The gastroenterology service: a survey of general practitioners' requirements

G A Moody MB ChB **R Mann** MB BS MRCGP **S Gay** MB BS **A C B Wicks** MD FRCP
J F Mayberry MD MRCP *Gastrointestinal Unit, Leicester General Hospital, Gwendolen Road, Leicester LE5 4PW*

Keywords: audit; gastroenterology; general practice; shared care; in-practice training

Summary

A postal questionnaire was sent to 634 Leicestershire general practitioners about the service they wanted from their local gastrointestinal unit. Their views were specifically sought in relation to the care of chronic gastrointestinal disorders such as coeliac disease and inflammatory bowel disease. This initial survey was 'testing the water' before addressing GP needs in all areas of gastroenterology including, management issues in peptic ulcer disease and hiatus hernia.

The design of the questionnaire was simple with only 12 'yes' or 'no' stems. The response rate to one mailing of the questionnaire was 41% with the rate for each question ranging from 83% (on whether a telephone hot-line would be useful) to 99% (on the value of treatment protocols). There was a poor response rate to some individual stems, with rates of less than 10%, because most GPs only answered 'yes' to the stem they were interested in without answering 'no' to other parts.

Most GPs wanted a regular news bulletin on the management of both inflammatory bowel disease and coeliac disease as well as detailed protocols on their treatment. Sixty per cent of respondents wanted a telephone hot line to senior gastroenterologists, with direct dialling to provide immediate advice. Eighty per cent of GPs want shared care with hospital consultants of such patients. A similar proportion thought that this decision should be made jointly by patients and their doctors.

There is a clear desire by GPs for a more specialist education in line with the current trend of extending their role. GPs in Leicestershire would value a more active role in the management of patients with chronic intestinal diseases and it is likely that such views are widespread in Great Britain.

Introduction

Current interest in patient management in the UK has sharply focused on the role of family doctors in purchasing investigations and treatments for their patients. Future government policy will investigate who should provide various aspects of assessment and treatment. Much of the substance of these investigations will be enlisted in treatment protocols which will guide general practitioners in their care programmes and referral practices.

In an attempt to identify which gastroenterological services were useful in selected chronic diseases we approached GPs in Leicestershire and asked about the nature of the services they wanted and who should have ultimate responsibility for long term care of patients with coeliac disease and inflammatory bowel disease. Historically clinical decisions have been with hospital-based consultants rather than with GPs. The reasons are multiple and complex but have included concern about the quality of training for such conditions in general practice and with the small number of patients encountered in each practice.

Methods

A questionnaire was designed to investigate those services GPs thought a gastrointestinal unit should provide. The questionnaire was developed by a panel of GPs from outside the district and two consultants. It was subsequently approved after a pilot test in a large general practice in Central Nottinghamshire. Each of the 634 GPs in Leicestershire were mailed a copy of the final questionnaire.

The questionnaire consisted of 13 questions, nine were of a closed yes or no type while four had several stems each of which required yes or no answers. The questionnaire is given in the appendix.

Replies were analysed after a single mailing. The percentage of positive replies to each stem was expressed as a proportion of the total number who returned the questionnaire. The additional comments were also reviewed.

Results

Of the 634 GPs mailed, 259 replied (41% response rate). The response rate for each question ranged from 83% on whether a telephone hot-line would be useful, to 99% on the value of treatment protocols (Table 1). There was a poor response rate to individual stems with a response rate of less than 10%, because most GPs only answered 'yes' to the stem they were interested in.

Table 1. Views on possible gastroenterological services available to GPs

Topics	*Expressing an opinion*	*in favour*
Regular news bulletins	98%	70%
Treatment protocols	99%	90%
Use of protocols as base for audit	83%	60%
Talks by consultant gastro-enterologists at GP meetings	93%	60%
Pharmaceutical support of such meetings	85%	60%
Telephone hot-line to senior gastroenterologists	96%	60%
Shared care		
(i) coeliac	72%	70%
(ii) inflammatory bowel disease	88%	80%

Table 2. Long term care of patients with chronic digestive diseases

Long term care	*Family practice*	*Hospital OPD*	*Both*	*Patient*
IBD	0.06% r=13%	0.01% r=8%	80% r=88%	—
Coeliac disease	22% r=27%	0.05% r=10%	70% r=72%	—
Who should make decision	0.01% r=11%	0.02% r=8%	85% r=95%	0.02% r=7%

Seven questions were answered by almost all respondents, with more than half reporting a need for treatment protocols (90), regular news bulletins (70%), talks by senior gastroenterologists (60%), inpractice training in proctoscopy and sigmoidoscopy (60%), and telephone hot lines to senior gastroenterologists for advice (60%). GPs were mostly in favour of pharmaceutical support for educational meetings in their practices. Shared long-term care of patients was wanted by most GPs for coeliac disease (70%) and IBD (80%) (Table 2). Almost all practitioners (99%) felt patients with colitis should automatically be entered into a hospital-based colorectal screening programme (response rate of 98%).

Other suggestions spontaneously made by GPs included a 'Coop' card similar to that used in antenatal clinics (five GPs) and easier access to dietitians in the community (five GPs).

Discussion

In the present climate of economic efficiency and with many NHS hospitals becoming independent Trusts any business plan must be squarely based on the requirements of local family practitioners and their patients. Such knowledge is critical to the successful marketing of gastroenterology within a district. The concept of 'Working for Patients' depends upon the ethic of knowing what the customer wants and these customers are both patients and GPs. Cooperation and joint care are the clear messages from this survey, with an emphasis on informed choices, between patients, GPs and hospital consultants.

The consensus opinion of GPs in Leicestershire was for joint follow-up of people with coeliac disease and inflammatory bowel disease by hospital consultants and GPs. This was particularly requested of coeliac disease, although the reasons are unclear. A recent survey of consultant members of the British Society of Gastroenterology has seriously questioned the need for such hospital-based follow-up[1]. Interestingly most respondents felt that patients, consultants and family doctors together should together decide who was responsible for long-term care.

We did not assess other digestive tract diseases and there is a need to complete any gastrointestinal business plan by reviewing conditions such as peptic ulcer disease[2] and the role of endoscopy, as well as the use of protocols by family doctors and practice nurses to manage patients with well-established illnesses[3,4]. Other suggestions such as an antenatal style 'coop' card have sound reasoning behind them and many such devices will appear soon[5]. Easier access to dietitians in the community will provide more accurate assessments and their inclusion in the primary health care team is highly desirable[6].

There is a clear desire by GPs for more specialist education in line with the current trend of extending their role[2]. This is especially relevant against the background of growing concern about hospital follow-up of too many chronically ill patients.

References

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(Accepted 23 March 1992)

Appendix

The questionnaire

(1) Would you like to receive a regular news bulletin on the management of coeliac disease and inflammatory bowel disease?
(2) If this bulletin was associated with PGEA approval would you be prepared to subscribe to it?
(3) Would you like to receive a treatment protocol on the management of coeliac disease and inflammatory bowel disease?
(4) Should such a protocol form the basis for general practice audit?
(5) Would you like a telephone hot-line with direct dialling to a senior gastroenterologist to provide advice?
(6) Would you like a senior gastroenterologist to talk about the management of these conditions at your practice?
(7) Should such meetings be supported by pharmaceutical companies?
(8) As part of an improved service would you welcome in-practice training in proctoscopy and sigmoidoscopy?
(9) Should long term care of patients with inflammatory bowel disease be:
  (i) in general practice
  (ii) in hospital outpatients
  (iii) both
(10) Should long term care of patients with coeliac disease be:
  (i) in general practice
  (ii) in hospital outpatients
  (iii) both
(11) Who should make the decision as to where long-term care is to be based:
  (i) the patient
  (ii) the general practitioner
  (iii) the hospital consultant
  (iv) all three in consultation
(12) Should patients with extensive ulcerative colitis be automatically entered into a colorectal screening programme?
(13) Would you like to make any comments on ways in which the service to GPs for patients with inflammatory bowel disease and coeliac disease could be improved?