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Colorectal Cancer, Dunedin Gastroenterology Department, SDHB and colonoscopy access in Otago Southland

A General Practitioner response by Dr Dave McKay.

I am a full time medical practitioner working half in General Practice (GP) and half in Palliative Medicine at Otago Community Hospice. I have worked as a Doctor in Otago over the last 31 years since my graduation from Otago Medical School. These are my observations on the state of affairs at Southern District Health Board (SDHB) and Dunedin's Gastroenterology Department (GD) in respect to the difficulties GPs, physicians and surgeons have faced obtaining colonoscopies for the diagnosis of colorectal cancer in our patients. These observations reflect my own and my colleagues experiences, having canvassed many Dunedin GPs and other specialists.

It has been apparent to GP's in Dunedin over the last decade or so, that access to Dunedin's Gastroenterology Department (GD) for colonoscopies, has become increasingly limited. We understand that resources, be they staff, equipment, space and time, and the growing demand for investigations are the reasons that not every referral requesting an endoscopy would be granted. These limitations to the GD services have been known to the SDHB, but not addressed appropriately. GP's understand that sometimes a request for service may be deferred on the basis of clinical grounds however there was an increasing culture of declining requests from GP's based on the economics around access as defined by SDHB and embraced by the GD and management. As the SDHB seemed to need a way of bridling the flow of referrals from GP's and other specialists, for colonoscopies specifically, local Guidelines (LG) were adapted from national guidelines, introduced and strictly applied, to all referrals for request of colonoscopies; the aim was specifically to reduce the load on the colonoscopy service. I understand it has been successful in achieving this.

As a counterpoint to this evolving institutional doctrine, there is the reality of our population needs and local epidemiology. The southern region of South Island, has the third highest incidence of colorectal cancer (CRC) in New Zealand, amongst the highest in the world. An aging population, also inevitably results in an increased presentation of colorectal cancer in our community. GP's are the frontline specialists who after longitudinal relationship with and understanding of their patients health are not only responsible for but in the privileged position of often being able to make an early diagnosis of CRC. The role we have in early recognition translates into early referral for definitive diagnosis, which in the case of CRC is colonoscopy, the gold standard investigation. Some of these patients fit into a "grey area" where they don't qualify "yet" due to not having a full complement of symptoms and signs. Despite

early diagnosis equating with curative treatment, GP's have noticed that their referrals for colonoscopy were more frequently being declined. There are of course times when it is appropriate to defer investigation when all the clinical determinants are considered, and the diagnosis of CRC or other significant colonic disease is unlikely in the light of a more probable diagnosis. Sadly though this is not always the case, and we all have stories around late and failed diagnosis on the basis of often unreasonably strict triage process enforced on our referrals to GD. At the same time a bowel-screening program has started in Dunedin, before we have satisfactorily addressed the patients in the "grey area" who would benefit from colonoscopy.

The Bowel screening program is now well established. Despite its limitations resulting from a scarcity of resources, it is proving beneficial to our population. There is, however, a consequent increase in demand for colonoscopy as a result of patients screened testing positive. Unfortunately, this has likely impaired access for our patients who already have symptoms who are declined timely colonoscopy from SDHB's GD.

Given a declined request for colonoscopy, GPs' often have to watch and wait, looking for the patient to develop more symptoms and progression of signs. Or they have to re-refer to a gastroenterologist or surgeon in private for request of investigation. In the past I have needed to re-refer in private for the positive diagnosis of CRC after receiving a declined colonospy referral in public GD. The other option is radiological investigation, such as CT colonography, at cost to patient. CT colonography is available in the public system, however the access is also constrained by LG triage, leaving the private route the only viable option. This of course indicates inequity in the possibility of early CRC diagnosis in those who do not meet public hospital LG, and cannot afford private investigation.

A recent changing tone in letters to GP's and specialists from the GD has been noted by many colleagues. GPs often feel that these letters are abrupt, dismissive and lacking in advice, although recently they do invite a right of reply. Justification of rejection seems to be based on strict adherence to the LG, often not taking into account the history and trajectory of progression of symptoms and signs, and clinical impression of the referring Doctor as well as the fears of the presenting patients. Referrals are often dismissed outright if only one of several required parameters in the LG is missing (e.g. ferritin having dropped to the low normal range, but not yet in the low abnormal range).

Over the years GP's, and I understand many others, have expressed their concerns to SDHB. I have myself met with Dunedin GD a number of years ago, alongside our previous GP /SDHB Liaison officer. I recall expressing my concerns around GP access to colonoscopy. I was informed that maybe GPs were not doing a good enough job with their referrals. I remember being somewhat taken aback. I know a good number of my GP colleagues and they are excellent clinicians and

excellent communicators. They are dilligent in the care of their patients. Their referrals are not made without thoughtful consideration.

After experiencing several declined referrals often GPs become frustrated and I understand are more reluctant to refer, especially the “grey area” patients, as they believe they have no alternative but accept the strict culture around triage of colonoscopy access. Undoubtedly GPs have altered their referral practices, holding on to patients they would have once referred. Most concerning are the patients in the “grey area”, but equally, any person presenting with unexplained rectal bleeding but without other features that would be required to make colonoscopy available by LG. Possible reluctance of GPs to refer for colonoscopy is based on the learned experience of refusal in these more uncertain and early presentations (the ones that do not strictly adhere to LG but still may manifest early CRC), and even in cases with a clear trend towards iron deficient anaemia. This is extremely concerning.

GP’s all hold that optimal, timely, and patient centred care of patients is our core ethic with additional responsibility for their families. We do this job because we care and want to maintain health wellbeing. Sitting on concerns around patient wellbeing without action is intolerable for GP, patient and their family.
GP’s need to provide timely diagnosis as early as possible in the trajectory of a disease, a process at variance with the SDHB policy, effectively limiting access. This tension is very confusing emotionally and cognitively for our patients and GPs alike. A GP or other specialist will nevertheless often believe there is possible disease on clinical grounds, informed by longitudinal knowledge of the patient and understanding of a “change” in the person’s function and clinical findings examination.

Early, more complex and nuanced presentations are often swiftly rejected on the basis of not reaching a “guideline threshold” rather than being appreciated for the early stage of disease that their symptoms may represent. This is alarming and additionally leaves the GP in a very vulnerable medico-legal position. Should this person later develop the very CRC that was thought possible in the early differential diagnosis, it is the GP who takes full responsibility, seemingly not the service that declined the referral.

A growing reluctance amongst GP’s to refer those patients who do not strictly qualify in the now artificially high perceived threshold for colonoscopy lend us significant concern around some of those patients developing advanced cancer. Palliative care then becomes the first line treatment of their CRC. I have seen this in my Palliative practice; the very poor ranking of the SDHB with unacceptably high number of patients presenting with obstruction at the emergency department is potent evidence of the failure of their earlier diagnosis. This is a consequence of high incidence of CRC and inadequate access to colonoscopy in our region.

The recent completion of an audit into a number of patients referred to Dunedin's GD for colonoscopy on the basis of suspicion of CRC, has been welcome by GP's and its findings are alarming. I fully support my colleagues, Surgeon Associate Professor Phil Bagshaw and Gastroenterologist Dr Steven Ding, and congratulate them for their careful consideration of the problem and possible solutions. I also support our senior specialist colleagues who have also experienced difficulties in access for colonoscopies on the basis of strict GD guidelines. The negative culture around this issue is clearly evident. Media reports suggest that the source of the problem is just that professionals on each side of this specialist secondary care system are not seeing eye-to-eye. The GP perspective has not drawn comment, as their involvement has been less concentrated than those of other hospital specialists in terms of numbers of patients involved in these issues. Clearly, this issue is not a limited "stoush" between gastroenterologists and surgeons, and will not be ameliorated by placing those parties in a room to solve any suggested personal grievances. This is not simply a personality issue, it is also very much a SDHB issue and I believe that the board must accept responsibility for the problem as it has evolved.

GPs are experiencing the same issues that the Surgeons and other specialists within the SDHB are facing regarding access of colonoscopy to patients we believe may have CRC but do not fit GD criteria based on LG. In addition, GPs rightly or wrongly have in recent times felt disempowered by the tone and requirements for acceptance of their patients for colonoscopy. Yet we are seeing more late diagnoses, some of which had been previous declined colonoscopy. Having an appreciation of the very bad situation as it has evolved, we remain committed to the very best care for our patients and would like to be involved in solving this problem. We would see reacquiring professional respect from the GD and SDHB as vital in the ongoing efficacy of care for our patients in the community. The situation with suboptimal access for colonoscopy and increasing late diagnoses of CRC must be addressed, and the Bagshaw-Ding Report recommends an appropriate plan of response. This problem needs a solution quickly so that we can reopen appropriate respectful channels of communication and investigation for our patients. As GPs we support a successful GD and with that support improvement of colonoscopy access and improvement in CRC early diagnosis in every suspicious presentation on behalf of the patients entrusted to our care.