Patient-orientated Gastroenterology

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Summary

Analysis of the first year's working of a combined gastroenterology clinic in a district hospital has shown that the major benefit was improved patient management. Hospital attendances were reduced, the diagnostic process accelerated, and unnecessary radiological investigations and surgical operations avoided. There were no obvious major disadvantages.

Introduction

For many years gastroenterology has been regarded as the province of either the general physician or the surgeon, each usually working in isolation. More recently, however, gastroenterology has become accepted as a specialty which derives particular benefit from a multidisciplinary approach. Nevertheless, joint medical and surgical gastroenterological units are comparatively rare, particularly outside teaching centres, and in most hospitals the usual practice is still for gastroenterological problems to be seen initially in either the general medical or the surgical departments with subsequent cross-referral as necessary. This seemed to us an unsatisfactory arrangement, but set against a climate of financial stringency it seemed unlikely that we would obtain support for any scheme to improve the clinic organization which involved significant expenditure or structural alteration.

Accordingly, we decided from the beginning of 1973 to launch a combined consultative outpatient clinic for gastroenterological problems with contributions from physician, surgeon, radiologists, and pathologist. This required nothing for its establishment other than the enthusiasm and co-operation of all parties, and the project was made easier by the fact that the physician and surgeon already had a simultaneous outpatient clinic which had the potential for a medicosurgical merger. With the support of the medical division but misgivings from the surgical department referrals to the clinic were invited for the beginning of 1973 and it soon became clear that our plan to hold the clinic fortnightly would cause an unduly long waiting list. It therefore became necessary to hold the clinic at least three times a month.

Clinic Procedure

About 12-14 new referrals are seen at each clinic with review appointments being kept to a minimum. Where possible the follow-up is supervised by either the physician or the surgeon individually with the case only coming back to the combined clinic if any particular problem occurs.

Each patient is seen by either the physician or the surgeon, both working from the same consulting suite, though the initial clerking is often done by the junior staff. Particular emphasis is placed on thorough clinical assessment in order to make a working diagnosis with the minimum of specialized investigations.

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Starting at 9 a.m. the appointments are timed so that consultations are finished by midday, when the clinical staff are joined by the radiologists and a pathologist for a joint discussion. After each individual case has been presented the available x-ray pictures (which have usually been arranged by the referring general practitioner) are reviewed and a general discussion, aimed particularly at formulating a management plan, ensues. A provisional diagnosis is made and a combined decision can then be made whether (*a*) no further investigations are requested and no clinic follow-up indicated; (*b*) further outpatient radiography is required with possible subsequent review; (*c*) "medical investigations" (gastric acid secretion measurements, endoscopy, assessment of small intestinal function, etc.) either as a day case or an inpatient are needed with possible subsequent review, or (*d*) operative intervention is clearly indicated and the patient's name added to the surgical waiting list.

Organizational Problems

So far there have been remarkably few organizational problems for we have been particularly fortunate in having had the enthusiastic co-operation of the nursing and administrative staffs.

Unpredictable absences inevitably occur occasionally, and when this applies to the clinical staff the remaining consultant simply has to cope as best he can. When advanced notice is available that a consultant will be away the number of new patients booked for the clinic can be reduced, and on the rare occasions when both are absent simultaneously the clinic is cancelled.

The clinic has one secretary only. This is essential to enable records to be traced easily and for inquiries from either general practitioners or patients to be referred to the right person. The secretary also maintains a diagnostic index.

First Years' Work Load

An analysis of the referrals for the first 12 months showed that 483 new patients were seen (see table). As might be expected

Analysis of Referrals in First Year of Combined Medicosurgical Gastroenterology Clinic

Diagnostic Category	No. of Referrals	No. needing Surgical Intervention
Oesophageal conditions:		
Gastro-oesophageal reflux	34	7
Carcinoma	4	2
Achalasia	1	1
Gastric lesions:		
Benign ulcer	17	7
Carcinoma	7	4
Combined gastric and duodenal ulcer	8	6
Duodenal ulcer	90	46
Dyspepsia after previous gastric surgery	12	4
Functional dyspepsia	51	0
Biliary tract disease	49	31
Pancreatic disease:		
Chronic pancreatitis	1	0
Carcinoma	2	2
Coeliac disease	2	0
Crohn's disease		
Small gut	2	1
Colonic	6	4
Combined	1	0
Colorectal disorders:		
Carcinoma	8	7
Diverticular disease	18	7
Proctocolitis	16	2
Irritable bowel syndrome	52	0
Simple constipation	17	0
Anal lesions	5	0
Psychiatric disorders	40	0
Miscellaneous disorders	40	5
Total	483	136

the major problems encountered were gastro-oesphageal reflux, peptic ulceration, biliary tract disease, the irritable bowel syndrome, functional dyspepsia, and psychiatric problems, with most of the sophisticated conditions which occupy so much space in the specialized gastroenterological journals being seen comparatively rarely. Clearly these figures in no way reflect the true incidence of gastrointestinal disease in the area but do show the problems with which the general practitioners need most help and highlight the divorce between "ivory-tower gastroenterology" and the specialty as it is practised at the grass roots.

The "miscellaneous" group (see table) included such diverse conditions as hyperthyroidism, diabetes, carcinoma of the bronchus, ischaemic heart disease, urinary tract disorders, bacterial endocarditis, etc., which emphasizes the necessity for any clinician interested in gastroenterology to retain a general approach.

Only 28% of the total referrals were judged to need operations, which rapidly dispels the belief that most patients referred to a gastroenterology clinic need abdominal surgery.

Advantages

The main advantage and raison d'être of the combined approach is undoubtedly that of improved clinical management. The patients clearly benefit from a firm plan of action drawn up at their first visit and a consequent acceleration of the diagnostic process. This attempt to reduce to a minimum the number of times a patient has to attend hospital is particularly important in a predominantly rural area such as ours where transport is a problem.

The correct sequence of radiological investigations is selected by discussion and unnecessary radiography avoided. Unnecessary surgery may occasionally also be avoided, and conversely the physician can be stopped from procrastination when surgical intervention is patently necessary.

The educational value of this co-operative venture is another major advantage, and is appreciated by the consultant members as well as the junior staff, who are extremely keen to attend. They grasp the opportunity to see patients under supervision, to present cases, and participate in the joint discussion. We have also been able to institute some small research projects with a strong pragmatic and clinical, rather than academic and laboratory, orientation.

We are aware from both the continuing flow of new referrals and informal discussion that the local general practitioners find ours a useful service.

Possible Disadvantages

There was a natural concern among the remaining general surgeons that a clinic aimed at attracting gastroenterological problems would seriously affect the distribution of clinical cases. Our intention, however, was not to create a gastrointestinal monopoly, and their fears have not been realized. As we expected there has been no apparent reduction in gastroenterological referrals to either the general medical or surgical clinics, and neither scrutiny of operation lists not an analysis of gastroenterological *x*-ray requests from the surgical department indicates any significant change from the previous pattern.

Concern was also expressed lest the clinic surgeon would be faced with an excessive operation load. This fear resulted from the basic misconception that most patients referred to a gastroenterology clinic need abdominal surgery. Clearly, however, the effect of a combined approach is often to recommend a more conservative management, and less than one-third of the total referrals in the first year needed surgical intervention.

There was also some anxiety lest the establishment of the combined gastroenterology clinic would lengthen the waiting time for non-gastroenterological referrals to be seen at the general medical or surgical clinics. This has not been so in the surgical department and has been prevented on the medical unit by the institution of an extra outpatient session.

Conclusions

We have shown that a combined gastroenterology clinic at district hospital level is a viable proposition, the only requirement being the enthusiasm and co-operation of those concerned. The major advantage of a combined approach has been to improve patient management, and no major disadvantages have become apparent.

We hope that our experience will encourage gastroenterologists elsewhere who are at present working in isolation to consider whether this concept might be applicable in their own situation.

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Letter from . . . Canada

Musings from the Hot Stove League

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The elevation of hypocrisy to the level of principle is a Canadian characteristic. With a heavy cultural inheritance from Scottish presbyterianism, we come by this honestly enough and naturally our politicians are not slow to utilize the potential.

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The Conference of Federal and Provincial Health Ministers held in Ottawa in January decided that they should limit immigrant doctors coming to Canada, to those with either "a firm job offer, or those ready to move into underserviced areas." The reasons given were, "to better balance the supply and distribution of physicians and to give priority to Canadians aspiring to medical careers." The real reason, of course, was money, and everybody in Canada knows it. The subsidiary reason, which every Canadian will at once deny, is prejudice, with stolid overtones of racial intolerance. The concealing euphemism here is that Canada should not draw away precious citizens from the underdeveloped countries.