A Realistic Analysis Of Patients' Decision-Making Regarding "Clinically Unnecessary" Use Of Emergency And Urgent Care

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Abstract:

When patients do not require the levels of clinical care or urgency thatthe service they contact provides, the demand is referred to as"clinically unnecessary."

Goal: to determine program theories that aim to explain why patients seek urgent and emergency care, which is later determined to be clinically unnecessary.

Methods: Four recent systematic reviews of the demand for urgent and emergency care, as well as a search that was updated as of January 2017. Context-Mechanism-Outcome chains from 32 qualitativestudies were used to develop program theories, which were then tested by examining how they related to 29 quantitative studies and current theories of health behavior.

Conclusions: Interventions could involve societal changes to improvecoping skills and modifications to the accessibility and structure of health services, rather than merely concentrating on the behavior of individuals.

Keywords: Emergency medicine, Urgent care, Patients.

Introduction:

People turn to a variety of health services when they need urgent medical advice or treatment, such as emergency ambulance services, emergency departments, general practice after hours, urgent care centers, walk-in centers, minor injury units, dentists, and 24-hour telephone health helplines. There are significant differences in the available options between and within nations. High demand for someof these services, particularly emergency ambulances, emergency rooms, and general practice, has raised concerns (O'Cathain, 2007).Interventions to lessen the demand for overburdened health services may be informed by an

understanding of the reasons behind patients'decisions that are deemed clinically unnecessary. But it's also criticalto recognize that patient behavior is just one aspect of the situation. Clinically unnecessary use of health services is a controversial concept. When seeking help, patients must balance their desire to take charge of their health without being perceived as wasting a busy service's time. The availability of services may influence assessmentsof the clinical necessity of demand; these assessments become more severe when demand exceeds supply. Individual clinicians and services may also have different staff opinions about acceptablejustifications for service use (Iacobucci, 2018; Booker, 2017).

A deeper comprehension of the factors that lead patients to seek urgent care when it is clinically unnecessary is required. Previousreviews have addressed overall demand, including both clinically necessary and unnecessary use, included perspectives from patientsand health professionals, or concentrated on a single service. In orderto better understand what motivates patients to seek care urgently andto better understand the reasons behind their decisions, a thorough review that focuses specifically on patients' perspectives of clinically unnecessary service use is necessary. A more thorough understanding of patients' decision-making processes could be provided by realist synthesis, which focuses on the mechanisms that lead to outcomes and the contexts that influence these mechanisms and outcomes. Therefore, the purpose of this review was to use realistsynthesis to determine the reasons why patients use services that provide urgent and emergency care that is deemed clinically unnecessary (Hobbs, 2007).

Patients made clinically unnecessary use of services providing emergency :

Were found to be responsible for patients' clinically unnecessary use ofemergency and urgent care services**:**

(a) the need to minimize risk, which can be brought on by anxiety stemming from a lack of certainty about the severity of symptoms, increased anxiety brought on by traumatic event experiences in the past, or fear of the repercussions when making decisions about other people, like children.

(b) a need for speed, brought on by the need to get back to normal in order to take care of obligations, the need for instant pain relief, or the fact that patients had been waiting for their symptoms to go away and could not wait any longer.

(c) low treatment-seeking burden, which results from a complex or stressful life that makes it difficult to cope.

(d) compliance, as a result of advice from friends, family, or health services.

(e) Customer satisfaction, as compared to primary care, emergency rooms were thought to provide the necessary tests, knowledge, and convenience.

(f) annoyance, as patients had tried to schedule a GP appointment but were unable to do so within the desired time frame. A person's behavior when seeking care is probably influenced by a variety of underlying mechanisms rather than by any one mechanism acting alone.

Existing theories on health behavior provided support for these programtheories, and some of them were backed by quantitative data.

Programme Theories:

Although we were able to provide a deeper understanding of the waysin which these issues affected people, the authors of the original reviews from which we drew our qualitative studies had already identified some of the program theories. Consumer satisfaction in terms of positive views of emergency departments offering the expected investigations in one place, negative views of general practice due to lack of confidence in GPs, and frustration with accessto primary care; stress and the need for low burden when seeking care in terms of social deprivation affecting ambulance use; uncertainty causing anxiety and the need to manage risk by getting reassurance; and fear of consequences, particularly around children and the role ofbystanders in using ambulances (Uscher, 2013; Durand, 2011).
Research on the overall demand for emergency and urgent care alsoprovided support for some of our program's hypotheses. The programtheory that poor access to general practitioners (GPs) affects emergency department use for all users of emergency and urgent care, not just clinically unnecessary use, received a lot of support. Numerous studies, including a comprehensive survey of general practitioners in 31 countries, have linked poor access to generalpractitioners to increased use of emergency rooms (Kawakami,2007).

Some issues that have been identified elsewhere were not included in our program theories: lack of transportation; lower cost/financial considerations; patient misunderstanding of the role of a service; not having a general practitioner; geography in terms of rural and urban locations; health knowledge; the convenience of the setting in terms of shorter distances to travel to an emergency department or GP out of hours service; and awareness

of services, even though only 3% ofpeople reported this as an issue in one study(Bell C, 2017).
Due to their weak presence in the qualitative literature on patients' perceptions of clinically unnecessary use, these were not developed into program theories. Even though our study involved numerous in- depth team discussions to address this risk, it's also possible that some issues were chosen subjectively. Furthermore, another important problem noted by other reviews and studies was that we lacked a program theory regarding patients seeking emergency and urgent care due to its convenience (Llanwarne, 2017). Our program theories on the need to return to normal as soon as possible to attendto obligations and the impact of stressful lives creating the need for low treatment-seeking burden may have represented this factor in ourreview.

Recommendations:

Testing the theories in comparative quantitative studies was a significant drawback. Despite their availability, these studies failed tomeasure certain issues pertaining to our program theories.
Similar results to earlier reviews were found using our realist approach, but we went one step further by investigating the causes of the findings, such as why people experienced anxiety. A number of new issues were also identified, including the impact of prior traumatic experiences and the necessity for immediate pain relief.

The review had certain limitations:

First, the majority of the included articles in the review were about emergency rooms, with a specific gap concerning the use of daytime general practice, which is the most typical initial point of contact for people in need of urgent care.
Second, because of the moral aspect of help-seeking behavior, patients may present as "the rational me, the irrational other," makingsituations seem more reasonable and justified than they actually were. This is why the program theories developed and improved herewere based on qualitative interviews with these patients. It is crucialto comprehend these presentations, though, and our review offers insightful information about how patients explain their decision- making.

Third, unlike other reviews, the included studies' participants were not a uniformly defined group; rather, they were chosen for interviews based on a variety of definitions of "clinically unnecessary." Depending on the definition and context, the percentage of clinicallyunnecessary use can range from 4.8% to 90%

due to the inconsistent assessment of non-urgency in various studies.

Fourth, the qualitative articles did not always provide sufficient information to demonstrate how various issues interacted within individuals or when interviewees used a service as their first or last option.

Lastly, because of the age of the included studies, digital sources of health care advice did not appear in our findings, despite their growing use.

Conclusion:

Reducing clinically unnecessary use of emergency and urgent care may require a combination of interventions. Instead of concentrating only on the behavior of individuals, these are likely to involve modifications to the accessibility and configuration of health services aswell as the social circumstances of patients.

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