

# GP specialists could alleviate ENT bottleneck

Analysing referrals to the ENT department, **Emma Cashman et al** find that consultant-patient ratios need to be urgently addressed



**THE LONG LENGTH** of out-patient waiting lists in this country is well documented and is certainly not a new phenomenon. The main factors are an increasing population and, in particular, a growing elderly population.

The population served by our own ENT department has increased by 16% over the past decade.<sup>1</sup> In recent years, the population of Ireland has been growing more rapidly than at any other time since the foundation of the State and the number of people over the age of 65 is projected to increase by more than 80% to over 800,000 between now and 2025.<sup>1</sup>

Another major issue is that of rising referral rates to hospitals. A recent task force in the UK stated that the ideal ratio of consultant to patient is 1:80,000.<sup>2</sup> Our ratio in the southeastern region is in the region of 1:110,000 and the current routine OPD waiting list, based on the figures from our study, is 23 months. It is noteworthy that per head of population, the UK has twice the number of consultants in all surgical disciplines compared to Ireland.

The most recent Comhairle na hOspideal report in 2005, which builds on the 1983 review, recommends one consultant otolaryngologist per 70,000 population based on a minimum of three otolaryngologists per ENT centre.<sup>3</sup> Since the Comhairle report in 1983, total consultant numbers across all specialities have seen a 67% increase. This compares with only 25% in the consultant establishment in ENT in the same period.<sup>3</sup>

## Study

Our study was conducted over a three week period in February 2008. All referrals from GPs to both OPD and ENT casualty were included. We also noted the percentage of referral letters marked routine or urgent by GPs.

Referrals were divided into adult and paediatric groups and were divided into four main categories: otology, rhinology, airway/swallowing/voice and general ENT. Self-referrals to ENT were also included. Casualty referrals were analysed retrospectively to assess whether they actually represented an acute pathology.

## Results

The total number of referrals to the unit was 633. Of these, 286 referrals were to the out-patient department and 347 were to ENT casualty. Of the 286 OPD referrals, 56% were paediatric and 44% were adult patients.

Only 35% of GPs had stated on the ED or OPD referral letter whether they felt their patient needed routine or urgent assessment. Referral letters to the out-patient department unit were prioritised by consultants.



The majority of referrals to ENT OPD (38%) were otological with rhinology (16%) and airway/voice/swallowing (9%). Almost two-fifths (37%) were general referrals including epistaxis, tonsillitis and quinsy.

Over half (52%), of otology referrals were for otitis externa and wax impaction. Chronic rhinosinusitis accounted for the majority (54%) of rhinology referrals.

Hoarseness was the main indication for referral in the airway/swallowing voice group and recurrent sore throat accounted for 45% of referrals in the general ENT group.

ED referrals totalled 347. Of these, 64% were GP referred and 36% were self-referred. Similarly in this group the majority of cases were otological (43%). Rhinology accounted for 14%. Airway, swallowing and voice represented 11% of referrals and general ENT represented 33% of referrals.

Referrals deemed urgent by SHOs and requiring immediate referral to a consultant clinic totalled 4%. A further 4% required admission for treatment. Malignant pathology was detected in three cases of ED referrals and one OPD referral.



### Discussion

Several reasons exist for GP referral to ED. These include patient's expectations and anxiety, the need for a specialist opinion or further treatment, and the need for further investigations unavailable to GPs in the tertiary setting. GPs are undeniably forced to direct many patients through casualty services because of long out-patient waiting lists.

One of the main problems encountered in the primary care setting is the lack of equipment to accurately diagnose and treat patients with ENT complaints. A high proportion of the otology referrals in our study series were for wax impaction, otitis externa, and mastoid cavities requiring maintenance – conditions that may need micro-suctioning, which is not directly available to GPs. While many GPs do offer a syringing service for patients with wax impaction, however, many patients are unaware of this fact and therefore self-refer to ENT casualty departments for micro-suctioning. If, as in specialist GP centres in the UK, GP practices were to advertise the availability of some limited ENT services more widely, this might go in some way to alleviating the strain placed on ENT casualty services.

Airway, swallowing and voice represented 9% of our total referrals and again GPs do not have access to, and are not trained in, the use of equipment such as flexible laryngoscopy, which permits direct visualisation of the nasopharynx and hypopharynx.

A proportion of referrals may stem from a lack of experience or confidence on behalf of the referring GP. It has previously been acknowledged that there is little opportunity for GPs to obtain further teaching in the treatment and management of conditions relating to ENT.<sup>4</sup> Furthermore, the time allocated in the Irish medical undergraduate curriculum to clinical ENT teaching is limited and lack of confidence in managing such patients may result in increased referral rates.<sup>5</sup>

ENT problems may represent up to 20% of the workload of GPs and ENT referrals constitute the third largest group of patients referred to hospital specialist clinics.<sup>6,7</sup> This trend is mirrored in the UK where more than one-quarter of medical schools do not have compulsory ENT attachments.

Of note, in our series, more sinister pathology passed through the ENT casualty than OPD and this may reflect a worrying trend of GPs directing pathology through the ED service because they know OPD waiting lists are very long. The most worrying aspect of this trend, however, is the fact that ENT casualties tend to be manned by SHOs who in most cases are the least experienced members of the ENT team.

It is more fitting that these more 'complex' patients are reviewed in consultant-led clinics as there is probably a greater risk of pathology being missed in the ED setting. This is undoubtedly the main threat posed by the so-called 'walk-in' unit, where overwhelmed junior staffs often have difficulty dealing with huge patient volumes.

### Electronic referral system

In an attempt to expedite OPD referrals, a 'choose and book' electronic referral system was introduced in the UK in 2006. Through this system, the responsibility for prioritisation is transferred to the GP. It is worth noting that in our study only 35% of GPs stated whether they felt their referral warranted routine or urgent intervention. In 'choose

and book' if the referral is considered urgent the patient will be booked into an 'urgent slot' in the template of the consultant's clinic booking system. If the referral is routine, the appointment will be made for a routine slot.

The GP decides if an urgent referral for suspected cancer is appropriate. The GP then fills out the two-week wait referral template, which may be compiled electronically in the practice's clinical system. Completed referrals are then faxed to the provider trust.

GPs can keep track of referrals, which reduces both the administrative burden on the practice and the risk of the patient being 'delayed' or 'lost' in the pathway of care. The use of templates improves the consistency of the referral assessment, offers a secure and auditable trail and reduces administrative burden in compiling performance reports. Such templates are currently being used in St James's Hospital, Dublin.

### Self-referrals

The high proportion of self-referrals to so called 'walk-in' units is well documented and a recent study by the ophthalmology department in the Royal Victoria Eye and Ear Hospital in Dublin estimated the number of self-referrals after 5pm to be 72%. Almost three-quarters (73%) did not have an acute ophthalmic condition.<sup>8</sup>

Our figures are consistent with much of the data in the literature. Only 4% of our ED referrals represented a true emergency and required subsequent admission. A further 4% were deemed by the attending SHO to require urgent referral from ED to a consultant OPD.

While many patients inappropriately self-refer to ED units such as ours, many authors feel this trend is inevitable in such 'walk-in' units.<sup>9</sup> An audit conducted in 1990 by O'Driscoll et al of ENT casualty services at the Eye and Ear Hospital found that many of these patients who self-refer could have been adequately treated by their own GPs. They concluded that further training was indicated for GPs and recommended an overall expansion of ENT outpatient slots.<sup>10</sup>

### Conclusion

OPD waiting lists are too long and there is increasing pressure on GPs to direct pathology through EDs in order to expedite patient treatment. This places a burden on already over-stretched, under-resourced units.

This problem could be approached on two fronts. Firstly, as proposed in the UK, the establishment of so-called GP specialists, particularly in busy, larger practices may reduce the number of non-emergency referrals and therefore alleviate some of the burden on specialist referral units. Secondly, consultant-patient ratios need to be addressed to facilitate the expansion of OPD slots. Such changes cannot be implemented overnight; however, studies such as ours provide a timely reminder of the potential detrimental effects of the existing healthcare framework to patient's wellbeing. 

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References on request