Medical audit

Surgical OGD – a dying art?

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Introduction: Reductions in surgical training and the increases in medical gastroenterology have raised concerns that surgeons may not be adequately trained in upper gastrointestinal (GI) endoscopy.

Method: To evaluate this problem, a questionnaire was sent to all current surgical specialist registrars (SpRs) in the South Thames East Region.

Results: There was an 82% (52/63) response rate. Only 50% (26/52) of trainees had received more than 6 months' training in upper GI endoscopy. 83% (43/52) were in posts which did not provide adequate elective exposure for training. 50% (26/52) were required to provide an emergency service, despite a paucity of experience and less than 50% were able to perform therapeutic injection. In the main, emergency endoscopy is performed with substandard equipment, poor facilities, and untrained staff.

Conclusions: Surgical trainees are poorly trained and do not have the necessary skills to provide an emergency service for upper GI haemorrhage. Emergency endoscopy facilities are severely under resourced.

Key words: Endoscopy – Training – Acute GI bleed service

Upper GI endoscopy has been largely confined to surgical practice, but in the last 10 years there has been a dramatic increase in medical endoscopy. In consequence, there has been a reduction in the training opportunities for general surgical trainees. Nonetheless, emergency 'out-of-hours' endoscopy remains a largely surgical problem. Most hospitals have a modern, highly equipped endoscopy suite with appropriately trained staff for elective endoscopy. Despite this, emergency upper GI endoscopy has remained the responsibility of the general surgeons who are often required to use out-of-date equipment in the emergency operating theatre without adequate assistance.

In an attempt to standardise training in endoscopy, an intercollegiate Joint Advisory Group was charged with

setting guidelines for endoscopy training.¹ This group recommended that training should take place in a modern unit performing a minimum of 1000 upper GI endoscopies per year with access to a videoscope. Furthermore, trainees should attend regular weekly sessions for at least 6 months and should perform at least 200 diagnostic examinations under supervision before being taught therapeutic procedures.^{1–3}

The aims of the current study were to assess the quality of training in upper GI endoscopy for general surgical SpRs, with particular reference to the provision of the emergency 'out-of-hours' service across the South Thames (East) Region. A secondary aim was to evaluate the facilities available for emergency endoscopy.

Surgical Training & Upper GI Endoscopy

1. Current hospital
2. Year of Specialist Registrar training
3. Specialist Interest
4. Have you been trained in Upper GI endoscopy (please circle)?

YES	NO
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5. If 'yes', were you trained as an SHO or SpR?

SHO	SpR
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6. If 'yes', how long was your training period?

< 6 months	6–12 months	> 1 year
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7. In your current job do you do elective OGDs?

YES	NO
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8. If 'yes', how many elective OGDs do you perform each month?

0 –1	1 – 5	5 –10	>20
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9. Is there a 24 hour acute GI bleed service in your current hospital?

YES	NO
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10. If 'yes', who provides the 'out of hours' service?

SURGEONS	PHYSICIANS
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11. If it is the surgeons who provide cover after hours, is it a consultant or the junior staff that provide the service?

CONSULTANT	JUNIOR STAFF
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12. If it is the surgeons, are you given adequate facilities to perform an emergency OGD, *i.e* access to scopes, trained staff (additional questions were asked regarding the provision of a videoscope)?

YES	NO
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13. How many emergency OGDs have you performed in the last 12 months?

0 –1	1 – 5	5 –10
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14. Are you able to perform emergency injection of a bleeding ulcer?

YES	NO
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15. Do you think that the current training in Upper GI Endoscopy is:

Poor	Adequate	Good	Excellent
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16. Comments.....
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Figure 1 Questionnaire.

Materials and Methods

A postal questionnaire was sent to all the SpRs currently training in the Region ($n = 63$). There were 15 questions covering training, elective and emergency endoscopy and the ability to perform therapeutic procedures (Fig. 1). A telephone poll was conducted to determine the standard of equipment available for emergency endoscopy in each hospital.

Results

There was an 82% (52/63) response rate. All hospitals in the Region ($n = 16$ – 2 teaching hospitals and 14 district general hospitals) were represented amongst the respondents. Of the respondents, 60% (31/52) professed an interest in gastrointestinal surgery (colorectal, 18; upper GI/hepatobiliary, 10; GI surgery, 3).

Training and elective endoscopy

The duration of endoscopy training was variable and predictably increased with the year of SpR training. However 8/52 (15%) had received absolutely no training in upper GI endoscopy and 18/52 (35%) had less than six months' total training. Half the surgical trainees in the Region had very little experience in upper GI endoscopy, but half of these (13/26) were expected to provide an emergency service.

Only 50% of the posts in the Region offer an opportunity for training in elective endoscopy. In these posts, the majority of trainees (17/26, 65%) were only performing 1–5 endoscopies per week.

Of the respondents, 50% rated their current and previous training in endoscopy as poor (Figs 2 & 3).

Acute GI bleed services in the South East Thames Region

The provision of an 'out-of-hours' emergency service varied across the Region and is summarised in Table 1. Two hospitals had a purely consultant-based service and were excluded from further analysis. In one hospital, it was impossible to determine from the replies how the

Table 1 Provision of 'out-of-hours' emergency endoscopy service across the Region

Providers	Number of hospitals
Physicians	5
Physicians & surgeons	4
Surgeons	6
Uncertain	1
Total	16

Figure 2 SpR assessment of the quality of training in upper GI endoscopy.

Figure 3 SpR posts involved in emergency endoscopy and their duration of training.

emergency service was organised and, again, they were excluded from further analysis.

For the trainees that were required to provide an emergency service, there was very little opportunity to practice as only 17/26 were given any elective exposure, of whom only 8 performed more than 5 endoscopies per week.

Therapeutic injection of bleeding points has been shown to reduce the requirement for emergency surgery, but not all junior surgeons providing the service had the necessary training. Of those trainees who were providing an emergency service, 9/26 (34%) were unable to inject and, of those

who had been trained to do so, 6/17 (35%) had less than 6 months' total training in endoscopy. Overall, 42% of trainees were unable to inject a bleeding ulcer.

In those hospitals where surgeons participated in the emergency GI bleed rota, only 1/8 had access to the endoscopy suite and videoscope equipment. In most hospitals (7/8), the equipment was limited to obsolete end-viewing endoscopes.

Discussion

If, in the future, general surgeons are to be responsible for the management of acute GI haemorrhage, trainees in general surgery must be given full training in diagnostic and therapeutic endoscopy in accordance with the recommendations of the Joint Advisory Group.¹

The Association of Upper Gastrointestinal Surgeons' (AUGIS) survey on upper gastrointestinal surgical services (1999) reported that surgeons were performing 36% of elective upper GI endoscopy.³ The present study would suggest that this is an over-estimate. It is apparent that gastroenterologists dominate the elective work in the endoscopy suite, but do not always play a correspondingly full emergency role.

Endoscopy has revolutionised the management of upper GI haemorrhage and the injection of bleeding ulcers has reduced the need for surgery by 50%.^{4,5} It is, however, a potentially difficult technique and requires an experienced endoscopist supported by appropriately trained staff and modern equipment.⁶ In 1991, a working party published quality standards for the provision of endoscopy services stating that: 'it was no longer acceptable for endoscopy to be performed by untrained medical staff assisted by part-time helpers'.⁷ The present study has shown that a decade later this 'unacceptable' situation persists in many hospitals. The report recommended that surgeons should be encouraged to perform routine endoscopies and that theatre personnel should have regular training sessions so that they remain familiar with the procedures.⁸ Current practice would recommend that emergency endoscopy for acute GI haemorrhage should be carried with modern equipment, trained staff and an experienced endoscopist. The procedure should preferably take place in the endoscopy suite; however, if anaesthetic support is required, it is often safer to perform the procedure in theatre.

To resolve this problem, there will have to be collaboration between surgeons and gastroenterologists to establish a suitable training programme for those surgeons who are involved in the management of gastro-intestinal haemorrhage. Centralisation of services to those hospitals that are able to provide a 24-h service with trained endoscopists and a fully staffed and equipped endoscopy suite is an option that is already in place for other services such as vascular surgery.

The potential benefits of non-surgical treatment for upper GI haemorrhage have never been better, but the delivery is still sub-optimal and requires urgent action.

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