

**JOINT ROYAL COLLEGES OF PHYSICIANS TRAINING BOARD
(JRCPTB)**

**Annual Specialty Report for Gastroenterology to
The Postgraduate Medical Training Board (PMETB)
for August 2007 to July 2008**

1. Establishing Schools

The SAC is not aware of any difficulties that Gastroenterology has experienced and although it is early days, no issues have so far emerged.

2. Triggered Visits

No triggered visits have been reported by the respondents and the SAC Chairman is unaware of any in Gastroenterology

3. Effect of changes to the specialty

a) The introduction of the National Bowel Cancer Screening Programme has led to an increase in the need for service provision in colonoscopy. JAG has introduced a system for accreditation of Endoscopy Units - a measure that has in itself enhanced the quality of service provision in endoscopy much more widely. Apart from the introduction of dedicated bowel cancer screening lists, the quality of endoscopy has definitely improved. Screening lists are consultant-provided but more generally, all modalities of endoscopy now involve much closer consultant leadership and direction. It's clear that no longer are trainees providing a service unless they have achieved certification as being able to practise the procedure independently. There has been a significant increase in the number of consultant gastroenterologists appointed in 2008 compared with the two previous years.

b) The UK Upper Gastrointestinal Bleeding Audit (2008) identified major deficiencies in the emergency endoscopy service - especially that provided out-of-hours. This is leading to an ongoing review in each trust as to how the demand for evening and weekend emergency endoscopy provision might be delivered. Some neighbouring trusts are combining senior endoscopy staff resources to provide complete round the clock emergency endoscopy services for patients admitted with acute upper gastrointestinal bleeding.

c) As endoscopy becomes more specialised, the gastroenterology community recognises it needs to provide training for those who potentially have the expertise to perform, for example, excision of large colonic polyps or endoscopic ultrasound. This requires intensive periods of highly concentrated training. We need to identify trainers and select appropriate trainees.

d) It is evident that, across the board, specialisation is required to deliver high quality services in nutrition, inflammatory bowel disease, hepatology and cancer. It's just no longer possible for a 'general' gastroenterologist to cover all the bases in terms of providing a comprehensive clinical service. In larger units, gastroenterologists increasingly focus on such areas of individual expertise. Although hepatology is an

established subspecialty, the growth in the problem of liver disease means that currently there is an unmet need for liver specialists - both in terms of existing numbers of specialists as well as trainees coming through the system.

4. Key concerns for the future of the specialty

Generally, a debate is beginning as to whether it is reasonable to expect gastroenterologists to sustain their heavy clinical commitment to their specialty but also contribute to the general medical take. This is particularly an issue for smaller trusts where the workload is high, staffing levels are small and the pressure to provide an increase in quality and range of services as well as out-of hours cover is substantial. The SAC proposes a major revision of the specialty training curriculum in 2010 to meet these challenges

5. RITAs/ARCPs. The following includes the responses we have received from the Heads of Specialist Training for this specialty

All trainees for this specialty have had successful RITAs/ARCPs. For the 519 trainees enrolled in Gastroenterology it was been reported that 1 RITA E and 1 RITA D were given in the period Aug 07 – July 08. Both trainees subsequently obtained RITA C at next RITA

1 trainee took and passed the speciality exam, although the trainee is on the 2003 curriculum

6. European Working Time Directive (EWTD): The following includes the responses we have received from the Heads of Specialist Training for this specialty

From those who responded, it seems that the specialty is fully compliant. In most cases this is complete compliance, although at the effect of impairment of the teaching and training activity. One region has 9 posts that do not train in GIM and this has generally enhanced the gastroenterology training in those posts. The effect of EWTD has been to fragment gastroenterology training, in that many units now do blocks of intense acute GIM with hardly any gastroenterology during that period. The main issue would be the inability of many units to provide the free ½ day as outlined in the curriculum for audit/research/private study, only 2 units in the aforementioned region reliably do this.

7. Training Programme Director Report information

We have not received these reports for every Deanery for this reporting period but intend to include the themes in subsequent reports.

8. Examinations

We do not have examination data available for this reporting period.

9. Assessments

Workplace based assessments for the medical specialties including Direct Observation of Procedural Skills (DOPs), mini CEX, and Multisource Feedback (MSF) have been in place since 2005. Although there have been concerns within each specialty with regard to the time involved to complete these, their use has been widely encouraged so that PMETB standards are met. We continue to pilot further workplace based assessments.

10. e-portfolio

Pilots for the specialty e-portfolios have been completed and the eportfolio for Gastroenterology is now live and available for use by enrolled StRs. During the transition period trainees had been advised to complete paper records or to continue to use their CMT e-portfolio.