General practitioner access to gastroscopy: is 'censorship' valuable?

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SUMMARY

An audit was carried out on the activities of a one stop clinic where patients referred by GPs for endoscopy are first interviewed by a gastroenterologist, directly before the procedure. Such a barrier to open access endoscopy did not seem to reduce the workload or the rate of normal examinations.

Keywords: gastroscopy; endoscopy; referral to hospital for investigation.

Introduction

ALTHOUGH well established in many hospitals, open access gastroscopy is still not available nationwide.[1] Many endoscopy units have expressed concern that this service may lead to a lowering of the referral threshold, resulting in a massive increase in workload,[1] an increase in the number of examinations, and thus a greater proportion of normal examinations.[1-4] Whether some form of 'censorship' of general practitioners' (GPs') referrals might reduce the risk of over-investigation is still debatable.[1,5] Censorship could be achieved either by a pre-endoscopy interview or by assessment of the referral letter. We studied the value of censorship in the form of a pre-endoscopy interview by establishing a 'one stop clinic' (OSC) in which patients referred for gastroscopy are first interviewed by a gastroenterologist before a decision about further investigation is reached. The activities of this clinic were audited over a 22-month period between January 1993 and October 1994.

Method

The 'one stop clinic' was established at St Bartholomew's hospital, London in 1992 and all local GPs were informed about the service. The clinic is run weekly either by a consultant or by a career registrar or senior registrar in gastroenterology. Patients are referred to this clinic either directly by GPs (GP/OSC) or by a consultant gastroenterologist (C/OSC) after reading the GP's referral letter to the regular gastroenterology clinic. The patient is interviewed for 10 to 15 minutes and, if deemed appropriate, an unsedated gastroscopy is performed immediately after the consultation. The findings and management plan are then communicated to the patient and his or her GP. A retrospective analysis of all patients seen in this clinic over a 22-month period was undertaken.

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Results

Two hundred and seventy-two patients were seen in the OSC over the study period, of whom 137 patients (50.3%) were referred directly by their GP. Sex distribution (M:F 1:1), mean age (GP/OSC: 48.5y [range 20 to 82] and C/OSC: 47.9y [range 18 to 81]), and waiting time (GP/OSC: 25d [range: 1 to 35] and C/OSC: 28d [2 to 35]) were similar between the two groups. Table 1 shows the relationship between the opinion of the GP regarding the appropriateness of the gastroscopy (i.e. whether a gastroscopy was specifically requested) and the opinion of the gastroenterologist (i.e. whether the gastroscopy was performed after the interview). In the GP/OSC group, the gastroenterologist agreed with the GP that a gastroscopy was indicated in 113 out of 120 patients (94.2%). Even when the GP did not ask specifically for a gastroscopy, 16 out of 17 patients (94%) nevertheless underwent a gastroscopy. In patients allocated to the OSC on the basis of the GP referral letter to the regular gastroenterology clinic (C/OSC), 53 out of 62 patients (85.5%) had a gastroscopy when the GP letter asked specifically for one.

The rate of normal endoscopic findings in all patients seen in the clinic was 42%, irrespective of whether they were referred directly to the OSC by their GP or allocated by the consultant. There was no difference in the distribution of positive findings between the two groups.

Discussion

In many places where open access endoscopy is offered, many consultants practise 'censored' open access endoscopy, selecting patients for endoscopy without necessarily seeing them first, or subsequently in the outpatient clinic before the examination.[1]

The present audit indicates that a pre-endoscopy interview does not substantially reduce the gastroscopy workload. In the group of patients referred by the GP to the OSC with a view to gastroscopy, 129 of 137 patients (94%) underwent gastroscopy after the interview. Even in the group of patients referred to the general gastroenterology clinic, when the GP asked specifically for a gastroscopy in the referral letter, a gastroscopy was performed in 85.5% of cases (53 of 62 patients) after the interview. Thus, the majority of gastroscopies requested by GPs were judged appropriate by the gastroenterologist. The implication is that it is sufficient for the consultant to read the GP's letter and refer the patient directly for gastroscopy, avoiding an outpatient appointment and saving a day off work for the patient. Whether the management would have changed if a 'true' open access gastroscopy was available is beyond the remit of the present audit. However, it has previously been shown that treatment given by GPs is appropriate to gastroscopy findings in 80% of cases.[4,6]

The rate of normal gastroscopies in this audit was 42%, which is comparable with previous studies from 'true' open access gastroscopy.[6] Preliminary interview did not reduce the rate of normal endoscopic findings nor the distribution of positive findings.

In summary, more than 90% of GPs' referrals to open access gastroscopy are appropriate and a pre-endoscopy interview does not help in selecting patients nor does it reduce the rate of normal endoscopic findings. Thus, 'censorship' for open access

Table 1: Relationship between the general practitioner's specific request for an oesophagoduodenoscopy (OGD) and the decision after the interview.

	GP requested OGD *n*	OGD performed *n* (%)
GP/OSC		
Yes	120	113 (94.2%)
No	17	16 (94.1%)
C/OSC		
Yes	62	53 (85.5%)
No	73	56 (76.7%)

gastroscopy seems unjustified and the time spent in the interview could be used more effectively.

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