

**2010 Gastroenterology ARCP Decision Aid**

<b>Blueprint Sections</b>	<b>Assessment</b>	<b>ST3</b>	<b>ST4</b>	<b>ST5</b>	<b>ST6</b>	<b>ST7</b>
	<b>External</b>					
	SCE		Specialist Exam <sup>a</sup>			
	<b>Workplace Based Assessments</b>					
<b>Common Competencies</b>	mini-CEX <sup>b</sup> / CbD <sup>b</sup>					
	Competency Progression <sup>c</sup>	30%	50%	80%	90%	100%
<b>Basic and Applied Science</b>	mini-CEX <sup>b</sup> / CbD <sup>b</sup>					
	Competency Progression <sup>c</sup>	30%	50%	80%	90%	100%
<b>Upper GI tract disorders</b>	mini-CEX <sup>b</sup> / CbD <sup>b</sup>					
	Competency Progression <sup>c</sup>	30%	50%	80%	90%	100%
<b>Intestinal disorders</b>	mini-CEX <sup>b</sup> / CbD <sup>b</sup>					
	Competency Progression <sup>c</sup>	30%	50%	80%	90%	100%
<b>Hepatology</b>	mini-CEX <sup>b</sup> / CbD <sup>b</sup>	3 mini-CEX, and 6 CbD				
	Competency Progression <sup>c</sup>	30%	50%	80%	90%	100%
<b>Nutrition</b>	mini-CEX <sup>h</sup> /CbD <sup>h</sup> /DOPs	3 mini-CEX, 3 DOP's and 6 CbD				
<b>Total mini-CEX / CbD per year</b>		6	6	6	6	6

<b>Endoscopy</b>	Formative –DOPS <sup>d</sup> Summative-DOPS <sup>d</sup>	Formative x 10 in each modality	F-DOPS; S-DOPS	F-DOPS; S-DOPS	F-DOPS; S-DOPS	F-DOPS; S-DOPS
	DOPS <sup>d</sup>	2	2	2	2	2
<b>Generic skills</b>	MSF <sup>e</sup>	Satisfactory		Satisfactory		
	Audit assessment <sup>f</sup>	1	1	1	1	1
	Patient survey <sup>g</sup>		Satisfactory		Satisfactory	
	Supervisors report adequate Y/N					

**Notes:**

- a) Specialist Exam: Can be attempted in ST4 onwards, must be achieved for attainment of CCT.
- b) Six assessments in total (mini-CEX; CbD) per year to cover requirements, to be guided by the core outcomes blueprint grid. One assessment in each major domain 1-5 covered during placement, with endoscopic procedures assessed more frequently. If progression is inadequate as evidenced by WBA's and supervisor report then ARCP outcome 2 or 3.
- c) Indication of percentage of curriculum covered. Will help to identify gaps in training in particular nutrition / hepatology where experience may be focused into a specific training period.
- d) Endoscopy: should have a formal formative DOPS x 10 in all procedures being practiced each year (since all procedures will be directly supervised this is easily accomplished). Summative DOPS for JAG accreditation can be taken when appropriate. Other procedures should be assessed by a total of DOPS x 2 annually.
- e) MSF should be carried out at end of years 1, 3, and as required. If there are no concerns, two MSF's over the specialty training would be satisfactory. If there are areas for improvement, there is the option to add in further MSF's as necessary.
- f) There should be evidence of audit undertaken on an annual basis, which has been assessed by the ES.
- g) A patient survey should be carried out during years 2, 4, and as required. If there are no concerns, two Patient Surveys over the period of specialty training would be satisfactory.

## Advanced Specialist areas

### 1. Hepatology

Blueprint section	Assessment	Induction <sup>1</sup>	Month 6	Month 12
Liver transplantation	SCE, CbD, mini-CEX, MSF <sup>2</sup>			
Acute liver failure	SCE, CbD, mini-CEX			
Hepatitis C	SCE, CbD, mini-CEX			
Hepatitis B	SCE, CbD, mini-CEX			
Complications of cholestatic liver disease	SCE, CbD, mini-CEX			
Vascular liver disease	SCE, CbD, mini-CEX			
Pregnancy associated liver disease	SCE, CbD, mini-CEX			
Liver tumours Benign Hepatocellular Cholangio Ca	SCE, CbD, mini-CEX			
Intensive care	SCE, CbD, mini-CEX, MSF <sup>2</sup>			
Competency progression <sup>3</sup>				
Audit <sup>3</sup>	AA			
Total assessments required			5	10
Endoscopic management of varices	Log book, DOP's		10 <sup>5</sup>	20 <sup>5</sup>

<sup>1</sup> Sum of relevant assessments undertaken prior to Advanced Specialist training

<sup>2</sup> MSF should be directed to intensive care or multi disciplinary assessment of malignancy or need for transplantation

<sup>3</sup> Review of evidence produced suggesting satisfactory progression (Y/N/ action required)

<sup>4</sup> Evidence of audit involvement should be assessed at month 6 for inception and month 12 for completion

<sup>5</sup> Endoscopic DOP's should include variceal banding, injection of Histoacryl glue / thrombin, use of APC for those wishing to undertake endoscopy as a consultant

It is strongly suggested that a log book be kept by the trainee to demonstrate exposure to the breadth of the curriculum in terms of cases seen in clinic, on the wards, and in an ITU setting

## 2. Inflammatory bowel disease

Blueprint section	Assessment	Induction <sup>1</sup>	Month 6	Month 12
Principles	SCE, mini-CEX			
Diagnosis	SCE, CbD			
Management Routine Surgical Biological	Modified ACAT, CbD, mini-CEX, log book			
Team working	MSF <sup>2</sup>			
Complex disease	CbD, log book			
Disease in pregnancy	SCE, mini-CEX, CbD,			
Nutrition in IBD	SCE, mini-CEX, CbD, log book			
IBD in adolescence	SCE, mini-CEX, CbD			
Competency progression <sup>3</sup>				
Total assessments required mini-CEX / CbD			5	10
Colonoscopy in patients with IBD	DOPS		Log book >30	Log book >60
Audit <sup>4</sup>				

<sup>1</sup> Assessments involving IBD cases should be reviewed on commencement of Advanced Specialist training

<sup>2</sup> MSF undertaken between months 4 and 8 using members of MDT and supervisors

<sup>3</sup> Review of evidence produced suggesting satisfactory progression (Y/N/ AR action required)

<sup>4</sup> Evidence of audit involvement should be assessed at month 6 for inception and month 12 for completion

It is strongly advised that a logbook is kept recording all cases seen in clinic / on wards for review during advanced specialist training.

### 3. Nutrition

Blueprint section	Assessment	Induction <sup>1</sup>	Month 6 <sup>3</sup>	Month 12
Enteral nutrition	CbD, mini-CEX,			
Parenteral nutrition	CbD, mini-CEX			
Intestinal failure-general	CbD, mini-CEX			
Short bowel -IBD -ischaemia -jejunostomy/high output stoma -jejunum in continuity with colon	CbD, mini-CEX,			
	MSF <sup>2</sup>			
pancreatitis	CbD			
Post-op. complications/management	CbD, mini-CEX			
Enteric dysmotility	CbD, mini-CEX			
Eating disorders	CbD, mini-CEX			
Abdominal malignancy/chemo-radiotherapy	CbD, mini-CEX			
Ethical/legal issues	CbD			
Total assessments required mini-CEX / CbD			8	16
Insertion and removal of parenteral feeding lines	DOPS		8 (logbook)	16 (logbook)
Audit <sup>4</sup>				

<sup>1</sup> Assessments involving nutrition cases should be reviewed on commencement of advanced specialist training

<sup>2</sup> MSF undertaken between months 4 and 8 using members of MDT and supervisors

<sup>3</sup> Review of evidence produced suggesting satisfactory progression (Y/N/ AR action required)

<sup>4</sup> Evidence of audit involvement should be assessed at month 6 for inception and month 12 for completion

It is strongly advised that a log book is kept recording all cases seen in clinic / on wards and procedures performed for review through advanced specialist training

#### 4. Advanced Endoscopy

Blueprint section	Assessment	Induction <sup>1</sup>	Month 6	Month 12
<b>Endoscopic ultrasound</b>	DOPS, CbD, MSF	Accredited in diagnostic upper gastrointestinal endoscopy and preferably flexible sigmoidoscopy prior to training	cancers of oesophagus, stomach or rectum, >25; sub-epithelial lesions, >15; pancreatico-biliary, >25 and FNA, >15 (50% solid pancreatic lesions); >20 DOPS luminal, > 10 subepithelial; > 20 pancreatico-biliary; 10 CbD; 1 MSF	cancers of oesophagus, stomach or rectum, 75; sub-epithelial lesions, 40; pancreatico-biliary, 75 and FNA, 50 (50% solid pancreatic lesions); >40 DOPS luminal, > 20 subepithelial; > 40 pancreatico-biliary; 20 CbD
<b>ERCP</b>	DOPS, CbD, MSF	> 20 procedures; 7 DOPS	>120 procedures; 50 DOPS; 10 CbD; 1 MSF	>250 procedures; 100 DOPS; 20 CbD

<sup>1</sup> Sum of relevant assessments undertaken prior to advanced specialist training.

Completion of this period of training does not necessarily confirm eligibility to practice in this specialist area independently