

- Professional independence

Chinese credentialling and revalidation

- 600 AD examinations for qualification
- Physician rated according to successes and failure
- 1100 AD formal schools
- Professors fined for their students' poor performance
- 13 specialties by 14th Century

De-credentialling in Ancient Babylon

Code of Hammurabi, 18th Century BC

- "If a Physician make a large incision with the operating knife and kill him.....his hands shall be cut off"

REFERENCES

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2. Joint Committee on Higher Medical Training. Curriculum for higher specialist training in gastroenterology. London, July 1998
3. American Society of Gastrointestinal Endoscopy. Guidelines for credentialing and granting privileges for gastrointestinal endoscopy. *Gastrointestinal Endoscopy* 1998; 48: 679-682.
4. American Board of Internal Medicine. Subspecialty Board on Gastroenterology. Internet 2001.

Credentialling in endoscopy - A multidisciplinary model

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Training in a procedural skill such as endoscopy is an ideal model to outline training programmes for health professionals. World wide the practitioners of endoscopy vary in their background and training. In some parts of the world, all of endoscopy is done by clinicians of internal medicine background whilst, in other parts of the world, it is solely the domain of clinicians with a surgical background. In most countries, a mix exists and this mix is expanding to incorporate clinicians from other specialties and, for some countries, nurse practitioners who carry out certain types of endoscopic procedures.

In Australia (for example), training is conducted by a conjoint committee for the recognition of training in gastrointestinal endoscopy.

SIGNIFICANT NOTES:

What is endoscopy?

- Diagnostic tool for digestive conditions
- Means for therapy of digestive conditions
- Mode for access to the digestive system

Modes for access to the digestive system

- Endoscopy
- Open surgery
- Laparoscopy/thoracoscopy
- Percutaneous - image controlled

Endoscopists

Specialists

- physician gastroenterologists
- digestive surgeons
- pediatric gastroenterologists

Generalists

- physicians
- surgeons
- radiologists

Rural/remote area

- general practitioners

Others

- nurse practitioners

"Who should do endoscopy?"

"...those with an interest and practice in gastroenterology, whether it be medical or surgical and who have achieved the required standard of training."

Principles

- Endoscopy is done by doctors who practice gastroenterology (physician or surgeon) and achieve a required standard of training
- Recognition of cognitive as well as procedural training

Committee structure

- Equal representation from physician and surgeon
- Representation from :
 - GESA (1 physician, 1 surgeon)
 - RACP (2 - physicians)
 - RACS (2 - surgeons)
 - Rural surgery and medicine (2)

Guidelines

- Learning under supervision of recognised endoscopist
- Approved facilities
- Combine cognitive and procedural training
- Principles and practice of cleaning and disinfection

Requirements

- Complete a minimum number of supervised procedures
- Maintain a log book of all procedures signed by supervisor
- Satisfactory report from supervisor
- Complete specialist training [Colleges] (gastroenterology or GI surgery)

Supervisor

- Endoscopist (physician or surgeon) in active, approved unit
- Recognized by Conjoint Committee in area of Endoscopy

Endoscopy training

- Gastroenterologists
 - upper endoscopy
 - colonoscopy
- Digestive (General) Surgeons
 - upper endoscopy
 - colonoscopy
- Optional
 - ERCP

Credentialing

- Hospital Boards seek information as part of deter-

mination of competence to practice

- No certificate
- No specific qualification - (Colleges)

Summary

- “Conjoint Committee” sets a standard of training in endoscopy for Australia
- Colleges and GESA underpin these standards

Conclusion

- Training in endoscopy is a model for training in procedural medicine
- Multidisciplinary requirements recognized
- Objectives of training defined

Results of training are accessible to evaluation and assessment

Endoscopic Simulators

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A simulator as a training tool is well established, especially in aviation.¹ The airline industry has demonstrated that by using flight simulators, the skills of pilots may improve and mistakes be avoided, thus saving lives.² Therefore, it is natural to use simulators in medical training as well, especially in fields such as laparoscopy,³ cardiology^{4,5} and anesthesiology.^{6,7} Changes in medicine, legal awareness and progress in technology have contributed to greater use of simulators in medical training.

Endoscopy requires a minimal number of procedures to achieve competence. Various organizations have different standards as to the minimal number of procedures needed. It ranges between 100-300 for esophagogastroduodenoscopy, 100 for colonoscopy and 100-200 for ERCP.⁸⁻¹¹ Therefore, any device which saves time would be valuable. An endoscopic simulator obviously saves time, as the trainee can learn and be tested quickly and safely, with less discomfort for patients, and less supervision time.