
Leading article

ERCP training—time for change

It has become increasingly clear that no longer is it appropriate or practical to train all specialist gastroenterology registrars in endoscopic retrograde cholangiopancreatography (ERCP). This realisation has caused much disquiet and uncertainty among trainees, concern among trainers, and debate in the journals.¹ At present the implication of the Joint Committee for Higher Medical Training (JCHMT) curriculum for higher specialist training in gastroenterology is that all trainees are expected to become proficient in all areas of endoscopy. In recent months this issue has been extensively discussed by the appropriate bodies—Training Committee of the British Society of Gastroenterology (BSG), Joint Advisory Group on Endoscopy Training (JAG), and in particular the Specialist Advisory Committee in Gastroenterology to the Joint Committee for Higher Medical Training (SAC to JCHMT). It is the JCHMT alone that has the statutory powers to enforce decisions on training.

The SAC Gastroenterology, with the approval of the other bodies, has decided that from now, ERCP will no longer be an essential requirement for a certificate of completion of specialist training.

Most gastroenterologists would accept the need for full training in oesophago-gastro-duodenoscopy and in colonoscopy. These are areas of endoscopy where demand can be expected to continue to rise, especially with the increasing need for cancer screening. In contrast, despite the recent sharp rise in demand for ERCP coming on the back of laparoscopic cholecystectomy, it is likely that numbers will plateau or even fall as magnetic resonance cholangiopancreatography and laparoscopic exploration of the common bile duct become more widespread. Even with the existing numbers of cases it is not possible for all trainees to meet the requirements of JAG and become proficient in ERCP, nor would trainers be able to maintain their expertise.

These concerns were very clearly expressed in a recent paper by Wicks *et al*, with a commentary by Baillie from Duke University, suggesting the need for limits on training and decrying the lack of any formal training guidelines in the UK.^{1,2} Wicks *et al* express the need for a change from the current ad hoc apprenticeship with its assumed level of competence to a formalised training and assessment process with a standardised form of accreditation. At the time the article was written they were unaware that this statement was no longer true and that significant progress had been made. JAG had been commissioned three years earlier by the then Conference of Royal Colleges to tackle the whole issue of standards in endoscopy training. JAG was made up of representatives from the BSG, SAC in Gastroenterology, Royal Colleges of Surgeons, radiologists, and general practitioners. The remit of JAG was to

produce exactly what Wicks *et al* were requesting. The need to address standards in endoscopy had been appreciated for some time. Attempts to instigate accreditation seven years ago were vigorously rejected when presented at the AGM of the BSG. The endoscopy section of the BSG and JAG have been battling with these issues, particularly in the past two years, but the need has been brought sharply back into focus following major litigation issues over clinical competence, highlighted by the Bristol cardiac deaths. JAG's aims were to establish clear guidelines, a high standard of endoscopy training, a means of documenting the training, documenting the training facilities, accrediting the unit for training, and accrediting the trainees. Many hurdles have been placed in the way of developing these aims but in January 1999 the recommendations were finally accepted, published, and distributed widely to all endoscopy units and endoscopists throughout the UK. These guidelines cover all areas of endoscopy (with the exception of small bowel enteroscopy and endoscopic ultrasound) and lay down specific requirements of units, trainers, and trainees. All units should be registered with JAG by the year 2001. Thereafter, endoscopic training will only be recognised when carried out in accredited units.

The next revision of the JAG document will address small bowel enteroscopy and endoscopic ultrasound training.

An endoscopy unit must undertake at least 250 procedures a year to register for ERCP training. The trainee should carry out at least 100 procedures under supervision and achieve a high percentage of success before performing the procedure independently. Cannulation of the desired duct in more than 90% of cases and ability to provide biliary drainage is necessary for competence in ERCP.

The JAG document is only a start. It relies predominantly on numbers to measure competence. This is clearly an unsatisfactory over simplification. Ultimately what are needed are reliable measurements of quality and competence. At a recent workshop in Manchester, convened by the European Society of Gastrointestinal Endoscopy, representatives from Europe, the UK, and the USA met to initiate steps to develop quality indicators and to examine the whole area of audit in endoscopy. Pilot studies are underway at present to try to identify quality standards which can be used to assess competence which will in turn

Abbreviations used in this paper: ERCP, endoscopic retrograde cholangiopancreatography; JCHMT, Joint Committee for Higher Medical Training; BSG, British Society of Gastroenterology; JAG, Joint Advisory Group on Endoscopy Training; SAC, Specialist Advisory Committee.

provide a better measure of the quality of endoscopy. The aim is to incorporate these into appropriate software programmes which will be used nationally. Recently, JAG has established a training course committee which is multidisciplinary and which is developing curricula for training in all areas of endoscopy with a view to establishing training programmes on a regional basis throughout the UK, including "training the trainers" courses, the first of which was run in January 2000 with others planned for the future.

Specific problems are apparent in relation to ERCP. In a recent study performed on behalf of the clinical services committee of the BSG by Alison and Colin-Jones, based on a survey of endoscopists in the UK, the estimated requirement for a health district of 250 000 population was 180 ERCPs per annum, of which 75% would be therapeutic. Assuming one gastroenterologist per 80 000 population, each gastroenterologist, if they were aiming to do one list per week, would be averaging little more than one ERCP per week. This could hardly be considered sufficient to maintain the skills of the trained endoscopist, let alone provide the opportunity to train trainees. Even in some of the specialist ERCP units the demand for training by specialist registrars exceeded the capacity to deliver the training specified by JAG. Furthermore, in most district general hospitals the number of ERCPs performed per year would not qualify those units to train specialist registrars in ERCP.

Thus as things stand, training in ERCP cannot be provided for all trainees, even if it was felt desirable. However, the JAG requirements are not set in stone. The value of 250 procedures per year may in reality be too high. In excluding hospitals which perform fewer ERCPs one may be depriving specialist registrars working in those hospitals of valuable experience. It may be more realistic to accept a lower figure as a threshold for units registering for ERCP training but to demand that initial training is carried out in larger units with a higher throughput, certainly more than 250 procedures per year. Nevertheless, some restriction of training for ERCP is inevitable. How can we select fairly those who should be encouraged to train in ERCP and exclude those who should not? We need to identify those trainees who intend to practise ERCP as a major part of their work. This would include those who wished to specialise in hepatobiliary disease. We need to be able to identify those who do not have the necessary skills. Some

endoscopists have good hand/eye coordination and will quickly master ERCP while some do not and will never achieve the desired skills for safe therapeutic ERCP. Selection probably needs to be made by the third year of specialist registrar training to allow those committed to ERCP to concentrate on the technique and those who are not to pursue alternative skills such as endoscopic ultrasound, gastrointestinal motility, or advanced nutritional support. We need a measure of the number of trained specialists in ERCP required to meet national demands and can then gauge the numbers of specialist registrars who should be selected for ERCP training.

In the present climate, trainees will inevitably feel disadvantaged if prevented from training in all areas of endoscopy. This must not be the case, as changes in policy must not disadvantage current or future trainees. Attitudes must change! Training documents must clearly indicate that ERCP is not a mandatory requirement of completion of training. Trusts must be made fully aware that not all consultant posts in gastroenterology require ERCP skills. Such skills may be superfluous to the trust which would be better served by the appointment of someone with alternative and complementary skills. In advertising for consultant appointments, trusts must decide what type of gastroenterologist they require, ERCP or not, and clearly state this in the job description and advertisement.

Postgraduate deans and regional specialist advisers who will be notified of the changes in ERCP requirement will be instrumental in advising and guiding trainees in their future training with these changes in mind. It would be unreasonable to place these restrictions on training without ensuring that trainees are treated fairly and not disadvantaged in future consultant appointments.

M D HELLIER

*Vice-President (Endoscopy) BSG
Chair—SAC Gastroenterology*

A I MORRIS

*Chairman—Joint Advisory Group on Gastrointestinal Endoscopy
Royal Liverpool Hospital, Prescot St, Liverpool L7 8XP, UK*

Correspondence to: Dr M D Hellier, Princess Margaret, Hospital, Okus Road, Swindon, Wiltshire SN1 4JU. Email: mikehell@epulse.net

- 1 Wicks ACB, Robertson GSM, Veitch PS. Structured training and assessment in ERCP has become essential for the Calman era. *Gut* 1999;45:154–6.
- 2 Baillie J. ERCP training: for the few, not for all. *Gut* 1999;45:9–10.