Editorial

Safe practice of endoscopy

The safe practice of endoscopy no longer simply involves ensuring that the endoscope is passed successfully through the gastrointestinal tract and that the appearances are interpreted accurately; or indeed that complications are seen infrequently. It involves ensuring that we practise a skill to the best of our ability, having received the best available training, using the best equipment, aided by the best support staff in the best possible environment; and that having done so we genuinely monitor our complication rates via prospective audit and are open to critical review by our local colleagues and outside national review bodies. This is no easy task but we must rise to the challenge for the new millennium.

Endoscopy as a discipline has had a rapid if not explosive growth over the last 30 years not only just in terms of numbers performed and the numbers of different clinicians that practise it; but also in the very wide range of techniques it offers. Not surprisingly then it is small wonder that criticisms have been levelled at endoscopic practice in recent years over how it has been discharged.

The government has made training in all branches of medicine an essential requirement, and the onus is on endoscopists to provide high quality instruction. For a while there had been concern about the uniformity of training in gastrointestinal endoscopy across all specialties. Discussion about how this should be done was understandably impeded by the fact that the endoscopist came in many different forms: surgeon, gastroenterologist, physician, radiologist, and general practitioner. Early work by the British Society of Gastroenterology (BSG) was a useful guide and a number of papers have been written over the last decade suggesting minimum numbers of years/sessions/procedures, etc that an endoscopist should complete before performing endoscopy unsupervised. Recently the Joint Advisory Group (JAG) on Gastrointestinal Endoscopy, which includes representatives from gastroenterology, radiology, and surgery have spelt out in more detail the recommendations for training. In short they recommend that training should only be practised in units approved by the JAG and which provide a gastroenterological service with cooperation between the physician, surgeon, radiologist, and pathologist. The recommendations that were developed and the system for registration of training units are now available, and all training units are encouraged to register with the group. (Further information can be obtained by contacting the BSG office.) Registration will be voluntary at first but it is hoped that as more and more units receive accreditation from the JAG, it will become mandatory by the year 2001.

Trainees now require a logbook to record details of their experience. The numbers of procedures required in each endoscopic modality are the subject of review and may be revised from time to time but, for example, current guidelines suggest that the trainee should carry out 200 diagnostic endoscopies as a minimum under supervision and then up to a total of 300 with a degree of independence. The training should be carried out weekly for at least six months. Therapeutic endoscopy should be only taught when the trainee is competent with diagnostic endoscopy. Training should be supplemented with courses on sedation techniques and complications. Of utmost importance is the ability of the trainee endoscopist to reliably interpret the endoscopic appearances effectively; this can be facilitated by the use of CD-ROM teaching programs. Trained endoscopists should continue their education with regular meetings and courses. The benefit of interdisciplinary meetings between histology, radiology, and surgery should be emphasised for both trainee and trainer who of course should continue to carry out at least one list per week or a minimum of 200 procedures per year in order to maintain the title of endoscopist, and of course his or her competence.

Where should we practise endoscopy? The vast majority of procedures are performed in hospital—endoscopy units, day units, theatres, etc. Of course all should be armed with the necessary resuscitation equipment, which should be available on the unit itself rather than nearby. The recovery area should be adequate and the unit manned by sufficient endoscopy assistants so that a minimum of two assistants (one of whom should be trained), are available during the endoscopy itself with further staff present at all times in the recovery area. It is now totally unacceptable for a patient to be left unattended after a procedure for which they were sedated having been told to ring for assistance if required. Again we now have minimum acceptable requirements for endoscopic facilities issued by the BSG. What do these recommendations mean for the practice of diagnostic endoscopy in general practitioner surgeries? While it may yet be deemed appropriate for selected cases to be performed at such sites this practice has yet to be challenged. It seems unlikely that it would be possible to meet all the requirements necessary to perform endoscopy outside a hospital environment. Despite strict guidelines issued by the General Dental Council, dentists practising
Audit, clinical governance, standards for best practice, guidelines and information technology, these are all tools now available to add to our armamentaria to enable us to practise endoscopy better. Make no mistake, the political pressure is there and endoscopists will need to respond, improving their practice and being able to demonstrate the improvements. It is a tough challenge for the new millennium—we believe that our patients expect us to meet it successfully.

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Postgrad Med J 2000 76: 455-456
doi: 10.1136/pmj.76.898.455

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