National Training Programme for Gastroenterology and Hepatology

Summary

The Council of the British Society of Gastroenterology commissioned this report from a Working Party set-up to examine future training in Gastroenterology. The need for re-examination of training was driven by two considerations - the rapid changes in healthcare organisation in Britain, and by accelerating technological progress in diagnosis and therapy of gastrointestinal conditions.

The predominant organisational changes are the trend towards increasing primary care supported by ready access for general practitioners to diagnostic tests; outreach clinics by consultants and prompt access to appropriate, cost-effective secondary care; yet higher levels of emergency acute admissions. The ageing population and the necessity to provide technologically appropriate care for them is an important demographic trend.

Technologically it seems likely that change will be even more rapid over the next 30 years than it has been in the past 30 years; this makes prediction difficult, but undoubtedly endoscopic techniques - both diagnostic and therapeutic - will increase in number and safety.

Working party

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The Future

Gastroenterologists, like many hospital specialists, are facing major changes in the way in which they work with general practitioners and develop hospital-based gastroenterology and hepatology services. These changes will no doubt continue to evolve as the emphasis on primary care increases and the need for hospital specialists to provide rapid access to day-care services expands. The development of new technologies such as advanced therapeutic endoscopy are putting increasing demands on gastroenterologists, while at the same time the majority continue to make a major contribution to general and emergency medicine services in their hospitals.

The expansion and continued evolution of gastroenterology services in the United Kingdom has prompted the Council of the British Society of
Gastroenterology to set up a Working Party to consider how future service needs will drive this evolutionary process and to anticipate the training needs of the gastroenterologist and hepatologist of the future. To assist this process, a sample of 10% of consultant gastroenterologists were questioned about their current work-load and how they might wish to change their job plans in the future (Appendix I). In parallel with this, the Working Party considered the training requirements for the future, made proposals for a curriculum, its implementation and methods of assessment. The Working Party was made aware of the results of the survey towards the end of its deliberations and took these into account during the writing of this report.

The work of the Training Working Party was facilitated by Christine Farrell (Director, Clinical Change Programme) and Angela Towle (Project Manager for Medical Education) of the King's Fund Centre, London.

**Structure and process of training in Medical Gastroenterology and Hepatology**

**3.1 Objectives**

3.1.1 To provide a comprehensive and structured higher medical training programme in gastroenterology for those who have completed general professional training in order to equip them for specialist practice in gastroenterology.

3.1.2 To enable trainees to reach agreed standards of quality and satisfy the assessment process.

3.1.3 To encourage flexibility in content and duration (full time or part time) so that those who show special aptitude for teaching, research or detailed sub-specialist work may pursue this, subject to sufficient career opportunities after completion of training.

At present the Government devolves responsibility for setting and maintaining standards of training for junior medical staff to the Royal Colleges. The three Royal Colleges of Physicians discharge this responsibility through the Joint Committee on Higher Medical Training (JCHMT), which in turn looks to individual Specialty Advisory Committees (SACs) for approval of training programmes and accreditation of trainees who have satisfactorily completed such programmes.

The SACs draw their membership from both the Colleges and from the specialist societies; hence the SAC in Gastroenterology has three members.
from the BSG and three from the Colleges, acknowledging the importance of the specialist society in this function of setting training standards. At local level, postgraduate deans, in consultation with College Regional Advisers, have responsibility for assessing higher trainees annually and overseeing their programmes.

In recognition of the increasing complexities and demands that accompany the more structured 'post-Calman' training programmes, the JCHMT wishes to strengthen the regional network by putting in place for each specialty such as gastroenterology a Regional Programme Director, nominated by the postgraduate dean and approved by the JCHMT. This fits in well with the independent conclusions reached in this document for the supervision and assessment of trainees.

3.2 Structure of training posts
In order to cater for the varied needs of individual trainees, a modular training structure is proposed with a Core module and a series of Option modules (see 4.2.1 and 4.2.2). This structure will allow trainees to develop their own interests within the subject while ensuring that they have a broad background in both gastroenterology and general medicine. It is anticipated that dual certification in Gastroenterology and General Medicine will require a 5 year training course. Training will aim to provide dually accredited trainees who would be pluripotential, fulfilling future teaching hospital, DGH and academic needs. Flexibility is the key to this arrangement.

3.2.1 Core:
Core training in gastroenterology would be two-and-a-half years in General Medicine and Gastroenterology concurrently. Trainees would also be expected to complete a further 30 months in Option modules in gastroenterology/hepatology. Training would therefore be completed in 5 years giving dual accreditation in General Medicine and Gastroenterology.

3.2.2 Options:
Proposed optional subjects are listed in Section 4.2.2. Depending upon the option, it is anticipated that 3 to 6 months will be required to reach competence in a given option. Trainees wishing to specialise in a particular aspect of gastroenterology or hepatology will be able to choose to spend longer in that field to achieve excellence. In many instances this will be for a year. However, those wishing to specialise as clinical academics, hepatologists or advanced endoscopists may choose to spend the entire 30 months available for options training in research, hepatology or endoscopy.
Some of the Option modules may be provided by other disciplines and surgeons, radiologists and pathologists may participate in those modules.

Training in the option modules will generally take place during the working day. Trainees will be required in addition to join general medical rotas for out of hours work. This will be important to ensure:

a. that option module training does not compromise hospital rotas;
b. that concurrent training in general medicine and gastroenterology can take place.

In order to facilitate the organisation of a weekly time table the options may be taken as whole time (four days per week), half time (two days per week) or quarter time (one day per week).

Throughout the Core training period the trainee will be expected to undertake self-directed study to ensure that the theoretical aspects of the subject are learnt. Self-directed learning should be supplemented by regionally-based teaching programmes.

**Entry to the training programme**

Entry to the Specialist Registrar Grade in gastroenterology will be by open competition and interview before a properly constituted Advisory Appointments Committee for each group of training hospitals. The Advisory Appointments Committee should consider applicants for both full-time and part time training. Candidates will have the MRCP(UK) and have completed general professional training.

**3.3 Regional Programme Director**

There will normally be one Programme Director for each region (as defined by the area covered by a Regional Post-graduate Dean) who will be responsible for implementation of the curriculum and delivery of a planned, progressive programme of training and education through agreed standards of quality and quantity.

The Regional Programme Director will be appointed by the Postgraduate Dean with the advice of the trainers. S/he will be responsible to the Postgraduate Dean and maintain links with the Royal College Regional Adviser.

The Programme Director will have the following responsibilities:-
a. To plan a programme of training containing both core and appropriate options in conjunction with the Trainee and the local educational supervisors. The Programme Director should ensure that the training provided is likely to meet the needs of most hospitals to maximise the chances of appointment to a Consultant post at the end of the training programme. Links with the Manpower Coordinator of the British Society of Gastroenterology and Royal College of Physicians Gastroenterology Committee will be essential to ensure that this goal is achieved.

b. The training programme will almost inevitably involve rotation between hospitals which will require supervision by the Programme Director.

c. The Programme Director should ensure that the experience in each post fulfils the stated requirements for that period of training (module).

d. The Programme Director will need to liaise with the Trainee, Trainer or local Education Supervisor, and other bodies in the event of problems with the Trainee or the training post.

e. The Programme Director will arrange and facilitate the assessment of each Trainee at appropriate intervals - probably yearly.

In view of the responsibilities of the Regional Programme Director in decisions, co-ordinating and assessing training in Gastroenterology and Hepatology it is anticipated that 2 sessions will be required each week to complete the task, and a source(s) of funding will need to be identified to support this activity.

3.4 Trainer
The Trainer will be one of the Consultant staff on the firm or in the department to which the Trainee is attached and will usually have day to day contact with the Trainee. The Trainer will plan a weekly programme, agreed with the Regional Programme Director and the Trainee which will provide an appropriate balance between training and service commitments. Training commitments will include time for academic meetings, audit, self-directed learning, research, study leave, and supervised service. The Trainer will also arrange for regular assessments of the Trainee.

3.5 Trainees
The Trainee should agree and implement a weekly time table with the local Trainer and the Regional Programme Director. The Trainee should ensure that there is a formal meeting with the Trainer every three months and that any problems with training are identified and resolved in good time. The
Trainee should keep a record of practical procedures in a Personal Training Record and ensure that the experience from the post will fulfil the stated requirements for that period of training. Any problems which are not resolved locally should be reported promptly to the Regional Programme Director or failing this, the Specialist Advisory Committee. Trainees should see and sign any formal reports or assessments about their training.

3.6 Alternatives to Full-time Training (Flexible training)
There is increasing demand for periods of less than full time training in all medical specialties. All training programmes in medical gastroenterology/hepatology must have posts available for trainees wishing to work part-time at any stage in the programme. These trainees must apply through a specifically designated officer appointed by each Regional Postgraduate Dean to oversee part-time training. Competition for posts on regional part-time training programmes must be alongside full-time applicants and appointments made by the same Advisory Appointments Committee, although a separate Committee may be needed if no appointments to full-time regional trainee posts are made within six months of application for a part-time post. A part-time trainee will be required to work a minimum of half-time but may work further hours up to full-time but all Option modules should be available on a less than full-time basis. Part-time trainees should have equal access to each of the Core and Option modules of a training scheme as full time trainees and the same commitment from trainees and Regional Programme Directors. It would be expected that flexible Trainees will have a regular on-call commitment.

The frequency of assessments for trainees will depend on the numbers of hours worked. The progress of their training will be considered in terms of the numbers of hours committed to each Core or Option module unless this can be defined in terms of numbers of procedures (eg endoscopy) or the acquisition of a precise skill (eg imaging).

3.7 Outcome
Trainees completing the training programme whether full-time or part-time, would be qualified to practise general and emergency medicine and general gastroenterology/hepatology. In addition, the programme is sufficiently flexible to allow further specialisation within the field of gastroenterology and hepatology, allowing the development of individuals with a major commitment to:

a. academic gastroenterology/laboratory science;
b. hepatology;
c. advanced endoscopy.

3.8 Recommendations
3.8.1 Regional Programme Directors in gastroenterology/hepatology should be appointed under the auspices of Post-graduate Deans and in conjunction with trainers.

3.8.2 It is anticipated that 2 sessions each week will be required to devise and oversee a Regional Programme and thus sources of funding to support Regional Programme Directors will need to be identified.

3.8.3 The funding of part-time posts will have to be clarified in relation to the funding of all career grade medical gastroenterology/hepatology posts.

Trends in Healthcare which may influence the practice of Medical Gastroenterology and Hepatology

The Working Party made a fundamental assumption that medical Gastroenterology and Hepatology in the future will differ from the way in which it is currently practised. The Working Party attempted first to identify ways in which practice may change and then suggested adjustments to training programmes to satisfy future needs. A number of factors were identified that are presently under change or recently changed which will influence both training and practice.

2.1 The changing emphasis in Primary Care
Current health policies are attempting to move much secondary care into primary care. Fund holding General Practitioners wish to ensure that their patients get the most cost effective secondary care and are already requesting changes in the practice of gastroenterology and hepatology.

2.1.1. Rapid access services must be developed to provide 'one-stop' diagnosis in District General Hospitals.

2.1.2. Out-patient consultant opinions will be sought more often and easy, prompt access to consultants will be expected. Therapeutic decisions made by consultants may be modified by primary care physicians.

2.1.3. In rural areas, access to diagnostic facilities will need to be improved which may involve outreach clinics, ultrasound and endoscopy.
The exact extent of the shift of care towards primary care will determine how much change is required. In some areas it appears that there will be little change while in others major redistribution is likely. Consultants need to be trained in the development of local management guidelines and with these could oversee therapy for a number of chronic gastrointestinal disorders in general practice. The emphasis will be on out-patient consultation.

2.2 New technology and technologists
The endoscopic revolution from gastrocameras to video endoscopy has occurred in less than 30 years. It would not have been predicted that cholecystectomy could be performed laparoscopically or that endoscopic stent insertion for the management of extrahepatic cholestasis would reduce requirements for hospital beds. Digitised video images can now be transmitted transatlantically and it is likely that endoscopic advice may be required by telephone using such systems. Communication with General Practitioners may follow similar lines with tele-clinics or 'hands-off' outpatients.

Endoscopists are likely to be trained from a non-medical pool in the foreseeable future in attempts to improve service, reduce costs and provide more out-patient time for consultants. A greater proportion of the endoscopy practised by gastroenterologists is likely to be more therapeutic and time consuming, but time may be made available by reducing the diagnostic load.

Screening for colonic cancer is likely to develop in one form or another. A non-invasive screening tool (genetic/molecular) will probably become available and will re-focus the need for colonoscopy, but until such time colonoscopy will continue be a growth area. Time and personnel need to be made available for this.

2.3 Audit and evidence-based outcomes
Present outcome audit is rudimentary, but pressure is being applied by the Royal Colleges to audit and purchasers are going to direct resources to the most effective units. Consultants need to be involved in developing the right measures and identifying the problems (case-mix, racial, social and environmental) which in turn affect outcome measures. This activity will be time-consuming and personnel will be required. Training in audit technology is needed.

2.4 Sub-specialisation and the implications for secondary and tertiary care
Fewer but larger hospitals are likely to remain following the present round of reorganisations and purchasing authorities are likely to merge. These hospitals will have more consultants with a greater out-patient and investigative role but may have fewer beds. In such an environment gastroenterological groupings are likely to include individuals who specialise in certain gastrointestinal areas - liver, inflammatory bowel disease, nutrition, etc. Internal management guidelines will be just as important as in general practice. The opportunity will exist for surgeons, pathologists, radiologists, specialist nurses and technicians to work in multi-specialty teams with gastroenterologists and hepatologists.

There is increasing demand to re-group certain conditions, for example gastrointestinal cancer. In this case a specialist gastrointestinal oncologist may be needed to work in association with a gastroenterologist who will provide continuing care.

2.5 Increasing requirements for general and emergency medicine
There is an increasing number of hospital emergency admissions and gastroenterologists have traditionally participated fully in the receipt of such cases. The need will remain but gastroenterologists' time will be eroded through provision of increasing out-patient and endoscopic services. Most gastroenterologists accept that they will continue to participate in the general medical service but some will probably opt out. Thus there will be a need to ensure that most trainees have adequate experience in general medicine and to identify training schemes for sub-specialist gastroenterologists.

2.6 Demography
An increasing elderly population with experience of high-tech medicine will pressurise against ageism. Colon cancer surveillance programmes for example may not be age restricted. Patients with gastrointestinal disorders will have multiple conditions and gastroenterologists will be expected to be able to deal with them. Endoscopic gastrostomy feeding could become standard practice in many conditions of the elderly associated with poor appetite.

2.7 Postgraduate training and research
Reduction in junior doctors’ hours is widely supported but is likely to have a detrimental effect on the aspect of training which comes from direct consultant supervision. Patient care may deteriorate through lack of continuity when provided solely by consultants because of inadequate replacement of lost hours. The pressure will divide loyalties to gastroenterology (predominantly out-patient and easily controlled) and
general medicine (mostly in-patient and uncontrollable). Solutions could be more prolonged training, which goes against The Royal College of Physicians recommendations and European commission and government directives, or massive consultant expansion including part-time posts, with more hands-on general medical involvement.

An important and expanding managerial role has already developed in Gastroenterology, with consultants often managing teams of endoscopists, nurses, stomacare nurses and administrative staff. Consultants require training in this area. As training becomes formalised, consultants will need support and opportunities for improving their own skills as a trainer. The need for continuing medical education will include these areas in addition to those of medical and gastroenterological clinical practice.

The research emphasis will tend to be into the health services: health provision, identification of needs, outcomes and cost-effectiveness. This assumption is borne out by the 'health services research initiatives'. Basic science research had traditionally played a part in the training of many gastroenterologists. The importance of some formal training in research methods may subsume the previous emphasis on attaining a higher degree through research for some, while a minority will have the opportunity for extended basic research training.

**A curriculum for training in Medical Gastroenterology and Hepatology**

4.1 **Aims**

4.1.1 To produce gastroenterologists who are clinically skilled and sufficiently competent to provide a general gastroenterological and hepatological service.

4.1.2 The training programme should have flexibility to encourage a degree of specialisation and choice commensurate with career aims and service needs, and enable the trainee to face the changing needs of gastroenterology in the NHS.

4.1.3 The training should encourage a critical and analytical approach to effective clinical management and a positive approach to health service management, teaching and research.

4.2 **The Curriculum**
The curriculum should be divided into Core and Option modules. The Core of the curriculum will provide education in the theoretical basis of, and training in, the clinical care of patients with common gastroenterological
conditions in the in-patient and out-patient setting. Such training will include basic diagnostic and therapeutic endoscopic and investigational skills, in harmony with European trends and consistent with the relevant EEC Directive 13/93.

4.2.1 CORE
4.2.1.1 Scientific basis
During specialist training the trainee should acquire sound scientific and theoretical knowledge of the normal structure and function of the gastrointestinal tract as well as knowledge of the aetiology, pathogenesis, natural history, clinical presentation, investigation and treatment of diseases of the gastrointestinal tract, including the hepato-biliary system and pancreas. Such knowledge includes histopathology, haematology, microbiology and parasitology, chemical pathology, immunology, genetics, molecular biology, epidemiology and statistics. An understanding of medical demography and health care economics is required.

4.2.1.2 Clinical knowledge
The trainee will be expected to have a broad based education in most areas of gastroenterology. Knowledge of the indications and contraindications for, and the complications of, various imaging, investigational and surgical techniques together with understanding of their limitations will be essential in a variety of clinical settings.

All training will fulfil the requirements of the Specialist Advisory Committee in Gastroenterology and the Joint Committee on Higher Medical Training.

4.2.1.2.1. General and emergency medicine
4.2.1.2.2. Core Gastroenterology (to include the in-patient and out-patient management of the following) :

a. inflammatory bowel disease;
b. hepatobiliary disease (acute and chronic liver disease, jaundice & alcohol related disorders);
c. functional bowel disorders;
d. malabsorption and pancreatic disease;
e. gastrointestinal infections and AIDS;
f. oesophageal and gastroduodenal disease;
g. oncology (oesophageal, gastric, pancreatic and colon cancer);
h. gastrointestinal Emergencies (acute abdomen, bleeding, fulminant colitis, cholangitis);
i. nutritional support;
j. gastroenterological manifestations of systemic disease.
4.2.1.3 Clinical care and expertise
Trainees should have supervised practical experience in the clinical care of patients in the above groups, both as in-patients and out-patients. The clinical management of patients in the primary care setting and at home should be understood. Clinical experience must be gained mainly in substantive posts with appropriate development of clinical responsibility. Teaching by direct supervision of clinical work and attendance at multi-disciplinary meetings must be an integral part of the training programme. Pharmacological, psychological, dietetic and surgical treatments available for the above conditions will need to be understood and experience gained in their use.

4.2.2.1.4 Competence/skills required
In order to manage patients with these conditions training will be required in the following skills:

a. diagnosis and treatment;
b. basic diagnostic endoscopy This should include rigid sigmoidoscopy, oesophagogastroduodenoscopy and colonoscopy, and possibly exposure to endoscopic retrograde cholangiopancreatography. Principles of disinfection, safety and sedation;
c. basic endoscopic therapeutic techniques This should include stricture dilatation, injection and/or banding of varices, haemostatic techniques and polypectomy. The indications, contraindications and complications of these procedures should be understood;
d. communication skills Trainees should acquire an attitude to, knowledge of and skill in doctor/patient communication and the management of communication in hospital and beyond. This should include basic communication skills, information-giving, negotiating, writing comprehensible prepared material, participating in hospital-wide communication initiatives and working in a multidisciplinary team;
e. cancer care This should include palliative care and palliative techniques, pain relief, terminal care, informing patients, psychological support, counselling, management of bereavement and ethics;
f. non-endoscopic techniques This should include liver biopsy, paracentesis and knowledge of other investigative techniques used in gastroenterology and hepatology;
g. management training This should include experience of audit, information technology, Health Service management, contracting and marketing.
4.2.2 Option modules
The trainee will be required to undertake a variety of advanced option modules (clinical and research) after discussion with the Regional Training Supervisor. Some of the options will be full-time whereas others will be part-time and permit training in both Core and Option to run concurrently.

All options will include training in the teaching of patients, nurses, medical students and doctors relevant to that module.

a. Advanced gastroenterology (experience in specialist units such as inflammatory bowel disease, or coloproctology, or oesophageal disease).

b. Advanced hepatology (management of fulminant hepatic failure, transplantation, specialist hepatitis referral centre).

c. Physiological measurement (oesophageal manometry and pH measurements, gastric and pancreatic function testing, ano-rectal physiological studies).

d. Nutrition (assessment of requirements, catheter placement, nutrition team service management).

e. Paediatric and adolescent liaison gastroenterology (to acquire experience in gastroenterological conditions that start in childhood and continue into adulthood).

f. Advanced therapeutic endoscopy (ERCP, or laser therapy, or photodynamic therapy, or management of strictures and fistulae, or enteroscopy).

g. Imaging (ultrasound, endoscopic ultrasound, CT, MRI, nuclear medicine).

h. Cancer care (drug therapeutic regimens, radiotherapy, combined modality treatment and brachytherapy of all common gastrointestinal and hepatic malignancies).

i. Palliative care (pain relief, hospice care, terminal care, palliative endoscopic techniques).

j. Communicable disease (advanced AIDS, intestinal infection, hepatitis, tropical disease, parasitology, special experience with Helicobacter pylori).

k. Psychological medicine (basic liaison psychiatry; the knowledge of psychiatric disease in hospital patients and the nature and management of physical symptoms with no organic basis. Eating and drinking disorders, factitious disease).

l. Research: basic (experimental design, basic techniques, statistical planning, critical appraisal);
m. Research: advanced I (cellular/molecular biology), II (whole organism pathophysiology), or III (clinical trials/epidemiology).

n. The interface between primary and secondary care in gastroenterology.

o. Teaching and presentation skills (including training in presentation, educational methods, audiovisual techniques, media management, information technology).

p. Health service management (audit, information technology, budgeting, contracting, negotiating skills, personnel management, marketing).

q. Elective Free Option (e.g. 'pure' epidemiology, genetics, microbiology).

4.3 Practical experience
The Core curriculum will run during the first 30 months of specialist training. Trainees will in addition be required to undertake several Option modules during their training to meet their own educational and clinical interests, as well as their career aims. The number of Option modules available in each region will vary, and arrangements will need to be made to allow as much choice as possible. The total number of Option modules should remain flexible and dependent on career intentions. It is anticipated that in many cases the Option modules and Core curriculum will run simultaneously.

The number of practical procedures that are undertaken by the trainee will be in line with that advised by the Joint Advisory Group on Endoscopic Training.

4.4 Recommendations
4.4.1. Training in Gastroenterology and Hepatology should be a basic 5 year programme with the option of an additional year to allow flexibility in clinical training and research.

4.4.2 The training programme should consist of a compulsory Core component and broad range of Option modules to enable trainees to structure their training towards a variety of career outcomes.

4.4.3 The Core will consist of 30 months Gastroenterology and Hepatology concurrently with General and Emergency Medicine. Options will require a further 30 months, each having a minimum duration of 3 and a maximum of 12 months whole-time equivalents and a further optional 1 year may be taken for research.
4.4.4 The training programme will produce broadly trained Gastroenterologists/ Hepatologists but in addition will enable some trainees to gain special expertise to pursue careers in academic gastroenterology (including clinical and basic science), advanced hepatology and advanced endoscopy.

4.4.5 The British Society of Gastroenterology should develop a syllabus for the Training Programme to cover the theoretical basis of the practice of gastroenterology/ hepatology.

4.4.6 Approaches to implementing this syllabus should be investigated with consideration given to both self-directed learning (eg by the development of interactive computer based learning programmes) and by the development of a regionally based teaching programme to complement the former.

Methods of Assessment

5.1 Training unit and the Trainer
Current Guidelines and Practice by The Specialist Advisory Committee of Unit Assessment will be adhered to. A unit will be deemed suitable if:

a. there are a minimum of two consultant gastroenterologists or, if only one, adequate cover arrangements, so that day to day practice can realistically be supervised;
b. there should be at least one half of the work undertaking supervised clinical responsibilities such as endoscopy lists, ward rounds and outpatient clinics;
c. it is able to provide facilities to allow the best standards of specialist practice, including facilities for appropriate clinical investigation and management;
d. there are adequate opportunities to gain clinical experience as indicated by out-patient and daycase attendances and completed consultant in-patient episodes;
e. there are adequate library facilities and other forms of academic support;
f. adequate study leave is provided in the form of day release and for longer training courses within or outside the region.

Currently, the Specialist Advisory Committee undertake unit assessments every five years. In addition to these the Postgraduate Dean or representative and the Regional Programme Director, who will be a gastroenterologist/hepatologist, will validate the unit and trainer on an
annual basis. The Postgraduate Dean may elect the Regional Programme Director to be his representative. These annual assessments will need to ensure:

a. The Unit and Trainer are fulfilling the requirements of the core curriculum and any option modules they may be covering.
b. The Trainee is receiving Trainer assessment and adequate supervision on a day to day basis. At these annual assessments the trainee will be given the opportunity to give unbiased feedback on Trainer and Unit, which will subsequently be fed back to the trainer by the Regional Programme Director and/or the Regional Postgraduate Dean.

It will be the responsibility of the Postgraduate Dean to ensure that the Trainer is adequately prepared to be a trainer. Provision of training courses for Trainers may be required.

5.2 Trainee Assessment
5.2.1. Local
On arrival in post there will be a 'formative' first appraisal assessment by the Trainer which will:

a. Determine educational needs with respect to the Core curriculum for Option modules offered by the particular training unit. The Personal Training Record will be used to assess the Trainee's progress and to identify gaps in experience. The needs of a first year Trainee will be different from a third or fourth year trainee. Difficulties in achieving training goals will be identified.
b. Set future training goals on the basis of need. Goals will be set and agreed upon between Trainer and Trainee, documented and signed by both. This will be an informal process. A second 'summative' appraisal interview with the Trainer will take place either one year later or at the end of the post, if this is shorter. The summative appraisal will:
   a. determine the extent to which Trainee goals have been achieved;
   b. examine the Personal Training Record with the Trainer signing the Trainee up for the various skills attained;
   c. assess trainee competence including strengths and weaknesses;
   d. set new goals.

A written record of the experience and training of each Trainee must be maintained and agreed by both Trainer and Trainee, in advance of the annual assessment organised by the Postgraduate Dean. This will form
part of a report containing also an assessment by the Trainer of the Trainee's technical ability on an agreed scale. The report will also indicate the Trainee's ability to work as a member of a multi-disciplinary team and their ability to relate to and communicate with patients and other staff at all levels. The aim should be to ensure that the Trainee is developing these and other skills (eg management) essential for consultant practice in the NHS.

In addition to this formal assessment at local level, informal continuous assessment will continue on a day-to-day basis during:

a. At least one consultant-led ward round per week
b. Outpatient clinics, in which the Trainer might join the Trainee during consultations on a monthly basis.
c. Endoscopic training suggested by the Specialist Advisory Committee guidelines (Appendix II)
d. Regular multi-disciplinary meetings (radiology, histopathology, etc.) and journal review sessions.

5.2.2 Regional
Trainees will be assessed annually at an interview organised by the Postgraduate Dean with the College Regional Adviser as Chairman. Other members would normally include the Regional Programme Director, another Consultant in Gastroenterology not directly connected with the training scheme or unit, and a Consultant Physician from another specialty where the training also involves General (Internal) Medicine.

The Trainer will also be asked to evaluate the competence of the Trainee. As a result of this assessment a written report would be prepared, signed by the Trainer, Trainee and Regional Postgraduate Dean/Regional Adviser. A copy will be kept by each as well as one sent to the JCHMT. At the penultimate annual assessment, the panel will include a Gastroenterologist from outside the Region nominated by the JCHMT. This assessment would permit identification and correction of problems with the aim of avoiding an adverse final assessment.

If the Trainer or the Regional Programme Director feel that the Trainee is failing in any respect, or the Trainee wishes to opt out of the training programme, it will be the responsibility of the Regional Programme Director to organise appropriate career counselling. At this annual interview the Trainee will have the opportunity to give feedback on the Unit and Trainer.
At the end of training, a final summative appraisal will be undertaken in a similar format and the report sent to the JCHMT and CCST to enable certification.

A final 'exit' examination for trainees at the end of the training period was felt undesirable but that standards could be maintained by continuous self-assessment by the trainees and by the trainers.

5.2.3. Appeals Procedure
If there is a dispute between Trainer and Trainee on the description of experience, training or performance, arbitration will be co-ordinated by the Postgraduate Dean and the SAC. If the final assessment is unsatisfactory, an appeal mechanism independent of the JCHMT and Postgraduate Deans should come into play. The British Society of Gastroenterology may wish to assist this process.

Patterns and Future Structure

6.1 Patterns of training
The training pattern proposed is based on a more structured core of scientific education than now, partly achieved by 'distance learning' techniques, with periods of self-assessment. This core scientific knowledge will be the basis for clinical experience in approved units, with as much stress on consultative skills as on technical achievement. Appropriate exposure to general internal medicine (including acute admissions) as well as Core gastroenterology will be assured. Training will be supervised, recorded and appraised. In addition to this essential Core, there will be a number of Option modules covering advanced areas of clinical gastroenterology, endoscopy, psychology and epidemiology, research etc. Every Trainee will undertake several such modules, the pattern being determined by agreement between the trainee and supervisor.

6.2 Structure of training
The training programme has been designed to fit in with the reduced hours of work/training likely to be acceptable in the future. Core gastroenterology training would run concurrently with general medicing for 30 months during training. A trainee would be expected to have completed a further 30 months training in Option modules before applying for consultant posts.

The necessary organisation of this complex scheme would be the responsibility of a Regional Programme Director under supervision of the
Regional Postgraduate Dean. There would be local educational supervisors (Trainers) and regular feedback sessions between them.

To ensure that this compressed training programme will have the right outcome, the units providing training and the trainers will need regular assessment (by the SAC every five years and the Regional Postgraduate Dean and Regional Programme Director annually). The Trainee will also be assessed annually by local trainers and by the Regional Postgraduate Dean or Regional Programme Director. On all these occasions a written report will be prepared with copies kept by trainer and trainee.

6.3 Outcomes
The final product will be three types of gastroenterologist. The trainee with a minimum number of hours in a broad range of modules would be a 'general physician/gastroenterologist'. Others would be 'specialists' with a broad general training, but with more specialist training in a smaller number of modules in areas such as nutrition, oncology, management. Finally there would be 'super-specialists' who would have spent most of their modular option training in one area such as research, hepatology or advanced endoscopy.

The days of clinical apprenticeship - 'picking it up as you go along' - are over. Training in the future must be at once faster, yet more comprehensive; stimulating yet better supervised. The changes envisaged make considerable demands on future trainees, but require even greater changes in attitude, expectation and training ability from existing consultants. These will not easily be achieved along with the many other rapid changes demanded of senior professionals, but the force for such change is irresistible.