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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.¹ 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.² 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,³ dentists practising

sedation techniques have come up against the glare of publicity during the last year after court cases and complications of such techniques. Many general practitioner endoscopists avoid the use of sedation to get around this problem; but they need to be able to demonstrate the safety and acceptability of this service (as some are already doing). This needs to be addressed further.

What of the nurse endoscopist? There has been mixed enthusiasm for this concept depending largely on local interest. Concern has arisen also over how to ensure that the pathology is interpreted correctly. Nurse endoscopists must attend for retraining in resuscitation skills alongside clinicians.

The issue of informed consent within medical practice and research has come increasingly to the fore, as patients demand more involvement. Consent now needs to be well informed; requesting it hastily moments before performing the examination is now considered substandard. Outpatients should be provided with information (usually sent through the post), about the risks of each procedure well in advance and at least 30 minutes before the investigation. Attendance for the test, having been informed of the risks at an earlier date, has been considered in the past to be a form of consent but some units are now going a step further and issuing postal consent forms. A doctor who fully understands the procedure and its associated risks should gain consent. In addition to this patients' views about the service must be sought and kept under regular audit so that it can be upgraded where possible. A document recommending best practices for informed consent was drawn up by the BSG last year.⁴

The related disciplines of audit, clinical governance, and accountability are now clearly recognised as important. There have been a number of large scale regional audits organised by the colleges and BSG, namely the audit of upper gastrointestinal endoscopy a few years ago and more recently the audit on colonoscopy, and these larger audits serve a good purpose in examining complication rates for procedures where large numbers are required to show problem areas. The first audit highlighted a number of factors that were important in a patients' safety throughout the endoscopy; for example pneumonia was a more likely sequelae when local anaesthesia was used in addition to significant doses of benzodiazepines particularly in high risk patients.⁵ The audit also established mortality and morbidity rates against which local units could monitor their own practices. We wait with interest the results of the audit on colonoscopy practice.

Successful audit at local or regional level demands accurate and effective documentation and good quality data records are essential for either. The pressure of work discourages this and we need to develop systems for auditing easily and effectively. Local audit can select different areas for audit such as: checking that all patients with gastric or duodenal ulceration have correctly been examined for *Helicobacter pylori* and offered eradication, or calculating rates of bleeding or pancreatitis after sphincterotomy. Documenting complications of endoscopy is a huge area and each unit needs to be able to produce reliable data on their complication rate. Most units have the facility to document complications occurring on the unit but unfortunately few units have a system for recording complication occurring off the unit—which of course is one reason why nationally run audits requiring extra administration are still necessary.

From good audit comes guidelines and local units should be encouraged to use best practice guidelines which are evidence based and measurable—some of these will be locally developed guidelines but others will be standards as set by the Royal College of Physicians (RCP) and BSG,

both of whom have a number of documents covering many areas of endoscopy practice.

These will all help to ensure that we are carrying out best practice and will help to direct further audit.

The discipline of audit, which we should have by now come to accept as an essential part of our practice, has now been taken a step forward into the concept of clinical governance. This is the way in which every health organisation at a local level will meet its duty of quality: "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".⁶ What does this mean for an endoscopy unit? Each department will be required to set up leadership and accountability arrangements for clinical governance. All endoscopists in the team will be required to play a part in the organisation's assessment, to work within the team to look at the strengths and weaknesses of the services they provide, and to suggest ways for improvement and to take a full part in continuing professional development programs. Overall responsibility will probably fall to a selected senior clinician to whom all endoscopists are accountable regardless of their specialty. All practising endoscopists should be aware of the best practice guidelines and should adopt/implement uniform practices. They will be required to monitor their own performance and that of the unit.

Firstly such monitoring will be done at a local level. An individual unit through their local medical director will demonstrate to their trust board that their service they provide is up to standard. Systems are currently being developed for demonstrating good clinical practice to an outside body. There is already a system in place for review of trusts by the RCP to assess medical training programs. This is done through the Joint Committee of Higher Medical Training, and is coordinated by the RCP. This visitation is taken very seriously, as withdrawal of accreditation from training would be a devastating blow to a hospital and action therefore usually follows significant recommendations by the college visitors. A possibility to consider is to add a gastroenterologist to the visiting team so that the endoscopy service can be reviewed among other areas.

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.

M A QUINE
D COLIN-JONES

Department of Medicine,
Queen Alexandra Hospital,
Southwick Hill, Cosham,
Portsmouth, Hampshire PO6 3LY, UK

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- 6 Department of Health. *A first class service: quality in the new NHS*. London: DoH, 1998.