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Exploring attendance at emergency departments for children with non-urgent conditions in Turkey: a qualitative study of parents and healthcare staff perspectives

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Abstract

Background: Overcrowding in Emergency Departments (EDs) is a significant global concern with negative consequences for patients, healthcare staff, and healthcare systems. The use of EDs by parents of children with non-urgent conditions is associated with overcrowding, higher healthcare costs, lower quality of care, and longer waiting times. Research in this area has largely been conducted in high-income countries, with a dearth of work originating in middle and low-income regions. The aim of this study was to explore the reasons for parents attending EDs with their child for non-urgent conditions in Turkey.

Method: Semi-structured interviews were conducted with 13 parents, 15 ED staff, and 10 General Practitioners (GPs) in 2 regions of Turkey between March and May 2017. Data were analyzed using the principles of grounded theory.

Results: The findings were classified into 5 core categories: (1) parents' feelings, knowledge, and perceived inability to provide self-care; (2) perceived limitations of healthcare services, system, and staff; (3) parents' preferences for hospital and ED services; (4) adverse impact on ED services; and (5) perceived needs for care.

Conclusion: This is the first study conducted in a middle-income country regarding parental reasons for using the ED for non-urgent conditions. Greater efforts must be made to reduce unnecessary visits to the ED to better meet service user needs and to increase the satisfaction of both parents and healthcare staff. The findings of this study may inform healthcare providers, policymakers, healthcare staff, and researchers to design interventions in order to mitigate overcrowding in the ED.

Keywords: Emergency departments, Healthcare staff experiences, Non-urgent, Overcrowding, Parent experiences, Qualitative research

Background

The use of emergency departments (EDs) for non-urgent conditions is on the increase, and the pressure on EDs is a worldwide significant concern for ED staff, ED directors, and policymakers.^[1,2] A large number of patients use ED services for non-urgent conditions, which could and

should be handled in primary care services or through self-care.^[3] A recent review highlighted that 40% of ED patients were discharged, requiring no treatment,^[4] suggesting that they had presented with non-urgent conditions. Parents have been identified as a group who frequently use the ED for their children's primary care needs, which could have been more appropriately handled by a family physician.^[5] Parents' use of EDs when their children have non-urgent conditions is associated with overcrowding, higher costs, lower quality of care and longer waiting times.^[6,7] Non-urgent ED use contributes to overcrowding and causes problems such as patient density in the ED, increased workload, and further resource utilization.^[8,9] Furthermore, overcrowding in EDs can result in delayed care, poor health outcomes, and higher risks of medical error.^[7] A number of studies have found a relationship between overcrowding and patients' negative experiences of ED, leading to reduced satisfaction.^[10–12]

The majority of research on exploring why parents use the ED has taken place in high-income countries with a dearth of work originating in middle- and low-income regions. Recent systematic reviews have suggested a need for further investigation among middle-income countries due to differences in healthcare systems and cultural norms.^[6,13] The data obtained from the Ministry of Health in Turkey showed that there were approximately

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111 million ED visits in 2015, 118 million in 2016, and 124 million in 2017,^[14] which is equivalent to approximately 1375, 1475, and 1550 ED visits per 1000 population, respectively. This statistical data show that EDs in Turkey are 3 to 4 times more overcrowded than those in high-income countries and justifies the need to explore why parents use the ED for non-urgent conditions in the Turkish context.

Aim

To explore the reasons for parental ED use from different perspectives, namely, the perspectives of parents, ED healthcare staff, and GPs, in the context of a middle-income country.

Method

Participants and settings

The participants were self-referred parents, ED staff, and General Practitioners (GPs). Parents of children aged under 18 years and those who triaged as non-urgent were included (see Table 1 for parents' characteristics). ED staff and GPs with at least 1 year of experience in their workplace were included without considering their gender or age (see Tables 2 and 3 for ED staff and GPs' characteristics, respectively). The ED healthcare staff were ED consultants, ED doctors, ED nurses, and hospital directors. The settings for recruiting parents and ED healthcare staff were the Pediatric Emergency Department (PED) of Mardin Public Hospital and the ED of Midyat Public Hospital, in Turkey. GPs were recruited from 7 different GP practices, 4 of which were situated in Mardin and 3 in Midyat, Turkey. The population of Mardin and Midyat is around 305,000 in total, with EDs and GP

practices adhering to the same regulations and statutory obligations as other healthcare providers in Turkey. As such, patients engaging with services in Mardin and Midyat are likely to experience comparable levels of care to other regions of Turkey and are thus representative of the region. In order to recruit those individuals with experience of the phenomena of interest and to address the research questions, a purposive sampling method was used. Parents of children with non-urgent conditions, ED staff, and GPs with at least 1 year of experience in their workplace were invited to participate in the research.

A semi-structured interview method was chosen to collect data as this approach allowed the researcher to ask both closed and open-ended questions in addition to allowing the freedom to ask additional probing questions based on the ongoing conversation between the researcher and interviewee.^[15] The interview schedule was developed and piloted by the researcher prior to data collection. Table 4 presents the interview schedule conducted with the parents, while Table 5 presents the interview schedule conducted with the ED staff and GPs. Interviews were conducted by the lead researcher (AB) between March 30 and May 18, 2017. Data saturation was reached when the researcher observed that similar issues repeatedly emerged, and no new information was gained.

Procedure for the interviews

ED doctors were provided the inclusion and exclusion criteria and were informed to apply this criteria in order to reduce selection bias. ED doctors acted as gatekeepers by identifying, approaching, and inviting parents of children who had been triaged as "non-urgent" to take part in the study. Parents were referred to the researcher for further information, assessment, eligibility, consent, and partici-

Table 1
Characteristics of Parents (*n* = 13)

Participant ID	Parent Age (years)	Child Age (years)	Relationship with Child	Family Size*	Level of Education	Occupation	Monthly Income† (TL)	Home Distance to ED (miles)	Working Shifts of Admission	Frequency of ED Attendance in the Last Year (times)
P1	25–30	0–2	Mother	5	Bachelor's degree	Teacher	0–1400	0–10	Out of hours	4
P2	25–30	2–5	Mother	3	Bachelor's degree	Accountant	1400–2500	0–10	Out of hours	30+
P3	25–30	0–2	Mother	5	Primary school	Housewife	0–1400	10–20	Office hours	20
P4	25–30	2–5	Mother	4	Bachelor's degree	Nurse	1400–2500	10–20	Office hours	6
P5	40+	10–14	Mother	6	Primary school	Housewife	0–1400	0–10	Out of hours	6
P6	35–40	5–10	Father	4	Primary school	Self-employed	0–1400	10–20	Office hours	3
P7	35–40	2–5	Mother	7	Primary school	–	0–1400	10–20	Office hours	2
P8	25–30	2–5	Mother	4	High school	Housewife	0–1400	0–10	Office hours	7–8
P9	25–30	0–2	Mother	3	High school	Housewife	1400–2500	0–10	Out of hours	4–5
P10	25–30	0–2	Father	3	Bachelor's degree	Trader	0–1400	0–10	Out of hours	15–20
P11	25–30	0–2	Father	4	Primary school	Baker	0–1400	0–10	Out of hours	20–30
P12	30–35	5–10	Father	5	High school	Jeweller	2500–4000	0–10	Out of hours	2–3
P13	40+	2–5	Father	6	High school	Secretary	0–1400	0–10	Office hours	Approximately 50 for all his children

ED, emergency department.

*Inclusive of mother and father.

†£1 equals approximately 4.50 Turkish Lira (TL) (<https://www.oanda.com/currency/converter/>) (Date of the currency exchange: 1 June 2017; the dates during the conduct of these interviews were taken into consideration).

- 0 – 1400 TL = £0 – £311
- 1400 TL – 2500 TL = £311 – £555
- 2500 TL – 4000 TL = £555 – £888

Table 2
Characteristics of ED Healthcare Staff (n = 15)

Participant ID	Age (years)	Gender	Occupation	Work Setting	Years of Experience
ED staff 1	25–30	Female	ED doctor	PED	1–2
ED staff 2	25–30	Female	ED doctor	PED	1–2
ED staff 3	25–30	Male	ED doctor	PED	1–2
ED staff 4	30–35	Female	ED nurse	PED	10+
ED staff 5	25–30	Female	ED nurse	PED	5–10
ED staff 6	25–30	Male	Hospital director	PED	2–5
ED staff 7	25–30	Male	ED doctor	PED	1–2
ED staff 8	25–30	Male	ED doctor	PED	2–5
ED staff 9	40+	Male	ED consultant	PED	10+
ED staff 10	35–40	Male	ED chief nurse	PED	10+
ED staff 11	25–30	Male	ED doctor	ED	1–2
ED staff 12	30–35	Male	ED consultant	ED	5–10
ED staff 13	25–30	Male	ED nurse	ED	1–2
ED staff 14	35–40	Male	Hospital director	ED	10+
ED staff 15	30–35	Female	ED chief nurse	ED	10+

ED, emergency department; PED, pediatric emergency department.

pation in an interview. The researcher attempted to recruit participants from 3 different working shifts (ie, 8 AM to 5 PM, 5 PM to midnight, and midnight to 8 AM), as parental reasons were thought to differ depending on when data collection was conducted. Taking this approach allowed us to explore a range of parental experiences based on the timing of ED attendance. A private room located in each of the 2 hospitals (Mardin and Midyat) was arranged for the researcher to use for the duration of data collection by the directors of both hospitals. Interviews with parents were conducted in these private rooms, which included a sofa, table, and other office equipment. The researcher asked for the participants' permission to lock the door, so that they could feel the room is "theirs." This ensured confidentiality and provided a relaxed atmosphere to establish rapport. The ED staff were interviewed at the same hospitals in a private office. The GPs were interviewed in their offices.

All interviews were conducted in Turkish. Prior to the commencement of the interview, participants were asked to sign a consent form and complete a preinterview information sheet by providing demographic information. All interviews were audio-recorded. The duration of the parental interviews ranged from 9 to 25 minutes, the ED staff interviews ranged from 13 to 65 minutes, and the GPs' interviews ranged from 13 to 39 minutes.

Transcription and translation of data

The audio-recorded interviews were transcribed in Turkish by the researcher (AB), with multiple checks carried out to ensure data accuracy. The transcribed data were then translated into English by the researcher (AB) for analysis. This ensured that the research team would be able to verify the creation of categories, increase transparency, and thus improve rigor. Nine English transcriptions (representing 23% of all transcriptions) were given to a Turkish-to-English translation service to be checked for accuracy.

Data analysis and rigor

The principles of grounded theory, including open coding, axial coding, and selective coding, were used to analyze the data.^[16,17] NVivo11 Pro software was used to perform the data analysis. The data were analyzed, and the generated themes, concepts, and categories were discussed and agreed upon by team members throughout the data analysis process. This analysis revealed 5 core categories which are presented alongside the emergent concepts and themes in Table 6. Member checking, or respondent validation, was conducted with 2 parents, 2 ED staff, and 2 GPs to ensure that the generated themes accurately

Table 3
Characteristics of GPs (n = 10)

Participant ID	Age (years)	Gender	Location of Their Work Setting	Years of Experience
GP 1	35–40	Male	Mardin	10+
GP 2	25–30	Female	Mardin	2–5
GP 3	35–40	Male	Mardin	10+
GP 4	30–35	Female	Mardin	5–10
GP 5	25–30	Male	Mardin	2–5
GP 6	25–30	Male	Mardin	1–2
GP 7	25–30	Male	Mardin	5–10
GP 8	30–35	Male	Midyat	10+
GP 9	25–30	Male	Midyat	1–2
GP 10	30–35	Male	Midyat	5–10

GP, general practitioner.

Table 4**Parental Interview Schedule**

Question 1 (Unique question)	What do you think about the quality of healthcare services for children in Turkey?
Question 2 (Retrieved from Berry et al. ^[28] ; Howard et al. ^[29])	What health services do you have in your community? Prompts: GP, health visitor, pediatrician and telephone help-line? Did you bring your child to the ED over other options like self-care and visiting GP? Could you tell me why you did not visit your GP?
Question 3 (Retrieved from Brousseau et al. ^[30])	Who do you go to for advice when your child is sick?
Question 4 (Retrieved from Keizer Beache and Guell ^[31])	Can you tell me what happened to make you to decide to visit the Emergency Department? Prompts: Why did you feel your child needed to go to the ED? What symptoms did your child have before visiting the ED?
Question 5 (Unique question)	Did you try to treat your child at home? Prompts: If yes, what did you do? If no, why not? How did this makes you feel?
Question 6 (Retrieved from Alyasin and Douglas ^[32] ; Howard et al. ^[29])	Who was involved in the decision to attend the ED?
Question 7 (Retrieved from Berry et al. ^[28])	Do you think visiting ED was the best option in this situation? Prompts: Why do you feel/believe/think that way?
Question 8 (Retrieved from Alyasin and Douglas ^[32] ; Berry et al. ^[28])	Can you tell me what were your reasons for bringing your child to the ED instead of GP? Prompts: Is this normally the case? Did you think your child's condition needed urgent care? Why? Could you tell me more about this?
Question 9 (Retrieved from Brown et al. ^[33])	How many times in the last year did you use an ED?
Question 10 (Retrieved from Brousseau et al. ^[30])	Where you satisfied with the care your child received in ED? Prompts: Can you tell me why? (If they are happy with ED) What makes ED more satisfactory?
Question 11 (Unique question)	How is your child doing now?
Question 12 (Unique question)	Looking back, would you bring your child back to the Emergency Department for the same condition? Prompts: Why do think that way?
Question 13 (Unique question)	What changes do you think could be made to healthcare in your community to reduce your use of ED? Prompts: Why? How? Tell me more?

ED, emergency department; GP, general practitioner.

Table 5**Healthcare Staff Interview Schedule**

Question 1 (Unique question)	What do you think about the quality of healthcare services for children in Turkey?
Question 2 (Retrieved from Brousseau et al. ^[30])	Tell me about your practice setting? Prompts: Types of patients (rich/poor; urban/rural), number of patients and staff, working hours.
Question 3 (Retrieved from Brousseau et al. ^[30])	When a parent with a child has a non-urgent condition during working hours, what is the usual procedure they follow?
Question 4 (Slightly changed and retrieved from Keizer Beache and Guell ^[31])	What health services are available in this community for a parent with a child with a non-urgent illness after regular working hours? Prompts: Is there any outside nurse/help line?
Question 5 (Unique question)	What do you think about the demands on your health services (GP or ED)? Prompts: How this affect the nature of ED setting like quality of care, staff workload, cost etc.?
Question 6 (Unique question)	Why do you think parents take their children to ED for non-urgent conditions rather than their GP? Prompts: In your experience, how does this affect ED? Resources, Communication problems, staff etc.
Question 7 (Unique question)	What could we do to reduce non-urgent ED visits by parents? Prompts: Tell me more about this? Explain? How? Barriers? Facilitators?

ED, emergency department; GP, general practitioner.

reflected parental narratives. Reflexivity is viewed as a strength in qualitative research as it provides the researcher with a unique understanding and encourages transparency of the study's findings.^[18] Reflexivity should be employed by the researcher at different stages of the research process, including the research design, data collection, analysis, and interpretation.^[19] The lead researcher used reflexivity to consider their role as nurse and parent when designing the interview schedule, and while analyzing and interpreting the data.

Results

Thirteen parents were interviewed; 8 were female and 5 were male. All parents were either the mother or father of a child who had previously been taken to the ED. Seven parents had attended the ED outside of work hours, and 6 had attended during office hours. The majority of parents ($n = 8$) were aged between 25 and 30 years. The majority of the children ($n = 10$) were aged between birth and 5 years. Demographic information on the parents showed that the majority ($n = 9$) had a low monthly income. Residential distance to the ED was between 0 and 10 miles for the majority of participants ($n = 9$). Furthermore, ED staff interviews were conducted with 2 ED consultants, 6 ED doctors, 5 ED nurses, 2 chief nurses, and 2 hospital directors, who also had at least 1 year of work experience, without any consideration of their gender or age. Ten ED staff were recruited from the PED, Mardin Public Hospital (Turkey), and 5 were recruited from the ED, Midyat Public Hospital (Turkey). In addition, 10 GPs with at least 1 year of work experience were recruited from 7 different GP practices. Seven GPs worked in 4 different GP practices located in Mardin, and 3 GPs worked in 3 different GP practices located in Midyat. Further characteristics of ED staff and GPs are provided in Tables 2 and 3.

Core category 1: parents' feelings, knowledge, and perceived inability to provide self-care

Parents' feelings of concern for their child's well-being naturally influenced their decision to use the ED. Parents expressed feeling worried, anxious, and nervous, becoming upset, feeling compelled to take the child to the ED, and feeling that they could not wait any longer. Parents reported that their fears about their child's illness led them to use the ED. These fears included fear of fever and infection when visiting outpatient clinics, which led them to visit the ED, fear of the condition getting worse, and possible complications. The findings showed that the parents were extremely afraid of fever as an indicator of serious illness.

"... when he has a fever, we are afraid. Of course, we become nervous, it is a feeling of motherhood ... He is my only child." (P9, mother, aged 25–30, 1 child).

A hospital director who had ED working experience stated that:

"They're probably worried and afraid that something could happen to their child ... With the influence of anxieties such

as this and the stories they hear in the community, they prefer to come to the ED with these fears and anxieties." (ED staff 14, Hospital director, ED).

The findings showed that first-time parents and those who have a young child were particularly sensitive to the perceived dangers of fever. This could be due to a lack of experience in caring for a child, being more sensitive about a first child, or because the child was young and, therefore, more likely to be ill than adults. In addition, being worried, anxious, and nervous were feelings that parents frequently expressed during their interviews. Parents wanted to seek care as soon as possible in order to allay their fears and worries. Parents' worries increased when they could not provide self-care or when their self-care did not work. Some parents could not cope with their child's condition and became distressed when their children suffered from an illness. Moreover, the inability of children to explain their current situation affected parents' decision to visit the ED in order to get help for their child.

"We couldn't cope with it ... He [the child] becomes anxious. He started to have some sleeping problems at night. Because he is just a two-year-old and does not understand what is going on with him, he is not aware of anything. He woke up at night and was crying. What could I do in this situation?" (P9, mother, aged 25-30 years, 1 child).

The level of health literacy was another important component in the decision to visit the ED. Parents suggested a number of reasons for using the ED including the inability to cope with the child's illness, running out of ideas for self-care, lack of knowledge about self-care, and management of childhood illness. Some parents stated that they had insufficient knowledge about what to do when their children became ill and, therefore, felt compelled to visit the ED in such situations. This was illustrated by 1 parent:

"We were at home and did not know what to do. We thought about using the ED, so we took her to the ED." (P11, father, aged 25-30 years, 2 children).

It was evident from the data that some parents did not know how to provide self-care or did not feel confident about providing it. It seems that the parents who had limited knowledge or confidence about caring for a child were afraid that their self-care interventions would have a negative consequence on their child. The safety net of 24-hour ED provision meant that some parents relied on professional support rather than risk the consequences of attempting home care. This was illustrated by 1 father:

"Because we don't know what to do, we're afraid it might cause a side effect. We thought that it's not appropriate to do anything as we already have doctors." (P6, father, aged 35–40 years, 2 children).

Core category 2: perceived limitations of healthcare services, system, and staff

Lack of availability of out-of-hour services was one of the reasons for parents to use the ED. In Turkey, there are no

Table 6**Core Categories, Concepts and Themes from Parents and Healthcare Staff**

Core Categories	Concepts	Themes
Core category 1: parents' feelings, knowledge, and perceived inability to provide self-care	Concept 1: parents' feelings impact on their decision-making process	Themes from parents Fear Being worried, anxious and nervous Being afraid and becoming upset Feeling compelled to take the child to the ED Unable to wait any longer The importance of the child to a parent Themes from healthcare staff Parental worries and anxiety Perceived urgency
	Concept 2: lack of knowledge and perceived inability to provide self-care	Themes from parents Unable to cope with the case Ran out of ideas for self-care Lack of knowledge about self-care Management of childhood illness Difficulties of self-care Themes from healthcare staff Lack of knowledge of parents Lack of public awareness
Core category 2: perceived limitations of healthcare services, system and staff	Concept 1: lack of out-of-hour services	Themes from parents Unavailability of out-of-hour services
	Concept 2: problems with pediatric outpatient clinics and pediatricians	Themes from parents Limited number of pediatric clinics and pediatricians Overcrowding in outpatient clinics and related problems The complex care environment Being unable to be admitted to outpatient clinics Unsafe care environment Lack of interest by pediatricians Themes from healthcare staff Overcrowding in pediatric outpatient clinics Lack of capacity Redirection of patients to the ED.
	Concept 3: problems with GP practices and GPs	Themes from parents Lack of engagement with the healthcare system Limited resources and interventions Lack of interest Being provided with limited and unclear information Dissatisfaction and negative experiences with the GPs Mistrust of GPs Perceived lack of experience of GPs Themes from healthcare staff Lack of engagement with the healthcare system Poor public perception of GP practices Limited resources Lack of professional commitment Lack of trust in GPs Dissatisfaction with GPs Poor public perception of GPs Redirection by GPs
Core category 3: parents' preferences for hospital and ED services	Concept 1: trust in ED services and greater resources	Themes from parents Trust with the ED services and ED staff ED staff expertise in children ED resources Better care in the ED Expectation of receiving ED treatment Habitual use of the ED Themes from healthcare staff Perception of receiving quicker care Perception of receiving better care Prior positive experiences with the ED

(continued)

Table 6
(continued).

Core Categories	Concepts	Themes
	Concept 2: convenience and access	Themes from parents Convenience Working parents were unable to take time off work A perception that ED was faster and easier Proximity to their home Themes from healthcare staff Convenience Ease of access
Core category 4: adverse impact on ED services	Concept 1: impact on ED services	Themes from parents Ineffective assessment and treatment Leading to revisits Themes from healthcare staff Increased resource use, costs and workload Decreased quality of care Prevention of timely care Disruption to ED services
	Concept 2: impact on ED staff	Themes from parents Staff distress Medical errors Violence towards staff Staff being unable to spend enough time with the patients Themes from healthcare staff Adverse psychological and physiological impact Decreased job satisfaction Staff burnout Decreased productivity Risk of malpractice and medical errors Violence towards staff.
	Concept 3: impact on patients	Themes from parents Dissatisfaction Poor patient outcomes Lack of interest Patients being unable to fully explain their problems Themes from healthcare staff Risk to patient safety Breach of patient confidentiality
Core category 5: perceived needs for care (Emerged only from parents)	Concept 1: parents' perception of urgency	Perceived urgency
	Concept 2: reassurance	Reassurance Did not want to take sole responsibility
	Concept 3: advice from social networks	Visiting the ED following advice from their social network

ED, emergency department; GP, general practitioner.

out-of-hour services, which means that ED services are the only available healthcare services outside working hours. This means that members of the public often have no other recourse but to attend the ED, even when their conditions are not urgent. Some parents explained their desire to visit other healthcare services, rather than using the ED, if they were made available to them.

"I came at 2 am in the night. There's no GP available at 2 am in the night. We are forced to come here [ED]." (P10, father, aged 25-30 years, 1 child).

Lack of satisfaction with pediatric outpatient clinics and pediatricians led parents to bypass these services and seek

care at the ED. Parents stated that they had difficulties in receiving care from pediatric clinics because of the limited number of clinics and pediatricians and overcrowding in these services. This overcrowding and the complexity of the care environment in pediatric outpatient clinics dissuaded parents from using such services, which led them to use the ED. Parents reported that specialist doctors were unable to allocate enough time for patients, which resulted in ineffective medical examinations and treatment, and left parents with unanswered questions. Such negative experiences caused dissatisfaction and decreased the effectiveness of pediatric outpatient clinics, leading parents to seek care at the ED.

“The number of pediatricians should be increased because one of the important reasons which led us to the ED is that the specialist doctors are working very intensively. At least 70-80 patients are examined before lunch time. How can they help my child in one to two minutes?” (P5, mother, aged 40+ years, 4 children).

“Sometimes, they visit the outpatient clinic but because there is overcrowding there, then they come to the ED.” (ED staff 6, Hospital director, PED).

In addition, dissatisfaction with GPs and negative experiences with GP practices led parents to use the ED rather than their own GP. Moreover, parents complained about encountering a lack of interest from their GP in addition to being given limited information during their visit. These negative experiences decreased the likelihood of parents revisiting GP practices in the future. One participant said:

“They don’t show any interest. They don’t talk to patients. They don’t give a full diagnosis. If you don’t ask a question, they won’t give you an explanation . . . They need to fix these kinds of things right away. They need to show more interest.” (P3, mother, aged 25–30 years, 3 children).

“The trust relationship is very important. Sometimes we can’t establish a trust relationship. Or they don’t trust us.” (GP 2).

Core category 3: parents’ preferences for hospital and ED services

Parents expressed having a greater trust in the ED services and staff because of the availability of resources and staff expertise with children. This influenced parents’ trust in the ED and in ED staff. Parents preferred to use the ED instead of their GP due to the perception that ED staff possessed more skills in caring for their children compared to a perceived lack of skills among GPs. Parents felt that their child would receive better care and believed that the ED staff showed greater interest in their children. The availability of more resources in ED settings compared to GP practices was one of the reasons parents gave for using the ED. These sentiments were expressed as follows:

“The ED staff are interested in everything in the ED. The tests, examinations, medications, all of these are available here [ED]. So, we brought her because there is better healthcare delivery here.” (P6, father, aged 35–40 years, 2 children).

“Their problems can be solved immediately [in the ED]. That’s why people like the ED and want to visit the ED.” (ED staff 11, ED doctor, ED).

In addition, some parents found visiting the ED more convenient and comfortable than using other healthcare services. Some working parents had difficulties in taking time off work and were therefore unable to visit the GP. Furthermore, some parents preferred to use the ED because of its proximity to their home. The findings show that the distance between healthcare services and the

patient’s home affected their decision. One interviewee explained this as follows:

“Since the ED is very close to my house, I generally take her directly to the ED.” (P2, mother, aged 25–30 years, 1 child).

“Especially working parents; if they can’t take the child to their GP during working hours, they are going to visit the ED even if the child’s condition is not urgent. We all see this.” (GP 4).

Core category 4: adverse impact on ED services

Overcrowding of ED services was negatively perceived by the parents. Parents felt that overcrowding had negative consequences that impacted both themselves and the staff. The consequences for parents included dissatisfaction, poor outcomes, staff showing a lack of interest, inability to fully explain their problems, and revisits to the ED or other health services, which may increase the total cost of healthcare services. Parents felt that the negative consequences for ED staff included medical errors, risk of violence toward staff, staff being unable to spend enough time with the patients, and ineffective assessment and treatment.

“In terms of quality of care, it increases the risk of missing something from the treatment. Because the number of patients is very high, the time allocated for each patient is decreased. Thus, the likelihood of forgetting something in the treatment of patients is increasing. People’s health is at risk.” (ED staff 7, ED doctor, PED).

Violations of social and cultural norms such as queue jumping caused upset to parents who viewed such practices as unfair. Overcrowding in the ED and the pressures of time and resources created an unsatisfactory environment where parents felt that neither patients nor staff were well served. This results in dissatisfaction as parents who are unable to give their medical history in detail feel unheard and dismissed by staff members, and staff members are unable to provide the quality of care they want for their patients.

“Sometimes the doctors get depressed. Like I said, there’s a lot of patients out there, nobody waits their turn [jumps the queue]. Of course, the doctor cannot take care of all these patients at the same time.” (P13, father, aged 40+ years, 4 children).

“High numbers of non-urgent patients negatively affect the quality of care, staff performance, and the service provided.” (GP 4)

Moreover, parents perceived that overcrowding in the ED caused by non-urgent attendances can divert ED staff from more urgent cases. This was the case when patients with non-urgent conditions wanted to be seen as soon as possible, complained, or caused disruption in the ED, which could prevent staff from dealing with urgent cases and caused increased stress among staff.

“Since this [overcrowding] increases the workload, it sometimes prevents me from spending time with real urgent patients. For example, we might have a patient on resuscitation or a patient suffering from a seizure, and while we are

dealing with these, some families with non-urgent conditions can complain about why we don't look at their children straight away . . . This makes us stressed . . . Therefore, I think it prevents us from taking the necessary care of the really urgent patients.” (ED staff 1, ED doctor, PED)

“These non-urgent ED presentations prevent staff from looking at real urgent cases. They cause trouble for them [ED staff].” (P11, father, aged 25–30 years, 2 children).

Core category 5: perceived needs for care

Parents' perception of urgency was one of the most frequently mentioned reasons for attending the ED. This perception of urgency differed between the healthcare staff and parents, as parents are subjected to feelings of concern, fear, and anxiety for their child, which could lead them to exaggerate the urgency of their child's condition. Parents were asked about their child's condition, whether they needed urgent care, and the majority of them ($n=8$) thought that their child's condition needed urgent care. One parent said:

“When I find out that my child's condition is urgent, when I see his discomfort in a certain way, when I get panicked, we take him to the ED . . . I thought it was urgent and took him to the ED.” (P8, mother, aged 25–30 years, 2 children).

One of the GPs stated that some parents exaggerated the conditions of their children and were therefore presented to the ED.

“Parents sometimes miscalculate the child's symptoms. For example, there is nothing urgent with the child and it's something that we can easily handle. However, they exaggerate the situation and perceive as it as urgent and that there is a need to visit the ED for it.” (GP 9).

It was evident from the findings that some parents had visited the ED in order to gain reassurance that their child's condition was not serious. Some parents did not want to take sole responsibility for their child's condition and visited the ED as a means of sharing this burden with members of healthcare staff. Getting reassurance was important to avoid parents feeling guilty in case their child's condition deteriorated while in their care. This worry was articulated by 1 participant as follows:

“I keep thinking that if the child's condition became more serious, or if she started having febrile convulsion and got worse at my hands, I would feel guilty. That's why I took her to the ED.” (P4, mother, aged 25–30 years, 2 children).

Some parents' decisions to visit the ED were influenced by advice from family and friends. Seeking advice from trusted individuals prior to deciding on a course of action provided reassurance and confirmation that outside assistance was required.

“My mother is close to me; I ask my mom. She leads us. They [relatives] also advise us to take the child to the doctor immediately. They direct us to the hospital.” (P3, mother, aged 25–30 years, 3 children).

Discussion

This study found that parental decisions regarding ED use was multi-dimensional and subject to many competing influences. It was evident that parents' feelings have an important impact on their decision-making process in relation to ED use. Such feelings might have prevented parents from making rational decisions regarding the use of healthcare services. However, it is important to state that parents should not be blamed for the fact that their feelings led them to use an ED. In agreement with these findings, Watson and Blair^[20] found that parents' worries affected their decision-making process. First-time parents and younger parents reported higher levels of stress and worry, and less confidence in their ability to care for a child than older parents.

The level of knowledge about the management of common childhood illnesses and the ability to provide self-care were other factors that drove parents to use the ED. Those who had limited knowledge about, and lacked experience of self-care preferred to visit the ED rather than risk the health of their child, which concurs with the findings of Kraaijvanger et al.^[21] This study found that low parental health literacy was associated with the inability to provide self-care and, therefore, led parents to use the ED for their healthcare needs. Educational interventions that increase the level of health literacy may decrease the healthcare demand. Increasing parents' health literacy and educating them on how to manage common childhood illnesses would increase their ability to provide self-care and make informed decisions regarding healthcare service utilization.

Perceived urgency, the need for reassurance, and gaining advice from family and friends also influenced parents to use the ED. Parents are more likely to overestimate their child's condition because of their feelings of concern for the child's welfare. The findings in relation to perceived urgency are in agreement with those of previous studies conducted in high-income countries,^[22,23] in addition to those of Watson and Blair^[20] who found that parents' emotions affected their decision-making process and led them to feel less in control of their child's condition.

Lack of availability of out-of-hour services was one of the most important reasons for parents to use the ED in Turkey. This study adds to the existing literature by identifying how the lack of availability of out-of-hour services contributed to ED utilization in the context of countries that have no such services. Lack of availability of out-of-hour services left parents with no other option than seeking care for their children at the ED. A resource-intensive solution would be the introduction of out-of-hour services in low- and middle-income countries to divert patients from the ED.

A unique finding of this study was parents' dissatisfaction with pediatric outpatient clinics and pediatricians, including overcrowding in such clinics, and perceived lack of staff interest, which drove parents to seek care at the ED rather than using these clinics. One possible explanation for this finding could be related to the provision of outpatient clinics on a drop in basis without the need for prior appointment or GP referral and the

relatively easy access to pediatricians, resulting in a high demand and perceived overcrowding of these services compared to the ED. Improving pediatric outpatient services may encourage parents to use these services rather than using the ED, and therefore, reduce demands on the ED. Provision of educational opportunities for healthcare staff to improve communication skills, raise standards of care, and improve patient flow may improve parents' experiences and usage of these clinics. For change to occur, an investment in resources is required to ensure that a greater number of patients can be seen at outpatient clinics in order to reduce the demand for EDs.

Dissatisfaction with GPs, including a lack of engagement with the healthcare system and a perceived lack of interest by GPs, led parents to use the ED. The findings showed that parents preferred not to use their GPs due to a lack of trust and a perceived lack of GPs' experience with children. Similarly, Kraaijvanger et al.^[21] found that parents who believed their GP lacked experience in pediatric care would avoid their practice in favor of attending the ED. This suggests the need to increase parents' awareness of GP practices and establish better relationships and trust between GPs and their patients. Staff in GP practices should willingly engage with parents to increase the appeal of primary care services and lead parents to use their GP. Capp et al.^[24] also found that dissatisfaction with primary care services led parents to use the ED. Parents described the need for GP practices to be better resourced and, therefore, allowed staff to undertake more interventions. Parents tended to use healthcare services where they had previously had positive experiences, rather than where they had less successful experiences.

Trust in ED services and staff, in addition to greater resources, make the ED more attractive to parents. These findings are similar to those of other studies which found that EDs are seen as services for accessing many resources and tests in one place,^[9,25] as well as the availability of specialist doctors,^[26] reinforces parents' attendance. Some parents found that they received faster and more convenient care in the ED. It would seem important to build trust in other healthcare services if the problems of ED over usage are to be addressed.

Our findings showed that the negative consequences of ED overcrowding as perceived by parents included poor outcomes, dissatisfaction, ineffective treatment, medical errors, and revisits. Similarly, other studies suggested that poor patient outcomes, reduced quality of care, reduced patient satisfaction, increased risk of revisits, and exposure to medical errors were all consequences of ED overcrowding.^[8,27] Therefore, it is important to improve patients' experiences with EDs and send them home with positive subjective and clinical outcomes. This may help to increase the effectiveness of the ED and reduce the number of revisits.

Strengths and limitations

One of the strengths of this study is the collection of data from a range of parents, including mothers, fathers, and those who attended the ED during and outside

office hours. The perspectives of healthcare staff including ED staff and GPs were also obtained. This provided us with diverse participant characteristics to aid our understanding of this complex issue. Therefore, the findings might reflect the populations from which the sample was drawn, which enhances transferability.

Despite these strengths, this study has several limitations. In terms of demography, all respondents came from 2 regions: Mardin and Midyat, Turkey. Members of the public in more developed cities in Turkey, such as Istanbul, might have different experiences and greater access to healthcare services, including private hospitals and better-resourced primary care services. Therefore, it is possible that our findings may not represent all individuals' experiences.

Future research

Further research is required on how to improve patients' experiences following their ED visit and therefore reduce the number of revisits to better meet patient needs. Research is needed on how to improve parents' experiences of pediatric and GP-led clinics in order to improve service provision to meet their needs and reduce the use of ED for non-urgent care. There is a need to develop targeted interventions that meet the needs of middle- and low-income countries that take into account the unique cultural and economic circumstances of such countries. It is important to develop these from a bottom-up perspective to ensure that services adequately address the identified gaps in provision from a service user perspective.

Conclusion

This is the first Turkish-based study to explore parents' reasons for using the ED for their children with non-urgent conditions. This study helps us better understand the motivations of parents in relation to ED use in Turkey, including differences at societal and healthcare system levels. This research highlights the limitations of the Turkish healthcare system which contribute to parents' decision-making in relation to ED use and may inform healthcare providers, policymakers, commissioners, healthcare staff, ED directors, and researchers to design interventions in order to mitigate overcrowding in the ED. Greater efforts must be made to reduce unnecessary visits to the ED to better meet service user needs and to increase the satisfaction of both parents and healthcare staff.

Conflict of interest statement

The authors declare that they have no conflicts of interest. This study has been completed as part of Ahmet Butun's PhD studies at Queen's University Belfast.

Author contributions

All authors participated in the research design, conduct of the research, data analysis, and writing of the paper.

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Ethical approval of studies and informed consent

This study was conducted in accordance with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. The study was approved by the General Secretary of the Association of Mardin Public Hospitals (Turkey) on October 13, 2016 (Ref: 74380343/663.08), and from the School of Nursing and Midwifery, Queen's University Belfast (UK) on December 20, 2016 (Ref: 04.12.16.M2.V2), and written informed consent was obtained from the participants.

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