

## Open access endoscopy – a nationwide survey of current practice

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### Abstract

In a postal survey of 450 members of the Endoscopy Section of the British Society of Gastroenterology carried out during 1990, 47% of respondents stated that they were offering some form of open access endoscopy. Virtually all of these were offering open access gastroscopy, but one in three were also performing open access flexible sigmoidoscopy. Those units that offered open access endoscopy had significantly more endoscopists sharing the workload, including a greater number of clinical assistants. Only 10% of those who replied, however, were offering 'true' open access endoscopy, the remainder used some form of 'censoring'. There were also important differences in consultants' attitudes to the investigation and management of patients referred with dyspepsia, which may account for the patchy availability of the service. Some 71% of those who did not offer open access endoscopy cited an inability to cope with numbers as their main reason for not doing so. Support for these concerns is gained from the finding that 52% of those that offered the service have had a waiting list exceeding six weeks at some time. Nevertheless, open access endoscopy is becoming more widely available with a large increase in participating units during the past 12 months.

General practitioner access to investigative facilities other than laboratory based blood tests varies enormously from health region to region.<sup>1</sup> The reasons for these differences are not always clear and the availability of one investigation in a certain area may not necessarily reflect a planned policy to provide equipment and personnel for that particular investigation or a deliberate policy of restricting access to hospital based requests only. Local factors, including the attitude of hospital specialists, usually determine whether or not investigative facilities are offered to general practitioners on an open access basis. 'True' open access endoscopy refers to an endoscopic procedure requested by a general practitioner and carried out without any selection by a hospital consultant. 'Censored' open access endoscopy refers to the widely adopted approach of endoscoping patients before (or without) a clinic appointment. This decision is made by the specialist to whom the general practitioner has written. Open access endoscopy has been available to general practitioners in some areas for

over 10 years,<sup>2,3</sup> and experience with open access gastroscopy is steadily increasing.<sup>2-5</sup> Flexible sigmoidoscopy<sup>6-7</sup> and even colonoscopy<sup>8</sup> have also been available to some general practitioners on a very limited basis. The extent of open access endoscopy nationwide is unknown. This paper reports the results of a survey carried out in 1990 in order to establish the extent of this service and why its availability is so variable.

### Methods

In June 1990 a structured questionnaire was sent by post to 450 members of the Endoscopy Section of the British Society of Gastroenterology resident within the United Kingdom. This group were targeted in view of their self proclaimed interest in endoscopy as well as being representative of current clinical practice. At the end of three months all returned questionnaires were analysed and, where appropriate, results were interpreted using the  $\chi^2$  test. No reminder was sent. Open access endoscopy was defined as an endoscopic procedure carried out without the patient having first been seen in a specialist clinic.

### Results

A total of 353 replies were received, representing a response rate of 78.4% and covering 290 different hospital units. A total of 44 questionnaires were returned anonymously but otherwise completed satisfactorily. These replies are included in the total of 353 respondents answers available for analysis. Out of the total number of replies 168 consultants stated that they offered open access endoscopy while 183 did not. There was no relation between the length of service in post and availability of open access endoscopy (Fig 1).

### OPEN ACCESS GASTROSCOPY

Open access gastroscopy was the most widely available service offered by 167 consultants (47.3% of total), usually after a letter to the consultant who then decided whether to gastroscop the patient either before a clinic appointment (103 replies – 61.7%) or without a clinic appointment (117 replies 70.1%). Only 36 replies indicated the use of a completed form to evaluate the need for gastroscopy (21.5%). Pre-medication consisting of a topical throat spray

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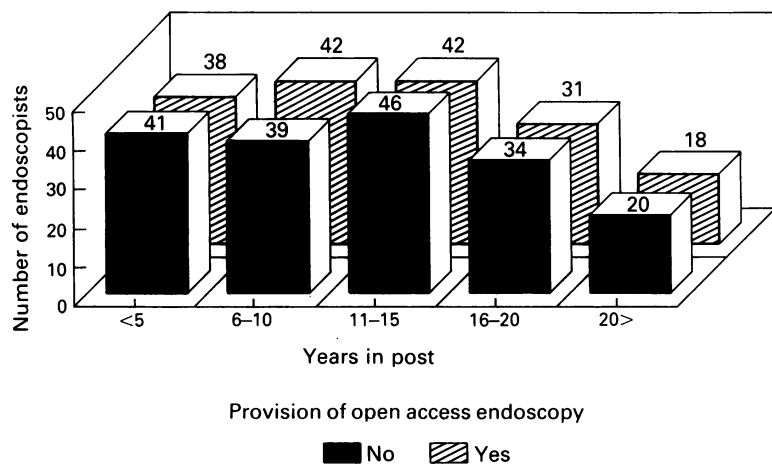


Figure 1: Provision of open access endoscopy by consultants in relation to number of years in post.

was used for most cases by 18.5% of endoscopists while intravenous sedation was used predominantly by 46.3% of endoscopists. The remainder (35.2%) used both methods to an equal extent. Thus, approximately one third of patients undergo open access gastroscopy after a topical throat spray alone.

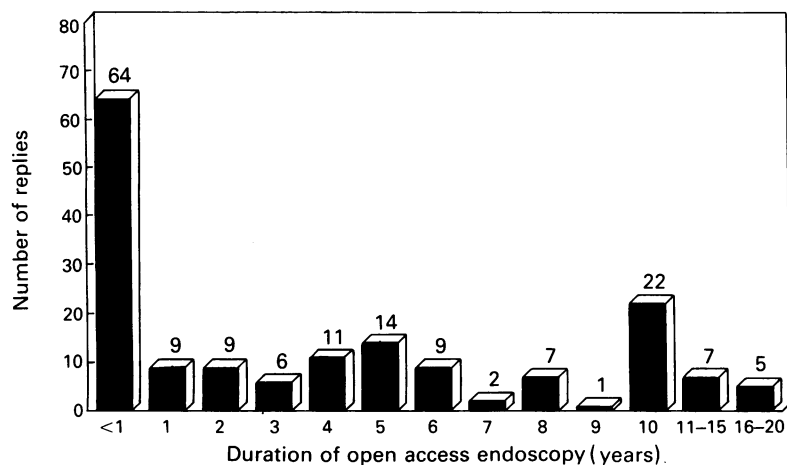
**Local radiology services**

Absence of open access barium meal examination was not a significant factor in districts offering open access gastroscopy. Altogether 158 of 167 (94.6%) replies from districts offering open access gastroscopy stated that this service was available compared with 149 of 183 (81.4%) replies from consultants with no open access service ( $p < 0.05$ ). Open access ultrasound was equally available irrespective of whether there was an open access gastroscopy service or not (113 replies – for each group).

**Duration of open access endoscopy**

There has been a steady increase in the number of consultants offering open access endoscopy during the past 10 years, with a very noticeable increase during the past 12 months (Fig 2). Over half (52%) of those offering this service, however, stated that waiting periods had exceeded six weeks at some time in the past.

Figure 2: Duration of open access endoscopy in those units offering this service.



Specified reasons why open access endoscopy was not available (n=183)

Reasons	Agreement	
	Replies	(%)
Unit unable to cope with numbers	130	71
Not enough consultant time	117	64
Not enough nursing time	112	61
Inadequate facilities (eg secretarial, clerical)	87	47.5
Not computerised	57	31
Quality would be sacrificed for quantity	43	23.5

**OPEN ACCESS LARGE BOWEL ENDOSCOPY**

Flexible sigmoidoscopy and colonoscopy were offered on an open access basis by 60 (35.7%) and 26 (15.5%) respondents respectively. Open access radiology (barium enema examination) was not available locally in 23 (39%) areas where open access flexible sigmoidoscopy was practiced and in eight (30.8%) areas where open access colonoscopy was practiced. The corresponding figure for areas that did not offer open access endoscopy was 79 of 183 (43.2%) replies. Thus, open access barium enema examination was available in less than half of the districts surveyed irrespective of whether open access endoscopy was available or not. Half of the 60 replies from consultants who were already performing both open access gastroscopy and open access flexible sigmoidoscopy indicated that they would like to extend their service further at some time in the future.

**NO OPEN ACCESS ENDOSCOPY**

One hundred and eighty three (53%) replies indicated that open access endoscopy was not available. Those who did not offer open access endoscopy were asked to indicate which of the statements in the Table they agreed with. There was an overriding feeling that consultants would not have enough time to practice open access endoscopy (117 (64%) replies) and that their endoscopy unit would be unable to cope with the potential numbers (130 (71%) replies). Lack of nursing time (112 (61%) replies) was almost as important as lack of consultant time. Only 29 (15.8%) replies indicated that some form of open access endoscopy was planned for the future.

**Clinical assistants.** There were significantly more clinical assistants in units offering open access endoscopy compared with those that were not ( $p < 0.001$ ), but even in units that did not offer this service, 66% of general practitioner clinical assistants were endoscoping their own patients (Fig 3). In general there were more endoscopists sharing the workload in units offering open access endoscopy than in those that were not (3.1 v 1.1).

**CONSULTANT ATTITUDES TO PATIENT CARE**

All consultants were asked the following questions:

- (1) Do you think all patients should be seen by a consultant prior to endoscopy?
- (2) Is there a danger of consultants becoming

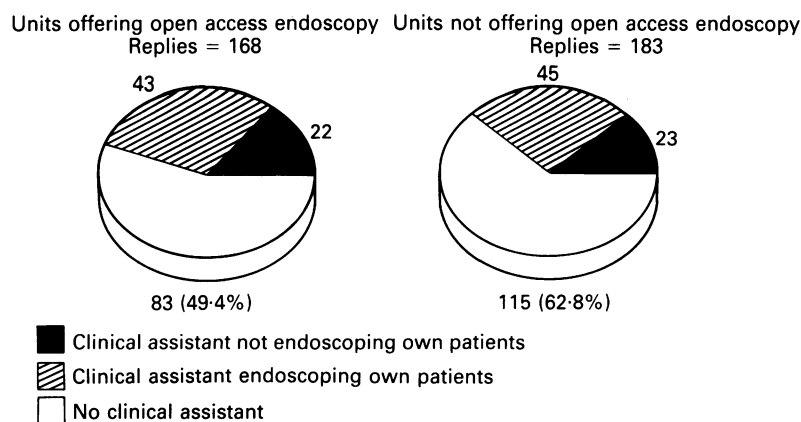


Figure 3: Details of clinical assistant sessions in unit offering and not offering open access endoscopy with reference to those endoscoping their own patients.

'technicians' if open access endoscopy is widely available?

(3) Does open access endoscopy blur the margins of responsibility in respect of who is looking after or investigating the patient?

One hundred and forty one (84%) consultants who offered open access endoscopy felt it was not necessary to see patients before endoscopy compared with 119 (65%) consultants in the larger group that did not offer this service ( $p < 0.001$ ). Similarly, only 59 (35%) consultants who offered open access endoscopy felt that there was a danger of consultants becoming technicians compared with 119 (65%) consultants who did not offer the service ( $p < 0.001$ ). The replies to the last question were also significantly different – 123 (67%) consultants who did not offer open access endoscopy were worried by the lack of clear guidelines on patient responsibility compared with only 69 (41%) consultants who did offer an open access service ( $p < 0.001$ ).

### Discussion

This is the first nationwide survey of endoscopy practice relating to the provision of open access services in the United Kingdom. A previous survey by the British Society of Gastroenterology in 1986 indicated that 28% of 50 hospitals were offering such a service.<sup>9</sup> Although at first sight it seems that open access endoscopy is now more widespread, with 47% of respondents indicating that they practice this, most consultants are engaged in 'censored' open access endoscopy, selecting patients for endoscopy without necessarily seeing them first, or subsequently, in the outpatient clinic. This cannot be described as true open access endoscopy as it is the consultant who makes the decision whether or not to endoscope the patient, while the general practitioner makes the referral to an individual rather than to a department as is usually the case when requesting a barium meal examination. Many gastroenterologists seem reluctant to release full responsibility to the general practitioner, but there are also many other constraints which are relevant in the context of consigning an endoscopy unit to such an open ended commitment. This study has shown several factors which are important.

Firstly, it is unrealistic to expect single handed endoscopists to commit themselves to open access endoscopy (mainly gastroscopy). It is clear that units which are offering this service

have significantly more endoscopists and clinical assistants sharing the workload and this enables them to carry the extra burden. Secondly, it is equally unrealistic to expect an endoscopy unit to accommodate the increased workload when there is insufficient nursing time or inadequate facilities. The deficiencies in nursing staff (61%) and facilities (47.5%) seem less than those highlighted in the BSG survey four years ago,<sup>9</sup> while the fear of being inundated with requests for open access endoscopy paradoxically prevents this service being offered to general practitioners. In the new NHS, however, with a purchaser/provider split it is quite possible for the enthusiastic endoscopist to budget for an increased workload within the unit's business plan. Conversely units that do not offer open access endoscopy may find their patients (and money) going elsewhere.

Apart from human and technical resources, it is clear from the results of this survey that consultants differ in their attitudes to the relation between hospital and general practitioner and that these differences are independent of the consultant's age and length of service. In some cases the fear of litigation that may result from not performing a full consultation could be diminished if clear guidelines are drawn up and included on a formal request form issued to general practitioners. A BSG working party is currently examining this and should be making its recommendations soon (C Swan – personal communication). In this survey, only one fifth of consultants who performed open access endoscopy were using such a form, but even this form may be inadequate in many instances. Of further concern was the possibility that the endoscopy services would be used inappropriately with an increasing number of 'normal' gastroscopies being performed. This reservation has been voiced before<sup>10</sup> but others with more experience of open access gastroscopy state that with the passage of time requests do not keep going up and the detection rate of important lesions remains constant.<sup>3</sup> There should be advantages to patients in terms of waiting times if open access gastroscopy is widely adopted but it is worrying that 52% of respondents reported a waiting time longer than six weeks for open access endoscopy at some time in the past.

One surprising finding uncovered by this survey was the availability of other open access investigations in districts with open access endoscopy. It seems that open access gastroscopy, in particular, is not being offered because of any lack of open access barium meal examination. Indeed the converse was true, districts with no open access endoscopy service were more likely to have restricted access to barium meal examination. This must surely make the job of the gastroenterologist even more onerous, with general practitioners only able to investigate patients by referral to a consultant outpatient clinic. More open access gastroscopy and access to other investigations for general practitioners should reduce this outpatient burden enabling patients to be investigated and treated more quickly.

In summary 47% of members of the Endoscopy Section of the BSG offer some form of open

access endoscopy. Of these, approximately one fifth offer open access without censoring the request, leaving patient management in the hands of the general practitioner. This means that only 10% are offering true open access endoscopy. During the past five years, however, many units have initiated such a service, but many consultants still feel reluctant to take this step because of both resource implications and attitudes to patient care.

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