POSITION STATEMENT

ABE/ASGE position statement on training and privileges for primary endoscopic bariatric therapies

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The Association for Bariatric Endoscopy (ABE), a division of the American Society for Gastrointestinal Endoscopy (ASGE), was established to provide state-of-the-art education and practice support to endoscopists who have an interest in endoscopic bariatric management, with an emphasis on ensuring high-quality healthcare for patients with obesity. This document outlines the fundamental principles for effective training to provide comprehensive care, acquisition of the requisite endoscopic skills, and ensuring that quality care is provided as endoscopic bariatric procedures are integrated into practice.

Abbreviations: ABE, Association for Bariatric Endoscopy; ASGE, American Society for Gastrointestinal Endoscopy; EBT, endoscopic bariatric therapy

DISCLOSURES: The following are the conflicts of interest disclosed at the time of submission. All authors consulted openpayments.gov. Dr Kumar was previously a consultant for Aspire Bariatrics. Dr Abu Dayyeh is a consultant for Metamodix, BFRW, DynaMx, Boston Scientific, and Medical Device Business Services; the recipient of research support from Apollo Endosurgery, USGI, Spatz Medical, GI Dynamics, Caarin Diagnostics, Aspire Bariatrics, and Medtronic; and a speaker for Johnson and Johnson, Endogastric Solutions, and Olympus. Dr Dunkin was a consultant for Boston Scientific, Ethicon, Medtronic/Covidien, and Olympus; has ownership interests in Surgiwise and Orhtel; and is an advisor to and the holder of stock in ClearCam and Allo trope Medical. Dr Neto is a consultant for Fractyl, GI Dynamics, GI windows, Apollo Endo Surgery, USGI, Cohlbris Mx, and Keyron and a speaker for Ethicon Endo Surgery, Medtronic, and Olympus. Dr Gomez is the recipient of consulting fees from Olympus. Dr Kumbhari is a consultant for Apollo Endosurgery, Boston Scientific, Medtronic/Covidien, FujiFilm, Pentax Medical, ReShape Lifesciences, and Obalon and the recipient of research support from ERBE and Apollo Endosurgery. Dr Pannala is a consultant for HCL Technologies; the recipient of research support and general payments from Apollo Endosurgery, and the recipient of general payments from Boston Scientific, Abbvie, and Olympus. Dr Ryou is a consultant for Medtronic/Covidien, Pentax, Olympus, Fuji, Boston Scientific, EnteraSense, and GI Windows and a stockholder in GI Windows. Dr Sullivan is a consultant for Aspire Bariatrics, USGI Medical, Obalon Therapeutics, GI Dynamics, Elrta, Spatz FGIA, Endo Tools Therapeutics, Phenomix Sciences, and Nitnote; the recipient of research support from Aspire Bariatrics, Allurion, BARONova, Elrta, Finch Therapeutics, Obalon Therapeutics, and ReBiotic; and the holder of stock warrants from Elrta. Dr Thompson is the recipient of research support from Aspire Bariatrics, Boston Scientific and the recipient of general payments from Olympus Corporation, Boston Scientific, Spiration Inc, Coridien LP, Apollo Endosurgery, Aspire Bariatrics, FujiFilm New Development, ERBE USA Microtech Endoscopy, Endogastric Solutions, and Olympus Latin America. The other authors disclosed no financial relationships.

PURPOSE

Obesity is a multiorgan systemic chronic disease for which GI endoscopy plays an increasing therapeutic role. As with the treatment of any disease, endoscopic treatment of obesity and its attendant metabolic comorbidities require both technical skill and an understanding of pathophysiology. The purpose of this statement is to outline principles and provide practical guidelines to assist credentialing committees in granting privileges to physicians to perform bariatric endoscopy and to ensure that appropriate care is provided before and beyond the endoscopic procedure.

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Appropriate training in GI endoscopy is critical to providing quality endoscopic care. In 2002 the ASGE, with the Society of American Gastrointestinal Endoscopic Surgeons and the American Society of Colon and Rectal Surgeons, established training guidelines that state that the acquisition of endoscopic skills should be in the context of training programs in gastroenterology or surgery, and these were updated by the ASGE in 2017. Privileging or credentialing for the performance of endoscopic bariatric therapy (EBT) should be based on prior demonstration of proficiency and competence in the performance of these procedures. The ASGE and the American Society for Metabolic and Bariatric Surgery have stated that a multidisciplinary approach, using a program that provides comprehensive care and postprocedure weight loss maintenance, is essential to ensure optimal care of the patient with obesity. Training should include an understanding of the role of diet therapy, exercise therapy, behavior modification, and pharmacotherapy. Ultimately, it is the responsibility of the endoscopist to ensure that proper procedure utilization and high-quality multidisciplinary care are in place before performing EBT.

PRINCIPLES

The 3 essential principles for provision of quality EBT are as follows: broad and in-depth understanding of the management of patients with obesity, mastery of GI endoscopic skills, and procedure- and device-specific knowledge necessary to provide specific EBTs and manage potential associated adverse events. Criteria for assessing competence for each procedure will be established, and competence for each should be substantiated by documentation.

Management of patients with obesity

The ASGE Position Statement on Endoscopic Bariatric Therapies in Clinical Practice outlines program requirements for the integration of EBT into existing practice. These include current knowledge and understanding of lifestyle interventions, behavior modification, pharmacotherapy, and bariatric surgery (including the American Heart Association/American College of Cardiology/The Obesity Society Guideline for the Management of Overweight and Obesity in Adults), in addition to current knowledge regarding EBT.

Endoscopic skills

The ASGE, along with other digestive disease organizations, has developed and approved Standards of Practice of Gastrointestinal Endoscopy and a statement of Principles of Endoscopic Training to represent endoscopists in gastroenterology and surgery. These requirements specify that residency or fellowship training in GI endoscopy is necessary, with documentation of skills and competence. Specifically, completion of formal structured training in an Accreditation Council for Graduate Medical Education–accredited training program in adult or pediatric gastroenterology or general surgery is necessary. These standards apply uniformly to all endoscopists, regardless of specialty. The ASGE Guidelines for Privileging, Credentialing, and Proctoring to Perform GI Endoscopy provide a model for the acquisition of technical and cognitive endoscopic skills within the context of training in digestive diseases, establishing competence, and awarding privileges.

EBT procedure- and device-specific knowledge

Physicians should have comprehensive knowledge of the indications, contraindications, risks, benefits, and outcomes for EBT. Because EBTs vary across a spectrum of requisite technical skill and procedural risk, privileges should be granted on a procedure-specific basis. The degree of training, direct supervision, and proctoring will vary, but verification of competence is necessary. Subspecialty board certification or membership in national or international societies should not be the primary criterion for granting EBT-specific procedural privileges.

The ASGE and the American College of Gastroenterology have defined the tenets of endoscopic competence and skills (Table 1) as follows:

- Competence is the minimum level of skill, knowledge, and/or expertise, derived through training and experience, required to safely and proficiently perform a task or procedure. It encompasses knowledge of endoscopic anatomy, technical features of endoscopic equipment, and use of accessories.
- A minor skill is a novel technique or procedure that is a minor extension of an accepted and widely practiced technique or procedure. An example is placement of endoscopic balloons. For most GI endoscopists, attaining competence will entail completion of a short course including didactic education followed by practical exposure in a short course.
- A major skill is a new technique or procedure that inherently involves a high level of complexity (and additional risk) and/or new type of technology. An example is sutured endoscopic sleeve gastroplasty. Acquisition of competence is initially demonstrated at teaching centers. The ASGE Methods of Privileging for New Technology in Gastrointestinal Endoscopy document states that formal instruction or preceptorship, which includes evaluation, is mandatory for the acquisition of major skills; completion of a short course that offers limited exposure will not be sufficient to attain clinical competence.

PHYSICIAN CERTIFICATION

In addition to education and training, certification or recognition of completion of a formal didactic curriculum and procedural exposure should be developed for
endoscopists who wish to perform endoscopic bariatric procedures. Eligible physicians will have completed an accredited gastroenterology fellowship or general surgery residency with an endoscopy component.

Didactic education

The ABE, ASGE, and Society of American Gastrointestinal Endoscopic Surgeons plan to provide courses, which will

- Allow endoscopists to objectively determine the appropriate EBT and all alternatives, including behavioral, pharmacologic, endoscopic, and/or surgical
- Provide comprehensive knowledge of indications, outcomes, risks, benefits, and contraindications of specific EBT
- Provide knowledge of endoscopic anatomy, equipment, and procedure technique, including recognition of and management of adverse events.

These courses should provide the fundamental knowledge base to deliver care for patients with obesity. State-of-the-art continuing education programs will evolve to include developments in technology and procedure techniques. Assessment of knowledge after didactics should take place in the form of an examination.

Procedural education

The method of education will vary according to the specific knowledge and technical demands of the EBT. The ABE and ASGE are working with partners to develop and offer dedicated short courses as well as courses integrated with meetings. These courses (as well as completion of formal didactics and, if applicable, examination completion) will offer a certificate of successful demonstration of knowledge and skill attainment.

PHYSICIAN PRIVILEGES

Privileges refer to authorization by an institution for an individual to perform a procedure based on education, license, training, experience, competence, and other factors. Each institution must define criteria to award privileges. The ABE and ASGE recommend that privileges be awarded in a standardized fashion to endoscopists who have met training requirements for endoscopy and who have demonstrated competence relevant to the performance of a specific EBT. For the assessment of major skills, proctors may be necessary. The proctor should be an independent and unbiased monitor capable of evaluating both cognitive and technical skills. Periodic renewal of privileges should be determined by demonstration of continuing education, quality assurance data, and clinical activity. For example, in the United States the Joint Commission mandates renewal of clinical endoscopic privileges at least every 2 years for hospital-based endoscopy centers; ambulatory surgical and endoscopy centers require renewal of clinical endoscopic privileges at least every 3 years, unless otherwise required by state law.

ASSESSMENT OF QUALITY

The ASGE has outlined metrics to monitor the quality in the delivery of endoscopy, delineating a pathway to quality improvement. The ABE supports the use of quality tracking in the delivery of EBTs. Metrics that can be applied to EBT include the rate of eating disorders in patients selected for EBT; the rate of early device removal, if relevant; the rate of dietary, lifestyle, and behavioral therapy during follow-up; 6- and 12-month follow-up rate; procedure- or device-related adverse events; and weight maintenance rate during follow-up. Additional EBT-specific measures will be developed as therapies enter practice. The ABE supports the development of a registry for EBTs to track quality measures and outcomes and encourages institutions performing EBTs to develop multidisciplinary quality improvement programs that integrate nutrition and behavioral providers.

PROGRAM RECOGNITION

To promote quality and safety in endoscopy, the ASGE recognizes endoscopic units that follow guidelines on privileging and quality assurance through its Endoscopy Unit Recognition Program. Additionally, detailed guidelines to ensure safety during endoscopic procedures have been published by the ASGE. Although such a program for bariatric endoscopy units remains under consideration, the following can provide a roadmap for EBT programs under development.

Staff

The bariatric endoscopy program should be directed by at least 1 physician with expertise in bariatric endoscopy. Support staff within the center or its referral network should be able to provide the following services:

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<th>TABLE 1. Endoscopic skills</th>
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<tr>
<td>Minor skill</td>
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<tr>
<td>Type</td>
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<tr>
<td>Extension of widely practiced technique</td>
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<td>Major skill</td>
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• Comprehensive care for patients with obesity, provided by a physician
• Behavior modification, provided by a psychiatrist, psychologist, or other independently licensed behavioral health provider with specific training in the care of patients with overweight, obesity, and eating disorders
• Nutrition or obesity medicine, provided by a registered diettian or physician with specialty certification
• Physical or exercise therapy
• Lifestyle modification

**Facility and office**

Equipment should allow accommodation of patient weight and size, including examination tables, procedure tables, blood pressure cuffs, sequential compression sleeves, gowns, wheelchairs, walkers, chairs, and scales. Facility design and construction including doorways and bathroom facilities should be undertaken with consideration of patient weight and size.

**Procedural care**

Periprocedural care should include instructions on diet, activity, and follow-up. Procedural safety guidelines should delineate risks specific to the care of patients with obesity, including the provision of airway management and Advanced Cardiovascular Life Support (ACLS) during procedures and recovery. Follow-up care should be provided in accordance with the EBT performed and should include multidisciplinary support to maintain weight loss.

**CONCLUSION**

Obesity is a chronic and complex disease; however, a multidisciplinary approach including endoscopic therapies will provide a more complete spectrum of care, allowing a more individualized approach and potentially better outcomes. As these endoscopic therapies are approved and integrated into practice, the ABE is committed to ensuring safety and quality in the delivery of EBTs. Endoscopists must be able to determine when EBT is appropriate and must ensure that patients are part of a comprehensive and multidisciplinary program before and after the procedure. The ABE is working in concert with other societies to develop the requisite didactic and procedural education and physician certification to allow endoscopists to optimize quality and safety in the delivery of endoscopic care to patients with obesity.

**REFERENCES**