ASGE, AASLD, ACG, and AGA Statement Regarding the ABS Mandate for Surgery Resident Training in Endoscopy

The American Society for Gastrointestinal Endoscopy (ASGE), the American Association for the Study of Liver Diseases (AASLD), the American College of Gastroenterology (ACG), and the American Gastroenterological Association (AGA) have developed the following position statement in response to the American Board of Surgeons' (ABS) recently established guideline regarding surgery resident training in endoscopy. The new ABS guideline requires all surgery residents to perform 50 colonoscopies and 35 upper endoscopies as part of the requirements for surgical training. Many surgical training programs, however, are not equipped to meet the requirements of this training mandate. This training requirement is not only an added manpower burden (often requiring that surgical residents train with gastroenterologists), but also is of concern regarding the quality of endoscopic training, especially when the surgical residents are required to perform only a fraction of the procedures necessary to achieve competency. If we are to train surgical residents in endoscopy, we should be training them to become competent endoscopists, and all trainees should be held to the same quality standard regardless of the type of training program (surgical residency or gastroenterology fellowship).

It is the position of the ASGE, AASLD, ACG, and AGA that:

1. The ABS procedure number requirements for endoscopy are inadequate to achieve training and/or competency, and should not be considered as part of training criteria for surgery.

2. The ABS numbers should be seen as a means to provide basic experience in endoscopy, however, similar to other surgical procedures, surgeons wishing to incorporate endoscopy into their practices will require substantial additional training beyond the ABS experience figures.

3. The ASGE, AASLD, ACG, and AGA encourage medical and surgical endoscopists at training programs to work together and through a consensus process create the means to achieve their educational goals and ensure practitioners performing endoscopy are well trained and provide quality endoscopy.

Though the ABS does not state that completion of this requirement makes these residents competent in endoscopy, the ASGE, AASLD, ACG, and AGA are concerned that this brief exposure to endoscopy during surgical endoscopy training is then being used to obtain privileges in endoscopy once a surgical resident completes training. This endoscopic exposure during surgical residency falls far short of the ASGE guidelines for training in endoscopy. This new ABS mandate for endoscopy training during surgical residency does not address cognitive competency and the numbers fall far below the ASGE minimum requirements of 140 colonoscopies and 130 upper endoscopies that must be performed before technical competency

can even be assessed. Even at this minimum volume, competency is rarely achieved (therefore, the established threshold is for assessing competency, not achieving competency). A recent study by Spier et al[1] looking at procedural competence found that after 140 colonoscopies, no trainee exhibited procedural competency. By 500 procedures, however, all fellows had achieved procedural competency benchmarks. Other data suggest certain competency benchmarks are reached on average between 200 and 300 procedures.[2] In light of these new data, the ASGE is revising its minimum requirement for training in endoscopy to be published later this year in a revised "Principles for Training in Gastrointestinal Endoscopy."

Competence, as defined in this and other ASGE guidelines,[3] is the minimal level of skill, knowledge and/or expertise derived through training and experience that is required to safely and proficiently perform a task or procedure. Specific components, as outlined by the ASGE in "Guidelines for Credentialing and Granting Privileges in Gastrointestinal Endoscopy," include the ability to integrate gastrointestinal endoscopy into the overall clinical evaluation of the patient. This includes a thorough understanding of the indications, contraindications, risk factors, and risk-benefit considerations for the individual patient. In addition, the endoscopist must be able to identify and interpret endoscopic findings accurately, appropriately manage, endoscopically or otherwise, the patient based on their endoscopic findings, and have the cognitive and technical expertise to handle complications. The importance of considerable formal training in endoscopy in the United States and Canada is underscored by evidence that physicians who are intensely trained in endoscopy are more proficient at colonoscopy than other physicians. A recent large population-based study of 50 to 80 year olds in Ontario, Canada, showed that patients who had their colonoscopy in a hospital performed by physicians who were not intensively trained in endoscopy were at significant increased risk of subsequent incident colorectal cancer (CRC).[4] A U.S. study done at 20 Indiana hospitals reported that the risk of missed CRC was higher for patients with procedures performed by non-intensely trained physicians.[5]

The ASGE, AASLD, ACG, and AGA are committed to excellence in endoscopy and this begins with high-quality, intensive training for all physicians that will later be privileged to perform endoscopy in practice. Inadequate endoscopy experience and training during fellowship or residency leads to increased complications, poor outcomes and exposes patients to unnecessary risks.

References:

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2. Chung JI, Kim N, Um MS, et al. Learning curves for colonoscopy: A prospective evaluation of gastroenterology fellows at a single center. *Gut* 2010;4:31-35.
3. ASGE Technology Committee. *Ensuring Competence in Endoscopy* prepared jointly by the ASGE Task Force on Ensuring Competence in Endoscopy and the ACG Executive and Practice Management Committees, 2005.
4. Rabeneck L, Paszat L, Saskin R. Endoscopist specialty is associated with incident colorectal cancer after a negative colonoscopy. *Clin Gastro Hep* 2010;8:275-79.
5. Rex DK, Rahmani EY, Haseman JH et al. Relative sensitivity of colonoscopy and barium enema for detection of colorectal cancer in clinical practice. *Gastroenterology* 1997;112:17-23.