POSITON PAPER

Granting Privileges for GI Endoscopy: SGEI Position

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Background

Gastrointestinal (GI) endoscopy has rapidly advanced over the last 40 years to become an integral part of clinical gastroenterology. The practice of GI endoscopy is dynamic and continues to evolve. Standard endoscopic procedures continually undergo refinement and new major techniques are introduced. Guidelines for the practice of endoscopy are developed by ASGE and some other societies using evidence based methodologies.

Competency in performing endoscopic procedures requires competency in the technical, interpretive and cognitive aspects of endoscopy, and the capability to integrate endoscopic findings into clinical practice. As previously outlined by ASGE, the six principles of endoscopic training are:

- understanding of implications
- expeditious performance of procedures
- correct interpretation of findings
- integration of these findings into therapeutic management plans
- avoidance and management of complications
- recognition of personal limitations in performing endoscopic procedures.

Training should be comprehensive and provide a working knowledge of the pathophysiology, diagnosis and management of digestive diseases for which endoscopic procedures are indicated.

Guidelines for formal training in endoscopy include performance under supervision of at least 100 upper GI endoscopies or colonoscopies to acquire competency in either procedure. However performance of an arbitrary number of procedures does not guarantee competency. Endoscopists performing diagnostic procedures such as colonoscopies must be capable of performing appropriate therapeutics such as polypectomy at the same sitting. Short, 2-3 days course of self-instruction in endoscopy without additional supervised experience do not provide adequate training in these or other aspects of endoscopy.

Inadequate endoscopic examination may result not only from failure to insert the endoscope completely, but also from failure to recognize pathology, formulation of inappropriate management strategies or failure to accomplish necessary therapeutic intervention such as polypectomy at the time of diagnostic study. The implications of such examinations include missed diagnosis, the need for repeat endoscopy or the need for alternative procedures. Such outcomes are neither desirable nor cost-effective.

The conventional route for acquiring skills in GI Endoscopy is via 2-3 years of gastroenterology fellowship or 5-6 years of surgery residency. Physicians or surgeons who have not received formal training in GI Endoscopy may wish to acquire privileges to perform endoscopy. Prior to being granted privileges, an endoscopist should demonstrate competency by undergoing proctoring by an impartial qualified endoscopist. The physician/surgeon should receive formal supervised hands-on training in endoscopy in the form of a preceptorship, sabbatical or education in a practice setting by a qualified endoscopic instructor. Proficiency in one procedure does not imply proficiency in another. Competency in performing elective procedures does not imply competency in performing emergency therapeutic procedures. It is also suggested that prior to undergoing endoscopic procedures, patients have access to information regarding the level of training of the endoscopist.

The decision to use non-physician endoscopist should be based upon competence in endoscopy. Factors that have led to the use of non-physician endoscopist include availability of physician resources and the volume of procedural demand as dictated by local conditions. The majority of literature that involves non-physician endoscopist pertains to the performance of sigmoidoscopy and specifically for the purposes of colorectal cancer screening. As with physician endoscopists, non-physician endoscopists require either direct or indirect supervision after the procedure.

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3) For those who have not undergone DM, DNB Course, a proper training (minimum 6 month to 1yr) must be received by concerned physician/surgeon from a reputed center/hospital/institute after postgraduate in Medicine or Surgery. Concerned trainer must give a certificate of competence to the physician mentioning how many procedures have been performed by concerned doctor & whether they have been done under supervision/unsupervised. During such training, a log book must be maintained by concerned doctor, which should be counter signed by the trainer.

4) Society of GI Endoscopy of India does not encourage doctors without postgraduate degree & formal training to practice GI endoscopy. Society firmly believes that endoscopy techniques go much beyond introduction of scope. It involves completing the procedure without undue risks, with capacity of interpretation of data, ability to perform therapeutic procedures in same sitting, ability to use the information in patient management as well as recognizing and treating the complications.

5) At present time, Society does not feel appropriate to have non-physician performing endoscopy in India.

References

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