

Co-location of Out of Hours Primary Care and Emergency Department in Belgium: Patients' and Physicians' View

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Abstract

Background In Belgium, General Practitioner Cooperatives (GPC) aim to improve working conditions for unplanned care and to reduce the number of inappropriate emergency visits. Although this system is well organised, the number of inappropriate visits does not decrease.

Methods We explored the position of patients and physicians on the co-location of a GPC and an emergency service for unplanned care. The study was carried out in a cross section design in primary and emergency care services, including patients and physicians. Main outcome measures were the position of patients and physician on co-location a GPC and an emergency service.

Results 404 patients and 488 physicians participated. 334 (82.7%) of all patients favored a co-location. The most important advantages were fast service (104, 25.7) and adequate referral (54, 13.4%). 237 (74%) of the GP's and 38 (95%) of the emergency physicians were in favor of a co-location. The major advantage of this system was a more adequate referral of patients. 254 (79%) of the GP's and 23 (83%) of the emergency physicians believed that a co-location would lower the workload, decrease waiting time and increase care quality (resp. 251 (78%), 224 (70%) and 37 (93%), 34 (85%).

Conclusions To meet all concerns and to reach for high care quality information campaigns and development of workflows are necessary for a successful implementation of a co-location of primary and emergency care.

Background

In Belgium, General Practitioner Cooperatives (GPC) aim to improve working conditions for out of hours primary care and to reduce the number of inappropriate emergency visits by patients. Although this system is well organised and elaborated, the number of inappropriate or un-referred emergency visits does not decrease (1, 2). Inappropriate use of the emergency department (ED) is defined as a use for non-urgent conditions or conditions that can be handled by a general practitioner (GP) (3, 4). As compared to other countries, the number of these patient visits is very high in Belgium (5). Patients have free access to the ED where they expect to receive a fast, efficient and sophisticated service (6, 7). Besides, patients are more familiar with this type of out of hours or unplanned care than with the service offered by the GPC's or GP's on duty (7, 8).

To address the problem of inappropriate use of emergency services, the government installed the nationwide number 1733 for unplanned, non-live threatening out of hours care (9). An operator directs the caller to the appropriate level of care: three levels of ambulance intervention, urgent or planned referral to out of hours primary care services or to planned care (<https://www.health.belgium.be/en/health/need-call-physician-call-1733>). These operators are trained to follow digital protocols. These protocols are the result of a collaboration between academic partners, the Federal Public Service Health, experts in general practice and in emergency medicine (9, 10).

Internationally, there is also a plea for a physical collaboration between the ED's and the GPC's in organising unplanned care (11–13). On this so-called co-location, both services offer one entrance to care with a triage to the appropriate care level following predefined protocols. Both services operate independently but maintain a high level of mutual consultation and referral.

This relatively new approach of a single entry with triage to the appropriate care level requires a broad support of all actors and a bottom up development of work flows. In this research, we explored the position of patients, GP's and emergency physicians on the co-location of a GPC and an emergency service for unplanned care.

Methods

The study was carried out in a quantitative, cross section design. The primary research question was: what is the position of patients and physicians (GP's and emergency physicians) on the co-colocation of a GPC and an emergency service.

The questionnaires were the result of the findings of previous research, expert consult and the input of the advisory board of the federal taskforce (9, 14).

In the patient questionnaire, the following themes were addressed: patient registration by telephone (national 1733 number), triage to the appropriate care level (emergency service, urgent or planned referral to out of hours primary care services or to planned care) and all practical and infrastructural consequences concerning availability of speciality care and accessibility of the services. The answer options were distributed on a 5-item Likert-scale (fully agree to fully disagree).

The physician questionnaire addressed the position of the physicians on the concept and the organisation of a co-location service for unplanned care. This questionnaire used a 2-item Likert scale for the answer options (rather agree-rather not agree). Above, the participants rated seven statements: ideas and expectations on co-location, time efficiency, care quality, logistic and practical conditions to collaborate and mastering of competences.

Recruitment took place in a representative region of Belgium. Indicators for representability were characteristics of the care region (a federal framework to organise care) and demographic characteristics. Patients were recruited in three regional GPC's and one emergency service. The inclusion criteria for patients were domiciliation in the region, older than 18, Dutch speaking or understanding. Physicians were recruited through the local GP-organisations and hospitals. The inclusion criteria were working as GP or as emergency physicians in an emergency department.

Because patients were recruited on site, they were invited to complete a paper version of the questionnaire. The physicians received an electronic invitation of the questionnaire. The questionnaire was conducted in QualtricsXM-software on a secured server (University of Leuven). For univariate analyses we used Excel 2016 and for the multivariate analyses SAS 9.4. A multivariate logistic regression

analyse was performed with 'in favour of co-location' as dependent variable for both datasets separately (patient and physician). Odd ratios and 95% confident intervals were calculated for the independent variables referring to the predefined themes.

The study took place between July 1 and December 31 2019.

Results

Patients

404 patients completed the questionnaire. On average, these patients visited a GP 5.5 times a year, 0.7 times a year a GP on duty (for unplanned care) and 0.5 times a year an emergency department. When visiting an emergency department, patients were referred by their GP in 28.3% of the cases. 62 (15.3%) of all patients did not know how to reach a GP on duty (Table 1).

Table 1
Characteristics of patients

	n(%)	n(%)			n(%)
Age (years)		Visit < 6 months		Location GP on duty	
18–30	90 (22,3)	GP		Own practice	7 (1,7)
31–45	125 (30,9)	0	13 (3,2)	GPC	317 (78,5)
46–65	136 (33,7)	1–4	199 (49,3)	- Independent	313 (77,5)
65+	53 (13,1)	≥5	189 (46,8)	- Next to ED	4 (1,0)
Care region		Blank	3 (0,7)	National number for unplanned care (1733°)	5 (1,2)
Rural	117 (29,0)	GP on duty		Combination	4 (1,0)
GP	71 (17,6)	0	255 (63,1)	Own practice and GPC	2 (0,5)
GPC	46 (11,4)	1	84 (20,8)	1733 and GPC	2 (0,5)
Semi-urban	179 (44,3)	>1	65 (16,1)	Don't know	62 (15,3)
GP	149 (36,9)	ED		Blank	9 (2,2)
GPC	30 (19,8)	0	268 (66,3)		
Urban	108 (26,7)	1	102 (25,2)		
GP	80 (19,8)	>1	34 (8,4)		
ED	28 (6,9)				
GP: general practitioner					
GPC: General Practitioner Cooperatives					
ED: emergency department					

Overall, 334 (82.7%) of all patients favored a co-location (Table 2). The most important advantages of this system were a fast service (104, 25.7%) and an adequate referral (54, 13.4%). According to the patients, the major advantages of a telephone triage were a fast service (108, 26.7%), reassurance (74,

18.3%), advice (52, 12.9%) and limitation of unnecessary transfers (83, 20.5%) (Table 2). The major disadvantage of telephone triage was the risk on an inadequate operators' assessment caused by the absence of a clinical examination, an inadequate assessment of symptoms and the lack of knowledge about patients' medication and medical history (resp. 30.4%, 12.4% and 8.7%) (Table 2). When calling for unplanned care (telephone triage), 237 (58.7%) of all patients expected to be in direct contact with a physician and not with an operator (Table 2). 234 (57.9%) of the patients believed that a referral to planned care, made by an operator is less reliable than a referral to this care level made by a GP (Table 2). When emphasized that telephone operators are well trained to refer patients, 349 (86.4%) patients were convinced that the referral is adequate. When co-location implies that patients cannot refer themselves, then they agreed with the system if the waiting time for unplanned care decreases (resp. 246, 60.9 and 259, 71.5 for GP and ED) (Table3). Although for particular musculoskeletal problems or cutting wounds patients (307, 76% and 306 75.7%) preferred a visit to the ED, most patients (353, 87.4%) had confidence in the technical skills and interpretation of examinations performed by a GP (Table 2).

Table 2
Advantages/disadvantages of telephone advice and triage by GP and of co-location

Telephone advice by GP					
Advantage	n(%)	Disadvantage	n(%)		
Time to care		Wrong clinical assessment			
Fast service	108 (26,7)	No physical examination	123 (30,4)		
24/7 available	8 (2,0)	No patient history	35 (8,7)		
Telephone contact with physician		Limited anamnesis	50 (12,4)		
Reassurance	74 (18,3)	Barriers in anamnesis due to language/understanding	4 (1,0)		
Advice	52 (12,9)	Not specified	18 (4,5)		
Assessment by physician	12 (3,0)				
Practical advantages		Not reassured	25 (6,2)		
No extra transfer	83 (20,5)	Long waiting time	11 (2,7)		
Cost saving	17 (4,2)	No prescriptions	10 (2,5)		
Reduce workload for ED and GP	2 (0,5)	High responsibility	1 (0,2)		
Other	7 (1,7)	Other	8 (2,0)		
No advantage	13 (3,2)	No disadvantage	7 (1,7)		
Blank	118 (29,2)	Blank	158 (39,1)		
Co-location					
Options	n(%)	Advantages	n(%)	Disadvantages	n(%)
Fully agree	90 (22,3)	Fast service	104 (25,7)	Further from home	19 (4,7)
Agree	244 (60,4)	No extra transfer	103 (25,5)	Parking/transport	3 (0,7)
Disagree	31 (7,7)	Correct referral	54 (13,4)	Longer waiting time	19 (4,7)
Fully disagree	6 (1,5)	Multi-disciplinary	29 (7,2)	Other	41 (10,2)
Blank	33 (8,2)	Well equipped setting	18 (4,5)		
Telephone registration on co-location n (%)					

Telephone advice by GP						
Options	Physician at telephone	Telephone advice	Operator assessment	GP assessment		
Fully agree	100 (25,1)	159 (39,4)	47 (11,6)	101 (25,0)		
Agree	137 (34,3)	208 (51,5)	187 (46,3)	226 (55,9)		
Disagree	127 (31,8)	22 (5,4)	133 (32,9)	61 (15,1)		
Fully disagree	35 (8,8)	11 (2,7)	32 (7,9)	10 (2,5)		
Blank	5 (1,3)	4 (1,0)	5 (1,3)	6 (1,5)		
Triage on co-location n (%)						
Options	Correct referral operator	Ignore referral operator	No own initiative visit GP	No own initiative visit ED	No free choice	Adequate referral
Fully agree	83 (20,5)	16 (4,0)	57 (14,1)	86 (21,3)	55 (13,6)	167 (41,3)
Agree	266 (65,8)	90 (22,3)	189 (46,8)	203 (50,2)	210 (52,0)	164 (40,6)
Disagree	36 (8,9)	213 (52,7)	113 (28,0)	72 (17,8)	93 (23,0)	94 (23,3)
Fully disagree	13 (3,2)	71 (17,6)	33 (8,2)	24 (5,9)	26 (6,4)	20 (5,0)
Blank	6 (1,5)	14 (3,5)	12 (3,0)	19 (4,7)	20 (5,0)	167 (41,3)

Table 3
Characteristics of physicians

Years of experience	0->5y	171(36)
	6->15y	114(24)
	16->25y	70(15)
	26->35y	75(16)
	> 35y	48(10)
Gender	Gender neutral	1 (0)
	Male	236 (48)
	Female	249 (51)
Discipline	Other (management)	15 (3)
	ED resident	35 (7)
	GP	320 (66)
	GP resident	77 (16)
	GP	40 (8)
Type of practice GP	Other	12 (4)
	Duo	53 (17)
	Group	174 (54)
	Solo	71 (22)
	Local Medical Centre	9 (3)
Type of practice ED physician	Other	1 (3)
	Regional Hospital with co-location	9 (23)
	Regional hospital without co-location	22 (55)
	University Hospital (without co-location)	8 (20)
Location GP on duty	Other	13 (3,3)
	Co-location	45 (11,3)
	Own practice	54 (13,7)
	GPC	285 (71,7)

Patients who preferred to be in telephone contact with a physician instead of an operator were less likely to favor a co-location (OR = 0,93 (95% CI 0,88–0,96). In particular younger patients and patients who were

satisfied with a telephone advice, were in favor of a co-location (resp. OR = 0,98 (95% CI 0,98–0,99); OR = 1,25 (95% CI 1,14–1,38). Patients who agreed that a co-location implies that self-referring and a free choice of care provider will disappear, were more likely to be in favor of a co-location (resp. OR 1,25 (95% CI 1,15–1,37; OR = 1,11 (95% CI 1,01–1,22)).

Physicians

488 physicians participated of which 320 (66%) GP's, 77 (16%) GP residents, 40 (8%) emergency physicians and 35 (7%) emergency residents. 232 (73%) of all GP's participated in an unplanned care GPC and 36 (11%) operated on co-location. 22 (55%) of all emergency physicians worked in a regional hospital without co-location for unplanned care (Table 3).

237 (74%) of the GP's and 38 (95%) of the emergency physicians were in favor of a co-location (Table 4). For GP's and emergency physicians in favor of the co-location (respectively 97/237 and 18/38), the major advantage of this system was a more adequate referral of patients. Overall, 254 (79%) of the GP's and 23 (83%) of the emergency physicians believed that a co-location would lower the workload. In this system, according to the GP's and emergency physicians, waiting time would decrease and care quality would increase (resp. 251 (78%), 224 (70%) and 37 (93%), 34 (85%) (Table 4). GP's and emergency physicians believed that patient satisfaction would increase in the co-location system (resp. 217 (68%) and 30 (70%)) (Table 8). 200 (63%) GP's and 20 (50%) emergency physicians agreed that the ED infrastructure should be available for the GP in a co-location (Table 5). 104 (33%) GP's and 226 (65%) emergency physicians believed that GP's were sufficiently skilled to interpret the standard technical examinations (lab results, imaging) (Table 5). 212 (68%) GP's and 33 (83%) emergency physicians expected an increase of technical examinations prescribed by the GP in case of a co-location (Table 5). Physicians also believed that the cost effectiveness would be higher in a co-location than in the regular system (resp. GP and ED physicians 227, 71% and 28, 80%) (Table 5). Physicians were in favor of an independent organizational and financial structure for both services on the co-location (resp. GP 238, 74%, ED physicians 25, 63%). 154 (48%) GP's and 16 (40%) of the ED physicians stated that the opening hours of co-colocation should cover the off duty hours of the GP (Table 5). Half of the ED-physicians (20, 50%) and 13 (4%) GP's wanted a 24/7 opening of the co-location. 215 (67%) GP's were willing to work in a co-location service (Table 5).

Table 4
Major advantages when in favour of co-location by physician

Answer options	GP	ED physician	GP resident	ED resident
In favour of co-location	237 (84)	38 (95)	63 (82)	31 (89)
Efficient care	44 (19)	10 (26)	13 (21)	3 (10)
Adequate referral	97 (41)	18 (47)	19 (30)	22 (71)
Improvement of care quality	23 (10)	5 (13)	6 (10)	3 (10)
Proximity of hospital for technical examinations	54 (23)	NA	23 (37)	2 (6)
Reduction of workload	7 (3)	2 (5)	NA	NA
More referrals to ED	5 (6)		1 (11)	
Inappropriate protocols	7 (9)		2 (22)	
Insufficient confidence in system	7 (9)	0	NA	NA
Increase of workload	10 (13)		2 (22)	0
Decrease of independency	24 (30)	1 (50)	2 (22)	0
Overuse of technical examinations	11 (14)	NA	1 (11)	NA
Legend: Only fully completed records				

Table 5
Perspectives of physicians on co-location

Perspective	Rather agree n (%)				Rather not agree n (%)			
	ED 40 (8)	GP 320 (66)	GPres 77 (16)	EDres 35 (7)	ED 40 (8)	GP 320 (66)	GPres 77 (16)	EDres 35 (7)
Decrease of workload	27 (68)	254 (79)	66 (86)	29 (83)	11 (28)	57 (18)	3 (4)	4 (11)
Improvement of care quality	34 (85)	224 (70)	56 (73)	30 (86)	4 (10)	67 (21)	9 (12)	1 (3)
Decrease of time to treatment	37 (93)	251 (78)	62 (81)	31 (89)	1 (3)	59 (18)	7 (9)	2 (6)
Increase of patient satisfaction	30 (75)	217 (68)	54 (70)	27 (77)	7 (18)	80 (25)	12 (16)	5 (14) 217 (68)
Use of ED infrastructure by GP	20 (50)	200 (63)	57 (74)	20 (57)	18 (45)	100 (31)	9 (12)	12 (34)
GP competent technical ex.	26 (65)	NA	NA	23 (66)	12 (30)	NA	NA	8 (23)
GP interpretation technical ex.	NA	225 (70%)	48 (62)	NA	NA	72 (22)	16 (20)	NA
Meer technical ex.	5 (13)	79 (25)	12 (16)	4 (11)	33 (83)	219 (68)	53 (69)	28 (80)
Independency of services	25 (63)	238 (74)	57 (74)	18 (51)	13 (33)	60 (19)	13 (33)	13 (37)
Higher cost effectiveness	29 (73)	227 (71)	54 (70)	28 (80)	8 (20)	72 (23)	12 (16)	4 (11)
Multi-disciplinary consult	34 (85)	277 (87)	59 (77)	31 (89)	2 (5)	24 (8)	7 (9)	1 (3)
	ED 40 (8)		GP 320 (66)		GPres 77 (16)		EDres 35 (7)	
Pre-triage								
Other	1 (3)		10 (3)		2 (3)		3 (9)	
GP	4 (10)		43 (13)		6 (8)		4 (11)	
Trained personnel	8 (20)		148 (46)		27 (35)		9 (26)	
ED physician	6 (15)		6 (2)		0		1 (3)	
ED nurse	18 (45)		33 (10)		20 (26)		10 (29)	
Legend: Only fully completed records								

	Rather agree n (%)		Rather not agree n (%)	
	ED 40 (8)	GP 320 (66)	GPres 77 (16)	EDres 35 (7)
Opening hours				
24/7	10 (29)	13 (4)	4 (5)	20 (50)
Other	2 (6)	21 (7)		
Only out of hours	17 (49)	154 (48)	38 (49)	16 (40)
From 6 pm till midnight	1 (3)	11 (3)	2 (3)	1 (3)
Only Weekend	1 (3)	96 (30)	20 (26)	1 (3)
Committed to work in co-location				
Part time	NA	15 (5)	8 (10)	NA
Only duty hours	NA	215 (67)	49 (64)	NA
Fulltime	NA	3 (1)	5 (6)	NA
No	NA	65 (20)	2 (3)	NA
Legend: Only fully completed records				

If the co-location would be set up, physicians who were not in favor of the system preferred to work full time in this service (OR 24,6, 95% CI 12,0–50,4). These opponents of the co-location also rejected the assumption that care quality would increase through the system (OR 0,030, 95% CI 0,015 – 0,057) and declared that the system would lead to an increased prescription of technical examinations by the GP's (OR 2,6, 95% CI 1,282-5,156). Opponents also predicted that the waiting time until treatment would not decrease in a co-location system (OR 0,292, 95% CI 0,164-0,522).

Discussion

In this study, we explored the position of physicians and patients on the co-location of a GPC and an emergency service for unplanned care. The majority of patients calling for unplanned care were in favour of a co-location. More than two thirds of all patients believed the benefit of co-location lies in decreases of waiting times. Although for particular problems patients preferred to visit an ED, the majority also had confidence in the competences of a GP. Co-location is particularly preferred by younger patients, patients who had confidence in a telephone operator and patients who were satisfied with a telephone advice.

The majority of ED-physicians and three quarter of the GP's were in favour of a co-location for unplanned care. Physicians believed that the adequacy of referral was the major advantage of this system. They also expected a decrease in workload and waiting time and an increase of care quality. Only one third of

the GP's believed that they were sufficiently skilled to work in a co-location. In particular ED physicians feared an increase of prescription of technical examinations by GP's. Only half of the ED physicians and a handful of GP's were in favour of a 24/7 opening of the co-location.

When patients use unplanned care services they are mainly concerned about waiting times, adequacy of referral and competences of the attending physician (and medical staff) (6, 8, 15). Waiting times for unplanned care are a major concern in most health care systems (16). Self-referring patients, understaffing and infrastructural restrictions are the main cause of this problem (5, 8, 16). Patients in our study were prepared to accept a referral for unplanned care if a trained telephone operator performed the triage. In addition, patients do not always expect a physical encounter with the attending physician and in some cases a telephone advice suffices. From earlier research, we know that referrals by this operator happen safe and adequate to all levels of care (9, 17–20). Increasing the adequacy of referring will undoubtedly decrease the patient inflow for unplanned care, workload and waiting lists. In a co-location service, patients expect a reduction of transfers for further examination or follow up (7, 11, 12, 21–23). Therefore, a particular point of attention in the organisation of unplanned care is the accessibility of the services. Local government can play a role in housing and supporting the ease of access to these services but also in public campaigns to promote the correct use (10, 24). Second point of attention is the patient who expects to be directly in contact with a physician when seeking unplanned care. These patients are less likely to follow the advice of an operator and will probably present to their preferred level of care, which in reality will mean that they will sign in to the ED (5, 6, 23). This action will slow down the time to intervention for the index patient but also for correctly referred patients by interfering with the regular workflow. A third group that needs particular attention are the older patients being less prepared to accept a referral to a co-location service. This might not surprise as they are used to the current system (6, 25, 26).

Although patients considered visiting the ED for particular problems, they declared to have enough confidence in the skills and competences of the GP. The link between these type of problems (wounds, musculoskeletal problems) and emergency care is rather the result of an image problem than of a rational believe that GP's are unable to deal with minor traumas (5, 22, 26–28). Younger patients, patients who adhered less to the common principle of self-referring or patients who relied upon the advice of an operator were more likely to be in favour of a co-location. It seems evident that the more knowledge and confidence patients have in the current healthcare systems, the more they will accept new systems (10, 29). Repeated and comprehensible public campaigns play a major supporting role in the acceptance of a new system (10).

A higher number of ED physicians were in favour of a co-location as compared to the GP's. GP's are reluctant to be involved in hospital care fearing that their input and expertise will be overruled or even dispensable (8, 11, 30) Therefore, in a co-location care system a strict flowchart and role definition is very important (17, 23, 31). Both groups confirmed indeed that a co-location might improve the adequacy of referral, lower the workload and decrease waiting times. These indicators have a high impact on health care outcome and satisfaction of patient and care provider (6, 28). The GPs' concern to play only a minor

role in a co-location can be altered by adjusting the infrastructure and working conditions to the needs of primary care. Above, most GP's did not feel competent enough to work in a highly equipped environment with access to technical examinations. Together with adjusted infrastructure, GP's will also need an introduction to use the available devices and to (co-) interpret results of technical examinations. Since particularly ED physicians feared an increase of technical examinations, an on the spot initiation and introduction of GP's will meet this concern and probably reduce the number of unnecessary or inadequate technical examinations (11). This intervention will also meet the expectation of both groups that a co-location will be cost effective. Another important issue was the claim by both groups to remain an independent 'organisation'. To align this structural independency with collaboration in patient care, a robust corporation agreement will be indispensable (7, 29). The observation that GP's and ED physicians disagreed on opening hours of the co-location might be a first subject of discussion. GP's were reluctant to opt for a 24/7 service. Other than the ED-physicians, GP's operate independently in their own practice during the regular hours. Day shifts in a 24/7 service imply a reorganisation of their practice schedule. Second, ED-physicians already work in a 24/7 schedule meaning implying that a full day and night service will not affect their working conditions. Physicians who rejected the idea of a co-location were more likely to prefer a 24/7 system. This apparent contradiction can be explained by the assumption that in a 24/7 service, scheduling of duty will be executed under better circumstances and conditions. For GP's it is reassuring that patient follow up is guaranteed when they are on duty.

The major strength of this study lies in the population reached. A representative part of the target population participated during the test period. This is also the first study giving insights in the bottom up construction of collaboration between ED and primary care for unplanned care. The questionnaires were constructed with the aid of the task force of unplanned care in Belgium. This group of experts was at the base of the restructuring of unplanned care and therefore well placed to support this research.

A participation bias cannot be ruled out since most questionnaire were completed by patients visiting the GP. The population frequently visiting the ED might be absent in this study. Although, most patients in Belgium have a GP and visit the GP at least once a year. Second, no distinction was made between patients who completed the questionnaire for themselves or third parties accompanying a patient. However, in case of a third party, this person will also decide on the level of care needed. Finally, this study did not focus on objective outcomes as cost effectiveness, care quality and patient and physician satisfaction. The study only relied on the assumptions, expectations and insights of the participants.

Conclusions

Patients and physicians favour a co-colocation of ED and GPC for unplanned care under certain conditions and circumstances. To meet all concerns and to reach for high quality standards information campaigns, cooperation agreements and bottom up development of workflows and procedure are highly necessary.

Further research should focus on cost effectiveness, care quality and patient and physician satisfaction in a concrete co-location site.

List Of Abbreviations

General Practitioner Cooperatives (GPC)

Emergency department (ED)

General practitioner (GP)

Declarations

Ethics approval and consent to participate

The study was approved by the Medical Ethical Board of the University hospitals of Leuven under the number MP009864. Patient participants signed an informed consent after verbal briefing by a researcher. A more comprehensive information letter was available on simple request.

Consent for publication

Consent for publication was obtained through the informed consent letter

Availability of data and materials

The complete dataset is available on simple request and will be sent as a link to a google-drive directory

Competing interests

None

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None

Authors' contributions

Conception and design of the research: all authors

Acquisition of data: JVC, TB, JW

Analysis of data: all authors

Drafting the article: JVC, TB, JW

Revision the article: all authors

All authors read and approved the final manuscript

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