

Family Physicians Can Perform EGD: Right Answer, Wrong Question

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With training, family physicians can safely perform esophagogastroduodenoscopy (EGD). Family physicians can competently deliver babies and perform cesarean sections, vasectomies, and colposcopies. They can competently care for patients with diabetes, congestive heart failure, and myocardial infarction. In fact, with proper training, family physicians can treat almost any condition. Who remains to be persuaded that this is true? Are there any readers of the *Journal* who are yet to be convinced?

In this issue, Pierzchajlo and colleagues¹ report a series of 793 EGD procedures that were performed over a 7-year period by a family physician in a rural solo practice. The results compare favorably with previous reports regarding this procedure in a family practice setting. The study will no doubt be helpful to family physicians who seek hospital privileges to perform EGDs in their local hospitals. Physicians are well paid for performing this procedure and, as the authors tell us, reimbursement rates for EGD are higher in the hospital than in the office.

So we have our answer. A family physician in rural practice can perform EGD competently and safely. But, is this the right question? Think of the other issues that are raised by Pierzchajlo's paper. How many people in a small rural town in Georgia require EGD each year? The procedure was performed 793 times over a 7-year period. This averages 113 procedures per year in a community of 32,000 people (annual incidence = 3.53 procedures per 1000). Does one out of every 283 people in town need this procedure each year? The authors state that as many as 1% of the population might require endoscopy each year (annual incidence = 10 procedures per 1000). Is the procedure being done too often or too rarely?

Dyspepsia, abdominal pain, or heartburn was the indication for 71.2% of the procedures performed in this study. The authors state that most of these patients did not respond to medical therapy

before the EGD, but they do not specify what therapy was used. Neither do they tell us what percentage of these patients smoke or use alcohol to excess. We do not know what percentage were obese. These are common causes of failed therapy for esophagitis and gastritis, the two diagnoses that accounted for 79% of the cases. What percentage of the patients came to the office with these symptoms and ultimately required EGD? What constitutes good care for patients with these common conditions in a community-based family practice? How many of the patients got better after the procedure? How often did endoscopy add value to the patient's care?

Dr Pierzchajlo received his endoscopy training in a continuing medical education course and was precepted while performing the first 59 procedures he did in practice. From the data, it certainly appears that he became competent to perform the procedure. A previously published multisite study reported similar outcomes when EGD was performed by nine family physicians who averaged only 8 supervised cases (range, 0 to 25).² Another recent study reports that 24.2% of 359 surveyed family practice residencies provided EGD training to residents.³ At the majority of these programs, residents performed an average of less than 10 procedures before graduation. How many precepted procedures are required before a family physician can competently perform EGD to the community standard? Are 8 to 10 cases enough? Can residencies provide the necessary volume of training?

Family medicine as a discipline is now more than a quarter of a century old. We should get serious about delineating what constitutes efficient and effective care for common problems in the community setting. Studies performed in a university gastroenterology clinic cannot tell us which patients with heartburn in a family practice office will benefit from EGD. We know more about which doctors can do this procedure than we know about which patients will benefit from it! We also know far too little about the essential components of training to achieve competency in common office and hospital procedures. Much can be learned

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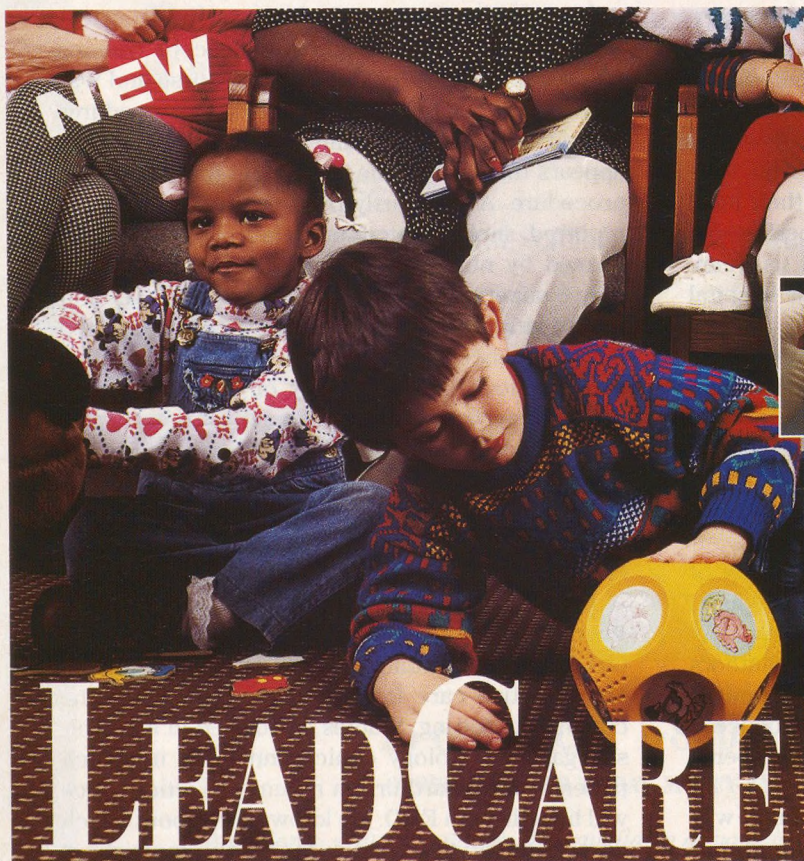
from the surgical specialties about how to measure and quantify procedural competence.

None of this should detract from the value of the report by Dr Pierzchajlo and his colleagues. They should be congratulated for the clarity and conclusiveness of their data. We need practice-based information such as this to learn more about the process of caring for common problems. But this study tells us a lot about what we already know. It does not tell us enough about what we need to know. It does not address the questions that really matter to patients. Patients often have simple questions: "When do I need to have this test done and

how will my health be improved from what you learn?" Until we can answer these questions, we will not be sure whether access to EGD in rural practice really matters.

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