

## **LAPAROSCOPIC COLORECTAL SURGERY PRECEPTORSHIP**

### **INTRODUCTION**

At present there is no structured training programme for established consultants to take on laparoscopic colorectal surgery. In order to address this, a joint initiative has been developed between the Association of Laparoscopic Surgeons of Great Britain and Ireland (ALSGBI) and the Association of Coloproctology of Great Britain and Ireland (ACPGBI). These two professional bodies have set up a joint Laparoscopic Colorectal Preceptorship Group and this document sets out the principals of this Group.

### **TRAINING OF CONSULTANTS TO BE PRECEPTED**

The training programme for consultants wishing to be preceptored should encompass the following aspects:

a – Consultants wishing to be preceptored should have seen at least 10 live laparoscopic colorectal resections – this can be achieved by attending 2 recognised courses such as those run in the various Minimal Access Training Units.

b – Appropriate laparoscopic equipment suitable for this sort of surgery is not always available in all hospitals. In addition, the Theatre team (senior scrub nurse, second theatre nurse, ODA and theatre manager) undertaking this intervention need to be trained in order to support the development. In order to resolve the above issues, it is recommended that the team visit a hospital that is regularly undertaking laparoscopic colorectal surgery. In addition, all aspects of clinical governance in the hospital wishing to take on this development, need to be addressed before a consultant is preceptored, so that following preceptorship independent practice may continue without delay.

c - The preceptor will either travel to the hospital of the consultant wishing to be preceptored or the reverse might happen depending on the preceptors' wishes. It is recommended that preceptorship involves 2-4 cases.

d – Those being preceptored would be responsible for auditing their own data which should be entered in the ACPGBI database and reviewed by the preceptored surgeons' peers at their local hospital MDT meeting. Data should be audited locally in line with advice regarding introducing new techniques.

e – During the first year of this programme, which is likely to start in October 2004, priority should be given to consultants who have considerable laparoscopic, as well as colorectal experience.

f – Analysis of the learning curve reveals that conversions are more frequent in patients who have a body mass index of 28 or greater, those who have undergone previous intra abdominal surgery, those undergoing surgery for benign conditions and during surgery for rectal cancer (unpublished observations from Mr R H Kennedy). In view of the higher conversion rates in such conditions it is advisable that, after preceptorship, surgeons should undertake at least 20 straightforward colorectal resections before undertaking more complex procedures. The most straightforward resections are

deemed to be sigmoid, right colonic and left colonic resections, bearing in mind the increased conversion rates in the circumstances described above. Although the advice in the United States has been that surgeons should undertake at least 20 laparoscopic resections for benign disease or resections in patients with metastatic colon cancer, before treating potentially curable colonic cancer, this advice has been modified in Britain. It is not felt to be appropriate to restrict the first 20 resections to benign disease as often such resections can be difficult and appropriately selected procedures for malignancy are frequently the most straightforward.

## **SELECTION OF PRECEPTORS**

Preceptors have been drawn from those surgeons who have undertaken more than 100 laparoscopic colorectal resections and who have an annual workload exceeding 25 such cases. Potential future preceptors are encouraged to write to Mr Kennedy.

## **COSTS OF PRECEPTORSHIP**

Preceptors and up to one member of nursing staff involved in the preceptorship will be reimbursed for travelling expenses and, if necessary accommodation and may charge an honorarium.

## **EDUCATIONAL MATERIAL**

Video material will be available for those surgeons being preceptored, demonstrating a range of techniques and instrumentation. This may be used as an aide memoire for both the surgeon and his/her operating team on future occasions.

## **ORGANISATION OF THE PROGRAMME**

### **Application for preceptorship**

Surgeons applying to be preceptored should do this via Miss Fiona Wilson, Acting Speciality Manager of the Association of Laparoscopic Surgeons. A preference for a particular preceptor may be expressed, but when it is not possible to fulfil that, allocations will generally be based on geographical proximity.

### **Assessment of preceptors**

Those consultants being preceptored will be asked to complete a standard assessment form to provide feedback on the programme.

### **Chairmanship of the Laparoscopic Colorectal Preceptorship Group**

This will be for a maximum period of 3 years. The chairman will be supported by a small steering group of 2-3 other surgeons.

## **Business plans**

Generic business plans that might help future units to develop laparoscopic colorectal surgery will be available from Mr M Tobin, Ethicon Endo-Surgery and Mr D Fredericks, Tyco Healthcare.

## **Accreditation**

The preceptorship programme is not designed to provide accreditation or hinder the development of potential laparoscopic colorectal surgeons. It has been set up as there is currently little 'hands-on' training available to established consultants who wish to take on this technique. Although it is an improvement on the current situation, it cannot be compared to the traditional surgical apprenticeship experienced by trainees during a 6-12 month period. It is entirely voluntary and those consultants requesting preceptorship should regard it as part of their professional development and not an accreditation. If consultants being preceptored wish to receive advice about their future laparoscopic colorectal practice, that should be available from the preceptor, on an informal basis.

Consultants visiting a hospital to preceptor will require an honorary contract to be issued by the hospital being visited. The preceptor will not however be deemed responsible for the clinical care of the patient subsequent to the operation, or for providing a formal report on the consultant being preceptored.

## **Research**

It is hoped that in addition to submitting data to the national audit of bowel cancer outcomes, it may be submitted for research purposes.

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