Changing practice in gastroenterology in a changing environment

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Introduction

Until recently, physicians were appointed to a consultant post in general internal medicine (GIM) with an additional special interest. The special interest was left vague, often simply 'to complement the special interests already represented'. These special interests have grown considerably usually as a result of technological innovations and the development of new drugs and treatments. Special interests are now frequently specified in job advertisements and often in some detail. This increasing specialisation has resulted in most consultants in neurology, cardiology, nephrology and rheumatology opting out of GIM. Other specialties have also grown, for example gastroenterology, at a time when there has been a striking increase in the amount of acute unselected GIM. Not only has the volume increased but deadlines, guidelines, targets, waiting times and other improvements in service delivery have also been added to a reduction in junior staff input to clinical care. How has gastroenterology coped, and how will it cope in the future? Currently most gastroenterologists still undertake acute unselected medical admissions although an increasing number have expressed the view that they would like to give up GIM in order to develop their own specialty. This is more likely to occur in the large district general hospitals (DGHs) or teaching hospitals.

Drivers for change within gastroenterology

Several other key changes have had a major impact on the work of gastroenterologists.

Endoscopic service

A major expansion and improvement programme in the provision of endoscopic services has taken place, initially under the auspices of the NHS Modernisation Agency. This has led to the introduction of a Global Rating Scale used to assess the quality of endoscopy. Ninety-eight per cent of all units take part in reporting to this scheme and sequential improvements in standards have been demonstrated since its inception.[1] The Department of Health's 'two-week rule' for cancer referrals and the need to meet this and other targets has also become a priority in trusts and has required improved access to endoscopic services.

NHS Bowel Cancer Screening Programme

The introduction of the NHS Bowel Cancer Screening Programme (BCSP) has focused minds on improved standards and service delivery to meet stringent demands. To become a screening centre (around 100 are planned in England) the unit wishing to be considered has to undergo a detailed inspection. The required quality of service delivery to pass the inspection is demanding. For the screening unit and its delivery of service to be approved there has to be a team of vetted, accredited colonoscopists in place. The assessment visit takes a full day and the team includes a national or regional endoscopy training lead, the nurse lead from the training centre, a strategic health authority (SHA) lead for endoscopy and a representative of the BCSP. Ideally the regional gastroenterology programme director would also be invited to join the visiting team. Preliminary site visits (pre-Joint Advisory Group visits) are now being held to facilitate the definitive visit. The idea for endoscopy unit inspections was proposed by the Joint Advisory Group on Gastrointestinal (GI) Endoscopy (JAG) to accredit training units. The BCSP visits are now know as JAG+ visits (the plus being related to service delivery and suitability for becoming a BCSP centre). At present all national and regional training centres have been visited and the programme is being expanded. Ten centres were up and running by April 2007 with a progressive expansion over the next two years to full numbers.[2]

Training

Another area of change involves the training of gastroenterologists. The specialist advisory committee (SAC) in gastroenterology has completed a new curriculum on behalf of the Postgraduate Medical Education and Training Board which endorsed the major changes in training suggested by the British Society of Gastroenterology (BSG). The UK tends to produce general gastroenterologists

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Clin Med 2007;7:551–3

rather than super specialists. There have been worldwide developments in advanced endoscopy, specialist care for liver disease (hepatitis B and C) and inflammatory bowel disease (IBD) and so a move to a system of two to three years of general gastroenterology training with sub-specialisation in hepatology, hollow organ gastroenterology, (upper GI, small and large bowel) or advanced endoscopy has been proposed. It is hoped that this will provide the NHS with the appropriate level of specialists for the future needs of the community.

Improved endoscopy training standards are also required. In its last three documents the JAG has developed with the SAC in gastroenterology and general surgery, and the relevant specialist societies (BSG, Association of Upper Gastrointestinal Surgeons for Great Britain, Association of Colo-Proctology etc) guidelines for training in endoscopy. This has identified the need for trainers to be trained further, and a range of training courses, covering all the main areas of endoscopy have been introduced. Attendance at these courses is compulsory for trainees, regardless of discipline. In addition, the curriculum has moved from completion of a set number of procedures as a means of attaining independent practice to a formal, continual assessment of competence based on a detailed scoring sheet. It will remain important for trainees to undertake adequate numbers of procedures to ensure they have seen examples of all major pathologies.

Gastrointestinal emergency service

Another major impetus for change is the need to provide 24/7 cover for GI emergencies. This is to supply a GI bleeding service and specialist input to acute GI problems such as acute liver failure and severe acute IBD. A recent BSG survey of acute hospitals has shown that only about 50% of hospitals with acute unselected medical admissions provide any out-of-hours GI cover. This is clearly unacceptable and puts patients and trusts at risk. A working party of the BSG has produced a paper on how trusts might arrange such out-of-hours services.[3]

Drivers for change within general internal medicine

The need for patients to be seen and transferred from the acute admissions area within four hours imposes considerable logistical problems for the specialty services. Consultants have to cancel their normal fixed commitments on the days they are on acute medical take, extending both outpatient and endoscopy waiting lists in gastroenterology. The introduction of shift work for junior staff, the European Working Time Directive, training days and formal courses (based on a recent BSG audit) have shown that gastroenterology trainees lose approximately 25% of their specialty training time. Many consultants, who provide an on-call, out-of-hours gastroenterology service cannot continue a GIM on-call commitment as well. In many large hospitals, particularly in teaching hospitals, gastroenterologists are opting out of acute GIM to provide appropriate specialty care. Independent sector treatment centres (ISTCs) pose another threat to gastroenterological services. In some areas these services have been contracted to deliver much of the core care, with adverse effects on the training of gastroenterologists and others, and a depletion of trained endoscopy support staff threatening the viability of hospital-based units that have complex patients to look after.

What actions have been taken to address some of these issues?

Non-medical endoscopy

The use of non-medical, mostly nurse, endoscopists has helped in many areas. These endoscopists, nationally in excess of 300 and trained to the same JAG standards as all other endoscopists, help to reduce waiting lists, ease the workload when the regular endoscopists have other calls on their time, and provide a core service in routine diagnostic endoscopy (upper endoscopy, flexible sigmoidoscopy and increasingly colonoscopy). Their more flexible timetables enable them to backfill lists and increase throughput through an endoscopy unit by as much as 30%. Nurse endoscopists are likely to provide the basic diagnostic service, and so trainees will have less input into service delivery. It is also likely that the ISTCs may try to attract these workers. Many nurse endoscopists are now extending their roles and skills to encompass therapeutic endoscopy, colonoscopy and even out-of-hours emergency endoscopy.

Nurse-led clinics

The current trend to devolve chronic disease to primary care has encouraged many gastroenterologists to send patients with Barrett's oesophagus, coeliac disease and chronic stable IBD, as well as stable cirrhotic patients, back to the care of their general practitioner. Some conditions require regular review and surveillance (varices and hepatomas in cirrhotics, dysplasia in Barrett's and osteoporosis in coeliac disease). These can be undertaken by working to joint primary and secondary care protocols with routine endoscopies programmed directly using information technology and database management systems. Other clinics are particularly suitable for specialist nurses such as iron deficiency anaemia clinics, hepatitis B and C clinics, drug monitoring clinics (for immunosuppressant drugs eg methotrexate and azathioprine). The introduction of such clinics enables the consultant to see more new patients and follow the severely ill while in turn meet targets and reduce waiting times.

Sub-specialisation

Sub-specialisation is occurring in the larger hospital with three or more gastroenterologists, usually with one concentrating on hepatology and one on IBD or nutrition.

Implementation of change

The need for gastroenterologists to provide out-of-hours emergency cover for GI bleeding, acute severe colitis and acute liver

failure has been discussed already. As less than 50% of acute trusts have such a service there is a national imperative for change. Many gastroenterologists, particularly those in smaller trusts, who are on the GIM acute take rota, are unwilling to take part in two on-call rotas. It is probably unsafe to try and combine both on-call duties, even if there were enough other consultants to take part in the gastroenterology rota.

The BSG has been asked to comment on this problem, and advise on whether gastroenterologists should relinquish GIM and concentrate solely on gastroenterology. It was the view of the BSG council that the society would support those colleagues who wished to withdraw from GIM, but that this would have to be arranged and managed at a local level. Those consultants who wished to continue to undertake both GIM and gastroenterology were also to be supported.

The BSG, however, felt that it should offer some advice and help with regards to the better provision of out-of-hours services. It is clearly impractical for small trusts, even with the support of GI surgeons, to provide a separate on-call GI service. The key was for gastroenterologists to formally inform the chief executive and medical director of the trust that adequate cover is not available as this is clearly a matter of both risk management and clinical governance. One potential answer is for small trusts to group together and offer more than a district-wide service. Contributing trusts must therefore be responsible for cover on certain days. Another approach being considered is that all severe GI bleeds are transferred to major centres (usually teaching hospitals) while the minor bleeds are managed locally with early endoscopy on the next routine list.

This raises both funding and staffing problems in the referral centres as well as the problem of bed availability. The safe transport of unstable, bleeding patients remains a problem. With continued mortality overall of around 10% from GI bleeds, and the rise in the incidence of cirrhotic patients, a national plan is clearly needed.

Gastroenterology has undergone many recent changes although it is likely that further changes will continue to be necessary to meet new expectations, targets and aims of service delivery and patient care. This should not be seen as a threat but as an opportunity to provide higher standards of care. Even the BSG has undergone some major changes in its structure to better serve its members, and provide better advice to the NHS as a whole. At least one BSG president has been to 10 Downing Street to plead for continuing funding for training and to warn of the lack of out-of-hours emergency cover.

Reference

1 Global Rating Scale. www.grs.nhs.uk
2 Bowel Cancer Screening Programme. www.bcsp.nhs.uk
3 British Society of Gastroenterology. *Out of hours gastroenterology.* London: BSG, 2007.