COPING WITH ACCIDENTS AND EMERGENCIES: A STUDY OF HOW THE COMMUNITY USES THE HOSPITAL ACCIDENT AND EMERGENCY DEPARTMENT

One Volume

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DECLARATION

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SUMMARY

The problem over the use of accident and emergency departments was portrayed in terms of a typical conflict between professional and lay needs. However, in contrast with the more common image of the professional hospital doctor successfully developing both structural and interactional strategies for maintaining professional dominance over the patient, it was argued that the structural characteristics of the accident and emergency department posed control problems for the profession. These control problems were exacerbated by developments in other areas of the health service and led to the development of policies which emphasised both clinical and social elements of patient need. Although there was apparent recognition by providers of the importance of taking into account patient need, the proposed policies were based on professional images of how patients "ought" to use the service. What was clearly lacking were comprehensive data on how the public and the community actually used the service and why.

This study set out to identify how, where, when, and why people used the accident and emergency department at a district hospital. Emphasis was placed on the need to understand the patterns of help-seeking behaviour from the views of the patient and others involved in decision taking in emergency and accident episodes; and a sociological framework was adopted as a means of describing such a perspective. The data were derived from detailed interviews with a random sample of 637 attenders at an accident and emergency department. These data were supplemented by a series of in-depth interviews with patients and others involved in

sixty episodes selected from the main random sample.

The results identify three categories of user. First, patients who were referred by general practitioners or their receptionists. In these cases the accident and emergency department appears to be fulfilling both a complementary and substitutory role for the general practitioner. Second, a large group of patients were referred directly by representatives of the community such as the police, teachers, employers and bystanders. It was evident that the accident and emergency department was fulfilling a role as a "community" emergency service. The third group were the patients and their families who went directly from home to the accident and emergency department. Many of these patients presented with traumatic conditions such as cuts, and for them the hospital accident and emergency department was the most appropriate place for the treatment of these conditions.

The theoretical implications of these and other findings are discussed and various policy proposals were evaluated in the light of these findings.

CHAPTER 1

Introduction

'The one thing that has dogged us in this field is our inability to get away from the public.'

Quotation from Consultant, Accident and Emergency Department, about the relative failure of professional development in this field.

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1.1 The Accident and Emergency Department: Arena for Conflict

In recent years considerable concern has been expressed within and without the medical profession about the type and quality of service available in 'emergencies'(1). Patients and their representatives have expressed concern about the increasing difficulties of obtaining a general practitioner in an emergency(2). This apparent or real difficulty in being able to contact a GP has been blamed upon changes in organisational arrangements in the delivery of primary care which have, it is claimed, created a barrier between the general practitioner and his patient (3). These organisational changes include the growth of appointment systems and deputising services (4), the increasing use of receptionists and the apparent increased unwillingness of general practitioners to carry out home visits and visits at unsocial hours (5). Thus it appears that the patient population is becoming increasingly dependent on both the

ambulance service and the accident and emergency department when they want medical care urgently[6]. In addition, there is some evidence that an increasing number of patients use the accident and emergency department either as their specialist treatment centre for all types of injury or as a substitute for their family doctor[7]. Therefore, some patients appear to be attempting to maximise their choices of sources of primary medical care. However, the availability of the hospital service has also been limited by the introduction of a policy of centralisation which has either led to restrictions on opening times in smaller casualty departments or the closing down of local community hospitals altogether[8].

On the other hand those involved in organising and running the emergency service have identified a number of problem areas which are different from those which concern the patient[9]. Their attention has been focussed mainly on the accident and emergency department in the hospital and they have been attempting to define more specifically the 'true' functions of the department[10]. Definitions of function vary between different medical interest groups. Some argue for a service which specialises in the treatment of trauma[11] and others have proposed that the department should be the focus of the community emergency service [12]. The one common theme throughout all these different approaches is the expression of a need to eradicate the present abuses of the service[13]. By defining their work in terms of a specialism, they appeared to hope to draw a clear line between what constitutes a legitimate attender and patients who should either have gone to their general practitioner or not troubled the medical services at all.

It appears that some patients and doctors have differing wishes

and demands about the way that the accident and emergency service should be organised. Some patients are becoming more dependent on the open accessibility of the accident and emergency department, whilst those involved in the organisation and running of the service are attempting to regulate access, one of the consequences of which may make the medical work more specialist.

It could be argued that the potential tension between doctor and patient in this organisational setting is another example of the tensions and strains which appear to be inherent in professional-client relationships[14]. Freidson[15], using the medical profession as an example, argues that the most strategic distinction between occupation and profession lies in legitimate, organised autonomy. A profession is distinct from other occupations in that it has been given the right to control its own work - it has functional autonomy. He argues that by using the ideology of professionalism, such as laying claim to having exclusive access to a body of knowledge, or having a training course which covers the appropriate length of time, occupational groups gain the position 'profession' within a given social structure and gain control over the division of labour. The recognition of this status is a licence of functional autonomy, secured from the State by political action, giving the profession the exclusive right to control the access to, and organisation of, the tasks that constitute its work. This is a simple and general description of how professions gain their formal status in society sustained by political and legal organisations[16]. It is evident that medicine is one of the few occupational groups that have achieved a relatively high degree of professional autonomy. However, this process of professionalisation has not been uniform

throughout the profession and different medical interest groups have developed at different speeds and reached different levels. As a result, some medical groups have achieved a higher status than others. This study of the professional development of occupational subgroups appears to have been a neglected area.

It is necessary to move from Freidson's general description of profession and professionalism to a more concrete level to examine the social conditions in which the achievement of professional development is both successful and problematic.

A number of different aspects of the expression of professional development can be identified. One of the most significant appears to be the nature of the work setting of the professional. The argument here is that there are work places or settings which encourage or discourage the attainment or reinforcement of professional autonomy and which either promote or inhibit the progress towards achieving status within the profession. Good professional performance can also bring prestige and within some medical care systems a higher income[17]. Thus the more the work setting is conducive to maximising professional autonomy, the more it is attractive to the professional.

Professionals who organise and run accident and emergency departments attempt to define their work in terms of a hospital specialism and try to control patient intake and are, in effect, reinforcing professional autonomy and thus maintaining professional status. However, the special structural features of the medical setting of the accident and emergency department in a hospital has implications for the structure of the professional-client relationship[18] and appears to be one of the reasons why professional development in this particular area of medicine has been so problematic.

In simple terms, the accident and emergency department is situated at the interface between the community and specialist hospital treatment. The peculiar position of the hospital accident and emergency department has had considerable implications for past and present policy development.

1.2 The Structural Features of the Accident and Emergency Department

> As Gunawardena and Lee[19] point out, 'the idea of the accident and emergency services represents everything that is believed valuable in the National Health Service in that it visibly demonstrates man's concern for his fellow-being'.

They provide a cornerstone to the service in that they provide an instant response to the unpredictability and uncertainty of illness or accident. These services provide support at a potentially critical moment in an individual's life, and this principle must be one which all consumers would deem a basic condition if asked to outline their ideal type of medical care system. In an attempt to meet this basic need the accident and emergency department was set up with open access for patients on a 24-hour basis. As a consequence of this open accessibility, this hospital setting appears, at least in theory, to be attractive to the patient. The accident and emergency department has a number of structural characteristics which may suit the needs of a potential patient[20]. For example, the department provides a 24-hour service free of charge and there are no formal organisational arrangements such as appointment systems for limiting access; the department has access to all the technological facilities available in a hospital; specialists are on call and in theory in easy reach; and the department provides a point for admission. One disadvantage with using an accident and emergency department is the impersonal nature of the setting and the likely dehumanisation of

patient care[21]. Adherence to a general routine and emphasis on organisation and technical procedures are likely to give a patient the feeling that his personal requirements and wishes are being neglected. The significance of this neglect will vary with patient expectations. Certainly, if patients are confident about the diagnosis and require technical treatment, such as in the case of cut fingers that require stitching, then the impersonal nature of the setting may be of limited significance[22].

In contrast, accepting the approach to professions referred to above[23], the setting of the accident and emergency department would appear to pose considerable problems for the doctor in furthering professional development and professional status. One of the prime strategies for increasing professional autonomy is to have potential clients monitored by a professional colleague before consultation. Thus specialists in outpatient clinics in hospitals have their clients referred through general practitioners. This procedure fulfils the function of controlling the type of patient who has access to a hospital doctor and hospital facilities, not just in clinical terms but also moral terms. Thus, given this structure, the hospital doctor can develop specialist clinical interests which may increase his chances of doing scientifically interesting work, an activity which is accepted as prestigious by the medical profession operating in a wide variety of medical care systems[24]. This referral structure also aids organisational arrangements for controlling the intake of patients. Appointment systems can be set up so that the doctor can organise and routinise his work. In addition, the specialist nature of the work leads to the doctor being able to create and

maintain autonomy from the influence of other colleagues, other members of staff and from patients.

Assuming that these are most of the requirements which help the professional maintain autonomy, how prevalent are they in the formal structure of the accident and emergency department? Apart from the department being situated in a hospital, which is attractive in itself for doctors because of the value placed on the scientific and technological aspects of medicine within the profession, this setting may have a limited attraction for the professional. Most patients come to the hospital of their own volition or are referred by non-medically trained people. Thus doctors are presented with a variety of complaints defined in terms of lay diagnostic criteria. Not only does the doctor have no formal control over the type of complaint that he sees, he also has no control over the type of patient that he sees. The wide variety of complaints and lack of continuity of care means the doctor has little time for the development of specialist interests or the evaluation of the effectiveness of his treatment, and gives him or her little autonomy from colleagues and from other staff. Finally, the lack of formal organisation procedures for limiting patients' access also means the doctor cannot create a formal time-table for seeing patients.

It is evident then that this setting may appear to be relatively unattractive to hospital doctors intent on reinforcing their professional autonomy through creation of a specialism and thus increasing professional status. The unattractiveness of the accident and emergency department for the medical profession may be partly due to its structural characteristics. On the other hand, at the formal level, there are some characteristics which are attractive to the

patient. In the United States, where patients put a stronger emphasis on receiving specialist treatment, the attraction of such a setting may be greater than in this country. Certainly there is evidence[25] that hospitals in the U.S. have become general sources of care not just for the poor but also for more affluent groups. The hospital offers what private practice could seldom do; it provides a full range of services by many high level specialists[26].

In Eliot Freidson's terminology this particular setting could be termed a client-dependent [27] rather than a colleague-dependent setting, although it must be remembered that dependence on clients will be greater within a system which uses 'fee for service' payments. It must also be emphasised that the structural characteristics of the work-place may only be important in terms of their implications for professional autonomy and attainment of professional status within the hierarchy of the medical profession itself. Treating patients who have approached the hospital directly, using their own lay diagnostic criteria will not necessarily threaten professional autonomy. Professionals working within and outside institutions have been shown to have many other procedures, both strategic and structural, available to them to protect and increase professional autonomy. For example, sociological studies of hospital outpatient settings show how the routine procedures which are operated by the medical staff act to exclude the patient from exerting any influence on treatment or diagnostic policy. Accident and emergency departments are no different and seem to operate with rules and routines which minimise the negotiating power of the patient and the patient's influence on the resulting definition of the situation. As Gibson points out:

> 'Interactions between doctors and patients occur in many different settings, not all of which fulfil the conditions amenable to the kind of negotiations described in the literature. Medical staff may not have long-term or continuous care of a patient, and so have no opportunity for the continuous "offers and responses" that Scheff describes. Or they may have responsibility and care of the patient which is limited to very specific goals, the accomplishment of which is routine and which does not lend itself to protracted discussion. Finally, the staff may be in such a position of power over the patient that they can make decisions without consultation, or the interaction may be so routine that lengthy negotiations are unnecessary.' (28)

The hospital accident and emergency department, therefore, seems to be a medical setting where professionals have limited control over the type of patient using the service because of the structural characteristics of the setting. However, the nature of the consultation and the nature of the patient's condition may create patient dependence and reinforce professional power at the interactional level. It could be that these interactional characteristics act as a kind of deterrent to the patient using the service regularly. Other hospital settings tend to exhibit both structural and interactional characteristics which appear to favour the attainment and maintenance of professional autonomy(29).

1.3 The Development of the Accident and Emergency Service

It could be argued that since 1948 and the setting up of a free comprehensive health care service tensions between patient and doctor as well as between hospital doctor and general practitioner about the organisation of the casualty service have increased. These tensions may be due in part to the special structural characteristics of this hospital setting which have been outlined in the previous section and which have limited the extent to which specialisation,

which had occurred in other parts of the hospital system, took place. Against this background of inherent tension, a short history of the development of the accident and emergency service will be outlined with the intention of showing which facets of this tension became manifest and why. I will also attempt to show how various interest groups cope with these tensions and whether or not their strategies were successful. In addition, related changes in other sectors of the medical care system will be identified as well as changes in the general public's attitude towards the service. The aim of this analysis is to show how the combination of a special hospital setting, various changes in the medical care sector and changes in the public's attitudes,have forced the providers to take account of the views and needs of the patient. However, the view of the patient and his needs presented in policy statements up to the present time still reflects professionals' views about how patients ought to behave. The implication of this is that a comprehensive study of patient demand should be carried out in order to investigate the views and needs of the potential patient.

Throughout the post-war period until the present there has been a gradual increase in the number of new attenders at casualty departments(30). This trend has been a consistent one, with the steepest rise occurring during the late nineteen-sixties(31). The rate of increase for new attenders at casualty was higher than that for outpatient attenders(32). Evidence suggests that it was not until the early nineteen-sixties that the origins of these new attenders at casualty in terms of medical referrals and self-referrals

began to change. An increasing proportion of patients attending casualty were bypassing their general practitioners and going direct to hospital[33]. In the earlier post-war period this change did not appear to have occurred as rapidly. There are a number of reasons which may explain why this was the case. For example, during the earlier postwar period little attempt had been made to develop a specialist service of any kind, and pressure for investment in new casualty departments was lacking. Hence the casualty service appeared to be neglected and unattractive. It must be remembered that in hospital medical departments, where patient access was controlled by the medical profession, specialisation had developed rapidly during that earlier postwar period[34]. Under the NHS Act of 1948 the casualty department was seen as a place where the patient would go in extenuating circumstances when he could not contact his general practitioner[35]. The principle upon which this system and the GP consultative system had been built itself developed as a result of activities which had occurred about seventy years before [36].

The development of the casualty department has always been tied closely to the development of the hospital outpatient department. The division between the outpatient department, as we know it today, and the casualty department occurred because patients began to use hospital departments as a substitute for their family doctors. This arose during the nineteenth century when the receiving room at the hospital had two functions. One function was coping with the more predictable illnesses and the other coping with those patients who had suffered from conditions generated by more unanticipated episodes. However, as Abson puts it:

> 'This division into two functions became complicated and confused by the continued failure of poor relief or (state) medicine to provide for the destitute. One response to the problem of the destitute and in particular the disabled was the setting up of outdoor dispensaries or GP surgeries in hospitals. However, as more and more voluntary hospitals appeared and allowed their receiving rooms to be used as dispensaries, private practitioners found themselves deprived of patients as even the more affluent were flocking to the hospitals for free treatment. Abuse of the hospital outpatient departments became the topic of editorials in the "Times" and the "Lancet" and the outcome of this dispute was a code of conduct within the profession which gave the patient to the practitioner and the hospital to the specialist.' (37)

Abson further points out that this saw the beginning of the GP consultative service and thirty years later the receiving room became divided into two different buildings, the Outpatient department and the Casualty department. The lack of interest shown in this area during the post-war period by medical groups may reflect the acceptance of this ethic and the recognition that attempts to create clinical specialisation in this area were difficult and inappropriate. This lack of interest also meant that the casualty departments did not have available to them large resources and thus neglected deparments may not have been seen by patients as having many advantages over their family doctor.

Other, more subtle, types of control may have existed which inhibited patients using the hospital. In the introduction to this chapter it was argued that, from a theoretical point of view, the accident and emergency department had a special feature which made it client-dependent rather than professional-centred. Much of this argument was based on the fact that the department is openly accessible to patients. However, research into the organisation of institutions has clearly shown that informal rules generated by staff and patients play equally important roles in influencing behaviour as formal rules

do[38]. In the case of accident and emergency departments there is evidence of staff developing and using restrictive policies for patient access at both the formal (official) level and the informal level. Results from one study[39] show that of the eighteen departments sampled the majority operated some restriction of patient access. The basis of these restrictive policies was the ethic that patients belonged to GPs. Sometimes this took the form of a 'polite notice', backed up by informing GPs of function of the department and asking for their cooperation, as well as 'friendly persuasion' by the staff. Sometimes it was more extreme such as 'the rigid barrier notice, without explanation, black-listing defaulting GPs, turning patients back without seeing a casualty officer'[40]. Apart from the inhibiting effect on patients attending the department this restrictive policy, or the philosophy behind it, may have been taken on or accepted within the lay world. The idea of 'never by-passing' the GP may have been an ethic which the general public readily complied with. In addition, there is evidence that on an informal level staff operate with a set of stereotypes or images of the types of patients that are appropriate attenders and those that are not. Studies have shown that these stereotypes contain both clinical and moral dimensions[41].

How far such stereotypes are enacted and elicited through encounters with patients is uncertain, and so their inhibitory effect is unclear. What is evident is that these settings are highly routinised and impersonal, which may act to protect the staff's autonomy and serve to elicit information from patients without compromising the staff's position[42]. However, this routinisation may be more a product of the new, larger accident and emergency department, with its

emphasis on technological medicine.

One fact that may have influenced patient action is that there may have still existed a stigma about using the hospital. This may have been a hangover from the pre-National Health Service period when care in some hospital departments was free only for the poor. Rigorous means-testing took place and many were turned away and redirected to their general practitioners. This may have generated a fear on the part of the patient about moral evaluation. Similar practices have been found to occur in hospitals in the United States(43).

One other form of informal control or rationing of resources is the time spent waiting for treatment in accident and emergency departments(44). The prevalence of this during this early post-war period is difficult to estimate, although some examples indicate its existence. For example, just after the war the Newcastle Regional Hospital Board was pressurised by a local trade union over the time that their members were kept waiting in casualty. The outcome of this pressure was that casualty cards had to record the time the patient entered the department and the time that the patient was discharged. This example also illustrates the vulnerability of the casualty department to complaint from the general public or general public's representative(45).

It is interesting to note that some of these informal controls have eased since that time. Nurses without special qualifications are no longer allowed to decide the type of treatment that the patient should have(46). This occurred as a response by administrators to complaints from the public and fears about litigation. Coupled with that, increasingly, immigrant doctors work in casualty departments and in some cases are unaware of the ethic upon which the present

system is organised. The open-door policy, which was adhered to in many other countries, is the principle upon which many of these doctors may have been working(47). During the early post-war period, therefore, while the numbers of new patients attending casualty departments were steadily increasing, there is no evidence of any shift in patients' views about the role of the casualty department.

The relative neglect of the casualty department during this early post-war period is indicative of the real difficulties involved in attempting to professionalise the service. By the second half of the 1950s, however, interest was beginning to be shown. The Nuffield Provincial Hospitals Trust suggested that they had always maintained an interest in the area. They stated that

> 'The interest of the Nuffield Provincial Hospitals Trust in casualty services which dates back to 1940 was continued and embodied in the reports of the hospital surveys, published in 1945, including such recommendations as the placing of casualty departments on a proper footing; the appointment of senior men to direct casualty services; the reorganisation of such clinics as existed within accident services, and the need for casualty departments to have adjoining short-stay or "observation" beds.' (48)

In spite of this interest nothing of real significance in terms of pressure for policy change occurred until the second half of the 1950s. It is difficult to identify why such action occurred at this particular stage, but it is evident that pressure for policy change came from a number of different quarters, some of these not necessarily involving sub-groups of the profession. It is interesting to note that the lay public were also cited as being instrumental in the process of pressurising for change(49). This again reflects the specific difficulties the profession had in maintaining autonomy in the organisation of this service. In fact, throughout the recent history of the casualty department, the media, particularly the newspapers, have played an important part in portraying the activities of

the casualty department. Inexperienced casualty doctors frequently tell of their fears of getting into the newspapers. The public nature of the accident and emergency department has also brought other groups into the arena. For example, some of the strongest pressure for change in casualty services came from the Medical Defence Union(50). They were concerned with the increasing number of their members who were becoming involved in litigation. Other groups, such as trade unions, also became involved. Thus pressure for change came from a variety of sources, not least from the lay public or those who claimed to be its representatives. At that particular point, apart from direct representation through the unions or through the press, patients' voices about organisation of the services had no real chance of being heard. The non-statutory pressure groups, such as the patients' association, had yet to be organised, but patients did have formal representation on Regional Hospital Boards and Hospital Management Committees. However, as Ham suggests:

> 'Although it is not possible to give a definitive answer to this question, there is evidence that they (the RHBs and the HMCs) may have paid only lip-service to their duty to represent consumer interests. In view of their position in the administrative structure of the service, RHBs and HMCs were potentially a very important means of translating opinions into policy decisions. Yet in most cases they were seemingly unaware of these opinions and made few efforts to find out what local communities felt about the health service provided in their areas.'(51)

Within the medical profession at this time, three different groups were beginning to show interest in the area. These were the orthopaedic surgeons, the traumatologists, and a group of doctors who had been working in casualty and who later were to be officially organised into a group called the Casualty Surgeons' Association (C.S.A.). Of these three groups, the British Orthopaedic Association (B.O.A.) were the

strongest and they were then particularly interested in this area, because it would have given them premises and access to patients with clinical conditions such as fractures. With the loss of tuberculosis patients, polio and rheumatoid patients, and patients with congenital disorders, they had become short of specialist areas on which to focus. Not surprisingly, they were pushing for a service that concentrated on treatment of accidents rather than the general area of casualty(52).

The strength and political importance of the BOA is reflected in the Platt report's(53) statement that the BOA's memorandum on Accident services was one of three reports which reflected the prevailing views about the development of the service. This report emphasised that the recommendations made by these three different groups were totally in agreement. The other two reports came from the Nuffield Provincial Hospitals Trust (N.P.H.T.)(54) and the Interim Report of the Review Committee on the Accident Services of Great Britain under the auspices of the BMA(55). While the BOA argued for urgent action on a grand scale for accident services, the NPHT study did not specifically identify the area of accident services as the priority for policy recommendations.

In the light of criticisms they received from senior medical people and laymen at a seminar in 1957, the NPHT carried out a nation-wide survey to find out how accurate these criticisms were. Many of the criticisms focused on poor accommodation, medical staff being too inexperienced, the casualty department's supporting services being inadequate or frequently non-existent, their relationships with other special departments not being close enough, and the lack

of adequate follow-up treatment and of links with the rehabilitation services. The results of the NPHT's survey were published in 1960[56].

Over the same period other groups apart from the BOA were putting forward their proposals. The traumatological group organised around the Birmingham Accident Hospital were, like the orthopaedic surgeons, interested in developing a more coherent system for coping with accidents. However, unlike the orthopaedic surgeons, they were interested in all types of trauma or injury. It is difficult to estimate their impact on policy development. They do seem to have held considerably less power than the BOA, although they did have representatives on committees such as Platt. It is interesting to note that the Birmingham Accident Hospital received support from a variety of sources, one of the most influential being local businessmen who saw the hospital as a centre for coping with and rehabilitating victims of industrial accidents[57].

So two independent medical groups were interested in the development of accident services although for different reasons. It is also of interest that while the traumatologists were centred around the Birmingham Accident Hospital the orthopaedic surgeons, although having the BOA as their national mouthpiece[58], also had specific small centres where orthopaedic medicine in relation to the treatment of accidents was carried out. These groups argued that they were being frustrated in the development of their specialisms (specialisms which had had successful results)[59] by the inadequate organisation of services. In their criticisms, emphasis was placed on inadequate accommodation, inadequate facilities for staff and inadequate training facilities, as well as poor coordination of services.

In contrast to these two groups who placed an emphasis on developing a hospital specialism around trauma, a different approach was being developed. In 1956, Dr.Patterson, then Senior Administrative Medical Officer of the Newcastle Regional Hospital Board, suggested the temporary appointment of senior trained doctors awaiting consultant specialist appointments, wholetime, to supervise these departments. Thus Senior Casualty Officers were introduced and employed as a group of experienced doctors focusing their attention on these departments. These were doctors who could be termed high-grade 'generalists', employed specifically to cope with the variety of complaints presented in casualty.

So, on the one hand, the BOA and the traumatologists were pushing for specialist doctors to work in the area of 'accidents' and, on the other hand, 'high-grade' generalists were being employed to deal with the general area of casualty medicine. Thus there appears to have been two groups with conflicting ideas about the principles on which the service should be based, although both were aiming to improve the service.

The report of the NPHT came out in 1960 and its main recommendations were as follows[60]:

1. Need for general reorganisation of the casualty services. Medical staffing of such services demands special attention, particularly the provision of adequate consultant cover and the supply, supervision, and training of junior staff.
2. Because of the increasing number of accidents, the most urgent need is to improve the service for those casualties requiring immediate medical attention and treatment, i.e. 'urgent emergency and accident cases'.

3. Rationalisation of present casualty services and organisation of services should be based on well-defined catchment areas and should be planned to take account of all the services for medical care already available there.
4. Because of the importance of providing a service for the relatively minor, non-urgent conditions, there is a need for the fullest consultation between the hospitals and local medical committees as to how GPs can help to relieve the hospital of the burden of such cases, and so enable the hospitals to concentrate on what they are best fitted to do.
5. The most important principle proposed for reorganisation of the casualty service is that there should be full 24-hour cover by doctors adequately trained for the work they are called upon to do, and who are assured of the stability and importance of this phase of their medical career.
6. The functional requirements of casualty departments should be studied and the results applied to new departments or to the adaptation of old.

The above six points are a summary of their recommendations. At the same time as the NPHT was compiling its report, two other committees were also meeting. Unlike the NPHT study, both these other committees were concerned with the accident services and not just the casualty department. The BMA Accident Service Committee had been meeting regularly and its first report in 1960 recommended the introduction of a three-tier structure for services dealing with trauma. A more detailed set of recommendations came from the Standing Medical Advisory Committee who set up a Sub-Committee in 1959 'to consider the organisation of

hospital casualty and accident services and to make recommendations regarding their future development'. It is difficult to know how far they communicated with the NPHT about the results from their study but, judging from their recommendations in 1962, little contact could have been made. This committee was chaired by a leading orthopaedic surgeon. The dominant principle underlying this committee's report was that the services should be centralised around accident and emergency centres attached to District General Hospitals. The following were their more important recommendations.

1. The name 'Casualty Service' should be altered to 'Accident and Emergency Service'.
2. The medical staffing of major accident and emergency units should be increased to allow each unit to have three consultant surgeons, each devoting a substantial part of his time to this work, supported by adequate numbers of intermediate and junior medical staff.
3. The number of accident and emergency units should be greatly reduced so that each could be adequately staffed at all times. A unit should not normally serve a population of less than 150,000.
4. Many existing units were in quite unsuitable accommodation and much building would be required if even the reduced number of units are to be satisfactory.
5. Accident beds should be provided at the rate of 30 to 35 per 100,000 population and should be supported by an adequate number of associated geriatric beds.
6. Responsibility for seeing that proper clinical records are used

should rest upon the consultant in administrative charge of the unit.

Many of these recommendations were adopted a year later and they formed the basis of reorganisation of the service with a two-tier system of major accident and emergency centres being attached to district general hospitals and smaller casualty units serving the peripheral areas. The change of the name was an attempt to deter the casual or, in their terms, non-urgent cases who could have gone to their GPs. Much emphasis in the report and subsequent recommendations was placed on the need to have skilled hospital treatment to deal with trauma and it is evident that the proposed reorganisation was based on the principle that 'casualties' should be turned into centres for dealing with trauma.

This development certainly met the requirements of the BOA who, as was previously mentioned, were almost entirely at that time concerned with developing a traumatology service. In practice, in many hospitals the orthopaedic surgeon ran the department. The aim of this policy of centralisation was to overcome problems of 24-hour staffing as well as provision of all relevant specialties in one place.

Support for this policy change came from other interested parties. The Royal College of General Practitioners, in their evidence to the Platt committee, wanted to see the majority of patients who go to hospital on their own volition encouraged to go to their GPs. Thus, GPs, although losing no financial remuneration from their patients by-passing them, were still concerned to maintain the ethic of the GP consultative system. The Royal College of Nursing also suggested that 'casualty departments were

being "abused" by those patients who were using them as a short cut to hospital admission and thus as a way of avoiding waiting lists'[61].

It appeared, then, that the accident and emergency department was being viewed, in some senses, like any other outpatient department in that the development of clinical specialisms were being encouraged and attempts were made to control, to some extent, the intake of patients through GP referral. Much emphasis was placed on developing techniques for redirecting patients away from the hospital towards the general practitioner[62].

This policy of centralisation was slowly implemented and by the late nineteen-sixties new accident and emergency departments were in evidence dotted around the country[63]. So far policy changes had led to the improvement in working conditions, facilities and accommodation in casualty department. The improvements were due in part to the interest of a politically strong medical group that was looking for premises which gave access to patients with conditions that could be treated by their specialism.

In spite of these improvements, the general policy of attempting to impose the traditional model of specialisation which had developed in other outpatient departments,with the general practitioner acting as gatekeeper, was not entirely successful. The major reason for this was that it was becoming more and more difficult to restrict patients' access to the department. Coupled with this, a number of changes were taking place in the wider medical care system, which may have had a bearing on the development of policy by putting more pressure on the casualty department to operate

an open-door policy. While the gradual increase in the rate of new attenders was still taking place, no dramatic increase had occurred during this period. However there was some evidence of a shift in the composition of the caseload during the nineteen-sixties in terms of how the patient reached the hospital department. There is some indication that the proportion of self-referrals was increasing. For example, in the NPHT study [64] and Fry's study[65], the figures were 66% and 60% respectively. In a study carried out in London[66] five years later, the figure was 78%, and a similar proportion was found in a study carried out in Newcastle in the early nineteen-seventies[67]. This shift may have been due to a number of developments which were taking place over a similar period. One of these developments involved the increasing attempts by general practitioners to regulate and order the provision of their service. The introduction of appointment systems, deputising services, group practices, and the increasing use of receptionists could be interpreted as an attempt by general practitioners to regulate patient access and thus to maximise professional autonomy. One of the most popular claims by general practitioners at the time was that much of their time had been wasted by patients with trivial conditions[68]. Some authors[69] suggest that the general practitioners' preoccupation with trivia indicated how their views about their role in healthcare were dominated by an ideology generated in the hospital. It is only in recent years, when the GP has attempted to develop a more positive role in his own right, that the concept of trivia has become relatively insignificant. This recent shift in the approach to patient care adopted by the GP has, as will be shown, further implications for the provision of accident and emergency services.

The attempts to professionalise the general practitioner service through the creation of organisational barriers may have led the patient to begin to look for alternative sources of medical care when they had urgent medical needs. Of course the changes may have influenced the patients' ability to gain a personal service from his general practitioner. Even today this is one of the most common and important reasons given by patients when asked to account for their continual use of their general practitioner[70]. In addition the changes may have influenced patients' expectations about choice of medical care setting for treatment of conditions such as minor trauma. Recent evidence suggests that, increasingly, patients see their GP less and less as an alternative source of medical care for the treatment of minor trauma[71], or even minor general complaints such as sprained ankles. Whether general practitioners are increasingly less willing to carry out minor surgical procedures or treat minor injuries on their premises remains to be seen. It might, however, be assumed that the requirement to be available to treat injuries might have led general practitioners to avoid providing such a service, given their concern for more control and regulation over their work. There is some evidence which shows that accidents are one form of medical condition which general practitioners considered to be troublesome[72]. More direct evidence suggests that general practitioners may be treating minor injury less often nowadays. One study[73] showed that 13% of a sample of general practitioners interviewed in 1977 said that they would never stitch cuts, compared with only 6% in 1964, although there was no change in the proportions who said they

excised simple cysts. In a more recent study[74], just under 20% of general practitioners expected their patients to go direct to the district general hospital for the treatment of a cut, and 50% said that a patient with a suspected fracture should go direct to hospital. Of the non-traumatic conditions, people who fainted (19%) were more likely to be expected to go direct to casualty. Another study[75] suggested that patients underestimated the likelihood of their general practitioner treating minor injury.

This apparent change in the approach to the treatment of minor injury by general practitioners could also be accounted for in terms of changes in the provision of medical supplies. During the early nineteen-sixties, the Central Sterile Supplies system was set up, which provided prepacked sterile equipment to hospitals free of charge. General practitioners had to pay for that equipment if they were not working in cottage hospitals. Previous to the CSSS, sterilisation was carried out by the medical staff themselves in both casualty departments and in general practitioners' surgeries. It is possible to conclude that with the development of the CSSS the general practitioner may not have felt that it was worthwhile competing with casualty departments on both financial and moral grounds.

Alternatively, this change in the approach to the treatment of minor trauma by general practitioners may be accounted for by the shift in emphasis in the education of general practitioners. The traditional emphasis in the training of general practitioners had been on the development of surgical skills (hence doctors' surgeries). More recently, the psycho-social aspects of general practitioner care have been emphasised in education[76] with less emphasis on surgical

skills. Thus the GPs who are still carrying out surgical procedures might be the older ones who wish to retain their traditional skills. However, the more recent upsurge in the provision of health centres, as well as the increasing availability of practice nurses, might have provided the appropriate setting which might lead to a change in this overall trend.

This leads on to the other development which may have influenced patient demand for the services provided by the hospital accident and emergency department. Gunawardena and Lee[77] suggest that as there has been a parallel increase in demand for hospital emergency services in other countries with different medical care systems, then the explanations that emphasise change in organisational arrangements may be less important than those that focus on changes in consumer opinions and preferences for medical care. Certainly this period saw the beginning of the consumer movement in healthcare. The idea that patients do and should think critically about the quality of care available became more manifest. Coupled with patients becoming more critical and accident and emergency departments becoming more attractive sources of medical care was the idea that patients were generally moving towards hospital-oriented medicine, with its emphasis on efficiency and technology and moving away from the more informal and personal form of medicine found in the general practitioner setting. Evidence to support such an argument is limited, but Cartwright and Anderson[78] show that between 1964 and 1977 there was a fall in the proportion preferring the general practitioner as the first line of care. This trend is particularly strong in metropolitan areas[79].

So both the movement to professionalise the general practitioner service, which culminated in the Charter of 1965[80], and the increasing knowledge and awareness of consumers about health matters, as well as the increasing number of patients who looked to the hospital for specialist treatment for minor injury, may partly explain why patient demand for the services that the accident and emergency department provided was not curbed. As was mentioned before, some of the informal barriers to patient access to the hospital accident and emergency department were slowly being eroded.

Within the medical profession itself, the principles upon which the Platt proposals were based came under increasing criticism from a group of casualty doctors (Casualty Surgeons' Association)[81]. Their criticisms seemed to gain effect because the profession recognised the difficulties involved with their previous approach to professionalise the service and that other medical groups who had been involved previously were beginning to turn their interest to other areas. For example, as Loudon[82] points out, orthopaedic surgeons realised that the work of the AEDs provided little that could be regarded as being of an orthopaedic nature.

Casualty doctors were worried about the proposal to have closer and indirect supervision by consultants as well as the attempts to define the nature of the work by a change of name. These questions were first posed at the Senior Casualty Officers' Sub-committee of the BMA in 1963, and it was following this that the Casualty Surgeons' Association (which was formed by the Senior Casualty Officers in 1968) eventually published their memorandum, 'An Integrated Emergency Service'[83].

This group argued that the Platt recommendations were all right

on paper, but in practice they were not working. It must be remembered that under Platt's recommendations there was no room for the Casualty Consultant, which was where a number of Senior Casualty Officers had originally envisaged their future after their initial commitment to this area. They argued that, while the ideal of being able to tap a number of specialties in the accident centre was a good one, in practice the specialists were usually unavailable, and the doctor dealing with the complaint was the most inexperienced of the staff able to deal with the case. They advocated the appointment of casualty consultants who would be high-grade generalists experienced at dealing with a variety of complaints. In fact, this notion of a casualty consultant with its attendant career structure, which was also proposed by the NPHT(84), received approval of the Annual Representative Meeting of the BMA in 1973 and has now become established.

The call for a high-grade 'generalist' is, according to members of the CSA, not a proposal which is based on abstract ideas about the function of the service, but a recognition of the fundamental requirements of the service. They saw the casualty service as a <u>community medical emergency</u> service which complemented the family consultative service offered by general practitioners.(85) This principle of the casualty service serving the community is, according to the CSA, the one on which the refinement of casualty service should be organised. The CSA argued that their service existed to serve members of the community when they find themselves in emergency situations or predicaments. The CSA suggested that the work of the Accident and Emergency department does (or should) consist of the provision of medical services in emergency situations. The element of

emergency attaches not only to the clinical severity of the illness or injury and to the complexity of the treatment, but also to the circumstances under which the illness or injury occurs. The Accident and Emergency Department in this view exists to serve all the needs of patients that cannot be served elsewhere. These needs may incorporate social as well as clinical elements. Implicit in this view is that 'appropriateness' of attendance at Accident and Emergency departments is to be judged not solely in medical terms (for a large proportion of the conditions treated by the departments may be equally capable of treatment by general practitioners), but also in terms of whether treatment could have been obtained elsewhere with no additional costs to the patient of time and inconvenience. If such alternative treatment could not have been obtained, then attendance at the Accident and Emergency department is legitimate, regardless of the illness or injury.

The basic assumption in this proposition is that laymen and their families should have routine strategies for dealing with matters concerning health. They should have their own criteria for evaluating symptoms and deciding to seek professional advice. These criteria would usually not be of a clinical nature, but will be related to the activities that the individual and his family carry out in everyday life. It is assumed that even with unpredictable events such as 'accidents' or 'sudden illness' where possible the family or individual will follow this routine. It is also assumed that for the majority of individuals and families the general practitioner will act as the professional healthcare agency in their routines. The CSA argued that use of the accident centre occurs when these routine strategies for dealing with ill health are disrupted

by special sets of social circumstances or social situations. For example, a tourist spending a short time in an area, becoming ill or injuring himself and requiring immediate medical treatment in order to continue with his activities, such as returning home, will go to the A & E department. The CSA argued that in this case the individual is in a 'social predicament'; he cannot organise the situation so as to follow his routine pattern of healthcare because his general practitioner is inaccessible. Immediate medical attention is required because the condition is serious enough to disrupt his activities or the activities of others. Perhaps in more 'normal' circumstances, where the individual may have been able to withdraw from those activities, the requirement to consult medical attention may not have been so urgent. In these special circumstances, the opportunity to withdraw from the activities is not so easily available, as he was away from home and planned only a limited period of time in the area.

In other examples of the CSA's circumstances or social predicaments, emphasis was laid not so much on the patient's predicament or the priority he puts on the restoration of the flow of routine activities, but more on the predicament of the 'other' people involved with the episode. In the case of a road accident, the CSA argued that the police or other 'officials' use referrals to the accident centre as a means of restoring to normal that aspect of public life which is disrupted and for which they have some responsibility. The assessment of urgency, then, is not based so much on the perceived clinical severity of the patient(s)' condition and subsequent evaluation of the most appropriate hospital care, but on the need to get things back to 'normal'. Similar explanations

were offered for referral procedures at work, school, in the street, or on the sports field. In such cases the patient's routine strategy for dealing with health and illness is disrupted by the introduction of 'others', usually officials. These 'others' might have an influence on the decision to seek medical care, but bring into the situation another set of priorities which are related to their official position. For example, the first-aid man at work may adopt a policy of referral to the accident centre, not only because of the need to restore the individual back to his or her work activity as quickly as possible, but also in cases of litigation. The same may apply to 'episodes' at schools or in childminding.

This shift towards defining the nature of the work at an Accident and Emergency department in a 'social' rather than 'clinical' manner did not mean that the CSA were advocating a complete change from the hospital clinical specialism of critical care medicine towards the department becoming an extension of the primary care system. These doctors were concerned about their professional position, vis-a-vis their position as hospital doctors, and they were concerned to confine their work to a specialist area, i.e., the development of a community emergency service(86).

The CSA have proposed that their legitimate area of work should not only cover those patients who have gone through the more conventional process of consulting their GP and being subsequently referred, but also should be extended to those who are in social predicaments and could not contact their GP. The emphasis is on a more traditional approach, with the GP consultative system and the casualty service providing a complementary service rather than a

substitution for one another. Evidently the casualty service is seen by the CSA as an emergency service, even if emergency is defined in terms of social predicaments and not as an alternative source of primary care. Of course the CSA do not legitimate the attender who had the opportunity to contact his general practitioner but preferred not to.

The CSA's proposals received a mixed reception from the two other medical groups involved in the area. At the time of publication of these proposals, the BOA suggested that they were retrogressive. They said that:

> 'There is also a danger that independent consultants sharing the view of the Casualty Surgeons' Association, that an emergency is "any patient who finds himself in an emergency situation who is not able to use the normal GP services", may increase the misuse of Casualty Departments; by a section of the public as a more convenient alternative to their general practitioner services by a section of general practitioners, as a more convenient open-access consultant clinic for the referral without appointment of non-emergency cases, and by the consultant himself, as consultative, minor operating, and follow-up clinic for non-emergencies in his own field of interest; to the detriment of the prompt and efficient treatment of the injured, for which he and his staff may no longer find time ... We are concerned, as consultants currently responsible for the Accident Services, to record our view that such changes in the control and use of casualty departments would be retrogressive, recreate the very problems which were condemned by the Platt report in 1962, and set back for twenty years progress in the organisation of hospital services for the injured.' (87)

The antagonism of the BOA to the CSA's approach not only reflects competition between professional services for scarce resources, but also the concern that while there may have been an increase in medical knowledge, technology,and treatment skills over the past years in the treatment of trauma, their application has been restricted by the slowness with which organisational changes in emergency health care have been made. These changes would have made trauma-

tologists' work more efficient and more effective.

The role of the casualty consultant also caused particular concern amongst the traumatologists. There was recognition by traumatologists and orthopaedic surgeons alike that too much emphasis has been placed on more serious conditions, which are a small minority of those seen in casualty departments. Hence the establishment of casualty consultants received the support of these two groups. Orthopaedic surgeons, however, were concerned that these doctors didn't trespass on other areas of inpatient work in the hospital; and the traumatologists proposed that in some circumstances there was a need to develop accident medicine as an independent specialty which should be separated from non-traumatic 'emergencies'. Thus they argue that in some larger hospitals the specialty of accident surgery should be developed(88).

A little time after the CSA's proposals were published, the House of Commons' Expenditure Committee(89) raised the question of the 'minor' case. The report recommended that patients should be educated about 'appropriate' use of accident and emergency departments through the increase in TV 'fillers'. The availability of general practitioners was also seen to be one of the important influences on the 'influx' of the minor cases into accident centres. Some of the blame was attributed to inflexible appointment systems, to deputising services deterring members of the public from consulting their GP and to patients' ignorance of the temporary residents provision. In addition there were criticisms of GPs' provision for 24-hour cover for their patients, even in group practices. One proposal to overcome the problem of providing an efficient 24-hour service for minor injuries recommended the building of more health centres which could provide for the ambulant person with a minor complaint. This proposal didn't receive much support

in a subsequent government response to the report[90].

This brief description of how the accident and emergency developed during the post-war period highlights a number of issues. Perhaps the most important point is the apparent shift in the professional definitions of the principles upon which the accident and emergency department should be organised. The shift, which slowly seems to be gaining acceptance within the medical profession, has been away from the idea that the service should be organised around the principle of clinical specialisation, with the gatekeeper being the general practitioner, towards a service which should be based on principles which contain both a 'social' and 'clinical' element. The acceptance of such a shift in definition, although not complete, can be explained in a variety of ways. Gunawardena and Lee identify two reasons, the first of which is closely associated with the argument that the structural features of the accident and emergency department are such that policies aiming at specialisation must attempt to take into account the needs of the patient population. They argue that this shift in definition was forced on the medical profession:

> 'if only because it is virtually impossible for a hospital to turn away patients unexamined'. (91)

The CSA might argue that this difficulty in turning patients away is not due to any professional ethic, but due to the predicament that the patient finds him or herself in. There is some evidence that patients are turned away, but it appears that nowadays this is very rare because of the increase in patients' awareness about the quality of medical care and their emphasis on specialist help and the erosion of informal and formal policies for restricting patient

access due to fears of litigation or media coverage. In addition, pressure from patients for an extension of a primary care service in the hospital has come partly as a result of professionalisation in the general practitioner service, where attempts have been made, at least initially, to routinise and 'detrivialise' the service.

The second reason suggested by Gunawardena and Lee is that the providers need the high intake of non-urgent cases to justify their existence for the episodic use of expensive technological equipment. It could also be argued that the casualty departments attached to teaching hospitals provide a continuous variety of material for medical teaching. Thus, these hospitals may support a policy of open access.

The third reason for the apparent acceptance of this 'social' definition of accident and emergency work is the lack of real opposition to it by other groups. The orthopaedic surgeons became less interested in the area and grudgingly accepted the proposals for a casualty consultant. Finally, the fourth reason is related to the relative increase in the professional prestige of general practitioners compared with their hospital counterparts. General practitioners frequently used social definitions when describing their role, and it could be argued that the providers of the service at the accident and emergency department were beginning to recognise that, nowadays, acceptance of a definition of work which contained a social element did not necessarily bring with it a drop in professional prestige(92).

One possible conclusion from this account of the hospital accident and emergency department is that the attempts by the providers to impose the traditional model of hospital medicine with

the emphasis on clinical specialisation and control of access has been continually hampered by the inability of the providers to effectively control the influence of the general public and its representatives. The continuing low prestige of casualty doctors within the professional hierarchy is enough to support this interpretation(93). The recognition by the providers that certain needs of the potential patient should be taken into account in future policy development does not, however, represent the dramatic shifts in medical opinion that it initially suggests. As will be seen from the next section, these proposals contain implicit moral prescriptions about how the patient should utilise the medical care system; and they reflect a medical group's intentions to maintain control over the provision of what is still conceived of as a specialist service.

1.4 The Image of the Patient in Policy Statements

The discussion in the previous section described the different ways in which the "appropriate function" of the Accident and Emergency department has been defined. Each definition has implications for patient utilisation in that the appropriateness of an attendance is a function of how the work of the accident and emergency department has been defined. It is possible, therefore, to identify within the various policy statements the image of patient behaviour or patient action which is portrayed(94).

Firstly, the most popular approach has been the one which is closely associated with the idea of the Accident and Emergency department as a centre for dealing with injury and sudden serious ill-

ness. Given the availability of general practitioners, patients ought to utilise the general practitional service for all complaints and let the general practitioner decide when hospital treatment is necessary. However it happens that legitimate attenders can include those who have gone to hospital without contacting their general practitioners only in real 'emergencies'. Emergencies are defined in clinical terms and patients should be able to distinguish between them and 'trivial' cases. When patients' behaviour doesn't accord with this organisational solution either the unavailability of general practitioners is blamed, and thus the patient has reacted to the organisational obstacles, or the patient is unaware of the prescribed organisational solution and must be 'educated' into understanding it. A small minority of patients are identified as 'bad' because they are intentionally playing the system or maximising their choices and do not adhere to the organisational solutions. This deviant behaviour is accounted for in terms of some deficit in the individual's make-up. The general assumptions about the patient in this approach is that the majority accept, or should accept, the providers' policy, and when the plan is not conformed to it is mainly due to patient ignorance or some organisational barrier. It is assumed that the patient shares, or should share, the same view of the way that the medical care system should be used as the professionals, and are, or should be, passive recipients of these solutions.

Secondly, the view of the patient implicit in the Casualty Surgeons' Association's approach, with their emphasis on a social component, is very similar to the approach outlined for the first group. Both types of explanations emphasise the complementarity

of the GP consultative system and the accident and emergency department. Both explanations assume that the patient ought to follow the organisational plan of utilising the GP for routine medical matters. It is interesting to note that in neither of these approaches is there an account of patients referring themselves to the hospital because they are dissatisfied with their general practitioner. The assumption is that patients defer to medical competence or should defer. Both explanations portray the patient as passive, compliant, and uncritical. The only difference is that the second approach substitutes social predicaments for organisational barriers. In addition, the approach put forward by the Casualty Surgeons' Association is willing to accept that non-medical people (mainly representatives of the community) should be seen as legitimate sorters-out of who should use the hospital in addition to the general practitioner. The Casualty Surgeons' Association proposals show a willingness to extend the gatekeepers' responsibility to include a group of non-medically trained people.

Up to now these two explanations of patient behaviour are implicit in the policy statements about the organisation of the accident and emergency services in this country. Both reflect directly the professional views about the way the service ought to be run and are constructions which may not be based on how patients actually use the service. Gunawardena and Lee conclude that:

> 'The future planning of A and E services needs to be considered not only within the framework of both general primary care and critical care medicine but also within the framework of patients' wishes and expectations.' (95)

Judging from the discussion of the development of these services outlined in this chapter, it is evident that such a proposal is not just a plea to democratise the service, nor just a means of evaluating the quality of care, but a recognition that from both the providers' and the patients' point of view it is possibly the most rational approach.

1.5 The Need for Research: Preliminary Objectives

It is proposed to carry out a comprehensive study of how, why, where, and when patients use the accident and emergency department. Many proposals for policy have been put forward by professionals about the way the service should be organised and operated. Many studies have been carried out in examining the way Accident and Emergency departments work at both the formal and informal level[96]. However, a comprehensive and detailed study of patients' use of these hospital departments remains to be carried out. A study would need to start from the premise that patients' ideas about when to use an accident and emergency department may differ considerably from those of the providers of the service, who base their judgments of views of how patients ought to use the department. These judgments are made using their own 'professional' criteria to assess the 'true' functions of the department. Results from a number of sociological studies of illness behaviour have shown that patients have a great deal more control over illness situations than is commonly thought. As Johnson states:

> 'The choice about whether to seek medical attention or not is a real if problematic one for most people. And if the evidence is to be believed, very few consult without due thought and consideration about the significance of the symptoms to them nor without some clear idea as to what they want from seeing the doctor.' (97)

The intention of this study is to examine how, why, and when patients use the accident and emergency department, and also to attempt to examine patients' decisions and the basis of these decisions in terms of lay definitions. It will be of interest to see how far these definitions compare with the professional assumptions about patients' behaviour. Evidence from such a study could contribute to the development of a more coherent policy for the accident and emergency services. However, before the research objectives are outlined in more detail, there is a need to critically examine the various ways that this 'problem' has been approached in previous research.

CHAPTER 2

An Evaluation of the Research on Use of Accident and Emergency Departments

2.1 Introduction

The major aim of this research is to develop and carry out an empirical research study which focuses on how and why and under what circumstances people actually use the accident and emergency department. More specifically, this research aims to examine the empirical validity of some of the assumptions about patient behaviour and patients' motives for action which are implicit in the policy statements described in the first chapter. This research will attempt to assess the empirical validity of explanations such as those which emphasise that the majority of patients use the accident and emergency department because they can't contact their general practitioners due to organisational barriers or social predicaments, the assumption being that patients would go to their general practitioner if they could. Alternative explanations emphasize the critical power of the consumer, suggesting that patients choose between the accident and emergency department and alternative sources of medical care on the grounds of their perception of the urgency with which medical attention is required or on the grounds that specialist treatment is required. In some senses this study is focussing on why patients choose an accident and emer-

gency department in preference to a general practitioner. It is also attempting to find out if, under the circumstances in which decisions to seek medical care are made and within the framework in which these decisions are made, these choices available organisationally have the intended meaning for the potential patient.

In the light of these preliminary objectives, the published literature on the use of A and E departments is examined. The main aim of this review is to see if similar research has been carried out before and, if so, how the "problem" has been approached and what the substance of the findings are. The theme throughout this review is that there has been a change in the approach to use of emergency services in hospital departments in that more recent studies have tended to see the use of emergency services in the wider context of the medical care system. There has been a recognition of a need to take into account the views of the patient and that the needs of patients may be entirely different from those proposed by providers. In spite of this change, much of the evidence, both theoretical and empirical, which has been accumulated by medical sociologists in the field of illness behaviour has been neglected.

There are two different bodies of literature which are of relevance to this area of study. Firstly, there is the work that has been carried out on utilisation of A and E services and, in particular, the influences on patients' choice of medical care system. A considerable amount of work has been carried out on this topic, especially in North America. Secondly, and this will be reviewed in the following chapter, there is the work that has

been carried out in the more general area of illness and utilisation behaviour. Much of this work could be loosely termed 'sociological' and it is of value not only because it brings novel ideas and concepts to the field of utilisation of A and E services, but because it brings a theoretical understanding of the various approaches that have been proposed and also offers more coherent theories of patient demand.

2.2 Research on the Use of the Accident and Emergency Services

Much of the research in Great Britain has focussed on the issue about "appropriate" patient usage of the A and E service. Firstly, there are the studies that use a sample of attenders at an A and E department and describe their characteristics. In many of these studies the prime purpose has been to identify the proportion of "inappropriate" attenders. Many of these definitions of appropriateness are based on case-mix or severity/acuteness criterion. Gunawardena and Lee[1] argue that this approach is not surprising, given a climate in which the whole medical tradition is geared towards compartmentalising medical care. Some studies have attempted to classify patients according to the reasons for using the accident centres. These classifications are usually simple and make distinctions between "medical" and "social" attenders. The second type of study has offered a more analytical approach to patient use of accident centres. Sampling from both accident centres and general practitioners, some of these studies have concentrated on examining factors related to patients' choice of treatment. Other studies have attempted to develop conceptual frameworks of patient use of health care systems, and have assessed the extent to which A and E departments constitute part of the patient's

routine pattern of health care.

The proliferation of studies examining why patients use A and E departments illustrates, once again, the gradual recognition by providers that patients' needs should be taken into account. Although, as we shall see, in many of these studies definitions of patient need are taken primarily from a professional viewpoint.

2.21 The Characteristics of Attenders of A and E Departments

2.211 Demographic Characteristics

The available evidence suggests that the heaviest demand for accident services comes from school children and young adults, and there is a larger proportion of young males than females[2].

The relationship between social class and use of emergency services has been much less extensively explored in this country than in the United States[3]. This may be due to the importance of financial barriers to health care in the United States, but it may also be due to studies in this country failing to identify the background population in the catchment area of the hospital under study, thus being able to compare the social class distribution of the attenders with the social class distribution of the population from which they came. However, in the Newcastle Accident Survey such a comparison was possible and no social class differences were found[4].

2.212 The Range and Severity of Clinical Conditions

Several studies have described the clinical distribution of the case load of an accident department, but perhaps the most comprehensive study was carried out by the NPHT[5]. Using data collected from a cross section of eighteen A and E departments (then called

casualty) in a variety of geographical locations, samples were taken of 200 cases running concurrently from each of the departments for the same period of the year. The largest proportion of the case load were patients suffering from trauma of some kind, mainly soft-tissue damage or skeletal injury. In general, medical and surgical work was small. A more intensive analysis of the clinical nature of the case load of eight hospitals was made. Fractures composed 13% on average of the case load, and wounds of all severities 22% on average. Burns composed 5% on average.

This study was carried out up to 1960, and there may have been changes in the clinical case mix of attenders since that time. Such changes might have been expected because of changes in both the organisational structure of the A and E services[6] and GP services[7]. To my knowledge no one hospital has been studied at more than one point of time and comparison of findings from different studies based on different hospitals for this purpose lead to major problems in interpretation because of the lack of uniformity in definition, the large variations in the composition of the catchment areas between hospitals, differences in sampling procedures as well as differences in time of the year when the data were collected.

The nature of the case mix at A and E deparments appears to be a function of its geographical and social-environmental location. For example, in a survey of accident departments in London it was concluded that:

> 'On average non-traumatic conditions accounted for about 40% of the total case load but there was an obvious increase in the non-traumatic element of the case load as one neared the centre of London'.[8]

A similar difference in the case mix between central urban city emergency centres and suburban emergency centres has also been shown in studies carried out in the United States[9]. These variations in the U.S. reflect, according to these researchers, the different functions of the hospitals. They argue that one of the functions of the emergency clinic in large city hospitals is to act as family physician for the urban poor; hence the high proportion of non-traumatic conditions in the case load. In contrast, the emergency clinic situated in a peripheral area of the city with a larger proportion of traumatic cases has the more conventional function of providing acute emergency care for the community and also fulfilling the role of a substitute for a private physician and the outpatient department during the off-peak hours when services are not available or not appropriate to the patient's problem. Comparable studies have yet to be carried out in this country. However, speculative explanations have been made, particularly in relation to the variation in case mix between accident departments in London and those in the provinces. Lack of availability of general practitioners as well as the large number of commuters have both been cited as explanations[10]. More recent studies[11] have shown about a fifth of attenders have no GP and that the hospital is being used as a GP service for some groups.

The question of assessing severity of clinical conditions in the case load also poses problems of definition. Should severity

be assessed in terms of clinical criteria such as signs or symptoms, duration or type of treatment, or level of skill needed for treatment, or should it be assessed socially, according to the degree of disruption in the patients' and his family's everyday activities? Many studies use clinical criteria, and these are usually closely associated with what the authors consider to be the appropriate function of the A and E department. Thus Crombie devised a scale of severity of condition[12] which was later adapted for use in the NPHT study. The scale used as its criteria for assessment both the level of skill needed and the facilities available to treat the condition. He divided conditions into three different groups: firstly, patients with conditions which could have been treated by a nurse without reference to a general practitioner; secondly, patients who could have been treated by the writer in his own general practice; and, thirdly, patients who should be treated in hospital because the conditions are more serious than in the above. Eighty percent of the 410 casualty department attenders could have been treated by a general practitioner or a nurse. In the NPHT study,[13] using the same scale, 71% need not have been treated at hospital. This percentage is based on an average from a sample of 1,963 attenders at all the hospitals surveyed.

For many other authors the "minor" casualties in clinical terms were also imputed to be "unnecessary" attenders. Blackwell[14] suggested that 35% of 200 attenders at an accident centre situated in London should have been treated elsewhere, and Evans and Wakeford[15] in a study in Cardiff found the figure to be 70%. A

large-scale study carried out throughout the Wessex region[16] found that 65%-71% of the attenders at the major accident centres were "minor" cases and could have been treated by community health services. The figure for accident units situated in peripheral areas varied between 76% and 89%. In a study of 2,379 attendances at an accident centre in Derby,[17] 68% were assessed as being "minor" casualties which could have been appropriately managed by general practitioners.

In other studies, necessity of attendance has been defined in terms of clinical urgency. Gampel,[18] in a study of 3,283 new attendances at an accident unit in London, defined 50% as 'non emergency'. Others have defined "appropriateness of attendance" in terms of particular types of events or types of condition. Thus Griffiths et al[19] found 28% of their sample to be "inappropriate" because they were not in the categories of accidents, medical emergencies, and surgical emergencies. The NPHT study[20] defined wrong attenders as those patients without a letter from their general practitioner and with a non-traumatic condition which did not require urgent treatment.

It is noticeable in the majority of these studies that the assessment of clinical seriousness is usually made by the research worker after final diagnosis and after a number of tests have been carried out which may confirm or refute the initial diagnosis. Thus these assessments not only do not take into account the patient's judgement of seriousness at the time of the "episode", but also does not include the medical staff's initial suspicions of serious-

ness. This distinction between initial diagnosis and final diagnosis is important, as it might be argued that even in the "minor" cases the medical staff need to carry out tests to be certain of "what is wrong", so how does one expect laymen to make such judgements. In the United States, however, a study has been carried out which examines the proportion of the case load at five hospital emergency clinics which are defined as "urgent" cases[21]. Urgency is classified according to whether the staff gives some cases precedence over all waiting patients. When the staff reaction is not clear, the case is classified as "borderline". Of the five hospitals, at most 8% are classified as urgent and 10% as borderline, but for each hospital combination of urgent and borderline cases never reach more than 13%.

2.213 Source of Referral

Another type of classification of patients that has been used to define "appropriate" attendance at an accident department is "source of referral". Although some writers have suggested that a large proportion of the group of patients referred to hospital by their GPs have been wrongly referred,[22] much more concern has been expressed about the self-referral; i.e., the patient who arrives at an accident unit on his own volition. This concern about the legitimacy of the "self-referral" appears to derive from the assumption that laymen are incapable of making an accurate diagnosis of their conditions, and therefore would need professional advice for directions to the appropriate medical care agency. This directive should come from the GP. The other explanation, which is closely associated with the first, hinges on the

attempts of clinicians to improve the status of casualty medicine in relation to other medical specialisms. In the latter, the GP acts as a screening agency and channels the flow of the patients accordingly. Some casualty doctors are concerned that similar procedures should operate with their patients to ensure that they spend the majority of their work coping with real "emergencies".

The two most relevant questions in this debate are firstly, is there any evidence to suggest that the proportion of self-referrals is increasing, particularly in the light of evidence that shows a gradual increase in the numbers of new patients attending accident centres over the last decade? Secondly, are self-referrals more likely to be assessed as clinically "trivial" cases than professional referrals. There is some indication that the proportion of self-referrals is increasing which has been illustrated in Chapter 1. However, even with these figures, the lack of uniformity in definition brings into question the validity of such an interpretation. Apart from the problems of comparing findings from accident centres situated in different locations, there appears little consensus over definitions of source of referral. For example, in the NPHT,[23] a referral from a GP had to include a letter. Fry did not distinguish between those who came with or without a letter in his classification of GP referral and in the Newcastle study a distinction was made between those patients who actually consulted their general practitioners and were examined and then referred, with those who spoke over the telephone to the GP and were then referred and those who could only contact their GPs receptionist and were advised to go to hospital. The last category was defined as a self-referral and the first two were GP

referrals.

Few studies have examined the relationship between clinical conditions, severity and source of referral. Crombie, using his scale of clinical expertise, found a much higher proportion of trivial cases amongst the "self-referrals" compared with other groups. He also distinguished between patients attending on their own volition from those patients who received "non-medical advice" as a cause for attendance. There was little difference in the ratio of trivial to serious cases between these two groups.

2.214 Summary and Conclusions

These studies are valuable in a number of ways. They show that the accident and emergency department is an important source of medical care for young males. Given that trauma may account for a considerable proportion of young males' morbidity it could be speculated that the A and E department may be the major source of medical care for this age group. Results from these studies have shown the geographical and socio-environmental variation in case mix, suggesting that accident and emergency departments perform different functions for the population in different areas. This brief review has also highlighted the various attempts to define the work of the A and E departments in terms of a medical specialism. Urgency, severity, type of clinical condition, and source of referral have been used as means of defining the boundaries of the work of the A and E department. With regard to the major aim of this study, to develop an understanding of patient demand for these services, these studies are of limited value.

2.22 The Analytical Approach

Two types of approach predominate in the studies that fall into this section. The first type of study compared a group of patients who attend an A and E department with those who initially contact their GP. The purpose of such studies being to identify any differences in characteristics of the patient or the episode which would shed some light on why some people use the A and E department and some of their general practitioners. The second type of study concentrates less on the characteristics of the episode and more on the ways that the attendance at the hospital emergency department fits in with the patient's overall strategy for seeking medical care in its broadest sense. The former approach has been more common in Great Britain and the latter more common in the U.S. There are a number of reasons why such a difference occurs, but possibly one of the most important is that the "problem" has been conceived by the two countries in two different ways. In the United States the hospital emergency department has been accepted as a part of the primary care system whereas in Great Britain the hospital A and E department has been seen as a source of hospital medical care which is different from that provided by general practitioners.

The ideal method of testing the propositions which have been developed in the first type of study would involve taking a large random sample of individuals and their families and carrying out a prospective study, continually monitoring and observing their patterns of "illness behaviour". Thus it would be possible to identify the special characteristics of the patient or the episode which leads the patient to go to the hospital rather than his general practitioner. Such a task, however, would be lengthy and expensive, and

may pose considerable data collection problems in that many of the "episodes" under study are unpredictable.

Researchers concerned with a similar problem have opted for a more pragmatic approach in that they have compared a group of patients who initially went to a GP with those who went direct to the accident centre. The difficulty with such comparisons is in defining the range of conditions to be included. Firstly, there is a lack of consensus about what is considered to be "appropriate" work for the GP and the accident centre. Secondly, if only a limited range of conditions is included, then this may create an implicit bias in the model - in that clinical condition or the way symptoms or signs are evaluated by laymen may, in fact, be the crucial discriminator in terms of the choice of care.

In a study carried out in Bristol,[24] Dixon examined the number of attendances for "minor" conditions at a hospital accident centre with those at a health centre over a six-month period. The health centre is situated within the catchment area of the accident centre and this catchment population is defined as 11,417. Dixon excluded all those attenders who were referred to the accident centre by any person with medical or nursing qualifications, as well as those who arrived at the hospital in an ambulance. Also excluded were those with conditions which could probably not have been managed at the health centre, in that they had radiological examination performed or a plaster cast applied, or were admitted to hospital or referred to the outpatient department or to some other person or place apart from the health centre or family doctor. Dixon was, therefore, concerned to exclude all conditions which were not potentially treatable by a nurse or doctor in a health centre.

In the study period, 1,487 patients attended the health centre and of these 1,430 were managed entirely by the medical staff there. In comparison, 826 attended for minor conditions at the accident centre. In comparing the characteristics of the two groups, Dixon found attendances at the accident department reached a peak during the early evening, and included relatively more males, more adults, more patients with injuries than with symptoms, and more residents from the area immediately adjoining the hospital. The implication of these findings is that patients prefer to take trauma to an accident centre rather than a health centre. Whether such a result would still hold after the other significant variables are allowed for is not clear.

Such an analysis was carried out in a study in Newcastle which compares the characteristics of patients attending three different accident centres with those attending the corresponding general practice for minor trauma only[25]. All patients came from the same catchment area and all patients were suffering from minor trauma as defined by the I.C.D. system. The data were collected in two parts and there was a two-year period in between the collection of data at the accident centres and that collected from the general practitioners. However the data were collected in both parts during the same three months of the year. The findings showed that of 346 patients with minor trauma 155 went straight to the A and E department with 191 who went to their general practitioner as a first reaction to injury. This evidence clearly suggests that GPs still deal with a substantial proportion of minor trauma. Whether this proportion is decreasing is uncertain.

This study also provided important evidence with which a number of the speculative explanations for the increasing number of attenders at an accident centre could be evaluated. The more popular explanations are as follows:

(i) the increasing use of appointment systems by GPs

(ii) the increasing use of deputising services by GPs

(iii) the declining frequency of house calls and the demand for regular working hours by the GPs

(iv) population mobility and the resulting lack of a family doctor

(v) convenience motives of both the patient and the physician

(vi) changing public attitudes about outpatient facilities

(vii) the declining willingness of GPs to deal with trauma

Thus these explanations either emphasise the importance of the changing structure of the organisation of the GP service or the changing wishes of the patient. The two are clearly interrelated.

The research team in the Newcastle study went about exploring these propositions by analysing the two data sets jointly through a multi-discriminate technique, the dependent or outcome variable being the choice of treatment. The purpose of the analysis was to identify the best predictor of the outcome. The potential predictive variables were divided into four distinctly different types: epidemiological, social, psychological, and circumstantial. The reason for such a distinction lies with the problem of assessing the suitability of the various conceptual types of variable for the analysis. They state:

> "Do all these variables have an equal claim to appear in the discriminant function? Is it as useful to know how a patient's attitudes affect his initial choice of care system as to appreciate how his reaction to minor trauma depends on his distance from both the A.E.D. and from his general practice ... We consider this issue in the context of strategic policy decisions. Our data on distance is objective,

> in two senses; that the patient's perception of his source is unlikely to have been affected by his subsequent treatment; and that the same response would, in all probability, have been obtained using a different method of data collection. Furthermore, the spatial distribution of the population of this country is well-documented. Consequently, data which describe the effect of distance on the utilisation of medical care can be used in the evaluation of alternative strategies by predicting likely responses."

In contrast, they argue that the data on attitudes to medical care are neither objective nor predictive and can only fulfil an explanatory role which will have a lower priority in the analysis than variables which are both objective and predictive. The circumstantial variables, e.g., site of accident, is objective but not predictive and cannot, they argue, be as clearly distinguishable from the social-psychological variable as can these two from the epidemiological variable.

To accommodate this problem of the different statuses of variables, they concentrated on firstly identifying the best discriminant function restricted to the 27 epidemiological variables and then extended it to the best unrestricted function by selecting further discriminators from the 14 circumstantial and 11 social-psychological variables.

The results of these two analyses showed that the restricted function comprises but five discriminators and the unrestricted function only 10. In other words the remaining 22 epidemiological variables, 12 circumstantial variables and 8 socio-psychological variables have no significant effect on the patient's initial choice of care system, over and above that of the 10 selected discriminators.

Table 2.1 shows the results of the multi-discriminant analysis. In the "best discriminator" section, the five epidemiological vari-

ables are ranked in order of their ability to discriminate. Age and final diagnosis are equally ranked. The five non-epidemiological variables are those ranked sixth to tenth in their ability to discriminate. Care system preferred for cut, expected hospital action for cut, expected GP action, are ranked equally.

With respect to the explanations outlined previously about the increase in attendances at the accident centre, this analysis shows that the presence or absence of an appointment system and use of deputising services are of little importance in their ability to predict outcome. The analysis used both the perceived presence and the actual presence of these organisational practices and similar results are found. The lack of an association between presence of deputising services and changes in the pattern of the use of accident centres is shown in other studies[26].

Time of day and day of week of accident are also shown to have little to no discriminatory power. This may have some direct significance for the proposition that there is a relationship between increasing use of accident centres and the hours of opening of GPs' surgeries.

The problem with these data, as with many statistical models, is one of translating the findings into a model of decision-making in "illness" and "accident" situations. No coherent theory of decision-making was articulated (not that the authors set out to find one), so it is difficult to make sense of how the variables of differing epistemological statuses relate to each other. For instance, distance from hospital and distance from general practitioner is the best predictor of choice of treatment; it is still not apparent how this "objective" distance manifests itself in the decision-

making process; i.e., how does objective distance relate to perceived distance? The crucial question is what in fact does "objective distance" mean to the actors involved in the decision-making process? It is difficult to see how final diagnosis can be a predictor variable. It should possibly be replaced by "presenting signs and symptoms when the 'episode' happened". The requirement, then, if practically possible, is to replace the variables used in the study with the underlying concepts which they represent, and thus it should become clear as to the model of decision-making implicit in the work.

A further criticism of the study is why was "minor trauma" selected as the type of condition which is the focus for the analysis. Perhaps the non-traumatic conditions which are taken to casualty might have been a more interesting group for study.

In spite of these apparent weaknesses, the Newcastle Accident Study is the most comprehensive study that has been carried out on this particular issue in this country to date. Therefore their findings need to be scrutinised closely in order to pick out clues to the way further research should be approached, as well as to understand the process by which people come to use the A and E department. The results from the analysis provide support for a variety of perspectives. The approach which emphasises the importance of organisational barriers as significant influences on patients' choice of the A and E department, instead of GPs, is supported by partnership size being included in the best five epidemiological predictors. The Casualty Surgeons' Association's proposition that social circumstances play an important part in influ-

encing choice of medical care system is supported by the presence of "distance" in the best five epidemiological predictors. Further support is found within the presence of site of decision and advice-giver in the best five non-epidemiological factors. Finally, the presence of age and final diagnosis, patient's preference for care, and patient's expectations about GP treatment all support the idea that patient's ideas about the appropriate setting for treatment of specific conditions are also significant.

Before the implications of these findings are discussed, a word must be said about the variable final diagnosis. There appears to be a bias built into the findings related to final diagnosis. For example, the hospital has more accurate facilities for diagnosing fractures than have general practitioners, and therefore it could be argued that there is a greater likelihood of having a fracture diagnosed at hospital. Therefore the finding that fractures are more likely to go to hospital may be a function of the ability to detect fractures. Now this argument will be invalid if GPs refer to hospital those patients with signs and symptoms which are exactly the same as those in which x-rays are carried out in hospital. Thus there will be just as much chance of fractures being detected for both sets of patients. However, if the GP does use a screening process which differs from that used in hospital, then there is the likelihood of a bias in the findings, especially as only new patients and re-attenders are included for analysis.

The problem with the interpretation of these results, as stated previously, is trying to translate them into their meaning in everyday life. Decision-making, whether it is routine or novel, involves actions, and decisions are made by human actors. The results from this analysis suggests that actors' decisions are subject to numerous

effects. Individual decisions are based on both cognitive and affective dimensions. Fear and anxiety, generated by the evaluation of the meaning of a symptom, may play a crucial part in the patient's evaluation of the severity of his or her condition. It is possible to make assumptions about the results. Thus the finding that patients with fractures and cuts are more likely to opt for hospital care fits with the finding that patients' preference for care when confronted with a small cut is to go to hospital. Similar connections can be made between the other epidemiological and non-epidemiological factors. However, a further dimension is added when other people become involved in the decision-making. In this particular instance, patients who made their own decisions or received advice from family, go to a GP. So the decision-making process does not necessarily just involve the patient or the patient's family but also other people. The "other" people involved in the decision-making process will depend on the setting of the decision. The implication from the findings is that any theory about patients' help-seeking behaviour in this area must not only involve attempts to translate the effects of organisational structures or the impact of disturbances in body functioning on the individual's cognitive and affective interpretative mechanisms, but also the approach must take into account the interpersonal nature of decision-making, and the ways different settings influence the interpersonal encounter. Certain settings may bring with them extra pressure or obligations for the participants. Normal behaviour or expectations about normal behaviour may vary between social contexts. More will be said about this in the final section of this chapter.

Studies in North America have attempted to identify the characteristics of those who use the Emergency Room compared with those who go to their family physician. For example, a study carried out in the U.S. specifically focussed on "Emergency Room Misuse"[27]. In this study, 29% of 400 visits to the hospital emergency room were considered to be unnecessary. The authors determined the visits to be justified if the duration of complaint or the onset of symptoms made it necessary that the patient be seen at the Emergency Room rather than in the Family Practice Centre during office hours. They showed that when 29% of the total outpatient visits to the Family Practice Centre Model Office were made by recipients of Medical Assistance, the same population accounted for 53% of the Emergency Room visits. They claim that 64% of unnecessary visits were made by Medical Assistance patients. The authors emphasised that this study was carried out in a setting outside the heavily urbanised areas where previous studies had been carried out. The special feature of this environment was the availability of a stable family practitioner service. Other studies have emphasised the circumstantial element in patient demand. For example, in Canada, a study[28] compared the patterns of local and tourist use of an emergency department. The tourist group was used as a control group in that it "is doctor-deficient and lacks knowledge of the local medical network". On the other hand, 85% of the local group were able to identify a family physician. Perhaps the most interesting finding was that the pattern of illness taken to the emergency clinic by the tourist group is strikingly similar to that taken by the local population. The author concludes from

this that public attitudes, rather than availability of health professionals, determine the pattern of illness observed in an emergency department.

The evidence presented so far shows that while a number of factors have been identified as important in explaining patients' choice of medical care setting, no coherent theory of patient demand has been developed. Both public attitudes and preference for choice of medical care setting and the interpersonal nature of the decision-making process have been identified as significant influences on choice of medical care setting, but as yet they haven't been integrated into an overall scheme for explaining lay help-seeking behaviour.

Much interest and concern has been expressed in the United States about the growth in demand for emergency clinics. This attention is reflected in the plethora of studies that have been carried out on the subject in recent years. While it must be recognised that the organisation of the medical care system in the U.S. is different from that in G.B. (less emphasis is placed on the family physician as the major source of primary medical care in the U.S.), some of the approaches that have been adopted are relevant to this present study.

It is possible to divide the studies that have been carried out in the U.S. into two groups (a similar division can be made for the British studies, but this distinction is less marked due to the negligible amount of research that has been carried out using the second perspective), in terms of the nature of the explanations that are used to account for patients' use of the emergency clinic. In the

first group are those studies that argue that patients use the emergency clinic because alternative or other sources of care are unavailable or inaccessible. Patients, therefore, given the constraints on their choice, have no alternative but to go to the emergency centre. In the second group, emphasis is shifted from problems of unavailability or inaccessibility to an understanding of the influences on patients' choice of medical care system. It is appreciated that patients have ideas about suitable or appropriate sites for medical care for certain conditions and that these should be taken into account just as much as the organisational aspects of the delivery of medical care. While both types of explanation are useful, it is the second approach that will be concentrated on here, as an attempt has been made in these studies to move away from the approach which merely explains patient action in terms of how the medical care system should operate. In this second approach, the meaning of patients' action is taken seriously and attempts are made to make sense of it in the patient's own terms.

The second group of studies take two different forms: on the one hand there are the group which have explained patient use of the emergency clinic in terms of socio-demographic characteristics of the users. Such facts as social class, age, income, ethnicity, and usual medical care have all been postulated as relevant(29). Much of this evidence is contradictory and inconsistent, and the reason for this according to some authors is this:

> 'The inconsistent research findings, however, may also be attributed to methodological deficiencies. For example, most E.R. studies attempt only to document E.R. utilization, that is, they seek to describe in detail the characteristics of the Subject E.R. and its patient population. Few of these studies of E.R. Utilization incorporate their data into any sort of theoretical construct of the utilization process. In the absence of a theory of patient demand for health care services, basic hypothetical relationships between patient-wants and actual utilization can neither be formulated nor tested. As a consequence, because little of the literature addresses either the subject of patient demand for Emergency Room care or the process by which care is received, we know little of patient motivation in choosing one department over another or an emergency department over an ambulatory care site, or why a particular set of patients over-responds or under-responds to a given symptom, or how and why at what stage a patient decides to call an ambulance'. (30)

This call for the development of a more coherent framework for patient demand for emergency room facilities leads on to the second type of approach in which the authors have attempted to do exactly that. It must be emphasised at this point that, as in the U.K., the justification for the need for this research is not only the growth in demand for emergency rooms but also the increasing use of these facilities for "non-urgent" conditions. One group of authors who have attempted to develop a more coherent framework of patient demand are Solon and Rigg(31). They argue that the network of medical care requires more explanation than identifying the individual's usual source and enumerating other sources that the patient uses. A conceptual organisation of the sources the patient uses must be made to the more reflective of how they are used and how they interrelate. The role of the hospital unit can best be depicted - both for the individual and cumulatively for the population - within a framework that encompasses the totality of sources used and somehow represents them in the respective roles they occupy in the individual's "total pattern of care".

In their study, they interviewed a complete one-week sample of patients attending either an emergency unit situated in an inner-city setting with a substantial lower-class population, or an emergency unit in a suburban middle-class milieu. They concentrated on examining their data in terms of four concepts related to the individual's overall pattern of medical care. These concepts were central source of care, volume source, configuration of care, and cohesiveness. They were concerned in anwering the following question: are these socio-cultural and economic differences of the two hospital's emergency patients accompanied by differences in their patterns of securing medical care?

The actual source of care is defined as the patient's central source of care. This is the source of care that the patient is not necessarily using most frequently but the facility or doctor which is most important to him in that he has the greatest continuing trust or reliance. As Solon and Rigg put it, it is the patient's medical "home base". Private physicians were found to be predominantly the central source for both patient populations in the way their central source of care was used when the central source of care was a physician. "Suburban Hospitals' emergency patients whose central medical resource, getting their specialty care from other more specialized providers ... Substantially more of the Inner-City patients with a private doctor as central source used him for speciality as well as general care." These differences can possibly be understood when the importance of material circumstances as an influence on patients' choice of health care in the U.S. is taken into account.

The volume source of care refers to the source of care most frequently used by patients. The findings showed that for the vast majority at both hospitals, the volume and central source are one and the same.

The configuration of care concept "addresses all of a person's sources and attempts to encapsulate the essential ones in a meaningful framework. It does this by designating the individual's significant sources of care, and by inter-relating his sources of general medical and specialty care. The configuration retains only the important continuing sources used by the individual, eliminating insignificant details". The dominant configuration in both emergency service settings is that of private physician. Nearly one-half of emergency inner-city emergency patients follow this pattern and so do nearly 70% of the suburban group. In the inner-city group, the O.P.D. and emergency unit enter into the configuration of other much smaller clusters. The O.P.D. is essentially the sole source of care for 6% of those patients, and additionally with the emergency unit's participation with it in general medical care, the O.P.D. accounts for another 8%. In the suburban emergency group, the only significant cluster are the 11% who additionally resort to the emergency unit for some of their general medical care.

The authors also tried to account for the circumstances that lead to unanticipated use of a hospital emergency clinic. They asked the patients how the emergency unit fits into their own way of getting medical care and 73% of the Inner-City users as compared with 87% of the suburban users claimed to confine their use to emergencies.

Finally, the fourth concept, cohesiveness and compactness is considered. "Compactness" refers to the number of sources from which an individual secures his medical services. Cohesiveness re-

presents a judgement as to whether the person's pattern of obtaining care has a unit or coherence about it. More suburban patients (51%) use a single source of care than inner city patients (37%), whereas more inner city patients (33%) used multiple types of sources compared with 17% as asmong suburban patients. Interestingly, a substantial proportion of the patients using a multiple source of care had a cohesive pattern of care, i.e., their multiple sources were used in a complementary rather than duplicatory fashion.

This approach has yet to be applied to the use of emergency services in this country. However, the assumption made in some policies proposed in G.B., that for the majority of individuals and families their routine pattern of health care revolves around the general practitioner, is supported in the findings from this study. For the majority of patients in both hospitals, the central source, volume source, and configuration of care, is based around the family physician.

The approach of Solon and Rigg to this issue in the U.S. was a relatively new one in that it related patients' use of emergency rooms to alternative sources of medical care and also related this use of emergency rooms to the patients' overall pattern of medical care-seeking. The problem with this type of approach is that while there is emphasis on taking the patients' behaviour seriously and building up a coherent theory of patient demand the interpretation of patient behaviour is still made in terms of the authors' theoretical conception of what the behaviour means. The question of why patients behave or act in a certain way is left to the interpretation of the researcher without recourse to the patient's own interpretation of

why he or she follows a certain routine. Thus, while Solon and Riggs' approach is valuable, it doesn't go far enough in attempting to answer why patients behave in a certain way. This question is important given that these researchers are concerned to understand patient motives, since it is the patients and others who made decisions to seek medical care and the nature of the decisions are derived from their own framework which may be distinctly different from that of the researchers.

The question of how to find out how patients "perceive" the applicability of different services has received attention in the U.S. literature. For example, Kahn et al[32] state that "...the patient's decision to use the Emergency Room is influenced by his perception of the accessibility of alternative care sources". Thus the argument runs that presence of facilities alone does not mean that the patient will perceive them as accessible.

A more recent study has taken Solon and Riggs' conceptual framework further, and a more elaborate theory of patients' motives in utilising medical care settings is proposed[33].

They outline the basic tenets of their theory of patient behaviour as follows:

> "Our explanation of patient utilization is based upon the economic concept of utility. We assume that the patients will utilize the facility that they believe will provide them with the greatest overall satisfaction which is a function of an appraisal of the merits of alternative sources in relation to the patient's own unique set of evaluative criteria. We don't suggest that a person actually sits down with pad and pencil and calculates the costs and benefits associated with alternative sources. We do believe, however, that some sort of analogous subconscious reckoning does take place, and that the choice is the product of a deliberate decisional process". (34)

These authors, therefore, are some of the earliest to emphasise the rationality of patients' action in using the emergency room. In their community survey of households (N = 527) in the Rochester area of New York, they looked at (1) public opinion about the role of the E.R., (2) the perceived urgency of the problems that people bring to the E.R., (3) the accessibility of medical care, and (4) the factors that prompt the use of the E.R. rather than other sources of care. Perhaps the most significant finding from this study was that patients' use of Emergency Room is associated with problems that they believe to be urgent. They conclude:

> "Our results show that people can and do distinguish between the attributes of Emergency Rooms, given an urgent medical need, just as they can distinguish between the attributes of other sources of care for routine problems. Our analysis shows that many people evince an overriding concern for the location of the E.R., a matter that is apparently prompted by both their perception of the urgency of their medical problem and the accessibility of alternative health care sources." (35)

It seems that patients' perception of urgency is directly associated with their view of the accessibility of alternative case sources in that the patient uses the E.R. for "urgent" conditions because it was more accessible.

The more telling remarks are made in the conclusion:

> "To understand patient utilization, we must realize that the utility of factors such as time, convenience, or discomfort that influence patient decisions is perceived differently by each person. It is, of course, within the province of the professional to appraise the urgency of a patient's medical needs, and, admittedly, many problems are not urgent, by professional standards. But this does not alter the fact that they may be quite important to the patient. To assert, as some do, that these other matters should not be important to patients or to criticise patients because they do not conform to professional standards is presumptuous. In the public view, the E.R. is a 'place to get medical aid in a hurry'". (36)

Now this approach reflects a marked change in perspective on utilisation of emergency services, since it shows that the world of the patient and the world of the professional are distinct and different; and, therefore, notions of urgency and availability or accessibility of alternative sources of care must be seen in terms of the patient's world or the patient's perception. Further evidence to support this approach is found in a Canadian study which examined primary care for non-traumatic illness at the emergency department and the family physician's office. The authors of this study concluded as follows:

> "There are indications that the patients who visit an emergency department for primary care differ from those who visit a family physician's office, or that the conditions causing these two groups to seek care at these settings differ. Patients appear to assess the urgency of their presenting complaint and select where to seek care accordingly. Thus, patients with acute, urgent, generally rapidly resolving illnesses go to an emergency department whereas those with chronic, non urgent, slowly resolving or unresolving illnesses go to their family practitioners". (37)

As was stated previously, patients' perception of urgency is closely linked with patients' perception of the accessibility of medical care services. The question of perceived accessibility of alternative sources of care has been shown to be important in patients' accounts of why they went to a hospital rather than attempt to contact a GP. For example, Holohan[38] is concerned with identifying the reasons for patients who did not contact their GPs but went direct to the accident centre. Of the 182 self-referrals, Table 2.2 shows the patients' principal reasons for self-referral. All these respondents were interviewed in their homes shortly after

the attendance. The table includes responses to a similar question to attenders at emergency clinics in Michigan, U.S. However, the two studies defined "self-referral" in different ways. The Michigan study excluded all those who made an attempt to contact a GP on the grounds that (i) a patient who attempts to contact a GP does not make a decision to use emergency services and (ii) one of the objectives of the study was to study the importance of the financial motives for using the emergency department, and patients are unlikely to call a doctor first if they wanted free medical care. In the Newcastle study, only those who made contact with GP or receptionist are excluded.

Table 2.2

Types of Explanations for Self-Referral

Newcastle	%	Michigan	%
Patients' principal reason for self-referral		Categories of reason for physician not called	
Availability of hospital care	32	Patient believed private physician not available	43
Appropriateness of hospital care	17	Immediate care or hosp. facilities were required	15
Accessibility of hospital care	13	Patient taken involuntarily by police amb., etc.	6
Automatic reaction	10	Patient sent to hosp. by employer, teacher	11
Anticipated referral	9	Patient became ill while at hospital	6
Other	20	Hosp. is more convenient or no family physician	11
	100 %	Insurance coverage for hospital care	2
		Other reasons	6

The results in the table show the "availability or accessibility" explanation predominates in both studies. This may imply that for the majority the GP is felt to be not available and so they attend the hospital. However, the Michigan study[39] in their categories have attempted to take account of the circumstances and the role of "others" in the decision-making process, i.e., they differentiate between patients attending on their own volition and those being taken by police, ambulance, or being sent by employer and teacher. In contrast, in the Newcastle study, Holohan is not concerned with identifying the context in which the decision is made. Thus, the patient gives the reason for using the accident centre which may not have been the result of his own decision.

It is interesting to find that in both studies the second most frequent reason given is that hospital facilities are appropriate. This may imply that patients have a general notion about certain conditions that should be taken to hospital and where the GP is not relevant.

A further point refers to the question of asking people why they came to the accident centre. The use of the question "why" or any related questions implies that the decision of whether to go to the general practitioner or accident centre is both a real one for the laymen and a problematic one in that they are asked to "account" for it. "Accounts" in this context imply justification of behaviour or what Scott and Lyman[40] have argued, a normalisation of deviation. This normalisation process may mean that patients who are aware of the official ideology about "appropriate" use of the service will answer in the ways that will fit with this ideology. There is also

the question of the relationship between explanation and behaviour. Patients' accounts of what happened at the scene of the "episode" may be coloured by a number of factors which may have occurred after the "episode", and they may, in fact, have "constructed"an account of what happened. For example, Stimson and Webb[41], in their study of interactions in consultations between doctors and patients,suggest that patients tend to exaggerate the degree of their participation in the consultation. They observed the consultation and then asked the patient after the consultation what went on in the consultation.

Holohan[42]has developed a different explanation for patients' use of accident centres. She argues that patients who attend for accidents have a different set of motives and a different social background from those attending the non-trauma. Other studies, however, have suggested that, because of the circumstances, many patients' use of the accident centre is unanticipated. Holohan places more emphasis on patient's intention. She argues that GPs have only a minor role to play as legitimators of referral in cases of trauma and explains this by suggesting that in the majority of trauma, diagnosis is in the realm of competence of individual and colleague, and thus the patient needs the doctor for the instrumental role of treatment. The accident was regarded as an isolated incident which did not have a prolonged medical history which would need continuity of treatment. Hence patients are much more likely to see the casualty doctor in this instrumental and technical role rather than as a GP, where the interaction may be more expressive. Holohan's assumption about patient behaviour implies that choice of treatment depends upon patients' ability to evaluate signs and symptoms and make a diagnosis. From

such an evaluation the most appropriate agency is used.

The patients who attended for non-traumatic conditions are described as patients who are in the main socially isolated and who accordingly sought little advice from those around them. In some patients this isolation is extended to their relationship for diagnosis, but many patients felt that social interaction with professionals is possible only in a hospital setting.

Holohan's approach is important because it brings a different explanation of patient action. In essence she argues that when patients know what is wrong with them the medical help needed is entirely technical, and thus the doctor-patient relationship is of limited importance. This is not totally incompatible with the authors who have suggested that patients' perception of the urgency with which medical help is needed is closely linked with choice of medical care setting. Thus the clearer idea that the patient has about what is wrong the more likely the patient is to know whether his condition is "urgent" or not.

Other studies which have concentrated on trying to understand the patients' point of view have also examined the use of emergency services for one particular type of condition. For example, Calnan[43] examined the action of mothers who suspected their children of being "poisoned" by a medicine or household product. This study grew out of a home accident study aimed at investigating the various factors that cause accidents in the home. Those cases in which either a GP was contacted, an ambulance called, or a direct visit to the hospital was made were included. Initial interviews with mothers about the episodes showed that the label "poisoning" which had been attached to the episodes subsequently by medical staff was, in some cases,

problematic. It became apparent that mothers had considerable difficulty in knowing whether their child had actually ingested a dangerous substance and the evidence available to them was circumstantial. This study also illustrated the role of other people in the local community who were mainly medically untrained but were considered by the mothers as reliable sources of knowledge. Of 135 cases 27% went to their GP or to the local health centre and a further 6% contacted the ambulance immediately. This suggests that in emergencies in the home (the majority of these cases were seen by one or other of the parents as emergencies) the family doctor is felt to be an important source of advice and medical care. Another 18% consulted relatives, 14% consulted neighbours and 3% went to the chemists, 27% consulted nobody before going to the medical care service. All but one of the 183 cases of suspected poisoning, irrespective of whether they went to their GP or not, ended up at an accident and emergency department. It seems that in cases of suspected poisoning **the GP's normal policy is** to send them to hospital. This was borne out by a study of GPs' advice about six hypothetical situations involving an ingestion of an unknown quantity of six different substances. The substances ranged in the level of toxicity from acute toxicity to innocuous. The majority of GPs favoured advising patients to take their child to hospital immediately. For the less dangerous substances the GP advised referral to hospital as much as they did advise parents to bring their child to the surgery immediately. Therefore, according to these data, the GP's role varies according to the believed dangerousness of the substance suggested. With the toxic substances GPs may feel that they don't have the treatment facilities available to cope.

Evidence from Calnan's study suggests, therefore, that when certain types of emergencies occur at home, the primary source of medical care is either the ambulance or a direct visit to the accident and emergency department. However this study didn't present any evidence on the factors that might have influenced the choice of medical care setting. It might indicate that the majority of patients don't think that the GP is the appropriate place for treatment of these cases. This belief seems to be borne out be the policies of the GPs.

2.23 Summary and Conclusions

This review has highlighted a number of different issues which need to be taken into account before proceeding with the outline of the research design for this study. It is evident that there has been a shift in the way research studies have viewed the problem. This is particularly evident in the research carried out in the U.S. There has been a move away from the piecemeal approach which isolated the use of casualty or emergency departments from patients' other patterns of medical care seeking, towards a development of an approach which sees the use of the hospital department in terms of patients' overall strategy for seeking medical care. From a substantive point of view, evidence has shown that the family physician in the U.S. and the GP in G.B. are still seen by patients as their focal point for general medical care. There has also been a shift in the way the patient is portrayed in the research. In more recent studies it has been recognised that the lay perspectives on health, illness, and help-seeking behaviour may be different from the providers' perspec-

tives. Thus, if the study aims to try to explain the basis of patient help-seeking behaviour, then these explanations must be couched in lay definitions rather than providers' or medical definitions.

The major weaknesses in the research so far are two fold: first, given the various shifts in perspective described in the above, there is still not a coherent theory of patient demand which places patients' views about utilisation of A and E departments within the patients' routine pattern of help-seeking behaviour. As yet the attempts to do this have floundered on the assumptions that researchers have constructed themselves about what is or should be happening. As a result, researchers' definitions of how laymen should behave are replacing providers' definitions. Second, research evidence has shown that not only are patients' perceptions of the appropriate medical setting for treatment and their expectations about their GP's propensity to treat certain conditions or availability crucial factors in choice of medical care setting, but that, also, the context in which the decision is made and who makes the decision to seek medical care may play an important part in influencing the choice of medical care setting. The recognition that decision-making in illness is an interpersonal activity suggests a movement away from the images of the patient as a mechanistic figure with fixed views which are mirror images of the value system to a perspective which sees social activity as a process which is changing and the patient active and reflective and formulating orientations in the light of his experience. The majority of studies, although emphasising the importance of viewing the patient in their social context, have failed to recognise that (i) the social context is interpersonal so decisions about illness or help-seeking

behaviour are sometimes a result of social interaction between a number of actors, and (ii) that the social contexts in which decisions are made may actually vary. While some studies have identified the site of the decision to seek medical care as a significent influence on choice of medical care, what these variety of settings represent in terms of who is involved in the decision-making, what influences the decision, and whether the basis of the decision is different from those occurring in other settings, appears to have been neglected.

Therefore the major purpose in the following study is to attempt to examine the relationship between the various social contexts in which decisions are made and patients or patients' families' views about use of alternative sources of medical care.

Table 2.1

Results of multi-discriminate analysis (Newcastle study)

	Epidemiological	Non-epidemiological
Best predictors	Distance - to G.P.s surgery Distance - to the hospital Age - older patients tend to seek general practitioner care Diagnosis - Fractures/ wounds are more likely to opt for hospital care Partnerhsip size - patients with single-handed practitioners tend to present to the A.E.D.	Site of Decision - decisions taken at the site of accident are more likely to lead to hospital Advice - patients who make their own decision or receive advice from family go to G.P. Patient's preference for care when confronted with hypothetical problem of a 'small cut needing stitiches' Whether patient expects 'small cut' to be stitched by doctor or a nurse at hospital Whether patient expects his G.P. to cope with a sprained ankle himself or sent it to hospital
Significant assoc. but no sig. imprv. to prediction of choice	External cause of injury Sex Marital status Attendance at an A. and E. within past year	Site of the accident
No demonstrable effect on patient's decision	Social Class Admission as a hospital inpatient in past year Attendance as a hospital outpatient in past year No. of G.P. consultations within past year Duration of registration with his G.P. Whether his G.P. uses an appt. system Whether his G.P. uses deputising services	Time of the accident Day of the accident G.P's estimate of the frequency with which he straps sprains

CHAPTER 3

Sociological Approaches to the Study of Illness and Help-Seeking Behaviour

In the light of evidence presented in the previous chapter, the aim of this chapter is to examine the various approaches to illness behaviour and utilisation of the health services which have been developed and to assess their value for a study focussing on how and why patients attend an A and E department. One of the more obvious conclusions from the review in the previous chapter was that much of the research was fragmented and lacked theoretical and conceptual coherence. Similar criticisms can be made about much of the vast amount of literature which has been written on the subjects of illness behaviour and utilisation of the health services over the last twenty years[1]. However, recent research has developed a more coherent framework for understanding patient action. While this recent research does not specifically concentrate on the stage of decision making involving choice of medical care system, it does provide a sounder framework for understanding both illness behaviour and help-seeking behaviour.

3.1 The Emergence of the Study of Illness Behaviour

Traditionally, it was assumed that if the provision of medical care was made free to all, all those in need of medical care would visit their doctor or other relevant medical services. No one questioned whether an individual would be able to know whether he needed medical attention or not. The process of becoming ill was thought to be a clear cut situation. The majority of people were expected to perceive that they were obviously and normally healthy; a minority were assumed to be equally aware that they were ill because they could perceive their symptoms and appreciate their significance.

It was assumed that once the economic barrier had been overcome with the setting up of the National Health Service differential unequal accessibility to and use of the health service would be eradicated. However, results from morbidity surveys carried out since the end of the second world war suggested that such an assumption was misguided. Those people who seek medical care only represent the tip of the iceberg and a large proportion of morbidity in any community will never reach the medical care services.

During the 1950s, morbidity surveys began to show that not only was there a considerable amount of ill health not reaching the official medical services, but there were marked differences in consultation rates according to socio-economic status and other socio-demographic features. There was an increasing realisation that there were a number of non-medical factors influencing patient perception of symptoms and decisions to seek medical care.

One result of these findings was that research workers began to examine the problem of"underutilisation". Such questions as why do people with symptoms of cancer delay seeking medical care were

typical of the questions being asked. More recently concern has been expressed about delay in seeking medical attention for heart disease and venereal disease. Attention has also been turned to prevention and to the maintenance of health, and questions are beginning to be asked about why people smoke or drink excessively, why they don't take exercise or eat "proper"foods. Concern has also been expressed about the low level of continuing compliance with screening programmes such as those for the early detection of breast cancer. As a result of this attention researchers began to examine in more and more detail how the public evaluates and responds to health and ill health. As regards ill health there developed the study of illness behaviour which has been defined in many ways but is most conventionally defined as "the way in which symptoms are perceived, evaluated and acted upon by a person who recognises some pain, discomfort or other signs of organic malfunction".(2)

As the research in the area of illness behaviour evolved a wide variety of concepts were developed. More significantly, there was a clearly identifiable shift in the approach. This shift typically illustrated what usually occurred when a topic which had traditionally been the concern of the medical profession had been taken over by medical sociologists. It involved a change of opinion away from the interests and the orientation of those involved in sociology as applied to medicine to those involved in the sociology of medicine.

3.2 Changing Perspectives in Illness Behaviour

This change has occurred at a number of inter-related levels. First, there has been a change in focus from the emphasis on the need to explain or account for the problems surrounding utilisation of service to an emphasis on the question "What is illness?". Help-seeking behaviour is viewed as one response to the problematic experience of illness. Second, and this is clearly stated by West:

> "Very generally, this (shift) has involved due formulation of the problem from one in which the task was viewed as the identification of social and psychological variables that impeded the (irrational) proto-patient from doing what he ought to do - consult the doctor, to another in which much greater attention is directed to the person as a conscious, reflective actor engaged in the process of making sense of various kinds of body changes within the framework of his own 'lay' knowledge." (3)

The change in approach is not just a response to changing fashions in main-line sociological theory, but is derived from empirical research. As the quotation from Johnson (4) illustrated in Chapter One, patients do have a lot more control over illness and help-seeking behaviour than is generally believed and they do have 'good' and rational reasons for their help-seeking behaviour. Perhaps a good example of this is found in the study of patient compliance. At the broadest level, the issue that this study is concerned with is why patients don't comply with the organisational solutions offered by the providers. One of these solutions is to go to their GP for all their complaints where possible, and only in extenuating circumstances to use the A and E department. However, studies of patients compliance has mainly been concerned with medical instructions to take medicines and drugs. The two issues are comparable in that there is a moral prescription implicit in the approach that patients should adhere to professionals' wishes or plans. In the case of use

of medicines and drugs, the non-compliers have been viewed in various ways, although the common theme portrays the non-complier as deviant and having deviant attributes. Stimson(5), in a review of patient non-compliance in the taking of drugs or medicines, found an inconclusive and contradictory pattern, and concluded that it was not possible to identify an uncooperative type; almost anyone can default at one time or another. Stimson shows how the perspective underlying default research generates a search for the cause which must, in a sense, inevitably be seen as residing in the patient. As West puts it:

> "The dual notions of the doctor as an expert legitimated to make rational pronouncements and the patient as passive and obedient are simply taken for granted, ensuring that attention is not directed either to the patient's view of the situation nor the nature of the doctor-patient interaction. Inverting the paradigm, non-compliance can be seen either as resulting from some aspect or aspects of the medical encounter, the doctor's performance for example, or from a rational decision made by the patient in the context of knowledge about illness and its treatment. In effect, there may be many 'good' reasons why patients choose not to follow the doctor's orders." (6)

This is a clear example of the change in perspective which has occurred in many areas of medical sociology. Perhaps the better exponents of this approach in the study of illness and illness behaviour are Dingwall(7) and Fabrega(8). Before their frameworks are described and related to the proposed study, some criticisms of the previous work which are taken from Dingwall(9) will be outlined. This is useful because these criticisms can be directly applied to the work that has already been reviewed on the use of A and E services.

Dingwall has organised the research on illness behaviour into what has been termed the individualistic approach and what has been termed the collective approach. The former approach attempts to account

for observed behaviour by reference to the personal characteristics of individuals. These may be derived from some form of psychometric assessment. For example, Kosa and Roberston's[10] which emphasises the significance of "anxiety" as a factor in producing variations in illness behaviour. Other examples of this approach can be found in the area of health behaviour. One model which has been proposed to explain variations in patient compliance is the health belief model[11].This model is made up of a number of different dimensions, such as an individual's perceived readiness or propensity to act, perceived susceptibility and perceived seriousness. This approach can be described as the "ballistic" approach, since the image of the proto-patient is one of a missile ready to be launched towards the health services. The factors which have been identified as important in influencing whether the proto-patient is actually launched are age, sex, social class, and what are called enabling factors. More recently, this health belief model, with its essentially psychologistic approach has begun to take on board sociological factors such as the concept of social support. However, as Dingwall points out, why and where all these factors were derived is never explained.

Examples in the field of utilisation of emergency services are found in Perkoff and Anderson's work[12] on the relationship between demographic characteristics, patient's complaint, and use of the emergency room. The collective approach, on the other hand, places individuals at the nexus of a balance of social forces and accounts for their behaviour in terms of the forces that impinge. An example of this work is Suchmann's[13] study of the underutilisation of medical facilities by the poor and ethnic minority groups. In this particular study, underutilisation is explained in terms of the deviant or deficit beliefs of this group due to the social disorganisation

as opposed to the fit, between the values of the medical profession and the mainstream values of middle class American society. A more recent example of the type of approach[14] is found in a study of health behaviour which suggested that patterns of health behaviour were associated with types of family structure. Factors identified as important were the nature of the marital relationship, the structure of social networks, and parental child rearing policies. An example of this type of approach in the area of utilisation of A and E services is found in Wingerts' et al [15] work on the relationship between types of family organisation and the use of paediatric emergency services.

Dingwall has outlined a number of substantive criticisms of both of these models[16], but only the more general theoretical issues which are common to both models will be described. Dingwall argues that the major weaknesses in these studies from a sociological point of view are firstly that their dependence on the methodological procedures of the natural sciences means that it is assumed that natural scientific phenomena are the same as social phenomena. Dingwall argues that this is not the case, and, whereas social phenomena merely behave, human beings act and they have intentional action and language. Dingwall emphasises the need for sociological work to examine individual's action and the meaning of that action and not to assume that actors are empty organisms responding passively to the demands of the social system. Thus, while it may be useful to relate social class or family size to utilisation behaviour, the important question to ask is why such a relationship is found. Secondly, Dingwall argues that this dependence on natural scientific methods

in social enquiry also reflects a specific orientation towards knowledge. This approach claims that its theories and explanations and bodies of knowledge have a unique access to truth. This is an absolutist version of knowledge in contrast to a pluralist approach in which all accounts of the world are of equal status. Therefore, medical theories and lay theories are, from a sociological point of view, of equal interest and status. Magic, religion, politics, science, sociology, can all be seen as folk systems for understanding the world. They can all be taken equally and seriously.

Dingwall argues that previous studies of illness behaviour, through their reliance on natural scientific methods, have failed to develop a truly sociological theory of illness. They have concentrated on behaviour without attempting to understand the meaning of that behaviour and thus failed to develop a sociological theory of action. Implicit in this dependence is an acceptance of an absolutist version of knowledge and this acceptance has meant that many of these studies have based their assumptions about lay and patient behaviour on a version of the social world which has been derived from official medical practitioners and have treated this definition itself as unproblematic. Thus lay theories of illness are treated as in some way inferior to biological and medical explanations. Dingwall argues that since clinicians' accounts have no known relationships to the experience of sick people they cannot advance the understanding of illness as social conduct. For Dingwall, a biology of illness is complementary to a sociology of illness and in no way a substitute for it. Each has an autonomous realm of problems and once this is accepted a more pluralist approach to social life can be developed.

Before Dingwall's and Fabrega's models are described, a number of comments on Dingwall's criticisms will be made. Firstly, it is evident from the previous review of the literature on emergency service utilisation that more recent research in this area began to recognise the need to view the patient or proto-patient as a social actor with the ability to make judgements and decisions in a critical, rational, and reflective manner. Thus Dingwall's point about the need to examine the meaning of individuals' actions has been taken in some respects. However the methodologies used may indicate a not too clear framework in which the patient's action can be understood.

This is illustrated by the weakness that Locker has identified in Mechanic's approach to illness behaviour. Locker argues that while Mechanic's concept of illness behaviour does challenge the deterministic approach of others by recognising the differential responses of individuals to those phenomena, in fact, his idea of illness behaviour as a social process is nothing more than the interaction of factors or variables in a unidirectional pathway of cause and effect. As he says in Mechanic's theory, "man is reduced to a medium through which variables operate to produce behaviour". In much of the research on utilisation of A and E services, while researchers have become sympathetic to the approach focusing on the "intentions" or "motives" of laymens' action in their empirical research, the image of man that has been adopted is similar to the one that Locker criticises Mechanic for adopting.

The second point that Dingwall makes about taking the culture or body of knowledge to which laymen adhere in their decision-making about illness or injury as being distinctly different from the frame-

work of knowledge in which medical practitioners' work, has not been recognised in the previous research. Certainly much emphasis is placed on examining the "problem" of what influences choice of medical care treatment, which is a problem defined by those involved in the medical world. Not surprisingly, therefore, it has been taken for granted by some authors that this organisational issue is also an issue for the patient and that in trying to explain patients' choice of treatment the notion of injury and illness has been taken for granted as unproblematic.

3.3 Sociological Models of Illness Behaviour

This shift in the approach taken by sociologists towards illness and illness behaviour began, in some respects, in the work of Freidson. For example, he stated that "what a layman picks out as a symptom of illness is contingent on what his routine capacities and experiences are in the light of his ordinary activities".(18)

Thus, a symptom for any individual will be perceived as serious according to his standard of normality which is established by everyday experience. Previous work on how layment define illness supported this point and the assumption that the lay definitions of ill health might be similar to medical definitions began to be questioned. However, Freidson's approach tended to suffer from the problem of embodying conflicting conceptual approaches. For example, Calnan and West(19) show that in his earlier work Freidson argues that patients or laymen are critically evaluating medical knowledge and doctor's performance. Patients do not passively respond to medical definitions but tend to evaluate them using their own assumptions and criteria. In Freidson's later work, not only was professional domination so overriding that laymen lost their critical ability but also

their interpretative power. This is illustrated in Friedson's notion of the lay referral system. Calnan and West state:

> "...although Friedson develops the analysis of lay referral systems he does so in a manner which suggests that such structures tend to complement rather than conflict with medical organisation, constraining the sick person in the direction of professional help. Thus, while structural and cultural factors may mitigate against the utilisation of professional services, professional dominance is such that extensive referral networks located in the community, like the school, both initiate 'medical" definitions and push people along pathways, or careers to eventual patient roles. It is this rather mechanical conception of societal reaction and its consequences that now marks the concept of lay referral". (20)

In more recent theoretical models of illness behaviour or illness action, notably those by Robinson[21], Fabrega[22], and Dingwall[23], the research question has been changed from "Why do people not use the official health services?" to "What is illness?", "How do people come to feel ill and what do they do about it?". Now in each of these three approaches there appears to be a tacit acceptance that man's ability to evaluate, interpret, and define the meaning of his world and the world of others will be influential in the course of action that he follows. While these writers are not talking about "causal" influences on action, they do explain illness action in terms of the antecedents of the action. As Locker puts it[24], "respondents statements are taken to be descriptions of the actor's point of view within which measures the precursors of action, can be located".

Robinson[25] studied the illness behaviour of twenty four families in South Wales. Each family consisted of husband, wife, and at least two children of whom one, at least, was under five years old. Each family was seen several times to gather details of medical histories, family details and attitudes towards illnesses and doctors.

In addition, each mother/wife after a trial week, filled out a health diary for a four week period. Robinson was concerned with why a person does or does not assume the sick role and the personal and social factors that influence access to the status of being sick. His study overcame the methodological criticisms of previous research in that he did not deal with a captive audience of people who have already made crucial decisions about health and illness. His was a prospective study investigating the decisions that were made at the time they were made and in the context that they were made.

In this review, Robinson's study will not be described in depth; however there are a number of points which are relevant to this study. Robinson tries to analyse individual's illness decision in terms of a rationality which involves an assumption that individuals wish to maximise their gains and minimise their costs as they define them. According to Robinson, the symptomatic person is faced with two important decisions. Firstly, what are the costs which result from the symptomatic person not receiving treatment. Secondly, what are the costs of going sick. These decisions also apply to significant others in the illness situation. The behaviour or course of action which is eventually taken is a function of the overall sum of the gains and costs of treatment. However, this model is based on the classic theory of rational man where man has full knowledge of choices available to him and full knowledge of probabilities of the outcome of the alternative choices of action available. In illness situations this full knowledge of consequences of action or non-action can rarely be made. Because of this degree of doubt in illness situations, Robinson suggests that in some cases the decision to contact the doctor for the doctor's assurance that something is wrong may "clear the air" for the

family of the sick person.

The family, in these cases, is under great pressure to do something. Robinson cites an example of a family with three children under five years old:

> "An analysis of one section of the J family's health diary reveals a definite build-up of tension about children's ailments of one sort or another over a period of several days. The climax comes when the doctor suggests that one child should have an X-ray and see a specialist. After this, no symptoms are reported for nine days ... On every visit I made to see Mrs. J., she would tell me how some member of the family was just getting over some ailment or other while another was "sickening for something". (26)

> "The worrying part for the Js was definitely their uncertainty about whether a symptom was a sign of something more important; whether a symptom was serious enough to consult about, or whether the doctor understood what the real trouble was." (27)

Thus, it appears that from this evidence for everyday health matters, the decision that something is wrong is not a clear cut one. However Robinson also makes the point that neither were there many long drawn-out series of assessments. In the majority of cases, individuals did not think out and weigh up alternative strategies to obtain a series of defined goals. Normally individuals knew what to do and did it. Robinson, however, still argues that this seemingly unconsidered behaviour is rational.

> "The decision is made by reference to the past or from the example of others, at the suggestion of her mother, from remembrance of her own treatment in a similar case, or from her recent reading of a magazine article on a relevant subject." (28)

Robinson points out that it is with reference to this kind of body of knowledge which has been acquired and built up, that the

majority of illness decisions are made. It appears, therefore, that the breadth of opportunity for decision-making will vary with the familiarity and severity of the illness situation. For example, in a situation were a person is unconscious or has a bleeding traumatic wound, formal decision-making for the patient is limited. However, in a trivial case where a patient develops a rash, the patient is afforded a great deal of opportunity for decision-making. In some cases where trivial symptoms are familiar, the decision will become routinised.

The type of study Robinson carried out, although a rarity in the field of illness behaviour, is important for a number of reasons. Firstly, it deals with illness behaviour in the context in which it occurs and therefore where it retains its true meaning. Secondly, it is concerned with the everyday health matters that occur in families. Unlike most of the previous research, it is concerned with the decision-making of less severe and more marginal complaints on a micro level and why, in certain situations, an individual becomes "sick" and in other situations no illness behaviour occurs. Thirdly, the study applies sociological models, in this case specifically of social interaction to the empirical situations, and explains why, in reality, these patterns of action deviate from the hypothetical models of action.

Fabrega's and Dingwall's approaches, in contrast to Robinson's approach, are based on theoretical propositions rather than empirical data. In his theoretical model, Fabrega[29] focuses on the information that a person might be expected to process during an occurrence of illness. "Concentrating in a theoretical way on

informational correlates of illness can be seen as articulating a set of rules that organize the data of illness (i.e. sensations, perceptions, beliefs, circumstances, etc.,) and explain the culturally appropriate acts or behaviour associated with illness occurrences in various contexts". He divides the "person" into four analy tically distinguished systems which are open or connected.

1. Biological - includes chemical and physiological processes
2. Social - includes relations between person and other groups or institutions
3. Phenomenologic - involves states of awareness/self-definition
4. Memory - unique history of the person includes experience gained from deviations in other three systems (illness categories).

Using these interlinked systems the person is continually capable of monitoring happenings and processes in the functioning of the various systems. A new deviation can be judged because of the availability of information experienced and internalised from other deviations in functioning or through the availability of "illness categories". The information available to the individual during an illness occurrence is processed in nine stages.

1. Illness recognitions and labelling - conviction that an undesirable state of affairs exists
2. Illness disvalues - evaluation of illness's meaning/or significance
3. Treatment plans - each person is believed to have available a set of unit treatment actions that can be implemented for purpose of coping with illness
4. Assessment of treatment plans - each person is capable of estimating the probability that a treatment plan will work.
5. Treatment benefits
6. Treatment costs
7. Net benefits or utility

8. Selection of treatment plans

9. Set up for recycling

This is a complex model, but it is evident from the use of certain terms that, as Fabrega admits, the approach is taken from traditional economics and elementary decision theory. People are basically rational and they will evaluate an instance of illness using the principles of cost-benefit analysis and will reach a decision regarding the best of optimal action that might eliminate the illness.

Dingwall's model of illness action[30] is similar to Fabrega's in that it distinguishes between the occurrence of biological events in the human body and the meaning of those events for the social actor. He argues that:

> "...biological events occurring in human bodies are no more intrinsically meaningful than any other natural or social phenomena. They likewise need to be cognitively organised and interpreted before becoming conditions for social action. This may of course include recognition of one's lack of comprehension and the need for inquiry as well as a positive identification of the phenomenon. Biological events may of course to some degree impose limits on the available possibilities for action, as in the case of paralysis, for example. However, for the socially competent actor, the sense and import of those limits is a cognitive phenomenon. The limitations that paralysis imposes take on a meaning only in the context of the desires of the paralysed individual."[31]

For Dingwall, then, if a model of illness action is to be developed, it must focus on the theories that individuals make use of in the context of disease.

Dingwall's explanation of the principles on which his model is based is complex, and this is not the place to discuss them in depth. However, Figures 3.1 and 3.2 show the model and there is a need to briefly summarise the main aspect of it.

Figure 3.1 shows the basic model proposed by Dingwall. The model shows that when a disturbance affects the body, depending on the priority accorded to the disturbance (i.e. the actor has a range of priorities within his plans in which body disturbance is located), the automatic expectation of a stable and predictable relationship between a person and his body may not be sustained. If he is to continue to sustain a presentation of himself to others as an essentially normal person, then remedial action is needed. Figure 3.1 shows the various processes that the actor goes through, beginning with interpretive work of the problematic experience; a decision to act is made and effects of treatment are assessed.

Fabrega argues that what motivates a person is how much the costs of the disturbance to the person outweighs the benefits. Dingwall suggests that the substance of this cost-benefit decision making by the actor depends on whether the disturbance does or does not interfere with the maintenance of an identity as a normal person.

Figure 3.2 shows an expanded version of the model which incorporates a number of aspects, two of which are the influence of others and the introduction of official health knowledge. Now the introduction of these two concepts have implications for the study of accident and emergency behaviour in that not only is decision making seen to be dependent on others but also a circumstantial element seems to be incorporated into the model. (It must be remembered that these two elements were identified in previous studies as being important influences on choice of medical care setting.)

Figure 3.2 shows an expanded version of the model which further incorporates a number of aspects, two of which are the influence of

the interpretive work of lay others and the introduction of official health knowledge. Dingwall has laid emphasis on the interpersonal nature of decision-making about matters of health and ill health and has attempted to translate some of the structural concepts which have been identified in the illness behaviour literature such as social network[32] or lay referral system[33] onto a level which can be understood in terms of actors' everyday decision-making. Dingwall's model outlines the importance of the process of interpretation, delay, and consultation between lay actors. He also refers to this process being "short-circuited" by a set of circumstances. He states:

> "The principal events in this set are screening programmes and accidents ... Screening programmes may reveal disturbances of which the sufferer is unaware, while accidents may create disturbances so suddenly that the sufferer is unable to act. Accidents may, moreover, short-circuit in two ways, either through the intervention of official medical agents or through the intervention of other laymen. The latter applies particularly to accidents in public - car accidents, train or aircraft crashes, earthquakes and other natural catastrophes. In these cases we find a relatively direct input of official health knowledge and official health services that we would not otherwise see until after a considerable amount of lay interpretation." (34)

This particular point is relevant to this study because not only does it specifically refer to accidents but also it identifies the public nature of decision-making in some episodes of illness or injury which may, according to this argument, be different because of the input of official health knowledge. Unfortunately, Dingwall doesn't specify in what ways the decision-making would be different and if such differences would influence patterns of help-seeking behaviour.

3.4 The Weaknesses in the Interpretive Approach to Illness Behaviour

The practical application of a theoretical model inevitably poses problems. Some of these practical problems will be discussed in the next chapter, but it must be emphasised that Dingwall's emphasis on the need to examine the substance of lay-theorising and lay-knowledge means that it would have been fruitless for him at this stage to propose *a priori* propositions for his model. However, with regard to the proposed research in this study, it will be of value to identify those aspects of the model that would be relevant or may need to be modified.

This study is specifically concerned with help-seeking behaviour and choice of medical care systems so questions about assessing problematic experiences and the imputation of the label "illness" are of consequence if they have some relevance for help-seeking behaviour. For example, the decision to go to the A and E department may be conditional on the complaint being labelled or interpreted in a manner such as "traumatic" or "emergency". Thus definitions of emergency or the application of diagnostic labels would be of importance in understanding patient action, if it led to them discriminating between sources of medical care. Previous evidence has pointed to the importance of the setting of the decision-making on the consequent pattern of help-seeking behaviour. The question "Why do certain settings or interpersonal circumstances lead to varying patterns of action?" is therefore important. Other related questions of equal importance are whether making an evaluation and decision by oneself leads to a different outcome than decisions involving others, and what others bring to the situation and under what conditions others

are influential. One of the possible weaknesses with Dingwall's approach is that there is no account of why,or how, possible actions emerge out of interpretations or interaction. For example, he discusses the importance of interpretative work by lay others, but under what conditions is their advice taken into account and in others disregarded? Nothing is said about what influences the nature of the interaction between individuals and why this should be influential.

Of particular importance in Dingwall's model are the ideas of lay and official knowledge. What seems to be neglected is the interplay or mixing of these concepts. While lay people may evaluate health or ill health within different frameworks or settings, to medical people the knowledge itself may consist of images or stereotypes that have been generated through official ideology and have been taken on by lay people. It is evident that Dingwall's ethnographic perspective is derived from anthropological work. Thus the differences between lay and medical knowledge may be more applicable to societies in which western scientific medicine competes equally with alternative frameworks of knowledge. On the other hand, in western society the monopoly of western scientific medicine with its attendant assumptions makes it difficult to ignore the problem of the intermixing of the two bodies of knowledge. Perhaps one of the most important questions is how far do lay people, adopting their own framework of lay knowledge, know and adhere to the solutions that are offered through providers or medical channels. This raises a fundamental issue which might illustrate the shortcomings of the interpretative approach. Dingwall, in attempting to explain lay

action through the eyes of the layman rather than through the official medical eyes, emphasises the interpretative powers of human beings and the difference in the framework of knowledge available to laymen. However, the power of medical monopoly and medical ideology means that lay ideas, assumptions, and knowledge may have been generated from western scientific medicine. It could be that interpretation of signs and symptoms may not be dominated entirely by medical knowledge, but official ideology about appropriate behaviour with regard to use of the doctor may have had an impact. This question of how, where, and why ideas originate is not one which has concerned those adopting the interpretative approach. Similarly, the question of why certain ideologies should or do dominate is neglected.

Another problem of Dingwall's approach is the apparent assumption that medical knowledge and its definitions are unproblematic. Quite understandably, Dingwall's emphasis is on examining illness and illness behaviour from the lay point of view, but there seems to be an assumption that, unlike lay knowledge, medical knowledge is unified, clearly understandable, and applicable. However, empirical research has identified numerous examples of the problems medical practitioners face because of incomplete knowledge about prognosis, diagnosis, and treatment. A good example of the differences in doctor's interpretative practices can be found in Bloor's work[35] on doctor-patient encounters in tonsillectomy clinics. Bloor showed that even when doctors agreed on what signs or symptoms are indicators of the need for surgical treatment there was still variation in the interpretation of signs and symptoms. However, it could be

argued that while medical knowledge may be problematic, medical ideology is all pervasive and it is this ideology that has been so effective in protecting medical knowledge from scrutiny (especially from the scrutiny of lay people).

A further weakness in the model seems to be the failure to account for the ways different situations influence not only the subsequent outcome or pattern of activity but also the nature of the interpersonal activity. Individuals take on a variety of identities, such as parent, employee, man, young person, etc. Their images of what type of person they should be in different contexts, such as what type of parent figure, may influence the nature of illness and help-seeking behaviour. For example, a parent may be more likely to go to the health services for a problem with a child than with themselves, or a neighbour, or a stranger, if involved in making a decision about someone else's illness or ill health may well appeal to a different set of images about what should be done if they personally were the sufferers. These are purely speculative points, but will be some which will be investigated in the proposed study.

These are some of the more substantive criticisms of the model, but there have been more fundamental criticisms of this type of approach - the interpretative approach - some of which have implications for both the study of illness behaviour in general and this proposed study.

Dingwall's model maps out the theoretical options of pathways that people follow or could follow when responding to "illness" or or "threats of illness". Now there is an implicit assumption that

certain events such as definition of the problematic experience as "illness" may lead to certain pathways towards the official medical services. While Dingwall doesn't provide any detailed formula for what may produce certain patterns of action nor does he provide for a theory of action, he does imply antecedent events leading on to other events. Thus he seems to be talking about the nature of the interpretative work carried out by laymen leading on to the social process of help-seeking behaviour. Now the identification of these antecedent events, in the case the meaning or nature of the interpretative work, suggests that this model attempts to incorporate an interpretative element into a positivistic form of analysis in that it maps out antecedent circumstances which may lead on to other events. Now this is interesting because one of the major criticisms of the interpretative approach is that it has "no room for an examination of the conditions which give rise to the actions, rules and beliefs which it seeks to explicate and, more particularly, it does not provide a means whereby one can study the relationships between the structural elements of a social order and the possible forms of behaviour and beliefs which such ailments engender..." Fay goes on to argue "...that the sociologist is not only interested in the meaning of particular types of actions, but those causal factors which give rise to and support the continuing existence of these meanings".(36) He proposes a type of framework which he terms uses the"quasi-causal" type of explanation. He argues that "Consciousness functions as a mediator that between antecedent factors and the subsequent action", and that "men act in terms of their interpretations of, and inten-

tions towards, their external conditions, rather than being governed directly by them".(37) He argues that external conditions are not causes but warranting conditions.

In Dingwall's analysis, external conditions are not mentioned, as such, which fits with the more traditional interpretative approach, and yet he does seem to imply antecedent events which influence outcome. This is perhaps a recognition that if one is interested in explaining what people do and why they do it, which is one of the major questions posed in this study, then some kind of "quasi causal" framework is necessary. The important point about the proposed framework is that it takes seriously the meaning of actions for lay people.

3.5 Empirical Studies and a Sociological Study of Illness Behaviour

Some empirical studies have adopted a similar perspective to that of Dingwall. For example, Cowie(38), in a study of cardiac patients, examined the way symptoms were evaluated and how patients responded to them. He found that their response was coloured by the context in which pain was experienced. Their perception of the need for urgent medical attention was more likely to occur when the paid had been sudden, acute, and unexpected. However, sixteen of the twenty-three patients initially applied a commonsense lay diagnostic category. Some identified it as a bout of indigestion; others related it to a recurrence of other illnesses they recently had which wasn't serious. This process of normalisation was upset by their failure to understand the physical experiences in terms of the interpretive framework available to them. It was also upset by a break

in the accommodation between interpretation and experience. This accommodation was based on changes in the quality and duration of the problematic experience. Cowie reports that this sometimes occurred when lay others, such as spouses, evaluated something as wrong because the sufferer was not acting in accordance with their conceptions of what their partner normally does. Cowie's study clearly illustrated the importance of understanding how illness is interpreted and how the social context in which illness is evaluated colours definitions of the need for medical attention.

Alonzo,[39] in his study of acute illness behaviour of cardiac patients, comes to a similar conclusion to that of Cowie when explaining decisions to seek medical care. He states:

> "...the individual is viewed as a social psychological actor who attempts to cope with an emergent health crisis by devising a strategy to mobilise resources perceived as effective in controlling the course of the illness, that is, in reducing, altering or halting symptoms and essentially gaining control or establishing a stable relationship with signs and symptoms. A stable relationship with symptoms implies that the individual perceives a strategy for controlling them to his satisfaction, to the satisfaction of lay and medical others and in a manner satisfactory for the social situations in which he expects or is obligated to participate."

He goes on:

> "This image of the individual is somewhat different than the image frequently reflected in studies of acute coronary artery disease where there is an emphasis on the pejorative aspects of delay, denial, or rationalization." (40)

Alonzo argues that health status crises occur when no effective coping strategies can be devised and thus there is a breakdown in the relationship between the individual and his normal body identity. Alonzo goes on to describe a six stage pathway to medical care. Of particular interest is his comment on the role of lay others. He

states that "It cannot be overemphasized that lay others - family, neighbours, friends, workmates or strangers - play an inordinately significant role in care seeking during acute life threatening illness"(41).

Among other findings, he showed that the lay others least likely to tolerate extended self-treatment and evaluation were non-family members and groups of lay others, family or non-family lay persons. This is important as it identifies the contextual influence on decisions to seek medical care.

In a previous paper, Alonzo(42) proposed a conceptual analysis which emphasised the contextual or situational conception of everyday illness behaviour. This analysis was concerned with explaining how individuals cope or contain illness and do not consult the medical services. Alonzo identifies four situational types:

(i) Everyday situations where participation is not expected to produce signs and symptoms such as family dining, reading, attending school.

According to Alonzo, body state deviations in these situations are containable as side-involvements within the situation.

(ii) Activities such as athletics, occupational setting with high risk and periods of excessive demand in daily situations such as examination where illness or injury is to be expected. Because of this expectancy, there are resources for prevention and containment. Also, there is a greater range of signs or symptoms that are containable compared with the first type.

(iii) those situations where person has time to tend to bodily changes and where social life gives him/her breaks or free time or transitional situations

(iv) Diagnostic, illness, health training or therapeutic situations where bodily changes are given dominant situational attendance

For Alonzo, situational containment of signs and symptoms is generally accomplished within the first three types of situations. Alonzo

identifies eight different factors that may influence containment of signs and symptoms. They are:

(i) commitment to situations. The obvious example is the evidence of soldiers committed to the heat of the battle take little notice of painful injuries. Commitment may be influenced by the severity of the surgery or illness but perceived severity will also be a function of degree of commitment

(ii) Others' assessment of containability of signs or symptoms

(iii) the power of the individual in the situation, who has the power to maintain, change, or terminate the situation

(iv) Propriety. Should an individual remain in a situation despite compromised performance? For example, should an airline pilot still work when illness may compromise his capacities?

(v) Availability of situational resources which help an individual cope, such as first-aid or time to take it easy.

(vi) Situations where those who have chronic illnesses or have normal processes such as pregnancy or ageing can contain disturbances or are not out of their depth

(vii) symptom meaning - some illnesses have a meaning over and above a situation such as heart disease compared with flu symptoms

(viii) age and sex circumstances such as expectations about men and women's thresholds for illness and containment

Although Alonzo doesn't emphasise the interpretative ability of individuals as does Dingwall, he does bring a number of important concepts to bear on the study of illness behaviour. This situational analysis is of particular relevance to the understanding of accident and emergency behaviour as there is evidence that situational differences may play a part in influencing utilisation behaviour. He also tries to take into account the issue of power in interaction which was neglected in Dingwall's analysis.

From the work of Cowie and Alonzo it is evident that the meaning attached to symptoms is influential in decisions to seek medical care and that meaning is directly understandable in the social context in which it was created. In addition, situational elements also colour the way body deviations are evaluated and responded to and the situational elements will influence an individual's action according to many of the factors described by Alonzo.

Finally, a recent Canadian study[43] has focussed on how patients negotiate their way into an emergency department. One of the aims of the study was to "secure a better understanding of the nature of the endemic disjuncture between lay person and hospital functionary in the emergency room context"[44].

The author of this study criticises the conventional approach to the illness behaviour. He states that "the theoretic approaches to lay constructions of dysfunctioning seem to invariably rely on some version of the reality of illness and the variability of response especially when making reference to so called obvious problems"[45].

Albert, the author, then quotes a study which emphasised the need not to negate the objective clinical disorder. This particular study suggests that a bleeding traumatic wound would obviously lead to medical attention, whereas those with a chronic and insidious disorder may or may not be a reason for seeking help. Albert suggests that this type of research treats the process of perception as social and the dysfunction as a concrete reality. Albert states:

> "This approach is valid insofar as it reflects some of the practical exigencies of the professional practice of medicine. However, for the lay person, illness is irrevocably experienced as a contexted or situated activity. Persons are cognizant at the time of awareness of dysfunction not only of what is the matter but of an entire range of relevancies which both inform

and create the 'just what is the matter'"(46).

This approach is similar to the one proposed by Dingwall, although the causal element which is significant in Dingwall is not apparent here. Albert then goes on to show how people go about discovering and presenting their problematic experiences in the emergency room. He found that the persistent disjunctive between lay presentations and subsequent professional evaluations of their complaints does not seem to be accountable by attribution of it to a lack of information on the part of the patients. He found that patients used several procedures to discover and prevent their complaints. First, patients presented self-evident complaints, such as a bleeding cut. The evidence stood by itself. It was the obvious thing to do and no case was needed to account for the use of the emergency services. Secondly, self-formulations were used, such as explaining that they weren't the type of person to waste the doctor's time but this was a special case. Third, ambiguity and ignorance were also cited as reasons for warranting treatment. The patient could not account for his injury or explain it. Finally, the fourth procedure was use of generic terms to classify the complaint as amongst a class of things that needed treatment, this under the term "type of thing".

Albert concludes by explaining the difference between lay and professional approaches. He states:

> "The medical professional expects a replication of approved medical versions and evaluation techniques in lay persons. They tend to act as if lay persons see these events in just the same way. Such replication, however,on the part of patients occurs in name only; the product ,in this case a treatable dysfunction is often a simulacrum of the 'real' professional item. It is arrived at by quite different methodical practices not by diag-

> nostics but by contexting it everyday structures. This difference is not due to an inability on the part of the lay populations to grasp the facts but,rather, to the constitutive differences between the lay and professional enterprises"(47).

One of the important points about this study is that instead of trying to account for lay people's use of emergency services, assuming ease of accessibility, it sees barriers to its use and concentrates on examining how lay people "accomplish" overcoming these barriers. If this study concentrates on explaining how lay people were able to get treatment at a casualty department,given the vast differences between professional and lay everyday worlds, it also emphasises the contextual nature of lay interpretations and suggests that accounts in the hospital context may be different from those given in other contexts which are more familiar to lay persons.

3.6 Summary

In summary, the sociological literature on illness and illness behaviour has identified a number of important concepts which have been neglected in research into the use of casualty services and will be useful for the proposed study. Some of the most important points were these.

1. The body of knowledge which laymen adhere to in matters of health and illness may be distinctly different from that of the professional or medical person. It may be more useful to start from the premise that these two bodies of knowledge are different and given equal status rather than assuming one is more dominant than another in lay-people's thinking. Thus there may be a potential tension between organisers and suppliers and the consumer. The

implications of this pluralistic perspective for empirical research is that the preconceived models of illness behaviour or assumptions about the way lay people cope with illness should be abandoned. If the intention is to discover and describe what goes on in illness episodes it must be assumed that the researcher does not know what activities are involved in evaluation of illness before he or she goes into the field.

2. The evaluation of illness experiences and decision making are interpersonal activities which involve lay others and, in special situations, may also involve official representatives. Thus the context in which the illness episode occurs will influence the type of social network involved which itself will influence the nature of the decision making.

3. Much of the previous sociological literature on illness and illness behaviour has never translated the effects of external conditions such as "triggers" into an interpersonal theory of social action. Similarly, the more recent interpretative approach may have neglected external influences. The work on situational analysis could possibly provide a framework for integration of the two approaches.

4. The shift in the approach to illness behaviour has not been as dramatic as first believed, as the more recent theoretical models have replaced psychological attributes or social orientations with meanings or interpretations as antecedent precursors of action.

3.7 Implications for the Research

It was evident from the previous chapter and from this chapter that much of the research on use of emergency services and some of the sociological research on illness behaviour has been dominated by a perspective which assumes that the lay population shares the same beliefs and ideas about illness, illness behaviour, and help-seeking behaviour as those held by the providers. Some sociological research has attempted to shift away from these medically dominated approaches, but then have replaced the professional assumptions about lay illness behaviour with other models which are derived from the researchers' preconceived ideas. Lately, it has been argued that if the aim is to follow the ethnographic pursuit of discovering what goes on in illness episodes than any preconceived ideas or models, whether they have been constructed by providers or researchers, need to be abandoned. This ethnographic approach would assume that illness is a problematic experience and illness action and help-seeking behaviour involves decisions which are potentially problematical.

The general aim of this research is to discover and to describe how people cope with accidents and emergencies in the community. The emphasis will be on discovering and explaining illness behaviour and help-seeking behaviour after an accident or an emergency rather than on concentrating on the way actors interpret and cope with the problematic experience of illness. It is impossible to divorce the two as many sociologists have pointed out and this will be clearly illustrated in the following chapters. The methodology and research design

for achieving such an aim is described in the following chapter. Chapter five outlines the range and the nature of the accident and emergency "episodes " under study as well as presenting a detailed description of the various pathways that patients followed to reach the A and E department. It is necessary to present these data as they provide the backcloth for the more in depth analysis and make it possible to locate the various elements identified for in depth study within the overall pattern of illness and help-seeking behaviour. It is hoped that this approach would provide a scientific method of examination of the use of the A and E department from the point of view of the user.

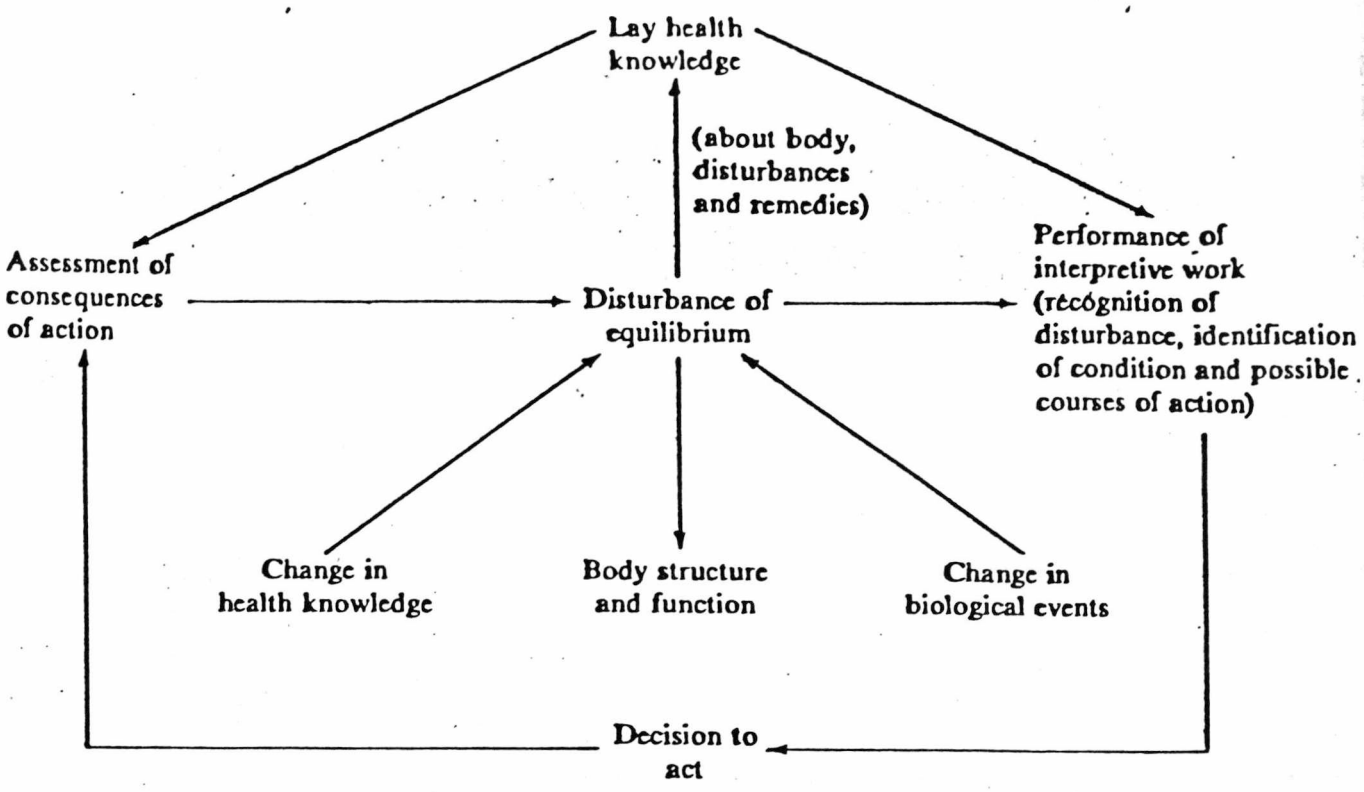

Figure 3.1 *Basic structure of illness action model*

(from: R Dingwall, Aspects of Illness in Everyday Life, Martin Robertson, 1976

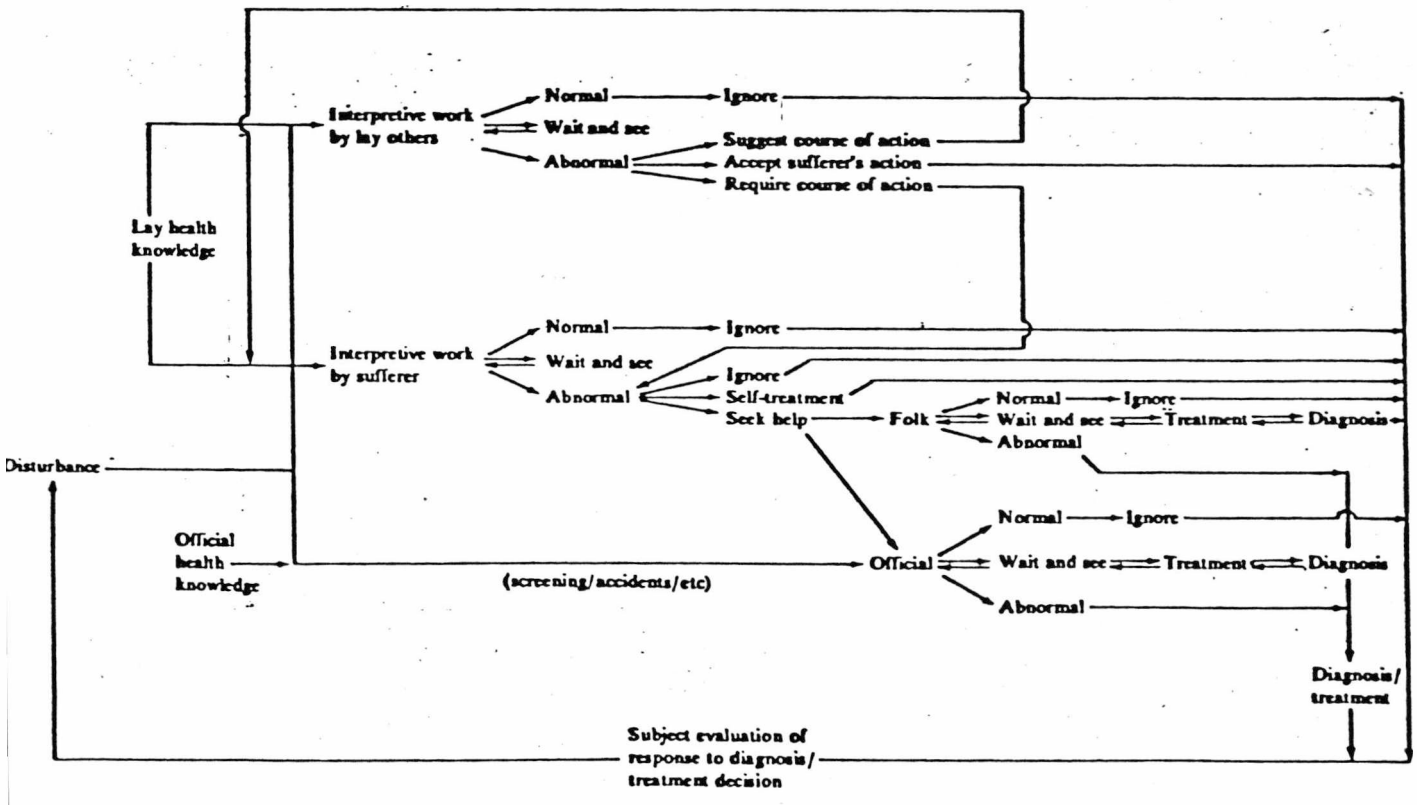

Figure 3.2 *Some pathways through illness action model*

CHAPTER 4

Research Objectives, Design and Methods

4.1 Research Objectives: a Detailed Statement

In the light of the literature review presented in the previous chapters, it is now possible to specify the research objectives in more detail. The major aim, as was stated previously, was to examine the conditions and reasons which explain patients use of the hospital accident and emergency department. However, it was evident that, to do this adequately, the sample must consist of a representative group of attenders at an accident centre and at general practitioners as well as a representative group of the population who did nothing at all. Such a study would need to be a prospective one and the data collected through observation at the "scene" of the episodes, thus placing the emphasis on "illness" and perception of disorder rather than "utilisation" behaviour. The practicalities of such a research design have already been discussed and previously researchers have had to make do with comparing samples of accident centre attenders with GP attenders with clinical conditions for which the patients are believed to have a choice of treatment facilities. These data are usually derived from the "accounts" of patients after the episode has happened.

In this study, there was the added difficulty of using only a sample of accident centre attenders. Taking such limitations into account, this study was carried out in the following way:

1. A random sample of attenders of the accident centre in the Kent and Canterbury Hospital was studied. The aim was to gain an overall picture of how, where, when and why patients come to an accident centre, thereby providing part of the information necessary to explain patients' choice of medical care setting.

2. The random sample of attenders will be used as a basic framework for two in depth studies that will examine

   (a) the influence of social circumstances and situations on decisions to seek medical care and choice of medical care setting

   (b) the influence of lay evaluation and interpretation of the sufferer's condition on decisions to seek medical care and choice of medical care setting

Data gathered through in depth interviews will be used to supplement data gathered in the main sample in the analysis of questions 2a and 2b.

Questions 2a and 2b were specifically picked out for examination in the study for a number of different reasons. First, the policy statements put forward by the providers (see Chapter I) contained various images of the typical attender of the A and E department. For example, the Casualty Surgeon's Association seemed to portray the typical attender as being a person who was a victim of social circumstances and social predicaments. Thus the analysis will attempt to examine the significance of social circumstances

on illness and accident behaviour. In other policy statements, the typical attender was portrayed as a person who was using the hospital department for a minor condition and the GP was deliberately bypassed. The analysis will attempt to examine how lay people classify and define conditions which professionals define as minor conditions and which are "inappropriate" for the hospital department to deal with. Also the analysis will attempt to examine whether the lay person believes a choice of medical care settings exists for the treatment of certain conditions or whether lay people have specific ideas about the appropriate place for medical care for certain types of medical condition. The idea that a real choice of setting for medical care exists for the lay person is one which appears to be taken for granted in many policy statements (see Chapter I).

Secondly, preliminary quantitative analysis based on data from this study[1] and results from other studies[2] suggest that the circumstances surrounding an episode such as site of episode and status of decision taker may play a significant part in influencing evaluation of an episode and choice of medical care setting. These analyses also identify signs and symptoms of a condition as being important influences on the way lay people assess the significance of a condition and the subsequent choice of medical care setting.

4.2 Methodology

4.21 Conceptual Approach

In the previous chapter, the importance of translating the research questions into a coherent framework of illness action was

emphasised, the assumption being that people do not just behave or react to external circumstance or react to "external" conditions, but they interpret; and this action may be based on this interpretation. In the case of illness, illness behaviour, and utilisation behaviour, it is not enough to say that individuals react to symptoms in different ways and different social contexts lead to variations in patterns of action. Individuals interpret and evaluate problematic experiences according to the meaning that the disturbance has for them in their everyday lives. This interpretative process will be the basis on which their judgement or decisions are made. Sometimes this decision-making process, instead of being based on the cost-benefit model, is routinised(3), because the individual or individual's family is confronted by phenomenon which are familiar. Thus the individual has available a plan or recipe for action which he takes for granted. Sometimes the action has unintended consequences. Thus, if the research questions were to be taken seriously, they had to be translated into a model for illness action which emphasised both the interpretive power and practices of individuals as well as the interpersonal nature of social life. Possibly one of the most coherent theoretical models of illness action to be developed to date was that proposed by Dingwall. Not only did it incorporate all the conditions described in the above, but it also appeared, if only superficially, to be able to account for the "circumstantial" elements in terms of a model of interpersonal relations. As with most theoretical models, their major weakness is their generality and Dingwall's is no exception. However, given the approach adopted by Dingwall, with its em-

phasis on examining how individuals themselves interpret and confer meaning on body disturbances, it would be illegitimate for him to attempt to explain these processes without recourse to empirical data. So the usefulness of the Dingwall approach is that it has translated the "circumstantial" elements into a meaningful framework but it **cannot** help with explaining the nature of the interaction between laymen and "others", and why, as a result of that interaction, certain courses of action are followed.

The Dingwall model has been used in this study as an overall frame of reference although it does not provide any of the substantive material necessary to build up a coherent picture. However, the application of this framework to practical research posed considerable methodological problems, problems which are of a general nature and would apply to any research design in any research context and those problems which are specific to this research context.

On the general level, Locker has identified a fundamental problem for the application of this type of theory to empirical study. He says that:

> "Whether the assumptions that actions emerge out of meanings can be verified is something of a problem, for in order to know what meanings were operative at any point in time the researcher has to make judgements about meaning himself or rely on the accounts presented by the action concerned. The first is illegitimate, and for the second to have any currency, those accounts must be collected at the time the actions are being studied and constructed." (4)

Locker queries the possibility of gaining such information as he says one would need "to get inside a person's head to prove direct connection between meaning and action".

Apart from this fundamental problem highlighted by Locker, there are also specific methodological problems which the research

was faced with in this research context. Ideally, the research should take a random sample of the population and monitor their health and illness behaviour through observation and interview. This would have enabled the researcher to identify when, how, and why individuals contact different professional medical agencies. As the area of interest was to identify what went on in situations where the individual's routines were disrupted by unanticipated events, I would have had to wait for our respondents to become involved in such "episodes". Obviously, this would only be possible in a situation where the researcher had unlimited time and resources as well as continuous access to the subject's daily lives. Therefore I had to limit the study to sampling from the population that attended the A and E department. This enabled me to contact patients who had come to the hospital after being involved in episodes in a wide variety of social situations. This emphasis on help-seeking is not the best way of identifying subjects if Dingwall's approach is to be applied, but given these practical constraints the choice was limited. Also, it would have been of limited use asking a random sample of the population about their action in various hypothetical social situations. Such data may be useful but without specific episodes to focus on, the amount of detail which was required about the episodes may not have been forthcoming. Future research might examine and contrast the way lay people perceive the experience of being involved in accidents and emergencies with how lay people imagine what it would be like.

Some problems of interpretation are raised by having to use retrospective accounts. First, in the analysis of pathways, the

respondents' accounts were taken on face value or as literal accounts, and some of the data were used as "facts". For example, where the episode occurred, who the person spoke to, how the episode happened, where the decision to seek medical care was made and who made it. I assumed that most of these data would be free from interpretation because of their apparent "neutrality" for the respondents concerned. Secondly,where the interview talk was the basis of the analysis, a problem arises because throughout the importance of seeing the individual as interpretive has been emphasised. Given that both the sufferer and others give retrospective accounts of what they did and why they did it, their stories could have been coloured by their state of knowledge at the time of the interview as well as their interpretation of the context of the interview. Perhaps one shouldn't take these accounts as literal translations of what the individuals meant by their actions at the time of the episode. It is not only that the respondents may give the interviewer a "public" account or an account which they feel the interview wants to hear or one that fits in with what they believe to be official morality; it is also that since the episode or episodes happened, the respondent himself may have constructed an explanation for himself which appears "rational" and which may have little to do with what he really felt at the time. However such limitations do not totally undermine the usefulness of these data for the present purposes, for they indicate rules and conditions which respondents use to guide them in social action. This is of particular relevance to people whose work involves decision

making about what to do with people who are ill or injured. This is particularly true of the police where they are frequently dealing with injuries or sudden illness. In the circumstances, individuals develop "rules of thumb" which, while adapted to altered circumstances, may not change significantly in their interpretation. While actors may be concerned to justify past actions, it is assumed that explanations of the basis of routines do not change markedly from context to context.

Previous studies have focused on examining illness behaviour in relation to specific illnesses. The major concern in this study is with help-seeking behaviour in relation to the use of the A and E department, although it is necessary to describe in more detail the nature of the episodes under study.

Episodes involving all categories of new patient attenders at the A and E department were included as topics for study (apart from rung-in admissions). It would have been illogical to have constructed definitions of the type of episode to be included in the study based on predetermined criteria, given that the emphasis in the study is on discovering how lay people interpret and evaluate these events. The terms "accident" and "emergency" are used loosely when applied to the range of episodes under study, and it is not implied that lay people imputed the labels "accident" or "emergency" to the episodes that they were involved in. One of the questions under study in this research is to discover how lay people define an episode as an emergency.

Literal definitions of both the terms "accident" and "emergency" include elements of suddenness or unexpectedness and unwantedness. The term "accident" implies a degree of unavoidability and unintentionality. The term "emergency" rather than accident may involve

an assumption of seriousness or serious disruption in "normal" activities and the need for immediate remedial action. The element of immediacy is involved with episodes labelled as "accidents" in the causation process rather than in the response to the event itself.

The evidence presented in Chapter One has shown that official and professional definitions of emergency and accident are varied. However, it is possible to predict the range of complaints that might be found in the study sample according to purely clinical criteria. It might be expected that the large majority of patients would be suffering from an injury and a smaller proportion suffering from illness. This prediction is based on available evidence which shows the case mix of a hospital A and E department located in a provincial area with the support of a general practitioner service. It is also difficult to predict how this clinical case mix might affect the pattern of help-seeking behaviour that might be discovered in this study. One difference in the way lay people may experience injury as opposed to illness might be in the way the cause of the disturbance in body functioning can be identified. In the case of those problematic experiences which are clinically defined as injuries the sufferer may immediately be able to attribute the reason why the body disturbance arose because a cause can be associated with a specific external event or specific activity which occurred at one particular point in time. It might be less easy to pinpoint an event or activity or a specific time when illnesses develop, although external agents such as viruses might be involved in causation. This simple conceptual distinction

between illness and injury is not always applicable. For example, some injuries are caused by movements of the body and no external cause can be directly attributed. However this distinction between the nature of injury and illness may have some implications for the way signs and symptoms are interpreted as well as influencing help-seeking behaviour. Evidence presented in the previous chapter has shown that lay people consult medical experts when they can no longer account for the presence of signs and symptoms and they are uncertain about what is wrong with them. The implications of this conceptual distinction between injury and illness for the study of help-seeking behaviour will be examined in detail in this study (See Chapter 8).

4.22 The Characteristics of the Catchment Population of the Accident and Emergency Department

This study focussed on the A and E department of one particular hospital - the Kent and Canterbury hospital. This hospital was chosen because it functions as the major accident centre for a large and predominantly rural catchment area, with extensive coastline and a large number of visitors during the summer months. The location, therefore, differs from the heavily urbanised setting in which most comparable studies of A and E departments have been conducted, and the results should be of comparative value in developing a general understanding of accident and emergency behaviour. In addition, this area contains a reasonably stable and accessible GP service, which means that the proto-patient has, at least in theory, a real choice between that and the hospital. This is borne out by

the finding that the vast majority of patients were registered with a GP in the local area.

The department at the Kent and Canterbury serves as the Accident Centre for the East Kent area. Given the rural character of the environment and the extensive coastline with its attractions for holiday-makers, a number of peripheral casualty departments are also present. Figure 4.1 shows the location of these peripheral casualty departments and their times of opening. Figure 4.1 shows that all these departments are open during the daytime only, apart from Margate, which is open from 8 a.m. - 12 p.m. In addition to these there are a number of Cottage Hospitals who provide a 24 hour service, staffed by nurses and with GPs on call. These cottage hospitals do not have X-ray facilities but the casualty departments, which are staffed by casualty officers, do. Thus for a 24 hour period all the major cases will be referred to the Kent and Canterbury Accident Centre. In addition, it serves as the casualty service for the Canterbury area on a 24 hour basis, as well as being the only casualty service available for most of the area during the evening hours and the only casualty service available between the hours of 12 p.m. and 8 a.m. It is evident that the catchment area of the Kent and Canterbury A and E department varies by time of day.

The emergency service provided by the hospitals is complemented by GPs who are required to provide, if possible, a 24 hour emergency service for all their patients. No data are available at present on the use or effectiveness of these services. Also, no data are available at present on how many GPs treat minor trauma, such as stitching of cuts or the provision of facilities in general practition surgeries

for dealing with such conditions. Health Centres are situated in Dover and Whitstable.

Other studies have suggested that the structure of GP services in the area has implications for the use of an A and E department. For instance, in the Newcastle study (see Table 2.1), the results from their statistical analysis show that presence of appointments systems and deputising services showed no demonstrable relationship with patients' decisions, although GP partnership size did. Patients with single-handed practitioners tend to present to the A and E department. Available data for East Kent[5] show that "as in England as a whole about 40% of general practitioners are single handed". The overall average GP list size for East Kent was very similar to that for England as a whole.

Variations in morbidity, mortality, and in consultation rates have been found to be related to socio- demographic characteristics of the population. Available data show that compared with England and Wales, the proportion of persons of retirement age is considerably greater, and of younger age groups smaller, than in England and Wales as a whole. These differences may have important implications for the interpretation of the results from this study as the A and E hospital service has been recently termed "the young males health service"[6]. The social class structure in East Kent as a whole is similar to that in England and Wales. Mitchellhill also argues that while the area had lost its attraction as a holiday resort, it is still seen as an appropriate place for retirement. She says that

> "In the coastal areas of Hythe, Herne Bay, Margate and Broadstairs, over one-quarter of the patients are over 65 years of age. Even though the number of holidaymakers specifically staying in the area may have decreased there had been a considerable increase in the amount of traffic going through the area to the ports for the Continent". (7)

4.23 Sampling Procedure

A random sample was taken of all new patients who attended the accident centre over a period of a year, excluding only those patients who were categorised as "rung in" admissions.* A separate study is being carried out on this particular group[8]. In all, 637 attenders were sampled. Given that the aim of the study was to identify the conditions and circumstances which lead to the utilisation of the A and E department, it was important to have a sample that embraced all types of new patient that attended the department. Hence the sample was taken throughout the 24 hour period. The sample had to be taken over a year because of the influx of tourists and other visitors during the summer months. It was assumed, therefore, that the sample would accurately represent the population of new patient attenders. No other study carried out in this country up to now appears to have used as representative a sample as this one.

The sample was selected by taking a random number out of a range of 1 to 50, in this case it was 39, and using that random number for selecting out the target respondent from each subsequent group of 50. Thus the 39th patient in such a group of fifty was selected for interview. The corresponding numbers were asterisked in the casualty register, so when the patient arrived at the accident centre it was possible for the receptionist to identify him. Each selected patient was given a form outlining the purpose of the study, emphasising the confidentiality of the data and asking for their

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*"Rung in" admissions are those cases where a GP has organised the admission of one of his patients and the patient is admitted through casualty.

co-operation and also for an appropriate time for interview. This form was given to the interviewer or the researcher who went to the patient's home where possible at the appointed time.

On the practical side of the day-to-day running of the study this sampling procedure worked well and was carried out efficiently by the reception staff. However it was assumed that all new patients who attended the accident centre were registered in casualty and that the sampling procedure would be representative of the population of new attenders. However it became evident sometime after the study started that not all patients going to the casualty were entered in the register. In some cases where the staff felt attendance was "inappropriate" the patients were redirected and not registered. Thus they would not have been available for sampling. It is believed that this group made up a "small" proportion of the overall patient load although a more accurate estimate is being identified.

The study itself began on June 27th, 1977 and finished exactly a year later.

4.24 Data collection procedure

In the first part of the study where possible the patient was interviewed in his or her own home as soon as possible after attendance at the accident centre. The reasons for interviewing in the home rather than in the accident centre were twofold:

1. After pilot interviewing in the hospital it became evident that patients' answers could have been influenced by their presence in the hospital setting in that they were aware of the rules that the hospital followed and didn't wish to upset these rules which could interfere with their treatment.

2. Many patients were too ill to withstand a 45-minute interview at the time of their treatment.

The problem about interviewing in the home even only a few days after the event happened is that the patient's account is retrospective, and it may have differed from an earlier account given directly after the event had occurred. The later account may have been coloured by information which had been received since the attendance at the accident centre. While it is not suggested that there is such a notion as the "true" account, it is believed that the earlier account may be a little nearer to what the patient understood to have gone on at the time of the episode than the later account.

Most of the interviews were carried out in the patient's home after attendance at the accident centre. When the patient did not live permanently in the area and was only spending a short time in the area then the interviews were carried out in the hospital. When it proved impossible to get an interviewer to the hospital in time to see the patient, e.g., in the middle of the night, the patient's home address was written on the appointment form and the patient was sent an interview schedule which he was asked to fill in and return in a stamped addressed envelope. This latter group proved to be very small and over half of these types of patients returned the form duly filled in.

The interview normally lasted 45 minutes. The bulk of the interviews were carried out by one interviewer who had been previously trained by the Health Services Research Unit. Another interviewer supported and tended to work the more "unsocial" hours or

was willing to be "on call" at weekends, etc. The interviewers were further trained by the researcher.

The interview schedule itself, which was designed and piloted by the researcher, was semi-structured with a large number of open-ended questions. There was a need for such questions, given the wide variety of circumstances that led the patient to visit the accident centre. Open-ended questions were also used because the theoretical approach emphasised the need to understand the way lay people perceived their help-seeking behaviour. The length of the interview was such that the interviewer had to fill in all the questions at the time of asking. However, this so interfered with the rapport and so limited the amount of answers being filled in on the form that the interviewers used tape-recorders as a "memory" and the forms were filled in afterwards. It could be argued that because there are two interviewers on the project there would be variation in interpretation and extraction of what is considered to be "relevant" data from the tapes to the schedule. The researcher did attempt to maintain some consistency by taping interviews and getting the interviewers to fill in the forms when listening to the tapes. This was done for each interviewer for a number of different tapes and the questionnaires were compared. Differences did occur on some questions and the researcher attempted to resolve some of these by discussion.

In the in-depth part of the study, "episodes" were selected from the main study on the basis of their occurrence in the circumstances which involved contact with public officials and other people, as well as episodes which involved certain conditions. The

patients, their families, and the "other" contacts were then interviewed. A similar questionnaire to that used in the main study was administered to the patient, but the "other" person was interviewed separately. The latter interview was also taped and the tape was subsequently transcribed. The researcher had a list of topics or areas to cover but as the study was in many ways exploratory the interview was less structured than the others. Sixty different "episodes" were included in these in-depth studies.

4.25 Response Rate

Of the 637 patients sampled over the year, Table 4.1 shows the different range of responses. In 92.6% of the cases, some information was collected on the pathways taken to hospital by the patient. However, in 98.6% (n=628) of the sample some information was collected from the patient at the time of the visit to the hospital so this figure will be used as the base for the data analysis. Some information was also collected on the non respondents as it gives some indication as to their "circumstances". Of the refusals, 14 did not give an explanation. In many cases the types of condition that were presented led to the patient or person responsible for the patient to feel guilt or embarrassment because of the "moral" nature of the condition. Thus an interview was refused. For example, one woman had been battered by her husband and didn't want to give information; one person took an overdose refused to talk about it; two mothers refused because a "child" was involved and two had "embarrassing" complaints that they did not wish to give details about how they had occurred. Two patients said there was no point as they lived in London and details of their circumstances were irrelevant,

and two were drunk and refused. One man had been on the survey before and said he saw no point in giving further information, and another was a porter who worked in the hospital and did not wish to give away any information to other members of the hospital staff.

In 12 of the no contacts, no reason could be found for not tracing the patient. In six of the cases the patient had moved or left the area and an address could not be found. In one case the patient had no fixed abode and the other was unavailable for interview as he had been arrested by the police.

Thus, even amongst the group of non-respondents, over a third were involved in circumstances that might have influenced their choice of medical treatment. Particularly in cases where the patient feels his complaint will be "morally" evaluated, the anonymity of the accident centre may be important.

4.26 The Analysis

Data from the large sample was coded, processes and placed on computer tape ready for the analysis. Most of the questions were coded and the planned analysis for this part of the study was of a quantitative but descriptive nature. However, a large amount of qualitative data were collected through these interviews and these data were complemented by the data gathered in the in-depth study.

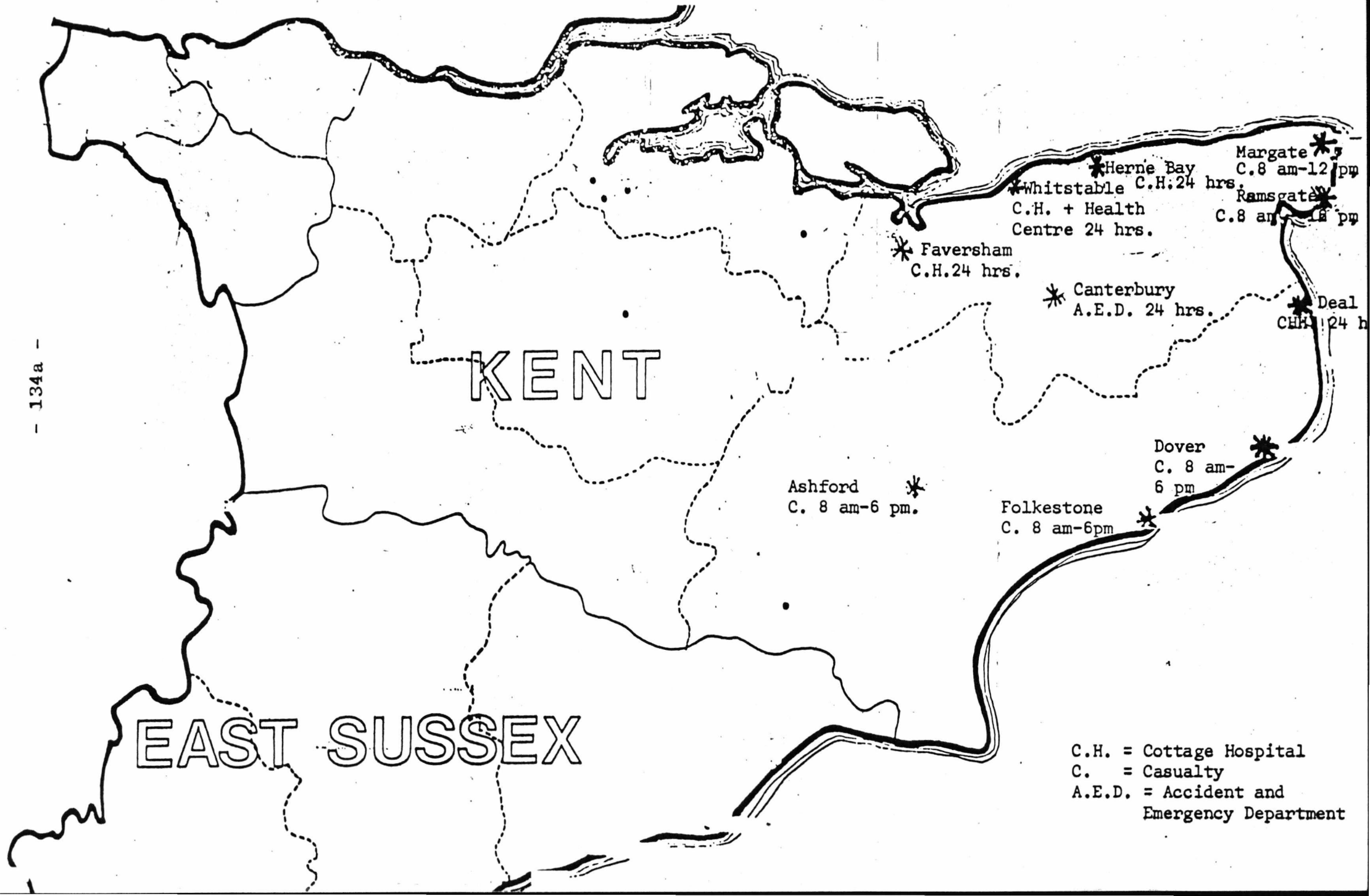
The more in-depth part of the study of sixty episodes is qualitative, and the analysis is based on transcripts from the tapes. Each case is written up individually and is compared with other cases in similar circumstances.

4.3 Summary

The study was carried out through a random sample of 637 new attenders at the Accident Centre at the Kent and Canterbury Hospital. The sampling ratio was 1:50 and the period of sample was continued for exactly a year. Overall, nearly 93% of the patients gave some data on the circumstances that led up to the episode and what influenced their choice of medical treatment. This response rate is very high given the long period of study and the type of population being sampled. Smaller, more intensive studies were carried out, focussing on specific types of complaints and specific social circumstances. The need for these in-depth studies was derived from preliminary quantitative analyses from these data and results from other studies and from the necessity to examine the validity of some of the policy propositions which were described in Chapter one.

Table 4.1 Response rate and nature of non-response

	%	no.
Full interview completed	90.3	575
Partial interview completed	1.7	11
Mail questionnaire completed	0.6	4
Refused interview	4.1	26
No contact	3.1	20
Language problem	0.2	1
	100%	637


KENT
EAST SUSSEX
Margate
C.8 am-12 pm
Herne Bay
C.H.24 hrs.
Ramsgate
C.8 am-12 pm
Whitstable
C.H. + Health
Centre 24 hrs.
Faversham
C.H.24 hrs.
Canterbury
A.E.D. 24 hrs.
Deal
Dover
C. 8 am-
6 pm
Ashford
C. 8 am-6 pm.
Folkestone
C. 8 am-6pm
C.H. = Cottage Hospital
C. = Casualty
A.E.D. = Accident and
Emergency Department

CHAPTER 5

Pathways to the Accident and Emergency Department

The intention in this chapter is to describe in detail the various pathways that new patients followed to reach the hospital A.E.D. The pathways will be described in detail from the onset of the episode and the circumstances that surrounded it through to the eventual attendance at the hospital. The various component parts of the pathway will be identified and will include the identification of the other who was involved in the decision to seek medical care and the choice of the medical care setting. These data will provide a backcloth for the more in-depth analyses which examined specific components of the pathways in more detail. Before these pathways are described, a brief description of some of the features of the episodes themselves is necessary.

5.1 Socio-environmental Characteristics of the "Episode"

The vast majority of patients lived in the local area and only 18% of the patients were not permanent residents of the area. Just under two-thirds of the episodes happened outside a private home. 16% of episodes happened on the road or in the street and episodes which happened in other public places used by the general public such as shops, parks, campsites, harbours, or other recreation areas accounted for 15.5%. Episodes which occurred at work and school

accounted for 17.3%. These data indicate that the majority of "episodes" which led to the use of the A and E department occurred in locations away from family or domestic environments.

The majority of episodes themselves could be described clinically as trauma (79%), and only a small proportion of episodes involved the development of signs and symptoms. Table 5.1 shows the distribution of these signs and symptoms as described by the patient. Table 5.2 shows the distribution of activities that led to a person suffering an injury.

The results show that the large majority of traumatic complaints appeared to be "accidental" in nature. The proportion involving deliberate violence was small and so was the number of sufferers who inflicted the injury on themselves.

5.2 The pathways that the patient followed to get to the accident and emergency department

Figure 5.1 shows the various routes that the patients follow to the accident and emergency department. In this section it is the intention to outline the routes in detail, including explanations given by the patient of why they acted in certain ways.

The figure begins with the socio-environmental location in which the episode occurred. It was felt that the socio-environmental location would influence a number of other characteristics surrounding the episode such as the number and the status of the people involved in the decision-taking process. The location was divided up into two, whether the episode occurred in the patient's own home or not.

In the previous section, other characteristics of the episode may have been equally as important in explaining the pathway adopted by the patient, such as whether the patient was alone or not when it happened, or whether the episode occurred in a rural or urban setting. However, at this stage this is only an attempt to present a descriptive picture of the pathways.

The figure shows that 63.2% of the patients were involved in an episode which occurred outside their own home and 29.8% of the patients were involved in an episode occurring at home.

The next stage which is portrayed in the figure is whether or not the decision to seek medical care was made as soon as was possible after the onset of the episode. Overall, 46.3% of the patients made the decision to seek medical care as soon as possible, and 51.2% of the patients said they didn't. Table 5.3 shows the reasons given by patients why they didn't contact the medical services as soon as possible after the onset of the episode and by place of onset of episode. The most common reason given by patients was that their complaint wasn't serious enough. This was true for episodes that occurred at home and outside the home. The other most common reason given was that the patient thought that the condition would improve. Patients' explanations for not going to the medical services as soon as possible after the onset of the episode emphasised the "medical" significance of the complaint.

The group who said they contacted the medical services as

soon as was possible were asked whether they could have put off contacting the medical services until a day after they actually did. Table 5.4 shows the distribution of these responses and location of episode. Of this group only 10.5% said that they could have put off contacting the medical services until the following day and a larger proportion of this group were those involved in episodes outside the home. The most common reason given by this group was that the decision to seek medical care was taken out of their hands and therefore they had no choice in the matter. For the group who said that they couldn't have put off contacting the medical services where the episode occurred in the home the most common reasons given were that their complaint was too painful to wait or that it was a deep cut and they were losing a lot of blood. In contrast, where the episode occurred outside the home, the most common reason given by patients was that they were told to go by other people and they had no choice in the matter. This is interesting because it highlights the significant parts "others" play in influencing patients' decisions particularly when the episode occurs outside the home environment.

Overall, then, 15.3% of the patients had an episode at home and the decision to seek medical care was made as soon as possible after the episode. Another 14.8% of the patients had the episode at home but delayed in making a decision. 33.1% of the patients were involved in an episode outside the home and made the decision to contact the medical services as soon as was possible; and, finally, 30.1% of the patients were involved in an episode outside the home and the decision to seek medical care was delayed.

The implication of these findings, particularly where the episode occurred outside the home and the decision to seek medicare is delayed, is that a proportion of these decisions were made in socio-environmental locations other than that where the original episode occurred. Table 5.5 shows the site of decision to seek medical care and whether it was made at the site of the episode. Over the whole sample (n=628), 30.2% of the cases involved decision to seek medical care being made at a location other than the site of the episode. In the vast majority of these cases the decision was made in the home.

In fig. 5.1 this concept has been translated into the question, "Was the decision to seek medical care made in the patient's own home?" This figure shows the proportions of patients who have followed various routes up to this final stage and the most common pathway appears to be where the episode occurred outside the home; the decision to seek medical services was made as soon as was possible after the episode, and the decision to seek medical services was made outside the home. This group accounted for 29.3% of the whole sample.

The overall picture portrayed by the data so far is that in a large proportion of the cases patients were in contact with the medical services shortly after the episode occurred. Table 5.6 shows the distribution of the length of time between the trouble starting or the episode occurring and an attempt being made to contact the medical services. In 45.7% of all the cases, the decision to seek medical care was made <u>within one hour</u> of the onset of the episode and in a further 15.7% cases a decision to

seek medical care was made within six hours of the onset of the episode.

Apart from where and when the decision to seek medical care is made, another important question is who was involved in the decision-making process. Table 5.7 shows the range of patients' contacts during the course of the decision-taking process. Some patients had contact with more than one person, but these patients constituted only a small proportion of the total. Table 5.7 shows only the first contact. 1.4% of the patients were described as "unconscious" at the time of the decision-taking process and obviously had no contact with anyone. A further 18.1% reported having no contact with anyone during the decision-taking process. The remaining 80.5% of the patients reported having contact with at least one person. The most frequent contacts were with parents or spouses (17.8%), and friends or neighbours (14.5%). 16.9% of the patients reported have formal contacts such as contacts with the police, employers, teachers, and others with some medical knowledge such as off-duty nurses or members of the St.John's Ambulance. In a further 6.4% of the cases, contacts were reported with strangers and bystanders and 4.1% involved contacts with workmates. Overall, four-fifths of the patients had a contact with at least one person about their injury or illness, and the majority of these contacts were of the informal kind, although not necessarily involving relatives. The nature of the advice given was varied in terms of the strength with which it was given and also in terms of its impact on the patients' decision-making. For example, of the contacts with strangers, 10.0%

advised contacting an ambulance. However, not only was advice given but the decision sometimes was made by the other person in that many bystanders/strangers called for ambulances. However, for the majority of patients, contact with another person took the form of information or advice given. The nature of the advice varied according to the person in contact with the sufferer. For example, very few people suggested contacting a G.P., and if such advice was given it most frequently came from parents/spouses or teacher/employers and workmates. The police and strangers never offered this kind of advice and the police predominantly told patients to go to the A and E departments. Policemen, teacher/employers and other persons medically qualified were more likely to give some advice than relatives, friends or strangers, but this may be because the patient specifically asked for advice.

In figure 5.1, this concept of who gave advice or information to the patient after the episode occurred was translated into the question,"Did the patient receive information or advice from his relatives only?" The figure shows that up to this fourth stage by far the most common pathway followed by the patients was where the episode occurred outside the home, the decision to seek medical care was made as quickly as possible and it was made outside the patient's home and advice was given by a person who was not a relative. This group accounted for 23.6% of the whole sample. The next most common pathway had exactly the same features as the previous group apart from the decision to seek medical care being delayed. This group accounted for 13.1% of the overall sample.

Not only were patients given advice or information by other people but in some cases the decision to seek medical care was made to seek medical care was made by people other than the patient. Now this can be a matter of routine in that parents may always make decisions about matters of health when it concerns their dependents, and it also can reflect the circumstantial element identified by the C.S.A. when non-family members are involved. Table 5.8 shows the distribution of persons who made the decision to contact the medical services. In almost two-thirds of the cases the decision to seek medical care was made either by the patient, his or her relatives, or the decision was a joint one between patient and his or her relatives. Of the remaining 27%, the most common decision-takers were employers or teachers (6.7%), friends (4.9%), strangers or bystanders (3.3%) and people without training in first-aid (3.7%). The implication of these results are that in about a quarter of the cases patients went to the medical services either voluntarily or involuntarily based on the decision of a person who it can be assumed is not usually involved in their routine everday decision-taking for matters concerning health. Returning to the figure 5.1, this fifth stage involves the question, "Was the decision to seek medical care made by the patient or patient's relatives?" The figure shows the proportion of patients who followed the wide range of pathways up to and including the fifth stage. It is interesting to note that even by this stage patients have followed twenty-nine different routes. The most common pathways are those where the episode occurred outside the home, the decision to seek medical care was made as soon as possible outside the home, and it was

made by a person other than the patient or patient's family. This group accounted for 14.7% of the overall sample. Other common pathways are those where the episode occurred in the home, the decision to seek medical care was made as soon as possible in the home, and it was made by the patient or his or her relatives. If this group is grouped with those who had a similar pathway but received advice from a person other than a relative, then together they account for 12.1% of the whole sample.

Up to now in this section, a distinction has been made between site of the "episode" and site of the decision to seek medical care, and also between the person who gave advice and the person who was reported as having made the decision to seek medical care. While these distinctions have been made for the purpose of the analysis, they are in reality more blurred, given that decision-making is a process and that it is not only difficult to identify at what exact point a decision is made or taken, but it is also difficult to identify who made the decision. It must be remembered that, when identifying decision-taker, patients may be influenced by what they feel is a rational or sensible answer and may be unwilling to present a position of uncertainty. For example, patients may feel it is more socially acceptable to say that the decision was taken by themselves than by friends, neighbours, or relatives, as it might appear to be more rational in that the patient is seen to be in control of his own decisions about matters of health. On the other hand, if the patient felt that the interviewer on the study was evaluating his behaviour in terms of whether it was morally justifiable to go to the hospital

for this complaint, then he may have been more likely to put the responsibility for referral on the shoulder of an "expert" or an official.

The characteristics that have been identified in the pathways so far have been when and where the decision to seek medical care has been made and who has made it. At this next stage, the decision to seek medical care itself is divided into whether this took the form of an attempt to contact a general practitioner or not and whether that attempt, if made, was successful or not. In this study, only 3.8% of the patients said they were not registered with a GP, of whom 2.7% were permanent residents of the locality and 1.1% were not. This figure is low compared with results found in some other studies, particularly those carried out on A and E department attenders in London. Wilkinson et al [3] showed that at least 16% of first attenders were not registered with a GP and another 5%, though registered with a GP, had moved too far away to continue seeing him. Cullinan[4] found 8% without a GP. In Newcastle, Morgan[5] found only 1.3% without a GP, and Cartwright's national study found 1%.

In Chapter 2 it was shown that many authors have been concerned about the number of patients who are self-referred. It appears that for some authors the only legitimate attender is the patient referred by their GP, and many studies have, therefore, set out to identify the proportion of self-referrals and GP referrals in the case load of an A and E department. Unfortunately there has been little uniformity in definitions, and comparison has proved difficult. In this study the main concern has been to look at some of the influences on the patient's decision to go

to an A and E department as opposed to a GP. Thus a distinction is made between those who attempted to contact a GP and those who did not.

Overall, 26% of the patients reported an attempt to contact a GP and 65.8% said they did not attempt to contact a GP. The sixth and seventh stages are incorporated into one in fig.5.1 and and translated into the question"was the attempt to contact a GP successful?" By this sixth stage patients have followed fifty different routes. The most common being where the episode occurred outside the home by a person other than a patient and no attempt was made to contact a GP (12.8%). Some of the other larger groups are those where the characteristics are similar to the former apart from the decision being made by the patient or patient's relative (7.6%). It is also interesting to note that of the group who were involved in an episode in their home,made the decision as quickly as possible at home and the decision itself being made by the patient or patient's relative. less than a half attempted to contact their GP. Of this group of 76, 42.1% made an attempt to contact a GP.

All those patients who said that they didn't attempt to contact a GP were asked why they didn't (see Table 5.9). 14.5%of the patients said that they had thought about contacting their GP and 80.6% said that they hadn't. Just over a quarter of the patients suggested that even if the GP was an appropriate alternative course of medical care,in their particular case they believed him to be unavailable or inaccessible. Others suggested that the GP was the inappropriate source of care in their case anyway. One group emphasised that their GP wouldn't have treated

them either because he didn't have the time or the specialist facilities. This group, in all, accounted for 22.5% of the patients. Another group emphasised the urgency with which they required medical treatment and the GP wasn't quick enough (4.8%). Another group suggested that taking their condition to their GP would be wasting their doctors' valuable time as their complaints were too trivial (5.6%). Finally, one group emphasised the more positive side to hospital care such as the availability of facilities, etc. (7.5%) and the convenience aspect (1.9%). In Chapter 2, patients' explanations for self-referral taken from two other studies were discussed. In the Newcastle study the availability of hospital care accounted for 32% of patients' explanations and the accessibility of hospital care accounted for 13%. In Michigan the "availability" explanation accounted for 43% of patients. In this study, compared with others, more of the patients suggested that they had specific ideas about the suitability of conditions for going to the GP and the hospital.

Although 26% of the sample reported an attempt to contact a GP, this does not necessarily imply that their attempts were successful. In fact,as Table 5.10 indicates, in six cases patients reported having no contact with the surgery at all. The Table also shows that at the initial contact 8.0% spoke with their practice receptionist. 86.5% of the initial attempts to contact (N=163) were made by the patient or patient's relative. Only 4.9% of the attempts were made by officials. The method of contacting the GP was predominantly by telephone (59.5% N=163) or by attendance at the surgery (31.3%).

What were the patients told when they contacted the surgery? Table 5.11 shows what patients were told on initial contact with the surgery. The results clearly show that the majority were referred to hospital. Now this table shows who referred patients to hospital or who gave the information. Table 5.12 shows how many patients actually were successful in consulting a GP. "Successful" is defined in terms of whether or not they spoke to or saw a GP, which included their own doctor's partners or other GPs. Of the group of patients who attempted to contact their GP and were successful in contacting the surgery (N=157), 42.5% actually saw their GP or other doctor and a further 9.6% spoke to their doctor on the telephone and were referred to hospital. In addition 2.5% of the patients spoke to their doctor on the telephone and were given advice other than to go directly to hospital and a further 2.5% attended the surgery and the doctor's nurse relayed information to the patient without the patient seeing the doctor. Therefore, of the 163 patients who attempted to contact their GP. 59.8% had some success, however indirect, in contacting him or another doctor. Now translating this figure in terms of the whole sample, the results show that 26% attempted to contact a GP, and only 15% of the whole sample (N=628) actually had some contact with a GP before going to the hospital. This latter group were defined as the "successful" contacts and this was translated in Fig. 5.1 into the question, "Was the attempt to contact the GP successful?" As this question didn't apply to those who didn't attempt to contact a GP, the most common pathways identified by this seventh stage are little differ-

ent from those at the sixth stage. Interestingly, in the group where the episode and the decision to seek medical care was made in the patient's own home and the decision was made as quickly as possible by the patient or patient's relative and an attempt was made to go to a GP, only 18 of the 26 patients who made attempts to contact their GP were actually successful.

The final two stages of the pathway refer to the nature of the transport used by the patient to reach the hospital, i.e.,if the patient went by ambulance or not and if the patient went to another casualty before going to the K. and C. accident centre.

With regard to the transport utilised by patients for going to a hospital, the majority of patients used private transport which belonged to themselves, family, friends, or neighbours (57.3). However, almost a fifth went by ambulance (see Table 5.13) which appears to be a high proportion. Table 5.14 shows who called for the ambulance and shows the most frequent callers were bystanders. Further discussion of this particular finding will be presented in Chapter 7, but it does tend to highlight once again the significance of "other" people in the decision-taking process. In Figure 5.1 the question has been phrased,"Did the patient use an ambulance to get to hospital?" By this eighth stage, overall, patients have followed ninety-two different pathways. By this stage there are three different pathways which appear to be the most common, although it must be emphasised that between them they account for only 18.0% of the whole sample. These three pathways are as follows:

1. The episode occurs outside the home; the decision is made as soon as possible after the episode has occurred outside the patient's own home by a person other than the patient or patient's relative.

No attempt is made to contact a GP but an ambulance is called. This group accounted for 7.0% of the whole sample.

2. The second group has all the characteristics of the first group apart from an ambulance not being called (5.9%).

3. The third group has all the characteristics of the second group apart from the decision to seek medical care being made by the patient or patient's relative (5.7%).

The final stage, the ninth stage, involves the question of whether the patient went to another casualty department before attending the Accident Centre at the Kent and Canterbury Hospital. 6.4% of the patients went to another casualty department before going to the K. and C. and 86.1% went direct to the Accident Centre at the K and C hospital. In Fig. 5.1 this ninth stage is incorporated into the pathway by the question, "Did the patient go to another casualty before going to the K. and C. A.E.D.?"

Conclusions

It is now possible to pinpoint the most common pathways followed by patients attending the accident and emergency department. The purpose of this analysis was to give a detailed picture of how people got to the accident centre, where they came from, and who was involved in referring them. The question of why such paths were followed will be examined in Chapter 6 and it was hoped that this detailed picture of the pathways which patients followed would shed some light on how complex and varied the circumstances were which led to utilisation of the A and E department.

It is clear from the results presented in Fig.5.1 that the pathways patients followed to the A and E department are complex and markedly varied. By the time the patients reached the hospital they had followed 144 different routes. Despite this multiplicity of pathways it was possible to identify major groups of patients who had followed similar routes. These were the most common pathways ranked in order of their size:

1. Site of episode outside home, Decision made as quickly as possible, Site of decision outside home, No information given by relative, Decision made by non-relative, No attempt to contact a GP, Ambulance called and taken straight to A.E.D. - 7.0% (N=628)

2. Site of episode outside home, Decision made as quickly as possible, Site of decision outside home, No information given by relative, Decision made by non-relative, No attempt to contact a GP, Did not call ambulance and went direct to A.E.D. - 5.6%

3. Site of episode outside home, Decision delayed, Site of decision at home, Information given by relative and decision made by relative or patient, No attempt to contact a GP, Ambulance not called and went direct to A.E.D. - 4.9%

4. Site of episode outside home, Decision delayed, Site of decision outside home, No information given by relative, Decision made by relative or patient, No attempt to contact a GP, No ambulance called and went direct to A.E.D. - 4.9%

5. Site of episode outside home, Decision made as quickly as possible, Site of decision outside home, No information given by relative, Decision made by patient or relative, No attempt to contact a GP, No ambulance called and went direct to A.E.D. - 4.9%

6. Site of episode outside home, Decision delayed, Site of decision outside home, No information given by relative, Decision made by non-relative, No attempt to contact a GP, No ambulance called and went direct to A.E.D. - 4.0%

7. Site of episode at home, decision delayed, Site of Decision at home, Information given by relative and decision made by relative or patient, No attempt to contact a GP, No ambulance called and went direct to A.E.D. - 2.9%

8. Site of episode at home, Decision delayed, Site of decision at home, No information given by relative but decision made by patient or relative, No attempt to contact a GP, No ambulance called and went direct to A.E.D. - 2.7%

Table 5.1 Distribution of signs and symptoms reported by patient with non-traumatic complaint

	No.	%
Traumatic complaint	502	78.8
Non-traumatic complaints		
Collapse	15	2.4
Swollen and infected body area	19	3.0
Problems with ear, eye, nose or teeth	11	1.7
Pains in stomach or chest	16	2.5
Fits	3	0.5
Flu symptoms	2	0.3
Headache	2	0.3
Other	17	2.7
N.A.	41	7.8
Total	628	100%

Table 5.2 Distribution of activities that led to injury

	No.	%
Self-inflicted injury including intentional ingestion of drugs	9	1.4
Intentional assault by other	15	2.4
Fighting	9	1.4
Accidental ingestion of drugs or other substances	8	1.3
Foreign body accidentally entering eye or other part of body	32	5.0
Fall on or from stairs, steps, ladders or scaffolding	37	5.8
Fall from or out of building or other structure	10	1.6
Fall due to slipping, tripping or stumbling on same level	81	12.7
Other type of fall	44	6.9
Bites and stings by animals/insects	24	3.8
Struck by or against objects	106	16.6
Crushed between objects	21	3.3
Strenuous movements, twisting, etc.	20	3.1
In contact with cutting or piercing instruments	23	3.6
Burn or scald	16	2.5
Pedestrian hit by motor vehicle	2	0.4
Motor vehicle in collision with other motor vehicle	36	5.7
Other	9	1.4
Not applicable (non-traumatic complaints)	85	13.3
Not answered	41	7.8
Total	628	100%

Table 5.3 Patients who said they didn't contact the medical services as soon as possible after the episode occurred and location of episode

Patients who said they didn't contact the medical services as soon as possible because	Episode occurred at home		Episode occurred outside home		Total	
	No.	%	No.	%	No.	%
Their complaint wasn't serious enough	37	39.8	85	45.0	122	43.3
Thought that their complaint would improve	20	21.5	32	16.9	52	18.4
General practitioner not available	2	2.2	6	3.2	8	2.8
Wasn't told to go by official or person with medical training			8	4.2	8	2.8
No transport	3	3.2	7	3.7	10	3.5
Didn't want to bother doctor	3	3.2	2	1.1	5	1.8
Just wanted to take time	1	1.1	3	1.6	4	1.4
Other	24	25.8	32	16.9	56	19.9
No information	3	3.2	14	24.0	17	6.0
Total	93	100%	189	100%	282	100%

Table 5.4

Patients who said they contacted the medical services as soon as possible after the episode occurred and their reasons for saying they could or could not have put off contacting the medical services until the following day

	Episode occurring at home				Episode occurring outside home					
	Put off contacting the medical services until the following day				Put off contacting the medical services until the following day				No information	Total
	Yes		No		Yes		No			
	No.	%	No.	%	No.	%	No.	%		No. %
It was convenient to go out at that time	1	12.3	-	-	4	16.7	0	-		5 1.6
No advice, told to go by other	4	50.0	7	8.0	12	50.0	32	17.4		55 18.1
Complaint - too painful	-	-	16	18.2			21	11.4		37 12.2
Complaint - too serious	1	12.3	8	9.1	1	4.2	16	8.7		26 8.6
Deep cut/loss of blood			14	15.9			23	12.5		37 12.2
Suspected fracture			1	1.1			13	7.1		14 4.6
Restricted activities			2	2.3	1	4.2	4	2.2		7 2.3
Specific medical treatment needed	1	12.3	6	6.8	1	4.2	13	7.1		21 6.9
Needed medical attention	-		21	24.0	2	8.4	28	15.2		51 16.8
Uncertain about diagnosis			3	3.4	1	4.2	8	4.4		12 3.9
Other	1	12.3	8	9.1	1	4.2	16	8.7		26 8.6
No information	1	12.3	2	2.3	1	4.2	11	6.0		15 4.9
Total	8	100%	88	100%	24	100%	184	100%		304 100%

Table 5.5 Site of decision to seek medical care

Site of decision to seek medical care	No.	%
Decision to seek medical care at site of episode:		
Home	162	25.8
Other's home	31	4.9
School	15	2.4
Hospital	14	2.2
Street	38	6.1
Road	33	5.3
Work	47	7.5
Recreation	24	3.8
Other	34	5.4
Decision to seek medical care not at site of episode:		
Home	109	17.4
Other's home	18	2.9
Other	62	9.9
No Information	41	6.5
Total	628	100%

Table 5.6

Length of time between trouble starting or episode occurring and an attempt to contact the medical services

Time difference

1 hr.		1 < 3 hr.		3 < 6 hr.		6 < 12 hr.		12 < 24 hr.		24 < 48 hr.		2 days +		No Information		Total	
No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
287	45.7	58	9.2	41	6.5	40	6.4	45	7.2	37	5.9	57	9.0	63	10.0	628	100%

Table 5.7

Distribution of patient contacts and advice given by contacts (both at and away from site)

	No advice given		Rest - don't move		Go to AED		Go to G.P.		Go to AED or GP		Ambulance		Other		No Information	Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%		No.	%
Parent/Spouse	27	24.1	5	4.5	51	45.5	15	13.4	1	0.9	3	2.7	10	8.9	2	112	100%
Other Relative	7	38.9			10	55.5	1	5.6								18	100%
Friend	24	32.4	4	5.4	31	41.9	3	4.1	11	1.4	2	2.7	9	12.1	2	74	100%
Neighbour	8	29.6			10	37.1	3	11.1			3	11.1	3	11.1		27	100%
Stranger	14	35.0	8	20.1	7	17.5					4	10.0	7	17.5		40	100%
Policeman	3	17.6	2	11.7	10	58.8							2	11.7		17	100%
Other Official	2	28.5	1	14.0	2	28.5							2	28.5		7	100%
Employer/ Teacher	10	18.1	6	10.9	21	38.2	8	14.5	1	1.8			9	16.3	1	55	100%
Hospital Staff			1	16.6	3	50.0							1	16.6	1	6	100%
Other person with training in first-aid	3	15.0	2	10.0	11	55.0	1	5.0					3	15.0		20	100%
Chemist							1									1	100%
Work mate			15	40.5	4	10.8	9	24.3	1	2.7	1	2.7	7	18.9		37	100%
Other	2	9.5			8	38.1	1	4.8			2	9.5	6	28.6	2	21	100%
No Information																70	
No contact with anyone																114	
Unconscious																9	
Total																628	

Table 5.8 Distribution of persons who made the decisions to contact the medical services

Who made decision to contact medical services	No.	%
Patient	152	24.2
Relative - parent/spouse	180	28.7
Relative - other	10	1.6
Friend	31	4.9
Neighbour	11	1.8
Stranger	21	3.3
Policeman	11	1.8
Other official	13	2.1
Employer/Teacher	42	6.7
Hospital staff	8	1.3
Other person with training in first-aid	23	3.7
Chemist	2	0.3
Joint decision	52	8.3
Work mate/Team mate	5	0.8
Other	12	1.9
No Information	65	10.3
Total	628	100%

Table 5.9 Patient explanations for not attempting to contact a G.P.

Patient explanation for not attempting to contact a G.P.	Did you think about contacting a GP?				No Information		Total	
	Yes		No					
	No.	%	No.	%	No.	%	No.	%
Not registered with a GP or too far away from GP			50	15.0			50	12.1
GP not available - inappropriate time	11	18.3	55	16.5			66	16.0
GP wouldn't have treated or would't have seen	17	28.3	52	15.6			69	16.7
Contact GP not quick enough	6	10.0	14	4.2			20	4.8
Condition not appropriate for GP - too trivial	1	1.7	22	6.6			23	5.6
Condition not appropriate for GP - needed specific treatment	4	6.7	20	6.0			24	5.8
Hospital is appropriate place			31	9.3			31	7.5
Hospital is more convenient	4	6.7	4	1.2			8	1.9
Other	17	28.3	75	22.5			92	22.3
No Information			10	3.0	20	100	30	7.3
Total	60	100%	333	100%	20	100%	413	100%

*413 are patients who didn't contact or attempt to contact a G.P.

163 Not applicable

52 No information

628 Total sample.

Table 5.10 Proportion of patients who did and didn't attempt to contact a G.P.

Attempt to contact a G.P.	No.	%
No	413	65.8
Yes - couldn't contact surgery	6	1.0
Yes - spoke to family doctor	51	8.1
Yes - G.P's partner	14	2.2
Yes - practice receptionist	50	8.0
Yes - practice nurse	3	0.5
Yes - G.P's wife	7	1.1
Yes - Don't know who spoke to	5	0.8
Yes - other	25	4.0
Yes - no information	2	0.3
No information	52	8.0
Total	628	100%

Table 5.11 What was the patient told on initial contact with G.P.'s surgery.

What was patient told?	No	%
To make an appointment to see G.P.	9	5.7
To go direct to hospital	84	53.5
No appointment available	1	0.6
G.P. would call	13	8.2
Stay home and rest	2	1.2
No doctor available	1	0.6
Prescription to be collected from surgery	1	0.6
Nothing	1	0.6
Other	40	25.5
No information	5	3.2
Total	157	100%

Table 5.12 Patients who attempted to contact a G.P. and how the initial contact was made, who patient spoke to and what patient was told and if the patient saw the G.P. before going to hospital.

How patients reached their general practitioner	No	%
Spoke to G.P. or other doctor on telephone and then saw G.P.	10	6.4
Spoke to G.P. or other doctor on telephone and told to go to hospital	15	9.6
Spoke to other person (not a doctor) on telephone and then saw G.P.	22	14.0
Spoke to other person (not a doctor) on telephone and told to go to hospital	31	19.7
Spoke to doctor on telephone but didn't see doctor	4	2.5
Spoke to other on telephone and didn't see doctor	9	5.7
Attendance at surgery and saw G.P.	39	24.8
Attendance at surgery and told to go to hospital by other but didn't see G.P.	7	4.5
Attendance at surgery, doctor told nurse to tell patient to go to hospital but didn't see doctor	2	1.3
Attendance at surgery, didn't see G.P. but spoke to other	4	2.5
No information	14	8.9
Total	157	100%

Table 5.13 How patient reached Accident and Emergency Department

How patient reached A.E.D.	No.	%
Ambulance	123	19.6
Police vehicle	2	0.3
Private car	360	57.3
Walked	18	2.9
Bus	13	2.1
Taxi	13	2.1
Works transport	29	4.6
Other	17	2.7
Pit ambulance, etc.	6	1.0
No information	47	7.5
Total	628	100%

Table 5.14 Who called for ambulance?

Who called for an ambulance	No.	%
Patient/relative	16	13.0
Neighbour	7	5.7
Friend	15	12.2
Bystander	29	23.6
Police officer	9	7.3
Other officer	15	12.2
G.P.	19	15.4
Employer	7	5.7
Hospital staff	6	4.9
Total	123	100½
N.A.	505	

CHAPTER 6

Referral of Patients to an Accident and Emergency Department

Episodes which occurred in the Community

In the previous chapter an overall descriptive picture was presented of the various pathways that new patients followed to reach the hospital A and E department. The previous chapter presented a general picture of the various dimensions of the process of decision making and evaluation in episodes involving accident and emergencies. In this chapter and the two following chapters, the nature of the decision making processes and the nature of the processes involved in the evaluation of signs and symptoms and choice of medical care setting will be examined in more depth. Qualitative data are used to explain why certain decisions to seek medical care were made and why certain choices about medical care settings were made.

A preliminary statistical analysis[1] using the data collected in this study suggested that the site of the episode, the site of the decision to seek medical care and the involvement of others in the decision-making procedure may play a part in influencing the choice of medical care setting. These analyses also examined the influences on timing and the site of the decision to seek medical care and the results suggested that the site of the episode and the involvement of others in giving advice and decision-making may be influential.

In this Chapter and Chapter 7, the aim is to identify whether the patterns identified in the statistical analysis can be identified in the more in-depth qualitative data and to determine why these relationships might exist. The analysis focuses on five socio-environmental locations where episodes occurred. They are as follows: School, Work, Street or Road, Recreation areas, and the Home. (The episodes which occurred in the home are discussed in Chapter 7.)

In this chapter, two specific questions are examined. These questions were derived from the preliminary quantitative analysis referred to previously. They are:

1. Why should the presence of a policeman, teacher, employer, or other at a site of an episode or a site of decision to seek medical care influence the choice of medical care system?
2. Why should the presence of a policeman, teacher, employer, or other at the site of an episode lower the threshold at which medical care is required?

6.1 Accidents and Emergencies at School

6.11 Position of Teachers and Staff of Educational Institutions

In a number of cases, the patient was a school-aged child who injured himself or herself or became ill at school. Thus, in many of these cases, the staff of the school became involved in deciding what the appropriate course of action would be. The word "involved" is used because in some cases the "episode" occurred at school and the child was taken directly to hospital; in other cases the child's parents were contacted and the child was taken home for the decision to seek medical help to be made, and in other

cases the episode occurred at home but a teacher decided that medical attention was warranted.

The method of analysis is as follows. A number of cases from the main sample were selected for study. In each case an interview was carried out with the child and parent (if possible) and a member of the school staff. These interviews were tape-recorded and transcribed. From the two interviews, a "case" history was constructed outlining the history of the event and including the explanations offered by the different people involved.

The interviews with the parents and child took the form of the semi-structured interview which took place with all the respondents in the general sample. The interviews with teachers were less structured and focused around the "episode" as well as how the course of action compared with what they "normally" did, so as to build up a picture of the different strategies that teachers used to deal with such "episodes".

The problem posed for the analysis is if, as the evidence suggests, there is an association between contact with a public official and choice of medical treatment, why such an association exists. Is it, as the Casualty Surgeons Association suggests, that the official brings to the situation another set of priorities, associated with factors other than the condition of the sufferer, which cause the decision to seek medical help to be made at the site, and the accident centre or the use of an ambulance to be seen as more convenient? Alternatively, is it because officials have a training in first-aid which gives them a more "expert"

understanding of the possible risks to the victim of not receiving medical attention? Their propensity to think medically may lead to their seeing the need for medical attention far more often than if they relied entirely on "commonsense" knowledge.

Ideally, to examine the propositions more rigorously, a random sample of all schools in the area should be selected in order to compare schools in terms of their policies as well as being able to allow for the influence of such organisational aspects as size of school, provision of medical facilities, type of school, which all must play some part.

In this study only those schools where a pupil ended up at the accident centre have been selected and whether they are representative of all schools in the vicinity is open to question. This problem applies also to the following sections on employers, the police and other settings.

In all, 42 "episodes" were identified as either occurring on the premises of an educational institution such as a school, training college, or university or a representative of either of these institutions had spoken with the sufferer about their condition after the "episode" had taken place.

Table 6.1 shows the pathways that these patients took to the Accident Centre, but five cases were excluded because they involved teaching staff or other adults who were not affiliated to these establishments in any way. Three of these were teaching members of staff who injured themselves at school. All three went home after the episode. Two of them decided at home that medical

help was needed: one went straight to the accident centre the following morning and the other contacted the nearest GP in the area where he lived (he has recently moved and was not registered with the GP in that area). The practice receptionist referred him to hospital. The third teacher went to school the following day but had to go to A.E.D. from school as his condition became worse. The other two excluded cases involved a delivery man injuring himself at a school while unloading his lorry. He was treated by the school secretary and it was suggested that he went to the accident centre, which he eventually did. The final case of the five involved an adult who was on holiday staying at the University. She was referred to the Accident Centre by the University doctor.

Results in Table 6.1 show that in 12 (34%) of the 37 cases, a GP was contacted and only one of these contacts occurred at the site of the episode. The remaining cases involved the parent attempting to contact a GP from home after the child had been taken home by the parent or by the teaching staff. The one case where the decision to seek medical care was made at school and an attempt was made to contact a GP is complicated. The headmaster decided that medical help was needed, and the father was sent for, but before the father went to the school he rang his GP to ask for advice. The GP supported the headmaster's judgement, so the father went to the school and took the child to the accident centre. Although it appeared that the headmaster in this case made the decision to go to the accident centre, the course of action was dependent on the

father's agreement which in itself meant referring to his GP for advice.

In Table 6.1, contact with an educational representative is identified as a potentially important influence on the patient's action. However, the notion of contact varied markedly. For example, in eight cases where the episode occurred at school, the school staff made the decision to contact the medical services by themselves, delaying contacting the parents until after they went to the medical services or not being able to contact them at all. In four of these cases the decision for referral was made by a nurse who was resident at the institutions. Two were in boarding schools and two in further education establishments. In none of the cases, therefore, were there any parents accessible and the decision had to be made by a representative of the school, but in three cases there was some delay between treatment by the nurse and the actual decision to go to hospital. This was due to the nurse giving instructions, but not taking the sufferer to hospital. With smaller children the situation was different and the sufferer was taken to the accident centre by one of the staff. This occurred in four cases and none of these schools had anyone professionally trained. A physical education teacher usually acts as the first-aider with basic St.John's training, but generally there are limited medical facilities available in schools. More detailed data are available on three of these cases as interviews were carried out with members of staff involved.

One case involved a boy who was attending a special school for educationally subnormal children. He suffered from epilepsy, and, after a fight with other children on the school field, he had a fit and went into a coma. He was taken to the medical room

and observed by a welfare assistant. The procedure in the school for coping with children having fits (there are 12 children in the school diagnosed as epileptic) is to observe them and, if they come out of the attack within a reasonable period of time, the parent is written to and the parent then refers them to a family doctor. If the attack is excessive, and according to the headmaster it was in this case, this is the procedure:

> "If the child is out for an excessive period of time, by out I mean unconscious in a coma, then we feel that we are not medical practitioners, that we do need the child under skilled medical supervision, because although we watch for signs of blueness or oxygen starvation, this is a matter really for medical people to determine ... So we then would send for the ambulance and have the child taken up to the hospital and send the welfare assistant with the child and the child's school medical record. At the same time attempting to contact the parents and letting them know. In cases of normal illnesses, then we would contact the parent and ask them would they arrange to take the child and see the doctor that evening."

In this case the ambulance was called. The headmaster went on:

> "We called the ambulance because we thought he had been out for long enough. A message was sent to the mother informing her of what had happened and asking her to come up to the accident centre and pick him up."

The mother did this but suggested that the school staff had over-reacted. She said:

> "Apparently he was in a fight with another boy and and because he was unconscious they took him to the K. and C. He suffers from serious epilepsy and although I am used to it and can cope with him, the school get frightened and send him to K. and C... He probably had a minor attack and they couldn't bring him round ...I did not worry because he's been taken to the Accident Centre before and when I had the message that he was there I didn't hurry to fetch him because I'm used to it...He wouldn't have worried about it."

The mother said that on two previous occasions when he had been taken to the accident centre he should have been brought home. She suggested that the reason why staff did take him to hospital was that they panicked and "because he wasn't their child- they were playing safe".

The headmaster, well aware of the mother's opinion, said that the staff do panic, but not as much as they did and offered a further explanation:

> "...you see the school has to exercise a greater than average caring attitude. I mean the courts are quite clear about this; you not only have to act as a good parent would but as the best sort of parent would".

Clearly then, this pattern of action was coloured by socio-legal conditions and parental opinion played no part in the course of action that followed.

A second case occurred at a nursery school. The child cut his head while playing at the school. This was the second time he had injured himself in a week. A member of staff recounted how these injuries happened.

> "It was not the first time that he did it, because he banged his head once and it came up in a big bump,because they were running around" No one was contacted "because it was just a bump and he just had a slight cut and so we just put pressure on it with cotton wool and it eventually stopped bleeding and we just put a plaster on top of it...I didn't think it was serious. It was a cut then, but the second time, you see I don't know but he managed to do it in exactly the same place. He was running along here, tripped over someone on a bike, and landed on the wall, that time at exactly the same place so it really opened it, making it deeper and then because it came up in such a colossal bump".

The staff actually saw the accident happen.

"I saw him fall over and as he got up the blood was coming

> down his face but you couldn't tell until he got up and he was coming towards me".

The member of staff immediately carried the boy into the office.

> "He was crying and I carried him into the office, because that's where all our medical things are and I think he was a bit frightened because it was bleeding so much, and then the deputy head said,'I think you ought to take him up to check over and made sure he's alright' because it had come up into a nasty bump and it had re-opened the cut that had already started to heal".

The school does not have a nurse but has first-aid facilities.

> "Usually they are just minor grazes or cuts and bumps so we've got witch-hazel and lint and savlon and various antiseptic ointments. We usually just administer things ourselves, but in that case we were worried. It all re-opened up and he had such a big bump, and as they are not our children we wanted to cover ourselves, so we decided to do that...".

The legal position of the staff at this school is complicated by the type of child that is in the school.

> "We have an accident book here because a lot of the children that come here are children that are at risk at home so if they have an accident on the premises, it's always written down and someone signs it and if someone else has been out in the garden and was there at the time they witness it".

The member of staff went on to say that the child in this case was on the "at risk" register because he had been beaten by his parents.

> "But it was only the once. So this is the case with a lot of children, that's why we always keep an accident register. We write it down so that we know that it happened at the nursery".

In talking to the matron of the same nursery school, it became evident that for injuries a GP is hardly ever contacted For example:

M.C. "What would you normally do with an accident like this?"

Matron. "Exactly what we did do. Take them to casualty".

M.C. "Do you think of contacting their GP or anything?"

Matron. "No, because we feel that it's our responsibility. It has happened on our premises. I mean it depends what it is...I mean, things like a cut on the head or I mean we've had a child who's been knocked with a swing and cut his head open, and we've just popped him up, you know".

The staff gave the impression that in theory they would try and contact the parents when the child hurt himself but the practical circumstances limit it. The Matron said:

> "I mean we've no way of getting hold of parents at all. If we can 'phone them at work if we know the work telephone number, but I mean, they're always changing jobs or doing something so we never know. I tried to reach one the other day and the 'phone was cut off, so you know you're back to square one".

The other member of the staff also hinted that they tended to go to the hospital without contacting the parents. In this particular case, the sister at the hospital sent a policeman around to contact the parents. The member of staff said this about the parents' arrival at the hospital:

> "Yes. They were worried because I don't know what the policeman said, you see I expect they were worried and I said, 'I'm awfully sorry to drag you out but they (the hospital) wouldn't see us' because there wasn't anything done at the time and they were quite worried but it was obviously because they didn't know the extent of the injury".

In this case the child was taken to the accident centre immediately after the accident happened and the member of staff who took him waited with him at the hospital until his parents arrived before going back to the school. Throughout the interview the staff emphasised the need always to have a child examined. The

matron mentioned an insurance risk because they had to play safe in case there were further enquiries about an injury. She also said that none of the health visitors or social workers (which most of the children and their families have) are ever available and the hospital is the only place to which they can go.

The third case also involved a school teacher taking the decision to seek medical help, once again going to the accident centre, but in this case no attempt was made to contact the parents. Both child and parents thought the trip to the hospital was unnecessary. The child thought the mother could have dealt with it and the mother thought she could have gone to the health centre, commenting that "they do everything there".

In this case, a thirteen year old girl injured herself.

> "I slipped when I was walking to school. It was wet and my foot slipped out of the clogs I was wearing".

This incident happened at 7:55 a.m. and the girl went on to her school. During the morning it became painful and she was taken to a teacher who was in charge of first-aid. The first-aid person said,

> "She came to me at break at about ten-thirty saying her ankle was hurting her. In actual fact, two other second-years carried her up".

The first-aid person examined it and said,

> "It was obviously swollen. I just treated it for a sprain. We did a cold compress, put it in cold water, bandaged it for her which made it more comfortable".

The girl then went back to her classes but had difficulty walking and her friends carried her around the school. In the afternoon the domestic science teacher called the first-aid person to come and look at the girl's injury again because it was uncomfortable.

> "We took the bandage off that we had put on and she said it felt better. Again I thought it was just swollen up and she still was not walking very well on it, so we took her up just as a precautionary measure".

The girl on the other hand felt her injury wasn't at all serious. She said,

> "I just sprained it. I didn't want to go to hospital. I didn't think it was at all necessary but my teacher made me".

She did mention it was very painful. The first-aid person (P.E. teacher) said that the girl did not want to go to hospital "but as far as we are concerned we take the view that rather be safe than sorry".

The teacher's reason for sending the child to hospital involved a combination of explanations which included both "medical" and "social" influences. Firstly, she emphasised the medical aspects:

> "Well, it's very easy to disregard a symptom which you are not capable of recognising".

And, secondly, she mentioned both the legal and social position. She said:

> "I don't think there would be a legal position if it involved an accident coming to school. Certainly any accident that happens in school we have a certain amount of responsibility for".

She went on to describe why she wouldn't have gone to the Accident Centre if she had been involved in a similar incident:

> "As far as I am concerned, I am an adult and I am responsible for myself and the child is not responsible for itself and I think we are here <u>in loco parentis</u>".

The first-aid person then went on to say how, when she had first seen the girl in the morning, she had told the girl that she must tell her mother what had happened, and that she ought to go

to her GP that evening. However, she went to the hospital,

> "because it was uncomfortable in the afternoon for her. I thought she might have chipped something or broken something that we hadn't recognised, so she went for an x-ray, but we would always take a child for an x-ray if there was any possibility of there being a break".

In nine of the thirty-seven cases occurring at school, the influence of the teaching staff's decision was limited by the involvement of the parents in consultation. The nature of the consultation varied according to how strongly the staff felt that action to seek medical care was needed. In some cases, the teaching staff attempted to make sure that what they thought was appropriate was carried out. In one case a young boy, attending a state secondary school, injured his right wrist while playing in the school playground. It disrupted his activities at school so the Deputy Head looked at it. He said,

> "I thought he had probably sprained his wrist...he said that it hurt. He appeared to be able to move it but it did have some signs of swelling, mild signs of swelling. I thought probably a bad sprain".

The deputy head then went on to elaborate a theory of his own about wrist injuries:

> "Well now, with the wrists one never knows. They are funny things aren't they. Anything wrong with the wrist or any apparent injury to a wrist I'm usually very careful. I'm willing to go to treat it even if my inclination is to say well maybe it's just a twist or something like this. Because a bad fractured wrist can be a very long and difficult business".

In this particular case the normal procedure of trying to contact the parents was carried out and the mother came to the school.The boy with Mum was then taken to the hospital. According to the Deputy Head he was the one who made decisions to go to the hospital and the mother also said he made the decision. However, the mother said that she rang the hospital first, probably from home,

> "...because I wasn't sure if I had to have a letter from

my GP".

The mother, in this case, had accepted the school's decision but wasn't sure if going directly to the hospital was the correct procedure given the decision to go to hospital.

In another case, the form of "contact" between parents and school occurred in the form of a letter giving advice. This action by the headmaster reflected his distinctly different policies for dealing with episodes of injury or illness which occur on the premises and those that begin off the premises. In this particular case there were conflicting accounts of how the injury occurred. The child said that she had bruised her right arm while playing on the playground at school. In contrast, the Headmaster said:

> "If a child comes to school and obviously has an injury or a disability that has been caused outside the school, but which has not been receiving any medical treatment from the family doctor or because Mum has been reluctant to take her to hospital, then I am automatically informed of this. This child was one of these children. In fact, she apparently had hurt herself over the weekend and complained to Mum about her arm being sore and she was having difficulty in lifting it. Mum had said it's nothing to worry about but she had complained to us about three times in one particular day, and consequently the school secretary called me in and I decided that she should be referred to hospital and wrote to her Mum to tell her I thought she should either be taken to the doctor or up to the Casualty Department.
>
> If the injury had occurred at school there would have been no doubt. My policy is 'get in the car son', and he goes in the car and then when I visit the home, the principle that I adopt is that the child stays in the car. I simply go to the door and say, 'Your child needs medical treatment. I am prepared to drive you to the hospital.He is already in the car. Can you please come along as quickly as you can. I will wait in the car for you'".

In this case, because of the circumstances that the Headmaster believed surrounded the "accident", he took a more passive stance and left the decision up to the mother. The mother took the child to hospital immediately as she thought the arm might be broken.

She didn't contact her GP because he didn't have a surgery that evening and anyway she thought that he would have sent her for an x-ray. The family's normal way of coping with matters of health is to go to the mother's GP and if he is not available to go to her husband's GP. However, in the case of emergencies and injuries they go straight to the hospital.

There are two other types of cases where an incident occurred at school. There are those cases, eight in number, where the sufferer or sufferer's parents were not given any ad= vice about a course of action, and those cases, five in number, where the episodes occurred on the site of premises of an educational institution without any contact with a representative of that institution.

Considering the former group first, detailed information is available for two cases. In one case an eight year old boy hit his head on a desk in the classroom during playtime. It was a rainy day and the children couldn't go out to play so they were in the classroom. The child's teacher was present and the teacher said this:

> "He told me exactly what he was doing. You know he ran across the classroom; someone was chasing him and he fell over and he said it didn't even seem to hurt. He said it didn't hurt...It was quite a large lump. It had a blue line down the middle - I said ' You're very lucky because if that did split open it would mean hospital because it would have needed stitches'".

She said that this kind of thing happened regularly in the classroom, but she only took them along to the hospital if the skin had broken and a stitch was needed.

It seems that the teacher was cautious about "any child that has had a bang on the head" and so she took him to the Headmaster.

The Headmaster said this:

> "The Deputy Head was also present who very often takes responsibility for accidents and the three of us felt that this was not serious enough for him to go home immediately or certainly to be taken to hospital because he was perfectly bright and he looked quite normal and didn't seem to have any symptoms...The one thing I felt on reflection that I would have done is to inform the parents. I think that I should have "phoned or written immediately...not written, rather sent a message so that they knew, but instead we told the boy to tell his mother because we felt that he wasn't very seriously hurt".

The Headmaster said that with head injuries they always take special precautions:

> "He wasn't allowed out to play for the rest of the day and at dinner time he was given into the care of a dinner lady to keep a special watch on him and to come to me immediately if she saw any change in his condition".

The Headmaster had recently joined the school and was uncertain whether any of his staff had been trained specially in first aid. He did say that although he had no training in first aid, teachers had instructions from the County on how to deal with accidents and first-aid boxes were in various positions around the building.

The child carried on as usual and went home at the normal time. The father said the child was "as bright as a button" until bedtime. The Deputy Head had sent a letter telling them to watch him in case there was any delayed reactions. The parents saw blood in the child's ear and rang their GP immediately. The father said he couldn't have put off contacting the doctor because:

> "As soon as I saw blood from his ears, I know enough about first-aid to realise urgent treatment was required".

The father rang the GP and was referred to the hospital.

In another case, a similar pattern was found. This seventeen year old boy tripped over steps in the hall of the school and twisted

his ankle at about 9 a.m. in the morning. He went to do P.E. and he was sent to the first-aid person who bound it up and then telephoned for mother to take the boy home. The person who was responsible for first-aid, one of the clerical staff, said:

> "He came with a swollen ankle, saying he had tripped up two steps in the hall...I looked at it and it didn't seem to me too bad at the time, and he didn't say it hurt particularly, didn't say he'd banged it at all; he just said he'd tripped up the steps. It wasn't terribly swollen so I just put a crepe bandage around it and, ...as far as I can remember, his mother collected him. We telephoned the mother and she came and collected him and I believe she brought him into the hospital".

The first-aid person said she didn't think his injury was serious, "...just the puffed-up ankle...all his toes wriggled and he was able to walk on it". She went on:

> "I didn't suggest hospital. The mother came. I know the mother personally. She used to be an Air Hostess and I think she was more qualified than I am to look at her son".

The first-aider wasn't aware that the mother took her son home and visited her GP the following morning. The GP referred him to the accident centre for an x-ray.

Interestingly, of the five cases which occurred on school premises, no contact with a representative of the school was involved. Only one parent contacted his GP, even though all five children went home first to see parents. In one case the boy received advice from his sister who is a nurse and was told to go to A.E.D. The findings suggest that although parents are more likely to go to a GP when the decision is made at home their decision also seems to be related to whether they had contact with a teacher or staff member. Certainly teachers seldom gave advice to go specifically to a GP, and tended to leave the decision to the

parents.

In other cases where the incident did not happen at school but a school representative was there, three episodes occurred at festivals or sports' occasions organised by the local schools. One child was referred direct from the site to the A.E.D. by the St.John's Ambulance. One child was at the school camp in the locality. A nurse at the camp treated the child and the leader rang up the mother and asked her to come and take the child to hospital. Another child was at Cubs and cut his leg. The child was taken home to his mother, who was a trained nurse and she rang her GP.

These data seem to suggest that teachers either send children directly to hospital or send them home. The GP plays a part only when the parent is involved and the decision is made outside the school grounds. Also of all those for whom a decision was made at the site, there was contact with a teacher representative. This, however, does prove that contact with a teacher will bring more urgency to bear as teachers may have to make these decisions. Some of these decisions, however, were against the views of pupils and parents.

Why then do teachers adopt the policy of using accident centres instead of GPs, and how do they explain their assessment of urgency? The following explanations are taken from interviews with teachers about the specific cases already discussed and also about their routine policies.

6.12 Policies of Schools for Dealing with Illness and Injury

There are two specific questions that will be attempted to be answered in this section:

1. Why do schools prefer to use an accident centre and not GPs?

2. Why is the teacher's threshhold of urgency lower than parents? Is it because of their "greater" medical knowledge or do socio-legal conditions play a part?

Considering the first question, it appears that the schools in their everyday workings mainly have to deal with injury rather than illness. "Emergencies" are much more likely to involve children with injuries rather than illness, as it is on these occasions that the staff feel medical treatment is required. So it is mainly to accidents that they refer, although sometimes this distinction between injury and illness is not as clear cut as they describe. References are made by staff to that time we used the ambulance "when the child had a fit" and when an ambulance was called, implying that ambulances are used for emergencies irrespective of the complaint.

In one case the teachers explained that their reason for not going to the doctors instead of casualty was because the hospital has the appropriate facilities.

> "You see the school is mainly concerned with injury, and injury involves an x-ray, consequently the doctor would only refer you to the Accident Centre anyway".

One Headmaster explained that he preferred to take or refer children to the accident centre,

> "...because in most cases when I decide that hospital treatment is necessary, the doctor would come to the same diagnosis. Therefore there is delay in getting the child there. Very few doctors are readily available in their surgery and if stitching has got to be done, then it's usually the hospital that does it".

In both these explanations there was an element of convenience. Two other teachers referred to the convenience. One said:

> "If it's a straightforward case I bandage them up, pat them on the head and send them out into the playground again. If I consider the wound is deep enough to warrant stitching,

> which you come across from time to time, then if I can contact the child's parents, I do. If the child's parents have transport readily available, then I leave them. I advise them to take the child to the Accident Centre, and if I cannot contact the parent I take the child to the Accident Centre anyway...I cannot send children to their doctors. This being a village, the nearest doctor is a long, long way away. If I can contact a parent, then, as in this case, I will either advise contacting a doctor or the Accident Centre, according to how serious I consider the injury to be." In this case "the choice for the Headmaster is between going to the Accident Centre or contacting a parent and leaving it up to him, although the suggestion is that hospital is more appropriate for the more severe cases".

A first-aider suggested a reason for the infrequent use of the GP is because "It's much easier for us to contact the hospital because we have children coming from a wide catchment area". Most of the teachers suggested that their choice was between the accident centre or parents. However, a number of them explained the reason for not contacting a GP in terms of "ethics".

A Deputy Headmaster explained that he would never contact a GP because:

> "I don't think it would be ethical to do it. We would send them to mother or father to take to the GP. We would say that we think that, but that is all. It seems to me we couldn't bypass the parent".

He said that accidents needing treatment or even investigation would most certainly go to the hospital in any case. The school didn't have a doctor on call but used the clinic nearby if there was an emergency. This teacher implied that whenever accidents occur on the premises and they are judged to need medical attention, the staff decide to take the child to the hospital, contacting the parents at the same time. The hospital seems to be the place where injuries are taken and the decision is made by the staff, but keeping the parents informed. In the case of illness it appears that the parents are contacted and left

to make the decision themselves about going to the doctor although sometimes a suggestion is made by the staff. On no occasion does the staff contact a child's GP, and this is the case because of "ethical" reasons. It appears that the staff feel that their responsibility is to get the children to medical attention as quickly as possible when necessary, but the decision to treat depends on parents and "professionals".

The question of "ethics" or confidentiality was mentioned by others:

M.C. "Do you ever call a GP in here?"

H.M. "Oh no, no; we refer to the parent. We adopted our normal procedure. I never contact the GP directly. It's not my business ...as a matter of confidentiality".

M.C. "What do you mean 'confidentiality'?"

H.M. "Well, for instance, if a child is ill or if a child goes to a doctor, doctors do not talk about their patients normally to outsiders. Normally they talk about their patients if they are children to the parents, so we don't go through the parents to the doctor. In other words, I will write a letter suggesting that, to the mother,you know, something like, "Dear Mrs.Brown, I notice that Johnny has, or my attention has been drawn to the fact that Johnny has, a lot of rather nasty rashes, sores on his face. It's possible that this may be infectious but would you please go and see your doctor and ask him to diagnose if it's true.' In other words, we do not attempt to ever make a diagnosis. It is not our job. We are teachers".

While schools do have to deal mainly with injuries, some teachers did mention that they have a distinctive policy for injuries and illness as the Headmaster referred to in the above. This may be the case for the majority of complaints, although in certain circumstances, such as when a child is incapacitated by symptoms and in the staff's opinion requiring medical treatment, an ambulance is called which will usually go straight to the hospital. The use of the ambulance overcomes the predicament of whom to contact. It was the Headmaster

in the above who called the ambulance after a child had had a fit on the premises. Other teachers who have a different procedure for illness as opposed to injury sometimes use the hospital in "an emergency". For example:

> "If somebody is ill - just now we have an outbreak of German measles, they come down - I have a quick look at them and you usually tell pretty quickly; you know they sort of get you to see the rash. I usually 'phoned up the parents and asked them to collect them and they sort of carry on from there. If a boy is sick, then it really depends how bad he is. If he is just - well, you think it might just be games straight after lunch and that's made him sick, I say 'well, lie down for a while in the M.I. room.' Really, it's a sort of situation as it comes up".

But with accidents, he said

> "Yes (we prefer to take them to hospital rather than their own doctor)...usually when we have accidents, it's something pretty obvious and the children from here invariably have to go home on the bus and if a child's had an accident I don't think they are usually fit to go on a bus and that's really the main reason - we are out of town - it is difficult for them to get home quickly as they have to bus into town and then out to wherever they go; we cover a large area".

But this teacher later listed a number of "episodes" that she had dealt with which seem to contradict her theory:

> "There was another boy who had abdominal pains in his stomach. We didn't know what that was, you know. It could have been almost anything, so he was sent in (to hospital) as well. Actually it turned out that he had been fishing and that was what it was all about. He was just over a bout of flu, but you can't tell. It could be appendicitis. It's very difficult to tell".

In only one case was a GP asked to treat a child at school. This teacher said he sometimes used a GP, but this was in special circumstances. He said:

> "Yes (I have used the GP) on occasions. It's a delicate matter because it's a confidential situation and I would ask the doctor if I really wanted to know something and they are willing to give me information in the interest of the child".

The GP is then used as an information giver rather than treater, but then he said:

> "A girl in the first year had an epileptic fit and we called the G.P. out then and he came to school. He was here within about eight minutes of the child having the fit, so we can do it".

However, he then said:

> "We wouldn't normally send cases to a GP. No,if it was an emergency, it would be to the hospital, the accident unit".

GP's telephone numbers are only kept for children who have special complaints, such as diabetes or epilepsy, and usually they are used as informants.

So teachers seldom or never took children to GPs or brought GPs in for medical reasons (injuries should be treated at the accident centre), for convenience and also for ethical reasons. Some did distinguish between a GP for illness and an Accident Centre for injury, but such a policy was contradicted by the description of a number of cases where acute symptoms were manifested and the ambulance or Accident Centre were used. Such stories hint at the importance of circumstantial elements, and they suggest that injuries are believed to be appropriate for the accident centre, not merely because the appropriate medical facilities are there but also because the school feels more legal and moral responsibility for injuries than for illness occurring on the premises (as the latter type of episode wasn't strictly associated with the school). Moreover, injuries occur more often so their regular source of medical treatment, the Accident Centre, is seen as the more appropriate for the treatment of accidents.

There are two different aspects to the second question about the teacher's threshold of urgency. First it may be that the teacher has to make sure that the quickest course of actions should be followed

if medical attention is seen to be needed because of the teaching staff's commitment to other school activities. Thus, taking the child to hospital would be one of the most efficient alternatives given the circumstances of the teacher. Such explanations for the use of the accident centre were not offered immediately by the teachers, although they were discussed during the interview. Some teachers did refer to problems that their role as first-aider brought in terms of disruption to other (mainly teaching) activities, although many schools had procedures for minimising the disturbance. This Headmaster who acted as a first-aid worker described his position:

> "It is not really disruptive because most of these things crop up during play time and some of them have a habit of happening in the last few minutes of playtime and because I am a full-time teaching head, they're (the children) accustomed to me having to be called away to the 'phone or someone like yourself coming along during the afternoon, and I've only got to tell them what to get on with and they get on with it while I'm seeing to patients. If I have to go to the hospital, of course, this presents another problem because it means that I have to leave the class, but in most cases I can ask another teacher if I have one in this building on duty at the time, or I have secretarial assistance on four mornings a week and my secretary keeps an eye on the class. This is the only drawback, if it happens to happen at a time when there is only myself in the building, and an infant teacher over there; then I have to sort of leave the whole school in her charge".

Other schools have a first-aider who is one of the teachers and on such occasions, when no one is available, they call an ambulance. In secondary schools the sufferer seems to be taken up to the accident centre and left with another pupil until treatment is over when the school or the parents come and collect the child. In primary schools the staff normally stay with the pupils until the parents arrive.

The general impression given by staff was that although disruptions were caused by accidents the welfare of the child was the immediate priority.

> "Oh, it's a problem when accidents tend to happen at the most inconvenient time. But one drops whatever one is doing at that particular time and takes the child to the hospital. I mean no child ever leaves the school; if I have cause to send a child home, even during the day, no child leaves the school unless he is accompanied either by myself or by my secretary. I don't ask my staff to do it. My teaching curriculum is much less than those of my staff and consequently I feel that I can really put aside whatever work that I am doing and for instance the diabetic coma happened during a time when I was interviewing for a senior member of staff, so you can see how inconvenient it can be at some time or other, but nevertheless we stopped the interview. I went to the hospital with the child".

He goes on:

> "If I can't get hold of the parent immediately I will stay with the child until the parent arrives at the hospital. I feel to take a child home and to get her to the hospital might disrupt my work for three-quarters of an hour, but this is three-quarters of an hour which I can easily make up".

Certainly while teachers emphasised that they would do anything for the well-being of the child there was a suggestion, if only indirect, that problems are caused by injuries and that procedures are quite naturally worked out in some schools to minimise this inconvenience.

The second aspect to this question refers to moral and legal aspects of child care. Some teachers made it clear that when the injury occurs on the school premises they are in a different position than if it had occurred outside the school. One headmaster made a distinction between ailments that happen within the school and those that occur outside. If, as in the particular case in question, it was believed that the child had initially injured herself

outside school, then the headmaster would inform the parents that the child still has an injury which was troubling her and would suggest that they either contacted their GP or took the child to the accident centre. However, if the incident occurred at school, the headmaster would have taken the child to hospital, contacting the parents on the way. The reason for this difference seems to lie with the headmaster's interpretation of his position in loco parentis. He said he would never go to a GP for injuries occurring at the school:

> "I think when one goes to the Accident Centre, the fact that the accident has been recorded at the Accident Centre is also noted on a letter which I understand eventually goes to the GP. Therefore the GP is contacted. I am in loco parentis for all intents and purposes; therefore there would seem to be very little point in contacting the doctor at that particular stage".

This Headmaster suggested that this legal position does influence his behaviour, not in the sense of becoming over cautious, but inhibiting contacting professional medical sources. He said:

> "I deal with other people's children in the same way as I deal with mine and in the same way as I would expect my children to be dealt with at school. This is probably the extent of the care that we take".

He said that no legal position restricts him.

> "What I would like is...there have been a number of occasions when there has been a delay in being able to contact a parent. The longest delay was something like three and a half hours before we could get hold of either parent.In a case like that I wish that sometimes I had the authority to sign the paper to say, for God's sake go ahead and give an answer,get the child out of his misery".

This Headmaster's views were different from others that were interviewed. Some certainly suggested that they prefer to err on the side of caution. One said:

"I understand the school is responsible for the children whilst they, within school time, are on the school premises and that's just about it. We try to make sure. They are other people's children and we can't risk anything".

Another teacher said that if the injury had occurred to her she wouldn't have gone to the Accident Centre.

"As far as I am concerned, I am an adult and I am responsible for myself and the child is not responsible for itself and I think we are here in loco parentis".

One Headmaster was more explicit and cited an example which illustrated his position:

"Oh yes, you have to be extremely careful. What you do, there are forms and observances to go through, and you are walking...not so much walking a tight-rope, but one mustn't tell parents, you know, what their job is, and one mustn't tell doctors what their job is. What one must do, if one suspects a child is not well, not thriving, there is something wrong, is to draw the attention of the parent to it, in the hope that they will go and talk to their GP. The GP is always at liberty if he wishes to ring up or ask the school what is the matter".

He then went on to talk about the implication of this when dealing with the children.

"Well, you must do (err on the side of caution) because, I mean there was a case the other day that, my wife teaches infants, and I mean I have felt this before, where a child fell over or at least bumped into somebody and fell over in the playground and the teacher on playground duty noticed the child crying and said to the teacher that he had banged his arm. Teacher said it is all right; you can move your fingers. And actually,when the child got home at 4 o'clock, he still complained, so at five o'clock mother took him to the doctor. He had fractured his arm in two places. You see here was a case where the teacher sort of did the obvious thing but really I suppose the school should have had a medical room and somebody should have checked thoroughly, but it is very difficult to do if you've got 200 children. You can't follow each one through...but certainly we have to exercise caution because we do have children here who naturally have a greater average incidence of physical clumsiness and perhaps are less verbal in telling people what is wrong with them, check over fairly thoroughly".

This, if only limited evidence, suggests that for some teachers their notion of urgency is coloured by socio-legal conditions when dealing with children and other people's children. One headmaster said:

> "Yes, you see that we are in loco parentis and I suppose there is too much legality about things today, I mean, and the other thing is the new legalities governing accidents at work. Head teachers are doubly open in that it is not so much that the child has an accident and is treated, but whether the cause of the accident was something due to chance or due to negligence as if it were like a lead trailing over a floor or an electric plug".

6.2 Accidents and Emergencies at Work

6.21 The Position of the Employer

In all, 81 cases involved either an episode at work or referral to the medical services by a representative of the sufferer's employer. The Table 6.2 shows that all of the cases apart from one,occurred in employment circumstances. It is noticeable that compared with the table for educational institutions, there is a third category for those cases not occurring at work. There were 12 cases where the episode occurred at work but the decision to seek medical care was either delayed for a day or more or made at a different site.

Before further discussion of these results, some of the categories used in the table should be clarified. Contact with a work representative includes all those people who in some way or another represent the interest of the employer. These can range from employers themselves or to medical personnel employed by companies, even doctors themselves. Contact with workmates only, many of whom gave advice, is not counted as contacts with work representatives.

The circumstances of employment did not only involve industrial

contexts with the sufferer being in the position of employee. Some were employed in the service industry or the catering industry and farming. Some were on vocational training programmes or in the army. One was self-employed and others, although employees, were working on sites by themselves or with colleagues. So,unlike in educational institutions, these episodes occurred in a wide range of different contexts.

Once again, the use of GP services was rare; in only 17 out of the 81 cases, and in only five of those cases, was the decision made at work. In one case, a soldier who was staying at the local barracks temporarily was suffering from infection and he was referred to the local GP by his sergeant. In two other cases, the workmates, under instructions from their employers, took the sufferer to their local health centre, in one case specifically for treatment from the doctor and in the other for treatment by the nurse in the treatment room. This is what the sufferer said:

> "Someone bandaged it up for me and persuaded me to go down to the clinic with it. I could have put it off. I wasn't going to go at all. Well, I was persuaded to go and in the end I went...I had to report to the charge-hand to ask to go down to the clinic..."(He then explained about going to the health centre.) "I only went to the treatment room to get it dressed. To me it was just a cut. It wasn't worth going to a doctor. As it happened, the cut did not stop bleeding and in the evening I went to the accident centre".

This case also gives an illustration of patients using GP facilities for treatment, but for one reason or other the treatment is not successful and the accident centre is used as a second source of medical care.

In one case a student nurse became ill herself while working

at a local hospital. The ward sister rang the student nurses' GP who told her to go to casualty. In the last of these five cases the Personnel Officer rang the GP from the work. More details are available on this particular case.

This twenty-eight year old man was repairing large containers. He said:

> "I had a piece of metal in my finger and as it didn't cause any trouble I left it. This was when I was at sea about 5 years ago. I was repairing large bulk bins and I struck my finger with a hammer".

He was with a workmate at the time, and although he spoke to him about it, he has carried on working as usual. He said:

> "I was aware I'd always had something in my finger because I could see it there. This time I thought I'd chipped a bone or something...I thought I'd leave it to them at work. I certainly didn't expect to be off work, but my employer took me to A.E.D. and they made me take a week off".

He didn't think it was very serious. He said:

> "I didn't give it much thought...I still just thought I'd probably chipped a bone...It wasn't painful...it was just the fact that I couldn't move it. It was numb".

He didn't worry at the time.

> "I didn't at the time but it has since".

He said that it wasn't until several days after, when he couldn't carry on with his usual activities that he did something about it.

> "It was so tight by Monday that I had to go to the 'first-aid' at work".

It is important to note that this man gets paid according to the hours that he works. He said:

> "I need the money. I don't get paid when I'm not there".

He said he could have put off going to first-aid to the following day,

> "...but it would have got worse".

The Personnel Officer who dealt with this case said:

> "He came into us and he had hurt his finger. And what I said to him was that I had a look at it and it was stiff and I said,'Show me how you did it', and that time he wasn't precisely sure how he had done it. Since he is knocking in nails I suggested to him that he might have hit it with a hammer and he said,'Yes,I could have done'. So I said, 'well, quite honestly, looking at a thing like that, can you manage to work?'I said that'if you find that it's not getting any better, you ought to go and see your GP,'because at that stage I wasn't sure that there had been any accident".

At this point, the stories from the patient and the Personnel Officer are discrepant. The patient said that the Personnel Officer rang the man's GP at about 9.00 a.m., and the GP told the Personnel Officer that the man should go directly to hospital, which, according to the man (patient), he did. However, the Personnel Officer had this to say:

> "There was no doubt about it, that finger of his. I said to him that it wanted looking at medically. It was outside my scope, or indeed, anybody else's we've got here, to assess what was the matter with that finger and it wanted looking at".

But the Personnel Officer didn't think it was serious.

> "Well, no, not serious...that's why we rang the doctor and suggested that he...it's a fact that he didn't know precisely how he had done it and he obviously had got a lump on the knuckle and it was stiff, and very painful, and that's why we rang the doctor to get the doctor to have a look at it before we sent him off...because we didn't consider that that was the sort of thing that we would bother Canterbury with".

He went on:

> "We gave him leave to go and see his doctor. We made arrangements for him to get an appointment to see his doctor. We rang the doctor and asked to get an appointment to see his doctor. We rang the doctor and asked to get an appointment because we thought it was an accident at work, didn't know what it was but could he go down and see him. So he saw his doctor and the doctor rang back and said that apparently it was an aggravation of a previous injury and that there was no break, but there was a foreign body there and that the doctor thought he should have an x-ray, so he was taken down by one of our staff for an x-ray".

It appears that a GP was contacted and that his advice was eventually accepted. The man was taken to the hospital.

It is not feasible to explain the patterns of action of each case because of the large number of cases. However, there were a number of different types of cases which were of special interest.

Apart from two cases described above, where the person contacted a local GP before going to the Accident Centre, even though the person was not living in the locality, there were a number of sufferers who were not permanent residents but were working in the area on a temporary basis. In all, there were eleven such cases, including the two previously described which fell into this group. There was one other soldier, apart from the one previously described; another was on a police training course, and another was a sailor whose ship had docked in one of the local ports. Other cases involved people whose work brought them to the area. Two were involved in quarrying and two were involved in the entertainment industry. One of the latter was with a travelling circus and the other was appearing in the local theatre and travelling around with a company. In the case of the theatre, there is a local doctor on call but he wasn't used. One sufferer was a gypsy working in the area.

In nearly half of the 81 cases, the sufferer went directly from the site of the episode to the Accident Centre, the majority of these having contact with an employer's representative. In some cases the decision was made by the employer's representative. For example, three injuries occurred in a local colliery which had a medical centre staffed by a nursing sister and a medical room attendant, and with a doctor on call. Two of these three cases followed

a similar pattern and the details of one of them was as follows:

This is how a miner explained how he injured his left hand.

> "I was working seven miles along the mine, was putting a pack on. This is in order to hold the roof, as the pit advances the roof is packed behind you to hold it. The stone is used from the advancing tip to pack the sides. I was lifting one of the stones and my finger was caught".

He cut the little finger of the left hand and he also crushed it. He explained what happened then.

> "I carried on working for an hour. I didn't know it was broke. You don't come out of the mine with just a superficial injury. It is not the done thing. It creates of lot of inconvenience to a lot of people. It also involves production to a great extent, owing to the fact that the collier is 7 miles in. This means that to convey a man 7 miles out involves a lot of lapse in a lot of people's... then it became so painful...after an hour had passed I realised it was bad because it didn't stop bleeding...The first-aider discussed it but the overmanager didn't think it was bad enough to go immediately to hospital and we didn't think it was bad enough to stop the shift".

However, at some point an old miner told him that it was broken and this diagnosis was supported by the attendant at the medical centre. After the shift was over, the miner went to the medical centre where he was seen by a medical attendant. In this case the medical attendant referred the miner to hospital and he was taken in the mine's own ambulance. The miner said:

> "You have to do what the 'medic' advises because of claims".

In other cases, the decision was made by the sufferer himself and the employer agreed. For example, a 21 year old man who cut his right leg while working at an electrical firm explained how it happened.

> "We had some plastic trunking and I was trimming the ends with a knife because plastic makes a bit of a mess. It's got a mind of its own and I was cutting away from me and the plastic pushed the knife down instead of it going up the way I wanted it to go. I was sitting on a high stool and of course it went and cut my leg".

He continued:

> "My workmate got the first-aid box and we put a plaster on it...it didn't look too serious but it started bleeding a lot and I thought that I had better have it seen".

It didn't restrict him but his leg was slightly stiff. He discussed it with his workmate and said:

> "I wasn't sure. We discussed it between us and wondered if it was worth going to the hospital or not but someone said that even if it's only for the tetanus injections, it's worth going. So he went directly to the hospital with his workmate in the latter's own car".

He didn't contact his GP because:

> "Well, it was not worth wasting his time and I didn't think it was the right place to go".

The manager of the firm said this about the injury:

> "I wouldn't have thought it was that serious. Just a lot of blood. The wound was cleared, cleared of any dirt so as to see how bad it was, and, you know, assess it to see something needed doing to it. Yes, and put a temporary bandage on it. It was suggested that he went to the hospital and he agreed to go...I think they decided it needed stitches".

A similar injury occurred at another factory but in this case the chargehand played a more significant part. The sufferer explained how it happened.

> "Well as the material was coming through the oven where it is counted, I was cutting it off in its lengths and as I cut it, it cut awkward and I just cut my thumb".(The foreman on duty took him to the first-aid man. They felt it was a serious accident and was instantly dealt with. The safety officer described the symptoms.) "He (the sufferer) didn't have any signs of shock. I think the more shock happened to one of the first-aid men treating him when he saw the blood, but, as it happened, or other than the normal shock one would expect with loss of blood, he didn't faint and he didn't pass out; there were more of the shock symptoms, although undoubtedly he was shocked to a certain degree".

The foreman on duty rang for the ambulance and the first-aid man cleaned him up. The sufferer said that he thought his injury was "pretty serious" and he said, "I didn't realise that I had cut myself until I saw all the blood coming out and I got hold of my other hand to hold the gap together".

He said he couldn't put off going to hospital because it just would not stop bleeding but the decision to contact the medical services was made by the charge hand on duty.

Of the 50 cases where an episode occurred at work and the sufferers had contact with an employer's representative, 62% were told to go to the Accident Centre or were taken to the Accident Centre. In only 18% of the cases did the sufferer go to another environmental site after contact with an employer.

Table 6.2 shows that in twelve cases when the episode occurred at work there was a least a day's delay before medical help was sought, even though the decision to seek help was eventually made at work. Examples of this pattern are shown in the following case. There seems to have been some disagreement between the woman in this case who injured her finger and the woman who was responsible for first-aid. The injured woman said:

> "I was just working and as you pick the ends up because they are wooden boxes, your machine's in front of you and I banged my hand on the framer. It's the machine for framing the boxes. ...I carried on working but I had to keep my finger out of the way...By the next week it was too painful to work so I went to the first-aider and she took me to the hospital".

She said that at work they said initially that nothing was wrong with it.

> "They (at work) kept telling me there was nothing wrong with it. They said they couldn't put anything on it because there was not any cuts. The first-aider kept saying,'it's only a whitlow'."

The woman said she couldn't put off contacting the doctor or the hospital, or, in her case, telling the first-aider because,

> "My hand was all swollen up, all down my hand...It was so sore".

The first-aider who dealt with it agreed with the woman's account of how it happened and said this about her evaluation of the severity:

> "It looked rather painful on the day she actually told us. She came in and I think she said,'My hand, it's painful', and then she said,'Would you have a look at it?', and it was rather swollen".

The first-aider told the woman that if she had knocked the finger at work then she should really have reported it on the day that she did it. After initial examination, she said,

> "We all thought it was a whitlow. First of all because she had a swelling round the quick part and it looked very red there, and we said it could be a whitlow or certainly there was inflammation there because it was red...I mean to open something up, which is what we never touch...The only thing I did say to her was about bathing it. If it was a whitlow and she said, 'I have put a hot poultice on and it's done nothing and I said 'Well then, I think you'd better go to the hospital'."

The first-aider was uncertain as to whether it was a whitlow or not. She said:

> "It was the swelling really, you see, and after she said she'd knocked it, there was a possibility that she could have chipped something inside you see. This is more or less the reason why she was sent to hospital because of the swelling and saying it was knocked".

Concerning the decision to use the hospital instead of a GP, the injured woman said this:

> "I don't get home until 6.00 p.m. By the time I've collected my kiddies the nursery is closed".

She also said, possibly with insight about the nature of the treatment given, that

> "I wouldn't have fancied sitting in the doctor's surgery and letting him take my nail off".

The first-aider gave a different account of why a GP wasn't contacted:

> "Well, circumstances prevented that. We did ask this but her doctor lives in A. She's got no transport at all to get to her doctor and she lives in B. I did say this,"I felt that your own doctor, if it had been a whitlow, would advise you about this', and she looked at me and she said, 'Oh, I've got a problem because I've got a doctor in A and I've got no transport to get to A...' She's in rather a difficult position where her children are being minded about a mile and a half from the village where she has to walk to get the children. But we didn't send her for that reason. Circumstances do change it rather than if she had a local doctor, she could have gone in the evening because we generally, you know, you have to make an appointment with these doctors in the village, where we would have made the appointment from here for her if she had a local doctor".

This answer is interesting, not only because it appears that this woman's circumstances may have played a part in her going to the hospital, but the answer tends to indicate that the first-aider has an idea about what the hospital feels ought to be their function. Thus the social problems or personal problems that the woman had were not seen by the first-aider as a legitimate reason to account for her use of the hospital. The medical reasons given before this explanation seemed, according to the first-aider, more legitimate reasons to give. In fact, there are two different ways of interpreting these answers. Firstly, it can be argued that the respondent's account of the circumstances that led to the use of the hospital should be taken on face value and accepted as a plausible account of what went on and why it went on. However, secondly, it could be argued that this account represents a strategy used by the respondent to show that they are doing the 'right' thing or doing the thing that they think is publicly or morally acceptable. It appears that this respondent is using the interview to interpret what happened in the context of the present encounter with a representative of an official agency.

Table 6.2 also shows that some injuries or illnesses went unno-

ticed by employers even though they occurred at work. For example, an elderly woman injured her arm at work. She said after it happened:

> "I didn't think anything was wrong. I went and got on with my work. I have to use my hands as I make optical frames. It was only when I went to coffee that I noticed how swollen it was and I got a bit frightened...I carried on to 12 o'clock, but it was rather silly to do that. It was so painful and swollen...The girl at work saw me fall and I told her not to tell anyone, because I didn't want to make a fuss. She said I was silly not to report it as it happened at work."

She went home from work at her normal time and her daughter who lives next door came in and made an appointment to see the doctor.

The employer said this about the incident:

> "We didn't do anything because we were unaware that an accident had actually happened. She didn't tell the management on the Tuesday when it happened and the first we knew about it was when she wasn't at work the following day, and then, having made a few enquiries, I learned from her colleague that she had a fall".

Data presented in the above certainly indicates that when an episode occurs at work, and a representative of the employer becomes involved, then the Accident Centre is used if medical help is required. The GP or health centre is used minimally. However, the interviews suggest that not only do employers' representatives have an inclination to use the accident centre, but also a sufferer's colleagues would also suggest a similar course if asked. These data also suggest that in almost half the cases action was not taken to seek medical help immediately after the 'episode' took place. The use of GP services was more likely to occur when the decision was at another site and there was no contact with an employer's representative.

6.22 Policies of Employers for Dealing with Injury and Illness

In this next section, given the results from the above, two questions are proposed:

1. Why do employers prefer to use the Accident Centre rather than a GP?

2. Are employer's thresholds of urgency coloured by conditions other than the perceived severity of the complaint?

With regard to the first question, it became evident, as with educational institutions, that staff mainly had to deal with injuries rather than illnesses; hence many managers or employers, when talking about dealing with medical complaints, referred to their procedures for dealing with injury. One manager of an electrical firm with a staff of fifteen said this about use of GPs:

> "We never use a GP in these cases (cut hand) because we have somebody who is involved in this type of service anyway, and I think that if we felt the injury was serious enough we would call in the hospital direct anyway. The possibilities of getting a GP to come quickly as we could get somebody to the hospital are nonexistent really". (He went on to explain further the reasons for preferring the hospital.) "Convenience - and it seems as though that's the quickest answer to the problems at that time anyway. We geel that they're going to get attention for their injury far quicker than if we called a doctor".

Similarly, a medical room attendant on duty at a medical centre at one of the local collieries said:

> "We never contact a GP. If a man requires medical attention, we treat immediately; then we send him to hospital. But in cases where medical attention is not required immediately, such as strains, sprains, and minor wounds of one sort or another', patients are referred to their GP but do not go directly from the pit".

One manager of a bus company suggested that for all episodes the practice generally was to refer to hospital. He stated:

> "In the main it's straight to the hospital. I think in the main it's straight to the hospital because if someone demands immediate treatment, if there is some slight mishap which doesn't warrant going to hospital, a chap might be advised to go to the doctors or be sent to the company doctor".

For lacerations or suspected fractures, the hospital is always used.

"I don't think in the normal course of events the GP would have this sort of case sent to him. We don't normally call him for accidents. It's always to Casualty, up to the hospital. It's pretty well always to the Casualty Department".

The above evidence suggests clearly that for injuries the accident centre is nearly always the source of professional medical care. Is there any evidence to suggest that a similar pattern occurs for other types of complaint? A safety officer said this about his firm's policy about coping with illness:

"We might advise him (the sufferer) to go to the doctor if a man said he felt sick, we would send him home and let him consult his doctor and let him make that decision, other than the obvious heart attack, when we would, or if a man fainted, or if a man collapsed, but if a man merely said that I feel sick then we would probably have escorted him home or sent him home and advised him to see his doctor. I don't think we would cart him down to the doctor for sickness".

There is a suggestion here than when the individual is incapacitated by acute illness and can't make a decision himself, then he would use the hospital. Such a policy is also adopted by a large garage who employ 200 staff. The safety officer said,

"We don't contact GPs because we find that if the first-aider has decided that it's treatment, casualty,hospital, it's a necessity, in that particular case, then there is a delay period of contacting the GP, he can't come; he won't come; he's out on calls; he is taking his surgery; there is all sort of delay, delay."

M.C. "Say somebody cut his finger, would you take him to a GP?

Safety Officer: "I doubt it very much. If you ran him round to a GP and that GP was not his doctor, then the GP would say probably,

(a) that's a job for the hospital. It needs stitches in there.

(b) I am not his GP. I am not his doctor. He is not on my list. I would suggest you take him to his own doctor which could be seven and a half miles away. He may not live locally or take him to the hospital, so you have wasted that time, and you have come to that conclusion anyway initially. If the first-aider can't treat that person, then that person must be injured to a degree where a specialist is needed, and

the only way you're going to find a specialist able to treat that person is at an establishment such as the casualty centre or hospital".

M.C. "What happens with cases where a person collapses, faints, or has a fit?"

S.O. "We don't necessarily take them to hospital. Shall we say a person who is employed in a particular department is a known epileptic. He has fits and has had fits on the premises or elsewhere, but he is known; then the first-aider in that particular department would know how to deal with epileptics generally if they had a fit... however, if a normal recovery time for that particular epileptic fit did not seem to be happening, then they would probably contact his doctor if they could, or if that was not available, then they would have no alternative, but to take the person or arrange for an ambulance to take that person to hospital".

Some firms do seem to have regular contact with GPs and the choice between going to the doctor and the Accident Centre is a real one. A first-aider at a fruit-packing station said this:

"I talked to a young lady - I think it was Wednesday or Thursday - and she was coughing up blood and I was disturbed about this, so we sent her home, took her right home, and I got in touch with the doctor, well to supervise her, to let her in that very evening because, I mean, sometimes you can ring up, or they ring up the doctor and it could be two days away before the local doctors will even see them...So I felt it was one time when they could get a move on".

According to these first-aid workers, they also have difficulties contacting GPs direct because of differences in status. They talked about their British Red Cross Training:

"...but nearly everything is 'if you are not happy consult your local doctor but you see very often for the likes of a first-aid worker, I mean to pick up that phone myself; a doctor wouldn't even speak to you; you've got to go through the supervisor. Everything is done through the supervisors and I don't think unless you...I mean all you can do is to advise a patient to go to the doctor".

She went on to say that hospitals are used for accidents.

A personnel manager at another packing station also said that GPs are used:

> "We only send them to their GP if it's not an accident... if it's not an accident in the sense of the word, I mean... if we particularly wanted a doctor we would get a doctor up here, let's face it. We usually get the doctor if it is something medical rather than accident. If it's an accident, what we do is to treat it as an accident and invariably take them to one or other of the Accident Centres".

He talked about the use of the cottage hospital at Faversham and the Accident Centre at Canterbury.

> "We would ring them up (Faversham) and ask them if they could cope with it. Sometimes they say could you take them to Centerbury; sometimes they will cope. If it's a bit bigger, for instance,we had a girl who broke her arm a couple of years ago and what we did there was, of course with a known broken arm, was to send for an ambulance,get her straight up to the Accident Centre as quick as we possibly could. But if it's something medical, somebody is not complaining of feeling well and they've got spots or something of that sort, we then say, well, if you are not feeling well do you think you ought to go home. Perhaps you ought to see your doctor and suggest that they see their doctor, and if they say well can you make an appointment, of course we will make an appointment, and if they were not in 'walking' condition, if somebody had got raving flu, we would take them up ourselves to make the appointment...There are times when we say I'm sorry they'll have to go themselves, but if the circumstances is such that person, for instance we had a lady the other morning who came into work and she obviously had got a very bad dose of flu, so we wrapped her up in a blanket and got somebody to take her home..."

These data suggest that for most firms, when confronted with an injury which they feel requires medical attention, the accident centre is the usual source of medical care. Some firms seem to make a distinction between injury and illness and for the latter type of complaint a GP is seen to be the appropriate source of care. However, there were hints that in some circumstances ambulances are used.

The chief reasons for using accident centres for injuries seem to hinge on two different dimensions. Firstly, more firms with qualified medical personnel feel that if their first-aid man can't handle

the complaint, then only a specialist can, and so hospital treatment is warranted. Secondly, it is much more convenient going to the accident centre in that it is quicker and therefore more efficient. One first-aider referred to the "social barriers" involved in contacting a GP themselves.

With regard to the second question on the influences of non-medical factors on the staff's perception of urgency, the CSA would argue that the employer's perception of urgency is coloured by the need to maintain the firm's activities and thus get the employees back to work as quickly as possible. The data show that, of the the sufferers who were injured at work and went to the accident centre from the site of work, 19 out of 35 went back to work. Excluded from this analysis are those whose work was also their home (sailors,etc.) and those who were admitted to hospital. The problem with these figures is that, although in some cases the sufferer does go back to work, he does not perform his normal task and is sometimes given a less demanding job for the rest of the day. Of these cases, out of 19 cases 15 were advised to go to the hospital by the employer or employer's representative or were taken to the hospital by one of them. Of the 16 cases who didn't come back to work after their visit to the accident centre, 13 were instructed to go to the accident centre by an employer's representative. There is little difference between these ratios which might suggest other influences are just as important.

Results from further interviews suggest that employers take into account the economic aspects when referring a man to the medical services. One managing director of a local firm who was interviewed over the telephone (he didn't have time to see us) said that one of his employees is an ex-medical orderly who is "always" avail-

able to deal with medical matters. He said that because this man was only a paramedical, he couldn't take the responsibility for "stitching" a cut, and he would leave it to the professionals at the accident centre; and he went on to suggest that his major concern was with getting his employees back to work as quickly as possible. He said the employees wished to get back to work as soon as possible as well.

In contrast, one first-aider at a fruit-packing station said that her firm was very "good" in that the priority was given to the welfare of the patient. She said

> "The company don't mind a bit. That is something that you are expected to do...Oh no, time doesn't come into it, and you see often we've left girls up there (at the accident centre) and when we go home the Managing Director will stop here at anytime to go and pick them girls up and take them back".

This quote illustrates the humanitarian side to some company's policy, but a more balanced view was given by the safety officer for a motor garage who suggested that while the firm needed to make money so did the employees. He said:

> "Every company is interested in making money, and in commerce if you don't make a profit then you are no longer a viable company".

He then went on to give an example where money can play a part:

> "If a first-aider was appointed and that person appointed was, for instance, a technician who was earning money at a particular job function, then that job function also had the attraction of having monetary incentive, the more turned out the more he had paid. In those circumstances the person then was drawn from that particular occupation for about half an hour, three-quarters of an hour. Each time he was drawn away he couldn't be earning money, so, therefore, the incentive bonus, if you like, the payment for turning out that extra work would fall off, so he would lose money. In that instance,I can understand the person concerned,that is the first-aider concerned, being a little bit disillusioned in

> respect that all right, he is doing a good job; he is looking after people. That's a humanitarian need fulfilled, but where does his pocket come in? what about the money that is lost? Now from that point of view, his profitability if you like, the money, his earning power, the money he would have earned had he still been working instead of doing first-aid, yes I can see that that could be...it hasn't arisen here. It hasn't arisen because our injury rate is so low that I doubt very much whether our first-aider as such is called on once in three months to give first-aid treatment".

This security officer did admit that there was a problem mixing the welfare of the employees with the economic needs of running a company.

> "When appointing first-aiders, we have to think about the availability of the first-aider because a first-aider, to be effective, has to be available. This is why we try to cover more than one first-aider...We also have to consider what sort of work was that person employed on; what type of work was he or she available, would he be if that person is a technician working in the workshop, be in a position at any time during the day to give first-aid to another person".

The evidence suggests that economic aspects may play a part in influencing definitions of urgency but also large firms have developed strategies for minimising the impact on the firm's economic activities.

With regard to socio-legal aspects, where the firm may tend to err on the side of caution, there is some evidence to support this proposition. Some just said,

> "I'm concerned with the person and at Casualty you can get immediate treatment".

However, an interview with a Personnel Officer did bring out some of their worries.

The P.O. did not explicitly mention any legal pressure he was under but did refer to the need to err on the side of caution on a number of occasions. Firstly, in relation to the problem of having

to go all the way to Canterbury for an x-ray.

> "As a first-aider and when I am fairly sure there is no break, but I can't guarantee that I'm fairly certain that there is no fracture but then there is no x-ray in Faversham. Nine times out of ten there is in fact no fracture".

And, secondly, in relation to his worries about the proper use of the Accident Centre in Canterbury,

> "When we send them down, one wonders whether they think that we've given them work which they needn't necessarily have had. I think we try to get away from that, but we are in a position where, of course, where you talk about the legal thing. I mean the sort of thing we are very concerned with is if somebody gets something in their eye... We get a splinter now and again, but if somebody does get something in their eye, it's something we treat with utmost care, not that we don't with any others but what one tries not to do is to have to send down to Casualty somebody that is apparently trying to take you up for a trot. I think in general terms you can tell whether somebody has got a break or a fracture, but, nevertheless, if the pain is there, how can one tell? I mean quite often we do it on the basis that, firstly, we would like an expert medical opinion; and the other thing is that if the patient is quite sure that if they get expert medical advice, it settles their mind".

Others explicitly suggested that injuries on the premises were treated differently from those off the premises. This is an account given by a first-aid person at a fruit packing station.

> "When she said she'd knocked it at work, that's when you feel the responsibility is ours. You know, had she said, 'I just don't know what's happened to it', it would have been obvious that she might have done it at home. It's something that we can't prove but she definitely said that she had knocked it on her frame...We had to accept it,but there is no witness to these things. It's like if somebody sort of trips over and the next day they say 'I tripped over on such and such a thing and it is painful now. Who are we to disprove this is what they have done".

It is not clear if this influences their response in terms of seeking medical care, but one can guess that it becomes more urgent when it occurs on the premises. Although the staff was unclear as to their legal position, they thought it was the company who was responsible for injuries at work. As regards compensation for

injury, the first-aid person frequently indicated that claims were put in by staff. She said:

> "Oh, it frequently happens. Mrs.A. (in this case) did the same. I think it has become habit...We know each one that has an accident. Now they are getting quite good money for it, they are. I mean they are getting quite fantastic amounts. A few recently with the least little thing that happened. I think this is what came up with Mrs.A, wasn't straight away, with her foot not even in the door, which is rather annoying!"

Finally, the safety officer from the motor garage argued from a different point of view.

> "It not only involves a question of legality, but also involves the humanitarian side. If something goes wrong, do I carry the can for this particular person with the problem? For instance, say there was an injury serious enough to warrant some kind of informality and that person says,after the problem has resolved itself,they can't perform activities that they used to be able to. Now they may say that was due to the fact of bad first-aid work,a person not coming to the conclusion soon enough that they should be at hospital. Therefore one would expect that you would get a lot of terrified first-aiders who, at a drop of a hat, say hospital, hospital every time".

However, he goes on to suggest that in his firm this wouldn't be the case.

> "We say here is a first-aider working for our company. Is he or she under this sort of pressure of perhaps claims for damage, etc.? Civil courts and this sort of thing looms up in front of him and this is the thing which stops them from putting their hands up. No, I wouldn't have thought that because, again, they know that the company having employed that person has confidence in that person; they are not employed as first-aiders. This is only a secondary task. They are following their normal course of employment and I mean to take first-aid, because those types of persons have selected themselves, if you like. They have selected themselves because they feel something for their brother worker, if you like, and they have this humanitarian thing that they would like to fulfil the possibilities of first-aid. Some, of course, are St.John's or Red Cross people anyway. So they have this inner compunction, if you like, to do something with a firm hand, and they broaden their horizons by going to courses, etc. and learning how to do it properly, because an inexperienced person tackling an injury can sometimes do more harm than good. In certain circumstances, they feel they must do something; they want to do something and don't know how to go about it. They don't know the first thing what to do in the circumstances, what best to do for the person. Now I would have thought that the first-aider

> working for this particular company would know that the company would stand by them. We talk about insurance policies and so forth, and while the company has its insurance cover, would cover that person in the event that they had a claim against them, so they would feel they've got the strength of the insurance company's around, but I should think that would be a secondary thought at the time of injury for the person, the first-aider would feel that firstly could they deal with the problem and do what is best for the person and only as a secondary consideration, I would think, and a long time behind that would be what the implications might be".

It seems, therefore, if the last account is accurate, that the socio-legal aspects which influence perception of severity vary according to the size of the firm and approach to safety adopted by the firm. Certainly there is evidence that socio-legal aspects play an important part in the ways employers cope with industrial illness and accidents.

In concluding this section, these data suggest that employers generally prefer to use accident centres for coping with injuries and sometimes illness than to contact GPs. The reasons for this seem "medical" as well as reasons of convenience and efficiency. There is also a suggestion that because of economic reasons the quickest course of action has a high priority which means going to the accident centre. With regard to socio-legal influence in evaluation of severity, the evidence is inconclusive.

6.3 Episodes Involving the Police

6.31 Contacts with the Police and Others after "Episodes" in the Street and Road

Table 6.3 shows the distribution of patients who had or did not have contact with bystanders and the police and the location of the episode, the site of the decision to seek medical care, and the

choice of medical care system.

Before these data are analysed, some of the categories need to be clarified. The category labelled "contact with the police" included all those episodes where the police were at the scene of the episode or had some contact with the patient. Included in this category are those episodes where the patient had some contact with the police but no advice was given, or where advice was given but not heeded. The category "contact with 'bystander only'" includes only those episodes where the police were not present or played no part in dealing with the episode.

Further data have been collected on ten of the episodes where the police were involved. Patients gave their written consent for the researcher to approach the police in each case, and tape-recorded interviews were carried out with the police in police stations throughout the area.

In this analysis, the focus will be mainly on those episodes that happened in the road or street because these are the areas where the police are most likely to be involved. In all 106 different"episodes" are included in Table 6.3, but the majority of these episodes, 99 (93.4%) occurred in the street or road. However, before these are discussed in more depth, the seven cases are considered where the episode occurred at a different site from the street or road as they illustrate the variety of circumstances that leads to use of the accident and emergency services.

In one of these seven cases an attempt was made to contact a GP. In this case an elderly woman fell down at home and broke her hip. She was incapacitated and being by herself called for help.

A neighbour, hearing cries, tried to get into the house but the door was locked. The neighbour then rang the police who came and broke in. The police then rang for the ambulance and the ambulance men called out the lady's GP. In a similar case involving an elderly man who collapsed on the stairs in a home for elderly people, another resident found him and rang his daughter who lived nearby. The daughter came and rang the police. The police contacted the ambulance, which took him to hospital.

In two of the seven cases the patients were on holiday and in one case the patient was travelling through the area. He was coming through customs at a port and dropped a bottle of wine, cutting his hand on the glass. A policeman on duty at the port said he would take him to Dover hospital. The sufferer preferred to go to Canterbury hospital as he had friends he could stay with after leaving the hospital. The other case involved a patient staying at a boarding house in the area. The sufferer complained of stomach pains and his wife rang the police for a list of GPs in the area. The police told them to go to the A.E.D. as they were close to it.

The final three cases involved a remarkable contrast in circumstances. One patient was assaulted on a beach; the police were contacted and he was taken to hospital. More will be said about these cases when the "assault" category is considered as it has special implications for referral to hospital. Another case involved a member of a community for people with problems with mental health. The sufferer cut her wrist at the centre and a GP was called. The GP treated the wound and left. The sufferer then ran off and tried to throw herself under a car. She was picked up by the police and

taken to hospital.

Finally, a young child was kicked in the groin by a horse and came home. His mother spoke to a neighbour. The neighbour rang the police, since she knew the local doctor was ill in hospital. She spoke to a police doctor who told her to ring 999 immediately. The mother carried out these instructions and an ambulance arrived and took the boy to hospital.

Results from Table 6.3 show that a very small proportion tried to contact their GPs, either in episodes occurring on the road or in the street area, and the greatest number occurred when the sufferer had moved to another site to make the decision. In five of these 99 cases, the "episode" occurred in the street outside the sufferer's home and an attempt was made to contact the GP from home. Three of the five cases involved injuries as a consequence of accidents on the road. One elderly lady was riding on a bus and the bus was in collision with a car. She bumped her head and the following day went to her GP from home. Two others were involved in road accidents where the police came to the scene and offered advice. In one case the accident occurred very close to the sufferer's home and so the police told him to go to his doctor. He went home and attempted to contact the doctor. In the second case the police took the boy home and the GP was contacted from home. He said,

> "I mentioned my injury to the policeman, but he didn't seem to think there was anything wrong with me and did not advise me to go to the hospital".

Three cases involved sufferers whose complaints could be coped with at the scene. One had a nose bleed and two had foreign bodies

in their eyes. Two others had complaints that they brought home and subsequently attempted to contact a GP. The one case where the sufferer went straight from the site of the episode in the street to the GP's surgery involved a woman who was on her way to the doctor for something else anyway.

In the following pages those cases when the episode occurred in the street or road and the decision to seek medical care was made at the site will be described. In particular, the role of the police and the bystander will be considered in relation to referral to the hospital.

Taking the police first, there are two major types of episode on the road or in the street where the police are involved. One is the area of unintentional violence to the public, usually road accidents; and the other involves intentional violence to the public through assault or fighting. Of course there are other "episodes" to which the police are called such as collapses in the street.

Thirty-five "episodes" were road accidents: that is, the sufferer was either involved in a collision with a motorised vehicle (including motor bikes), or the motorised vehicle in which the sufferer was the driver or passenger came out of control. As was mentioned previously, in three of these cases the sufferer went directly from the scene of the episode to hospital; the vast majority went by ambulance. In 16 of these 26 cases the police arrived at the scene. Their involvement in the decision to refer obviously depends on who gets to the scene of the accident or episode first. In many cases the police arrive first, for example in a road accident occurring on a country road. This is how the sufferer ex-

plained what happened:

> "We were on our way to a pub for a drink. We went over a sort of bump and another car was coming towards us and it caught the back of our car and swumg it round and it hit a wall.The car was driven by my friend. The car was a total write-off... I couldn't stop shaking...somebody brought some blankets out to us".

Four others in the other car were not injured, but the driver of the sufferer's car cut his hand and arm. The sufferer explained his condition:

> "I just thought I'd hurt my hand, but when I couldn't move it I realised something more was wrong. I was unconscious for a while though, and everything is rather hazy...the people came out of a house and must have told us to stay where we were until help came, but as I can only remember my mate asking me if I was all right, I really don't know any more".

The police were contacted by local residents who had put blankets over the injured. The police didn't receive a 999 call but the local residents rang direct to the police station. The policeman explained the scene:

> "There was quite a few people. There were two vehicles involved,in which one had been carrying three passengers plus a driver. The other vehicle where there were people injured,one driver and a passenger and there was a couple of other people, local residents".

No ambulance had been called for. The police said, "When we arrived it was obviously apparent that somebody wanted an ambulance so I got on to them straight away and asked for an ambulance". The police then carried out their normal work at the scene:

> "When you first arrive and see the road is blocked, you see we put the police sign in the road with a warning light further down the road so that nobody will come. We look further at the injured. One of our traffic vehicles arrived later and was at the other end, so we could completely stop so nobody could come round because it was on a bend and obviously late at night.

The policeman didn't make a decision about who should go to hospital and left it to the ambulance.

> "I presume that when the ambulance came the one with minor injuries was taken as well because he said that he wanted it checked...No, I didn't say to him,'well you will have to go'. I was quite busy at the time when they turned up. He might have gone with him anyway as he was a close friend".

The accident caused the road to be blocked for twenty minutes but this did not cause much of a problem because the police said little traffic was about at that time of night. Both drivers were reported as there were allegations on both sides and the case was not clear. The police said:

> "Yes, they were both saying each was at fault. This was a narrow road. Both was saying that the other person was towards the centre of the road, more than they should have been and therefore a collision occurred and there was no other marking to suggest who was in the centre of the road".

The drivers were not arguing "because this chap was obviously injured and I think the other person involved didn't want to start an argument with him and he didn't want to know".

In other cases, the police do not play such a decisive role. An example is in the following case which involved an injury to a motor cyclist in a town. This is how the sufferer explained what happened.

> "There were two parked cars each side of the road, and I was turning as a car was coming up the middle of the road. Some boys were there and I couldn't see the car. I started to brake, but the bike started to slip and I came off and the bike landed up underneath this chap's car. He was the only injured person. I thought that I might have broken my hip or some internal damage. I thought I might have damaged my kidneys...A Red Cross lady came over and asked if I was alright and quite a few people that came up to me advised me to go to the Accident Centre".

It is not clear who called the police (the police were not sure either), but the police arrived. The boy said:

> "The police questioned me at first and didn't seem to think I was hurt. I asked to go to hospital and they called for an ambulance".

The police explained how they became involved.

> "I was notified by personal radio in the panda car. I went to the scene. One of the vehicles had been moved. The only person with any injuries was on the motor cycle and apparently recovered from the initial shock of the accident and I obtained details from the person concerned".

He said that there was no great rush. It was only a "minor sort of thing" and perhaps it wasn't necessary to call an ambulance.

> "Possibly not. It's always up to the injured person. They have the choice of whether they go to the hospital or not".

He went on:

> "The road was temporarily blocked, but when I got out I marked out the vehicles. Well, there was no great problem there".

This question of how the emergency services are initially contacted is difficult to explain. In some cases, as has been described, the police are contacted directly by a bystander and they contact the ambulance, either through the operations room at the time of the call or after they have received a call. In other cases the ambulance automatically refers the call to the police to see if they are interested. For instance, one policeman explained how he saw it working.

> "I have known occasions where an ambulance has attended an accident and called us up and told us of the accident. I think on a lot of occasions it's the more serious accidents that we get absolute notifications, i.e., when both

> parties are perhaps injured to a somewhat greater degree and, in fact, the ambulance has been called by a third party who has come across the accident or who has seen the accident happen; then somebody will ring up the police and ask them to attend, not necessarily because they feel that we might have a job to do there, but simply from the point of view of the road is blocked and there is no other person they can ring up. They know very well that the ambulance drivers won't deal with that. They will come along and deal with the people and the trouble is that if the people need hospital treatment you might need somebody else to help."

He then went on to talk about the general public's behaviour when ringing the emergency services.

> "Well, they will call the police and the ambulance. I think the men will back me up. I think if it is obvious to people that there is a serious injury involved, I think the ambulance invariably is there without us having to call for it, it's only in cases where probably the injury is not very significant where either an ambulance is called and the police are responsible for calling it. I think when people dial 999 and they are asked what services they want and when injury is involved I think the ambulance is called. I think that in a lot of cases you usually find that the accidents where the ambulance is called and we then get a call as a result of the ambulance being called, the sort of thing where you have just one vehicle perhaps involved, it's run off the road and the person who has seen it or has called the ambulance doesn't really think the police will be interested because it's one vehicle involved or something like that, perhaps a dog involved, as a result of it somebody has received an injury so they call the ambulance and the ambulance people pass it on to us to say that they are attending. I don't think they pass it on to us expecting us to attend. I think sometimes it's just a question of if it's a road accident they think we might be interested. I have an idea, I mean I don't know, but I think it is part of their policy; they attend at a traffic accident and are involved with injury. They notify us almost without exception. I mean I can't remember an incident where an ambulance has gone to the scene of a road traffic accident where there are injuries and they haven't notified us if we are not already on the scene".

Other police officers were also uncertain about how they received some of their calls. So an interview was carried out with a GPO te-

lephone manager and this is what he said.

> "They (the caller) asked for what they want...They usually say police or ambulance. If they say police and ambulance you know that the police have got contacts with the ambulance service and really I think that we normally get the police on, because then they can contact the telephone service". (He went on)"If we get a call and someone says someone has collapsed in the street, in that case we would connect to an ambulance. We make a decision, but in very few cases we do; it's very rare. But most people would say will you call an ambulance for us. You do know the situation that you are operating when you ask for a number".

Judging from this evidence, it seems that when both an ambulance and police are requested, the police will get the first call.

In some cases, no direct call to the police is made at all. In one case a policeman was informed by another motorist. He said:

> "I was on patrol on the scene,perhaps, and a passing motorist flagged me down. He just came down over the bridge and said there'd been a bit of an accident along the road. Following that report I carried on to where the scene of the accident was".

The policeman was first to the scene.

> "They (two cyclists and a motorist) were there, yes, they were still there and the chap himself, of course, was in a daze, but he didn't seem too bad at the time, but he was dazed and I called for an ambulance...He wasn't sure whether he wanted to go to hospital or not. I made the decision for him to transfer him. You know a bash on the head...He had knocked his head, which was a bit more to be concerned about, and not being a doctor I would prefer to have a professional opinion on such things".

In some cases no direct call is made to the police or ambulance and by chance they happen to be in the vicinity at the time. People have given accounts of ambulances "just appearing" before anyone called, and similar incidents happen with the police. For instance, one young man said,after he had falled from his motor bike and cut his leg:

> "The police in a car following me asked if I was all right and I said yes. I was determined not to let them get involved".

The boy went home and was taken to casualty by his father.

In two cases, the police arrived on the scene of the episode without being called. One was on duty:

> "I was just on normal patrol in the police car and I came across the scene. I wasn't called to the scene of the accident; I just saw the motor cyclist on the ground. The motor cyclist, who had been in collision with the car, was complaining of great pain in his leg and was in great distress...Well, I couldn't see any signs of injury,but he was very distressed and he appeared to be in great pain. He said he couldn't walk at all, so I called an ambulance".

In the other case the policeman was off duty:

> "I got to the top of the road and there before my eyes there was two cars obviously with a line of traffic behind them...there had been a crunch. I'm a rural sergeant as such I am on duty when I go out. If you are a consultant doctor, you're on duty when you are needed; that's my feelings".

Later on in the interview this police officer suggested that he was worried about the injured person who had banged her head.

> "A woman had a bang, but to me it didn't appear much; but in the past my job was a first-aid instructor for this division. You don't know with a bang on the head whether it is going to be anything - concusssion, compression - a person can be all right here and 24 hours later you've got a sudden death. I was a policeman. It's always safest to say, 'Off to hospital', which is what I did. I called an ambulance by my phone-radio and got them to attend..."

Then he referred to the man:

> "Well, he was complaining of feeling pain and hurt, and if somebody is like that and you've got an ambulance there for another one, the easiest thing is to kill two birds with one stone. Don't have two different sets of action going. Keep it to one".

The cases described in the above are typical of the circumstances where the police arrive first at a road accident.

In other cases the decision to call for an ambulance is made by others, and by the time the police arrive the sufferers are off to hospital and the ambulance men have given advice. For example, in one case a young woman was involved in a car accident:

> "We were travelling from A to B, under 30 miles an hour because of the windy road. This car came round the corner and was unable to avoid us. We were right into the edge of the verge. The funny thing was that he didn't seem to try to avoid us".

Three other people were injured, but this woman said:

> "At the time, I didn't think I had anything wrong with me but the others were needing more attention..I asked this man, who I happened to recognise, to telephone for the police and the ambulance".

She said that she only went to hospital because the ambulance men advised her to go. The policeman who was called to the scene said this:

> "We received a 999 call for an injury, R.T.A., and they said an ambulance was attending. In fact, when I got there, the two occupants, well, the four occupants of the two cars had already been taken to hospital...the other two were about to get in the back of the ambulance. If I had been another minute getting there, they would have gone".

He said about the woman in the study:

> "They wanted her to be retained in case of a head injury".

The policeman spoke to the woman but was not involved in decisions to go to hospital.

In these road accident cases it is evident that the police and bystanders use the ambulance as a source of medical care. Such policies will be discussed later, as well as the preference to use the hospital rather than the GP. It is noticeable also that in

some cases,where a person may not have gone for medical care immediately, the presence of an ambulance may mean that they are more likely to be taken along with the more seriously injured.

The second group of people with whom the police are involved are those in assaults or fights in streets or public places. There were fourteen cases where the injury occurred due to intentional violence or lawbreaking. Of these 14 episodes of assaults of some kind causing injury to the patient, one case involved a man who was carrying his takings to the bank and was attacked and robbed. He was hit on the head but managed to telephone his wife before collapsing and she rang the ambulance and the police. One man was stabbed but managed to walk to the local hospital. In two cases the sufferer was beaten up and an ambulance was called. In one case this occurred at a disco, and a nurse who was also there treated the man and rang for the ambulance. In the other case a man was beaten up while fishing on the beach. He said this about the episode:

> "I was attacked by two muggers who were just looking for someone to beat up for amusement. They tried to throw me into the sea. I knew that if they got me into the sea at that stretch of the beach I would never have got out again. So I put up a bit of a fight, in the course of which two of them got me down and kicked me in the head...My son and friends went for the police. I scrambled over to the amusment arcade. By then a crowd had come from the pin tables to see what the police had come for".

The policeman said this was how he was called:

> "If my memory serves me correctly, I think one of the sons who actually runs the fun-fair heard the noise and he called us. The general condition of him was that he was very,very shaken and a lot of blood was running from his mouth...He said that he wanted to go to the hospital and I thought he should go...I rang for the ambulance".

In other cases, in both assaults and fights in the street (there were five fights), the sufferers were taken to the police station

first, or went to the police station of their own volition and were then referred to the hospital for the injury to be recorded. A similar set of circumstances occurred when a man was bitten by a dog and telephoned the police to press charges against its owner. The police told him that he must go to the accident centre or they wouldn't be able to do anything. This will be discussed in the final section.

Finally, in this group, a youth stole a car and crashed it. The police caught him immediately, arrested him, and took him to the police station for the night. The following morning he was taken to the hospital under arrest. It seems, therefore, that with assaults and other types of criminal behaviour, because of the possibilities of litigation, the police tell people to use the hospital and they use the hospital themselves to record the injury officially.

Table 6.3 showed that the 21 cases involved the sufferer after contacting the police going straight to the hospital from the site. In those cases not involving contact with the police it became evident that many bystanders or local residents were involved in telephoning the emergency services. Some of these were first-aid people from the St.John's Ambulance Brigade or qualified nurses. In 16 of these 17 cases an ambulance was called by a bystander. An example of this was where a teenage boy came off his moped on a main road, injuring his knee and wrist. He collided with a car. He said,

> "I thought I'd broken both my legs. I couldn't move them and my arms were all crunched up. After I straightened my legs out, I felt quite happy about it".

A nurse who was passing told him to lie still and to wait for an ambulance. In another case a young teenager said this:

> "My friend had recently bought another skateboard and he said I could use his old one. I was going down this incline and got what is called 'speed wobble', and he said 'Jump off'. A fraction of a second later, the board fell from under me and I fell backward and my leg bent back at the same time and that was it. I was in agony and had to be dragged off the road...A man came by in a car and said he was a doctor and asked my friend, but at that moment he didn't realise how I was and let him carry on. I thought I was O.K., although I was sure I needed to get to hospital once I realised I couldn't move...A few minutes later, a passer-by asked if I wanted an ambulance and said to stay put until it arrived".

A further example in a possibly less serious situation is an elderly man who cut his eye after falling in a car park.

> "We had been out drinking, as it was my retirement. I fell over getting out of my friend's car to go to the shops. My glasses broke and cut my eye".

He said he was too drunk to realise what had happened and passed out. A bystander apparently took over and "told everyone to leave me where I was and call an ambulance". The ambulance was called by one of the shopkeepers nearby.

Obviously the bystander becomes involved when an individual is immobilised or incapacitated by his complaint, and it appears that one of the immediate reactions is to call an ambulance. This is further illustrated by a number of "collapses" in the street when sometimes the police become involved. In one case a man collapsed in the street. He was on holiday in the area. This is how he explained what happened.

> "Well, I'd been to Boots and crossed the road onto the pavement when my legs gave way. I had difficulty getting up. Someone helped me up and took me to the arcade and jewellers and sat me down. A policeman came along and asked me what the matter was. The jeweller brought a chair out and sat me down. A St.John's lady put my feet up. The police constable and the jeweller insisted I go to the hospital. I had no alternative. The PCs first words were 'hospital' and the jeweller rang for an ambulance".

A week before a similar thing had happened. He explained:

> "I collapsed in the market last week. Someone got me a chair. I felt myself going. But we shuffled along and I sat in a car-park attendant's hut and he kindly drove us to the town for me to pick up my car".

In a comparable case, no police were involved. The sufferer, an elderly man, explained:

> "I was waiting for a bus and I was talking to some friends of ours and I looked down the road to see if the bus was coming. It wasn't and I turned round to these people again and sort of heard something click and that's all I knew. Somewhere just above my left eye".

The man then collapsed and his wife said that he didn't even remember the ambulance driver giving him oxygen. The wife said that all the people at the bus stop said, "get an ambulance", and a girl in the bus queue went and rang the ambulance.

This evidence suggests that when the individual is incapacitated in some way, the bystander normally calls an ambulance and sometimes calls the police. In none of the four cases where a bystander had contact with the sufferer, and the sufferer went to a different site, was the sufferer not taken directly to hospital from that site. The implication of this evidence is that when an individual has contact with the police or a bystander after an episode on the road or the street, there is a strong probability of an ambulance being called. In the case of the bystander, the use of an ambulance is usually made when the patient is incapacitated. When the police are involved, incapacitation doesn't seem to be the sole criteria for sending the people to hospital.

6.32 Policies of the Police for Dealing with Illness and Injury

There are two specific questions that will be attempted to be

1. Why do the police prefer accident centres to GPs?

2. Why is the police's threshold of urgency lower than the sufferers? Is it because of their "greater" medical knowledge or do other non-medical conditions play a part?

Considering the first question, the evidence has shown that the police have to deal with illness and injury in a variety of different environmental settings and social contexts. In spite of this variety, the evidence suggests that the accident centre (or, more specifically, the use of an ambulance) is preferred by the police.

Taking accidents on the road and street first, it became evident that whenever police thought that the sufferer needed medical attention they either rang for an ambulance, conveyed the person to the accident centre, or told them to go to the accident centre themselves. If the sufferer or other was not "co-operative", then they suggested that the person saw their GP.

It also became evident that the choice between calling an ambulance and advising them to go to a GP depended on their assessment of severity of the injury. The policeman's knowledge of medical matters obviously depends on the first-aid training that he received and his interest in first aid. One policeman was a first-aid instructor and obviously felt quite confident about his medical knowledge and had a clear policy for dealing with injury.

M.C. (talking about a case where the police had called an ambulance after a road accident): "You didn't think of saying go home and contact your GP?"

P.C. "Not that one, not a bang on the head."

M.C. "But you do on other occasions?"

P.C. "Oh yes."

M.C. "Could you give me an example?"

P.C. "Certainly, kiddie comes off his bike, grazed his hand,

> grazed his knee. All it wants is a good wash, you know, just an abrasion. Something where the head is involved, or where there is any reason to suspect it's got possibilities, because we are not doctors and even doctors quite often need confirmation, a deeper examination, x-rays, and so as a policeman you are a complete layman".

He then went on to talk about suspicion of fracture.

> "Depends if it is convenient;say it's something in the home. It is in a home close to a doctor and somebody else is with them and it's involved in the locality,and a doctor is readily available, i.e., you know that they can go to the surgery. It looks as if it could be a sprain. Then you think to yourself,'I'm afraid'. Mentally I spin a coin, because you look at a sprained wrist and you think can you move it. Yes, how does it feel, go into its size and systems, what is it. And if you've got a sufficient doubt, then I would say, 'go to the Accident Department'. But if it is just a doubt which I can walk away from and not be greatly concerned, well I would say 'go and see your doctor. Let him decide'; but, you know, if it is the head or there is any other thing, without consideration, I would say 'hospital'."

Other policemen with less medical knowledge tend to use the hospital much more when they are in doubt.

> "I can only speak for myself, but if anybody is injured I tend to advise them that if they have any doubts at all to go to the hospital, even if they don't necessarily go by ambulance, but if they have somebody there, if they don't want to go immediately to the hospital, then we say, well, go and see your local doctor and let him have a look and confirm the fact that the injury is only a minor one or go up to the hospital. Tell them that you've been involved in an accident and tell them what has happened".

He went on later,

> "I think when you say minor injury, the sort of injury that I would consider saying to somebody 'well, at least go and see your GP' is something like a bang on the knee...but if you are in doubt at all, then the answer is to get him somewhere he can be seen by somebody who is competent to treat".

Thus, both these policemen have suggested that they use an ambulance or refer to hospital when they think medical treatment is required. Suggestions about the use of GPs are present when they think the complaint is less serious.

This appears to be the general view held by the police. Some policemen suggested it wasn't practical anyway to contact a GP.

> "It's far quicker to get the ambulance I find. Doctors do tend to sometimes, well, obviously they've got other work to do and they say yes, oh...I'm going but I've got to finish a job first. We can understand this...yes, the ambulance do get there; they do get there and do their job and they've gone".

And the policeman illustrated the time it takes to get a GP.

> "Well, the problem is getting the GP there. Quite often because of their work it can take a very long time to get to their patients. I apologise but they do. They can't help it because they've got to fit in with surgeries, on-calls, a very long time, especially if we had to stop and wait everyday. The other day we didn't know who a lady's GP was so we had to get the police doctor in to certify death. She was dead and the ambulance people could obviously certify death; rigor mortis had set in, so I knew she was dead, and it took a good two hours before we could get the GP, before the GP was free to certify death. And when a person is dead, of course, an ambulance man will not take them to hospital...It's just completely impractical for a GP to go to a road accident".

Other policemen suggested that the hospital was the best place for emergencies. For example:

> "I feel that hospitals have got everything, well, most hospitals. Certainly the Kent and Canterbury Hospital has got everything to hand to do emergencies and to deal with such things as road accidents, and other things more serious".

"Medical" type explanations have been identified, although some other explanations with a different emphasis were suggested.

One policeman suggested he preferred to use an ambulance because it was more convenient for him.

> "We think that if somebody is injured we automatically think ambulance and then when the ambulance comes and that takes away a certain amount of responsibility for us and it allows us to really deal with what we are meant to deal with; you know the other side of the incident".

He went on to talk about other incidents.

> "You see somebody came along to the police station, say two years ago, and somebody had a heart attack and doing first-aid like I rushed over to see what I could do. Just then the ambulance came and I was happy for him to take over. I have done what I can to deal with it, and it's their responsibility. And I rushed round to make sure the wife was okay...I think that most policemen think that as soon as the ambulance arrives, over to you. Then we can get on with what we've got to do".

One policeman said that they had been conditioned to call the ambulance.

> "You see, it's always down to us if an ambulance has already been despatched, and normally we call the ambulance and they are already despatched; all 999 calls go through the operator and they say there's been an accident. Then if there is any injuries, then the operator will put them through to the ambulance and then they will notify us. You know it's a joint thing and they will attend. Apart from that, it's down to the officer who actually attends the scene. If he thinks somebody is injured, then he will call an ambulance".

In the above circumstances surrounding road accidents have been described, but what about other types of incidents such as assaults or collapse in the street? Do the same considerations operate?

In the case of assault or other law-breaking behaviour, the police feel the need to have injuries seen by a professional medical person for the following reason:

> "Well, I would say, quite honestly, on a lot of occasions we do obviously have to get medical opinion. I would think in most cases, because if it comes to the Crown Court we are not qualified to say what the injuries are. You know, we've lost cases where the police have given an opinion as to a wound and the judge has turned round and said you are not qualified. You know it's the same with a case of assault and the lawman working on that case was asking for unlawful wounding, which is more serious than assault causing bodily harm, but you see we've got to prove there was an actual wound involved. The judge turned round and said 'you are not qualified. What are your medical qualifications to say there is a wound?' and we lost the job. It was downgraded, I say, downgraded to an assault causing actual bodily harm".

The policeman then said that he preferred to get medical opinions from the hospital and he preferred to get them as soon as possible.

> "I don't like to wait very long, to be honest, because I always feel that I like to know the state that the customer is in as soon as I can, and if it is a road accident, I usually say 'well, I'll leave it half an hour, three quarters of an hour, and then phone up', and I phone up probably two or three times, especially if it's a severe road accident".

He did say that only on two occasions had he consulted a GP for this kind of incident, and he said the circumstances in this case were civil rather than criminal:

> "Not really police business, but a wife had been beaten up and he was asked for advice".

Therefore, because of the urgency with which the police need medical opinions (some opinions are needed within 24 hours if a person is to be charged), the hospital seems to be the preferred place for medical treatment.

The police also use the accident centre for other reasons. One police officer said that it was a matter of economics.

> "I must be honest. You see the thing that might be at the back of their minds, it isn't very fair to Casualty; if we call our doctors, then we've got to pay for them. This is probably at the back of their minds...Yes if we call out a doctor, you know, well even if I phone the police surgeon, if we call him out we have to pay for his services. We get a bill for £12 or whatever it is. You know, this is at the back of your mind. But we have to pay for services of the doctor we call out in respect of a lot of incidents, so we normally wouldn't do that. (Take an individual GP.) If we have a prisoner or we have somebody in the cell that we want examined and they insist on their own doctor, then there is a possibility we could get a bill for him...If for some reason or other we can't get hold of the police surgeon and we call out another doctor, it is possible that we will get charged...
>
> It's the same with other matters. If we want a vet to an injured dog, we are responsible for calling him out. We don't often do it. I think we are brainwashed to call an ambulance. This is basically why we call an ambulance".

Judging from this evidence, it seems the police find it more convenient to use the accident centre as a source of medical opinion and treatment, particularly for cases where litigation will be involved.

Finally, in this section, the question of how the police deal with collapses or illness in the street is discussed.

In these circumstances, the police tended to use the ambulance and only rarely are GPs called out. One policeman said this:

> "I would say the ambulance was my first source of help because we call for an ambulance because it's quicker; the system is quicker and they can be there; they are usually very quick and a doctor could be on his rounds and you phone the surgery and they say he'll be an hour or something like this".

M.C. "Say you were called to a woman who had collapsed, an elderly woman had collapsed. I mean I am sure in your experience you have come across quite a few of these in the street. You were called across. What would be the procedure in that case? Would you call an ambulance in those cases?"

P.C. "No, not until I had found out what was wrong".

M.C. "But say she was unconscious. I mean you have no source..."

P.C. "Well, if a person is unconscious there must be something wrong. It could be epilepsy. It could be just blood pressure. It could be stroke. They could have knocked their head; it could be anything, so if a person is unconscious,even for a few seconds, then you have got to have a hospital check".

M.C. "Even if you arrived and they were sort of standing up, still a bit groggy?"

P.C. "Well, it depends, bearing in mind that I am slightly better off than a lot of policemen. I try to train all policemen to have the same approach: first, find out what has happened. If you find a person is an epileptic and they have been unconscious, well you are not going to send them to hospital unless they have got another injury that needs hospital treatment. You are going to waste everybody's time, casualty time. So you usually ask questions to establish what is wrong and if the person...in the other it may be a person who suffers

> from blackouts, not an epileptic, but through blood pressure or some other illness and there is somebody with them and you find this out and quite often it happens from time to time, you ask the other person; we've got tablets, so you are not going to waste time. You've got to ask questions, to establish what is wrong. If you can't and the person is unconscious and you can't establish that there is a reason for you not to send them off to the accident department".

Many other policemen reinforced this position, but some policemen did point to special circumstances where they had called a GP out or visited a GPs surgery.

> "As you mention it, now I wouldn't usually have taken that sort of action, but I will say this: on one or two occasions in the village where I come from, it's often been because either the doctor has been in surgery and I said,'well, come on. I will take you in my van', and we'd go and see the doctor then. Not so much with a road accident but where, perhaps, an old lady has fallen over in the street...She walked from our village down towards the Post Office and there is no footpath as such and she tripped over and badly bruised and cut her knee. I knew the doctor was close at hand and I just sat her down and went and got the doctor, called him out from where he was".

He then said that if he hadn't known anything about the doctor,

> "Well, most probably, I would have weighed up the situation, and however she felt, if necessary, I would have taken her to the hospital myself".

To conclude this section, it is evident that for all types of accidental injury and illness in the street or road, the police tend to turn to the ambulance as their primary source of help. This is because of a number of medical reasons and non-medical reasons which have been cited in the text. The need for urgency or speed was emphasized throughout, and this will be discussed in the final section. In cases where criminal behaviour is suspected, the police, for reasons of convenience, economy, and urgency, prefer to use the accident centre.

The second question refers to the police's threshold of urgency

and what influences it. The evidence presented previously has hinted at a number of different explanations which support the notion that when dealing with injury or illness to the general public the police lower their threshold of urgency.

There is ample evidence from the data that, given their medical knowledge, the police will tend to err on the side of caution. They emphasise that they are not doctors and their medical knowledge is far from complete. The policy seems to be if in doubt call an ambulance. Their justification for such a policy is found in the "atrocity" stories they recounted in the interview. For example, the first aid instructor, who is also a policeman, said this:

> "Well when you have had a sudden death from a person that appeared not to have been injured through cerebral haemorrhage, then you tend to learn through experience. You know because the person who deals with it, it's not just the hospital, but if it's as a result of an accident, then the police are the coroner's officer. They do the enquiries; they have to deal with the relatives, and their enquiries, and they are involved from the hospital side, so you learn from the Consultant or the Casualty doctor; you learn from the Sister; you learn from the pathologist, and as a result of the experience you gain as you go through the job. You then tend to channel through a certain course of action".

He went on:

> "We sort of tend to be trained to think, and I think you will correct me on this if I am wrong, that speed is of the essence with injuries. The quicker you can get a person proper medical attention, the greater that person's chances are of recovering (a) from danger, or (b) from any sort of other internal injuries that may have occurred. Policemen don't quite often realise that;what you do teach a bloke that has just joined the job is the fact that he is going to make a decision. It can be a fatal decision, but if you act correctly, in the scope of your knowledge, if you can, if a person has been injured and you think they need something more than just dipping their finger under a running tap, let me put it that way - it's a cut finger, so you put it under a running tap, let it bleed a little bit, dry it off, and put a sticky plaster on it. It doesn't need a doctor, doesn't need anybody. Just keep on eye on it; keep it clean. If it goes pussey, go and see your doctor,

> so you don't have to trouble anybody and common sense deals with it. But you get the instance in road accidents, industrial accidents, and people falling over, they will catch their head or their side in funny places. Handle bars of bicycles have killed people by popping under their ribs and rupturing a liver, and you haven't got a mark on the torso. So you've got different situations where speed is of the essence. If you can get a person in the appropriate centre for treatment quickly enough, not only will their condition stop deteriorating if it's going to be such, but their recovery will be speedy and it saves a lot of money, not just the fact of the hospital, but also to the country, also to employment. People don't realise that speed is the essence, is a life-saver and a money-saver".

This caution appears more to be associated with the moral responsibility to the public rather than a legal one. A number of officers mentioned that they were aware that they were in the public eye, but only one suggested that he was worried about being accused of neglecting his duty. He gave an example of an accident victim who refused to go to hospital. He said,

> "You say'come on. You'd better get it looked at' and he absolutely refused and I thought, 'well, you put an entry in your pocket book because things are peculiar now'.When I first joined the police force you never used to worry about what would happen as a result of your actions, but there's always at the back of your mind now what will happen if I don't insist".

This was an isolated case. A more typical case was this.

> "I think he does err on the side of caution...you see we try and look beyond...we think if we don't call an ambulance and we let that bloke go home and he collapses and dies, then that is not very well for us. We are going to feel a certain amount of responsibility. You see obviously we look on it that it costs nothing to call an ambulance; better to be safe than sorry, really...but it's not a legal responsibility, for example... We had an incident only this year where we have a drunk. He was on the steps of his home. It was decided to leave him there. Unfortunately he fell over,hit a basement and died. Now the officer was in tears, you know. He could, if he wanted, have arrested that person for being drunk and incapable, but as the person was on his own front doorstep that would be a little stupid. We would always and I hope our chaps always err on the side of caution...I would rather be safe than sorry".

But the police officer went on to say that in the case of accidents they have no legal responsibility to ensure people go to the hospital. If they don't want to go, then they leave it. This was reinforced by other statements.

In the previous section, some evidence hinted that policemen, because of the amount of work they have to do at the scene of the accident, will use the ambulance as an efficient way of getting the injured away, so relieving them of the responsibility for looking after the injured and getting on with their "real" work at the scene.

One police officer described his work:

> "When there is an accident and people are injured, we have to do a report, in which case there is a lot of details required, damage to vehicle, numbers, drivers, witnesses, injured person, or injuries, what they have said, so that we can sum up roughly who's to blame".

This policeman did deny he was under pressure, but others said there was some element of pressure. One policeman said:

> "Whilst you don't get a lot of pressure from other motorists, I've always felt that the sooner you can clear the rubbish, the sooner you can get the vehicles out of the way, and, in fact, have covered all details that you want on the road, so it's either marked there and you can go back at a future date to get the measurements, one thing and another, or it's all cleared away, the road is clear and the traffic can then move along quite safely. As soon as you are out of the road, the much safer you are and the much safer anybody you are trying to interview is, and so it is much safer for anybody else using the road".

The fear of being injured was mentioned by others. In fact, one of the cases in this study involved a policeman on duty in the road being hit by a car and going to hospital. Another policeman also acknowledged the pressure, but said it did not influence his actions unduly.

> "I think there is a nagging pressure, if you like, but, I am sure that the men will agree with me, you don't let it influence you unduly. I mean if you can get the road clear, but I mean for argument's sake I've been to an accident at Harbledown where those three motorcyclists were involved in an accident where I had the road blocked for about an hour and a half and there were queues of traffic right back to Canterbury, but that traffic wasn't going to go through until I had finished my work at the scene, the bodies had been moved off, and everything else, you know. So it's obviously a consideration and in your terms something we bear in mind, but it's not a pressure which we give precedence to over a lot of other things. I mean your first thing is that in a serious accident we are talking about now, is to look after the injured and then to get sufficient evidence to justify or to find out about the accident".

Overall, this evidence does suggest that the police at scenes of accidents and illness may have a lower threshold of urgency than others. This appears to be due to a number of factors. One is their feelings of responsibility, not legal but moral, which lead them to erring on the side of caution, and because of their feelings about the inadequacy of their medical knowledge. These situations also may lead to an immediate call for an ambulance so as to free them to get on with their own work. The urgency with which this work is carried out is also influenced by the pressure to get things back to normal again for everybody's safety, not least their own.

Previous evidence has shown that in other types of incidents where the police have arrested a person or are intending to arrest a person. The use of the accident centre occurs because of the urgency with which a medical opinion is needed on a complaint.

Finally, in this section, data presented in this chapter has thrown up the significance of two other actors in the process of referral to the accident centre. One is the bystander through advice or calling the emergency services, and the other is the ambulance personnel who was to play a significant role in making deci-

sions to take people to hospital. In many cases, as has been shown, the ambulance arrives on the scene before the police and takes the victims to hospital before the police arrive. As yet we have no evidence on how the ambulance men make decisions, but it is evident that in the vast majority of cases they transport a person to hospital rather than a GP or taking him home.

With regard to bystanders' behaviour, the evidence is limited. Both a policeman and an ambulance man attempted to explain bystanders' behaviour. The police said this.

> "People don't know what to do in an accident. We need some third party there to sort out the injured...and also sometimes you get an ambulance called and you in fact go to the scene and I have known on occasions, it's not very often admittedly but there are occasions, when you get to the scene and perhaps somebody has hit their nose on the dashboard or something and a serious nose bleed; so there is a lot of blood around and you stop somebody who might be passing, have a look, and say, 'my God, blood', you know. 'It must be a serious injury' and they will call an ambulance and the ambulance will get here and by the time the ambulance has got here the bloke is saying 'I don't want to go to hospital, thank you very much. I'm quite alright. There is nothing wrong with me. In fact, I've just had a nose bleed,' and then, of course, the ambulance then carries on and returns back to wherever it's going".

The ambulance man offered a different explanation.

> "You see so many people ring the doctor's surgery. Either they don't get a reply or they don't get a satisfactory answer as far as they are concerned and they think 'O.K. we'll beat the system. We'll ring 999 and dial for an ambulance".

Obviously, such limited data is inconclusive, and further evidence is needed, not only on the role of bystanders at accidents or other episodes and also on the use of ambulance services in general.

6.4 Episodes that occured in Recreation Areas

In a number of cases the episode occurred in a recreation

area. The definition of a recreation area includes both those locations where recreational activities take place over a short period of time such as sports fields or social clubs and those locations where people are living on a temporary basis, such as camp sites or caravan sites where people are on holiday. In the former case the provision of services for the ill or injured may be only necessary to cover a short period of time while the activity is taking place, whereas in the latter provision of services would be necessary over a 24 hour period as it would be for any holiday resident in an area. Table 6.4 shows the distribution of these episodes by choice of medical care setting, status of advice given or decision taker and site of decision to seek medical care. Even though in just over half the cases the site of the decision was somewhere other than the episode (which usually meant the decision was made at home). In only 17.5% of the cases was an attempt made to contact a GP. The results also suggested that the site of the decision to seek medical care did not appear to be related to choice of medical care setting.

6.41 Episodes that occurred on Caravan Sites or Camping Sites

Of the 80 cases, seven involved episodes occurring on camp or caravan sites, and a further four occurred while the sufferer was on holiday outside the country. In two of these seven episodes which occurred on a camp or caravan site, an attempt was made to contact a doctor. One of these cases involved a family staying at a camp site. One of the children suffered headaches and the parents decided that she needed medical treatment. They told the warden on the camp site. He tried to contact an emergency doctor but was unsuccessful. The following day the child was still in

pain, so the warden suggested that they should go along to the accident centre as the local casualty department was closed. In the other case an elderly lady was involved and she sustained a fractured wrist at a holiday camp where she was staying. She explained how it happened.

> "I was going along to the ballroom and there were two steps to go down. I think I twisted my ankle. I remember going down the first step, but I went down and fell on my arm...I think I had a suspicion of my hand going. I think I blacked out after then...I can vaguely remember someone carrying me to the first aid room in the camp and they got a doctor".

The first aid man who was on call at the camp site said this:

> "Well, this happened, as near as I can remember, somewhere round about 10.00 p.m., and the first thing that happens in anything like that, the manager rings me up. I only live five minutes away and I come straight in. She was already in here. I took one look at it; she'd got a strap on the wrist. I put it up on a splint. I rang the doctor who was on duty that night, got his authority to get an ambulance because at that time of night it's got to come from A to here then to Canterbury".

He explained the need to get medical authority.

> "Well, the thing is that a couple of years ago and it happens now you get campers coming in here who are used to medical services being on the button. Anything happens at home, they just get on the phone, get an ambulance, and it's only got to come two or three miles, perhaps not that, come straight to the place and whips them into the nearest hospital, and they tend to do that there. Well, you see an ambulance has got to come from A down here at night without medical say so. You know, they get a bit uppish about it, the drivers, and we have had trouble. So the sort of cases now down here, if an ambulance is wanted, especially for a case like this, a walking case, you've got to have medical backing. So, rather than risk the ambulance men coming in say, 'Oh well, this woman could have got to Canterbury under her own steam.' She couldn't, hadn't got a car; there wasn't a car available, so, rather than risk an argument about it, I ring the doctor first, then ring the ambulance and he will back it up. Well, that's the answer to that one".

In the other five cases, no attempt was made to contact a GP. It is interesting to note that one of these cases also occurred on the same holiday camp. In this case a woman sprained her back while playing sport at the camp. She didn't intend to do anything about it, apart from rest, until her husband injured his arm and was referred to the hospital by the first aid man on the camp site. She want to the hospital with her husband and received treatment at the site.

In one of the remaining four cases, the mother of a young child was worried about lumps on the child's arms and face and took him to hospital. The family wasn't registered with a GP anywhere and the mother said she preferred to go to hospital anyway. She said:

> "The doctor never knows what's wrong with you and only gives you pills".

In each of the four other cases, the sufferer or sufferer's representative did not have any contact with any "official" on the site and no medical facilities were available. One man explained his action of going direct to hospital.

> "We didn't know any doctors around here. I got in the car to try and drive myself to A.E.D., but I was in too much pain so my wife decided to call and ambulance".

In the other three cases, the respondents identified the hospital as the appropriate setting for treatment in terms of the need for specialist treatment.

6.42 Policies for Dealing with Illness and Injury on Camp and Caravan Sites

The limited evidence presented in the above suggested that

the majority of decisions to seek medical care for episodes which occur on camp or caravan sites are made by the sufferer or sufferer's family themselves. The evidence shows that medical facilities are not normally available on caravan or camping sites and patients do not normally seek advice from any available officials. Thus decisions are based on their general orientation to the use of a GP as opposed to the accident centre and on their knowledge of the availability of a GP for temporary registration.

In the limited number of cases where officials or medical facilities are personnel were available, attempts were made to utilise a GP. In the case of the holiday camp, a GP was regularly on call and could visit the camp regularly. Owing to the distance to the nearest hospital, much depended on the nurse who works for the camp and then the GP on call. So, unlike most caravan or camping sites where no facilities or personnel exists to treat injury and illness and patients make their own decision to seek medical care, most patients, in this case, are referred through the male nurse or the GP on call. Unlike other contexts, such as those in which the police are involved, or teachers, or employers, in this context a GP is easily accessible and the staff of the camp prefer to use him as their source of professional medical help.

The male nurse explained the position:

> "The doctor will put stitches in. I put stitches in myself if I feel that I can do it. I will never do it unless I ring the doctor first. I say I've got somebody with a split eyebrow. I think it needs a couple of stitches. Shall I put them in? And he says yes...If I can deal with it, I will deal with it, having such things as, over a weekend you get somebody going hot and cold, have a cough and they are bringing up phlegm alright, and they've got a bit of a temperature. I ring the doctor and say 'look I've got

> so and so. Can I start them off on some antibiotics which I keep?' I keep a few antibiotics and rather then call the doctor down here about three o'clock or four o'clock on a Sunday night or a Saturday night I say 'Can I start them off on this' and they say 'yes' and 'We'll see them on Monday morning'. There is no point in them coming out. There is nothing else you can give them. There is no place open. This is another difficulty here, and if the gremlins at the back of my mind say, "Well, I don't think a doctor is really necessary, but they are the ultimate responsibility. At least tell them over the phone; if they will see the patient, well and good. If they say "Oh I am not going to come down for that. You deal with it", I have shifted the responsibility'. If anything happens, I can turn round and say 'well, I have told the doctor'".

The male nurse said that the accident and casualty department was used, but only when the facilities were not available in the camp or in the GPs surgery. Even in medical "emergencies" a doctor was called. For example:

> "Well, yes usually; well it's usually a Saturday or Sunday when there is no doctor around and I got called out and she had had a stroke. I got her into her chalet and we managed to get her undressed, got her to bed, and I rang the doctor and I told him and he said,"Well,there is nothing very much I can do'. He said, 'I don't think we can get her into hospital even'; he said he would ring round and we couldn't get her into hospital and he came down and had a look at her. She wasn't all that bad, so she was sensible enough to, you know, do this. So I came over here and I got a crepe bandage and I made it into a ball and took this across to her and I said,'Well,you keep doing this and that', kicking her leg out as much as you can. 'Do it all night. Keep doing it'. And I said 'We'll see how we get on in the morning,'and by the next morning she was moving her hand, moving her arm, and the doctor came in and saw her and he said, 'Well you really ought to go to hospital'. She said, 'Oh, I don't want to go to hospital'; she says, 'I've only got another three or four days here. Can't I stop?' So he said, 'Well,alright, stay' and she stayed here and finished her holiday".

With regard to the question of the lowering of the threshold of urgency, the male nurse said he tended to err on the side of caution, but he didn't feel it was because of fear of litigation. He said:

> "Well, you see, I think I tend to err on the side of caution, but when you get down to brass tacks, your health is your own responsibility in law. If you don't go to the doctor, there is nobody on this earth can make you take the doctor's advice. So that applies to yourself. If I chopped my hand off, and I didn't want to go to the doctor, alright, that is my affair. I am the one that ultimately takes the responsibility; but if I am dealing with somebody who can come back, then I must shift the responsibility. I am not qualified to take responsibility, not to that degree where decisions have got to be made".

It appears that the male nurse feels it is not his responsibility for making decisions about other people's health, so he refers to the doctor. This may influence his threshold of urgency and he referred to another, more social, dimension.

The interviewer asked the first aider if, in fact, there was much pressure on him because it was a holiday camp to keep ill health and injury away from the rest of the camp because it would spoil the other visitors' holiday. In reply to that point he told how when the first group of old people come in, he goes round the dining rooms and the chalets, trying to find out or assess those people who may be suffering from a complaint such as a heart problem, or heart disease which may lead them to a serious illness or even death on the camp. He said that he did this regularly because he wanted to keep death away from the camp because, as he said, in the cases where there is a death in the camp, the coroner and the coroner's officer spend at least six hours in the camp before the body is taken away, and this would obviously disrupt the workings of the holiday camp and upset a lot of the people who are staying at the holiday camp. In these particular cases, when he suspects people are suffering from serious illness, what he does is to either tell them that they had better actually go back and see their doc-

tor because they won't enjoy their holiday, or, in fact, he sends them up to the doctor to be checked and they may be taken up to the hospital. He emphasised that he does that to prevent similar episodes occurring. Prevention is not only to protect the person's ill health, but also because he did not want to disrupt their holiday activities and the atmosphere of the camp.

It is difficult to generalise from this example, but the evidence suggests that when an official or medical personnel are present on holiday camps they feel that they have to be cautious with their visitors for both medical and social reasons. In this particular instance the lowering of the threshold of urgency had limited implications for utilisation of alternative medical settings as the casualty departments were too far away and a GP was therefore utilised in most emergencies.

6.43 Episodes occurring on Recreation Fields, in Sports or Social Clubs and other Recreation Areas

In only 13 of the remaining 68 cases in this group was there an attempt to contact a GP. In five of these cases the attempt was made at the site and in the rest the attempt was made at another site, mainly in the sufferer's own home.

The most common settings for these episodes were:
Sports centres (mainly on squash courts), sports fields (mainly on football pitches), recreation fields and orchards, woods or fields. A small number occurred in social clubs or disco's and at racing circuits. The remainder occurred in a wide variety of settings, ranging from a cinema to restaurants and public houses.

Eleven episodes occurred in sports centres and in two of these attempts were made to go to a GP although both these attempts were made after the sufferer walked home. In only three of the remainder of the nine cases did the sufferer go direct to the hospital from the sports centre. It appears with these three cases, as with others in this group, relatives and friends seem to play a significant part in deciding what to do. For instance, one man who lacerated his leg while playing squash was told to go to hospital direct from the sports centre by his brother and friend. He said:

"It was'Hobsons choice'. I have to go. They insisted".

In another case a young man ruptured his achilles tendons while playing in a sports centre. He said:

"My friends made the decision to seek medical care. They couldn't give me any advice except to go to the hospital and in the meantime to keep still".

Another example involves a man who bruis ed his ankle while playing in a sports centre. He said:

"One of the people we were playing with was a nurse and she said to go and run it under the cold tap".

It appears, then, in this group of "episodes", which happened at a sports centre, that the main participants in decision making were, apart from the sufferer, mainly relatives and friends. No mention is made of first aid people or sports instructors. Decisions seem to lie almost entirely with lay people and their informal networks.

Twenty three episodes occurred on recreation fields and eleven of these on a sports field. Most of the injuries incurred on the sports field happened during formal sports activities, such as

a football match. In two of the eleven cases, a GP was contacted directly from the sports field. On one occasion a young man incurred swelling and abrasions to his ankle while playing football. He said that he couldn't walk on it. A bystander who he didn't know rang the local doctor for advice who in turn advised the accident centre. In the other case a young man incurred a fracture to his right hand while playing football. He said:

> "I thought it was just badly swollen, nothing serious... It was giving me a lot of pain, but I didn't think it was serious as I've done it before".

After the match the football team trainer who usually acts as a first aid man for the team told him to go to "his own doctor about it". The following day the young man followed these instructions but found the surgery closed and so went to hospital.

Of the remaining nine cases, four went direct from the sports field to the hospital. In both cases the injuries had stopped the sufferers' participation in the game. In one case a young man described how it happened.

> "Well, just running down the football pitch and I slipped over and my knee came out and the goal keeper came out and straight into it and bump...The trainer came over and put water on it. There wasn't much he could do really".

He continued playing but it became very painful and

> "It got very stiff and I couldn't move".

He told the manager of the team.

> "He just told me to go and have it checked at the hospital and all that".

He then went off in his friend's car to the local cottage hospital. In this particular case injuries incurred on the football field are reported to the team manager who issues a sick note and sends it

off to the insurance company.

In the other case a girl was injured while playing football. She, too, was given advice by her team manager. She said this.

> "The captain asked me what was wrong. I said I just think I've pulled a muscle and she said 'well, there is not long to go to half time. Just go and get some spray.' And the manager asked me if I wanted to go back on. I said 'Yes, because there can't be long to go to half time,' so I went back on and that was all that was said".

However, at half time the injury became worse. She explained:

> "Well, when everybody went back on the pitch I couldn't go back on because I couldn't walk and he (the manager) carried me to the car and he told me to explain to him what I felt in my leg and he said it sounds as if you've pulled the ligaments and you better go to the hospital".

She said that she could possibly have put off going until the following day. She said:

> "I could have done. I expect so because the manager asked me who my doctor was and he didn't know if he would be in surgery because it was a Sunday, so he said I'd be better off knowing what I had done so it would be best to go to hospital as a doctor might not be there and it might be worse than what they'd thought".

From this evidence it appears that the pattern of help seeking behaviour for injuries incurred on the sports field depends on a number of factors. One of these is whether the team has a trainer (first aid man) or manager who, if present, seems to act as "expert" about the treatment of injuries. It seems that in minor cases the injury is treated by the trainer and the injured person resumes play. In cases which involve the player not being able to participate the manager or trainer usually recommends the hospital if he feels professional medical care is needed. Whether this is due to his beliefs about the unavailability of GPs at weekends when most football matches are played or due to beliefs about appropriateness of that setting for

that type of injury is difficult to know. What is also interesting is that of the seven cases who went to another site for a decision, all seven went home and subsequently decided to go to the hospital.

Twelve episodes occurred on a recreation field and thirteen episodes occurred in field, woods, or orchards. Of the episodes occurring in a recreation field, four went to the hospital direct from the site of the episode and the rest from home. In only two of these twelve cases were attempts made to contact a GP and both these attempts were made from home. In the four cases where decisions were made at the site of the episode, bystanders seem to play a part in decision taking. In one case a young boy broke his wrist. He said:

> "A man ran over and looked. I said I think I'd better go to hospital and he agreed. He was not the man that took me".

In the thirteen cases that occurred in woods, fields, and orchards, six involved decisions being made at the site of the episode. In these thirteen cases, only three involved attempts to contact a GP and two were at the site of the episode. These two cases involved special circumstances. In one a man collapsed and died while working on his allotment and a relative called his GP; and in the other a man in the army injured himself on a cross country run and was sent straight to the M.O.

It appears, then, for episodes that occur in both recreation fields and in woods, orchards, and fields, when a decision to seek medical care is made on site, the hospital is seen to be the most appropriate place. The decisions seem to rest almost entirely

with relatives, friends, and bystanders, and thus lay knowledge or beliefs about appropriate medical settings must be examined. Certainly evidence has shown that lay people do have specific ideas about what conditions are serious and when they are not, and when conditions should be seen to. It is also evident that many people are loathe to make decisions to seek medical care for children who are not their own. This is suggested by the high number of injuries incurred on a recreation field which were taken home before a decision was made.

Of the remainder of cases, four occurred at social clubs; four occurred on racing circuits and thirteen in a variety of other settings. In only four of these twenty-one cases was an attempt made to contact a GP, and two of these attempts were made at the site of the episode. One involved an elderly lady collapsing in a public hall. In this case her doctor lived across the road from the hall, so he was called. The other case occurred at a riding stable and the sufferer rang her GP immediately.

In the four cases occurring on a racing track, the sufferers went direct to hospital from the track. In all four cases the sufferer had contact with St.John's Ambulance, which referred him to hospital. In one of these cases, the sufferer injured his right leg while motor cycle racing. In this case the St.John's Ambulance

> "Just put a bandage on it so I could drive up to the hospital...the first aid man and the doctor at the circuit...told me to come to the hospital".

The sufferer also mentioned that he had to go to the hospital following the doctor's instructions because of the insurance. In a similar case involving an injury in a motor cycle race, a young man received attention from the St.John's Ambulance man. He reported

what they did for him:

> "They put me on a stretcher and took me back to their post where the injury was treated and dressed, and they said that for safety's sake and tetanus injections, I had better go to the hospital".

Given the wide variety of environmental settings involved in this group, it is difficult to make generalisations about the most common pattern of action. In the majority of cases, people in formal capacities were not involved, and many of the decision makings were made by patients, relatives, friends, and, sometimes, bystanders, and there was little evidence of influence from "officials". In settings where first aid facilities were available and sometimes personnel trained in first aid, such as in sports centres, on sports pitches, or at racing tracks, the hospital seemed to be the most common choice for medical care. Only rarely was a GP contacted from the site of the episode and in these cases it only occurred when the GP was in easy reach.

6.44 Policies for dealing with Illness and Injury in Recreation Areas

It is difficult to present evidence on reasons for choice of medical setting given the small proportion of people in official capacities involved with these types of episodes. In the previous section the position of first aid men on sports fields had been briefly described, and further information from them as well as from bystanders about the reasons for the apparent preference for the hospital in those circumstances would have been useful. In some social clubs and sports centres, specific facilities and specific policies have been set up to deal with members injuries and illness.

For instance an interview with a person responsible for a sports centre and for a swimming pool took the following form:

R. "If a member of staff is approached after an accident, they then take over, take them into the First Aid room, examine them, and, if they think it is necessary, then arrange for them to be conveyed to Canterbury Hospital. On some occasions, they even take them over in their own cars, but if the injury is,in their opinion, of a serious nature, then the ring the ambulance and the ambulance comes and takes them across".

M.C. "Do they ever contact a GP?"

R. "No".

M.C. "Why is this?"

R. "Well, we've never thought it to be necessary. The injuries received are mostly of a minor nature, cuts and bruises mainly and sprains, but if we suspect,as we have done on several occasions, that there is broken bones, then we run them to Canterbury Hospital, the Accident Section, and advise them we are either bringing someone over or that we have rung the ambulance station and,you know, they are bringing them over".

M.C. "Yes".

R. "We do on occasions after someone has received, shall we say, an injury that we think is minor, advise them to contact their local GP the following day, we may do this".

M.C. "Yes, so you have advised them on occasions to see their GP?"

R. "Oh yes,yes".

M.C. "So normally, then, when somebody is injured, they will go to your first aid room..."

R. "Well, can I put it this way, mm? We can only be aware of an injury if it's brought to our attention. Staffing at the centre is very limited;normally there is no more than a Duty Supervisor and two attendants to virtually police the whole of this building and they could be on some occasions engaged in coaching so there is not a visual supervision at all times of the centre court when clubs are using it. When the members of the public are using it as individuals, then a visual exercise is undertaken as supervision, but when clubs use it, then it's up to the club's organisers to ensure that supervision takes place on their own club resources".

M.C. "So you would prefer, would you, to send them to the hospital if you thought that it was necessary?"

R. "Yes, when in doubt we feel that it is best to get the correct, you know, expert treatment and advice rather than suggest treatment here or even try and do treatment here".

M.C. "I see".

R. "We have been told that, you know, when in doubt, take them to hospital".

He described a similar policy for the swimming pool. He said that mainly minor cuts occurred there and when they needed stitching they were taken to the accident centre. It is evident that in both these settings, sports centre, and swimming pool, the source of medical care that is always used is the hospital. In serious cases of near drowning which may occur in the swimming pool, an ambulance is called. In those cases where the sufferer has recovered sufficiently, the staff take that person home.

6.5 Summary and Conclusions

In this chapter, using evidence gathered from people involved in "episodes" which occurred in educational institutions, situations of employment, on the road and in the street and in recreation areas, an attempt has been made to answer the following two questions:

1. Does the presence of a policeman, teacher, employer, or other at the site of the episode make a marked difference on the course of action that the patient follows?
2. If the policmen, teacher, employer, or other does make a difference, why does this difference occur?

In regard to the first question, evidence presented in this chapter suggests that when an episode does occur in either of these

different settings, and contact occurs with either teachers, employers, police, or bystanders, then there is a stronger possibility that the patient will go to an accident centre than to their GPs.

The reasons for this vary according to the setting.

1. In educational institutions, teachers seldom or never took children to GPs or brought GPs in for medical reasons, for reasons of convenience, and also for medical reasons.

2. In work situations, employers or representatives of the employer, took or referred employees to the accident centre rather than GPs for reasons that could be described as medical, reasons of convenience and efficiency, and reasons that could be loosely termed economic.

3. In episodes that occurred on the road or in the street, police preferred to use the accident centre rather than GPs because, in the case of road accidents or illness in the street, the ambulance was the most important source of help and ambulances went to the accident centre. The reasons given for use of the ambulance were medical, reasons of convenience for both the patient and themselves and reasons of economics. In other cases where criminal behaviour was suspected the accident centre is used as a source of medical opinion for use in litigation.

4. In episodes that occurred in recreation areas, sufferers had limited contact with officials such as wardens, mana-

gers, or first aid men. Much of the decision making involved lay people, mainly family, friends, and by-standers, and when a decision was made at site the preference seemed to be toward the use of A.E.D.In the cases where people in "official" positions were involved, such as first aid people and managers at holiday camps, sports fields, racing tracks, and sports centres, the preference seemed to be towards using the accident centre, although in some cases GPs were used when accessible. The reasons for the preference for the accident centre seem mainly because of easier accessibility.

In all four different settings there was evidence that the teachers', employers', police's, first aid officials' and bystanders' evaluation of the urgency with which medical care was required was coloured by what can loosely be termed non-medical factors.

1. In the case of school teachers, emphasis was put on the legal position of being in loco parentis, and thus the need to err on the side of caution. It is not clear how much the moral position of looking after another person's children plays a part.

2. In the case of employers, the evidence suggests that while some firms are concerned about employees' health and welfare, they do put an emphasis on the needs of the company and their threshold of urgency is coloured by the need to get men back to work as quickly as possible or to minimise the inconvenience caused by disruptions.

3. In the case of police, their threshold of urgency seems to be coloured both by a certain moral responsibility which they feel as police officers and pressures put on them by other aspects of their work, whether it is an accident or involvement in an episode of intentional law breaking.

4. In the case of first aid personnel at recreation settings, the limited evidence suggests that episodes involving injuries or ill health are dealt with quickly, since, apart from concern about the sufferer's health, they upset the flow of activities in the setting and also upset the atmosphere in which these activities should, according to the staff, be carried out.

Table 6.1: Site of Episode, Site of Decision to seek medical care, Contact with representatives of an educational institution and attempt to contact a G.P. or not

	Site of Episode in educational institutions				Site of Episode outside educational institutions			
	Decision at site		Decision not at site		Decision at site		Decision not at site	
	Contact with Ed. rep.	No contact with Ed. rep.	Contact with Ed. rep.	No contact with Ed. rep.	Contact with Ed. rep.	No contact with Ed. rep.	Contact with Ed. rep.	No contact with Ed. rep.
Attempt to contact a G.P.	1		9	1			1	
No attempt to contact a G.P.	7		7	4	5		2	
Total	8		16	5	5		3	

Table 6.2: Site of Episode, Site and Timing of decision to seek medical care, contact with representative of employer and whether attempted to contact a G.P.

	Episode at work						Episode not at work			
	Decision at site on same day		Decision at site but following day or more		No decision at site		Decision at site		No decision at site	
	Contact with work rep	No contact with work rep.	Contact with work rep	No contact with work rep.	Contact with work rep	No contact with work rep.	Contact with work rep	No contact with work rep.	Contact with work rep	No contact with work rep
Attempts to contact a G.P.	3		2		2	9			1	
No attempts to contact a G.P.	29	7	7	3	7	11				
Total	32	7	9	3	9	20			1	

Table 6.3: Site of Episode, Site of Decision to seek medical care, Contact with Police or bystander and whether an attempt made to contact a G.P.

	Episode in street or road						Episode in other place					
	Decision at Site			No Decision at Site			Decision at Site			No Decision at Site		
	Contact with police	Contact with bystander only	No contact with either	Contact with police	Contact with bystander only	No contact with either	Contact with police	Contact with bystander only	No contact with either	Contact with police	Contact with bystander only	No contact with either
Attempt to contact a G.P.			1	2		12	1					
No attempt to contact a G.P.	21	17	8	8	4	26	2			4		
Total	21	17	9	10	4	38	3			4		

Table 6.4: Patients who were involved in episodes in recreation areas (which include recreation fields, parks, recreation buildings such as sports and social clubs and caravan, camping sites and holiday camps) and site of decision to seek medical care, if advice given and choice of medical care setting

	Episodes that occurred in recreation area			
	Decision at site		No decision at site	
	Decision made by patient or relative and no advice given by other	Decision made or advice given by person other than patient or relative	Decision made by patient or relative and no advice given by other	Decision made or advice given by person other than patient or relative
No attempt to contact a G.P.	9	23	15	18
Attempt to contact a G.P.	1	6	5	3
Total	10	29	20	21

CHAPTER 7

The Referral of Patients to an Accident and Emergency Department

Episodes that occur at Home

7.1 Accidents and Emergencies at Home

Table 7.1 shows where the decision to seek medical care is made, who the sufferer had contact with at the site of the episode or at the site of the decision to seek medical care and if an attempt was made to contact a GP for all those episodes that occurred at home. The reason for focusing on the home is that it appeared to be the place where it was most likely that sufferers would (or should) follow their routine pattern of health care seeking and to go their GP. Results presented in Chapter 5 suggested that such a pattern did tend to occur, although there was still a large proportion of patients who went directly from home to the hospital without attempting to contact a GP. In this section, the aim is to attempt to find out why these patients behaved in this way.

Table 7.1 shows that not all patients made the decisions to seek medical care at the site of the episode. 12.8% of these sufferers went to another site before a decision to seek medical care was made. This figure is misleading in some ways because in some cases,

although the decision to seek medical care was not made at home, it was made only a few houses away. Thus it seems arbitrary from an analytic point of view whether the neighbour or friend comes to the site of the episode or the sufferer or sufferer's representative goes to another site. In six cases, contact was made with a neighbour to either ask for advice about what to do or to ask to use their facilities such as a telephone or transport. This suggests once again that the idea of classifying when and where a decision to seek medical care is made is useful from an analytical viewpoint, but does not reflect the processual nature of decision making which occurs in reality. In two of these six cases a neighbour whose occupation was an ambulance driver was consulted. A young man who cut himself went to the ambulance man for basic treatment because the cut would not stop bleeding. The ambulance man swabbed and bandaged it. No other advice appears to have been given and the young man decided to go to hospital immediately. He said he didn't think of attempting to contact his GP,

> "...because it wasn't that sort of problem...he would have sent me to the hospital anyway".

In the other case a young child was involved. It is difficult to know whether patterns of help seeking for children are different from those of adults. There is evidence that there is more continuity of contact between GPs and families with young children involved. This three year old child crushed his right third finger and this is how the mother accounted for it.

> "Well, he was getting his pram to go out with my daughter and I don't know,if you've seen the baby buggies, there's a layer at the back. Well, sometimes if you go over a step you put your feet up to help the pram down. Well she pushed it down as they were going out the front door, and his finger was caught on the side".

The child screamed and the mother rushed to see what was wrong. She said:

> "I wasn't really sure because I couldn't see much for the blood and I held it under the cold tap, and I could see it was all cut, so I rushed him up to Uncle. He looked at it, but couldn't be sure, except he thought it was quite bad".

The husband wasn't at home at the time and she went on:

> "We ran up the road to the ambulance man (off duty) who said to get him to hospital as soon as possible and called an ambulance".

The mother said that she hadn't thought of contacting her GP because:

> "I'm not sure if you can get them over a weekend,can you? It's very difficult to get an appointment, far less get a doctor at the weekend".

In two of these six cases, attempts were made to contact a GP for the sufferer. One elderly lady who had cut her head at home said this:

> "I walked round next door and they felt I should see the doctor...so they rang for me and he came straight away".

Of the twenty four cases, eleven sufferers made their decision to seek medical care at work. In none of these cases was an attempt made to contact a GP, some of them being referred by industrial nurses and some being coerced into going by their workmates. Examples from these cases illustrate how the hospital staff uses the casualty as a source of medical help. A sixteen year old who had cut herself at home said:

> "Mum advised me to go to hospital because my cut looked worse than hers and she thought I might need a stitch...

> "I didn't think it necessary...Two days later I was doing my voluntary work at the hospital when the Ward Sister suggested that I come to the accident centre and get a dressing on it".

Of the remaining seven cases out of the twenty-four where an episode occurred at home but the decision to seek medical care was made at another site, four cases involved sufferers visiting relatives' homes where a decision to seek medical care was made. In two of the cases, an attempt was made to contact a GP. In one of these cases it appears that a young mother of a child who had injured his nose obtained conflicting advice. One of her friends had told her not to bother as it would be O.K., and another, whom she went to visit, said she thought it looked as if it might be broken. The mother took the latter's advice and rang her GP from her friend's home. The GP wasn't available and the practice receptionist referred the child and mother direct to the hospital.

In each of the three remaining cases, the hospital was involved indirectly. In one case a patient was attending the hospital gymnasium and was referred by the staff to the accident centre after the staff had examined him. In the two other cases the patient was visiting someone else in the hospital. In one case the patient had a sore eye and she said:

> "My future mother-in-law to be and I were at the hospital waiting for my father-in-law to be to be seen to...My mother-in-law to be suggested that I should go to the desk and ask if they could see me".

The other case was more complicated but once again illustrates the point made previously about the use made of casualty by the hospital staff. This elderly woman had made arrangements with her

friend who lived across the road from her to pick her up at a hospital after visiting her husband at hospital. She said this:

> "I went across the road to my friend's whose daughter is the casualty night sister at the hospital, B. I asked her if she would meet me at the hospital, A, and bring me home after visiting my husband. I spoke to my husband's ward sister at the hospital,A, about my complaint and she told me to come back to the casualty at hospital A at 9:00 a.m. the next morning. However,when my friend saw how much pain I was in she said she would take me into hospital B. I was glad to go".

Table 7.1 shows that in these cases where the site of the episode was at home and the decision to seek medical care is also made at home the majority of sufferers if they had contact with anyone at all; then it was usually a relative or a friend or neighbour. However, in nine cases other people were involved.

In three of these cases the police were involved. Two of the cases involved elderly people living by themselves and being found by neighbours who telephoned the police. The police on both occasions telephoned for an ambulance. Both these cases have been referred to in the previous section. However the third case involves a man in his fifties. This is how he said that he received his injury:

> "I was sitting here talking to my sister and my son was upstairs and his girlfriend was up there and they were arguing and shouting rather a lot. I went up there to tell them to quieten down and not make a noise because the neighbours have children next door and they were trying to sleep. You can hear through these walls. I just opened the door to get nearer and he just lammed out at me...My son very often wears a heavy ring and I think the injuries have been caused by the ring rather than the fist...I was unconscious. My sister came up when she heard the bump and saw me lying on the bed unconscious, but she said I came round a while later".

The man's sister said:

> "The boy was holding him up and they were both covered in blood all over the bed and everywhere".

It's not clear who contacted the medical services. At some point

the police arrived and an ambulance was called. Whether the police called the ambulance or the son's girlfriend called it is uncertain. The son's girlfriend may have contacted the police initially.

While the man wasn't able to make a decision to contact the medical services himself because of his state of unconsciousness, he did suggest that if he could have made a decision, he would have gone along to the accident centre anyway. He said:

> "It was a hospital injury...I've had accidents at work and I've used it. Fractured foot, x-ray on hands. So I choose it when necessary".

He said that for urgent complaints he would use the hospital because,

> "You're not sure if you can get him (his GP) in and the doctor's too busy anyway. The hospital is always available".

In two other cases the episodes occurred at home but a passer-by became involved. In one case a man who lived by himself explained what happened:

> "I was getting my breakfast and I'd been upstairs to the toilet and when I came down, suddenly, without warning, I made all this mess on the floor...It was terrible. I don't know how it happened. I was perfectly fit and on top of the world, rushing around like I always do. I honestly didn't know what was wrong. I hadn't got a clue. I've never been to the doctor for ages or needed him for myself".

He went on to describe how he contacted the passer-by:

> "I banged and banged on my neighbour's wall and blew and blew my whistle, but no one came. I managed to drag myself to the front door. When I blew again, a Mr.A., Chairman of the Council, was passing by and he went and called an ambulance for me...I don't usually by-pass the doctor, but in this case I think it was too urgent".

The passer-by, an acquaintance of the sufferer, explained how he

became involved:

> "I was walking the dog along the road. I heard a whistle being blown and I thought it a bit funny. I saw the door of this house open and didn't know if it was a child playing, but I thought I would go and see. I called out 'Is there anything wrong?' when I noticed this man on the floor...He was a bluish colour. He had obviously been sitting on a pot which was pretty full. I moved it away. He kept saying 'I've had a heart attack'...He kept on repeating himself and I wasn't too sure if it was a try on".

The passer-by obviously doubted the validity of this man's claim and was concerned to get him off his hands. He said this:

> "I hadn't made up my mind as to whether or not he was genuine. To be quite honest, I wanted to get him off my hands, although he needed some help of a sort. I didn't seek anyone else's advice. I didn't know whether this man was on the 'phone,so I went out and asked this person across the road if I could use their 'phone to dial 999".

An ambulance was called and the man was taken to hospital. It is clear from this case that the urgency with which medical attention was sought was influenced by the passer-by wanting to get the troublesome patient off his hands, although the evidence also suggests that the patient had made up his mind that an ambulance was needed.

The second case involved a man, once again living by himself, although this time in a more isolated country location. He explained what happened:

> "I got wet doing a job to help a chap with some fencing. It was that cold, snowy morning. I ached everywhere:legs, my feet, hands, and chest. I've got acute bronchitis,so they tell me...I got up Sunday morning and was staggering. I honestly thought I was on my way out...I didn't know what was wrong at the time. All I knew was I needed help badly and I'm so cut off down the lane where I live".

An acquaintance was passing by his house and he called to him:

> "I told him how ill I felt and he made me a cup of tea and went and got his van and said he'd take me to the accident centre".

He said he didn't try to contact a GP because before then he had been trying to fight it off and on the Sunday morning a doctor wouldn't be available. He explained:

> "There was no doctor's open if I'd 'phoned. You don't know when he's free to come. I didn't have strength for anything. No, by Sunday I was so desperate that I was glad Mr. A offered to take me to the Accident Centre. I thought I was dying".

These two cases are clear examples of the significance of the influence of passers-by, even when episodes occur in the sufferer's home, in utilisation of the A and E department. In the four remaining cases, two of which involved an attempt to contact a GP, the people who were contacted by or contacted the sufferer were a warden of an old people's home, 'welfare lady' at the clinic, taxi-driver, and a doctor. In the last case the sufferer burnt himself in a fire, and this is what he said the doctor did:

> "He (the doctor) looked at it and said it was better for me to go to hospital and get the treatment as he was busy".

So far, all the cases cited have involved either the sufferer going to another site to make a decision to seek medical care or a person in a formal capacity becoming involved with the decision making. Either of these elements could be influential in the choice of care system. Results from Table 7.1 suggest that an attempt to contact a GP is more likely to be made when the decision to seek medical care is made at home.

In the introduction to this section the stated aim is to

examine why some patients go directly from home to hospital after being involved in an episode at home without attempting to contact a GP. Is it because of some element in the sufferer's situation that has yet to be identified? In the above some of the potential elements were discussed: e.g., the role of people in formal positions. However the remaining data refer to only those where an episode occurred at home, a decision to seek medical care was made at home, and the sufferer had contact with only his family or his neighbours and friends. Table 7.7 suggests that sufferers who contacted friends or neighbours may be less likely to go to the GP than those who only contacted relatives.

In four cases out of nineteen, the sufferer or sufferer's representative attempted to contact a GP. In three of these four cases the sufferer received advice from neighbours about where to go for medical advice. In two of the cases the sufferer or parents of the sufferer went to the neighbours for advice. The neighbours told them in both cases to go to hospital but also in both cases the mother and the sufferer,respectively, decided to contact a GP. In the other case the neighbour told the sufferer that he would have to go to the doctor, which he did. Of the remaining sixteen cases, three involved conditions that were non-traumatic. One involved a young child who had a fit. The mother rang for an ambulance while the father went to the neighbour. The neighbour administered first aid. In the two other cases, one involving persistent nose bleeds and the other "a lump in the throat",friends suggested the hospital to the patient. Their reasons for not contacting their GPs was that it (the hospital) was the obvious place

to go for the case where the sufferer had a nose bleed, and for the other case the sufferer didn't attempt to contact a GP because she didn't think he would come and see her. Certainly, it appears for some traumatic complaints, sufferers or sufferer's family, friends, and neighbours have specific ideas about what kind of treatment is needed and where to get that treatment. For example, a twenty-one year old man cut his hand; his girlfriend was reported by him as saying this:

> "As soon as she saw it needed stitching and she cleaned it up and bandaged it".

They went direct to the hospital. Other people are sought out or give advice because they are believed to have "expert" knowledge. For example, a woman dislocated a bone in her shoulder. She contacted her neighbour "next door but one" who "works at the hospital and she advised me to go there". In another case, the "expert" wasn't a nurse or attached to the hospital in any way. In this case a woman sprained her ankle and she explained what happened:

> "When I came indoors I was in terrible pain and the ankle was enlarged, but within an hour you could see it gradually getting bigger and bigger, and I went to bed and rested it, thinking that by morning it would be a lot better, but by the morning I couldn't even put my foot to the ground".

Sufferer: "Well that night we didn't think; I didn't sort of give it a thought to go down to the hospital when it happened because I didn't think, you know, it was that serious enough. I thought well, I'm not one to worry them. I thought they've got enough to cope with, so I thought well, I'll rest it and by morning it would go, but first thing in the morning, M.A. (her boyfriend) said 'no, straight to hospital'".

M.C.:"Has Mr. A. had any medical training?"

Sufferer: "No, he's had two broken legs...he knows about these things and he also does recovery work for the police... accidents and all that sort of thing, so he knows. He's not medically qualified, but he's seen enough accidents on the road".

M.C.: "Did you think of contacting your GP?"

Sufferer: "No, straight down to Canterbury, because I thought if I call out my own doctor on a Sunday morning, the first thing he is going to say is 'well, I think it needs x-raying because of the size of it and the pain'. If I went to the Cottage Hospital, they would turn round and say exactly the same, so straight away we went to Canterbury".

It is difficult to judge how widespread this approach to the use of the hospital is. Certainly this woman not only received advice that she felt was expert, but she had a specific strategy of her own. She said:

> "If I think it's necessary to go to the hospital, I will, rather than waste the GPs time, and for quickness I go down there...I wouldn't go there for the least little thing, but I think if hospital treatment is necessary, then I would go there, especially with the children... if the children had colds or something, I'd just 'phone the GP...If the GP wasn't available, especially for an emergency, I would go straight to hospital".

It also seems that in the case of trauma, lay people have knowledge about when a cut, for example, needs stitching, even though they don't believe it is serious. One woman said this about how she distinguished a serious cut from a not so serious cut:

> "Well, you can usually tell, can't you, if something... I mean if I was to cut a finger indoors and it was sort of, I could see the bone and then I would think, that to me would be very serious, but I know, I mean, when I did my lip it wasn't serious to the extent that, how can I put it, I knew I had to go to the hospital to have it look at, because I couldn't do anything with it myself and they dressed it and put the stitch in".

The evidence from these nineteen cases suggests that, given the limitations in the population sample, when neighbours give advice, it is the hospital rather than the GP which is seen as the most appropriate source of medical care. It is difficult to tell whether this is due to the type of complaints presented to neighbours:

i.e., neighbours have specific ideas about what goes where (the evidence presented here, although based on a small number of cases doesn't support this), or whether it is due to neighbours being asked for advice when the situation is seen to be an "emergency" and so the hospital is seen to be the appropriate place for conditions requiring urgent medical attention. It may be due also to neighbours when they are put in the position of adviser or expert. When they are put in that position it is open to question that they will tend to be more cautious because of the moral responsibility involved in taking risks with other people or other people's children.

Table 7.1 shows that in twenty-three cases the sufferer did not have contact with anyone before going to, or attempting to go to, the medical services. These cases involved adults only as children whose parents make the decision for them are categorised under contact with relatives. As the table shows, just over a third attempted to contact a GP.

In eight of these twenty-three cases the sufferer had a complaint that was non-traumatic. These cases are of interest because it might have been suspected that they would be more likely to involve an attempt to contact a GP. In two of these cases, an attempt was made to contact a GP. One of these few cases involved an elderly lady with a suspected heart attack. This is how her husband described what happened:

> "We think it was a heart attack, but when we got her to the hospital, they said there was nothing wrong with her. I came home and found her lying on the bed, white as a sheet. She suffered loss of breath and terrific pains across her chest and around her back".

Their suspicions about these symptoms manifesting a heart attack appear to stem from her history of "slight heart attacks and she is on tablets for it". Her husband described what he did:

> "She lay for about three quarters of an hour, waiting for me to come, and as soon as I saw her I ran across the road to the doctor".

The husband said he knew that she needed urgent help because of his experience"as a nurse on a hospital ship". The husband went to his doctor's surgery nearby, but he could only see the receptionist as the doctor was "on call". It appears that this man always goes to his GP for professional medical help. He said:

> "He's my physician. He's the man I rely on. If he thinks it's necessary, then he would send me to the hospital".

The husband said the receptionist rang for an ambulance. The receptionist had this to say:

> "I thought it was probably a heart attack. She had got severe pain, mid chest. She'd collapsed on the bed and she was very distraught and her husband couldn't make very much of her. He came straight over to me. She had been on tablets for the heart for about two to three years, so I felt it was rather important that she was seen straight away".

This receptionist said that she had referred patients to the hospital when the doctor wasn't around:

> "Well, if it was a severe laceration, I would think the best thing then (to go to hospital), or epistaxis; then I would say 'yes, straight round to our local cottage hospital' where they have got the facilities for at least stopping the bleeding prior to seeing the doctor...I would in the case of someone having had a fall, an elderly person having had a fall. Back last year and I couldn't get hold of a doctor there and then and I thought that was important because just...I suppose sometimes you get a feeling and I just had a feeling that she had probably fractured a femur and she had. Then, yes,

> I do get in touch with the ambulance and get them direct down to the hospital and in a case like a heart attack, if I thought it was a heart attack and the doctor wasn't here, yes, then again".

According to the hospital, in this case both the husband and the receptionist proved wrong in their diagnosis, but the husband still felt his action of going to hospital was justified. He said,

> "Even if it was a scare it was the proper thing to do...If the GP had been available, he probably would have done, but it was wisest to go".

The second of the non-traumatic cases where an attempt was made to contact a GP involved a young woman who had an eye infection. She explained how it started.

> "It started in the morning and got worse by the afternoon...I had a suspicion what was wrong,because in December I had had a similar thing in the other eye, which they had trouble in diagnosing (at another casualty). They said it was just an eye infection".

She decided to try to contact her GP on Sunday evening, but he wasn't there, and then she tried to contact some friends.

> "My husband's at the A and we happen to know one of the people who is going out with a doctor, and it occurred that she may have something to cure the pain until I could get to the hospital, but we couldn't,in fact, get hold of her either...There was no one else to contact...My husband would have preferred to get hold of the GP because when I got back from B at Christmas I had been to see him to get some tablets and therefore he knew about it, but the only other thing was to visit the Casualty Department".

They visited the casualty department that evening but were dissatisfied with the diagnosis and treatment given, so on their return home they attempted to contact their GP again.

> "Several hours later we came back here. It was seven o'clockish and the thing just got worse and worse and at about half past nine we tried again for my GP. His daughter answered and said that he was on holiday and she gave us the name and number of the man who was standing in for him. I rang him and said this had happened and he came round within ten minutes, took one look at it, and rushed back to the hospital and got some stuff to put on it".

Apart from the urgent nature of the condition (the woman described the event as an emergency using medical criteria) this couple were planning to go on holiday the following day and treatment was needed urgently.

In another two cases the sufferer had had contact with a medical practitioner prior to going to the hospital. In one of these cases the patient was suffering from toothache and was referred by a casualty doctor in a London hospital to the A and E department at Canterbury. In the other case a woman explained what happened:

> "My stomach pains started on the previous Tuesday. I hung on as long as I could. A relief doctor is on duty on Tuesdays. He left some pain killers at the Cottage Hospital for my husband to collect. On the Wednesday the pain and sickness was still there and I had finished all the tablets. So I went to the doctor again and saw my own this time. I was given more pain killers. I was still being sick, so I rang the doctor again. This time I saw the doctor's partner who examined me and thought I had an ulcer, so he sent me back home in a taxi and called for an ambulance".

In the other four cases no attempt was made to contact a GP. Two sufferers said they didn't contact their GP because they anticipated that their GP would have referred them to hospital anyway. One sufferer said it was the weekend so his GP wouldn't be available, and in the other case a female sufferer with ear trouble said she didn't go to the doctor because she doesn't "get on with her". Her source of medical help is the Family Planning Clinic

and if they are not available she goes to the hospital. She said:

> "I never go to the doctor's. She's got no time for me and only seems to care about the kiddies... She doesn't like me and I don't like her".

Of the fifteen cases where sufferers had a traumatic condition, five patients attempted to contact a GP. In one of these cases an elderly lady had gone to her GP for her routine checkup. Her GP had noticed an injury to her wrist and sent her to hospital. Of the remaining ten cases, one person didn't have a GP in the area as he had only recently moved to the area and was using the hospital as his source of medical help. In the other cases two sufferers said they didn't attempt to contact the GP because it was the weekend and similarly one said it was the evening. One sufferer said he wouldn't have been able to see the doctor if he had tried to contact him, and another said the doctor would have sent him to the hospital anyway. Another didn't think his GP was competent and preferred the hospital, and another thought his condition was inappropriate for his family doctor as it was too trivial. The three other sufferers were more positive about their reasons for using the hospital. Two of them suffered from foreign bodies in their eyes and said that the hospital was the more appropriate as it had specialist treatment facilities for their conditions. In the other case the sufferer said it was more convenient. He said:

> "I wasn't sure of the surgery hours and also the hospital is so near. I thought casualty was the simplest way".

His routine policy for matters of health was simple:

> "If it was conventional, like flu, etc., I would go to the doctor; but if it's an accident, I'd go to the hospital".

For those people, then, who didn't have contact with anyone about their use of the medical services, over a third attempted to contact their GPs. A slightly higher proportion of those with non-traumatic conditions went to their GPs than those with tramatic conditions. One of the whole group of the twenty three had not registered with a GP. Reasons for not contacting a GP varied but one of the most frequent was that at the time of the decision to seek medical care the doctor would not be available.

In the vast majority of cases where the site of the episode was the home and also the decision to seek medical care was made at home, the sufferer had contact with a relative. Of this 109 cases, just over half (56 cases) involved parents making decisions for their children, mainly younger children. Of these 56 cases, 24 involved an attempt to contact a GP (42.8%) compared with 23 (43.4%) of the remaining 53 cases. Thus there is little difference between the two groups in terms of the likelihood of an attempt being made to contact a GP. Certainly this group as a whole, i.e., 109 cases, involved the highest proportion of patients who attempted to contact a GP.

Evidence collected in this study cannot show if patterns of help seeking behaviour of young children are different from those of other age groups. However, these data can highlight some of the special circumstances or conditions that parents of young children are confronted with and how these circumstances or conditions appear to influence choice of medical care setting.

In one case involving a young child who had some foreign body stuck up his nose the mother had planned to go to the family doctor. She said:

> "What happened was that I rang up the doctor last thing at night. He said, 'O.K. Come down in the morning'. Then there was the complication that I couldn't easily go down to the doctor because my father-in-law couldn't come in to get them. I rang up the doctor to say I'm afraid I won't be able to get in in time, and the receptionist said to me, 'there is a good chance that you might have to go up to the accident centre anyway if it's something in the nose, so just go up there and don't come down here'. That was really how I came to go to the hospital".

She went on:

> "I must admit I didn't think of hospital at all. I was going to the doctor. The problem was that I wasn't going to be able to get to the doctor's surgery in time, and the receptionist told me to go you see".

The mother was critical of her GP for sending her to hospital. She said this:

> "Several times I have been told by the doctor, told by the surgery to come up to the hospital when I have been prepared to go to a GP and would expect to. Sometimes when I don't think it's necessary".

She emphasised the inconvenience of going to a GP:

> "Having no transport is a great trouble. The GP always says 'get him up to the accident centre'. Well, we haven't got a car and I've got five children and it's not easy for me to go up. Thank goodness I've got a lot of really super friends, but one doesn't want to be forever on the cadge. It's far easier for me to go to my doctor. I've never welcomed being asked to go up to the accident centre".

This account has highlighted the problem of lack of transport and what to do with other children in the family, especially when another is ill which appears to have a great influence on parents' choice of medical care setting.

7.2 The Role of the Receptionist at the Doctor's Surgery

In a number of other cases, parents of young children attempted to contact their GP but were unsuccessful and ended up receiving advice from the receptionist. For example, a parent of a young child,who had cut her right hand while playing at home, rang her doctor. The mother said:

> "I rang up the surgery and spoke to the receptionist and she told us to apply pressure and take her straight to the hospital".

The receptionist said this:

> "Mrs. C phoned and said the child had cut her hand very badly. She couldn't stop the bleeding and it was quite open and she asked me what to do. Should she take her to the accident centre? And I said'well, yes,I thought that was the best thing".

The receptionist outlined her strategy for dealing with certain complaints:

> "I mean if somebody is bleeding quite hard and needs stitches, well the best place is the hospital,straight away there...If somebody has obviously fallen and broken a leg or done something like that, the best thing is to get an ambulance and get them to the hospital, if they ring through and say that they've fractured or got a breakage somewhere".

She also said that she didn't expect the doctors to stitch cuts at the surgery and said,

> "They (the doctors) would prefer that they went straight to the hospital".

Other receptionists told how they dealt with parents of young children. One talked of a specific case in which a boy had injured his wrist and the mother had telephoned the doctor. The receptionist said this:

> "Well, it seemed an obvious injury. He couldn't grasp anything with it and it was an odd shape and the mother

said it was swollen and it seemed to me that it was an obvious bone injury and worthwhile going up for an x-ray".

She explained how she generally dealt with cases when the doctor wasn't around:

"Well, I ask them their symptoms. I've been doing this job for a long time. Just ask the symptoms,see; you know what and just suggest that they may possibly go up to the hospital for treatment. For instance,I get mothers ringing up where young children have taken their pill, or swallowed some other noxious substance, and in that case I just advise them to take the child straight up to the hospital. This is what we do...I have to act on my own initiative because they are worried and obviously in trouble and you offer the first help you can. Sometimes they ring when they ought to use their own common sense and go anyway".

According to this evidence the accident centre provides a significant source of help for the receptionist when the doctor is unavailable. Also, it appears, that some receptionists believe that in some cases patients should go directly to the hospital without bothering a GP. For example, one said:

"Yes, it saves time if they go straight to the accident centre. Head injuries, anything like this".

This receptionist also went on to describe the criteria on which her policy of referral to the accident centre is based. She emphasises the importance of not taking risks:

M.C.: "And what about a sprained ankle? How does the doctor deal with that?"

R.: "Well you don't know if people have got a sprain. If people phone up and say they've got an ankle injury, if the doctor's here I say 'well, come in', but if I am here on my own and no doctor is available and possibly not until the next surgery which might not be for another five or six hours or even the next day, I suggest they go up for X-ray because a lot of people have what they think is a sprained ankle and they find they have actually fractured a small bone. After all there are more bones in the feet than there are anywhere else, aren't there?"

M.C.: "What about in the case of collapse?"

R.: "I don't even wait to ask the doctor what to do. I get an ambulance round there straight away because while I am waiting for him, you could have somebody with a coronary or it may just be a straightforward faint, but it's always to err on the wrong side and get them brought up and if I do get a collapse I do that and then tell the doctor what I've done. Well, for instance, one evening I was here and a man had gone home from work and found his wife unconscious. Well, he didn't know if she had taken an overdose, but even if she had, I took a chance, got an ambulance to her, but it so happened she'd had a haemorrhage, so I couldn't get into the doctor immediately and I think I saved about ten minutes, you see, by doing that. You just use your common sense.I probably err on the cautious side, but I'd much rather send 99 cases up and find they are alright rather than not send up the hundredth and find it's been a heart attack or something".

This receptionist, although not having any first aid training or qualifications herself, said that because she had always worked in administration and because she's had four children she has enough common sense to know what to do in any emergency.

One of the most common methods used by a receptionist to judge whether the episode in question was an "emergency",and thus justified being sent to hospital, was the reported time lapse between onset of the episode and contact with the surgery. For example, this interaction occurred while the interviewer was interviewing a receptionist:

Mother: "My daughter injured her finger four days ago. It has not improved and the school nurse has tried to puncture the nail but has been unsuccessful. What should I do?"

Receptionist: "Well, you could bring her to the treatments room here at the surgery for a nurse to look at it, but if you think it may be broken you should go to casualty. You say four days ago? Well, in that case it cannot be called an emergency. I think you had better let the doctor look at it then and let him decide. Would you like to come to the surgery at 5:30?"

Table 7.1 shows the distribution of explanations from patients or patients' representatives for not contacting a GP. These data show that in a quarter of the cases the patient felt that at the time of the decision to seek medical care their GP would not be available. A further 26.6% said that if they had gone to their GP the GP wouldn't have treated them or that they would have had to wait a long time for treatment. Only in 27.7% of the cases did the patient have something positive to say about the hospital: i.e., that it was the appropriate place because of the availability of specialist treatment, or, more generally, it "was more convenient".

To summarise the findings from this section on episodes occurring at home, it is evident that compared with other contexts there appears to be a much higher proportion of patients who tried to contact their GP. Only a small proportion of episodes involved outsiders in decision making such as strangers or the police, and this appeared to occur only when the sufferer lived alone. However, neighbours played an important role in information giving. The majority of sufferers had contact with and were given advice by a patient or spouse only, and this group had the highest proportion attempting to contact a GP. The predominant explanations given by patients or patients' representatives for not attempting to contact a GP were the unavailability of the GPs: i.e., at the time of the decision to seek medical care the GP's surgery wouldn't be open, or that the GP wouldn't have treated the sufferer's condition anyway, so it would be best to short-circuit the system by

going direct to hospital. It is interesting to see that much emphasis was placed by patients on the availability of GPs in their explanations of why they had not attempted to contact a GP. It seems that patients believe doctors are available only on weekdays. In the evening and at a weekend they cannot or should not be contacted.

It is also interesting to note that just over a quarter of the patients had specific ideas about the appropriateness of the hospital for their complaint and in these cases a GP wasn't seen to be the relevant source of medical care.

7.3 Summary and Conclusions

In this chapter, sufferers who were involved in episodes at home were examined. Compared with episodes occurring in other contexts there was a high proportion of cases where an attempt to contact a GP was made, especially when both the episode and the decision to seek medical care occurred at home. Although neighbours and outsiders did play a part in decision taking,in the majority of episodes the decisions were made within the family. The reasons given by sufferers or sufferers' representatives for not attempting to contact their GP could be divided into three different types. One group emphasised the unavailability of GPs at certain times of the day and the week; another group said that they went direct to hospital as they had anticipated that their GP wouldn't have examined them anyway, and the third group said that because of the facilities available at hospital that was the most appropriate place. These data suggest that the majority of patients wouldn't go to their GP for certain conditions even though they believe he is available.

Table 7.1: Site of episode at home, site of decision to seek medical care, contact with relative, friend or other and attempt to contact a G.P. or not

	Episode at home							
	Decision to seek medical care at home				Decision to seek medical care elsewhere			
	No contact with anyone	Contact with Relatives only	Contact with friends or neighbours	Contact with others	No contact with anyone	Contact with Relatives only	Contact with friends or neighbours	Contact with others
Attempt to contact a G.P.	9	49	4	3	--		3	1
No attempt to contact a G.P.	14	60	15	6		2	13	5
Total	23	109	19	9		2	16	6

Table 7.2: Explanations of patient or patient's representative for why no attempt was made to contact their G.P. after being involved in an episode at home and making a decision to seek medical care at home

Explanation	No.	%
Not appropriate time - at weekend or in evening	15	25.0
Specialist treatment at hospital	7	11.7
Obvious place to go	7	11.7
Doctor would have sent to AED	6	10.0
Wouldn't have been able to see G.P.	5	8.3
Too long a wait at surgery	5	8.3
Condition not appropriate for G.P. - too trivial	4	6.7
More convenient	2	3.3
No transport available	1	1.7
Doctor wouldn't have come out	1	1.7
Not registered with a G.P.	2	3.3
Other	5	8.3
Total	60	100%

CHAPTER 8

PROFESSIONAL AND LAY DEFINITIONS OF EMERGENCIES

One of the reasons why casualty departments became a focus of attention during the early nineteen-sixties was the concern expressed by certain professional medical groups about the apparently high proportion of attenders who were abusing the service. These "inappropriate" attenders should have either gone directly to their GPs or not bothered the health service at all. These professional medical groups saw the casualty department as a centre for serious accidents and "life or death" emergencies, and not as a centre for the treatment of "minor" ailments (See Chapter 1). One of the assumptions implicit in this approach was that lay people should have an adequate level of knowledge to be able to distinguish between a true emergency and a trivial condition. In this chapter, the analysis will concentrate on those patients who attend with minor conditions. Patients with minor conditions who attended the A and E department were, and are still, defined as "inappropriate" attenders. The emphasis will be on examining patterns of illness action and help seeking behaviour through the eyes of the sufferer and significant others. This in-

depth analysis will focus on two particular types of conditions. They are: (i) minor cuts (ii) minor illness

Cuts are chosen because previous analyses[1] suggest that the GP may play a minor role in their treatment. Minor illness, on the other hand, appears to exhibit the opposite characteristic in that GPs are expected to play a more significant role in providing care and treatment. The classification of the condition as minor is derived from a clinical classification used previously by the NPHT. Before this analysis is presented, it may be useful to show how professionals define emergencies at a more general level. These classifications can then be compared with lay classifications.

8.1 Medical definitions of emergencies and "inappropriate" attenders

Definitions of appropriateness are functions of how the work of the A and E department is defined. Therefore, it is necessary to include a variety of different classifications. One of the classifications adopted in this study was a medical classification of the urgency with which medical attention was required. The concept of urgency is used because it places the emphasis on the speed with which professional medical treatment is required rather than on the specialist treatment for specific complaints. Thus there is an implicit assumption in choosing medical urgency that part of the work of an A and E department involves or should involve dealing with complaints that need quick treatment, whether they are "serious" or not. Not only was a scale of medical urgency developed, but an attempt was also made to build into this scale

the uncertainties which confront the doctor in the diagnostic process. It was pointed out in Chapter 2 that a major weakness in previous assessments of severity or urgency was that classification was made after clinical tests, treatment and final examinations had taken place. The difficulties involved in using this approach were outlined previously, and in this study an attempt was made to overcome them by assessing the complaint at the time of the initial examination. Casualty officers were asked to fill in a form after initial examination, giving details of what the patient said was wrong, as well as the doctor's initial diagnosis and the clinical tests or treatment that were proposed. Originally it was planned to get the casualty doctors to assess the urgency with which the patient required medical treatment. However,because the value of such an assessment proved to be problematic given the marked variation in the definition of urgency between casualty doctors, the assessment of clinical urgency was made by a casualty consultant basing his assessment on the details given in the form. The assessment is therefore crude in that the assessor could not see the patient himself and was not enabled to use directly his clinical experience and that the assessment is based on other doctor's written interpretations of diagnosis. The assessment is based on the most probable diagnosis and urgency is dependent on the treatment available. The assessment also presumes that first aid had been carried out where appropriate, and when the assessor was in doubt he erred on the side of "urgency". The assessor carried out the assessment on two different occasions on each case, the second assessment being blind. The differences between the two

assessments were very small. Table 8.1 shows the assessment of urgency as well as the distributions.

The results show that only 6% of the cases were described as "life or death" situations, in which immediate intensive medical treatment was required. On the other hand, only 5% of the cases were described as not needing medical treatment until at least 48 hours after the trouble started. The large majority came into the two middle groups, with 45.1% requiring medical treatment within 6 to 48 hours of onset, and a slightly smaller group, 43.3% of the cases, requiring medical treatment within six hours of onset. Thus, in broad terms, half of the cases should be described as urgent (requiring medical treatment within six hours of onset) and half could be described as non-urgent (not requiring medical treatment within six hours).

In other studies, the "appropriateness" of the condition for treatment at hospital was defined in terms both of the level of skill needed and of the facilities available to treat the condition[2]. Such an assessment was carried out in the NPHT study[3]. In the NPHT study, each diagnostic category was given a code according to whether hospital facilities or clinical "need" were required, GP and /or hospital skills required, GP facilities or clinical need required, nurse S.R.N. and/or GP required, and, finally, nurse S.R.N. alone is necessary[4]. The diagnostic classification used by the NPHT was also used in this study, and so it is possible to use this "clinical care" scale in this study. The results show that 36.0% of the cases were said to be requiring

hospital facilities or clinical need, 2.2% of the cases were said to require GP facilities or clinical need, 7.6% of the cases required a nurse or a GP and 12.5% of the cases required a nurse only. In a further 4.9% of the cases, the complaint was not classifiable or no information was available. These results were compared with the average presented in the NPHT study and it appeared that the Kent and Canterbury Accident department had a higher than average proportion of complaints specifically requiring hospital care and facilities, 36.0% as against 29.0%, and the percentage requiring GP care was much lower, 36.7% as against the NPHT average of 52%.

Two different medical indicators of the "appropriateness" have been described. What does the evidence suggest overall? According to the various approaches, the percentage of legitimate attenders varied between a third and a half of the new attenders. If appropriateness was defined in terms of clinical urgency with which medical attention was required, then 6% were "emergencies" and another 43% were "urgent". Only 36% could be defined as appropriate, if appropriateness is defined in terms of a requirement for hospital facilities or clinical need.

8.2 Lay Definitions of Emergencies

Before the in-depth analysis of minor cuts and minor illness is presented, a more general classification of lay definitions of emergencies will be discussed. There are a number of different ways of defining emergency or urgency. For the present purposes, however, the following will be used. Patients were asked if they

would define the episode that they were involved in as an emergency and, if so, why they defined it in this way. The results showed (see Table 8.1) that 58.8% of the patients saw the episode as an emergency and 32.8% did not. This figure of 58.8% (almost two-thirds of the respondents) is much higher than the figures based upon medical definitions where the highest proportion of cases defined as "urgent" was 50%. Now this suggests that either lay people use completely different criteria for defining the category "emergency" or they use similar criteria but interpret them in different ways. Judging from the reasons given by patients for defining the episode as an "emergency", the latter type of explanation seems to be more convincing. Apart from the small percentage who identified as a "social dimension", for example,"any episode involving a child", and the 2.4% who stated "other people told them it was an emergency", a large majority used their health knowledge to define "emergency". These data seem to suggest that lay people have stereotypes about certain types of complaint being of an emergent nature. For instance, a suspected broken bone, an open wound, a head injury, and a collapse. While most lay people do not have detailed medical knowledge, these data do suggest that they have a set of categories which they use in defining "emergencies". Lay definitions of emergency were also imputed when the patient was "uncertain" what was wrong (6.1%).

These data show that the category "emergency" is defined by lay people predominantly in "medical" terms, but these terms are more general and more varied and appear to hold a different significance or importance for lay people than for the medical profession. This has implications for the use of this category in health

education propaganda which attempts to deter the patient from using the hospital or contacting their doctor out of hours for "non-emergencies".

Table 8.1 shows a comparison of lay and clinical assessments of the urgency with which medical care was required. In the most serious cases (according to medical definitions) the results show that there was a relatively high agreement with lay assessments. However, the major disagreements occurred amongst the cases that were classified as non-urgent on the clinical scale. Almost two-thirds of the non-urgent cases were classified as emergencies according to lay assessments. Also, nearly three-fifths of the cases who were medically assessed as being moderately urgent (requiring treatment within 48 hours) were defined as an emergency by the patients.

These findings suggest that medical and lay definitions differ in their criterion for assessing the significance of an episode in terms of the need for medical treatment. The findings suggest that most of the episodes that lead to immediate disruption in people's everyday lives, because medical treatment is thought to be required, are seen as crises or emergencies by lay people. This proposition will be explored further in the next section.

8.21 Comparison between patterns of help-seeking behaviour for conditions defined as minor cuts and those defined as minor illness conditions

8.211 Minor cuts

The cases included in the analysis were those that were defined as lacerations/open wound/penetrating injury requiring

cleaning and dressing only by the NPHT classifications. According to the NPHT classification, these conditions could be treated by a nurse S.R.N. alone if necessary and did not warrant hospital medical treatment. In all, 72 cases were classified in this way although in only 64 cases was there full information.

One of the most interesting findings, which once again highlights the difference in perspective between medical and lay people, is that, although all these cases were defined medically as being trivial and not warranting a medical practitioner's attention, three-fifths of the cases were defined as emergencies by the sufferers. It is also noticeable that out of the 64 cases in only three cases was an ambulance used and each of these three cases was a Road Traffic Accident.

Lay explanations in those cases in which the event was defined as an emergency highlighted a number of different dimensions of lay health knowledge. First, a number of people emphasised the deepness of the cut. For example, one man stated:

> "Well, I've never had an injury like that before, and it looked quite deep".

Secondly, a group of sufferers emphasised the amount of blood and their inability to stop it. The following statements were common:

> "I couldn't do anything more to stop the bleeding".

and

> "What frightened me was when I couldn't stop the bleeding".
> "Because of all the blood."

and

> "Because I couldn't get the wound to stop bleeding. It was running everywhere. I've been terribly thirsty since then and I've just had to take extra rest".

"I didn't want to bleed to death".

The third group of sufferers defined their cuts as emergencies because they found them so painful. The fourth type of explanation emphasised the part of the body. For example, one man stated:

> "Yes, it was an emergency. Always nervous of the head and there was a lot of blood. If it was the hand it would have been a different matter".

The dangers of blows to the head were mentioned on a number of different occasions. Some respondents emphasised the status of the person involved. Children were particularly seen to be vulnerable. For example, one mother said this:

> "From a mother's point of view, yes, it was an emergency. To look at Craig, he wasn't himself; he looked dopey and tired and from my point of view it was necessary".

and

> "At his age, when you see a nasty gash you draw your own conclusions".

By far the most frequent lay explanation emphasised the importance of having a tetanus injection as quickly as possible because of a fear of the development of lockjaw. The following illustrate typical responses:

> "In my opinion I needed a jab that day rather than wait until the following day. I knew someone who nearly died through neglecting to get a jab".

> "Yes, it was an emergency because of my work and fear of lockjaw".

> "Yes, well, I was worried because I've never had a tetanus and I didn't want to end up with lockjaw".

> "Dog might have had rabies".

> "Yes, it was a dirty sore and to me it was imperative he an anti-tetanus injection as soon as possible".

"Yes, I think mainly because of tetanus".

"Yes, because it was a gypsy dog and you don't know where it might have been".

All these explanations contributed to the sufferer's and others definition of the episode as an emergency. It is difficult to tell how far such accounts were invoked to legitimise attendance at the hospital and how far they played a legitimate part in influencing decisions about the need for urgent medical treatment. Two-fifths of the patients with minor cuts didn't see the "episodes" as emergencies but still went for medical attention.

Amongst those who didn't define their cuts as emergencies, there were three common explanations. One type involved the respondent emphasising that he knew medical treatment was required. For example:

"I knew the cut needed stitching".

or

"I knew an x-ray was necessary".

These people had a clear idea of what medical treatment was necessary.

The second type of explanation usually involved parents who made a decision to seek medical care because of their child's laceration. In hardly any of these cases was the seriousness of the condition invoked. Respondents felt that all that was necessary to say was that there was a child involved. A number of parents mentioned their moral obligation to seek medical care. For example, one mother states:

"My husband and I discussed it and he was the one that said we <u>ought</u> to take her to hospital".

> "She came and found me (mother) and I waited for my husband to come home and we both decided she should go".

It seems with children parents are able to go to the medical care services even if it involves erring on the safe side. Children seem to be legitimate users of the medical care service in the eyes of the public and in the eyes of the medical staff, even if their conditions are not believed to be serious.

The third type of explanation, and by far the most frequent among this type of sufferers, emphasised the role of others in influencing or making the decision to seek medical care. It is difficult to judge how far these explanations reflect the circumstances in which these episodes took place (many occurred outside the home) or were merely devices used to exclude the sufferer from responsibility for going. In some cases, authority figures such as doctors or policemen or schoolteachers were influential in the decision making or were said to be. In a case involving a dog bite, a youth said that the police had told him to go to the medical care service. He states:

> "The police took a statement from me and said I had to go to hospital or they wouldn't be able to do anything".

In another case a woman cut her nose while at work in a hospital. She was advised to go to the hospital by one of the doctors and she went because,

> "Dr. Smith had told me to go and I considered that was enough".

In other cases, bystanders, neighbours, friends, and relatives were invoked by sufferers as the reason for going to the medical care services. For example, a young man cut his right hand at work.

On returning home, he explained that his father had coaxed him to go to hospital. He states:

> "If he (his father) hadn't pushed me into it, I'd have just had a pint of milk and a couple of aspirins and gone to bed and I'd have been O.K. My dad thought I looked rough and he said in between the thumb and forefinger is a dangerous place to cut as you get lockjaw, and we couldn't remember when I'd had a tetanus injection".

In another case, a young woman was advised by her colleagues to seek medical care, even though she felt the injury wasn't serious. She states:

> "It was a minor injury and I didn't think it would require medical attention".

Another young woman told how she was persuaded to go to hospital.

> "My mum advised me to go to hospital because my cut looked worse than hers, and she thought I m ight need a stitch. I didn't think it was necessary".

She didn't take her mother's advice, but two days later a nursing sister at the hospital where she did voluntary work persuaded her to visit the casualty department. The woman stated:

> "I wouldn't have come if I hadn't been here on voluntary work".

In other cases, sufferers talk about bystanders, strangers, or workmates who had told them they "ought" to consult the medical care services.

These cases clearly illustrate some of the reasons why sufferers sought medical attention. Some thought that their condition required emergency treatment; others identified the circumstances of their case.

Of equal interest were the reasons given by patients for their choice of medical care setting. Table 8.2 shows the choice of

medical care settings for those people with "minor cuts". The table also includes some factors such as site of decision to seek medical care and involvement of others in decision making which were shown in the previous analysis to be one of the more significant predictors of choice of medical care setting. Of particular interest is whether sufferer's use of A and E departments is due to a deliberate choice about the most appropriate source of treatment or whether it was due to some circumstantial element that limited that choice.

In only ten of the sixty four cases was an attempt made to contact a GP and it may be worthwhile describing these. For most of these patients, their routine policy in matters concerning health was to contact their GP. The idea of having a choice between the GP and the A and E department seems to be one that these patients are not aware of. Some of them had specific policies. In one case, where the sufferer was referred to hospital by a practice receptionist because the doctor was out on call, he stated:

> "We're old-fashioned. We always have gone to the doctor ...My daughter is a nurse, but the doctor would always be contacted. We never go over his head...We always prefer to see our own doctor. He has been marvellous".

In another case, the family's policy of always contacting the GP appeared to override the advice of a headmaster who said that the injured child should go straight to hospital. In this case the father contacted the GP who advised going to the hospital. The father explained his policy:

> "The general practitioner is in first place as your immediate connection with the medical profession. I always regard the hospital as the second leg".

Other people, even when they were highly critical of their GP, still contacted him because they felt it was the appropriate thing to do. For example, one man stated, after ringing the doctor and being referred to hospital:

> "I have no faith in my general practitioner at all. He has no interest in non-private patients. He neglected me when I fell which resulted in my spending months in hospital when normally it would take only days. We had to bypass him in the end to get to see a consultant. My wife has had to change doctors. He's useless".

In all, this type of explanation was used by four patients. In four other cases, the sufferer or the sufferer's family weren't as explicit about their policies, but tended to see the GP as the first point of contact for advice in medical matters. In one case, a mother, knowing that the GP would not treat cuts, still rang him for advice about what to do. She emphasised the personal relationship between the family and the doctor. This personal relationship was also mentioned by the other three cases, and statements like "he knows us" were common.

In the other two cases, the GPs were called in by other people involved at the site of the episode and the sufferer had no control over the decision his or her doctor.

In eight of the ten cases the sufferer defined the "episode" as an emergency, and thus GPs were seen at least by this small group as a source of medical advice or treatment in emergencies. It is also interesting to describe what some of the GPs were reported to have said to patients when they contacted them. For example, one GP was reported to have said:

"It would be quicker and better if you go to the hospital".

It is also interesting to note that in none of these cases did the GP actually treat or examine their patients. Now it may be that some GPs do treat cuts and so they would not be included in the sample, although this evidence suggests that some GPs prefer that minor cuts "go to hospital".

The majority of patients with minor cuts in this sample went directly to the A and E department. However, as Table 8.2 indicates, many of these cases occurred outside the home and in situations where the control over decision making about choice of medical care setting was limited. The role of other people in decision making has been illustrated previously.

In spite of this limitation on patient choice, many patients did have clear ideas about why they went to the accident centre instead of their GPs. The vast majority of these patients said that their first contact in matters of ill health would always be their doctor. A small group of patients did mention the chemist, the ambulance, nurses who lived in the neighbourhood, or going straight to casualty. However, for cuts they did have specific ideas about the appropriate place. Typical answers to the question of why they didn't contact their GP are:

"I know doctor wouldn't look at it",

"Too much hanging about at the doctor's".

"Well, my doctor could have done it if I was bothered to go to a doctor. To me, it wasn't necessary to waste a doctor's time. I probably wouldn't have got an injection from doctor anyway".

"'Cos there's a great big notice in the surgery saying 'nearest accident centre'. I think it implies rather than wait in the surgery you should go to the accident centre".

"I don't know if my doctor stitches. My doctor may be more busy than the A.E.D.".

"No, he wouldn't have the facilities to deal with it. If I had gone to his waiting room, he doesn't have an appointments system in the morning, so I might have to wait an hour or more".

"I would have done if it had been late in the evening, but as the hospital was open I went straight along there".

"You get the service at the A.E.D. and I needed an x-ray. No GP would have done it, I don't think".

"No, well it was a minor thing and it was Sunday and he wouldn't have been very pleased. Anyway, he would have sent me to casualty anyway".

"Because it would definitely be done there. I'm not sure about my doctor doing stitching".

"I'd have had to go for an x-ray. Doctor would have sent me anyway".

"To save troubling the doctor".

"No accidents. You think of the hospital".

"No, I think it's just that you think first the hospital's there and fully equipped and it's just an extra burden on a family doctor".

"No, I don't think it was that serious".

"No, it seemed a trivial thing to go to him for".

"Doctor wouldn't have stitched me. He tells you he hasn't anything sterilised there".

"Doctor could do it, but doctors today seem to have these jobs taken away from them and they're sent to an A.E.D. I don't think it's part of a family doctor's job today, is it?"

These samples illustrate the range of ideas patients have about the value of going to a GP for the treatment of cuts. The most common explanations emphasised that the GP didn't have the facilities or didn't carry out the treatment, and the hospitals were the better equipped place. In addition, patients laid emphasis on the lack

of availability of GPs and the amount of time wasted waiting for treatment. The hospital was seen as the place where treatment was efficient and effective. One other common type of explanation emphasised the importance of not wasting the doctors' time with trivia. This is interesting as it seems that patients may be more inhibited by this philosophy than by the one proposed by the hospital A and E department about the appropriate use of the department. It is difficult to know why this should be so, although the continuity and personal nature of GP-patient relations may be a reason why patients don't want to upset them. On the other hand, the A and E department is anonymous and doesn't appear to involve any complications for obtaining medical care in the future.

In this section, it has been shown that patients with "minor" cuts predominantly see them as emergencies. The patients who defined their injuries as non-emergencies emphasised that their attendance was forced upon them by others. Circumstances did seem to play a part in determining the choice of medical care setting, although on the whole patients didn't feel that their GP was the appropriate source of care for minor cuts. A small minority of patients still followed the rule of "always contact your general practitioner first", although a larger group emphasised that their doctors' time mustn't be wasted.

8.212 Minor Illness

One of the questions discussed in the previous section was "Why on earth do patients go to GPs at all for the treatment of minor cuts?" In the case of minor illness, the opposite question

seems to be the legitimate one. "Why on earth do patients go to the hospital accident and emergency department for minor illness?"

It was evident from previous studies (see Chapter 2) that the majority of patients stressed the importance of their relationship with their GP mainly on the grounds of its personal nature and their GP's knowledge of their illnesses. Such a personal approach was not emphasised by patients who suffered cuts.

Minor illness includes complaints of a non-traumatic nature, excluding collapses and unconcsiousness. Also excluded are those cases where foreign bodies have been ingested and where specific treatment is required.

Twenty nine of the thirty four cases defined as minor illness were classified by the patients as "emergencies". This is a far higher proportion than found for the group with the minor cuts. Typical answers which described why patients thought they were emergencies were as follows: For a man with pains in his side:

> "I needed some attention. Had it been appendicitis it would have been an emergency".

For a man with bowel trouble:

> "He was getting very bad".

For a man with chest pains:

> "I was convinced chest pains plus feeling unwell meant something wrong. The doctor could have easily whipped out his own ECG machine but he doesn't".

For a woman with severe abdominal pains:

> "Because I didn't know what was happening to me".

For a man with a pain in the groin:

> "Because of the pain being so intense I felt it just wasn't ordinary".

For a woman with a swollen face:

> "Because it was getting worse and I didn't know what it was".

Many of the explanations emphasised the worry caused by signs and symptoms which the respondent couldn't account for. It appears that patients tended to wait and see if the signs and symptoms went away and the event was defined as an emergency when the signs and symptoms presisted or got worse.

Table 8.3 shows the choice of medical care setting by various circumstances surrounding the episodes. Compared with minor cuts, there was a much higher proportion of patients who attempted to contact their GP (almost half). In the other cases, as will be shown, circumstances played an important role.

Of the sixteen patients who tried to contact their GP, nine were referred by a doctor or a receptionist to casualty. The other seven involved cases where the patient couldn't wait for the doctor to come or couldn't wait for the appointment, and those where the patient saw the GP but were dissatisfied with their treatment. In the latter type of case the patient tended to seek a second opinion. One woman who was suffering from giddy turns, spots before her eyes, and blisters over the skin, said this about her GP:

> "We are constantly asking him to do something but he leaves us without any advice or help, just a load of pills without proper instructions. Doctor called at home with some pills but he didn't know what it was. So I decided to go to casualty".

The woman stated that she had no faith in her GP. Another woman with a swollen face attended her doctor's surgery. She said:

> "He said it would go away in a few days and gave no treatment. It didn't, and it got so bad on Sunday we decided it was better to go to the A.E.D.".

However, she had no complaints about her GP and said she would always go to him because of the personal nature of the relationship.

In another case a young child was suffering from a septic hand. The mother explained what happened:

> "I phoned my GP and he said it was his night off, but he did agree to give me some medicine and I was to take her to the surgery in the morning, which, of course, I thought was going to be too late, the way it was flaring up fast and furious. When we got there, my husband was absolutely livid. They said we certainly couldn't see him; we saw his wife. So we said, 'Right, we'll go straight to casualty'".

In spite of this, the mother said:

> "I've always contacted my own doctor first for any reason and I still would".

In other cases the respondents reported that their GPs had refused to come out. One GP was reported as saying he was too tired to come out.

So those who contacted their GPs with minor illness either were referred to casualty (for medical tests or reasons of convenience) or went to casualty because they wanted another opinion.

Of the eighteen cases where the patient had a minor illness and no contact was made with a GP, a considerable proportion was due to special circumstances. Two people were not registered with GPs. Five people were living temporarily in the area, due to work or holiday, and hadn't registered with a GP on a temporary basis, and one woman rang up the police for a list of GPs and was referred by the police to the casualty department. Each of these five people said they always go to their GP at home, but none were available where they were. This certainly emphasises the lack of awareness or the inconvenience involved in temporary registration with gene-

ral practitioners.

The remaining cases also contained some special circumstances. Two cases occurred at work and involved direct referral by an employer to casualty, and two were at casualty for a relative's complaint and decided to seek attention while they were waiting. Of the remainder, a number of respondents emphasised that they didn't think their GP would be available. In one case the patient used casualty because she was dissatisfied with her doctor. She was suffering from a painful wrist and a swollen elbow. She said:

> "Yes, I couldn't have seen my GP on a Saturday morning. They would have said 'You can have an appointment in 2-3 days' time'. If I'd gone to my own GP, I'd have had medicine and pills and that's no go. I've been dissatisfied with my GP. It's more of a direct route to casualty. I don't think my GP would have given me the right treatment. I only ever go to her when I need more medicine for my stomach - nothing else any more. She's treated me with all the wrong things".

Finally, one woman felt the occasion was inappropriate for contacting a GP:

> "I said you can't fetch the doctor out on a Saturday night and being Christmas Eve I never even thought of the doctor".

There was an equal proportion of minor illness cases who went to a GP and those who went direct to hospital in our sample. Doctors and their staff referred cases to casualty sometimes after seeing them and other times not. Some patients used the casualty department for a source of second opinion as they were dissatisfied with the service they received from the GP. Many of the cases of self-referral occurred because of special circumstances, such as patients being on holiday or working away from home. Very few of these patients did not have GPs and only one patient said she

deliberately chose casualty because of being dissatisfied with her GP.

8.3 Summary

Minor cuts and illness are two types of condition which have been defined as inappropriate conditions for treatment at A and E departments. GPs have also complained about having to treat patients with trivial conditions.

The in-depth analysis of the way people interpret and cope with minor conditions highlighted, once again, the marked difference between lay and professional views. The large majority of patients with either minor illness or minor cuts defined their condition as requiring emergency medical treatment. It appeared that both groups of patients saw their GP as the general focus for medical care, although among the patients with minor illness there was more of an element of dissatisfaction with their doctors. GPs seemed to be as important as the A and E department as a source of medical care for the group with minor illness and their failure to contact a GP was usually brought about by circumstances outside their control. The GP was seen to be less relevant as a source of medical care for the group with minor cuts because of patient beliefs about lack of available facilities at the surgery, lack of availability of GPs and fears about wasting their doctors' time.

Patients' interpretation of cuts were completely different from the way that illnesses were evaluated. Cuts proved no problem for patients in diagnosis and many patients self-diagnosed. Many of these patients had specific ideas about what treatment was necessary and why. These patients wanted a place where this treat-

ment could be carried out effectively and efficiently in the minimum time. Minor illness provoked different patterns of interpretation in patients. In these cases, the interpretation of signs and symptoms was more of a problem, and one of the major reasons for seeking medical care amongst this group was their need to find out what was wrong with them. These patients sought medical care when they could no longer accommodate to or account for their signs or symptoms.

Finally, it is evident that the A and E department seems also to function as a place where GPs can refer their patients when they either need medical support or when the patient causes a disruption in the doctor's routine. The A and E department seems to fulfil the dual roles of providing a service which complements the GP when he needs medical support and a substitute when the GP needs to control accessibility.

TABLE 8.1 Comparison of clinical and lay assessments of the urgency with which the condition required medical treatment.

	Medical assessment of urgency										
Patient's definition of an emergency	Emergency No.	%	Urgent Treat in 6 hrs		Moderate 6-48 hrs		Non-Urgent 48 hrs +		N.A.	Total	
Defined as non-emergency	3	8.6	74	28.0	115	42.4	9	31.0	6	207	32.8
Patients who defined event as emergency because:											
Other people told them	2	5.7	9	3.4	7	2.6	2	6.9	2	22	3.6
Didn't know diagnosis	4	11.4	16	6.2	16	5.9	1	3.4	1	38	6.1
Suspected broken bone			7	2.7	37	13.7	1	3.4	5	50	8.0
Painful	4	11.4	16	6.2	21	7.7	3	10.3	4	48	7.6
Collapse	6	17.1	5	1.9	3	1.1	3	10.3	2	19	3.1
Medically serious	5	14.3	18	6.9	3	1.1			3	29	4.6
Injury to the head	1	2.9	12	4.6	5	1.8	1	3.4	2	21	3.3
Open wound	2	5.7	53	20.1	4	1.5				59	9.4
Obvious need for medical treatment			11	4.2	8	3.0	2	6.9	3	24	4.0
Episode involved child			6	2.3	9	3.3				15	2.4
Other	4	11.4	13	5.0	12	4.4	5	17.2		34	5.4
N.A.	4	11.4	24	9.2	31	11.4	2	6.9	1	62	9.9
Total	35	100%	264	100%	271	100%	29	100%	29	628	100%

TABLE 8.2 Patients who were involved in episodes which caused minor cuts and site of episode, site of decision, status of advice-giver and choice of medical care setting.

	Minor Cuts							
	Home				Outside Home			
	Decision at site		Decision not at site		Decision at site		Decision not at site	
	Advice given by non family member	No advice given	Advice given by non family member	No advice given	Advice given by non family member	No advice given	Advice given by non family member	No advice given
Attempt to contact a GP	4	1				1	3	1
No attempt to contact a GP	5	14	3		20	4	3	5
Total	9	15	3		20	5	6	6

TABLE 8.3 Patients with minor illness, site of episode, site of decision and choice of medical care and setting.

	Minor Illness							
	Home				Outside Home			
	Decision at site		No Decision at site		Decision at site		No Decision at site	
	No Contact with others	No Contact with others	No Contact with others	No Contact with others	No Contact with others	No Contact with others	No Contact with others	No Contact with others
Attempt to contact a GP	2	8			1		2	3
No attempt to contact a GP	2	9	1	1	1		1	3
Total	4	17	1	1	2		3	6

CHAPTER 9

DISCUSSION OF RESULTS AND CONCLUSIONS

9.1 The approach to the problem: a summary

The "problem" over the use of A and E departments was portrayed in Chapter I in terms of a typical conflict between professional and lay interests. However, in contrast to the more common image of the professional hospital doctor successfully developing both structural and interactional strategies for maintaining professional dominance over the patient, it was argued that the structural characteristics of the A and E department posed control problems for the profession. Those control problems were exacerbated by GPs' attempts to develop a specialist service and thus enhance their professional prestige and status. It appears that the GPs' attempts to regulate the "type" of patient that they see were more successful than those adopted by the providers of the A and E services because numbers of patients began to turn to the A and E department for treatment of conditions that were previously taken to their family doctor.

These developments, coupled with the rise of the consumer health movement, led to some medical groups who were involved in providing accident and emergency services proposing a policy which appeared to embrace both clinical and social elements of patient need. This policy appeared to abandon the traditional approach to patient care in the hospital which emphasised the specialist clinical element. However, this shift in policy as proposed by the professionals was not as dramatic a change in approach as was initially thought. The proposed policy was based on professional images of how patients "ought" to behave. The assumption was that patients do or should share professional ideas about what are the correct organisational solutions. The image of the patient in this policy is of one who accepts official solutions as being correct and complies with officially prescribed rules. This shift in policy has involved an acceptance of a social element in the classification of appropriate patient usage without any real change in assumptions about the nature of the professional-client relationship. Recent sociological literature, however, has argued that this type of approach to doctor-patient relations contains contradictory expectations for the patient. The most important of these contradictions[1] was that patients were expected on the one hand to be able to make decisions about complaints which should or should not be brought to the doctor; on the other hand, patients were expected to forgo such knowledge in the encounter with their doctor and defer to the doctor as the expert. This leads to a recipe for conflict or tension between professionals and clients rather than consensus[2].

The image of the patient in this approach is one who should have adequate knowledge but not enough to threaten medical authority.

The literature on the use of the health services highlights a further contradiction. In the case of the primary care and casualty services, patients are expected to be able to judge whether a complaint is serious and requires emergency medical care, or whether it is trivial and does not warrant professional medical care. However, potential patients are also expected to be able to identify at an early stage signs of life threatening diseases such as cancer or heart disease so that they can contact the appropriate services without delay. So the message to the patient in one area of the health sector is to go to the doctor as soon as a sign appears; and in another area of health sector the patient is asked not to waste the doctor's time with trivia.

The approach which assumes that lay people do or should share the same ideas as the providers about the way the service should be used contain an approach to knowledge which has been described as absolutist. Some of the properties of the official absolution are that:(4)

(i) all normal adequate persons interpret the world in exactly the same way so that the same meanings are assigned to all social events by members

(ii) the assignation of meaning is completely unproblematic so that everyone, in all situations, can know with certainty what is a correct or an incorrect interpretation

(iii) social meanings are thought to be external to individuals and therefore independent of intention, with an existence and

meaning in their own right.

Recent studies of illness behaviour[5] have suggested that a pluralistic approach as opposed to an absolutist approach would be a more realistic framework for understanding lay people's evaluation and response to illness experiences. These studies have shown that not only do patient and doctors' ideas and definitions differ, but patients have good reasons for differing with officially prescribed solutions. Patients have developed strategies which enable them to use the health service in a manner which meets their needs. Therefore, if the desire to incorporate some aspect of patient need within policy formulation is to be met (this desire came from professionals as well as those concerned to democratise the service), then it was necessary to adopt an approach which actually examined the use of the service through the eyes of the user rather than basing it on professional images of how the service ought to be used.

The objective of the study was to find out why and under what circumstances patients actually used the A and E department. Given the prevailing philosophy about appropriate usage generated by the providers, it became evident that questions such as "What enabled the patient to use the casualty department?" were as important as "Why didn't the patient use their general practitioner?"

9.2 Discussion of results

The intention of the study was to look at patients' needs. In fact, the study concentrated on patient demand which is patients' enacted needs. The legitimacy of using demand as the basis for policy formulation has been debated frequently but Lee,

in weighing up the costs and benefits of the approach, concludes on a practical note. He states:

> "To the local planner, faced with an infinity of needs, and the near impossibility of satisfying them all from resources available, the only certain information that he has is on the volume of demands at present made upon the service. Given that within the NHS the onus is almost always upon the individual to seek assistance, it can be argued that an understanding of the demand for health care is -at the very last - a necessary if not sufficient condition for planning health services. Indeed, only when demand patterns are understood can the planner be well placed to change them." (6)

Patient demand for the service was also used because it tended to identify actual as opposed to imagined or felt needs. The unpredictable nature of many of these events meant that hypothetical ideas about use would only portray a partial picture of demand or need. Such an approach was borne out by the substantial number of events which occurred outside the patient's own home or outside the patients' control.

Also in this study an attempt has been made to view patient demand for accident and emergency services in terms of the overall demand for acute health care services. Thus, as much emphasis is placed on patients' approaches to the use of the GP services as it is on use of the hospital A and E department.

The data which outlined the pathways that patients took to reach the A and E department clearly illustrated the vast range of different routes. In spite of this complexity it is possible to identify the most common pathways. In actual fact, there were three main routes. They were:

(i) patients or their close relatives who went directly

to hospital A and E departments

(ii) other people (not including patients and relatives) who referred the patient to hospital A and E department

(iii) General practitioners who referred their patients to hospital.

Table 9.1 shows the distributions for the three different groups but also divides them up into whether the site of the decision to seek medical care was at home or not. It was felt that such a distinction would present a more accurate picture of the circumstances surrounding the episode. In addition, there were some unsuccessful attempts to contact a GP and so they were also classified.

Overall, 22.3% of the patients attempted to contact their GP, although only 14.0% actually spoke to a GP either over the telephone or saw him at the surgery. The vast majority of this latter group were referred to the A and E department. 19.5% of the patients were referred directly to the A and E department by persons other than close relatives such as the police, teachers, employers, and bystanders. The vast majority of these events occurred outside the home.

The third group involves episodes where patients decided themselves or were told by close relatives to go directly to the A and E department and accounted for 42.7% of the cases. As the Table shows, about half of these patients came from their own homes and half went directly from a site outside the home.

So the A and E department seems to be providing a service for three different groups: GPs and their representatives, patients and their families, and official representatives of the community

such as the police or teachers.

The more significant questions which needed to be answered were why and when do these different groups use the A and E department. In the case of patients and their families and officials, it can be asked why they didn't use alternative sources of health care. The analyses suggested that two interrelated elements might be important influences on the decision making. They were: (i) the site of the decision to seek medical care and who made the decision; (ii) the type of condition that the patient suffered from. Before these two elements are discussed in more detail, it is necessary to discuss the role of the GP in referral.

9.21 The general practitioners and their representatives

These data can only partially portray the role of the GP in coping with acute episodes as the study focused on patients who attended the A and E department(6). However, the evidence does suggest that less than half of the patients who were successful in contacting the surgery actually saw their GP. In a further third of these cases the patient was referred to the A and E department by a person other than a doctor. In most of these cases the referral was made by a receptionist or sometimes a practice nurse.

It appears that some practices do have treatment rooms but more commonly they do not; and it appears that for cuts and suspected broken limbs the GP and his representatives see the A and E department as the most appropriate setting for treatment. The evidence suggested that receptionists played an important part in the primary health care team in that they decided what were

appropriate cases for the GP and what were not. It is difficult to judge how far the knowledge or "rules of thumb" procedures that the receptionist adopted were derived from her GP or from the prevailing view of the staff within the practice and how much they had been developed from her own commonsense knowledge. Certainly, the rule that all patients should contact their GPs before going to hospital appears to be one that is not adhered to by receptionists. Apart from some traumatic conditions not being seen to be appropriate, it seems receptionists also felt that emergencies should go directly to the A and E department. It seemed that emergencies were defined in terms of the time between the onset of symptoms and presentation for professional medical attention. If this time span was small, then the receptionist might define the episode as an emergency. Immediate medical care was warranted which usually involved referral to the A and E department. If this time span was large, for example a couple of days, then the receptionist would tell the patient to wait to see the GP and an appointment was made. This approach is one that is adopted by medical staff in other medical settings as a way of distinguishing those cases that require urgent medical attention and those that don't. It is difficult to tell how valuable this method of distinction is, although it does seem to penalise the "delayers". These "delayers" may have been the very people who have adopted the prevailing philosophy about not wasting the doctors' time by presenting with "trivial" complaints. These patients, after initially waiting and seeing what would develop, when the complaint began to incapacitate or became too painful, defined the event as an emergency.

It seemed that referral to the A and E department fulfilled two functions for the GP and his representatives. First, a referral was made because the GP was out on call and unable to treat that patient or the GP needed medical support in the form of tests such as x-rays. In many of these cases, the A and E department performed a complementary role in the form of providing a back-up service. Secondly, there were some cases where the patients could have been treated by their GPs, but the GP considered it inappropriate - for example, because"it was out of hours". In these cases the A and E department performed a substitutory role. The line between these two categories of function is difficult to draw. For example, some GPs and their staff treat cuts whereas others do not. So when a patient is referred by their GP for the stitching of minor cuts the A and E department is being used as a substitute but when a patient is referred by GPs who don't consider that stitching cuts is part of their role then the A and E department is fulfilling a complementary function.

9.22 Community and official representatives

The results showed that at least one-fifth of the episodes involved referral of patients to the A and E department by a person other than a close relative. In these particular cases the actual decisions to seek medical care were made by non-relatives. As might be expected, the vast majority of these episodes occurred in the community (not at home) and this was where the decision to seek medical care was made.

Various people with differing statuses were involved in referral. These included the police, teachers, employers, and people responsible for recreation areas. Each of these had some kind of official responsibility for the wellbeing of the sufferer. In some cases it was a legal responsibility and in others more of a moral responsibility. Other people were also involved in making referrals to hospitals such as bystanders or neighbours who had no official responsibility for the sufferer but a moral one. In these instances the ambulance was the primary source of medical help.

It appears that for those in official positions in the community such as policemen, teachers, and employers, the A and E department services as their focal point for medical care when they decide medical attention is needed. For each of these groups GPs seem to be an alternative only when they did not feel responsible for referral and the decision to seek medical care was seen to lie with the sufferer or sufferer's family. It seems that if immediate medical attention is perceived by these people as necessary then the A and E department is the source of medical care as GPs are not seen as accessible or relevant. Thus much hinges on these peoples' definitions of urgency.

It is clear that employers, policemen, teachers, and others in official positions vary in their health knowledge. All policemen have training in first aid, but some take more interest in it than others. In schools, first aid boxes or people trained in first aid are usually available, and the facilities for medical care vary according to the size of the school. Employers also

vary in the resources given over to first aid and medical care according to the size of the company. The larger companies have their own occupational health system with medically trained personnel available, such as nurses. In the more medium sized and smaller companies, a first aid box or first aid person is normally the most that is available. It appears that the police, some employers, and many schools do have access to a doctor, but these are seldom used in routine acute episodes. In the case of the police it appears that use of the doctor is financially costly.

So, in these circumstances, the decisions to seek attention at the accident and emergency department were usually made by people with a sprinkling of official health knowledge derived from first aid training and through previous experience of such episodes. It must be emphasised that for many of the people, particularly policemen, coping with ill-health and injury was a routine part of their working lives.

The sociological literature clearly showed that lay evaluation of ill health and injury varied according to the social context in which the evaluation occurred. The social context may influence the type of health knowledge that is available to the individual when evaluating the signs and symptoms and also it may influence the situational commitments of the sufferer and others involved in the evaluation process. Both these aspects were identified in this study. The different representatives clearly had ideas and theories about the meaning of signs and symptoms, and it was evident that these theories were used to interpret and make decisions about what course of action was necessary. In addition to

this quasi-official health knowledge, some of these representatives also had various situational commitments which were tied to their official positions and these commitments appeared to influence the way episodes were defined and the courses of action taken. In particular, the situational commitments influenced whether the sufferer should have immediate medical attention or not. For example, in the case of the police, their threshold of urgency seems to be coloured both by a certain moral responsibility which they attach to their position as a police office and pressures put on them by other aspects of their work. These pressures vary according to whether the episode is an accident or an episode where there was intentional law breaking. In the case of employers, the situational commitments involved taking into account the requirements of the company. Employers' threshold of urgency were coloured by the pressures to get employees back to work as quickly as possible or to minimise the inconvenience caused by disruptions. Finally, in the case of teachers in schools, emphasis was put on the legal position of being in loco parentis and the need to err on the side of caution.

For these "community" representatives, then, the evidence suggests that their focus of medical care is the A and E department and GPs are of limited significance. In addition, their situational commitments associated with their official position colour their perception of the need for medical care.

It is evident that the ambulance is the primary source of medical care in the case of bystanders. Their situational commitments seem to be coloured by a moral responsibility that they should do something and yet they do not want to get too involved,

as involvement may lead to complications and disruptions in the organisation of their everyday lives. It appears that such a philosophy leads to getting medical help for the sufferer but ensuring that this doesn't lead to too much disruption in personal life. The calling of an ambulance means an episode is solved immediately without too many complications. In fact,in some cases, the caller of the ambulance remained anonymous.

9.23 The sufferer and his family

The approach in this study was on understanding illness and accident behaviour in terms of a theory of interpersonal action, and so the emphasis in the analysis was on identifying who makes the decision to seek medical care and explaining why particular types of decisions were made. Thus, in this section, those decisions made by the sufferer and his family will be considered. However, it must be remembered that some of these decisions were made in circumstances outside the home and once again situational restrictions played a part in influencing decisions. Before these and other factors are discussed, it is necessary to describe some of the background information.

For the vast majority of families and individuals living in the area under study, their GP was their general focus for primary medical care, although many saw the casualty department as a secondary source of medical help. Only a very small percentage of the patients sampled didn't have a GP and only a small percentage of patients saw the hospital accident and emergency as their central source of medical care(7). This pattern could be explained by the semi-rural nature of the catchment population which presents

barriers to accessibility to the hospital or to the relatively uniform spread of general practices throughout the area. In inner city areas where conditions are different there is a much larger group of people who use accident and emergency departments as centres for primary care. In addition, there is the transient nature of the population living in the inner city areas where a much higher number of people are not registered with GPs.

Why then did people go directly to the accident and emergency department given (i) the barrier to hospital accessibility created by the great distances involved in travelling; (ii) the apparent availability of GPs; (iii) the apparent commitment of patients to their GPs?

The preliminary quantitative analysis [8] and the in-depth qualitative analysis suggested that the major influences on decisions to use the A and E department were:

(i) the nature of signs and symptoms

(ii) circumstantial elements

These two elements are clearly interrelated. For example, when decisions to seek medical care were made in the home, a general practitioner was more likely to be contacted than when the decision was made in the community. Pressure from other people and the extent of the sufferer's incapacity were both influential in the decision to go to the hospital when the episode occurred in the community. There appeared to be a widely held belief within the lay population that the hospital is the most appropriate source for medical help when an event occurs in the community.

One of the more interesting findings was that lay people didn't seem to discriminate between choice of medical care setting on the grounds of the perceived seriousness of the condition. However, lay people do seem to have clear ideas about the appropriate medical setting for different types of condition. For example, the comparison of cuts and illness showed that patients felt cuts should go to the hospital and illness to their GP. The majority of people who went directly to the hospital for illnesses did so for circumstantial reasons. In contrast, circumstantial elements played a less significant part in influencing choice of medical care settings for patients with cuts as they clearly felt that GPs do not or could not deal with that type of complaint. The vast majority of patients with either minor cuts or minor illness defined their events as emergencies. It appears, also, that the majority of patients go to the hospital for conditions they regard as emergencies. The visibility of signs such as blood and the fear of developing serious and disfiguring illnesses such as lockjaw were some explanations given by lay people in assessing the seriousness of their cuts. In the case of minor illnesses, it was the inability to explain the disturbances in body functioning that frightened people. Sufferers could not account for their symptoms in terms of the framework of knowledge which was available to them.

Patients with minor cuts tended to self-diagnose and to choose between medical care settings on the grounds of the presence of appropriate medical facilities. Assessments of the appropriate place for treatment was also influenced by perceived

costs to patients in terms of wasted time. There were also the costs of upsetting their doctor with a condition which he might regard as a waste of his valuable time. Some patients emphasised the need to take "trivial" complaints to the hospital as the hospital was anonymous and thus it wouldn't have implications for the relationship with their GP. Only a small number of patients adopted the practice of routinely contacting their GP for everything. Thus, waiting at casualty is much preferred to waiting for the GP to be available. Once the process of self-diagnosis or lay diagnosis has taken place and the decision to seek medical care is made, then the most convenient place for treatment in terms of time and accessibility is sought. In the cases involving minor cuts, lay people appear to make calculated decisions about the appropriate source of medical care. In the case of illness, self-diagnosis or lay diagnosis is more problematic and GPs are seen to be more legitimate sources of advice and care. In the cases involving illness, costs of time and accessibility are much less important than receiving satisfactory and detailed information about the diagnosis and prognosis of the condition. The person with a cut, because he or she is able to self-diagnose, appears to retain some control over his or her body and does not necessarily become dependent on medical advice. In the cases involving cuts, technological expertise is required, but only on a short-term basis. On the other hand, illness involves uncertainty among patients about what is wrong and what the implications of their problems are. Thus, in these cases, the sufferer may find it necessary to enter into a dependent position in the doctor-patient relationships so as to obtain further information

about their conditions.

9.24 Summary and implications for the study of accident and illness behaviour

The evidence from this study suggests that patients either are referred to an A and E department by GPs and their representatives, or by official or community representatives or go to the hospital on their own or their family's initiative. Each of these three different groups has different types of reason for using the hospital service.

The theoretical implications of this evidence for the study of illness and accident behaviour are various. First,up until now in the study of patient demand for emergency services, the role of others in influencing patterns of illness and help-seeking behaviour has been neglected. This has not been the case in the general sociological field of illness behaviour where, in recent years, the importance of significant "others" and social networks has been emphasised. However, significant "others" and social networks have been employed to study the illness behaviour of the individual in his or her domestic setting. This study has clearly highlighted the influence of lay others (strangers and neighbours) and officials on illness behaviour and help-seeking behaviour in situations away from the home. This is a much neglected area and the study has highlighted the various pressures or forces that impinge on how individuals cope with episodes which occur outside their domestic environment, particularly when that person does not have available to him or her those coping strategies which are available in their domestic environment. The evidence from this study also showed that these

situations brought with them a whole set of priorities which influenced the interpretation of the patient's condition. Alonzo[9] suggested that certain types of situational commitments inhibited the decision to seek medical care being made. This study highlighted episodes where the situational commitments of various lay "others" and officials, through their assessment of the need for urgent medical attention, tended to promote the seeking of medical care. While Dingwall[10] suggested that lay interpretative processes could be short-circuited by certain types of "public" episodes, he neglected the importance of the influence of the"non-medical" elements that occur in these settings. There is a need for sociological research to further investigate the nature of illness behaviour in settings outside the domestic environment, particularly in institutions such as prisons where the influence of moral and socio-legal factors might be important.

Secondly, it appears that the nature of signs and symptoms and their interpretation are significant in the assessment of the need for medical help and the choice of medical care setting. Distinctly different patterns of action were found for different signs and symptoms. In the case of illness, the decision to seek medical care seems to have been made when the sufferer and significant others could no longer explain what the trouble was. In these cases, the sufferer or significant others could not develop ways of coping with or accounting for the disturbance within their framework of everyday knowledge. In contrast, with trauma and cuts, in particular, the sufferer tended to make self-diagnoses and assessments of severity based on their own theories, which resulted in many of these cases seeking care immediately. The major-

ity of both illness and injury cases were defined as "emergencies", although the "illness" group tended to define an "emergency" in terms of an urgent need for information or explanation of their problems, whereas the "injury or cuts" group tended to define an "emergency" as an urgent need for medical treatment. The importance of the interpretation of signs and symptoms for explaining patterns of illness action has, until recently, been much neglected. Some sociologists, in their haste to move away from an approach dominated by the medical model, have tended to highlight the social factors which influence differences in perception of symptoms rather than concentrate on the meanings that lay people give to disturbances in body functioning. This comparison between the action of patients with "illness" and those which "injury" is a useful method for identifying the specific features of behaviour associated with specific complaints. It might be a valuable way of developing a more general and coherent model of illness action.

Thirdly, apart from the association between the circumstances in which the episode occurred and the choice of medical care setting, the study showed that in contexts where sufferers and significant others do have control over decisions to seek medical care, then decisions are based around strategies that may have previously been designed to cope with such an occurrence. For example, in cases where the patient with a minor cut was not restricted by situational elements, the first choice for medical care was the hospital. These decisions were usually based on considerations about the availability of facilities, the availability

of the doctors, the amount of time and resources involved, and the long-term implications of the disruption of their relationship with their GP. Apart from these specific conditions, it was evident that, amongst this group of patients, the vast majority saw their GP as the focal point for medical care and preferred it that way. These findings have implications for the study of doctor-patient relations. Sufferers with "illnesses" tended to be willing, at least initially, to adopt the traditional patient position and defer to what they believe to be superior medical knowledge. On the other hand, patients with traumatic conditions such as cuts tend to know what is wrong with them, have a reasonable explanation of why they are suffering from this complaint, and appear to have specific ideas about the treatment required. Such an active and knowledgeable patient seems to be the opposite of what has been traditionally portrayed in doctor-patient relations. This patient seems to fit with the consumerist approach to patienthood which emphasises the need to be active and critical and seems to conflict with what doctors tend to define as a "good" patient. Thus, models of doctor-patient relations should be extended to embrace this particular type of patient and examine the implications for doctor-patient relations. It may also account for some of the apparent tension between doctor and patient in hospital A and E departments. Not only does the professional have no formal control over patients' accessibility to the service, but also a group of patients do not fit into the typical patient position of being deferential to medical knowledge.

Finally, one group of patients was referred to the A and E

department by their GP or his representatives. Previous studies have emphasised the power of the receptionist in controlling access to and rationing resources[11]. Evidence from this study illustrated the role of the receptionist in defining what was and what was not an appropriate condition for the GP to see and how their decisions had considerable implications for the patients' pathway to medical care. This area is one which has also been neglected in the study of illness behaviour and needs to be accounted for if there is to be a clear understanding of why people appear to "choose" certain health care facilities. The evidence suggests that GPs use the A and E departments for different purposes, some of which are not in accordance with how hospital staff think that the department should be used. In some cases it appears that, in contrast to the traditional role of the GP protecting the hospital doctors' professional autonomy through control of referral, the hospital accident and emergency department provides alternative facilities when the GP uses strategies to control his autonomy. Research investigating GPs perceptions of the functions of the A and E department might prove valuable in understanding further the relationship between the hospital and the GP.

9.3 Implications for Policy

In recent years sociologists, amongst others, have continually exhorted policy makers involved in providing and organising the health services to take account of the needs of the patient. The problem has been that too often policies have been dominated by professional interests and the patient has lacked the political

resources to be influential. Even when professionals did begin to see the importance of taking into account patients' interests the framework which was used was always dominated by providers' stereotypes of the professional-client relationship with the client being in the dependent role.

In the case of the accident and emergency service the structural characteristics of the A and E department have meant that attempts by professionals to create patient dependence through traditional strategies have not always been successful. Informal controls and barriers do exist, but they do not appear to be as strong as those in other medical settings. As a result, compared with other areas, provider-patient relationships in the A and E departments appear to manifest tensions and strain. Professional groups have made attempts to ease these tensions and still maintain control by proposing policies which appear to take into account the position of the patient. These policies appeared to represent a clear recognition by the providers that the traditional professional-client relationships which was common in other hospital settings did not fit easily into the A and E setting. The problem with the policies proposed by the profession was that although they emphasised patients' predicaments they are couched in terms of assumptions which attempt to reinforce the dependent position of the patient and the dominant position of the doctor. The philosophy was that lay people's interests should not be the criteria on which the organisation of the hospital department should be based, although one aspect of patient need was taken into account.

There was a clear need for a policy which incorporated the view of the patient because present policies contained contradict-

ory expectations about patient behaviour. This study attempted to move away from explaining patient needs in terms of professional ideology towards examining patient needs in terms of actual patterns of patient demand.

The more traditional approach to the organisation of the A and E services emphasised the need to develop a clinical specialty in A and E medicine. It was envisaged that patient access to the department would be controlled by professional colleagues. This policy seems to conflict markedly with the manner in which the department is actually being used. Even GPs and their representatives, according to this approach, would be misusing the department in that they make referrals for social as well as clinical emergencies. In addition, the two other groups that use the service - patients and their families and community or public officials - use the service for a set of reasons which are circumstantial and based on ideas about the most appropriate place for treatment for certain conditions. In many cases, the patient has no choice but to go because of situational factors such as being referred by the police or by teachers. In these cases the urgency of the episode is coloured by the nature of the situation itself. In other cases it is evident that patients clearly believe that their conditions warrants emergency attention and the hospital is the best place to go. As some patients do take their injuries direct to hospital, then the policy approach which argues that the hospital should be the centre for <u>accident</u> and emergency medicine might be suitable. However, it certainly does not take into account the circumstantial element which might mean any type

of condition could arrive at casualty. It does not take into account either that medical definitions may be completely different from lay definitions, and thus what is seen by the doctor as trivial might be seen by the patient as an emergency. This conflict in perspectives is not a new finding, but it clearly illustrates the futility of policies which try to teach the patient, through health education, to use the health service properly. It is asking a great deal to expect the patient or proto-patient to be able to distinguish between trivial and serious conditions, given the wide variation in knowledge among lay people as well as the wide variation in the social circumstances in which signs and symptoms are evaluated. In addition, it is evident that doctors themselves have trouble in agreeing amongst themselves in the identification and interpretation of of signs and symptoms.

It is clear that this type of policy can only work if access to the hospital department is controlled by professionals who share the same ideas as those who provide the service about its appropriate functions. The evidence suggests that at present such an approach is incompatible with the way lay and professional people use the department.

In the introduction, the Casualty Surgeon's Association's approach (CSA) was described in detail, and it became clear that in contrast to other medical groups involved in the area of casualty medicine, they saw the casualty doctor as specialising in "generalist" medicine. This "generalist" would complement the other

"generalist", the GP, in the supply of primary care services. Unlike the other medical groups who wished the department to develop on parallel lines to other outpatient departments with an emphasis on developing clinical specialty and patient access to the department being controlled by professional colleagues, the CSA's approach appeared to be more accommodating to patient needs. The CSA appeared to be willing to extend their work to include patients or others in the community who are in "social predicaments" - i.e., those people who had no realistic alternative but to go to the hospital. They proposed that patients should routinely go to their GP for all matters of health, including traumatic conditions, but only when these routines are disrupted (i.e., in an emergency) should the hospital be used.

In one sense this approach is sensitive to patient needs in that in this study two-fifths of the new patients came directly to hospital from a "community" situation. However, in another sense, the CSA may wish to develop the specialty of the "community emergency" service and so to control the patients' access to the department and to exclude those patients who are not in "emergency" predicaments and who have bypassed their GP. In inner urban areas there is evidence that casualty departments are being used "as family doctors" by some groups. However, in this study only a very small proportion of patients said that they went to the hospital routinely for all types of ill-health and only 3% were not registered with a GP.

It appears that in the particular geographical area where the study was carried out, the majority of the population use the GP

as their central focus for health care which appears to suit the requirements of the CSA's proposals. However, evidence from both the circumstances that led patients to utilise the hospital in the case studies and from patient responses to hypothetical questions about their choice of medical care systems for a variety of complaints shows that for particular traumatic conditions the hospital is seen as the most appropriate place for medical care. In addition to this and connected with the latter point, is the fact that some patients perceived their complaint as warranting urgent medical attention and the hospital was the most appropriate place to go for these cases. In other words, there is a group of patients who utilise the hospital specifically for treatment of certain types of condition which they believe require immediate medical attention and they believe that their GP is inaccessible or unavailable.

The CSA may define this latter type of attender as an illegitimate user of the service. They might argue that irrespective of the type of complaint or the perceived severity or urgency with which medical attention is required, this group should make an attempt to contact a GP. The legitimisation of patient utilisation of the department on the basis of lay diagnostic criteria would, according to the CSA, lead to a system similar to the "polyclinics" found in urban areas in Russia where ambulatory care is available in clinics attached to hospitals[12]. This would put the hospital doctors at further risk of low professional prestige with its attendant staffing difficulties. They are also, for similar reasons, against the proposed rationalisation of GP services leading to GPs

being situated in health centres or hospitals.

The evidence from this study suggests that the reasons for self-referral did not seem to be linked with patients becoming more hospital oriented in terms of their preference for high technological medicine, as was speculated upon in the introduction but that patients no longer felt it worthwhile attempting to contact a GP in situations where medical treatment was needed for certain types of conditions. This belief about the inaccessibility or the unavailability of GPs does seem to be a realistic one (just over a third of patients who attempted to contact a GP never spoke to or saw him). Also, more patients seem to be concerned about wasting their GPs' time than the hospital's time which seems to suggest that GPs seem to be of more value to the patient than the hospital. Certainly, some patients didn't seem to want to jeopardise their relationship with their GP. While Roth[13] seems to be accurate in his suggestion that patients have yet to understand the "non-urgent" function of the department (not many deliberately went for non-urgent conditions or minor illness), patients do seem to be willing to risk conflict or upset in negotiating access to the A and E department as opposed to their GP. The A and E department does seem to be used by patients for specific complaints only (apart from when they have no choice), although whether this is due to some form of complaince with official philosophy or because patients genuinely prefer to contact their GP for most other matters concerning health is difficult to judge.

The findings suggest that the A and E department may present more disadvantages for the professional in developing autonomy than it creates advantages for the patient. In the introduction it was

argued, at least from a theoretical point of view, that the accident and emergency department could be described as being more patient-centred than most medical settings. The evidence suggests that the patient centredness of a medical setting varies with patient needs. In this case, the setting is appropriate for efficient and dehumanised care when the patient has self-diagnosed and is in relative control of their complaint. On the other hand, in situations where patients are more uncertain and more dependent, the GP might be more important.

There are, therefore, weaknesses in each of these policies in terms of their failure to reflect how the A and E department is actually used. The CSA were the most realistic in recognising the futility of attempting to use professional controls to limit access. They quite accurately identified some aspects of the needs of the community, particularly those of employers for whom the A and E service is a substitute for, or an extension of, the occupational health service (14). This could also apply to the school and to the police. The integration of these services into one seems, at least at present, an efficient way of coping with emergencies in the community.

The system as proposed by the CSA might operate effectively if GPs would accommodate to the role prescribed to them: i.e., providing a 24-hour emergency service for the patient and his family. The problem is, however, that patients believe (and this appears to be a realistic belief in some cases) that GPs do not provide a 24-hour emergency service and they also do not treat certain complains, such as lacerations. It is widely felt amongst the general public and possibly among GPs that the hospital is the appropriate place for the treatment of trauma.

A number of policy questions arise out of this discussion. First, should the GP be asked to provide a 24-hour emergency service which includes provision of facilities for the treatment of minor trauma? Secondly, if this is the case, how would GPs be encouraged to revert back to this role and would patients want this? Thirdly, if the GP relinquished his emergency care function, would the hospital take over the role as the only source of emergency care?

It appears that patients do actually use their GP in emergencies which involve certain types of condition. However, the problem is that the education and training of GPs appears to be moving away from emphasis on the treatment of acute conditions to involvement with the patient as a whole. Lately, the preventative aspect of the GP's role has been emphasised. Thus, conditions requiring immediate medical treatment might prove disruptive to attempts to organise the service so that the doctor has more time with their patients. The treatment of minor trauma appears to be troublesome for the GP due to disruptions in routine and time lost, as well as sometimes not having appropriate skills and facilities. Patients seem to prefer to take traumatic conditions directly to hospital, although their preferences are in part based on the knowledge that their GP would not and could not treat their injuries. It is difficult to judge whether patients who were given an alternative would still choose to go to hospital. It appears that the patients' present image of the GP is less of a technician and more of an advice-giver or counsellor. This image is one which GPs seem to be trying to promote. It does seem that the present approach adopted by general practitioners is incompatible with the development of a role in emergency care, particularly with respect to the

treatment of trauma, although there are a number of policy options which might be of significance. One option involves the possibility of giving GPs financial incentives to provide facilities for the treatment of minor trauma. The development of health centres and group practices might aid the availability of such facilities as would the delegation of powers to practice nurses to treat patients without requiring doctors' supervision(15). In the latter case, the GP would not have to be retrained in skills which he might no longer want.

This community based approach would appear to be the best policy as the provision of a complete emergency service in the hospital would mean that the casualty service would be integrated with the emergency service. From the patients' point of view, such a development would be suitable for some conditions but not for many others. The bureaucratic and technological procedures adopted in hospitals are not conducive to the development of a type of doctor-patient relationship which many patients, particularly with illnesses, require.

In summary, it appears that the Casualty Surgeon's Association's propositions about the way the emergency service should be organised appear to be the most realistic of the approaches available. However, the major weakness in their approach is the assumption that GPs should perform the role traditionally expected - i.e., coping with all the family's complaints. The GPs' actual role has changed dramatically, which means that the intended complementary role of the GP and the hospital has now become a substitutory role on many occasions. There is little those involved in running the casualty service can do about this, given the struc-

tural characteristics of their departments, apart from develop further policies which might extend the primary health care teams' role in emergency care without compromising the GPs' new approach. At present, both the patients and the GPs are not complaining about the use of the A and E department for the treatment of minor trauma. However, the patient may not be as accepting if the GP reduced further his emergency are function, particularly in relation to the treatment of acute illness.

Table 9.1: Status of person who made the decision to seek medical care, site of decision to seek medical care and attempt to contact a G.P.

	No.	%
Decision to seek medical care made by patient or by patient's close relatives at home - no attempt to contact a G.P.	137	21.8
Decision to seek medical care made by patient or by patient's close relatives at home - unsuccessful attempt to speak to G.P.	39	6.2
Decision to seek medical care made by patient or by patient's close relatives at home - spoke to and/or saw G.P. before going to hospital.	57	9.1
Decision to seek medical care made by other person at home - no attempt to contact a G.P.	20	3.2
Decision to seek medical care made by other person at home - unsuccessful attempt to speak to a G.P.	1	0.2
Decision to seek medical care made by other person at home - spoke to and/or saw a G.P.	3	0.5
Decision to seek medical care made by patient or by patient's close relatives at site outside home - no attempt to contact a G.P.	131	20.9
Decision to seek medical care made by patient or by patient's close relatives at site outside home - unsuccessful attempt to speak to a G.P.	5	0.8
Decision to seek medical care made by patient or by patient's close relatives at site outside home - spoke to and/or saw G.P.	16	2.5
Decision to seek medical care made by other at site outside home - no attempt to contact a G.P.	102	16.2
Decision to seek medical care made by other at site outside home - unsuccessful attempt to speak to a G.P.	7	1.1
Decision to seek medical care made by other at site outside home - spoke to and/or saw G.P.	12	1.9
Not answered	98	15.6
Total	628	100%

Footnotes

(1) For example see Fourth Report from the Expenditure Committee Accident and Emergency Service, H.M.S.O., Vol.I, 1974.

(2) For example, see results of a survey carried out and published by Annual Report, Kensington, Chelsea and Westminster (South) Community Health Council, 1977, p.12. This report states:

"Patients' assessments of emergency arrangements were not enthusiastic. About half thought they were good, for the rest comments varied from 'allright' to 'downright bad' ...It is clear that the system for providing emergency cover needs to be reviewed".

(3) See R.C.G.P., Present state and future needs of general practice, 3rd Edition, 1973. This report states:

"Patients appear concerned that barriers to their doctors have been introduced by way of appointment systems, secetaries, rotas and emergency-call services and over ready referral to hospitals", (p.57). See also Patients Association, "The personal doctor - a vanishing species? privacy - a vanishing right?", press release, 1972, 10 Jan. Arber S., The General Practitioner, 7 March, 1978, p.9.

(4) Cardew, B., "An appointment system service for general practitioners: its growth and present usage", B.M.J. 1, 1967, pp.736-738. See also The State of the Public Health, D.H.S.S., H.M.S.O., in which the Chief Medical Officer of D.H.S.S. stated that the 50% increase in new patients seen at hospital accident and emergency departments between 1959-70 was being attributed by some hospitals in several regions to the operation of some appointment systems making it difficult or even impossible for patients to see their own doctors at short notice. See also Report of the Joint Working Policy on General Medical Services, H.M.S.O., 1974, pp.13-15.

(5) R.C.G.P., Present State and Future Needs of General Practice, 3rd Edition, 1973, p.57.

(6) For example, see Kensington, Chelsea and Westminster (South), Annual Report, Community Health Council, 1977, p.15, which states:

"It also emerges, and this is confirmed by the experiences of the hospitals, that the Accident and Emergency Departments are providing back up emergency cover. One man commented 'It's terrible, you can only telephone during surgery hours, otherwise, you don't know who to turn to as no-one knows where he lives. You have to go to St.Stephen's casualty' or 'It

worries me. I think I would phone 999'".

(7) Cartwright A., and Anderson,R., Patients and their Doctors, Occasional Paper 8, R.C.G.P., March 1979, p.17; Patel, A.R., "Modes of admission to hospital: a survey of emergency admissions to a general medical unit", B.M.J., 1971,pp.281-283. In some inner city areas, providers have been concerned with the "social problem" of use of A and E departments by the homeless, alcoholics, and vagrants as a source of primary care. See Leighton, J., "Primary medical care for the homeless and rootless in Liverpool", Hospital and Health Services Review, August,1976, 266-7.

(8) See The Politics of Health group's pamphlet, Cuts and the N.H.S., Chapter 4, 1974, p.21, which states:
"In many inner city areas primary care provision is poor and hospital casualty departments are used to provide some of the primary care facilities. For this reason, among the major demands of many closure campaigns is one to keep Casualty Departments open". In spite of this, Bethnal Green and other hospitals have been closed.

(9) Central Health Services Council, Accident and Emergency Services, Report of the Sub-Committee, H.M.S.O., 1962.

(10) Central Health Services Council, Functions of the District General Hospital, Report of the Committee, H.M.S.O., 1969. See also "What are accident and emergency departments for?", B.M.J., 6 October, 1979, pp.837-839.

(11) British Orthopaedic Association, Casualty departments - The Accident Commitment, 1973.

(12) Casualty Surgeon's Association, An Integrated Emergency Service, CSA, 1973.

(13) This was one of the topics which was central in the discussion at a seminar held at the King's Fund Centre in 1979, which was entitled, "Use, abuse and misuse of Accident and Emergency Departments".

(14) A vast amount of literature has been written lately about doctor-patient relations. Some studies have particularly focussed on tensions, strains and conflicts. For example Freidson,E., The Profession of Medicine, Dodd and Mean, N.Y., 1975, Chapter 14, pp.302-331, and Bloor, M.J. and Horobin,G.W., "Conflict and Conflict Resolution in doctor-patient interactions", A Sociology of Medical Practice (eds. Cox,C. and Mead, H.),

Collier-Macmillan, London, pp.271-284.

(15) Freidson, E., The Profession of Medicine, Dodd and Mead, N.Y., 1975, Chapter 4, pp.71-108.

(16) This approach to professions and professionalisation is a recent development and stands in marked contrast to the functionalist approach. Freidson's approach has been developed by a number of different authors more recently. For example, see Parry, N. and Parry,J., The Rise of the Medical Profession, Croom Helm, 1976, and Larson, M.S.,The Rise of professionalism, a sociological analysis, California,1978, pp.19-39. However, these sociological accounts have tended to concentrate on the ability of various occupational groups to attain and maintain professional status. Little attention has been paid to how subgroups within a profession compete for status.

A major problem for the researcher in this area is to attempt to apply the concept of profession to the everyday practice of medicine. The argument in this chapter is based on the assumption that there exists a community of doctors who are strongly influenced by ideas which are derived from professionalisation. The ability to perform professionally is, in turn, influenced by the structural characteristics of the setting in which doctors work. Obviously, this explanation by itself is over general in that doctors' actions can be influenced by age, sex, type of training or style of practice, amongst other things. However, it can still be argued that the structural setting in which casualty medicine has been practised may have been one of the factors which was influential in the development of this service and that the limitations that it brings to professionalisation may be one of the reasons why, compared with other areas of hospital medicine, it was slow to develop.

(17) For example, in the U.S. doctors are much more dependent on their clients' demands for their services than in a socialised medical care system. Thus, establishing a "good" reputation in the eyes of clients within a system of private medical care as well as providing a means for attaining professional autonomy. For more details of the position of the doctor in the U.S. compared with the position of the doctor in G.B. see Strong, P.M.,The Ceremonial Order of the Clinic, Rand K.P., 1979, p.247.

(18) Cang, S., "Structural aspects of doctor-patient relations", Health Services (ed. E. Jacques), Heinemann, London, 1978, pp. 53-68.

(19) Gunawardena, A.and Lee,K., "Access and Efficiency in Medical Care: A Consideration of Accident and Emergency Services",

Conflicts in the National Health Service, (eds.K.Barnard and K.Lee),1977, p.52.

(20) Roth, J.A., "Utilisation of the Hospital Emergency Department", Journal of Health and Social Behaviour, 12 Dec.,1971,pp.312-320.

(21) Robertson, L. et al, Changing the Medical Care System, Praeger, N.Y.,1974, p.6.

(22) Holohan, A.,"Illness and Accident Behaviour", The Sociology of the N.H.S. (ed. Stacey, M.), Sociological Review Monograph, 22, 1976, pp.111-119.

(23) Freidson, E., The Profession of Medicine, Dodd and Mead & Co., N.Y., 1975, pp.71-108.

(24) Navarro,V., Social Security and Medicine in the U.S.S.R.: A Marxist Critique, Lexington Books, D.C.Heath,1977,p.150.

Shortell, M., "Occupational prestige differences within the Medical and Allied Health Professions", Social Science and Medicine, 8, 1974, pp.1-9.

Shortell, in an analysis of prestige differences between medical specialties, suggests that the possible explanation for the existence of prestige differences may lie within the nature of the doctor-patient relationships rather than in functional autonomy. Those specialties that lead to a model of the doctor-patient relationship being of the activity-passivity type were more likely to be prestigious than those where the doctor-patient relationship is of the guidance-cooperation type or the mutual participation type. Shortell suggests, however, that the functional autonomy (defined in terms of the degree that the speciality is impinged upon by other specialities) is of less significance and may be more useful in explaining differences in prestige between professions and occupational groups. Even if these findings are accepted, Shortell's definition of functional autonomy is very limited. Patient dependence can be created not only as a result of the nature of the illness involved but also as a result of the structural and interactional characteristics of the doctor-patient encounter. For example, informational control can create patient dependence and this is more likely to occur in a hospital setting where the patient has been referred by a GP, lay definitions are not taken into account and negotiation is limited.

See Bloor, M.J.,"Professional autonomy and client exclusion: a study in ENT clinics", Studies in Everyday Medical Life , (ed. Wadsworth,M. and Robinson,D.), Robertson,M.,1976,pp.52-68.

Freidson, in his analysis, suggests that professional standards (ethical and technical) and its associated prestige may be dependent on the structural contingencies of the practice setting. He suggests that the more the practice is dependent on client control the more likely professional standards will be low. The opposite would be so for colleague-dependent practices and professional standards in those situations may be higher. E. Freidson, Profession of Medicine, Dodd and Mead,1975, pp.106-7.

(25) Roth,J.,"The Treatment of the Sick", Poverty and Health: A Sociological Analysis, (eds. Kosa J. and Zoka, I.K.), Harvard University Press, Cambridge, Mass.,1975,pp.214-43.

(26) Robertson et al, Changing the Medical Care System, Praeger New York, 1974, p.6.

(27) Freidson, E., The Profession of Medicine, Dodd and Mead, N.Y., 1975, p.105.

(28) Gibson, H., "The Dressing Clinic in an Accident and Emergency Department", Relationships between doctors and patients, (ed. Davis A.) Saxon House, 1978, p.13.

(29) For example see Macintyre, S., "Obstetric Routines in Ante-Natal Care", Relationships between doctors and patients, (eds.Davis,A.) Saxon House,1978, pp.76-105.

(30) See Gunawardena, A. and Lee, K., "Access and Efficiency in Medical Care: A consideration of Accident and Emergency Services", Conflicts in the N.H.S., (eds. Barnard, K. and Lee, K.) Croom Helm, 1977, p.58.

(31) Fry, J., Trends in General Practice, R.C.G.P.,1977, p.95.

(32) See Gunawardena, A. and Lee, K., "Access and Efficiency in Medical Care: A consideration of Accident and Emergency Services", Conflicts in the N.H.S., (eds. Barnard, K. and Lee, K.) Croom Helm, 1977, p.58.

(33) R.C.G.P., Report on Second National Morbidity Survey,1976, p.35. They state,when comparing the 1955-56 and 1970-71 studies, that

"...the equivalent increases in attendances at casualty departments where the majority of patients bypass their general practitional is 76%". The report also suggested that GPs were seeing proportionately less accident cases in 1970-71 than in 1955-56.

(34) See Forsyth, G. and Logan, P., Gateway or Dividing Line?- A Study of Hospital Outpatients in the 1960s, O.U.P. for N.P.H.T., 1968, p.123.

(35) Abson, E., History of the Casualty Service, forthcoming, for detailed information on the division between general practitioners and hospital doctors; see Honigsbaum, F., The Division in British Medicine, Kogan Page, Ltd.,1979.

(36) Wadsworth, M.E.J., "Towards Perspective in Medical Care Research", Social and Economic Administration, 1968,pp.106-115.

(37) Abson,E., History of the Casualty Service, forthcoming.

(38) Strauss, A. et al, "The hospital and its negotiated order", The Hospital in Modern Society, (ed. Freidson,E.) Free Press of Glencoe, N.Y., 1963, pp.147-69.

(39) National Provincial Hospital Trust, Casualty Services and their Setting, O.U.P., 1960, p.34.

(40) Ibid., p.131.

(41) Jeffereys, R., "Deviant patients in casualty departments", Sociology of Health and Illness, 1,1, 1974, pp.90-107. See also Roth, J., "Some contingencies of the moral evaluation and control of clientele", Amer.J.Soc.,77, 1972,pp.5-11, also Roth, J., "Staff and Client Control Strategies in Urban Hospital Emergency Services", Urban Life and Culture,1,1972, pp.39-60.

(42) Gibson, H. "The Dressing Clinic in an Accident and Emergency Department", Relationships between Doctors and Patients, (ed. Davis,A.), Saxon House,1978, pp.12-28.

(43) Roth, J., "Some contingencies of the moral evaluation and control of clientele", Amer.J.Soc.,77, 1972, pp.5-11.

(44) See Schwartz,B., Queuing and Waiting, studies in the social organisation of access and delay, Chicago, London, Univ.of Chicago Press,1975.

(45) Abson,E., personal communication, 1979.

(46) During the early 1960's, a course in Accident and Emergency Medicine for nurses was introduced. This gave only the nurses that had followed this course the right to decide the type of treatment that patients should have. Royal College of Nursing, personal communication, 1980.

(47) Abson,E., personal communication, 1980.

(48) N.P.H.T., Casualty Services and their Setting, O.U.P.,1960,p.30.

(49) Ibid., p.30.

(50) Ibid., p.30.

(51) Ham,C., "Power,Patients and Pluralism", Conflicts in the N.H.S., (eds.Barnard,K. and Lee,K.), Croom-Helm, 1977, p.101.

(52) British Orthopaedic Association, Second Memorandum of the Casualty Services, 1959.

(53) Central Health Services Committee, Accident and Emergency Services, Report of the Sub-Committee, H.M.S.O.,1962,p.10.

(54) National Provincial Hospitals Trust, Casualty Services and their Setting, O.U.P.,1960.

(55) British Medical Association, Report of the Review Committee on the Accident Services of G.B., B.M.A.,1961.

(56) National Provincial Hospitals Trust, Casualty Services and their Setting, O.U.P.,1960.

(57) Abson, E., personal communication, 1980.

(58) Scott, J.C., "The Development of the Accident Services, in Accident and Emergency Services", British Health Care and Technology, 1973, p.9.

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It could be argued that this apparent change in the proportion of new patient attenders at a casualty department who were self-referrals may reflect not so much an increase in self-referrals as a real decrease in GP referrals. This argument is doubtful given the apparent lowering of the threshold of referral by GPs, particularly in cases which may have socio-legal significance and referral for x-ray may be the most appropriate course of action in certain of these circumstances.

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Firmer evidence to support such a trend would be a change in the clinical case-mix of new patient attenders at accident and emergency departments. Evidence to test this proposition is difficult to find. In some areas the local indigenous population have always seen the local hospital as a source of primary care. For example, see Report of Accident and Emergency Working Party, Medway, 1978. See also Pedor,H. et al, "Coronary Heart -attacks in East London", Lancet 2,1975, pp.833-838. See also O.P.C.S., Access to Primary Care, H.M.S.O.,1979.

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For concise account of the development of the GP service up to the GP charter, see six part series of articles by R.Gibson, Pulse, 38, 1979, 28 April onwards. Also, with regard to treatment of minor surgical cases in general practice, the setting up of the N.H.S. may have taken the incentive away from the GP's in that they no longer had to depend on patient consultation for payment for their services. In addition, the remunerations given for the carrying out of other specialist activities such as provision of maternity services may have been a disincentive for involvement in the treatment of trauma. Certainly GPs have to pay for sterile supplies used for treatment of cuts. Some GPs have recently argued for remuneration for the provision of casualty services in their surgery or cottage hospitals. These doctors feel compelled "to provide casualty care because of isolation from casualty departments" (see Letter to B.M.J. by Leverton, M.J., "GPs and casualties", 3,March, 1979, p.625). It is interesting to see the use of the word "compelled" which implies that the treatment of casualties for GPs is work that is unattractive and not seen as being central to their role. In contrast, a small group of doctors calling themselves B.A.S.I.C.S. have become more positively involved in emergency care and have developed procedures for the attendance of and treatment of emergency victims on site. Many of this group are GPs working from surgeries. The therapeutic value of this work compared with alternative forms of emergency care is still in doubt. See Dooley,A. and Lucas,B.G.B., "The evaluation of emergency care", Annals of Royal College of Surgeons of England, 60, Nov.1978, pp.451-6.

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(80) For concise account of the development of the GP service up to the GP charter,see six part series of articles by R.Gibson, Pulse,38, 1979, 28 April onwards. Also, with regard to treatment of minor surgical cases in general practice, the setting up of the N.H.S. may have taken the incentive away from the GP's in that they no longer had to depend on patient consultation for payment for their services. In addition, the remunerations given for the carrying out of other specialist activities such as provision of maternity services may have been a disincentive for involvement in the treatment of trauma. Certainly GPs have to pay for sterile supplies used for treatment of cuts. Some GPs have recently argued for remuneration for the provision of casualty services in their surgery or cottage hospitals. These doctors feel compelled "to provide casualty care because of isolation from casualty departments"(see letter to B.M.J. by Leverton,M.J., "GPs and casualties", 3 March 1979,p.625). It is interesting to the use of the word "compelled" which implies that the treatment of casualties for GPs is work that is unattractive and not seen as being central to their role. In contrast a small group of doctors calling themselves B.A.S.I.C.S. have become more positively involved in emergency care and have developed procedures for the attendance of and treatment of emergency victims on site. Many of this group are GPs working from surgeries. The therapeutic value of this work compared with the alternative forms of emergency care", Annals of Royal College of Surgeons of of England, 60, Nov.1978, pp.451-456.

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(92) Unlike GPs, the casualty doctors, while accepting a social element in the definitions of why patients still attend hospital accident and emergency departments, still adopt a strictly clinical approach to patient care. Thus, the approach which accounts for the medical profession's adoption of "social" definitions of patient care as another example of the medicalisation of social life or the extension of medical control, may not be as applicable here as in other areas of medicine. An example of this conspiratorial approach can be found in Breilh, J.,"Community Medicine under Imperialism", Int.Journal of Health Services,9,11,1979, pp.5-24.

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Chapter 4

(1) This analysis is presented in Calnan,M., Pathways to the Accident and Emergency Department, H.S.R.U., University of Kent, 1979, pp.124-60.

The analysis examined the factors that were related to the choice of medical care setting. Calnan, in a summary of the findings, stated:

"The evidence presented in this chapter has suggested that factors such as the site of the decision to seek medical care, and the status of the person who gave advice to the patient who actually made the decision to seek medical care, may play a significant part in influencing the choice of medical care", pp.140-141.

The analysis also showed that only type of condition still showed marked differences between choice of medical care setting when circumstantial variables were allowed for.

A second analysis examined the factors that might influence site of decision to seek medical care and timing of the decision to seek medical care. Calnan, in summarising the results, states:

"The results of this analysis suggest that one of the most significant factors associated with the time period between onset of episode and decision to seek medical aid is the status of the decision-taker", p.140.

The results from these analyses suggest that where the episode occurred, who made the decision to seek medical aid, and the nature of the condition involved seemed to significantly influence the speed of the decision to seek medical care and the choice of the medical care setting.

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See discussion of results from Newcastle Accident Study in Chapter 2, especially Table 2.1.

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The statistical analysis showed that when the decision to seek medical care was made at home, a GP was more likely to have been contacted than when the decision to seek medical care was made outside the home. The analysis also showed that when the decision to seek medical care was made by a person other than the sufferer or his close relatives, then a GP was less likely to be contacted than when the decision was made by the sufferer or his or her close relatives. Other factors which produced the most marked differences in choice of medical care setting were: time taken to make the decision after the onset of the episode, type of condition, the time of day and day of week of the decision to seek medical care and the age and sex of the sufferer.

It was interesting to note that the emergent nature of the condition as perceived by the sufferer did not appear to be related to choice of medical care setting.

The second analysis showed that status of decision-taker was associated with the timing of the decision to seek medical care. If the decision taker was not the sufferer or a close relative, then there was a greater likelihood of time period between the onset of the episode and the decision to seek medical care being shorter than when it was. The results also showed that when the police, strangers, employers, and teachers make a decision to seek medical care there was a greater likelihood of a decision being made at the site of the episode than when the patients or their relatives made the decision.

There are a variety of explanations of these findings. First, if a policeman, school-teacher, or employer makes a decision to seek medical care they are more likely to be called to the site where it happened than to another site such as a home. Secondly, the police or others being called in may reflect the seriousness of the complaint in terms of the incapacity or immobility of the patient or his inability to make a decision. Thus a decision to seek medical care is more likely. Thirdly, when the police or others are involved in decision-making, they are more likely to make a decision at the site because of their lower threshold of "urgency".

Chapter 8

(1)

See Calnan, M., Pathways to the Accident and Emergency Department, H.S.R.U., U.K.C., pp.131-132.

Results from the statistical analysis showed that non-traumatic complaints were more likely to be taken or attempted to be taken to a GP than traumatic complaints, although there were marked variations between the different types of traumatic condition. In the case of lacerations there was little contact with a GP, which may reflect the fact that patients felt the hospital was the proper place for the treatment of lacerations, or it may reflect the fact that GPs treated most of them themselves instead of referring them to hospital. The evidenceshows a reverse trend for fractures and foreign bodies. In both these cases this may indicate that for these complaints the patients regarded the hospital or GP as real alternatives, but, once again, it may reflect the referral policies of GPs. GPs may be more likely to refer suspected fractures to hospital than other complaints because they do not have x-ray facilities, and a similar lack of facilities may apply to treatment of foreign bodies. Certainly, these data suggest, even given their limitations, that for the majority of traumatic complaints (possibly apart from lacerations) the GP is believed to be an alternative source of treatment by a substantial group of the population.

A different way of analysing these data involves comparison of the group who lived permanently in the East Kent area who were aware of the local network of health care facilities with the group who were only visiting the area for a short time and were presumably unaware of the local network. The analysis compared the range of complaints brought by visitors, the assumption being that if the range of conditions is exactly the same for these two groups it could be argued that, irrespective of socio-environmental location, patients only take certain types of complaint to hospital and thus have specific ideas about what is appropriate for the GP and what is not. If, on the other hand, the range is different, then there is an indication that in some circumstances the hospital is used as their central source of care. Results indicate that the range of conditions was different for the two groups in a way that might be expected in that the non-traumatic element in the case mix is larger in the visitors group than in the other group.

(2)

Crombie, D.L., "A Casualty Service", J.R.Coll.G.P.,2,1959, pp.346-51.

(3)

N.P.H.T., Casualty Services and their Setting, O.U.P.,1960,p.60.

Chapter 9

(1)

Johnson,M., "Patients: Receivers or Participants", Conflicts in the N.H.S. (eds.Barnard,K. and Lee,K.), Croom Helm,1977, p.85.

(2)

Bloor, M.J. and Horobin,G.,"Conflict and Conflict Resolution in Doctor/Patient Interactions", A Sociology of Medical Practice, (eds. Cox,C. and Meade,A.), Collier Macmillan, London, 1975, pp.271-284.

(3)

More recent writings on medical typifications of "bad" patients have suggested that it is misleading to regard them as simply evidence of "bad" professional conduct. Staff categorise patients when they are engaged in decision making which are practical **routine features** of getting on with the job. For example, Murcott, A.'s work on the typification of cancer patients who delay as "bad" patients shows that the nature of specialised cancer practice and its organisation create only one sort of pre-patient behaviour as acceptable. Murcott's work clearly shows that problems, such as "patients who delay" have their roots in the organisation of medical work. She states that "research about'patient delay' reproduces a particular medical designation of affairs. The gaze is still aligned with the professional looking at the client", Murcott,A.,"On the typification of bad patients", in Medical Work, Realities and Routines, (eds. Atkinson,P. and Heath,C.), Gower, 1981, pp.128-40. A similar 'clinical gaze' has dominated the way that research on the use of accident and emergency departments has been approached.

(4)

Dingwall, R.,Aspects of Illness, Robertson,M., 1976,p.

(5)

Freidson, E., Profession of Medicine, Dodd and Mead, 2nd edition, 1975, pp.278-301.

(6)

Lee,K., "Need versus demand - the planner's dilemma", Economics and Health Planning (ed.Lee,K.), Croom Helm, 1979, p.54.

(7)

Calnan, M., Pathways to the Accident and Emergency Department, H.S.R.U., U.K.C., 1979, p.91.

All respondents in the main sample were asked who or where they would turn to when they needed medical help or advice. In response to this question, only 2.3% said that they would go to an A.E.D. for help whereas 58.4% said that they would go to a GP. It is interesting to note, however, that 13.2% suggested "other" alternatives. The majority of these going to relations or friends or neighbours suggesting that at least a small group of the lay population still con-

sult a lay advice network before deciding to utilise official health services. A further 2% of the patients said they didn't have anybody or anywhere to turn to for medical advice and half of them said they would possibly go to to a GP and half said they would go to the accident centre. Similar questions were asked in a study carried out by Cullinan and Calnan on a random sample of attenders at a London Hospital Accident and Emergency Department. A larger proportion, 8%, said they didn't have anyone or anywhere to turn to for medical advice and the majority of these would go to the nearest hospital. One of these people said he was never ill so didn't ever need any help. However, the vast majority (76.4%) did say that they had someone or somewhere to turn to. 46.2% turned to their GPs and 3.5% said that they would use the medical facilities at their work which includes the works' doctor or nurse. Overall 6% of the patients attending the London hospital said that they would utilise the accident and emergency department when they needed medical help (addi- of those with A.E.D. as focus for medical help and those who utilise A.E.D. although do not have a focus) compared with 3.1% of patients attending at the Kent and Canterbury Accident and Emergency Department. Of equal interest is that less of the attenders at the London Hospital depend on their GP for help than in Canterbury but more of the London attenders depend upon occupational health facilities.

These differences are further highlighted when the answers to the second question - "If medical help is not available, where does the patient turn?" - are considered. For 35.5% of the respondents in the Canterbury study, the accident department is the second source of medical help but in London almost 50% said they would turn to the accident department. In both studies, the majority of respondents said that they would turn initially to the doctor for medical help. However, for this question about secondary sources of help in Canterbury, 31% of these said that they would go to their GP's partner or another GP, whereas in London only 6.5% of this group would utilise another GP.

The picture which these figures suggest is that the patient population who attend A.E.D.s in Canterbury are more GP oriented in terms of routine health matters than the patient population who attend A.E.D.s in London. Although even in London the majority of attenders at a hospital casualty suggested that they wouldn't want casualty departments to replace GPs totally; 60.8% (N=99) said they wanted the GPs service to continue; 13.6% said they wanted GPs replaced by A.E.D., and 7.5% didn't know. The remaining 18% gave no answer. The most common reasons for retaining GPs given by these respondents were that the hospital would be overcrowded and thus the serious cases would not obtain immediate treatment and that it was more "personal" going to a GP (Cullinan, T. and Calnan, M., unpublished report, 1979.)

(8) Ibid., pp.124-160.

(9)

Alonzo, A.A., "Everyday illness behaviour: a situational approach to health status deviations", Soc.Sci. and Med. 13A, 1979, pp.397-404.

(10)

Dingwall,R., Aspects of Illness, Robertson,M.,1976, p.104.

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See Foster, P., "The Informal Rationing of Primary Medical Care", Jnl.Soc.Pol., 8,4,1979, pp.489-500.

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Hindle, J.F., Plewes,L.W. and Taylor,R.G., "Accident and Emergency Services in Russia", B.M.J., 1, 1975, pp.445-447.

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Roth,J., "Utilisation of the hospital emergency department", J.H.S.B., 1971, pp.312-20.

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See also D. Karondikar, The General Practitioner,19,1980. The author states: "In reality most places of work lack facilities to treat even the most minor illness or injury. A recent survey carried out on the occupational health service in industry identified the most common activities of the occupational health service in industry identified the most common activities of the occupational health service as treatment of acute emergencies and of minor illness and injuries.

Sadly, it must be recorded that the same survey showed that about 85% of all firms have no occupational health service other than "First aiders", and only 2.5% had both medical and nursing staff employed to provide the service",p.56.

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