DIRECT ACCESS SURGERY – A SIX MONTH TRIAL IN GENERAL SURGERY

F Raiser, T Leese

Department of Surgery, Royal Lancaster Infirmary

INTRODUCTION

Direct access surgery is a logical progression in the trend towards day case and direct access procedures.

Figure 1

A six month trial of direct access surgery was set up at the Royal Lancaster Infirmary at the request of one of the local general practitioners (GPs).

When a GP has an otherwise healthy patient with a lesion suitable for day case surgery, he or she refers that patient to the hospital outpatient department for a surgical consultation (Figure 1). This can take anywhere from two to thirteen weeks (thirteen weeks being the general ceiling permissible under the Patients' Charter). Once the patient has been seen by the consultant surgeon he is either given a date or placed on a waiting list for a surgical procedure in the Day Care Unit. The operation takes place anywhere from four to fifty two weeks later (fifty-two weeks being the ceiling permitted by the Patients' Charter).

Clearly, there would be some advantage in referring the patient directly to the Day Care Unit for this surgical procedure, bypassing the outpatients department. This sort of direct access approach is already in place for some procedures such as endoscopy and works well.

Direct access surgery has potential advantages and

disadvantages (Table 1). One advantage is decreased waiting times for patients. Patients will have increased input from their own GP whom they already know and trust, rather than getting pre-operative counselling from a surgeon they have only met in the outpatient department. By eliminating some of the straightforward patients from the outpatient department time is freed up for the surgeon to see other patients, thereby decreasing waiting times. Finally, there is a potential for significant financial savings for the fundholding GPs who currently pay about £75 for each new surgical consultation.

On the negative side, there is always the danger of inappropriate referrals. Patients may be misdiagnosed or be inappropriate for day case surgery for medical or other reasons. It will be more time consuming for the GP since they are doing the counselling and paper work which is otherwise done in the surgical outpatients. It is entirely possible that because of the time restrictions on the GP, the patient may receive inadequate information regarding the procedure. This may be made worse if the GP does not have adequate knowledge of the procedures including the potential risks and benefits. The patient/surgeon relationship is bound to suffer. The surgeon will increasingly be seen as a technician rather than a doctor. The financial savings of the fundholding G.P's are a loss of outpatient income for the hospital.

Direct access surgery has been implemented elsewhere with good results⁽¹⁾. Smith and Gwynn at the Stafford District General Hospital published a study last year outlining their experience with a direct access approach. They made a wide variety of surgical procedures available including hernias, vasectomies, cystic scrotal swellings, subcutaneous lumps and skin lesions, symptomatic gall stones, varicose veins and ingrowing toe nails. They had 105 direct access referrals over a one-year study period resulting in 102 operations. They encountered only two patients referred with a diagnostic error and only one inappropriate referral for day case procedure.

There was quite a high satisfaction rate expressed by the patients and GPs. They concluded that with specific referral criteria, direct access surgery can provide substantial savings in time and resources. It is interesting to note that although they offered a wide variety of direct access procedure they only had 105 referrals in an entire year. This indicates that the vast majority of patients for these procedures were still being referred via the outpatient department and that uptake of direct access surgery was not high amongst the GPs.

The Smith and Gwynn study was brought to our attention by one of our local GPs. We were asked to attempt a similar service. The result of this discussion was a six month trial of direct access surgery at the Royal Lancaster Infirmary.

Direct Access Surgery	
Potential Advantages	Potential Disadvantages
Decreased waiting times for patients	inappropriate referrals
Increased input from patient's GP	Time consuming for the GP
Decreased waiting times for surgical outpatients appointments	Inadequate patient information
Financial savings for fundholding GP	Poor patient/surgeon relationship (surgeon as technician)
	Loss of outpatient income for the hospital

Table 1

PATIENTS AND METHODS

The study period was from the 1st of April to the end of September 1996. We decided to offer a narrow range of surgical procedures initially and to audit results of the direct access approach before extending direct access to other general surgical procedures or other surgical subspecialities.

The general surgeons selected four procedures for the direct Acc trial, adult unilateral inguinal hernia repair under general anaesthetic, adult circumcision under general anaesthetic, vasectomy under local anaesthetic and skin lumps and bumps under local anaesthetic. It was stipulated that the skin lesions should be less than five cms in diameter and the GP must feel reasonably confident of the diagnosis prior to referral.

All the GPs were circulated about the proposed study. The circular outlined the aims of the study and the referral method. Samples of patient information sheets and a general anaesthetic assessment sheet were included. Interested GPs were asked to contact the Day Care Unit to register for the study and to request a patient pack. This pack contained a supply of specific information sheets for the four procedures and the general anaesthetic assessment sheet. We tried to minimise the workload for the GPs. In order to refer a local anaesthetic case (vasectomy or skin lesion) the requirements were to discuss the procedure with the patient, to give the patient a specific information sheet provided by the Day Care Unit regarding that procedure and to write a standard referral letter to a named consultant surgeon but to mark the letter "Direct Access Surgery" and send it to the Day Care Unit. To refer general anaesthetic cases (hernia and circumcision) the same steps were required but, in addition, the GP was asked to fill in a day case suitability form and to enclose it with the referral letter. This form is designed to assess both the patient's social and medical suitability for day case surgery under general anaesthetic. This form is used in the Surgical Outpatients Department. It has a simple tick box format which takes about three minutes to fill in.

Once a direct access referral was received on the Day Care Unit it was registered in a log book and forwarded to the appropriate consultant's secretary. The patient was then allocated a date for surgery or put on a waiting list. A letter was sent to the patient giving admission details and this was copied to the GP. An audit sheet was placed on the front of the patient's notes and once the procedure was performed the audit sheet was completed and retained for analysis. The patient was discharged with a questionnaire to be filled in and returned to the Day Care Unit after one week in a stamped addressed envelope which was provided.

The audit sheet had three sections. The top section recorded the date the GP letter was sent, the date it arrived and the date it was forwarded to the surgical secretary. It also recorded the patients details, the procedure requested and the consultant's name. The middle section was filled out by the operating surgeon on the day of surgery. It recorded the date of the procedure, appropriateness of the referral and accuracy of diagnosis. The bottom section was filled in by the nursing staff on the Day Care Unit prior to the patient's discharge. It recorded any complications, whether the patient was happy with the admission, and discharge arrangements.

The patient questionnaire had a simple tick box format with 14 questions. These asked if the patient had accepted the first date offered for surgery, satisfaction with the pre-surgical information given by the GP, and any complications or GP

visits needed following discharge. Finally it asked if the patient was satisfied with the direct access approach and if they would have a direct access surgical procedure again.

RESULTS

Over the six-month trial period only 50 patients were referred via the direct access system. The procedures comprised 35 vasectomies, 9 lumps and bumps, 6 hernias and no circumcisions. Forty-five patients have undergone surgery. Four patients were withdrawn. One of these patients moved away and was lost to follow-up, two removed themselves from the waiting list for vasectomy because they changed their minds and one patient was removed from the list by his GP. One patient is still awaiting surgery having refused three dates offered by the hospital. Most practices requested patient packages (Table 2). The Rosebank practice which initiated the study sent most referrals. Uptake of direct access surgery among the other practices was sporadic.

Results	
Practices requesting patient packages	
Referrals	
Rosebank, Lancaster	18
Morecambe Health Centre	9
West End, Morecambe	8
Queen's Square, Lancaster	4
Owen Road, Lancaster	4
Heysham Health Centre	4
Lansdowne Road, Morecambe	1
Meadowside, Lancaster	1
Parkview, Milnthorpe	1
Dalton Square, Lancaster	0
Station House, Kendal	0
York Bridge, Morecambe	0
Total	50

Table 2

Inappropriate referrals were not a problem. Of the 45 patients who have undergone surgery, there was only one inappropriate referral. This was a patient referred for excision of a lipoma under local anaesthetic. On examination he was found to have a 10 cm lipoma deep within the muscle under the scapula fascia. This procedure was done under general anaesthetic rather than local anaesthetic.

If one looks at the use of direct access surgery by the type of procedure, the results are disappointing (Figure 2). Of 201 vasectomies done during the trial period all were done on the Day Care Unit but only 30 (15%) were direct access referrals.

Figure 2

Of 182 skin lesions done on the Day Care Unit, only 9 (5%) were direct access referrals. Of 119 unilateral hernia repairs one third were done on the Day Care Unit but of these only 6 (15%) were direct access referral. Of 215 circumcisions in adults eight were done on the Day Care Unit but none of these was referred as direct access.

Overall, of the cases that might have been done as direct access procedures (431) only 45 (10%) were referred in that way, the remainder continuing to come through surgical outpatient referral.

Patient satisfaction with the direct access surgery approach was high (Table 3). Only two patients admitted to not taking the first date offered. One patient felt he was not given an adequate explanation of the procedure by his GP. Only one patient was unhappy overall. He had an infection in his vasectomy site and had to see his GP for antibiotics. He was not sure whether he would have it done again as direct access surgery but clearly the infection rather than the referral method coloured his overall impression.

Patient Satisfaction Survey 30 returns		
	Yes	No
Did you accept the first date offered?	28	2
Were you happy with your GPs explanation?	29	1
Did your GP give you an information sheet?	30	0
Were you happy with the DCU?	30	0
Were you happy with your discharge arrangements?	30	0
Did you have any complications after you left?	1	29
Did you have to see your GP after discharge?	1	29
Did you have to go to casualty or be readmitted?	0	30
Overall, were you happy with the operation you had?	29	?
Would you have another direct access surgery?	29	?

Table 3

Despite low reporting of date changes by patients in returned questionnaires we experienced a significant problem. There was a 15% failure rate to accept the first date offered and 17% did not attend for surgery without warning on at least one occasion. These numbers are higher than we usually see on firms using a diary system to schedule procedures from the outpatient department where a date is agreed there and then between patient and surgeon.

The average wait for surgery using the direct access approach was 82 days from the date of the GP letter, ranging from 3 days to 105. This represents approximately half of the waiting period experienced by patients referred through the standard surgical outpatient approach.

DISCUSSION

Our results agree closely with those of the Stafford study. They averaged nine referrals per month via the direct access system. We encountered a similar number of referrals per month despite offering a narrower spectrum of direct access procedures. Patients were clearly happy with the direct access surgery and the wait for surgery was reduced on average by half. We did not have a problem with inappropriate referrals.

We were surprised by the relatively poor uptake of direct access general surgery by the local GPs. The initiating practice used it well but uptake in many practices was poor. Only 10% of potentially suitable patients were referred through the system. GPs were asked to give reason for not making more use of the system in a letter circulated at the end of the study. The responses are shown in Table 4. Extra

Reasons given by GPs for not making use of the direct access system	
Forgot it was available	5
Extra work for GPs	5
Inertia	3
Unsure about indications for surgery	2
Unsure about counselling for procedures	2
Waiting lists already short	1

Table 4

work involved for the GP, simply forgetting that the new service was available and general inertia account for the majority of reasons given.

The results of this trial were discussed with GPs at a meeting in the Postgraduate Medical Centre at the Royal Lancaster Infirmary in November 1996. It was clear that they were happy with the service and wished it to continue. The consultant general surgeons will continue to offer direct access surgery for these procedures. A summary of the simplified referral method for these procedures is shown in Table 5. Discussions will continue between the trust and local practices to decide if the service should be expanded to other procedures in general surgery and other surgical sub-specialities. It is important that any new procedures offered are subjected to a similar rigorous audit to ensure a good quality of service.

“ The consultant general surgeons will continue to offer direct access surgery for these procedures. ”

To refer patients for local anaesthetic procedures (vasectomy or skin lesion less than 5cm diameter)
A) The procedure should be discussed with the patient.
B) The patient should be given an information sheet about the Day Care Unit as well as a specific information sheet about the planned procedure.
C) A standard referral letter should be written to one of the three consultant general surgeons who have a day case surgery list at the Royal Lancaster Infirmary (Mr Abraham, Mr Brigg, or Mr Leese). This letter should be clearly marked "Direct Access Surgery" and sent to the appropriate surgeon's secretary.
To refer fit adult patients for general anaesthetic procedures (Unilateral inguinal hernia or circumcision)
The procedure is the same as for local anaesthetic cases but, in addition, a day case suitability form should be filled in to ensure that the patient's social and medical circumstances are compatible with day case surgery under general anaesthetic.
Supplies of the paperwork required (day case information sheets, specific procedure information sheets and day case suitability sheets) can be obtained by contacting the Day Care Unit at the Royal Lancaster Infirmary.

Table 5

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REFERENCES

1. Smith FCT, Gwynn BR Direct Access Surgery, Ann Roy Coll Surg Eng 1995; 77:94-96.