

Emergency Physicians) on this issue simply clouds the question and gives the ED physician a false sense of liability protection.

In the case of the stable and appropriately assessed patient in the ED, it is entirely reasonable, and clearly a courtesy to a colleague in small and mid-size Canadian hospitals, to write initial orders on behalf of the attending physician. Needless to say, that physician must have been notified by the emergency department physician at the time of admission, but to insist that he or she come to the hospital to re-evaluate a stable patient (especially at night) is neither reasonable nor prudent.

It is vital that CAEP continues to develop useful clinical guidelines and standards of practice for emergency medicine based on broad consensus and a careful reflection of reality. The present position statement is appropriate for large urban and especially teaching hospitals, but misses the mark in the majority of hospitals offering emergency services across the country.

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References

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2. Thompson J. Emergency physicians and admission orders [letter]. CAEP/ACMU Communiqué 1998; Winter 98–99:4.
3. CAEP Position Statement on the writing of patient admission orders. CAEP/ACMU Communiqué 1998; Winter 98–99:4.

Inappropriate patients

To the editor:

Although it is true that our society is “over-Medicared” (e.g., walk-in-clinics), perhaps the problem is not inappropriate ED use but, rather, lack of patient knowledge. If patients are asked what their perception of their medical problem is, and what their understanding of the real, possible, and most frightening consequences might be, then one might come up with answers that are closer to the truth.

We surveyed our ED patients for a month and found that those with minor problems came to the ED because of convenience, because of concern that they might have a “serious” problem, or because of perceived acuity. These are not bad people misusing our treasured yet crumbling health care system; they are just uninformed. Education is a powerful tool, and doctors, nurses, media and educators can help us solve this.

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To the editor:

The question of inappropriate emergency visits is a sensitive one; it forces us to examine a couple of key points. First and foremost is the issue of resource allocation. It is hard to suppress the feeling of frustration when we perceive the needless use of both emergency personnel and limited physical space. Both are in rather short supply, and we are all looking for

ways to decompress our emergency wards. Limiting patient encounters that could otherwise be dealt with in another setting would be a useful step toward achieving this goal.

Second is the issue of patient rights. According to the *Canada Health Act*, every Canadian citizen has a universal right to health care — health care that is not restricted to certain hours or specific locations. It is not appropriate for emergency personnel to decide what a patient’s threshold for seeking medical advice should be. These acts are driven by anxieties and health concerns that are unique to every patient. They should be respected and not scrutinized or minimized.

That’s not to say that all stubbed toes require costly ED registration and emergent attention. I simply feel that the present format of emergency triage is inadequate when faced with this type of patient. I believe it is our responsibility to provide a viable alternative for patients who arrive with non-emergent complaints. Many centres in the United States have walk-in clinics within the ED itself. The clinic is essentially a separate entity run by a nurse practitioner who may then refer a patient on for emergency evaluation. Registration costs are much lower than those incurred with ED visits, and personnel are kept to a minimum. This, along with on-going patient education, could serve as a more efficient way to deliver emergency care.

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