SUPERVISION

Correct supervision is essential for all training endoscopists[1], irrespective of their grade (Table 18). In 45 cases this was not answered, therefore in 26% (461/1,773) of cases the most senior endoscopist was not a consultant. Supervision has to be tailored to the experience of the trainee, and their competence in a particular technique. In most cases, the more junior an endoscopist, the more supervision is required – unless a senior colleague is learning a new technique.

Table 18. Location of supervising consultant when most senior endoscopist was not a consultant.

Grade of operator	In endoscopy room	In unit but not in room	Available in hospital	Available by phone	Other	Sub-total	Not answered	Total
SAS	10	18	79	7	4	**118**	32	**150**
General practitioner	0	0	0	0	0	**0**	7	**7**
Nurse practitioner	4	2	3	0	0	**9**	0	**9**
SpR post CCST	8	7	13	3	0	**31**	6	**37**
SpR year 3+	32	40	73	25	0	**170**	33	**203**
SpR year 1/2	13	11	11	3	1	**39**	6	**45**
SHO	0	0	0	1	0	**1**	1	**2**
Other trainee	1	1	3	1	0	**6**	2	**8**
Sub-total	**68**	**79**	**182**	**40**	**5**	**374**	**87**	**461**
Not answered	2	1	3	1	0	**7**	38	**45**
Total	**70**	**80**	**185**	**41**	**5**	**381**	**125**	**506**

On most occasions (88%, 329/374), the supervising endoscopist was somewhere in the hospital during the procedure; either the endoscopy room (18%, 68/374), or the endoscopy unit (21%, 79/374), or elsewhere in the hospital (49%, 182/374). JAG guidelines[1] do not define 'supervision' but it is difficult to teach a trainee if one is not present in the endoscopy room. Table 18 indicates that SHO and SpR year 1/2 trainees without a senior endoscopist in the room performed therapeutic procedures. The JAG guidelines[1] should specify explicitly what level of supervision is acceptable for trainees performing endoscopic procedures. Endoscopy units should audit their practice to ensure that such junior trainees are competent to carry out therapeutic procedures independently.
It is surprising that there was no response to this question where the senior endoscopist was a GP. It is our belief that a consultant should also supervise GPs undertaking endoscopies in hospitals.

In the opinion of the advisors, supervision was inappropriate in four cases for the experience of the trainee endoscopist. All of these patients had presented with haematemesis and/or melaena – and senior support was not requested.

Case Study

An elderly patient presented with melaena. The patient had a number of comorbidities, a haemoglobin less than 6 gm/dl, and was assessed as ASA 4. A senior specialist registrar year 3+ was unable to control the bleeding from two duodenal ulcers despite injection with adrenaline, 2 ml of 1 in 10,000 into each ulcer. No senior help was sought although a consultant was in the hospital. The patient died from continuing bleeding.