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EDITORIAL

Beyond boundaries: competence and collaboration in modern luminal endoscopy

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Endoscopy has undergone a remarkable transformation. What began primarily as a means of visualising the gastrointestinal tract has evolved into a sophisticated therapeutic discipline capable of managing conditions that previously required open or minimally invasive surgery. This evolution challenges the traditional boundaries between medical and surgical practice. The articles in this issue illustrate the changing landscape particularly well, encompassing adoption of new technology, training and the organisation of endoscopy services, quality assurance, and advanced diagnostic and therapeutic techniques.

Historically, much of the development of gastrointestinal endoscopy occurred within surgery. Surgeons were among the early adopters of flexible endoscopy and rapidly recognised its potential not only for diagnosis but also as an extension of operative management. The development of endoscopic sphincterotomy and endoscopic retrograde cholangiopancreatography (ERCP), the treatment of postoperative complications, management of strictures, and therapeutic intervention following bariatric surgery all demonstrate that endoscopy could become an alternative to, or complement, conventional surgery. In many centres, therefore, endoscopy developed naturally within a shared surgical environment.[1,2]

The distinction between surgical and medical endoscopy is increasingly difficult to sustain. The expanding capabilities of therapeutic endoscopy have created a field that sits between traditional disciplines. The patient with a bile duct injury may require surgery, ERCP or both. The patient with a complication following bariatric surgery may require endoscopic, radiological and surgical intervention at different stages. A patient with oesophageal cancer may require endoscopic palliation as part of a broader multidisciplinary treatment strategy. The most appropriate approach is determined by the patient's anatomy, disease and clinical circumstances rather than by the professional background of the individual holding the endoscope.

This is particularly apparent in the management of bile duct injuries. ERCP has become an important component of the management of selected injuries and leaks, often avoiding or reducing the need for further surgery.[3] Similarly, endoscopic therapy has changed the management of benign oesophageal strictures, while stenting provides an important option for selected patients with oesophageal malignancy.[4] These developments do not represent the replacement of surgery by endoscopy. Rather, they demonstrate how the two disciplines have become complementary.

The same principle applies to complications following metabolic and bariatric surgery. Altered anatomy can make these patients technically challenging, but therapeutic endoscopy has increasingly provided minimally invasive solutions to problems that previously required reoperation. The development of these techniques requires an understanding of both surgical anatomy and endoscopic intervention. It is precisely at this interface that collaboration between surgeons and endoscopists becomes particularly valuable.[5]

Not all progress in endoscopy, however, has been driven by increasingly complex intervention. High-quality endoscopy depends on fundamentals. Appropriate bowel preparation, completion of colonoscopy, competence assessment and the organisation of an effective endoscopy service remain essential. A technically sophisticated procedure is of limited value if the examination is incomplete, inadequately documented or performed by an operator who has not demonstrated competence.[6]

The question of competence is likely to become increasingly important. As endoscopic procedures become more specialised, training based simply on the number of procedures performed is unlikely to be sufficient. Competence requires appropriate knowledge, technical ability, judgement, recognition and management of complications, and the ability to work effectively within a multidisciplinary team, requirements that apply irrespective of whether the practitioner is trained primarily in surgery or medicine.[6,7]

Technological innovation continues to blur the boundaries between endoscopy and surgery, creating new opportunities to diagnose and treat gastrointestinal disease using complementary approaches. High-resolution manometry has transformed the assessment of oesophageal motility disorders and is central to the modern evaluation

of achalasia.[8] Capsule endoscopy has expanded the ability to investigate areas of the gastrointestinal tract that are difficult to reach with conventional endoscopes.[9] Single-use duodenoscopes represent a technological advance that addresses important issues surrounding infection control, reprocessing and availability of specialised equipment.[10] These innovations demonstrate that the future of endoscopy will not simply involve doing established procedures better; it will also involve reconsidering how gastrointestinal disease is investigated and treated.

The organisation of endoscopy services is consequently becoming as important as the individual procedure. Modern endoscopy requires trained personnel, appropriate equipment and reliable systems for sedation, anaesthesia and reprocessing. Quality assurance, complication management and access to surgical, radiological and pathological expertise are equally important.[6] In a shared medical–surgical facility, these components can be brought together to create an environment in which complex patients can move between disciplines without barriers created by specialty boundaries.

Perhaps the most important lesson from the evolution of luminal endoscopy is that competence matters more than ownership. The traditional question of whether a procedure belongs to surgery or medicine matters less than whether it is appropriate for the patient, whether the operator has demonstrated the necessary competence, whether the service can support it safely, and whether appropriate surgical, radiological and medical expertise is available when needed.[6,7] The history of therapeutic endoscopy is closely intertwined with surgical innovation, but the field has now matured beyond its historical origins.

Gastroenterologists, surgeons, interventional endoscopists, anaesthetists, radiologists, nurses and other members of the multidisciplinary team all contribute to contemporary endoscopic practice. Endoscopy services should therefore have the patient as their focus, with treatment tailored to the patient's anatomy, physiology and disease rather than to the skill set or management approach of a single specialty. The articles in this issue reflect this ongoing evolution. From the fundamentals of bowel preparation and colonoscopy competence to ERCP for bile duct injury, the management of oesophageal strictures and cancer, complications of bariatric surgery, capsule endoscopy, high-resolution manometry and single-use duodenoscopes, they demonstrate a discipline that has moved well beyond simple visualisation and increasingly requires integrated care. The future of luminal endoscopy should therefore not be defined by specialty ownership. It should be defined by competence, collaboration, innovation and patient-centred care. The shared medical–surgical endoscopy environment provides an ideal setting for this evolution. Rather than asking where endoscopy belongs, we should ask how the different disciplines can work together to ensure that patients receive the right procedure, competently performed by the right person, in the right environment, and with the appropriate expertise available when things do not go according to plan.

That is perhaps the real story of modern luminal endoscopy: not the movement of a discipline from one specialty to another, but its emergence as a genuinely collaborative, patient-centred component of gastrointestinal care.

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