Members will have cast envious glances at the cardiologists as yet another cardiac catheterisation suite comes on stream. Locally our cardiac surgery recovery area cleared of all equipment could render the rebuilding of Wembley Stadium redundant. The key to their success is the Department of Health’s report *A Commitment to Quality, A Quest for Excellence*. This report promotes National Service Frameworks which set standards and targets as well as describing models of best practice. The National Services Framework for the management of coronary heart disease has prompted many of these developments.

Closer to our own clinical practice, the National Service Frameworks for upper GI and colorectal cancer with aggregation of facilities in larger centres has been strongly promoted. This focus on improvements in cancer treatment outcome is to be welcomed, but the proposed centralisation tends to draw in surgical, radiological, histopathological and therapeutic endoscopic skills to the larger centres threatening the quality of services for patients with non malignant disease in the district hospital.

The Society is undertaking a review on a broader basis to develop a service framework for the delivery of gastroenterology and hepatology services. The Society and the Royal College of Physicians gastroenterology and hepatology committee has drawn on the expertise of its clinical services committee, the regional chairmen and committee members, the chairmen of sections and individual members of the British Society of Gastroenterology. The Society can then make recommendations concerning the development of appropriate gastroenterology and hepatology services.

We have received large numbers of enormously constructive and thoughtful responses which have already been subject to preliminary analysis.

Many examples are cited of amalgamation of individual hospitals and Trusts as part of an ongoing major change in the delivery of services. There is a general recognition that some services will always need to be centralised, but a number of different models of care are needed for urban and rural areas and no single pattern is appropriate.

The proposed centralisation of cancer services must be balanced by ensuring that there is no detriment to patient services for those with other non malignant disorders.

Many examples have been quoted of positive development which could be adapted for the development of new models for delivering gastrointestinal and liver services.

The NHS in Scotland has excellent examples of managed clinical networks, for example in the provision of an integrated vascular service. In this model the facilities in primary care, the community hospital, the local acute hospital and the Specialist centre for regional vascular services are integrated and based on agreed clinical protocols. There are a number of examples of managed clinical networks within our own speciality. For example a managed clinical network is being established for viral hepatitis in the Northern Region.

New models for the delivery of GI care in large urban areas have also received attention. The example in Leicester is of particular interest where the In-Patient service is being delivered from one hospital with other services in all three hospitals across the city.

The close links between primary and secondary care and the importance of a clinical network across both groups emerges from a medical think tank from the North Mersey Future Healthcare Project, chaired by Professor Alastair Watson. A clear message emerges from this and other groups that the separation of emergency and elective work is the key to ensure that both groups can deliver care without one being swamped by the other.

continued on page 2
Two week ruling –
how are we coping after 2 years?

In 1999 the two week target for investigating cancer patients was introduced by the Department of Health. Grave concern was expressed by many about the ability to deliver this requirement and the impact it would have on other services. To try and quantify this a questionnaire was sent to all GI units throughout the United Kingdom. 247 units were approached and replies received from 210. The results demonstrated that with existing funding for services most units would be unable to meet the target. The range of times which patients currently waited for urgent endoscopy was up to 17 weeks for gastroscopy and 41 weeks for colonoscopy. Only 21 units of the 210 as stated earlier felt that they could cope with this demand without more staff. 129 needed more doctors and nurses and eight said they needed more nurses. Thus it was clear that only a minority of gastroenterology departments were able to meet the Government’s two week requirement.

Lord Turnberg, then president of the British Society of Gastroenterology wrote to the Secretary of State for Health, Mr Alan Milburn, and to Professor M Richards, the Cancer Czar, expressing concern, making various constructive suggestions

continued on page 5
British training in gastroenterology

The debate continues on the principles of GI training in the UK. Following my humble article in Vol. 1, 2002, where I urged against the shortening of GI training if the aim was solely to achieve political aims, Peter Cotton offered an American perspective that British GI training may be too long and offers little flexibility for subsequent consultant development (Vol. 2, 2002). In this issue, Ian Gilmore and Chris Record offer their British view from the Royal College of Physicians’ and the joint committee for higher medical training perspective. Contentious issues are raised as to whether we should be training consultants to be team leaders, or team members comprising junior consultants providing a consultant-delivered service. There is much to compare and contrast with training in America and Europe – the issues are more complex than a comparison of the length of training.

We can learn from dialogue ‘across the pond’ and to encourage this further, the next annual BSG meeting will feature two fascinating symposia: the North American perspectives of endoscopy hosted by David Carr-Locke, followed by a BSG symposium concerning the delivery of GI services in the new millennium.

Medical manpower in gastroenterology is expanding; some of this has been necessary to cope with the ever increasing bureaucracy within the NHS, but thankfully more patients are being treated also. In England alone, consultant gastroenterologists in post have increased from 564 to 602 in the last 9 months, the biggest expansion in years. There are 420 SpR training posts in Britain and as a consequence of consultant expansion we are expecting a shortfall of SpRs by 2006-2008. Approval is being sought for an extra 120 new SpRs in gastroenterology, with a special plea for hepatology. The aim is to provide an extra full rotation for a region, e.g. 5 new posts providing a new five-year rotation with five one-year slots. Training committees will welcome an additional rotation rather than trying to insert one or two new training posts into current rotations.

Training the trainers: Crete 2002

We represented the BSG at the second course sponsored by the OMGE/OMED. No Cretian sunshine for us – we worked from 8.30am to 6pm each day and then had to play volleyball! The course covered a wide range of topics, aiming to enhance the teaching and running of courses. Two gastroenterologists from each of 26 nations participated. The methods were often similar to those used by the Royal College of Surgeons course. Few delegates had had any training in teaching and communication was in English, but participation was a major feature and there was no escape for those too shy to speak. Interestingly language is a surmountable barrier to training.

A brief resume of the principles of adult education and the drivers for appraisal and assessment preceded group working on problems set by the faculty. A spokesperson then presented the group discussions. One issue was assessment of training in endoscopy and we have as good a method as any – formal observational assessment by supervisors – but it is likely that that will be insufficient in the future. Problems were well rehearsed but solutions were usually lacking.

Endoscopic simulators are becoming available at a substantial price and it was useful to test and check out the inbuilt assessments. In one colonoscopy simulator the time to caecum, time of withdrawal, volume of air insufflated are recorded and pain, accompanied by computerised whingeing, is assessed. These tools may be useful to give trainees an early ‘feel’ for endoscopy or have a risk free go at therapeutic procedures but patients remain the main training models. A good trainer is still needed. The principles of evidence based medicine were covered and in small groups papers were critically appraised or a trial designed. For many the concept of critical appraisal was novel.

This led onto internet medicine and the use of CDs and DVDs as teaching aids. How, what and where to publish and how and why to set up screening programmes were covered in the last sessions.

We learnt some important lessons. Teamwork and team spirit can never be underestimated. From the first session the 5 groups stayed together preparing presentations on unfamiliar subjects. Some teams did better than others because they worked better together. This was extended to the volleyball teams where the same groups which gelled in the course made it to the final, played in a howling gale on a cold beach in near darkness. Teamwork helps – an obvious lesson but one made startlingly clear on this course. Our hepatological resilience was tested each evening but this was a worthwhile trip. The UK is ahead of much of the rest of the world but we have a long way to go!

By Duncan Loft, honorary secretary of the BSG

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Dr Robert Walt
Dr Simon Smale
but pointing out that although the BSG was anxious to comply with the Department of Health initiative on cancer, our ability to meet this requirement would be severely hampered without investment in more staff to cope with the load. A response was received indicating that the Department of Health was aware of at least some of the problems of the two week target and were trying to assess the size and nature of the shortfall. We have had no further information from the Department of Health since this exercise.

In order to try and pursue this issue it was felt necessary to repeat the questionnaire now that the two week ruling had been in place for two years to see how gastroenterology departments were coping. I am grateful to many of you who took the time to fill in this further important questionnaire. The results are as follows:

- 191 questionnaires were completed out of a total of 247
- Forty four (23%) of the 191 hospitals were unable to change their practice to meet the DoH requirement
- 130 (68%) had been able to meet the DoH requirement
- Ninety required more doctors (total doctors required 156)
- Eighty five hospitals required more nurses (total nurses required 288).

Table 1 compares the waiting times for endoscopy clinics between 1999 and 2001. It is apparent that whilst ‘urgent’ waiting times have remained stable, ‘soon’ and ‘routine’ waiting times have risen substantially. Maximum times for Upper GI ‘soon’ endoscopy appointments have increased from 22 to 50 weeks and for ‘routine’ appointments from 52 to 80 weeks. Maximum times for ‘soon’ colonoscopy appointments have risen from 45 to 88 weeks and ‘routine’ from 78 to 200 weeks.

The clear message that comes through from the many comments received is that although many departments have managed to meet the Government requirement they have done so by diverting funds from other areas of their practice and by delaying soon and routine appointments to fit in the extra urgent referrals. In one hospital 40% of cancer patients were detected on routine lists as they did not show alarm symptoms. The real concern from these results is that the pressure on departments to deliver the two week requirement has had a detrimental effect on ‘soon’ and ‘routine’ referrals. This might well result in younger patients with malignancy but without these specified criteria experiencing serious delays.

The bottom line remains the same. Departments throughout the country are willing to try and meet the Government’s requirements but, without more funding targeted at gastrointestinal outpatient and endoscopy facilities, this directive will distort referral practice. It will result in a delay in referral of younger patients with other non-malignant diseases and may have the reverse effect of that desired, ie a delay in diagnosis of cancer in those younger patients who might be more amenable to curative intervention.

It is our intention that this data will be sent once again to the Secretary of State, Mr Alan Milburn and the Department of Health to emphasise that the present situation is still highly unsatisfactory.

Dr M D Hellier
Consultant physician/gastroenterologist
Chairman – clinical services & standards committee

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<th>Table 1: Endoscopy waiting times for cancer patients</th>
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<td>Total questionnaires returned: 212/247</td>
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Its payback time

It cannot be said too often: the principal raison d’être for the DDF is to raise and distribute funds for research. The purpose of this newsletter, therefore, is to bring you up to date about recent research awards in the Digestive Cancer Campaign, and to tell you about the next round of applications for research support.

From a total of 41 outline proposals, the DCC’s Research Awards Committee invited definitive applications from eight multi-disciplinary collaborative centres and on 17 September 2002, it identified four teams as being of high quality and worthy of support. Three of these (led by Professor Nick Lemoine from the ICSM in London, Drs Richard Houlston and Ian Tomlinson from CRUK and the Institute for Cancer Research in Sutton and Professor Sue Watson from Nottingham) will each receive an initial award of £0.25 M and the promise of a further £0.25 M – if and when funds become available. The fourth, headed by Professor Malcolm Dunlop from Edinburgh, will be similarly supported – again provided that further funds can be raised. Congratulations to the winners, commiserations to the losers and thanks to all those whose hard work and donations made this possible.

The DDF will soon be inviting applications for a unique Fellowship, funded jointly with the British Liver Trust – the Sheila Sherlock Memorial fellowship for research into liver disease. At the same time, we will be offering fellowships for research into pancreatic disease (the Amelie Waring Fellowship) and nutrition (jointly with the British Nutrition Foundation).
British GI training:  
An american perspective

Dear Dr Loft,

Peter Cotton's letter was characteristically stimulating, and from one who had more than a decade of UK consultant practice before moving to the USA, we ignore it at our peril. His comments on the consultant career highlight one of the biggest challenges facing us at present. Unless we manage to get some 'shape' into the flat-topped pyramid that SpRs aspire to conquer by their early 30's, the next generation of consultants will become rapidly and seriously disillusioned. For those working as consultant physicians in the 70's and 80's, there was still a consultant led rather than consultant delivered service. It was possible, particularly in teaching hospitals, to go down a variety of other avenues, such as research, education, teaching and involvement in national activities. As we are being moved to a consultant delivered service, more closely managed job plans, waiting list targets etc, these avenues are closing. The RCP has recently published a report entitled Careers for Consultant Physicians – focus on flexibility and the DOH has brought out recommendations in Improving working lives of doctors, so maybe there are opportunities to reverse the trend. But talk of portfolio careers and alternative career pathways will not mean much to the average DGH gastroenterologist, struggling to cover the acute medical intake while keeping down the endoscopy waiting list, until faster expansion of consultant numbers occurs.

The_ccst, perhaps in general medicine, about 5 years after completion, most US trainees set up in private practice and possibly undertake a more limited range of gastroenterological practice than their counterparts in Britain. I understand that how such persons can have training of comparable experience and expertise as those in Britain. I believe there is a compelling argument for awarding numerary trainees one day and fully trained the next is nonsense. I believe there is a compelling argument for awarding the CCST, perhaps in general medicine, about 5 years after registration. This would allow these competent doctors to be acknowledged consultants but joining specialist teams to continue to acquire knowledge and skills. Clearly there are dangers. For example, in the perception of junior and senior consultants – and the existing consultants might try to walk away from acute care to leave the work to new style senior registrars by another name. But the transition could be managed within job plan review and would give real opportunities for career progression and flexibility.

I was interested in Dr Cotton's American prospective of gastroenterology training. In Britain, for accreditation in general medicine and gastroenterology training spans at least 60 months, 12 of which can be spent in research. There are 420 SpR training posts in Britain and about 60/year obtain CCSTs indicating that in practice training extends for nearly seven years. This is because most trainees voluntarily spent 2 or 3 years in research rather than the minimum of 12 months required under the Calman regulations. Recently there has been a large expansion in consultant posts within the specialty and very few trainees have continued in the training grades for more than a few months after obtaining the CCST. There does not appear to be any desire among trainees to shorten the training period and many express the view that it should be longer. The 5 year Calman training period includes one year which is predominantly spent in general internal medicine (GIM) and training in gastroenterology alone spans a minimum of four years. GIM training (currently under review) includes a minimum of two years as SHO making a total of three years, similar to the USA.

Dr Cotton rightly points out that British trainees undertake a large amount of service work which could be undertaken by fully trained gastroenterologists. Conversion of 120 SpR training posts into consultants would certainly enable the training period to be shortened from 7 to 5 years and no doubt the Government would welcome such a move. It would however diminish the range of experience encountered by trainees considerably and this might result in a deterioration in the quality of trained personnel. I am frequently asked by the JCHMT to comment on overseas graduates who wish to obtain direct entry into the British Specialist Register. Occasionally such persons have obtained their training in the USA. After 2 years of training (now three) and obtaining the American Gastroenterology Board exams, US trainees are eligible for direct entry into the British Specialist Register and I have frequently wondered how such persons can have training of comparable experience and expertise as those in Britain. I understand that after completion, most US trainees set up in private practice and possibly undertake a more limited range of gastroenterological practice than their counterparts in Britain. Referral to large specialist centres such as Dr Cotton's may be greater and perhaps lack of experience in training could account for delayed management decisions and thus the overall investigation of patients, which is frequently quoted as characteristic of medical practice in the USA.

Ian Gilmore  
Consultant, gastroenterology, Liverpool  
Registrar, Royal College of Physicians

Dear Dr Loft,

CO Record  
Chairman, Specialist Advisory Committee in Gastroenterology, Royal College of Physicians

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I am delighted to report that at the 2003 BSG meeting in Birmingham Professor David Carr-Locke and a group of eminent USA endoscopists will be taking a session addressing North American perspectives in endoscopy. The idea is to define differences in diagnostic and therapeutic endoscopy across the Atlantic and thereby stimulate discussion and reflect upon our own practice. There has indeed been much to stimulate us recently from the United States. Peter Cotton in a letter published in Gut has for example questioned the duration of training necessary for SpRs in gastroenterology within the United Kingdom. The American view is that a gastroenterologist can be trained within three years and this includes a significant exposure to research; a great contrast with the view of many consultants and trainees that the current five year Calman based United Kingdom training programmes are too short. This letter and the forthcoming BSG session from our American colleagues present considerable food for thought. Others have commented elsewhere in this newsletter about Peter Cottons’ letter and I would like to contribute to the debate.

I am convinced that in an optimum environment and using structured programmes it is possible to train a motivated, intelligent and dextrous individual to become an adequate gastroenterologist and endoscopist within a relatively short period. The problem in the United Kingdom, as I have stated repeatedly in my previous newsletters, is that our workforce is woefully inadequate to provide a clinical service and our workforce is woefully inadequate to provide a clinical service let alone train our SpRs. In most United Kingdom hospitals trainees are still essential for the service delivery of both gastroenterology and general medicine. Whilst this exposes them to a large volume of disease and experiential learning, much energy and time is devoted to general medicine and proper training in endoscopy is compromised. Endoscopic lists are congested and pressured, supervision is often imperfect (particularly out of hours) and formal training of trainees is exceptional.

This was brought home to me when Tony Morris, Bob Walt and I recently visited two hospitals (united as a single trust) on behalf of the gastroenterology SAC and JAG. These hospitals were situated in an urban environment and were six miles apart. One was the archetypal busy city District General Hospital, inundated with a large volume of acute general internal medicine and gastroenterology. A dedicated and dynamic consultant staff spent their working lives trying to cope with the acute general medical load, endeavouring (not very effectively) to prevent waiting lists for out patients and endoscopy becoming ridiculously long, complying with the two week rule and at the same time trying to undertake audit and some clinical research. It was not surprising that in this blitz culture the SpRs were regarded as foot soldiers rather than individuals who are there to be trained. It was also not surprising that this culture had led to a lack of development in an endoscopy unit which was uninspiring in its structure and depressing in its approach to training. In contrast the other hospital had a much lighter acute general medical workload and contained a state-of-the-art endoscopy unit with an enlightened staff devoted to training and teaching endoscopy to doctors and nurses. There was time and space to train and the concept of the SpR as trainee and not merely service provider was well established. In this environment I am absolutely sure that Peter Cotton is right; the endoscopists of the future (doctor and nurse specialist) could be trained within a relatively short time. As it stands however I am afraid the first hospital was much more typical of our working lives.

In this environment it is very difficult to see how the training time of our young doctors can be reduced. The acute general medical load (of consultants and SpRs) has to be reduced, training in gastroenterology and general medicine must be separated and the concept of the SpR as trainee and not merely a service provider must develop. Then we will produce better and more efficiently trained gastroenterologists and endoscopists.

JAG clearly are making inroads into changing our philosophy towards training and learning but unfortunately remain very poorly funded. I made a plug in my last newsletter and here is another one. Instead of donating your old and obsolete endoscopes to the local veterinary school, sending them to the Third World or carrying them to the local tip would you consider donating these to JAG to help in the development of endoscopy training laboratories? Tony Morris is making a plea for obsolete equipment and he will be delighted to receive them. He can be contacted at the Royal Liverpool Hospital.

**Obituary**

We are sorry to learn of the death on 22 July of Mr John Spencer, formerly from the Hammersmith Hospital. John was an honorary member and a past chairman of the surgical section.