GUEST EDITORIAL

Gently adjusting open doors

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Most accident departments face annually increasing workloads and many departments have medical staffing problems and inadequate numbers of nurses. This means less time for those patients who need us most. The definition of the inappropriate attender may be debatable and the level of abuse variable but most would agree that at least one, and perhaps two patients in five attending could easily be dealt with elsewhere. Most departments have adopted a policy of resignation to this situation,—after all, someone has to see them, and a community service is provided—but this care is given at the expense of poorly patients. A small number of departments have tougher criteria as to whether a patient is attended to or not—if the problem is over a day or two old, a patient will only be seen if they are referred by a general practitioner; but many serious problems take time to develop, and further damage may be caused by rigid rules imperceptively applied—and the importance of patients being able to obtain urgent second opinions has been recently illustrated (Jones & McGowan, 1989).

This vexatious problem has been the subject of discussion (Editorial, Brit. J. Acc. Em. Med., 1986) for years. Increasing public perception as to the nature and urgency of their problems and a better understanding as to where a particular difficulty can most reasonably be resolved should help (though such insights also expose our Health Service inadequacies). Some general practices and accident departments provide pamphlets indicating their facilities and range of responsibilities.

Some attenders could be managed comfortably by a nurse practitioner, leaving doctors free to concentrate on more pressing problems; surely, however, the nurse practitioner would function best at the health centres seeing those very people who should not be attending our accident departments. It has also been suggested that the problem be accepted and a department formally provide a general practice service. This may work for some departments with particular circumstances (O'Driscoll *et al.*, 1987) but is not the answer for most of us who lack both staff and space to handle such an invited increasing flow.

Our Health Service is changing whether we like it or not. District managers struggling with limited budgets may turn their cold fiscal eyes on an accident department which sees all and sundry. General practitioners are expected to be more

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accessible and handle modest 'casualties'— many do so already, but the appointments system and lack of financial incentive to deal with cases requiring time and material (such as suturing) are two reasons why patients come our way. More emergency appointment slots, the availability of a nurse practitioner at health centres and a fee for certain items of 'casualty' service would encourage the shift of patients back to primary health care.

Recently we introduced 'Extended Triage' into our Accident Department. We encourage general practitioners and other primary health carers to discuss all referrals by telephone with our Triage Nurse rather than simply sending the patient in. We also like members of the general public to phone themselves in whenever this is practicable. In this way the problem is made known to us and the propriety and timing of a visit can be discussed.

This system provides us with a measure of notice of impending workload which can, to an extent, be controlled by the Triage Nurse. Unannounced patients are triaged in the traditional manner but patients whose difficulties can best be handled by their general practitioners are referred back by letter or telephone. Such arrangements require the support of general practitioners, management and local people. 'Extended Triage' could be an answer to our unpredictable and increasingly heavy workload.

REFERENCES

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