Dialogue and interchange across the primary/secondary interface: piloting SpR secondment to a general practice diabetic clinic

Brian Hurwitz, Lorraine Albon, John S Yudkin

Brian Hurwitz
MD FRCP MRCGP, Professor of Primary Health Care and General Practice, Imperial College of Science, Technology and Medicine, London

Lorraine Albon
MSc MRCP, Specialist Registrar, Whittington Hospital

John S Yudkin
MD FRCP, Professor of Medicine, Royal Free and University College Medical School, London

Clin Med JRCPL 2001;**1**:374–7

ABSTRACT – The growing volume of diabetic care taking place in UK general practice and pressure to unload hospital clinics are resulting in entirely separate patient caseloads, in which structured care and monitoring of large numbers of patients over many years can take place in one health care sector alone. In these circumstances, it is important to guard against the GP service becoming educationally and clinically isolated from hospital diabetic clinic care and *vice versa*. Greater interplay of staff between health sectors could serve as an antidote. Educational objectives for brief SpR secondment to general practice diabetic clinics were formulated and three month SpR secondment to a central London practice clinic was set up and judged a success for GP and SpR alike. This was followed by GP and consultant sitting in on each other's diabetic clinics, allowing each to appreciate similarities and differences in their clinic, case load and practice setting.

For the past 14 years one of us (BH) has conducted a monthly two-and-a-half hour diabetic clinic in an inner city practice in London. A growing workload, combined with an increasing sense of educational and intellectual isolation from evolving patterns of mainstream hospital diabetes care, led to the proposal to second a specialist registrar (SpR) from the local hospital to the practice diabetic clinic. This paper describes the rationale behind the initiative, reports on its benefits and limitations, and discusses the educational opportunities afforded to both GP and SpR by the arrangement.

The practice and its diabetic clinic

Situated in South Islington Primary Care Group, the practice has a list of 5,000 patients with an age sex profile typical of the locality, served by 2.75 whole time equivalent (wte) GPs, and 1 wte practice nurse. When SpR secondment was first mooted in 1999, 117 patients with diabetes were on the register, 22% of whom were treated with insulin. In 1999, the practice prevalence of diabetes was 2.1% compared with an average prevalence in neighbouring practices of 1.2%[1].

During practice diabetic clinics, patient details are recorded in structured, manual and computer records, 94% of diabetic patients being reviewed annually (62% within the practice, 32% in hospital outpatients). Since its inception in 1987, the practice clinic has operated in close association with the diabetic clinic at the Whittington and other local hospitals, has participated in a number of diabetes-related projects[2], and has hosted brief attachments for GPs and community nurses.

Perceived problems running the practice diabetic clinic

By 1999, despite (perhaps to an extent *because* of) some successful features of this diabetic care, the practice clinic faced certain difficulties. First, the number of diabetic patients had outgrown the health care provision then currently offered: to review each patient annually, 10 rather than 7 patients would need to be seen in each monthly clinic. A significant proportion (up to 50%) of patients was thought likely to require assessment more frequently than once a year. In an effort to accommodate these needs, nurse-run review clinics had been introduced, but had had high non-attendance rates. The GP partners were therefore considering committing additional doctor review time to the care of diabetes. Second, a number of practice policy issues were awaiting decisions, including whether to institute microalbuminuria screening and how to ensure more rigorous management of risk factors for diabetic patients. Third, since its inception in 1987, the practice clinic had been run by the same doctor; while allowing one clinician to become thoroughly and comprehensively involved with almost all of the diabetic patients, this policy meant most patients had been assessed clinically by the same generalist over a prolonged period. In a rapidly changing complex field of health care this could be undesirable.

A specialist registrar to provide additional doctor time

Additional doctor input could be recruited from within or outside the practice partnership. It was reasoned that recruiting from outside the partnership, from the specialist registrar pool, carried the advantage of creating a forum for doctors in hospital training to share their clinical expertise with primary care physicians, and to gain hands-on experience of the general practice management of chronic disease. It was also hoped secondment would initiate a new dialogue between primary and secondary diabetes care sectors. The practice clinic was believed to offer a number of educational opportunities for a specialist registrar and, on the basis of these (see Table 1), SpR release from the Whittington Hospital endocrine clinic was agreed, on a three month experimental basis.

What happened during the secondment

The SpR attended three GP diabetic clinics. Much of the time was spent sitting with the GP in joint consultation, but some patients were seen by the SpR alone and fully discussed with the GP before any action was suggested. Before being seen by the GP or SpR, the practice nurse recorded patients' weight, urinalysis and the most recent glycated haemoglobin, and discussed diet, lifestyle and monitoring. The medical consultation then addressed problems experienced by the patient since the last review, defining any outstanding risk factors including blood pressure, glycaemic control, dyslipidaemia, or microalbuminuria.

SpR's reflection on secondment experience

Although brief, the secondment allowed first hand experience of problems encountered when dealing with patients with chronic disease in general practice. Even urinalysis and blood tests, manoeuvres generally taken for granted in hospital, can be difficult to ensure in a general practice setting. (In this practice patients are sent request forms 10 days prior to the diabetic clinic). The GP was seen to work in partnership with the practice nurse, but without on site support of dieticians, podiatrists or diabetes specialist nurses.

Patient mix was similar to that seen in a hospital diabetes clinic; patients were no less 'complicated' medically, possibly a reflection of the developed diabetes interests of this practice. However, the scope of problems brought to the GP seemed wider than in a hospital clinic – perhaps due to the long relationship between the GP and patients. Knowledge of social and personal circumstances is invaluable in the management of chronic conditions, yet for an SpR, the yearly attachments – all spent in hospitals – afford little opportunity to build relationships with patients, resulting in a tendency to see patient encounters as isolated events rather than as a part of an ongoing process.

In a specialty where the majority of patients are looked after in primary care, there are clear benefits for SpRs in training to be able to experience this health care setting at first hand; yet a diabetologist in training is required to attend renal, lipid, eye, adolescent and gestational diabetic clinics. In view of the already existing and competing time commitments of SpR training there needs to be clear justification for adding another clinic to this list. To fit in secondment to a general practice means removing some other attachment from the current pattern of SpR clinic-based experience.

Key Points

- **Throughout the UK, GP and hospital diabetic clinics operate separately and with little interchange of staff**
- **There is a risk of GPs who run diabetic clinics becoming clinically and educationally isolated from consultant-led clinics**
- **Educational objectives for brief SpR secondment to general practice diabetic clinics can be formulated**
- **SpR secondments to a practice can offer valuable experience that leads to education and learning for GP and SpR alike, but should not be seen as a contribution to staffing practice clinics**
- **Occasional sitting in by GPs and consultants on each other's diabetic clinics allows each to place their clinical work in a mutually helpful perspective**

Table 1. Learning opportunities for specialist registrar GP attachment.

- Gain first hand knowledge of providing diabetes primary care in an established clinic in a well organised practice
- Widen registrars' clinical experience of care to include a primary care setting in which medical problems arrive relatively unsorted, and where investigative and ancillary support are less accessible than in hospital
- Experience at first hand how to plan and manage the referral process between primary and secondary care
- Gain experience of hospital–GP communication in the management of chronic disease from the perspective of primary care
- Contribute to updating and improving diabetic services within the practice by contributing, for example, to:
  - planning and implementing audits of diabetic care
  - providing new practice services for diabetic patients
  - considering how best to redistribute clinical responsibilities between doctor and nurse
- Compare the pace of investigation, management and inter-vention in primary and secondary care
- Contribute to the creation and maintenance, on computer, of primary care diabetes datasets.

Consultant and GP sit in on each other's clinic

After the pilot SpR attachment over three diabetic clinics, a number of facts emerged. The educational advantages perceived by both SpR and GP were considerable. A particular benefit for the GP was the ability to replicate, in a small way, the discussions around decision making that hospital team work, ward rounds and clinics routinely provide, where management decisions are frequently discussed prospectively in a group. Though similar issues can be discussed in like manner in general practice, this almost always takes place by way of retrospective review, *after* clinical decisions have been taken, because the GP is almost always alone with the patient.

Are differences in attitude, approach and management between the GP and the SpR consequent upon differences in the setting of their usual practice, or are they due to discrepancies in experience between a GP principal of 16 years' standing and that of a third year SpR? We therefore repeated the exchange, on a one-off basis, with the consultant diabetologist sitting in the GP's diabetic clinic, and reciprocally, by the GP attending a hospital clinic.

To both participants this exercise proved instructive, with similarities in approach being more apparent than differences. Other than in pressure and workload, the GP observed how little the hospital clinic had changed in the 16 years since he himself had last worked there. By contrast, the GP clinic was far more efficient in terms of information technology, use of templates and protocols. If anything, work pressures in hospital outpatients meant that there was the same lack of discussion and mutual exchange as that experienced in general practice. Both GP and consultant remarked upon the feeling of familiarity in the other's setting, with the impossibility of limiting discussion only to diabetes when patients whom the doctor has known for years consult about a multi-system disorder.

Precedence for such exchange

In the case of diabetes care, increased permeability to patients and staff movement across primary/secondary care interfaces has long been identified and, to an extent, catered for within the NHS. In 1953, Joan Walker believed the functions of a diabetic clinic could not adequately be accomplished solely within a hospital setting. She argued the case for health visitor attachments to diabetic outpatient clinics, their role then being to provide expert domiciliary care, education, and insulin adjustment in patients' homes – a precursor of the modern diabetes specialist nurse[3–5]. Subsequently, a number of experiments have been attempted in which hospital medical staff provide outreach diabetic clinics[6–10], but none of these seems to have continued to the present day.

Logistical limitations of the exercise

The learning objectives from the point of view of the SpR have already been considered. From the viewpoint of the GP, three groups of objectives can be summarised as: overcoming isolation, continuing education and updating in newer aspects of diabetes management, and monitoring in the context of practice-based patient care (Table 2).

Yet is it really feasible for such functions to be provided by secondment of SpRs to general practices? Shared diabetic care has meant devolving responsibility for many diabetic patients entirely to the GP. However, this devolution has not been accompanied by a parallel movement of resources. Thus, many GPs find themselves in a similar situation to that described here; in turn, this is a major constraint to generalising from our particular initiative. SpR training in general (internal) medicine with diabetes and endocrinology requires outpatient experience in a wide range and large number of clinics (up to 230)[11]. Even if commitment were made to just one or two general practice clinics per SpR, such an approach could not offer a meaningful or sustainable way of sharing increasing GP workload. The pilot scheme, although judged by the participants an educational success, does not provide the answer to a problem recently labelled 'hamster health care', the tendency for demands upon health carers to rise, and provision of care to become more complicated, while time and resources devoted to providing it remain unchanged, leading to a fall in doctor satisfaction and quality of care[12].

Conclusions

The exercise of running clinics jointly with a professional colleague was rewarding for all. Even in hospital clinics, clinicians are isolated at the time when decisions are made. The ability to discuss these with an experienced colleague sheds new light on management habits that may have become almost conditioned reflexes. While we would encourage the adoption of GP diabetic clinics among the specialty experiences necessary for an SpR, the educational benefits have wider implications. Brief SpR secondment to a practice could provide a formal mechanism for mutual education, learning and renewal. Such a strategy might seem a pre-requisite for a Diabetes National Service Framework, if it is to recommend more primary and intermediate care of diabetes. We also recommend consideration of joint clinics, at senior as well as training level, as valuable contributors to continuing medical education for GPs and hospital specialists, and as a means of opening a new dialogue between them.

Table 2. Proposed learning aims and objectives for GP and SpR.

- Communication and discussion in decision making
- Updating in aspects of diabetes care including:
  - newer drugs and insulin regimens
  - risk factor management
  - monitoring assessments
  - complications' screening
  - overall management
- Planning and implementation of audit to improve clinical standards.

Acknowledgement

The authors thank Drs Peter Moult and Maria Barnard, consultant physicians, Whittington Hospital NHS Trust, for agreeing to second their SpR to the practice clinic at 2 Mitchison Road Practice, London N1.

References

1 Camden and Islington Medical Audit Advisory Group. *Annual report 1997/1998*. London: Camden and Islington Medical Audit Advisory Group 1998;13–15.
2 Burnett S, Hurwitz B, Davey C, Ray J, *et al*. The implementation of prompted retinal screening for diabetic eye disease by accredited optometrists in an inner-city district of North London: a quality of care study. *Diab Med* 1998;**15**(S3):38–43.
3 Walker JB. Fieldwork of a diabetic clinic. *Lancet* 1953;**ii**: 445–7.
4 Walker JB. The function of a diabetic clinic. *Proc Roy Soc Hlth* 1963; **35**:74–6.
5 Walker JB. *Chronicle of a diabetic service*. London: British Diabetic Association, 1989.
6 Malins JM. *Clinical diabetes mellitus*. London: Eyre & Spottiswoode, 1968.
7 Malins JM, Stuart JM. Diabetic clinic in a general practice. *Br Med J* 1971;**iv**:161.
8 Kopelman P, Keable-Elliott D. An inner city district diabetic care scheme. *Diab Med* 1990;**8**:558–61.
9 Kopelman P, Michell JC, Derrett CJ, Keast R, Sanderson A. A computerised system (DIASHARE) for the management and evaluation of diabetic care. *Diab Med* 1992;**9**:84.
10 Thorn PA. Care for diabetics in the United Kingdom. In: Mann JI, Pyorala K,Tenscher A (eds) *Diabetes in epidemiological perspective*. Edinburgh: Churchill Livingstone, 1983.
11 Joint Committee of Higher Medical Training. *Curriculum for higher specialist training in diabetes and endocrinology.*
12 Morrison I, Smith R. Hamster health care. *Br Med J* 2000;**321**:1541–2.

Address for correspondence: Professor Brian Hurwitz, Department of Primary Health Care and General Practice, Imperial College of Science, Technology & Medicine, Charing Cross Campus, St Dunstan's Road, London W6 8RP. E-mail: b.hurwitz@ic.ac.uk