Credentialing for Endoluminal Bariatric Procedures

Purpose

The purpose of this document is to recommend guidelines to local credentialing committees for the credentialing of endoscopists to perform endoluminal bariatric procedures. These guidelines aim to ensure that endoscopists have undergone appropriate training and have achieved a certain minimum level of skill to safely perform endoluminal bariatric procedures and to recognize and treat complications. These guidelines offer recommendations to institutional credentialing bodies regarding experience, and training and bariatric program requirement for surgeons and gastroenterologists seeking endoscopic bariatric privileges. It is acknowledged that special circumstances may apply to an applicant’s training background, and thus, guidelines must allow for some flexibility. Ultimately, the decision to provide credentials resides with the local institution credentialing committee or their appointee.

Skill Development for New Technology

A preceptorship or other method of formal instruction is mandatory for the acquisition of major new skills. The completion of a short course or workshop that offers limited exposure to cognitive background data or technical skills will not by itself, result in clinical competency and therefore should not be the sole mechanism for the acquisition of new major skills. Persons wishing to learn a new procedure should do so under the supervision of a preceptor, a recognized
authority in the new procedure on the basis of extensive clinical experience and/or publications.

The preceptor’s responsibilities include: setting objectives, developing a curriculum, demonstrating procedural techniques, overseeing the instruction and practice of skills, evaluating the preceptee, and documenting competency of the preceptee for future credentialing. Competency is defined as the minimum level of knowledge, skills and expertise, derived through training required to perform a procedure safely and proficiently. For primary endoscopic bariatric procedures, this includes the ability to recognize complications associated with placement and/or removal of such interventions. In addition, one must have the necessary resources available to treat complications inherent to the bariatric endoscopic intervention.

**Determination of competence**

- Completion of formal residency training in gastroenterology or surgery that incorporates structured experience in gastrointestinal endoscopy. Competence should be documented by the instructor(s).
- The Accreditation Council for Graduate Medical Education has mandated that programs in surgery and gastroenterology must provide experience to each resident in the performance of esophagogastroduodenoscopy and colonoscopy.
- Endoscopic training and experience outside a formal residency program after satisfactory completion of an ACGME accredited general surgery, pediatric surgery, colorectal surgery, gastroenterology, or the equivalent. Equivalent training and/or experience obtained outside a formal program is recognized, but must be at least equal to that described above. Certification of experience by a skilled endoscopic practitioner must include a detailed description of the nature of “informal” training, the number of
• Demonstrated proficiency in endoscopic procedure(s) and clinical judgement equivalent to that obtained in a residency program. This generally requires participation in gastrointestinal endoscopic training until competence in the specific procedure(s) is equivalent to that which would have been obtained upon completion of a residency program that incorporates structured experience in gastrointestinal endoscopy.

• The applicant’s endoscopic director should confirm in writing the training, experience (including the case volume for each procedure for which privileges are requested) and actual observed level of competency. It is recognized that by virtue of completing a residency program, the endoscopist will have acquired sufficient cognitive experience in anatomy, physiology, and disease processes, combined with the progressive development of visual and psychomotor skills and experience necessary for the performance of diagnostic and therapeutic procedures in the gastrointestinal tract. Such experience includes indications, complications and their management, and alternative approaches. The training director’s opinion and recommendation should be considered prima facie evidence for the trainee’s acceptance as an individual qualified in gastrointestinal endoscopy. Documentation and demonstration of competence is necessary.

• In addition, the management of bariatric patients will require for the endoscopist to be credentialed to perform bariatric surgery and if not, they should be an active member of an accredited, structured bariatric program that provides or coordinates comprehensive, interdisciplinary care of the bariatric patient.
Monitoring of Endoscopic Performance

To assist the hospital credentialing body in the ongoing renewal of privileges, a mechanism should be in place whereby each endoscopist’s procedural performance is monitored. This should be done through existing quality assurance mechanisms or, alternatively, through a multidisciplinary endoscopy committee. This should include monitoring endoscopic utilization, diagnostic and therapeutic benefits to patients, complications, and tissue review in accordance with previously developed criteria.

Recommendations

It is strongly recommended that all the facilities in which endoluminal bariatric procedures participate with the MBSAQIP, including compliance with data entry of all endoluminal bariatric procedures into the national outcomes registry. Requirements in this document as they pertain to the MBSAQIP also can be fulfilled by participation in an equivalent approved statewide or national bariatric quality improvement program. It is important to have institutional support for data management, bariatric surgery infrastructure, and personnel. All endoscopists performing advanced endoscopic bariatric procedures in accredited facilities are required to participate with the MBSAQIP or an equivalent regional/national quality improvement program, which involves submission of all endoluminal procedures performed at the accredited institution and periodic review of outcomes.

Recommended endoscopist requirements include the following:
• Participation within a structured endoscopic bariatric program that provides or coordinates comprehensive, interdisciplinary care.

• Commitment to use endoscopic bariatric clinical pathways.

• Investigational procedures or non-FDA approved endoscopic devices should be performed under an IRB-approved protocol.

• Continued active participation within a structured bariatric surgery program. Ongoing participation with the MBSAQIP program or an equivalent local/regional/national quality improvement program.

• The endoscopist must demonstrate continued critical assessment of his/her outcomes as determined by periodic review of outcomes from an acceptable regional or national outcomes registry.

• The chief of surgery and/or endoscopy or his/her designee should verify that these criteria have been met.

References

