injuries might be more acute, with a more clear diagnosis and straightforward treatment plan.[3]

The study may merely have demonstrated that patients with injuries, selected out by HCPs who feel most comfortable treating their condition, are more satisfied with their consultation than patients with minor illness. Many readers might consider this to be an obvious truism.

Furthermore, the study did not make clear whether those SHOs were also having to manage patients elsewhere in the department, potentially adding further to their stress, which may have an impact on perceived satisfaction.

What the study does suggest is that despite the biases described, SHOs and ENPs performed well, and middle grades performed best in all areas of patient satisfaction. There is a role for all professional groups within the emergency department but more balanced comparisons are required to fairly judge the satisfaction associated with each group.

Lastly, as emergency medicine continues to develop as a consultant-delivered service, it becomes less relevant to make comparisons with the most junior of the medical training grades. A Certificate of Completion of Training identifies the holder as a fully-trained emergency physician and future studies of quality of care should make comparison with this reference group.

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Boosting interface medicine

There are two types of doctor who remain at the interface of healthcare and society—general practitioners (GPs) and emergency medicine (EM) consultants. GPs manage millions of patients encountered in the community and skillfully refer to secondary care. EM doctors treat emergency cases and admit patients needing specialist hospital care.

What becomes immediately obvious at the outset is that GPs and EM consultants are an endangered species of doctors belonging to the "jack-of-all-trades" family. Their role is essential to ensure that hospital beds are used efficiently for the patients who need them most. The more the National Health Service supports and develops "interface medicine", the more cost-effective and efficient hospital care will become. As a result, we have recently seen a drive in advancing GP training to 5 years and the emergence of GPs with special interests. Longer training and specialist skills allow GPs to manage more patients and reduce the pressure on expensive hospital care. At the moment, EM trainees can specialise and gain accreditation in paediatric EM and intensive care medicine and gain expertise in more specific areas—for example, echocardiography, ultrasonography and toxicology.

What I would like to see is an expansion of EM to include specialisation in surgery too. Trauma is part and parcel of EM, and it is only logical that EM training include full basic surgical training and skills to deal with common surgical emergencies. This allows EM doctors to follow patients from the emergency department to the theatre. Rest assured that this would never replace the leadership of surgeons in the theatre, nor will it detract from the caseload of our surgeon colleagues, but rather decompress some of the pressures of on-call surgical admission. The development of surgical skills encountered in early orthopaedic and trauma training (eg, fracture reduction) and general/vascular surgery (eg, stab wounds, abscess drainage and haemorrhage control) by EM doctors as a subspeciality would allow greater flexibility when surgeons are not around and buy time for critically injured patients. As with the expansion of roles in general practice, surgical specialisation in EM would reflect a much needed boost in interface medicine and allow hospital specialists to reduce waiting times for complex elective admissions.

For me, personally, it would certainly mean greater satisfaction—I want the diversity of EM but at the same time yearn to acquire surgical skills and take part in theatre, something that I am sure many others would like too.

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BET 1: Which is the best clinical test for diagnosing a full thickness rotator cuff tear?

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The correct authors are Stephanie Pugh, Michael Callaghan, Craig Ferguson.