Gastrointestinal endoscopy training in India

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Fiberoptic gastrointestinal (GI) endoscopy is a young discipline that was born just 40 years ago, when Hirschowitz developed the first fibered endoscope in 1937. However, the worldwide dissemination of this technology over the last four decades, abetted by innovative development of new diagnostic and therapeutic applications and the support of industry to rapid improvements in fiberoptic technology, has made GI endoscopy an integral part of the modern practice of Gastroenterology (GE).

Expertise in diagnostic and therapeutic endoscopic procedures is an important aspect of training of a budding gastroenterologist. The ability to intervene proactively and to make a major impact on patient management by therapeutic interventions, often obviating the need for difficult and complicated surgical procedures, is probably the most fascinating aspect of Gastroenterology and is responsible for attracting a large number of trainees to this specialty. This is also the area about which the trainee is probably the most anxious at entry into the training program and the least satisfied at the completion of training.

Efforts at objectively defining the minimum requirements after which a trainee may be considered to have become an endoscopist have been made by the American Society for Gastrointestinal Endoscopy (ASGE) and the Gastroenterology Leadership Council (GLC) in USA and by the British Society of Gastroenterology (BSG). A similar exercise is called for in India, keeping in mind the different and diverse circumstances prevalent in our country.

Appreciation of the attractions and advantages of GI endoscopy has not remained confined to gastroenterologists; increasingly, generalists and specialists trained in other disciplines of medicine such as pediatricians, surgeons, and even radiologists and family practitioners, are undertaking GI endoscopic procedures in a variety of settings. This trend raises several issues of quality control in GI endoscopy. With the extension of the Consumer Protection Act (COPRA) to medical services, we have entered the era of defensive medicine even in India and need to set our house in order before being asked to do so by regulatory or judicial authorities. The onus for taking the initiative in this area rests upon our professional societies, like the Indian Society of Gastroenterology. We hope that this article will serve to stimulate such a concerted initiative.

The issues

The subject of GI endoscopy training involves several interrelated issues. Who should be the trainees? Who should be the trainers? What should be the minimum acceptable facilities and endoscopy workload at a center accredited for imparting endoscopy training? What should be the goals of an endoscopy training program and the level of training imparted? What should be the minimum acceptable duration for such a training program? What should be the minimum number of supervised and unsupervised procedures that the trainee should perform before he can be certified as an endoscopist? What should be the minimum component of didactic or theoretical teaching that should be incorporated in the training course? What should be the modalities for certification of the trainee as an endoscopist? What sort of regulatory mechanisms or laws should be established to ensure compliance with accepted recommendations?

The trainee

There is unanimity among the GE fraternity that GI endoscopy is not an end in itself; rather, it is a tool to be used for appropriate indications, for implementing a rational, problem-oriented and cost-effective management plan for the patient. Endoscopy training should not proceed in isolation from the overall management of the patient but should be closely integrated with a holistic therapeutic plan. Thus, the endoscopist must not only have the technical skills to perform an endoscopic examination or therapeutic procedure of acceptable quality, he should also have the ability to make the best use of the information derived from endoscopy for taking the most appropriate management decision for the patient’s problem.

Presently, in India, formal endoscopy training is imparted in the framework of a well-established subspecialty GE training program, usually a course registering students for the degree of DM (GE) in a subspecialty training hospital. The trainee holds the degree of MD in Internal Medicine or Pediatrics when he registers for DM (GE). Such a course usually lasts for 3 years; many centers in India that were imparting training for only 2 years have now moved to a 3-year framework.

The other stream for imparting formal GE training that is gaining popularity is that of the Diplomate of the National Board in Gastroenterology (DNB (GE)), a qualification awarded by the National Board of Examinations after an appropriate training program that includes endoscopy training. Other trainees may be GI surgeons or pediatricians training in Pediatric Gastroenterology. Only a few subspecialty courses exist in Gastrointestinal Sur-
gery (MCh [GI Surgery]); most of these courses do not provide structured training in GI endoscopy. Similarly, except in a few pioneering centers, Pediatric Gastroenterology has not attained the status of a separate discipline.

The minimum training requirement for certification as a qualified endoscopist cannot be diluted and must remain the same regardless of whether the trainee originates from the medical, pediatric or surgical stream. Accepting family practitioners or general practitioners as trainees for GI endoscopy is undesirable unless they simultaneously undergo an acceptable level of training in Gastroenterology.

The trainer

The trainer or the endoscopy training supervisor is a teacher and a clinician who is skilled and experienced in all those GI endoscopic procedures for which the candidate is training. He or she is responsible for didactic instruction, for training in endoscopic decision-making, technique and interpretation, for supervising elective and emergency procedures, and for evaluating performance and reporting of procedures. There should be at least two supervisors or instructors of this description in the unit or department, to ensure availability of the instructor at all times to the trainee. The trainer monitors the progress of the trainee and judges when he/she can progress from the fully-supervised to partially-supervised to the independent stages of performing GI endoscopy. A good gastrointestinal assistant or a team of such assistants is required for the smooth and efficient functioning of the endoscopy unit; one of their important responsibilities is to instruct the trainee in the care, disinfection and maintenance of endoscopes.

The endoscopy unit

In every hospital, gastrointestinal endoscopic procedures should be performed in the endoscopy unit, an area designated exclusively for endoscopic procedures, though it may be shared between the gastroenterologist, bronchoscopy, urologist, etc. Details of design and facilities desirable in this area are available elsewhere and should include easy access to radiologic and anesthetic facilities. Out-of-hospital endoscopy units should be located close to a hospital, should have emergency transport facilities and should conform to guidelines for facilities and endoscopic practices that are identical to those recommended for in-hospital units. Practices of obtaining informed consent for all procedures, observation of all sedated patients until recovery, photo- and video-documentation of procedures, meticulous record-keeping and reporting should be established and rigorously followed in all units. Minimum requirements of equipment, staff and space to assure acceptable quality of endoscopic procedures are detailed elsewhere.

The training program

An important issue is whether endoscopy training should be confined to established teaching centers which, in India, are usually superspeciality tertiary care centers in the public sector or can also be imparted by superspeciality centers in the private sector or in out-of-hospital setups. An obvious limitation of large teaching centers is their small number and limited trainee intake, which is inadequate to cater to the needs of our vast population. It is important to realize that the location of the training center, in the public or private sector, is a secondary issue; the quality of training imparted being the decisive factor.

The philosophy behind a training program is to provide a structured experience with monitoring and evaluation of the trainee’s progress. Training should be imparted in the framework of clinical care and problem-solving. The trainee should evaluate the indications, contraindications, risk factors and the risk-benefit equation before each procedure and discuss it with the supervisor. Deciding when not to perform an endoscopic procedure is also a crucial aspect of the training. The trainee should discuss the procedure with the patient, obtain informed consent, and monitor the patient till full recovery from the procedure.

Technical proficiency in GI endoscopy is acquired in a stepwise manner. Initially, introduction to the theory of endoscopic procedures including considerations of endoscopic anatomy, technical capabilities of the endoscopes, basic concepts of fiberoptics, electrocautery, photography, biopsy, etc., is required in a didactic setting. The trainee should observe several procedures before proceeding to perform each type of endoscopic procedure under direct supervision of the trainer. Once the supervisor judges that the trainee has acquired an adequate level of skills, the latter may proceed to less closely supervised procedures and, eventually, to performing procedures independently. Training should also be imparted in preparation of full, written reports, photo- or video-documentation and correlation with radiology and histology reports.

Duration of training program

This is a knotty issue. Training in the framework of formal DM training programs proceeds at a relatively leisurely pace, since the timeframe for completion of the overall training is 3 years. Presently, except for a few DNB (GE) candidates, there is no parallel stream of trainees in GI endoscopy. However, there appears to be no need to specify a minimum timeframe for completion of endoscopy training in such parallel streams, as and when they evolve, once the nature and minimum numbers of endoscopic procedures to be performed and documented are specified. The period required for adequate training would depend on the size of the endoscopy unit providing training, the volume of procedures performed and the number of trainees registered.

Short-course endoscopy training

Organized teaching programs lasting less than a few weeks, and often only for a few days, have gained popularity in
the last decade or so in India. Of late, such short courses and therapeutic endoscopy workshops have proliferated. Certificates of attendance at such workshops are often forwarded as evidence of competence in GI endoscopy by applicants requesting endoscopic privileges or by individuals setting up their own endoscopy practice. The role of such short courses in imparting endoscopic training has attracted criticism and such courses do not provide adequate training for the purpose of initial credentialing for endoscopic privileges by hospital accreditation committees. The quality and quantity of training and experience in GI endoscopy required for achieving the status of a certified endoscopist is not achieved in the setting of such short courses or workshops and such training cannot substitute for proper, supervised endoscopy training. The proper place of such short courses is in introducing new techniques to the trained endoscopist and in augmenting skills in older techniques.

Evaluation of endoscopy training

A formal mechanism for monitoring the trainee's progress should be enunciated. Evaluation should be ongoing throughout the training period, supplemented by an end-of-training examination. A detailed logbook of endoscopic procedures performed should be maintained by the trainee. This should include not only a record of the procedures performed but also brief notes on the learning experience for the trainee in specific cases, the final diagnosis established, its correlation with endoscopic findings, and follow-up information. Records maintained in the logbook should be periodically reviewed and initialed by the supervisor and would serve as an objective documentation of the quality and quantity of endoscopic training acquired by the trainee. By the end of the training period, the candidate should have completed or exceeded the minimum number of procedures specified for various endoscopic techniques.

An end-of-semester practical endoscopic examination should be performed in the form of an endoscopy quiz and assessment of practical skills in diagnostic procedures. The final DM practicals examination includes assessment of the trainee in the detailed performance of upper and lower GI diagnostic procedures and a viva voce on endoscopic accessories and techniques. In future, this examination may include performance of standard therapeutic procedures such as injection or banding of esophageal varices and hemorrhoids. Completion of formal training in GI endoscopy should be certified in writing and should find mention in the final diploma or degree certificate awarded to the trainee at the end of training. In addition, a formal certificate of "certified GI endoscopist" mentioning the training, experience and observed level of competence of the trainee should also be awarded to the trainee by the trainers, to establish his/her credentials as an endoscopist.

Sample endoscopy training programs

Endoscopy training at the Sanjay Gandhi Postgraduate Institute of Medical Sciences and the All India Institute of Medical Sciences aims to impart technical skills and proficiency in performing diagnostic and therapeutic procedures as well as to impart the theoretical knowledge and ability to interpret endoscopic findings and to incorporate this information into the overall management plan for the patient. The end result of the training process is a gastroenterologist who is a certified GI endoscopist, capable of performing routine diagnostic procedures, viz., esophagogastroduodenoscopy with targeted biopsy and brush cytology, rigid and flexible sigmoidoscopy, colonoscopy, esophageal retrograde cholangiopancreatography, and therapeutic procedures including piles banding and injection, esophageal variceal sclerotherapy and band ligation, foreign body extraction, esophageal stricture dilation, achalasia cardia dilation with pneumatic dilators, and colonoscopic polypectomy.

Structure of the program

Endoscopy theater postings: No formal endoscopy theater postings are made in the first 6 months of the 3-year DM program. The first year of training is devoted largely to clinical work and inpatient care. During this period, residents are encouraged to observe endoscopic procedures being performed on patients under their care. Full time endoscopy theater posting 2 days a week is done during the latter half of the first year and during the second year of training. This amounts to ~10 hours of endoscopy training per week.

Full time endoscopy theater posting 2 days a week and ERCP posting 1-2 days a week are made in the 3rd year. Emergency procedures are performed under supervision. This amounts to 10 hours of routine procedures and 4-8 hours of biliopancreatic procedures per week in the 3rd year.

Endoscopy theory class: This is held once every week or fortnight. The session is conducted by a consultant and is attended by all fellows/residents and the endoscopy theater staff. The mix of topics covers various aspects of diagnostic and therapeutic endoscopy and maintenance of endoscopes (Table 1).

Principles of fiberoptics and electrocautery, techniques of upper and lower gastrointestinal endoscopy and various therapeutic procedures are discussed. This serves to provide a sound theoretical basis for practical procedures and to familiarize them with the techniques and results of various diagnostic and therapeutic procedures as well as the structure, function, care, cleaning and disinfection of endoscopes. Indications, contraindications, results, complications and the ability to recognize complications of various procedures are covered during these classes.

Documentation: Proper preparation of detailed reports, photo- and video-documentation and proper filing of reports of endoscopic procedures are part of the training process. Maintenance of proper logbooks that record the number and type of procedures performed and documenting the
learning experience in the procedures performed or assisted, are an integral part of training. The logbooks are periodically reviewed and countersigned by the consultants under whose supervision the procedures have been performed by the trainee. Periodic data review sessions in which results of endoscopic procedures are analyzed serve as an in-house audit and generate material for publication.

**Evaluation:** In-training and end-of-training evaluation is an integral part of the training program. Endoscopy quizzes are held during the endoscopy classes to assess the theoretical knowledge of the trainees. Practical endoscopy examination is held at the time of the end-semester evaluation of the trainee. Evaluation of the logbook maintained by the trainee and rectification of any deficiencies noted therein are done at least once every semester. An elaborate practical endoscopy examination is held as a part of the final DM examination in which practical knowledge, familiarity with various equipments and accessories used during endoscopy and practical skills in the performance of routine diagnostic endoscopy are tested.

**Level of proficiency in GI endoscopy**

**Certified GI endoscopist:** The endoscopy training program is designed to produce a certified GI endoscopist, who is a gastroenterologist capable of performing procedures listed in Table 2. These requirements may move upwards over time.

<table>
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<th>Table 2: Levels of proficiency in GI endoscopy</th>
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<tr>
<td><strong>Diagnosis</strong></td>
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<tr>
<td>Endoscopic sphincterotomy</td>
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<tr>
<td>Stone extraction</td>
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<tr>
<td>Biliary endoscopy placement</td>
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<tr>
<td>Pancreatic duct stenting</td>
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<td>Biliary drainage by &quot;rendezvous&quot; technique</td>
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**Advanced therapeutic endoscopist**

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<th><strong>Therapeutic ERCP</strong></th>
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<tr>
<td>Pile banding and injection</td>
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<tr>
<td>Variceal sclerotherapy and band ligation</td>
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<tr>
<td>Foreign body extraction</td>
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<tr>
<td>Esophageal stricture dilatation</td>
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<tr>
<td>Achalasia pneumatic dilation</td>
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<td>Polypectomy</td>
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The minimum number of procedures to be logged by each candidate for various diagnostic and therapeutic procedures is spelt out in Table 3. While opinions may differ about the precise number of procedures necessary to develop acceptable levels of competence in complex endoscopic procedures, the principle of specifying a minimum number of procedures has been enunciated by various national bodies such as the ASGE, GLC and the BSG. The numbers set down here are the opinions of the authors, based on their experience as endoscopy trainers, about the minimum experience required for the average trainee to reach acceptable levels of competence.

<table>
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<th>Table 3: Minimum experience desirable for certified endoscopist</th>
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<tr>
<td><strong>Procedure</strong></td>
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<tr>
<td>Esophagogastrooduodenoscopy</td>
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<tr>
<td>With active bleeding</td>
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<tr>
<td>Variceal sclerotherapy / band ligation</td>
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<tr>
<td>Sigmoidoscopy and pile banding</td>
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<tr>
<td>Colonoscopy</td>
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<tr>
<td>ERCP (catenulation)</td>
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<tr>
<td>Esophageal stricture dilatation</td>
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<tr>
<td>Bougie</td>
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<tr>
<td>Pneumatic</td>
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<td>Colonoscopic polypectomy</td>
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proceed to perform independent diagnostic procedures, only occasionally needing to have endoscopic diagnoses corroborated by the trainer. Overall, during the training period, the trainee is expected to perform ~300 procedures, including at least 30 procedures in patients with active bleeding.

Similar step-wise training is necessary for other endoscopic procedures and recommended numbers of supervised and independent procedures for endoscopic sclerotherapy or variceal ligation, sigmoidoscopy and piles banding, colonoscopy, esophageal dilatation and ERCP are specified in Table 3. Training in ERCP is especially protracted. It should be recognized that the ability to reliably (~90% success) cannulate the duct of choiced is acquired only after an average of 150 procedures have been performed and much more experience is required for performing therapeutic biliary and pancreatic procedures with an acceptable degree of skill. Performing therapeutic biliopancreatic procedures independently requires the ability to reliably perform sphincterotomy and place biliary stents.10

Advanced therapeutic endoscopists: Although our centers are equipped to produce advanced therapeutic endoscopists, this is not feasible in the limited duration of the DM training program and an additional training period of 1-2 years is required for this purpose. Presently, there is no provision under existing training programs for producing this species of gastroenterologists. However, there is little doubt that this breed is needed and there is an urgent need for the development of appropriate training programs for them in the country. An advanced therapeutic endoscopist is a gastroenterologist who is capable of performing all the procedures listed in Table 2. This definition is likely to change as more and more complex therapeutic procedures mature from the realm of occasional endoscopic exotica to that of standard therapy.

The onus for initiating movement in this direction devolves upon the national societies, such as the Indian Society of Gastroenterology and the Society for Gastrointestinal Endoscopy in India in concert with the leading Gastroenterology training centers in the country, to project the need for such advanced therapeutic endoscopists and convince regulatory authorities like the MCI to establish formal accredited training programs for this purpose. A program lasting 1-2 years and focusing on these complex procedures should be established in selected training centers approved by the MCI and NBE.

Credentialed and hospital privileges

The need
Establishing norms and standards for training in GI endoscopy presupposes that only specialists who have such training and demonstrated competence in performing these procedures will be authorized to practise endoscopy. It is inevitable that, sooner rather than later, public and private sector hospitals and institutions granting privileges for performing endoscopy on their premises will seek to objectively establish the credibility of the credentials of specialists seeking such privileges.

The milieu in which medicine is practiced today has changed over the last two decades. On the one hand, the patient is more conscious of his rights due to the information explosion on the Internet and has higher expectations from his doctor; the print and electronic media are more strident and shrill though not particularly well-informed or knowledgeable, and medical services have been brought under the purview of the Consumer Protection Act, 1991. On the other hand, ever-increasing numbers of practitioners with widely varying levels of training and skills are offering an increasing variety of endoscopic treatment options that compete with established surgical procedures. In this scenario, it is inevitable that, in order to improve accountability and to maintain minimal acceptable standards of practice in GI endoscopy, a regime of formal credentialing procedures prior to granting endoscopy privileges will have to be enforced uniformly by public and private sector hospitals. The sooner this is accepted, the better it will be for the profession.

The mechanism

It behoves our profession and its leadership — national societies of gastroenterologists, hepatologists, gastrointestinal endoscopists and surgical gastroenterologists — to take the initiative in this area by setting up committees akin to the Standards of Training and Practice Committee of the ASGE, which has been approved or authorized by other American bodies such as the American College of Gastroenterology, the American Gastroenterological Association and the Society for Surgery of the Alimentary Tract.11 These committees will have the task of laying down standards for training and practice of endoscopy appropriate for India, for approval and voluntary implementation by the profession, under seal of legal sanction by regulatory authorities such as the MCI and State medical councils. Such steps will allow deliberate and calibrated movement in this sensitive area and will pre-empt precipitate and involuntary movement that may otherwise be mandated by injunctions from quasi-judicial (COPRA courts) or judicial authorities. Establishment of recommended credentials for practising GI endoscopy in India will simplify the task of hospital accreditation committees that need to be set-up in every hospital where endoscopic procedures are performed. Similarly, an accreditation committee of the state medical council needs to be established to scrutinize and approve applications for performance of endoscopic procedures in private clinics and nursing homes.

The process

The purpose of the credentialing procedures is to ensure that endoscopy is performed only by individuals with appropriate competence. Uniform standards should apply to
all specialists (gastroenterologists, surgeons, pediatricians and others) requesting privilege to perform endoscopy, so as to assure quality and ensure patient protection and cost containment. Privileges should be granted for each major category of endoscopic procedures separately, differentiating between levels of skills and training required for diagnostic and therapeutic work. Differentiating between the certified endoscopist and the advanced therapeutic endoscopist, as spelled out earlier, is relevant here.

The mechanism that needs to be set in place for implementing such a credentialing procedure is an accreditation committee, a multidisciplinary endoscopic procedure committee established in each hospital and at the level of each state; this committee should cover the entire gamut of responsibilities from initial granting of privileges, monitoring ongoing performance and outcome of endoscopic procedures, periodic renewal of privileges and granting privileges for new endoscopic procedures. This committee should also document the competence of each applicant requesting endoscopy privileges. Such competence may have been achieved as part of formal fellowship or residency training in Gastroenterology or Surgical Gastroenterology or may have been imparted outside a formal program. This training should have been of adequate duration, carried out in the setting of comprehensive patient care rather than in an outpatient setting, where mainly endoscopic procedures are performed. Total endoscopic experience must be adequate for each category of procedures; the guidelines and numbers detailed elsewhere in this paper may be helpful. Finally, a certificate from the endoscopy training director or trainer should confirm in writing the training, experience and observed competence level of the applicant.

Careful thought needs to be given to accreditation of applicants who have trained outside of such formal training programs. Endoscopic experience acquired by performing unsupervised procedures in the community is not an acceptable form of training and should not only be discouraged actively but should be made illegal. With the increase in numbers of formal training centers with DM or MCh fellowship programs and informal training centers that include large numbers of private sector institutions which fulfill requirements for DNB training, a critical mass of trainers is available in the country today, that can provide high quality training in GI endoscopy once a formal regulatory structure is in place.

In the interim period, while systems mature, between the phases of active discouragement and actual banning of unsupervised endoscopy training and the performance of endoscopy by non-accredited practitioners, the competence of such applicants may be evaluated by the process of proctoring, on the lines recommended by the ASGE. The proctor is a physician holding clinical privileges in the procedure being supervised and possesses sufficient skill and experience to judge the quality of care being provided. He is the representative of the accreditation committee who observes the cognitive and technical skills of the applicant and reports confidentially to the accreditation committee. Before such a system can be contemplated, written guidelines about the proctoring policy, the qualifications of the proctor, the precise role of the proctoring process and the specific brief to the proctor need to be spelled out.

Continuing medical education in GI endoscopy

The need for keeping abreast of the infotech explosion of the last two decades has been recognized by most professional bodies such as the Association of Physicians of India (API) 4,5 which has enunciated modalities for initiating this process for the entire community of physicians in India. For specialists, the need for these activities is even more pressing and nowhere more urgent in Gastroenterology than in GI endoscopy. Under the existing dispensation, each medical practitioner has to register himself or herself with the state medical council. Each higher qualification or proof of specializing in a particular specialty has to be registered afresh with the state medical councils. This process needs to be extended to GI endoscopy also. Certification as a certified GI endoscopist should be registered with the state medical council, as also upgradation to advanced therapeutic endoscopist, as and when such a qualification is formally recognized.

The next major step will be for the MCI to mandate renewal of accreditation or licensing to practise general and speciality medicine at the appropriate level of expertise every 3-5 years and to link such renewal with an appraisal of performance in the interim and proof of participation in continuing medical education activities, with accumulation of requisite credit points for these activities. In the field of GI endoscopy, this would require the development of mechanisms to monitor the performance and outcome of procedures for each endoscopist and for each endoscopy center. Endoscopists can maintain skills and remain cognizant with current developments in endoscopic techniques through the medium of CME programs and workshops that are regularly organized in the country. A system of formalizing the learning experience in such activities for each participant needs to be established. Thus, awarding CME points to participants based on lectures attended, procedures observed and messages internalized as assessed by quizzes and questionnaires completed at the end of such workshops can satisfy requirements for renewal of accreditation. Guidelines for assessing the learning component in endoscopy-related CME activities and workshops for awarding points by an accreditation committee of the national society can be established on the lines proposed by the API. 6

These efforts would go a long way in ensuring the
achievement and maintenance of the highest standards of quality assurance, patient protection and cost containment in GI endoscopy.

Summary and conclusions

A structured endoscopy training program with clear goals for proper teaching and evaluation serves to alleviate apprehensions in the minds of trainees regarding this crucial area. It also ensures that training is acquired not in isolation but in the setting of ongoing patient care, so that the emphasis is on how the procedure fits into the overall management plan for the patient. By specifying the details of the endoscopy unit set-up, the qualifications of the trainer and the number of procedures to be performed by the trainee, it is hoped that uniformity will be produced in the quality of training imparted, whether it be in a teaching or a non-teaching hospital.

The end-product of such training, through the DM/MCh or the DNB stream, is a gastroenterologist who is also a certified endoscopist, capable of performing all standard diagnostic and therapeutic procedures. A further period of focused training for 1 to 2 years is required to achieve the level of competence expected of an advanced therapeutic endoscopist. There is little room for short-term training courses in endoscopy for the basic training of an endoscopist, although such courses are useful as CME activities, for the maintenance and renewal of skills of the trained endoscopist, as well as providing him with exposure to new and evolving therapeutic techniques.

Efforts at improving and standardizing the training and practice of GI endoscopy in India are likely to remain exercises in futility without the active and dynamic involvement of all the leading professional societies in the country. The need of the hour is the establishment of technical committees for laying down standards in training and practice of GI endoscopy that should be voluntarily approved by all these societies so that they may then be implemented by the State medical councils and the MCI. A move in this direction from within the profession is far more appropriate and is also likely to find greater acceptance than such moves imposed from above, at the behest of judicial authorities.

A system of hospital accreditation committees for large public and private sector hospitals offering endoscopy services, supervised by the accreditation committee of the State medical council, needs to be established. Clinics and nursing homes offering these services also need to be approved by the same committee after meeting standards similar to those laid down for larger hospitals. Mechanisms for audits of performance and outcome of endoscopic procedures as well as periodic participation in CME activities for maintenance of skills and expertise need to be established and linked to periodic renewal of credentials for practising GI endoscopy. Procedures for credentialing for new endoscopic techniques need to be established.

The path ahead is long and arduous but we must tread it for it will only become more difficult if we procrastinate.

References


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