A comparison of workloads of physician-gastroenterologists and other consultant physicians

PREPARED ON BEHALF OF THE CLINICAL SERVICES COMMITTEE, BRITISH SOCIETY OF GASTROENTEROLOGY

ABSTRACT—In response to a workload questionnaire, carried out as part of an enquiry into manpower needs in gastroenterology, replies were received from 17 health regions, relating to 86 hospitals and 135 consultant gastroenterologists. The average yearly number of deaths and discharges of patients under the care of gastroenterologists was 992, while that of patients cared for by consultant physicians in other specialties was 679. When daycase admissions were also included, there were 1,553 annual discharges per gastroenterologist as compared with 871 for other physicians. These 682 extra cases per gastroenterologist largely represent the additional workload of gastrointestinal endoscopy.

With the rapid growth of both diagnostic and therapeutic endoscopy, and the development of new techniques such as oesophageal manometry, gastroenterologists have become increasingly aware of a steadily increasing workload in comparison with their medical consultant colleagues, particularly those working mainly as general physicians without major specialty interests. The Clinical Services Committee of the British Society of Gastroenterology (BSG) decided that this merited investigation as part of a detailed study of manpower needs in gastroenterology. In this paper we report the results of a survey in which figures were obtained for deaths and discharges attributed to gastroenterological physicians and for admitting physicians in other disciplines working in the same hospitals.

Material and methods

A letter was sent by the chairman of the Clinical Services Committee to all chairmen of regional BSG groups asking for the names of every medical gastroenterologist in their region, and the numbers of deaths and discharges per gastroenterologist for 1989 or 1990, with similar figures for their immediate colleagues in general medicine, with or without a sub-specialty interest, and who had admitting rights. The total number of medical deaths and discharges per hospital was divided by the number of consultant physicians in post and expressed as deaths and discharges per consultant per year.

Results

Replies were received from 17 regions, including Wales and two Scottish regions, relating to 86 hospitals or health authorities for 1989 or 1990. Deaths and discharges for 135 gastroenterologists totalled 133,920 patients, an average of 992 cases per year. For 300 other physicians the average was 679 cases per year. The 11 hospitals in the Trent region did not include gastrointestinal endoscopies in their figures. When these hospitals were excluded there were 1,039 deaths and discharges per gastroenterologist each year compared with 673 for other physicians. This corresponded to a mean of 366 extra cases seen per year by each gastroenterologist.

The returns from 24 hospitals provided separate figures for daycase endoscopies as well as for total deaths and discharges per consultan. For these 24 hospitals, there were 1,553 deaths and discharges per year per consultant compared with 871 for other physicians, an excess of 682 cases per year for the gastroenterologist physician. This excess closely corresponded to the mean number of day cases recorded as being dealt with by the consultant in these hospitals each year (702; 44% of the total case load).

Discussion

These results, obtained from over one-third of all medical gastroenterologists in Britain and obtained from 17 health regions, supports the view that their workload is considerably greater than that of their other physician colleagues, with almost twice as many deaths and discharges per year for those working in hospitals where day cases as well as total deaths and discharges

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are recorded. This greater workload is mainly accounted for by gastrointestinal endoscopies, which are performed in addition to the physician's normal inpatient case load. As almost all gastroenterologists also function as general physicians with admitting rights, the figures for them are properly comparable to those for the other physicians with admitting rights included in this survey, whatever their specialties. The latter group included a whole range of specialty interests and it could well be that if the comparison had been restricted to certain specialties such as cardiology, where there has also been a considerable increase in new diagnostic and therapeutic procedures, a comparable increase in workload would have been apparent.

Similar results to this survey would probably be obtained for the great majority of hospitals in the UK. However, some health authorities do not provide separate figures for day cases, or, until recently, did not classify them at all under discharges. In other regions, gastroenterology is not recorded separately from general medicine, and the completeness of this survey was further handicapped by the refusal of some records officers to divulge information relating to deaths and discharges for other physicians. With the advent of the new contract system, documentation should greatly improve, with the additional refinement of a replacement of deaths and discharges by consultant inpatient episodes. However, this system makes no allowance for emergency or diagnostic endoscopies done by gastroenterologists for inpatients under the care of other consultants, and this very important service provided by gastroenterologists also needs to be recorded.

Many of the replies received from the gastroenterologists stated that their outpatient load was also increasing, with growing waiting lists. This is likely to be true, for not only do symptoms relating to the gastroenterological tract account for 40% of referrals to general medical outpatients, but an increasing amount of therapy for gastroenterological disorders is also now managed on an outpatient basis. The results of the present investigation, however, relating to inpatient and day-case care alone, make a strong case for appointing considerably more consultant gastroenterologists, confirming the findings of Burnham and Newton [1] in a single district general hospital.

The current recommendation of the British Society of Gastroenterology is that there should be one physician with a major interest in gastroenterology per 100,000–125,000 population. On the basis of a recent BSG survey showing currently 340 physicians with an interest in gastroenterology, this indicates the need for at least 100 additional physicians. The recent survey also revealed that there are still 17 district general hospitals without even a single consultant gastroenterologist.

Reference

1 Burnham WR, Newton M. What a physician gastroenterologist does at a DGH. *Gastroenterology in Practice* 1991;**1**:18–22.

Acknowledgement

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The original data, identifying individual hospital and health authorities, is obtainable on request from The British Society of Gastroenterology, 3 St Andrews Place, Regent's Park, London NW1 4LB.

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