Why Patients with Primary Care Physicians Use the Emergency Department for Non-urgent Care

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Abstract

Emergency department utilization for non-urgent care has steadily increased over the last 30 years. Many patients who use the emergency department for non-urgent conditions have primary care physicians. It is unfortunate that they do not visit their physicians with these problems, since emergency department care is episodic and provides neither long-term follow-up nor comprehensive care. Our study gathers pilot data to identify reasons why primary care patients use the emergency department for non-urgent care, as well as factors encouraging or discouraging patients from contacting their primary care physicians before coming to the emergency department.

We interviewed 30 patients who had primary care physicians and presented with non-urgent complaints to the emergency department of a large urban medical center. Only half of the patients had tried to contact their primary care physician before coming to the emergency department. The only factor found significant in patients’ decisions to call their primary care physician was the duration of the physician-patient relationship. No demographic factors were significant. Most patients found their primary care physician to be knowledgeable (96.7%), responsive (92.6%), and personable (100%). One-third of patients cited the difficulty of reaching their physician as their reason for not seeing or attempting to contact their primary care physician.

From these data, it seems that patients who have primary care physicians visit the emergency department not because they are dissatisfied with their physician, but rather because the primary care physician is inaccessible to them even during weekday business hours. The current systems that primary care physicians have in place for answering sick-calls need to be improved so that patients will be more likely to visit them than the emergency department for non-urgent symptoms.

Introduction

Historical Background

The concept of “Emergency Medicine” originated during the Napoleonic wars, where soldiers were triaged (French for selected) so that those least injured could be treated rapidly and returned to battle. While battlefield Emergency Medicine has continued to grow and evolve over the years, an efficient program did not develop within the civilian community. It was even said in the 1970’s that prognosis was better after injury on the fields of Vietnam than on the streets and highways at home (Boyd, 1986).

The modern era of Emergency Medicine was initiated in 1966 by the report “Accidental Death and Disability - the Neglected Disease of Modern Society,” published by the National Academy of Sciences, National Research Council. This report detailed the many inadequacies of emergency medical care and ultimately led to the Emergency Medical Services Act of 1973, which granted federal funding for the expansion of emergency medical research and advanced training for providers. This eventually led to a significant improvement in the quality of care in hospital based Emergency Departments (EDs) (Boyd, 1986).

Increased Utilization of the Emergency Department

In the last 30 years, many EDs have experienced increasing numbers of visits every year. A ten-year study (1988-1997), conducted in a North Carolina Hospital, found that ED visits increased significantly more rapidly than the population of the county (Meggs et al., 1999). This trend is consistent for the United States as a whole. Many reasons have been proposed for this increasing use of the ED.

A 1978 study of this topic concluded that emergency care is no longer the main function of the ED. The author suggested that there are currently three major roles for the ED: 1) critical care treatment; 2) physician-substitutes when a private practitioner or outpatient clinic is not available; and 3) “family physician” to the urban poor. This expanded role of the ED to include non-urgent visits explains, in part, the increase in ED utilization (Davidson, 1978).

Non-urgent Visits to the ED

Interestingly, it is estimated that 85% of ED visits are for non life-threatening reasons. Padgett and Brodsky studied the psychosocial factors influencing non-urgent use of the ED. They described three groups of factors that influence the decision to use the ED. They are predisposing factors, characteristics that exist prior to the perception of illness and consist of demographic and social structural values; enabling factors, situational or individual characteristics that facilitate or impede utilization; and need factors, those variables pertaining to the symptoms of an illness as perceived by the individual. They found race to be the only significant predisposing factor, while many enabling factors such as income, insurance...
coverage, and geographic proximity were also important. In addition, need factors arising from psychiatric co-morbidities and alcohol abuse were significant. The study also noted the scarcity of primary care physicians in many urban areas as contributing to greater use of the ED. Thus, people who lack a regular source of medical care, who tend to be poor, uninsured, and ethnic minorities, depend on the emergency room for primary care. In addition, the study emphasizes the accessibility and convenience of an ED that is open 24 hours a day, 7 days a week (Padgett and Brodsky, 1992).

Another study of three hospital EDs in Rockford, Illinois, found several unifying themes among inappropriate ED users. These patients were often insured by Medicaid and unable to identify a primary care physician. When the patient was able to identify a PCP, there usually was no attempt to contact him/her. Patients who had a current relationship with their PCPs, particularly those who had contacted their physician during the ED episode, made more appropriate use of the ED (Buesching et al., 1985).

Do non-urgent ED users have PCPs?

Thus, it seems that patients receiving comprehensive care from a PCP should be less inclined to use the ER for non-urgent reasons. A study of 1,003 visits to an emergency room in Michigan found that patients who did not have a PCP present to the ED more frequently than those who had physicians. Moreover, patients who had PCPs presented more often with true emergencies than those without PCPs (Haddy et al., 1987). It is logical to conclude that having a PCP, particularly a physician trusted by the patient, would reduce the likelihood of a non-urgent ED visit. This suggestion is crucial considering that care in the ED for non-emergency reasons is episodic and lacks the long-term patient follow up and comprehensive care of family medicine (Nelson et al., 1979).

A 1980 estimate, however, found that approximately 50% of non-urgent patients in emergency rooms nationwide had PCPs (Committee on EMS, 1980). In addition, a study conducted in Kings County Hospital, a large New York City public hospital, found that 77% of non-urgent emergency room patients had a primary care physician. These non-urgent patients with PCPs attributed their ED visits to concerns about quality and accessibility. Cost was also a factor, since private insurance often did not cover the full cost of ambulatory care outside the emergency room (Habenstreit, 1986).

Another study comparing emergency room patients with and without PCPs found that both used the ED when they were unable to reach a physician. Specifically, patients with PCPs presented to the ER when their physician was unavailable. This study suggests that as long as the emergency room remains more efficient and available than the PCP, non-urgent use of the ED will increase (Kelman and Lane, 1976).

Why do patients with PCPs use the ED for non-urgent conditions?

From the above literature, it is apparent that many, if not most, non-urgent visits to the ED are by patients who have a primary care physician. It is unclear, however, why these patients use the ED when they have their own personal physician. Some possible reasons cited include, cost, convenience, and accessibility of the ED. No study to date, however, has assessed the nature of these patients’ relationships with their PCPs. Perhaps patients go to the ED when they are not satisfied with the care provided by their PCP. Did these patients even try to access their PCP before coming to the ER? For how many months or years...
have they been seeing their PCP? How satisfied are they with their PCP? Our study examines why patients with PCPs come to the ED for non-urgent care when their PCPs can provide better long-term care. This question is important in pinpointing the causes of non-urgent ER use. With this information, solutions can be devised and implemented to direct non-urgent patients back to their own PCPs where they can get better follow-up and more comprehensive care.

Methods

Data were collected for this study by means of a short interview of randomly selected non-institutionalized patients who presented to the Adult Emergency Department at the Moses division of Montefiore Medical Center, a 1048-bed urban teaching hospital in Bronx, New York. The Montefiore ED sees approximately 63,000 to 64,000 visits per year and admits approximately 1,500 patients per month. It has no trauma designation, though it functions as level II center.

The questionnaires were administered to each patient by a single interviewer. A total of 2 interviewers successfully interviewed 30 patients over 2 days time. The hours of collection were between 2:00 - 6:00 PM on successive Tuesday and Wednesday afternoons. These time periods were specifically chosen to under the assumption that PCPs’ offices were open and available to assist patients.

All patients in the ED were approached and asked to participate in the survey unless they were known to fulfill exclusion criteria. Spanish speaking patients were also interviewed with the help of a translator, usually the family member or friend who accompanied the patient to the hospital.

Exclusion criteria included (1) not having a generalist physician whom the patient had visited at least once and (2) the presence of symptoms representing an urgent or emergent condition. Schuman et al. (1977) have developed a system of categorizing the severity of presenting symptoms. They define emergent conditions as those in which “death is imminent without immediate treatment; body processes and vital signs are not normal.” Urgent conditions are those in which “life or bodily functions are threatened if medical care is delayed more than several hours,” while non-urgent conditions are those in which “the patient’s life or usual activities would not be immediately threatened by referral to an alternate care facility for treatment at a later time” (Schuman, 1977). Our study only addresses patients with non-urgent medical conditions. For this purpose we determined that injury, cardiac chest pain, and shortness of breath secondary to asthmatic chronic obstructive pulmonary disease exacerbation are emergent or urgent medical conditions. As most people would consider these symptoms to be obvious emergencies that require immediate attention in an ED, they are criteria for exclusion from our study.

Prior studies have gathered mostly quantitative data in an attempt to answer the same question we posed in our study. In order to understand the meaning behind patient behavior, it is important to use unstructured interview methods. Therefore, we designed a semi-structured qualitative interview to get a better sense of patients’ reasoning processes. Thus, our survey includes some questions that require a qualitative response from the patient and others that require a specific answer. This was done to allow for a wide variety of patient responses that would not necessarily be possible with a more rigid survey instrument. The information gained through these open-ended questions can later be used as pilot data to guide the creation of a more concise survey tool.

Results

Nineteen out of the 30 respondents were female; 11 were male. Demographic characteristics (educational level, estimated yearly income, ethnicity, type of insurance, and gender) did not significantly predict whether or not patients attempted to call their PCP prior to the ED visit.

Of the 30 survey respondents, each with a primary care physician, 50% attempted to contact their PCP prior to going to the ED, while the remaining 50% had not. Of the 15 patients who attempted to call their PCPs during weekday business hours, 7 were unable to reach them by phone. Three of the 15 patients who did not attempt to call their PCP cited physician off hours as the reason for not doing so. Other reasons for not calling the PCP are listed in Table 1.

Reasons for Not Calling the Primary Care Physician Before Coming to the ED

<table>
<thead>
<tr>
<th>Reason for not calling</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor not in office</td>
<td>3</td>
</tr>
<tr>
<td>Faster in ED</td>
<td>2</td>
</tr>
<tr>
<td>Location - Doctor's office is too distant</td>
<td>2</td>
</tr>
<tr>
<td>Cannot see doctor without prior appointment</td>
<td>2</td>
</tr>
<tr>
<td>Doctor cannot help with this problem</td>
<td>2</td>
</tr>
<tr>
<td>Recently discharged from hospital</td>
<td>1</td>
</tr>
<tr>
<td>Has emergency call button for other condition</td>
<td>1</td>
</tr>
<tr>
<td>Did not have doctor's phone number with her</td>
<td>1</td>
</tr>
<tr>
<td>Wants to see previous PCP who works in hospital</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 1: Reasons patients stated for not calling their PCP before coming to the ED, and number of patients with each reason.
Various factors influencing the decision to come to the ED, rather than contacting a PCP, were analyzed. Forty percent of the respondents reported being patients of their current PCP for less than 1 year, while 27% had been patients of their current doctor for between 1 and 3 years. The remaining 33% had been seeing their current doctor for over 3 years. Figure 2 below presents attempted patient contact in the context of the duration of the patient-physician relationship. Interestingly, patients with the longest relationships were more likely to attempt contact as compared to those with shorter relationships (p-value < 0.06).

Of the 10 patients who had been seeing their PCP for more than 3 years, 4 tried but could not get through to their own or any other physician. One patient did not even try because he knew his physician was not in that day.

Seven percent of patients reported seeing their physician less than once a year, 33% reported seeing their physician 1 to 3 times a year, and 60% reported seeing their physician 4 or more times a year. These responses did not differ between the group that attempted to contact their PCP and the group that did not.

73% of patients reported that they always call their doctor when concerned about their health, while 27% of patients reported that they do not. An equal number of patients in each group attempted to contact their PCP as did not attempt to do so.

Patients rated their satisfaction with their PCPs on a scale from 1 to 10. The mean rating of the group that attempted to call their PCP was 8.53, while the mean rating of the group that did not was 8.33. The confidence interval of these numbers overlap (7.32-9.75 and 6.84-9.82) and do not differ significantly. Patient satisfaction with doctors also did not vary significantly between the group that generally calls their PCP with health concerns (8.82, confidence interval 8.02-9.61) and the group that does not generally call with health concerns (7.38, confidence interval 4.38-10.37).

Ninety-seven percent of respondents felt that their PCP is appropriately knowledgeable. Ninety-three percent of respondents found that their doctors respond quickly to a phone message. One hundred percent of patients thought their doctors were personable. When asked, 80% of patients who did not attempt to contact their PCP stated that they would change nothing about the care they received from their PCP. Seventy-three percent of patients who did attempt consultation with their PCP said the same. All suggestions given by patients for changes in the care from their PCP are listed in Table 2.

Discussion
This study shows that patients with PCPs do in fact use the ED for non-urgent medical issues. The thirty study participants each had a generalist physician whom they visited for medical treatment. Further investigation
showed that patients that did not attempt to contact their physicians were equally satisfied with their medical care as those that did attempt to call their PCPs. Thus, for patients in this study, avoidance of the primary provider was not due to patient dissatisfaction.

In addition, almost all patients in the study found their PCPs to be knowledgeable, responsive to phone inquiries, and personable (97%, 93%, and 100%, respectively). Thus, patients not contacting their PCPs who present to the ED with non-urgent issues do not bypass their PCP because they distrust or dislike their physicians.

Further, when patients who did not attempt to contact their PCP were asked if they would like to change anything about the care they received from their PCP, a large majority responded that they would change nothing. A smaller majority of patients who actually did attempt consultation said the same. Again, we can conclude that dissatisfaction with quality of care from PCPs is not leading people straight to the emergency room.

Interestingly, patients who have longer relationships with their physicians are more likely to attempt to contact them before coming to the ED. With such a small sample size, the finding of statistical significance for this factor emphasizes its importance. Longer relationships may imply better relationships. They may promote greater trust and more personal bonds between patients and physicians. Further studies need to evaluate which factors in the patient-physician relationship would compel patients to seek out their PCP’s advice before coming to the ED.

Another important finding is that while patients often do try to call their doctors, many cannot get through to them. One-third of the patients in this survey complained of an inability (actual or perceived) to reach their physician. About half of the patients that did try to contact their physicians were unable to reach them, and some of the patients who did not try to contact their doctors cited off hours as the reason for not attempting to do so.

From both the quantitative and qualitative responses presented in this study, we conclude that patients visit the ED without referrals from their PCPs not because they are dissatisfied with primary care; their PCPs are not personable, knowledgeable, or responsive; or there is a problem with patient care, but rather because primary care doctors are often inaccessible when their patients need them. This is true even during the weekday business hours when this survey was conducted. The results of this study show that while a longer patient-physician relationship increased the likelihood of attempted contact; it was the inaccessibility of PCPs to their patients that sent study participants to the ED for non-urgent medical care.

Two limitations of this study can be reduced in further investigations. The first was the criteria for definition of “non-urgent” symptoms; the exclusion criteria used for urgency may have been too narrow. While injury, cardiac pain, and shortness of breath exacerbations are urgent conditions, the category may be expanded to include other urgent medical problems. The second deficiency is the small sample size; only 30 subjects were interviewed. With a larger patient group, more factors may be identified that are significant in patients’ decisions to call their PCP before coming to the ED.

Though the sample size is small, this study was intended to gather pilot data as to why patients prefer the ED to

<table>
<thead>
<tr>
<th>Patients who did call their PCP</th>
<th>Patients who did not call their PCP</th>
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<tbody>
<tr>
<td>Better adherence to appointment schedule</td>
<td>More pain medication</td>
</tr>
<tr>
<td>Doctors should do more research</td>
<td>More listening</td>
</tr>
<tr>
<td>More availability of appointments</td>
<td>Location</td>
</tr>
<tr>
<td>More paternalism. Tell patient who to do - do not ask patient what they would like done.</td>
<td></td>
</tr>
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**Table 2:** Patient responses to the question, “Is there anything you would like to change about your care from your PCP?” categorized by whether they did/did not call their PCP?
their PCPs. As such, it clarifies important issues. It points to inaccessibility as the most prominent obstacle preventing patients from contacting their PCPs.

Future studies should focus on possible solutions to the access problem. Questions may be added to the survey instrument, such as whether the PCP’s office has a nurse available to answer questions. Would the patients be willing to accept a nurse’s advice? Also, are there walk-in appointments available at that site? In addition, PCPs can be surveyed about what system they have in place for coverage when they are away from their office. They also should be asked if they have a way of answering “sick-calls” from patients who do not have appointments. The efficiency of these systems should be assessed. Eventually, this could lead to implementation of appropriate systems that allow for patients to be cared for by their PCPs rather than by the ED.

While EDs can be expanded to meet the demands of increased utilization, it would benefit patients to be redirected back to primary care. PCPs have a better understanding of their patients’ medical histories and can provide more comprehensive follow-up care. Exploration of the barriers patients faced by patients when contacting their PCPs may help to redirected patients back into primary care.

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References


