3.13 THE CLINICAL EXAMPLE ON

Digestive Health

This statement is part of the curriculum produced by the Royal College of General Practitioners (RCGP) which defines the learning outcomes for the discipline of general practice and describes the skills you require to practise medicine as a general practitioner in the National Health Service (NHS) of the United Kingdom. Although primarily aimed at the start of independent work as a general practitioner, it must also prepare the doctor beyond the training period and provide support for a professional life of development and change.
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KEY MESSAGES

- Digestive problems are common in general practice
- As a general practitioner (GP) you have a central role in the diagnosis and management of digestive problems in primary care
- Dyspepsia and gastro-oesophageal reflux disease (GORD) are common conditions, affecting around 28% of the population
- Prevention and early treatment of colorectal cancer are priorities for the Department of Health
- A national programme of screening for colorectal cancer is now in place, with plans for the possible addition of flexible sigmoidoscopy. Primary care has an important role, even though recruitment of patients and follow-up are centrally co-ordinated
- New treatment approaches are emerging for patients with hepatitis B and C
Beverley Chalmers is a 62-year-old librarian. She is married with two grown up children and three grandchildren. She says her marriage has been going through a particularly ‘difficult patch’ since her husband lost his job two years ago and markedly increased his alcohol consumption. She would like to retire but is concerned over finances. She consults you with symptoms of weakness and fatigue. She has lost 5kg in the last six months with no obvious cause.

You ask about Beverley’s gastrointestinal (GI) symptoms: she has had constipation on and off for a number of years, with occasional bloating which she attributes to ‘wind’. She saw you 12 months ago with a single episode of rectal bleeding and you noticed a small external haemorrhoid. The bleeding settled after conservative treatment. Beverley is stressed by changes at her library (a new supervisor is ‘making life difficult’ for her) and by the relationship difficulties in her marriage. She is also concerned about her 12-year-old granddaughter’s behaviour – she is missing school and not telling her parents where she is.

Over the last three months Beverley has become a little breathless – she first noticed this when climbing the stairs at work. She has mild rheumatoid arthritis. A locum in the practice recently prescribed a mild diuretic and temazepam (as she was sleeping poorly). She also takes a regular dose of a non-steroidal anti-inflammatory drug (NSAID). She has had a normal mammogram within the last 12 months. She has had two invitations, at age 60 and 62, to undertake a faecal occult blood test (FOBT) as part of the screening programme; the first was negative and she declined the second. There is no family history of note. Beverley has never smoked, and drinks only on rare social occasions.

On examination she has mild clinical signs of anaemia. Her BP is 130/70, lungs are clear. Abdominal examination is essentially normal. You perform a rectal examination which is also normal, and there is no sign of the haemorrhoid you previously diagnosed.

Initial investigations, including an Hb of 7.3 gm/DL, suggest she has iron deficiency anaemia and you commence iron replacement therapy. When you see her on a follow-up visit her tiredness appears to have worsened. She also appears anxious and is very concerned about her poor sleeping. She thinks the iron tablets are making her more constipated. She has lost a further kilogram in weight which she can’t understand. You need to give thought to the next steps you will take in investigating and managing Beverley’s symptoms.
To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Category</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care management</td>
<td>What next steps would I take? Would I refer Beverley and to whom? Would I expect a colonoscopy at this point?</td>
</tr>
<tr>
<td>Person-centred care</td>
<td>How can I take into account the wide range of psychosocial issues with which Beverley presents? How do I think they might be influencing her presentation? Would I want to see other members of her family? Why?</td>
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<tr>
<td>Specific problem-solving skills</td>
<td>What is my strategy for investigating this combination of symptoms and factual information (e.g. weight loss, anaemia, weakness/fatigue, psychological issues)?</td>
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<tr>
<td>A comprehensive approach</td>
<td>How will I address Beverley’s current concerns while being diligent in investigating her for serious illness?</td>
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<tr>
<td>Community orientation</td>
<td>How do people respond to invitations for FOBT screening? What influences this? What community services might be available to help Beverley and her family?</td>
</tr>
<tr>
<td>A holistic approach</td>
<td>What is the range of factors in Beverley’s life which could be influencing her presentation? What other aspects of her social and cultural background would I like to enquire about?</td>
</tr>
<tr>
<td>Contextual features</td>
<td>How well does screening pick up cancer early? How do societal norms influence the way people present with GI symptoms?</td>
</tr>
<tr>
<td>Attitudinal features</td>
<td>How does Beverley’s quite complex presentation make me feel and why? How would I take account of these attitudes in my management of the situation?</td>
</tr>
<tr>
<td>Scientific features</td>
<td>What sources of information can I identify to ensure I am up to date with the investigation of lower GI cancer?</td>
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LEARNING OUTCOMES

The following learning outcomes or objectives relate specifically to the management of digestive health. These learning outcomes are in addition to those detailed in the core statement, Being a General Practitioner. The core statement and this statement should be used in conjunction with the other curriculum statements. In order to demonstrate the core competences in the area of digestive health you will require knowledge, skills and attitudes in the following areas:

The RCGP areas of competence

1 Primary care management

This area of competence is about how you manage your contact with patients, dealing competently with any and all problems that are presented to you. (This area of competence is not limited to dealing with the management of the practice.)

This means that as a GP you should:

1.1 Be able to manage primary contact with patients who have a digestive problem
   1.1.1 Understand the epidemiology of digestive problems as they present in primary care and their often complex aetiology
   1.1.2 Know how to interpret common symptoms in general practice, including dyspeptic symptoms (epigastric pain, heartburn, regurgitation, nausea, bloating), abdominal pain, nausea, vomiting, anorexia, weight loss, haematemesis and melaena, rectal bleeding, jaundice, diarrhoea and constipation, and dysphagia

1.2 Demonstrate a systematic approach to investigating common digestive symptoms, taking into account the prevalence of these symptoms in primary care and the likelihood of conditions such as peptic ulcer, oesophageal varices, hepatitis, gastrointestinal cancers and post-operative complications

1.3 Understand that digestive symptoms are frequently linked to psychosocial factors and empathise with individuals who are psychologically distressed
   1.3.1 Explore gastrointestinal symptoms and psychological and social factors using an integrated approach
   1.3.2 Understand the range of gastrointestinal problems associated with alcohol and drug usage (see also statement 3.14 Care of People who Misuse Drugs and Alcohol)

1 Hellier MD, Williams JG. The burden of gastrointestinal disease: implications for the provision of care in the UK Gut 2007;56:165–6, doi:10.1136/gut.2006.102889
1.4 Understand the indications for urgent referral for suspected GI cancer
1.4.1 Be aware of the cancer risks associated with various symptoms and symptom complexes
1.4.2 Understand the National Institute for Health and Care Excellence (NICE) referral guidelines for suspected cancer
1.5 Use an evidence-based approach to management and prescribing for common symptoms such as dyspepsia, and be familiar with contemporary developments around drug treatment options for hepatitis B and C

2 Person-centred care

This area of competence is about understanding and relating to the context of your patients as individuals, and developing the ability to work in partnership with them.

This means that as a GP you should:

2.1 Recognise that it is difficult for some patients to discuss digestive symptoms, through factors such as embarrassment and social stigma
2.2 Demonstrate a non-judgemental, caring and professional consulting style to minimise the embarrassment of patients with digestive problems
2.3 Understand that digestive symptoms are often multiple and imprecise, and frequently linked to emotional factors
2.4 Be aware of the sensitive nature of GI symptoms and some GI examinations (such as rectal examination) – and do everything possible to put the patient at ease, including the offer of a same-sex doctor if appropriate
2.5 Understand the many cultural and social factors which can influence the way patients interpret symptoms and the manner in which this influences their expectations of medical management

3 Specific problem-solving skills

This area of competence is about the context-specific aspects of general practice, dealing with early and undifferentiated illness and the skills you need to tolerate uncertainty, and marginalise danger, without medicalising normality.

This means that as a GP you should:

3.1 Intervene urgently when patients present with an acute abdomen
3.2 Be cautious with telephone advice when the abdomen has not been examined
3.3 Understand the risks associated with various symptoms which may indicate GI cancer, and refer with appropriate levels of urgency

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3.4 Demonstrate a structured, logical approach to the diagnosis of abdominal pain, e.g. to enable a positive diagnosis of irritable bowel syndrome to be made, rather than making the diagnosis by exclusion
3.5 Understand dietary factors associated with various GI conditions and offer appropriate dietary advice (e.g. in weight loss, irritable bowel syndrome and primary cancer prevention)
3.6 Understand screening programmes for colorectal cancer, and the role of primary care in information provision and dealing with symptoms amongst screening invitees

**4 A comprehensive approach**

This area of competence is about how you as a general practitioner must be able to manage co-morbidity, co-ordinating care of acute illness, chronic illness, health promotion and disease prevention in the general practice setting.

This means that as a GP you should:

4.1 Identify patients’ attitudes and beliefs about digestive symptoms and disease, and how they might influence patterns of presentation
4.2 Advise patients appropriately regarding lifestyle interventions that have an impact on gastrointestinal health, such as advice on diet and on stress reduction
4.3 Know the gastrointestinal side effects of common medicines
4.4 Modify the form or modalities of treatment to cater for the patient’s GI function and preferences
4.5 Have strategies to respond to patients who attend frequently with unexplained GI symptoms, e.g. strategies might include educational and supportive counselling approaches
4.6 Have a good understanding of the impact of GI symptoms and illness on patients, their families and their wider networks
4.7 Support people to self care, particularly those with chronic symptoms (such as those typically associated with irritable bowel syndrome)

**5 Community orientation**

This area of competence is about the physical environment of your practice population, and the need to understand the interrelationship between health and social care, and the tensions that may exist between individual wants and needs and the needs of the wider community.

This means that as a GP you should:

5.1 Understand the evidence underpinning the national bowel cancer screening programme, and the public health implications of the programme
5.2 Have a good understanding of the availability of endoscopic services for upper and lower GI symptoms/diseases
5.3 Recognise the place in cost-effective management of simple therapy and expectant approaches (in which active treatment is deferred) while the patient’s condition is adequately monitored
5.4 Understand the high prevalence of GI symptoms in the community and the implications for primary care
5.5 Be aware of community-based services in areas such as drug and alcohol rehabilitation, both of which are implicated in gastrointestinal disease

6 A holistic approach

This area of competence is about your ability to understand and respect the values, culture, family structure and beliefs of your patients, and understand the ways in which these will affect the experience and management of illness and health.

This means that as a GP you should:

6.1 Recognise the effects psychological stress can have upon the gastrointestinal tract, especially with functional disorders, e.g. non-ulcer dyspepsia, irritable bowel syndrome, abdominal pain in children

6.2 Recognise the impact of social and cultural diversity, and the important role of health beliefs relating to diet, nutrition and gastrointestinal function

6.3 Holistically manage psychological symptoms and conditions which have associated GI issues, e.g. it may be appropriate to refer the patient to a support group or counsellor

The essential features of you as a doctor

The three essential features (EFs) below are concerned with the features of you as a doctor which may influence your ability to apply the core competences to real life in the work setting.

EF1 Contextual features

This essential feature is about understanding your own context as a doctor and how it may influence the quality of your care. Important factors are the environment in which you work, including your working conditions, community, culture, financial and regulatory frameworks.

Examples of this are:

EF1.1 The importance of recognising the full array of psychosocial, cultural and other determinants on the presentation of gastrointestinal disorders and to ensure that the practice is not biased against recognising these

EF1.2 The need to provide an environment where abdominal and rectal examination are easy to perform with dignity and under chaperoned conditions – for example, by having separate examination rooms available

EF1.3 Championing the availability and appropriate use of direct-access endoscopy and imaging for primary care practitioners
### EF2 Attitudinal features

This essential feature is about your professional capabilities, values, feelings and ethics and the impact these may have on your patient care.

Examples of this are:

- **EF2.1** How as a doctor you should explore your own attitudes to gastrointestinal illness and accept that these can influence the way you respond to individuals with digestive disorders
- **EF2.2** Being aware of the many issues relating to embarrassment and social and cultural factors which influence presentation to primary care, and how you can have a constructive approach to these
- **EF2.3** Appreciating the complex issues around drug and alcohol misuse, the ways these impact on digestive disorders and the management problems they are associated with, demonstrating a non-judgemental approach to individuals with, for example, chronic gastrointestinal symptoms, drug and alcohol problems

### EF3 Scientific features

This essential feature is about the need to adopt a critical and evidence-based approach to your work, maintaining this through lifelong learning and a commitment to quality improvement.

Examples of this are:

- **EF3.1** Understanding the epidemiology of gastrointestinal symptoms and disorders in primary care, and the evidence on the risks for cancer and other serious diseases associated with various symptoms and symptom complexes
- **EF3.2** Using contemporary management approaches to individuals with hepatitis B and C, and understanding the dynamics for screening for colorectal cancer and its influence on individual patient management
- **EF3.3** Understanding the evidence base for the national guidelines on screening and management of common and important gastrointestinal conditions
Work-based learning – in primary care

Primary care provides tremendous opportunities for you to gain a broad-based understanding of digestive illness. Virtually all gastrointestinal diseases present initially with symptoms in primary care. There is a high prevalence of gastrointestinal symptoms in the community and one of the fascinating challenges in primary care is to interpret these symptoms and identify those patients with problems which warrant further and/or urgent investigation. As a GP trainee it may be possible for you to spend time in community-based endoscopy facilities – these are sometimes led by primary care doctors with an interest in gastrointestinal disease. You should also take the opportunity to discuss screening programmes with patients in eligible age groups and check on their understanding of the screening process and how it relates to symptom-based diagnosis.

Work-based learning – in secondary care

As a GP trainee you should ideally take the opportunity of spending time in outpatient clinics, in both general and specialised areas – for example, hepatitis management, liver disorders, endoscopy clinics etc. There is a very broad spectrum of activity in which you could potentially get involved and the opportunities will depend to some extent on individual hospital environments.

Non-work-based learning

You will find many case-based discussions within GP speciality training programmes on gastrointestinal disorders. These cases are often challenging because patients with gastrointestinal diseases often follow unpredictable diagnostic journeys. Trainees with a particular interest might consider attending meetings of the Primary Care Society for Gastroenterology Society (see under Learning Resources).

Learning with other healthcare professionals

Trainees should take the opportunity of discussing gastrointestinal disorders with practice nurses and nurses in the hospital environment. Some practices have community nurses dealing specifically with drug and alcohol problems and it would be helpful to spend time discussing gastrointestinal disorders in relation to intravenous drug use and excessive alcohol consumption. It would also be helpful for you to accompany patients in investigations such as helicobacter breath testing and endoscopic procedures.
Formal learning

As a trainee you should be aware of the range of RCGP courses, many of them based on e-modules. For example, the RCGP certificate in the detection, diagnosis and management of hepatitis B and C in primary care: [www.rcgp.org.uk/courses-and-events/online-learning/ole/hepatitis-b-and-c.aspx](http://www.rcgp.org.uk/courses-and-events/online-learning/ole/hepatitis-b-and-c.aspx)
LEARNING RESOURCES

Examples of relevant texts and resources

- Delaney BC. 10-minute consultation: dyspepsia *British Medical Journal* 2001; 322: 776
- Hay DW (ed). *Blackwell’s Primary Care Essentials: gastrointestinal disease* John Wiley and Sons Ltd, 2002

Web resources

Primary Care Society for Gastroenterology
The Primary Care Society for Gastroenterology has a good website with lots of helpful guidance on common gastrointestinal conditions in primary care.

[www.pcsog.org.uk](http://www.pcsog.org.uk)
ACKNOWLEDGEMENTS

This curriculum statement is based on the original statement 15.2 Digestive Problems in the 2007 version of the RCGP Curriculum. It has drawn on various national guidelines and policies, current research evidence and the expertise and clinical experience of practising general practitioners.

The authors and contributors of this version of the statement are:

Author: Professor David Weller
Editors: Dr Frances Peck, Dr Charlotte Tulinius
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