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Special report

Staffing of a combined general medical service and gastroenterology unit in a district general hospital

A Report prepared for the Royal College of Physicians (London) Gastroenterology Committee and the Clinical Services Committee of the British Society of Gastroenterology

This paper describes the roles of a consultant general physician with a special interest in gastroenterology and associated staff working in a district general hospital. Its aim is to define the needs for staff in both the general medical and gastroenterological aspects of the service. Generalisations are based on data and comments received from 130 physicians. It is recognised that the staffing needs of University affiliated hospitals, or certain hospitals which provide a special service for patients outside their own district, differ from that presented here for hospitals which serve a local community.

Work of the district hospital physician with a special interest in gastroenterology

The physician/gastroenterologist, in a district general hospital fulfils a number of important functions. He/she shares with his colleagues in the rota for acute medical admissions, holds regular out-patient clinics and performs a substantial part of the diagnostic and therapeutic gastrointestinal endoscopy service. The staffing required to provide this service must be seen in relation to the volume and complexity of the work.

INPATIENTS – GENERAL MEDICINE

The number of patients admitted and the frequency of emergency duties vary according to the size of the hospital, its catchment area and the morbidity of the local population. According to a recent College survey[1] of district hospital physicians, the average frequency of emergency duties was one in 4·7 days with approximately 700 acute admissions each year. In the North East Thames Region, five district hospital physicians with a special interest in gastroenterology reported more than 900 admissions per year.[2] In East Anglia, six single handed physicians/gastroenterologists reported 750–1130 admissions annually.[3] These include admissions from outpatients, domiciliary consultations and personal referrals from general practitioners. The physician is also asked to advise on patients under the care of other consultants as well as supervising the care of his/her own patients. There is a regular commitment to administration and teaching.

INPATIENTS – GASTROENTEROLOGY

The majority of inpatients have general medical problems and the proportion of gastroenterology patients in the wards is at most 20–30%. Such patients may occupy disproportionately more time than other patients as they tend to be very ill. Gastroenterology forms about a third of inpatient general surgery so there are regular requests for consultation by surgical colleagues. Some gastroenterologists provide a nutritional advice service for their hospital and organise a clinical nutrition team responsible for enteral and parenteral feeding.

OUTPATIENT MEDICINE AND GASTROENTEROLOGY

In contrast with inpatients, most (70–100%) of the gastroenterologist's work in outpatients is in his own specialty. In addition to those with complicated physical problems, a large number are found, after investigation, to be suffering from functional disorders.[4] Consultations with this group of patients tend to be prolonged.

In the two regions surveyed gastroenterologists in district general hospitals saw 1000–1500 new outpatients each year with problems in the specialty.[2,3] Follow up patients are a mixture of about one-third general medicine and two-thirds gastroenterology.

ENDOSCOPY AND OTHER PROCEDURES

Endoscopy is now an essential technique for both diagnosis and treatment. All surveys show a steady increase in both types of procedure. Nationally, 35% of district general hospitals perform more than 1000 upper gastrointestinal endoscopies each year and some considerably more.[5] There is pressure for easier access by general practitioners to endoscopic investigation and this may increase the work load. A recent report suggests that about 160 colonoscopies per 100 000 population are desirable annually for immediate diagnosis and treatment and also for cancer surveillance in high risk groups.[6] Many district general hospitals are now undertaking diagnostic and therapeutic ERCP.

An average district hospital with a resident population of 240 000 now needs to staff at least seven, half day endoscopy sessions weekly; busier units need more. The physician/gastroenterologist is generally in administrative charge of the unit and is responsible personally for at least two or three sessions. Other sessions may be undertaken by another consultant trained in endoscopy (physician, surgeon, or radiologist) or an experienced clinical assistant.

The need to teach and supervise trainees in endoscopic procedures makes a considerable demand on the time of consultants. Junior medical staff or clinical assistants should not be expected to undertake endoscopies alone unless they have received adequate training which takes several months.

The work of an endoscopy unit demands considerable resources from the Department of Pathology for many biopsies need examination. ERCP and some types of therapeutic endoscopy, especially of the biliary system, needs the collaboration of a radiologist skilled in this type of work and the facilities of a Department of Radiology.

RESEARCH

Most consultants have research experience and wish to develop a clinical project.

Staffing needs of the general medical component

Junior staff are attached to the firm for two purposes. First, they assist the physician/gastroenterologist in the routine and emergency care of both medical and gastrointestinal problems in the wards. Second, they receive training and experience in acute general medicine and one of its major subspecialties. Most physician/gastroenterologists in district general hospitals care for patients with a wide variety of acute medical problems; thus training in all aspects of medical care in this setting is invaluable for the general physician of the future. The junior staff, especially at SHO/HP level are mainly concerned with care of patients in the wards.

It is not at present clear whether the new staff grade or associate specialist will form part of the team. The following structure is therefore based on junior staff in training but the staff grade could be incorporated.

INPATIENT WORK

To care for patients in the ward, most of whom are admitted as an emergency, and to provide an advisory service for other wards and the Casualty Department, a firm needs: (a) Registrar/senior SHO with at least two years postregistration experience. When on duty, this doctor is the most senior physician in the hospital at night and it is important that future changes in junior staffing structure take account of this fact. This doctor also assists in the supervision of the house physician and care for patients on the wards; is available to advise on patients in the casualty department (approximately 12 patients per week are sent home after assessment in casualty according to the North East Thames survey); performs emergency procedures. Assists and receives training in outpatients. (b) An additional junior SHO (less than two years postregistration experience) is needed on busy firms (say more than 700 acute admissions or more than 700 new outpatients per year). This doctor assists and receives training in the wards and out-patient work, but requires more supervision than the registrar/senior SHO. Gains experience in emergency procedures and assessment and treatment of acute medical problems. (c) Two house physicians.

OUTPATIENT WORK

For continuity many clinics need an experienced clinical assistant (often a general practitioner) who can deputise for the consultant. The registrar/senior SHO can see new outpatients under supervision and help with follow-up appointments. A junior SHO can work with the consultant in seeing new and old patients. The house physicians should not be involved in the outpatient clinics.

Staffing needs for the gastroenterological component

Gastroenterological work falls largely on the consultant, and other staff in career grades. To fulfil the inpatient and outpatient work in general medicine and gastroenterology, and to undertake the many diagnostic and therapeutic procedures in gastroenterology, every district needs one, and larger districts need two, general physicians whose major subspecialty is gastroenterology. Two consultants can not only share the outpatient and endoscopic workload but also deputise for one another during absence. The

arrangement also allows each of them to provide different personal skills – for example, in liver disease or nutrition, or in endoscopy.

INPATIENT WORK

A joint medical/surgical ward area is desirable for the joint care of patients with gastrointestinal haemorrhage, inflammatory bowel disease, obstructive jaundice and those requiring intravenous nutrition. Such an area needs nurses with special experience in stoma care, nutrition and other aspects of gastroenterology. This ward area will be covered by the junior staff already described.

NUTRITION SERVICE

Collaboration with a dietitian provides the best service for nutritional supplementation, enteral tube feeds or special diets. Successful parenteral nutrition with minimal catheter sepsis or other complications depends on strict nursing protocols. A nurse with specialist knowledge of this technique who can teach and assist colleagues is an essential member of a nutrition team. One doctor (physician or surgeon) should assume responsibility for placing parenteral feeding lines and supervision of patients.

OUTPATIENT WORK

Staffing needs are the same as for the clinic(s) already described under general medicine.

ENDOSCOPY PROCEDURES

At least seven sessions require cover by a consultant or experienced endoscopist. In most hospitals the consultant physician(s) bear the brunt of this work. Surgical colleagues (and sometimes radiologist) already assist and surgeons are likely to play a greater role.

In many hospitals one or more clinical assistants (often general practitioners), after a period of training, make an essential contribution by providing continuity and expertise for one or two sessions weekly.

A registrar/SHO may receive instruction in basic endoscopy but should not be asked to undertake endoscopy alone until adequately trained which is usually near the end of a period of rotation.

Trained endoscopy nurses, led by a sister, are essential if patient care is to be satisfactory and repair bills for endoscopes are not to escalate. A minimum of four nurses, some of whom may be part time (two per endoscopy room, one in the recovery area, one to cover holidays) is required for any selfcontained unit.

A secretary/receptionist is needed for the endoscopy services (in addition to a medical secretary for the inpatient and outpatient work) who should be provided with computer facilities for the maintenance of endoscopy records and generation of reports. Busy endoscopy units (more than 2000 procedures per year) will require both a secretary and a receptionist.

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