Outreach clinics in Israel: a common but unregulated phenomenon*

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Background. Specialist outreach consultations in the primary care setting have long been controversial with regard to both their effectiveness in treating patients and their potential in improving the interaction between family physicians and specialists.

Objective. The aim of this study was to establish the prevalence and nature of outreach consultations in primary care clinics in Israel.

Methods. Questionnaires were sent to the heads of all public family practices of the General Sick Fund in our district (38 practices with about 180 000 patients). All 38 practice managers returned completed questionnaires.

Results. Twenty-eight of the 38 practices (74%) have some type of specialist consultation available within their clinics. The most common specialties providing outreach clinics are cardiology (47%), nephrology (45%) and internal medicine (39%), where the consultation was performed with the family physician and the patient present. Psychiatry consultations (42%), however, were generally performed without the patient being present. Most of the practice heads felt that in essence outreach clinics could be a positive way of treating their patients.

Conclusions. Head physicians of primary care clinics tend to see outreach clinics as being a very positive tool with which to treat patients. Although many family physicians have some form of specialist consultation available, it is provided and performed mainly on an ad hoc basis. At present no data are available on how best to structure these consultations, or on which specialties outreach clinics are most suitable.

Keywords. Israel, outreach clinics, specialist consultations.

Introduction

The establishment of specialist clinics in primary care facilities (family practice clinics) has been seen as having many potential benefits for the family physician, consultant and patient.1

Advantages cited for the family physician include improved communication and access to specialists along with educational opportunities, while for the patient it can lead to shorter waiting times and easier access to specialist consultations.2 In Israel, although it is well known that outreach clinics exist, there has never been an attempt to find out how common these clinics are and whether or not family physicians find them beneficial.

The aim of this study was to establish the extent and nature of specialist outreach clinics in primary care and to investigate the head family physicians’ attitudes towards these clinics.

Methods

In the Central district of the General Sick fund there are over 240 000 affiliated patients. Most of them get primary care treatment in the 38 group practices in the district, while the rest have solo-practicing family physicians.

A postal questionnaire was sent to all the head family physicians of these 38 practices. This was followed up by postal, fax and finally telephone reminders to non-responders.

The questionnaire included the following details:

(A) Details concerning the clinic: number of practicing physicians and qualifications of the practicing physicians and head physician.
(B) Details of outreach consultations: the specialists and the frequency with which they visit the clinic and the type of consultation performed.

(C) Head physician’s attitude towards the outreach clinic’s modality and its effectiveness.

Statistical analysis

Data were analysed using distribution analysis and chi-square tests to investigate the association between categorized variables. Analysis was performed using the SPSS package for MS Windows 6.0.

Results

Completed questionnaires were received from 38 (100%) of the practices’ head physicians. Most of the practices were in urban settings (29/38, 76%); the average number of physicians in each clinic was 3.3 ± 1.7. Twenty (53%) of the head physicians were qualified family physicians.

In 28 of the 38 practices (74%) there was some form of specialist outreach clinic. In two clinics, outreach clinics had failed in the past. Another two clinics were located in close proximity to regional multi-disciplinary out-patient clinic facilities, making outreach clinics irrelevant to them. Of the other six clinics that had no outreach clinics, four head physicians claimed to be interested in establishing such a facility.

The most widely used service was cardiology (47%); other frequent services were psychiatry (42%) and nephrology (45%). In other specialties, outreach clinics were provided in a more sporadic fashion (Table 1). In one teaching practice there were six outreach clinics; in this clinic most of the specialist consultations took place with all the physicians and nurses of the practice present. This was done so as to integrate the educational value of the outreach clinic with the training of trainee family physicians. While 72% of the practice heads said that the consultant saw patients together with the family physician, in some clinics a “no patient” consultation, using the medical chart, or alternatively an interaction of the consultant and the patient without the family physician, were performed.

No differences in the pattern of outreach clinics were found between urban and non-urban (country and villages) clinics. There was no association between the qualification of the head clinic physician or other physicians in the clinic and the utilization of outreach consultations.

All the doctors who answered the question on whether they saw outreach clinics as an effective way of treating their patients said that they felt it was effective, while 35% said that they were willing to incorporate more specialist consultations of the outreach clinics fashion.

Discussion

Specialist outreach clinics in Israel appear to be a fairly common phenomenon, with 74% of the group practices in our region having some form of such clinics. As in keeping with the development of such clinics in Britain, psychiatry is one of the specialties leading the way in establishing outreach clinics. From the psychiatrist’s point of view it is an important tool for encouraging patients to contact the psychiatrist for conditions such as anxiety states, depressive states, etc. It is the psychiatrists leading this shift, and not the family physicians, who in this manner are passive.

In our region, the cardiology and nephrology departments of the regional hospital are particularly active in encouraging a shift in patient care from the hospital to clinics and from the regional multi-disciplinary out-patient clinic facilities to the primary health care setting. It is clearly reflected in the large number of outreach clinics they provide. This attitude is a result of their concept that the continuous daily care of the patient should be in the hands of the family physician while limiting their role as specialists to consultation rather than follow-up in the vast majority of cases. In this case, as in psychiatry, the family physicians are passive, using a service that is offered to them rather than demanding or developing the service themselves.

Other outreach clinics in our region were found to be set up in a sporadic fashion. These are based on historical connections, locally established inter-relations or as an educational tool in the case of teaching practices. We could not trace many signs of initiative on the part of the head family physicians in establishing or in the expansion of these services, which appears surprising, as a vast majority were interested in incorporating more specialist consultations of the outreach clinic fashion.

In contrast to studies in Britain, we found that most outreach clinics were established as ‘liaison attachment’ schemes, where the specialist and family physician see

| Table 1 Outreach clinics provided in 38 family practice clinics |
|---------------------|--------|--------|
|                     | No. (%)|
| Cardiology          | 18 (47)|
| Nephrology          | 17 (45)|
| Psychiatry           | 16 (42)|
| Internal medicine   | 13 (34)|
| Rheumatology        | 5 (13) |
| Orthopedics         | 5 (13) |
| Endocrinology       | 3 (8)  |
| Othersa             | 6      |

a Others include neurology, radiology, geriatrics and immunology (each in 1–2 clinics).
the patients together, as opposed to shifted out-patient clinics, where specialists simply provide the same service in a different setting. This clearly would seem to provide advantages of improved communication between specialist and family physicians, and educational opportunities, as well as truly integrated care for the patient.1,2

Liaison attachment consultations may have disadvantages for the patient. The usual coalitions are destroyed, and a true ‘second opinion’ is not obtained. Therefore the clear advantage of the consultant and family physician being able pass full information directly to each other may not be seen as beneficial by the patient at all. So before expanding the outreach clinics in the ‘liaison attachment’ form, this issue requires further investigation.

Conclusion

Head physicians of primary care clinics tend to see outreach clinics as being a very positive resource for treatment of patients. Although many family physicians have some form of specialist consultation available, it is provided and performed mainly on an ad hoc basis. At present no data are available on how best to structure these consultations or for which specialties outreach clinics are most suitable and further research is needed.

References


