DECEMBER 2008

Gastroenterology IN PRIMARY CARE

JOURNAL OF THE PRIMARY CARE SOCIETY FOR GASTROENTEROLOGY

GP Endoscopists: assessment and re-validation

OPPORTUNITY FOR GPS TO PILOT THE PROCESS

ANDREW SUMMERS, RCGP JAG REPRESENTATIVE, PCSG STEERING COMMITTEE MEMBER

This has been discussed quite extensively during the last year with opportunities for GPs to contribute in PCSG meetings, at the BSG and recently in London where commissioners of community endoscopy met to discuss quality assurance. We are now in a position to pilot a process of appraisal and assessment with a view to re-validation/accreditation of GPs practicing endoscopy either in hospitals or community units. We need to remember that the law does not recognise the term 'GP Endoscopist'.

Any practitioner performing endoscopy is expected and required to demonstrate the same standard of expertise and safety whatever their designation. To this end the JAG is developing a form of regular revalidation for all endoscopists and GPs have the opportunity to pilot the process and to shape it into a workable and meaningful exercise. GPs accredited as GPwSI have to undergo mandatory reaccredidation by April 2009 and the pilots we are developing will provide a mechanism for achieving this in endoscopy.

The pilots will be set up in one or two regions to test the feasibility and logistics. It is expected that the process should provide no problems for the majority of GP endoscopists and no one will 'fail' in the pilot but where considered appropriate extra training will be made available. A pool of assessors will undergo training once the assessment process is established and this will include GPs.

The process is likely to follow the well tested route used for trainees set out in the JAG accreditation website using a portfolio of experience and knowledge coupled with DOPs (Direct Observation of Procedural skills) assessment. A template for the portfolio was discussed at the London meeting and met with broad agreement but will need tuning and developing as experience dictates. The proposed document has a number of sections:

Brief CV

This is likely to be a one page entry listing the individual's current practice, where and how they were trained.

Summary of activity

This should include a summary of the practitioner's lifetime experience in each procedure undertaken with a record of serious complications, sedation practice and other KPIs (Key Performance Indicators). The previous 12 months activity would also be listed.

Case discussion

This section should include 4-5 cases from the previous year for discussion.

Examples given included:

- An 85 year old who died 5 days after PEG insertion, this raised issues around appropriateness, pre-assessment, family involvement etc.
- A 19 year old undergoing colonoscopy for suspected Crohns who was distressed before the procedure and wanted her mother with her throughout the examination. This raised issues about discussion at the time of referral, contract between patient and endoscopist about when to stop etc.

The cases are not expected to be exotic or of unusual diagnoses but to demonstrate continued learning and discussion.

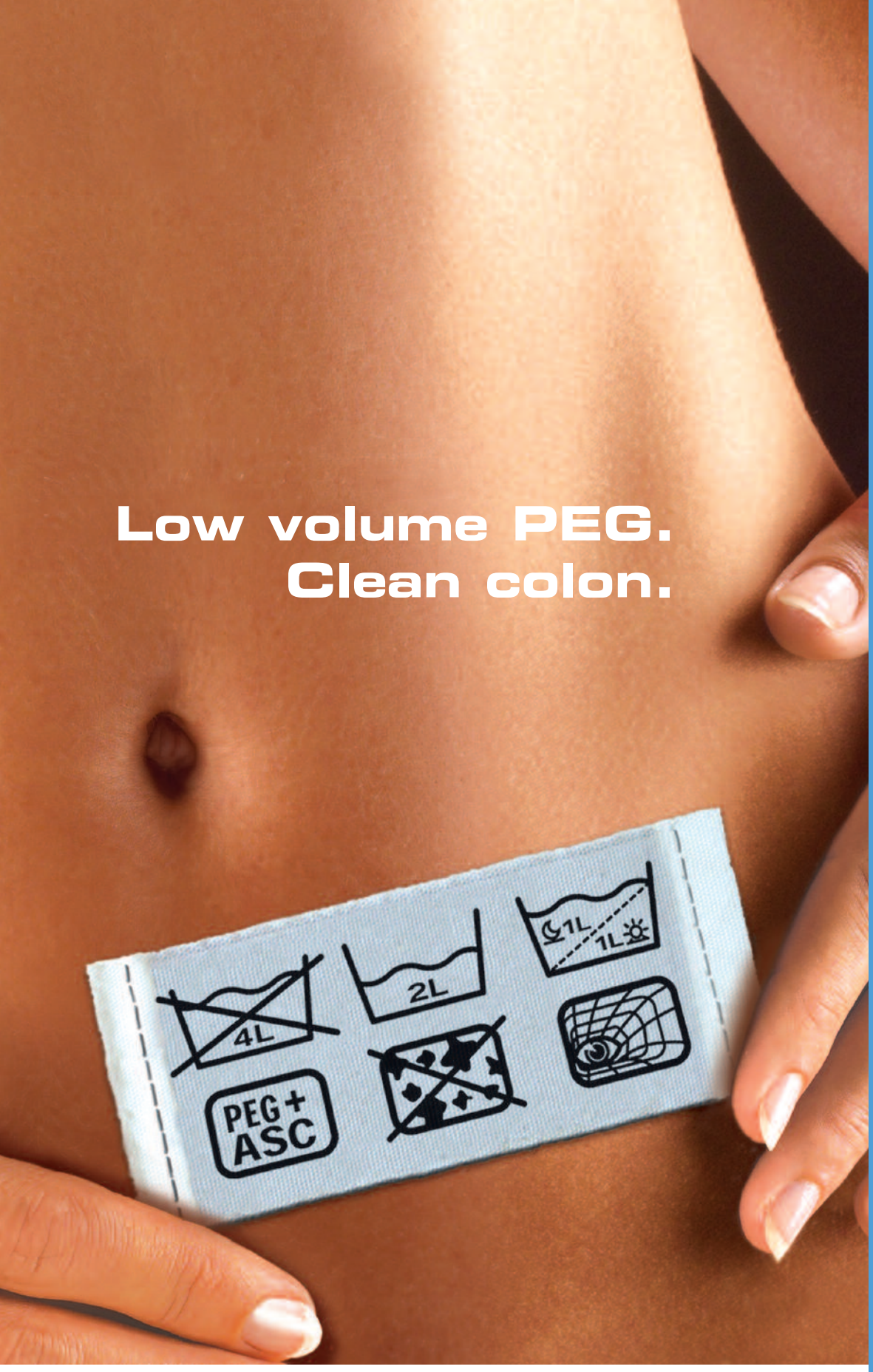
Critical events

We all have these and examples shown included:

- An elderly patient who fitted after colonoscopy preparation
- A patient who bled heavily after a phosphate enema

Continued on back cover

This issue...



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November 2008 MP/08/1526

EDITORIAL

Hard to find a more momentous day to write an editorial comment than the day the American people elected Barack Obama to be the 44th President of the United States by an overwhelming majority vote. This overcomes generations, indeed centuries of prejudices and vested interests, and sees a man with black skin elected to arguably the most powerful position in the world.

The potential is enormous to start the long uphill road to resolve the gigantic problems of racial differences, crumbling world finances and unresolving wars. I hope that it is also an opportunity for western governments everywhere to see the folly of making a nation's healthcare system depend on market forces when the bottom has so visibly dropped out of the world marketplace. The UK government in particular needs to abandon its determined effort to privatise large sectors of the British NHS and to reaffirm the value of a healthcare system for its citizens that is not dependent on ability of the patient to pay.

In the same twenty four hours that America has elected a new President, the UK government has agreed a smaller but important landmark that patients from now on will not be denied NHS treatment because they are electing to fund privately a part of their treatment that our current healthcare system cannot provide. No one in their right mind can imagine that a nation's healthcare system can afford every new super-expensive treatment coming on-line and resulting from the billions invested in pharmaceutical research.

One of the enormous challenges for a new American President is to move that country towards creating healthcare which becomes the rightful expectation of every citizen and does not leave about 15% of the population, or near 46 million people without health insurance coverage (Wikipedia 2007). In the UK, the tens of thousands of doctors, nurses and other health professionals who have devoted their working lives to NHS patient service for limited financial reward find it hard to come to terms with successive UK governments determination to shift our healthcare system towards the current US model. Is it too much too hope that 2008/2009 could see a shift back towards belief in a healthcare system that has uniform standards and availablility in every important sector whether in the community or hospital? Probably. It's more likely that the present shift will continue, maybe with a later swing-back to an 'all NHS' model if the current recession bites deep and long.

Certainly the ferocious concentration on standards, ever more intense as a result of Shipman, makes most sense in an integrated and non-fragmented system. There is an increasingly weighty and costly bureaucracy in place through the primary care organisations that can only mushroom further if our healthcare system passes into multiple ownership. This has become the antithesis to the intended simplification and local responsiveness that came from the penultimate system change when Area Health Authorities (in England) were replaced by local fledgling Primary Care Trusts. Now these have reamalgamated in larger and seemingly more remote bodies with their own complex internal political workings, once again more like the AHAs they replaced, and with substantial running costs, and working hard to divest themselves of direct healthcare provision.

Regarding standards in gastroenterology practice in the community, the opportunities presented by the White Paper in January 2006 are only very slowly inching forwards (where the plan is laid out to deliver a substantial proportion of traditional hospital outpatient practice in a community setting 'closer to the patient' by 2010, and clearly with the hope of a smaller price tag). Two important events related to this move took place in September, when Primary Care Contracting at the Department of Health staged a meeting to launch the 17 Practitioner with Special Interest (PwSI) frameworks (see page 6), and in October when the National Endoscopy Team staged a meeting about the accreditation of community endoscopy units and endoscopists - which Andrew Summers has laid out for us in the leading article in this issue. There are service redesign processes advancing in many parts of the UK to relocate parts of traditionally secondary care services to a community setting. PCTs are getting the help of GP practice patients to process map the patient journey from first GP encounter on through the system. This issue carries a patient perspective article on irritable bowel syndrome (IBS) and shows how the current NICE guideline could lead to a large cohort of IBS sufferers being both undiagnosed and unhelped. At the level of personal practice it is both educational and helpful to listen to the experiences and views of our service users and let them inform the pathways that traditionally only the professionals have set up to provide care.

Dr Richard Spence

Irritable Bowel Syndro

PATIENT PERSPECTIVE
Dawn Spence

My story of IBS starts just over 6 years ago. I spent a year in Canada where the food was very different and while working at the ski school I lived on an awful diet for 6 months of cheese and wheat, with apples, oranges and biscuits for snacks. I became more aware of the symptoms upon my arrival back in the UK, mainly abdominal bloating with sometimes painful cramping - this generally happened every evening following dinner, though sometimes I would get stomach aches in the afternoon following lunch or my afternoon fruit snack. Certainly stress and exercise played a big part in exacerbating my symptoms, but they seemed to flare up even if I was relaxing, so it became very frustrating.

I tried an anti-spasmodic briefly (Mebeverine) three times a day for a couple of months but after the first couple of weeks, it stopped making much of a difference. I also tried a few weeks on a dairy-free diet as I became suspicious of milk and cheese, though it made no difference. A blood test confirmed I did not have a gluten-intolerance.

In Australia, I continued coping with the bloating and abdominal pain symptoms for a further 3 years in the afternoons and evenings, which usually involved me curled up on the sofa after dinner before bed. It restricted my social life due to the fact that I dreaded going out to a bar or venue with no seating. I also started avoiding certain fruits as snacks as they tended to give me stomach pain. My GP in Australia recommended I try things like Mintec and Buscopan, but neither helped. The only thing actually that has ever provided any relief is Degas or something similar (containing Calcium Carbonate, Magnesium Carbonate Light, Simethicone and Sodium Bicarbonate).

About a year ago in Melbourne, I was referred to an allergist by my GP for a different reason entirely. The allergist asked about my medical history and when I mentioned the IBS he mentioned testing for lactose intolerance and fructose malabsorption. He referred me to a University research lab who were conducting hydrogen breath tests for lactose intolerance and fructose malabsorption. A fee was paid for three different tests (see Appendix A for more information). In short, I attended on three separate occasions, to drink a control drink (lactulose) for a base hydrogen reading, and then lactose or fructose on the other two occasions. The amount of hydrogen I produced in the next three hours following consumption of each drink was measured using a breathalyser. While waiting for the results, things seemed to get worse and I started to get diarrhoea once or twice a week. I started to lose weight and thought it was time to take some further action. My results finally showed that I had fructose malabsorption. I booked in to see a dietician who was a specialist in the subject and who also had been diagnosed with fructose malabsorption and was living with the change in diet. It was great to see someone who could understand the symptoms and explain the steps I could take. She explained what fructose malabsorption meant, a list of foods I should avoid, and a list of foods I could eat (See Appendix A).

I found the change in diet difficult to follow initially as my previous diet had pretty much consisted of all the high-fructose foods, primarily onion, honey, wheat, and various fruits. This actually made sense and finally gave me an explanation for some causes of my IBS. The more I stuck to the new diet, the better I felt and the fewer symptoms I suffered.

Now, I really notice that if I eat something I shouldn't, I suffer more symptoms, particularly if I build up the levels over several days. I might have one thing one day and feel fine so two days later have something else and again the next day, and by the end of the week my symptoms are back with a vengeance. It then takes about 3-4 days of careful eating to settle back down to normal again. Social events are still a trigger as alcohol and eating out tends to set off my symptoms again, but with home-cooking and moderation in alcohol and sugary foods, I am generally fine. I still believe that stress has a slight impact, but with the correct diet, the effects are massively reduced. It makes a real difference in my life to have some control over the symptoms, and to only have myself to blame if I eat or drink something I shouldn't.

APPENDIX A
Fructose malabsorbtion

Fructose malabsoption can be recognized using a breath-test (hydrogen or methane). Normally fructose is absorbed in the small intestine. Fructose malabsorption is a condition where the normal absorption of fructose is impaired. Unless the diet is balanced, unabsorbed fructose moves through to the large intestine, where bacteria can use it as a food source. When bacteria break down fructose, it can cause symptoms of stomach bloating and/or pain, wind, loose intestine motions and/or constipation. These are symptoms commonly experienced because of malabsorption.

Fructose can be present as a single sugar and as a chain of fructose sugar units (Fructans). Foods are generally a problem when:

1. they contain more fructose than glucose,
2. they contain fructans, or
3. too much fructose is eaten at once.

Note - when a fruit contains more fructose than glucose it is a problem as fructose needs glucose to help it be absorbed in the small intestine.

Foods that are a problem for fructose malabsorption

1 Problem due to excess fructose

- Apple*
- Pear*
- Mango*
- Watermelon*
- Quince*
- Lychee*
- Guava*
- Persimmon*
- Nashi Fruit*
- Honeydew Melon*
- Fructose
- High Fructose Corn Syrup
- Honey

***Note** - this food can be eaten in moderation by accompanying with glucose

ome and Fructose Malabsorption

2 Problem due to fructans

- Onions (brown, white, red, spring, onion powder)
- Shallots
- Leeks
- Artichokes
- Chicory
- Fructo-oligosaccharides (FOS; artificial dietary fibre)
- Inulin
- Wheat (in large amounts)

3 Problem due to fructose load

- Dried fruit
- Tinned fruit in 'natural' juice
- Dried fruit bars
- Coconut cream/coconut milk
- Tomato paste
- Lots of fruit in one sitting
- Fruit juice

Breath tests for fructose malabsorption, lactose intolerance, bacterial overgrowth

These measure Hydrogen, or Methane if you are a low or non-hydrogen producer after a lactulose control test. The tests following lactulose, fructose, and glucose sugar solutions are performed on different days and require adherence to a particular dietary pattern prior to testing. Gas samples are measured every 15 minutes over 2-3 hours.

Reference: www.coeliac.com.au - Shepherd Works

About the author: Dawn Spence graduated (First Class Hons, Sports Science and Geography) from Birmingham University in 2001. She was a ski instructor in Whistler, Canada for a season staying to work the golf summer season. There she met fiancé, Jason, who is from Melbourne and they returned to Melbourne for the last four years where Dawn has been a project manager for NCR and currently is still running the Australian ATM installation project from the UK. Look out for the NCR logo on ATM cash machines here!

Editor's note: The NICE guidelines February 2008 'Irritable Bowel Syndrome in Adults' state "The following diagnostic tests are not necessary to confirm diagnosis in people who meet the IBS diagnostic criteria - hydrogen breath test (for lactose intolerance and bacterial overgrowth)". We should note that not only could Dawn not discover the root cause of her IBS in the UK, nor did she find it in three years in Australia from mainstream medical advice. It was the chance consultation with an allergist that led to breath testing in a university research department, privately funded. Possibly many 'gastro' readers are unaware, as I was, of the problem of fructose malabsorption and intolerance. There is an informative section about it in the ubiquitous Wikipedia, a site that seems to know everything about anything! **http://en.wikipedia.org/wiki/Fructose_malabsorption**

Wikipedia says "Fructose malabsorption or Dietary Fructose Intolerance is a digestive disorder of the small intestine in which the fructose carrier in enterocytes is deficient. As a result of this problem, the concentration of fructose in the entire intestine is increased. Fructose malabsorption is found in approximately 30-40% of the population of Central Europe, with about half of the affected individuals exhibiting symptoms". So this opens a very large can of worms if 15-20% of a European population are supposedly symptomatic. **True** Fructose intolerance is caused by deficiency of the enzyme fructose-1-phosphate aldolase. Inherited as an autosomal recessive condition, it manifests with symptoms of hypoglycaemia after the ingestion of fructose, the result of accumulation of fructose-1-phosphate. Diagnosis is confirmed by the measurement of the enzyme in the liver.

KEY FACTS 3 Irritable Bowel Syndrome

Topic/definition

Irritable Bowel Syndrome (IBS)

Prevalence/incidence

Prevalence 10-20% but probably higher as data suggests that 75% self manage.

Common symptoms

- Consider IBS
- Abdominal pain or discomfort, bloating, change in bowel habit - reported for at least 6 months:

The diagnosis of IBS is supported if the person has abdominal pain or discomfort that is either relieved by defaecation or associated with altered bowel frequency or stool form.

and accompanied by at least two of the following four symptoms:

- altered stool passage (straining, urgency, incomplete evacuation)
- abdominal bloating (more common in women than men), distension, tension or hardness
- symptoms made worse by eating
- passage of mucus.

Investigations

- Full blood count (FBC), ESR or plasma viscosity, CRP, endomysial antibodies [EMA] or tissue transglutaminase [TTG].
- **Investigations not required:** ultrasound, rigid/flexible sigmoidoscopy, colonoscopy and barium enema, thyroid function test, faecal ova and parasite test, faecal occult blood, hydrogen breath test.

Do and don'ts of treatment

- Offer dietary and lifestyle advice.
- Instruct patients to self manage their medication.
- Prescribe antispasmodics, antimotility agents, laxatives or loperamide.
- Consider low dose TCAs as second line treatments.
- Consider psychological intervention if symptoms persist for longer than 12 months that has not responded to therapy.
- Dietary fibre should be soluble fibre and not exceed 12g/day.
- Changes for the Condition (i.e. IBS reduce Fibre intake).
- Make a positive diagnosis according to criteria.
- Restrict investigations.
- Self management.
- Reduction in dietary fibre.

Review articles

- National Institute for Health and Clinical Excellence. Irritable bowel syndrome in adults.
- Diagnosis and management of irritable bowel syndrome in primary care. *Clinical Guideline 61*. London: NICE, 2008.

Dr Jamie Dalrymple

PRACTITIONERS WITH SPECIAL INTERESTS

The Primary Care Contracting section of the Department of Health launched this programme at a meeting in London on 17 September. The day was chaired by Dr Philip Leech OBE, medical Advisor for the DoH to NHS Primary Care Contracting. Philip showed himself to be humorous and to have a good understanding of NHS general practice.

Prof Nigel Mathers introduced the theme of Practitioners with Special Interests. He chairs the Clinical Innovation and research Centre (CIRC) at the RCGP:

- PwSI is first and foremost a generalist
- acts without direct supervision
- has a level of skill in the specialist field which exceeds core GP competency
- 'quality alone will never demonstrate suitability for this role'
- subject to accreditation.

You can download Word documents of sample PwSI applications for accreditation and reaccreditation at:
www.primarycarecontracting.nhs.uk/173.php

Dr Clare Gerada (now Vice-Chair of RCGP) has been a pioneer in the development of the ideology behind GP with Special interest and spoke on the themes dear to herself currently. It is worth recording here that the PCSG has been solidly involved in this process with Clare and others at the RCGP since the beginning of 2002 and that the term 'GP Specialist' was to be avoided because general practice needs to be recognised as a specialty in its own right. Hence the term 'GP with Special Interest' was agreed as the best descriptor. Clare spoke about 'teams without walls', the fact that GPs are being increasingly performance-managed, that we are subject to cuts in areas beyond our control and that we are seeing the 'loss of a uniformly recognisable health service'. The Care Quality Commission established by government will be looking at the quality of care everywhere. Strategic Health Authorities are 'big players' in the new healthcare world.

Clare has just set up a Practice Federation involving her own practice. She believes that PwSI is 'key' to the next iteration of health service development and that GP training should now extend to five years in line with other specialty training (Clare herself went via Psychiatry). The MRCGP should be the equivalent of HSCC and Practitioner with Special Interest needs three areas of regulation:

1 assessment of the individual practitioner
2 accreditation of the service
3 who designs the Specialty Framework.

Catherine Davies spoke for the Department of Health in her role as Policy Development Manager. She spoke about the challenge presented by 'what the consumer wants - 24 hours a day, 7 days a week' and various DoH initiatives to examine different models - eg demo sites for 'Care closer to Home' involving six specialties, partnerships for older people, whole system demo sites using assistive technology such as telemedicine. A health reform demo site, and the 'see saw' simulation exercise published by Kings Fund. She referred to new service developments involving:

- transfer of specialist backup for primary care clinicians
- relocation of specialist clinicians to work in new settings
- redesign - services working in new ways (Bristol has current gastro example)

Two principles are fundamental to shifting healthcare:
1 working across the whole of health and care economy
2 recognising the local context is critical in delivering priorities

These are encapsulated in 'Meeting the Challenge', the report linked to the Next Stage Review. 'We can never mandate from the Centre what services should look like' - but provide support resources (eg current support packs for Urology, Dermatology)

Dr David Colin-Thomé, primary care 'Tsar' talked about PwSIs and their role in reshaping services. He stressed that generalist skills are a key part of a PwSI's effectiveness and that the 'Primary Care Home' includes PwSI (the 'medical home' is a popular US concept!). He also dipped into the Darzi 'next Stage review' the vision for primary and community care and responsibility for a registered population.

Speakers on developing PwSIs in specialties were **Dr David Millsom** (prescribing Champion RCGP headache service), **Dr Angelo Fernandes** (urgent care clinical Champion RCGP) and **Dr Imran Rafi** (RCGP genetics clinical Lead). Pharmacists were represented by **David Webb** (Principal Pharmaceutical Officer) and **Heidi Wright** (head of practice RPSGB). So far there are only two PhwSIs, both in anticoagulation. Other potential models for PhwSI are for older people (includes home visiting), substance misuse (legislation due to change to enable pharmacists to prescribe controlled drugs), and sexual health.

I spoke to Catherine Davies (DoH) during the meeting about the potential usefulness of getting PCTs to keep a register of local PwSIs (GPwSIs) employed locally whether by PCT or acute Trusts and under whatever existing contract. This would greatly facilitate workforce planning for local service redesign. This point was accepted.

Richard Spence

Specialty specific guidance

Updated specialty specific guidance has been launched by the Department of Health. These frameworks may be used to support local accreditation of GPs and Pharmacists with a Special Interest. Further details of guidelines currently available or in progress are available at:
www.primarycarecontracting.nhs.uk/173.php

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Dosage Instructions: Adults and children 12 years and over: 5-10ml after meals and at bedtime.

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Holder of Marketing Authorisation: Reckitt Benckiser Healthcare (UK) Limited, Dansom Lane, Hull HU8 7DS.

Date of Preparation: November 2007.

Adverse events should be reported to Reckitt Benckiser on 0500 455 456. Information about adverse event reporting can be found at www.yellowcard.gov.uk

1. Gaviscon Advance Aniseed Suspension SmPC, July 2007.

JOURNAL OF THE PRIMARY CARE SOCIETY FOR GASTROENTEROLOGY

KEY FACTS 4 Liver Disease

Topic/definition

Liver Disease (LD) in the UK

Prevalence/incidence

- It is estimated that 4% of the population have abnormal liver function tests.
  - **1% are due to alcohol abuse**
  - **~0.7% are due to chronic HCV infection**
  - **~2% are related to insulin resistance, obesity and fatty liver**
- Fifth most common cause of death in England, for both men and women and mortality is steadily rising. From 1993 to 2006, the number of deaths from chronic LD in England more than doubled, from 2,774 to 5,852; this is in the opposite direction to that in Europe as a whole.
- The average age at death for LD patients is 59. Average life expectancy in England is currently 79 years.
- Hospital admissions for alcohol-related liver disease increased by 147% in the 10 years to 2005/06.
- Morbidity is rising as well - more people are getting LD. There was a 46% increase in the number of diagnoses of primary LD, between 1999 and 2007 to 23,000. By 2015, if this trend continues, the number of patients requiring hospitalisation for LD will grow by nearly 50%.

Common causes of LD

The three principal causes of LD:

- **alcohol**
- **obesity**
- **viral hepatitis** (Hepatitis B and C)

- ALL are preventable or treatable before chronic LD develops.
- Fifty percent of all patients in hospital with a primary diagnosis of LD have alcoholic LD.
- About 25% of adults and 14% of children are now obese. By 2050, evidence suggests that 60% of adult men, 50% of adult women and 25% of children will be obese.
- An estimated 200,000 people in England currently have chronic hepatitis C infection, and around 180,000 have chronic hepatitis B infection. The majority of people with hepatitis B or hepatitis C are probably undiagnosed, as acute infection often occurs without symptoms.

Prevention of LD

- No effective liver function test at primary care level.
- Primary care could play a huge role in unmasking 'silent' liver disease earlier.
- Earlier detection would have a major impact.
- 564 days average time to diagnosis The is an opportunity to decrease the future burden on the NHS.

Socio-economics of LD

- There is a socio-economic divide for LD. There are 3 times as many LD-related deaths in the most deprived areas compared with the least deprived areas.
- For 25-49 year olds, there are 10 times as many deaths in the most deprived areas compared with the least.

Progression of LD

- Alcoholic fatty liver becomes chronic alcoholic LD after 15-20 years in 10-30% patients. Thirty percent develop cirrhosis after 10 years.
- Ninety percent of obese patients develop NAFL. After 10-15 years, 5% develop NASH of which 25% develop cirrhosis after 10years.
- Viral hepatitis Hep B 15-40% develop cirrhosis after 15 years; Heb C 40-45% develop cirrhosis after 20-30years.

Review articles

- National Plan for Liver Services - Specialised Services for Hepatology and Hepato-Pancreato-Biliary Surgery - *British Association for the Study of the Liver* May 2004.
- Liver disease workshop - Findings from stakeholder workshop, 12 May 2008 *Dept of Health.*

Dr Jamie Dalrymple

Event Diary

11 Feb 2009
Regional Meeting
Weetwood Hall, Leeds
Contact: 01923 712711 for information
Contact: secretariat@pcsg.org.uk

23-26 March 2009
BSG Annual Meeting
Scottish Exhibition & Conference Centre, Glasgow
Contact: 020 7935 3150 for information

STOP PRESS

From Bristol PCT Service Design Director

"I am delighted to inform you that all our hard work has paid off!!

I took the business case to PEC this afternoon and it was very well received. We have been given the green light to commission the (primary care gastroenterology) service so it is now full steam ahead to develop the service specification and the remaining pathways."

Continued from front cover

- A patient who withdrew consent on entering the endoscopy room

The intention is to demonstrate continued learning and that practice is changing according to new experience and continues to place the patient at the center of the service.

Meetings and courses attended

This is a diary of the endoscopist's contact with other practitioners and might include PCSG meetings, MDTs, endoscopy courses etc. Again the intention is to demonstrate that the endoscopist is not working in isolation.

Reading

This section would include just 4-5 articles or papers that might have influenced practice in the previous year. Examples shown were papers on the predictive value of dysphagia, the number of biopsies needed to confirm coeliac disease etc.

Feedback

Patient surveys, 360° appraisal if appropriate, patient comments etc.

DOPs

This will be completed on the assessment day. The endoscopists will perform a number of observed procedures which will be followed by feedback and discussion.

Objectives

As in all appraisals there should be discussion and agreement regarding future learning needs and objectives.

This portfolio initially looks quite daunting but when broken down, each section just represents a record of the activities that patients would expect their doctors to be undertaking. If it is to be meaningful it must be achievable by most endoscopists and if it becomes apparent that some items are not do-able, then like an exam question that everyone gets wrong it must be a poor measure and will be dropped or altered.

This is a pilot to be developed into a workable and acceptable assessment tool to be repeated perhaps every 3-5 years. The first training and assessment day is likely to be in Torbay or Gloucester in January 2009 and we will report progress in future issues of GIP.

Andrew Summers

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