

EDITORIAL

A one-stop clinic in gastroenterology - benefits and limitations

Most patients with gastrointestinal conditions may currently be studied and cared for in an outpatient clinic, with no need for hospital admission, when diagnostic procedures such as ultrasounds or endoscopy are properly used. Because of this, the Spanish National Health System must meet a high demand of clinical attendance. Over 80 million visits take place annually to medical specialists, and over 250 million visits to primary care physicians (1). Patients must wait for weeks for an appointment with their specialist, and may need a number of additional visits until diagnostic and therapeutic guidance is obtained. Responding by increasing health care structures is usually ineffective.

The development of actions intended to improve care continuity between primary care and specialist care is highly relevant. A proper coordination of primary and specialist care relying on agreed clinical guidelines and consensus referral protocols for the management of the conditions most prevalent in our setting is a key aspect. Consensus clinical guidelines are available for some digestive conditions that may provide a foundation for such agreements (2). Most of the commonly encountered digestive conditions (dyspepsia and gastroesophageal reflux, among others) may initially be managed by family physicians with access to diagnostic tests (e.g., breath test for *Helicobacter pylori*, ultrasounds, endoscopy) for those who need them; such conditions will be often solved with no need for referral, and patients who ultimately need referral will already provide the specialist with the results of their diagnostic tests.

High-resolution or one-stop clinics, which seek to solve health problems within one day by having the necessary tests performed while the patient is onsite, represent a mechanism for health resource optimization. Their aim is to provide patients with a diagnosis and treatment in the shortest time possible (within one day) (3).

In the present issue of REED, Zambrana-García et al. report a descriptive study performed at a hospital within a region with a high number of gastroenterology outpatient visits, and discuss the effectiveness of a one-stop clinic that was set up over a decade ago, as well as the conditions benefiting thereof (4).

The study randomized 179 patients, most of them referred from primary care; 72% were scheduled for a subsequent visit, and 13% were referred to a different specialty. Only 15% of patients were discharged after their initial visit, but 44% of all consultations were solved one-stop (the patient obtained a report including a diagnosis and treatment regardless of the need for a subsequent visit). Virtually all non-one-stop patients required a subsequent visit. Ultrasonography was the most commonly ordered test (4).

Clinical conditions with a higher percentage of successful one-stop visits included gastroesophageal reflux, dyspepsia, gallstones, and chronic liver disease (4). Some will require outpatient follow-up (liver disease), others will be referred to Surgery (symptomatic gallstones); prevalent clinical conditions such as dyspepsia should be managed in primary care (2), and the gastroenterology clinic should only keep selected unsolved cases for assessment once routine testing (breath test or upper GI endoscopy, which should be accessible for primary care physicians) is over.

Highlights from this paper include the potential effectiveness of one-stop visits, which has been demonstrated in various medical specialties (5-9). Their benefits for users seem unquestionable – fewer hospital visits for diagnosis, discussions with only one practitioner, and patient reassurance through reduced time to diagnosis. Furthermore, this approach reduces successive visits, and therefore waiting time for a subsequent appointment, when needed, in an overlaid health care system scenario (5). Similarly, it has an impact on labor productivity by diminishing lost time from work because of medical care.

While one-stop clinics are appealing to managers, we should note its feasibility is far from universal. In some specialties the benefits of high-resolution visits may be less obvious, as patients may require a prior preparation for selected diagnostic procedures, as occurs with gastrointestinal endoscopy. In addition, many such tests are performed under sedation, which involves a number of organizational issues. This results in somewhat distorted appreciations, as is the case with the exclusion of upper endoscopy from the list of available one-stop tests in the paper by Zambrana-García et al. (4), in recognition of organizational limitations. On the other hand, the results of some necessary tests for the diagnosis of digestive conditions cannot be obtained the same day (viral serology, celiac work-up, etc.), which inescapably leads to schedule a subsequent visit and precludes a one-stop diagnosis and therapeutic plan. As already stated, Gastroenterology is not in a position to implement this sort of clinic to the same extent as other specialties since a significant proportion of our diagnostic procedures require either preparation or sedation, or provide delayed results.

Implementing a high-resolution clinic requires a modification of the traditional first specialist visit concept, when diagnostic tests are ordered and an appointment is scheduled to review the results obtained and establish a diagnosis. The one-stop visit model has a number of requirements that need be fulfilled before implementation (10). Organizational changes in the outpatient

clinic are key to provide the time needed for patient assessment, which is longer than usual. Similarly, health care professionals must play a role in these changes if visits are to work out – reach agreements with Primary Care and the ER to establish a referral circuit with clear-cut triage criteria, and with Ancillary Departments (radiology, labs) to have the necessary tests timely performed. The one-stop visit approach must be discussed with the patient at the primary care level in order to meet his or her expectations. Similarly, internal procedures need be protocolized once patients access this high-resolution modality.

Finally, some authors point out that a high-resolution clinic might increase diagnostic test costs, and suggest that one-stop visits should be restricted to patients with suspected medical conditions as opposed to functional impairments; indeed, many referrals to specialist care correspond to patients with functional illness or who require a procedure primary care physicians have no access to (11). A cost analysis for diagnostic procedures should be included when planning the implementation of a one-stop clinic.

Wait times in the health care system no doubt represent a major issue for which efficient solutions are to be sought by means of organizational and managerial changes with the direct involvement of health care professionals, cooperation between primary and specialist care, and a proactive attitude by regulatory authorities in order to provide resources and support as required, while searching for mechanisms to optimize available resources, which are both finite and limited. In this scenario, one-stop or high-resolution care may suit a number of medical disorders, which may benefit from this care modality.

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