# The New Zealand Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy

*Quality Endoscopy by Quality Endoscopists.*

The Conjoint Committee is a National Body comprising representatives from the New Zealand Society of Gastroenterology (NZSG), the New Zealand Committees of the Royal Australasian College of Physicians (RACP) and Royal Australasian College of Surgeons (RACS). The Committee has responsibility for the provision of guidelines relevant to the acceptable standards of training in Gastrointestinal Endoscopic procedures and the maintenance of a register of specialists who have attained these standards.

Endoscopists who have received NZCCRTGE recognition of training may opt-in to have their details included on a publicly available online register. NZCCRTGE will not provide details of endoscopists to third parties except through this method. Inclusion of an endoscopist on the online register demonstrates that they met the recognition of training criteria at the time of application and is not a surrogate for current competence (which is determined through local credentialing).

**Table of Contents**

## PURPOSE

In order to support the provision of quality endoscopy in New Zealand, the major purpose of the NZCCRTGE is to provide;

1) Guidelines regarding standards of training in Endoscopy for trainees in Advanced Training Programs.
2) A peer-review assessment as to whether a trainee has met these standards (recognition of training)

Once training has commenced, trainees must record their training according to the guidelines as outlined below. Trainees must complete a minimum number of supervised training procedures to gain experience before they can submit their application for recognition of training. Trainees applying for recognition of training in endoscopy should forward the log books of their experience together with their completed training assessment (PBA/ ANZ Conjoint DOPS) forms and two Referee reports as outlined below so that their application can be assessed against the criteria. NZCCRTGE does not directly provide endoscopy training, which is the responsibility of the Royal Colleges and designated training organisations.

The provision of documentation demonstrating recognition of training in endoscopy from NZCCRTGE may be used to support credentialing decisions. It does not replace usual hospital credentialing processes, which should ensure safe endoscopy practice over time. Responsibility for credentialing of endoscopists to practice in New Zealand remains with the host institutions e.g. DHBs, and responsibility for ongoing skill maintenance and continuing medical education (CME) remains with the practitioners.

## GUIDELINES

The following requirements are based on current literature regarding the usual minimum exposure required to gain independence and utilise a variety of methods of assessment of skill. Some trainees will require substantially more than the minimum exposure, while others may acquire skill more rapidly. Logbooks should include all procedures attempted while under supervision on the training programme, whether independently completed or assisted.

Competence in endoscopy requires more than just gaining the technical skill to perform the procedure. It is important for trainees to have a comprehension of the anatomy and physiology of the GI tract, understand and recognise the pathology they may encounter and make sound management decisions. This knowledge is gained in other parts of the Advanced Training Programmes for Gastroenterology, General Surgery and Nurse Endoscopy and is not specifically assessed by NZCCRTGE.

At commencement of training, trainees must be registered with the NZCCRTGE. All trainees in the Advanced Training Programmes for Gastroenterology, General Surgery and Nurse Endoscopy are considered to be automatically registered in the first year of their training, and should be notified to the NZCCRTGE either by their training body or can individually inform the NZCCRTGE (nurse endoscopists should identify themselves when they apply for the basic endoscopy course). Registration as an endoscopy trainee will expire after a maximum of eight years, unless an extension is requested.

The NZCCRTGE specifically notes that at the time of establishment of the committee, Nurse Endoscopy was not considered as a future vocation. The role of the NZCCRTGE in relation to Nurse Endoscopists and Endoscopists who are not members of RACP or RACS (or the vocational equivalent as determined by MCNZ) is not explicitly stated. In the interests of providing a consistent peer-reviewed service for recognition of training that is accessible to Endoscopists from all backgrounds, NZCCRTGE will accept applications from Nurse Endoscopists to support DHB credentialing processes. It is expected that hospitals credentialing Nurse Endoscopists will have processes in place to manage sedation prescribing and patient follow up, as well as providing sufficient collegial support to Nurse Endoscopists. NZCCRTGE notes that recognition of training for nurses is not currently offered by CCRTGE in Australia and so reciprocal recognition for this group will not occur. Overall responsibility for governance of nursing practice remains with the Nursing Council.

The Medical Council of New Zealand (MCNZ) has noted that the only two medical specialties that have endoscopy as a part of their vocational scope are Physicians within the scope of Internal Medicine and General Surgeons. Other medical practitioners who wish to undertake endoscopy may only do so in a Collegial relationship with a practitioner who holds the correct vocational scope. While technical training in endoscopy may be acquired through an apprenticeship model, this does not necessarily provide the additional knowledge of anatomy, physiology, pathology and patient management that is gained in an Advanced Training Programme. NZCCRTGE recommends that where other types of medical practitioner wish to train in endoscopy, they must do so in a collegial relationship with a vocationally registered practitioner who holds the correct scope of practice. Prior to commencing training they must present to NZCCRTGE a training plan that outlines how the endoscopy syllabus learning objectives usually gained within an Advanced Training Programme will be met and how this will be documented, as well as how the technical training will occur. The RACP and/or RACS endoscopy syllabi may be used as a guide. It is strongly encouraged that evidence of DHB support be provided to ensure the practitioner has a clear expectation that they can be employed performing endoscopy once training is complete. This should include a provision for appropriate ongoing collegial support, as required by MCNZ. NZCCRTGE reserves the right to decline recognition of training if there is concern that training outside an Advanced Training Programme has not adequately prepared the practitioner for practice.

The NZCCRTGE reserves the right to co-opt advisors with additional specialist knowledge where that may help to progress an application, e.g. senior Nurse Endoscopists, Paediatric endoscopists, ERCP specialists.

## PRINCIPLES

1. Patient safety and comfort is of paramount importance in Endoscopy training and successful completion of the procedure for the patient is the primary goal during training.
2. Equity and partnership with Maori and Pasifika should underpin all decisions related to endoscopy training
3. Training in Gastrointestinal Endoscopy should occur in appropriately equipped facilities.
4. Exposure to Gastrointestinal Endoscopic procedures within any given facility should be available to all trainees, including physicians, surgeons and nurses on an equitable basis.
5. Training implies an expression of vocational ambition in Internal Medicine (Gastroenterology), Gastrointestinal Surgery or Nurse Endoscopy.
6. Cognitive and interpretive skills combined with a clear understanding of the role of Gastrointestinal Endoscopy in management are as important as technical skills. This can include (but is not limited to) attendance at radiological and histological teaching sessions and relevant operations.
7. Non-technical skills, in particular in communication and collaboration are essential for endoscopy practice
8. Endoscopists should understand the principles and practice of cleaning and disinfection of instruments in accordance with current guidelines.
9. Endoscopists must be competent in the safe use of procedural sedation and management of sedation related complications should these occur
10. Appropriate training in fluoroscopic theory and practice should be obtained where this is relevant to future practice.
11. The applicant must complete the specified minimum number of procedures under supervision before the logbook can be submitted.
12. Satisfactory training assessments (PBA/DOPS) and a satisfactory report from two referees will be required at the completion of the training program.
13. Reciprocal recognition of training will be maintained with Australia to ensure Trans-Tasman parity, with the exception of Nurse Endoscopy.
14. The NZCCRTGE encourages all endoscopists to maintain Continuing Medical Education (CME) in endoscopy on a regular basis and to actively participate in audit of their own endoscopic practice.
15. The NZCCRTGE explicitly acknowledges that recognition of training does not attest to an assessment of competency. Recognition of training does not guarantee the right to practice endoscopy, which is determined by hospital credentialing processes.

# SPECIFIC REQUIREMENTS FOR ENDOSCOPY PROCEDURES

Information Sheets and Forms

*** Capsule endoscopy requirements are addressed separately at the bottom of the IPP section ***

## Log Book

Details of all cases attempted must be included in the logbook provided as a complete record of training, with sign off by a designated supervisor on a regular basis. The logbook is expected to provide a validated and verifiable record of the training that occurred. A cover sheet demonstrating the essential KPIs will form the basis of the logbook assessment, with the complete logbook data supporting that. Patient privacy must be protected at all times, so unique identifiers must be removed prior to submission. Identifiers however must be accessible and able to be matched to the log in case of the need for verification. Paper logbooks will continue to be accepted for part or all of the training experience for trainees who commenced training prior to 2021. Procedures recorded in the GESA logbook for training that was conducted in Australia will be accepted, however to apply for recognition of training in New Zealand a proportion of the training must have been undertaken in New Zealand and there be a clear intention to work in New Zealand in the foreseeable future.

Successful independent completion of the procedure without assistance is the primary Key Performance Indicator (KPI). As recording of KPIs requires the denominator to be accurate, an attempted colonoscopy is defined as a colonoscopy undertaken with the intention to inspect the entire colon (reach the caecum/TI/neo-TI) in a patient with a fully prepared colon (e.g. has taken oral bowel prep). A procedure is considered to be independently performed if the supervisor did not need to physically intervene in any part of the procedure in order to ensure completion. Where a trainee has successfully completed the diagnostic part of the procedure (e.g. reached the caecum) but the supervisor needs to undertake an intervention (e.g. polypectomy) the trainee should record the procedure as being completed independently but should not log the intervention.

Interventions undertaken by the trainee and complications should be recorded. All procedures must be verifiable. The NZCCRTGE reserves the right to check the accuracy of applications as required. This may involve audit of a proportion of applications, including run-sheets and visual confirmation of completeness of procedure from reports (e.g. picture of TI, appendix orifice). Suspected falsification of logbooks will automatically be referred to the MCNZ or NCNZ Professional Standards Team for review. Logbooks must be signed off by the designated trainee supervisor..

Logbooks must be submitted within five years of completion of training (the date of the final entry in the logbook). Logbooks must clearly include interventions performed, with skill in injection and endoscopic clipping demonstrated. These skills are transferrable.

## Upper Gastrointestinal Endoscopy

These requirements take effect for trainees immediately, as the KPIs remain unchanged. Training assessment forms (PBA/DOPS) and Safe Sedation Training are required for all applications.

Trainees are required to -

- Perform a minimum of 200 Upper GI endoscopies under supervision. All independent and assisted attempts should be recorded as part of the training experience.
- A 95% D2 intubation rate or higher in the final 100 independent procedures should be achieved. Interventional procedures, and procedures where post surgical anatomy precludes reaching the duodenum e.g. gastric bypass may be excluded from the denominator.
- Examinations must include a minimum of 20 emergency or therapeutic procedures (excluding polypectomy) demonstrating the ability to handle instruments to achieve haemostasis.
    - The types of therapeutic procedures that may be counted are listed below.
        - Adrenaline

  - Argon Beam
  - Banding
  - Clipping
  - Coagulation
  - Dilation
  - Naso-jejunal feeding tube
  - PEG
  - Removal of a foreign body
  - Sclerotherapy
  - Stent
- Management of haemorrhage is an expected skill. As the skills for adrenaline injection, endoscopic clipping and haemostasis are transferrable between upper and lower GI endoscopy, haemostatic interventions for the colon can be recorded as part of the therapeutic procedures requirement, as long as this is clearly documented.

**Endoscopic Retrograde Cholangio-Pancreatogram (ERCP)**

These specific requirements take effect for trainees commencing their ERCP training in 2021 and beyond. Trainees who commenced training prior to 2021 including those who were selected in 2020 may choose to submit their logbook under the previous requirements, or the updated requirements. Safe Sedation Training is required for all applications from 2021, regardless of when training commenced, with four DOPS required for all applications from 2022. Trainees are required to -

- Have previous recognition of training in upper gastrointestinal endoscopy.
- Perform a minimum of 200 supervised ERCPs in patients with intact papillary sphincters. All independent and assisted attempts should be recorded as part of the training experience, including patients with previous sphincterotomies.
- An >90% cannulation rate for the target duct should be achieved in the 50 cases before completion of training
- Procedures performed must include a minimum of 80 supervised, independently performed sphincterotomies in patients with intact papillary sphincters
- A minimum of 60 stents should be placed, including plastic CBD or pancreatic stents, and metal stents. These should be supervised, and independently performed. The type of stent placed should be recorded in the logbook.
- At least four DOPS are required. The applicant must demonstrate independence in cannulation, cholangiogram interpretation, sphincterotomy; and in therapeutic manoeuvres for stone removal, stent placement and tissue sampling. Demonstration of competence will therefore require sufficient DOPS to document the full range of skills. While four DOPS is the minimum, more may be required to demonstrate

**Colonoscopy**

For calculating KPIs, unadjusted Colonoscopy Completion Rate (CCR) is calculated for all procedures attempted on patients who have had mechanical bowel prep and where the intention is to inspect the entire colonic mucosa. There are no exclusions, so the CCR is the total number of unassisted successes (to caecum, TI or neo-TI) divided by the total number of attempts.

Trainees who commenced training prior to 2021 including those who were selected in 2020 may choose to submit their logbook under the previous requirements, or the updated requirements. Training assessment forms (PBA/DOPS) and Safe Sedation Training are required for all applications from 2021, regardless of when training commenced.Trainees are required to -

- Perform a minimum of 200 lower GI endoscopies (including flexible sigmoidoscopy) under supervision. All independent and assisted attempts should be recorded as part of the training experience. This includes attempts in both intact and non-intact colons, and colonoscopy via stoma.

- Achieve an unadjusted Colonoscopy Completion Rate of >90% in the 50 cases before completion of training for all attempted colonoscopies (including both intact and non-intact colons, but excluding flexible sigmoidoscopy). Intubation of the terminal ileum should be attempted wherever possible, as a TI intubation KPI may be introduced in the future (target = 75% unadjusted).
- Perform successful, independent cold snare polypectomies in a minimum of 40 lower GI procedures.
- Perform a minimum of 10 successful, independent larger polypectomies with hot or cold snare (pedunculated polyps >1cm or sessile lesions 1-2cm requiring a lift technique) in lower GI procedures.
- Submission of one independent ANZ Conjoint DOPyS is required to demonstrate competence in polypectomy.
- Polypectomy rate, Adenoma Detection Rate (ADR) in patients over 50 years old who had a complete colonoscopy and withdrawal time should be recorded where able. These are not assessed KPIs for training, as these remain the responsibility of the supervising consultant rather than the trainee. Trainees should be aware of the importance of these KPIs

**Paediatric Colonoscopy and Paediatric Upper Gastrointestinal Endoscopy**

Trainees are required to –

- Perform a minimum of 100 unassisted, supervised, complete colonoscopies in patients with intact colons (i.e. no prior colonic resection)
- At least 75 procedures should be in paediatric patients (typically up to their 16th birthday) under the supervision of a recognised paediatric colonoscopist
- Achieve at least a >90% Caecal Intubation Rate in the 50 patients before completion of training, with an ileal intubation rate of >80%,
- Submit at least four satisfactory DOPS by a minimum of two different assessors using the ANZ Conjoint DOPS or an acceptable alternative
- Submit a scope cleaning log as for adult endoscopy
- Have two referees submit referee reports using the online form.

**Paediatric Upper Gastrointestinal Endoscopy**

Trainees are required to -

- Perform a minimum of 200 unassisted, complete examinations independently under supervision
- At least 100 procedures should be in paediatric patients (typically up to their 16th birthday) under the supervision of a recognised paediatric upper GI endoscopist
- Examinations must include a minimum of 20 therapeutic procedures,
    - The types of therapeutic procedures that may be counted are listed below.
        - Adrenaline
        - Argon Beam
        - Banding
        - Clipping
        - Coagulation
        - Dilation
        - Naso-jejunal feeding tube
        - PEG
        - Removal of a foreign body
        - Sclerotherapy
        - Stent
- Neither a polypectomy nor a biopsy may be counted as a therapeutic procedure.
- It is desirable that the examinations include some instances involving control of upper gastrointestinal bleeding.
- Submit at least four satisfactory DOPS by a minimum of two different assessors using the ANZ Conjoint DOPS or an acceptable alternative
- Submit a scope cleaning log as for adult endoscopy
- Have two referees submit referee reports using the online form

**Basic Safe Sedation Training**

Trainees are required to complete an appropriate basic course in safe sedation technique. Currently the American Society of Anaesthesiologists-endorsed SST-Moderate online course. ( https://www.safesedationtraining.com/ ) is recommended. Where available, local team-based scenario training is acceptable and encouraged, as long as equivalent learning objectives (especially around sedation safety and rescue) can be demonstrated. Documentation of local scenario training must be provided and verifiable. Other courses or training methods must be approved prior by NZCCRTGE. Safe Sedation Training will be a requirement for all applications submitted in 2021 onwards, with the exception of capsule endoscopy applications.

**Training assessment forms (PBA/DOPS)**

Trainees are required to submit a minimum of four satisfactory training assessments for each procedure type (gastroscopy, colonoscopy, paediatric endoscopy and ERCP). Acceptable training assessment forms include the online Procedural Based Assessment (PBA) and the ANZ Conjoint DOPS forms. These must be completed by a minimum of two different assessors. There is no maximum requirement and submission of training assessment forms from early in training demonstrating progress through training is encouraged. This requirement will be phased in, with two forms required for applications submitted in 2021 and four from applications submitted in 2022 onwards.

**Cleaning and Disinfection**

A minimum of 15 endoscopes must be cleaned under supervision by an experienced endoscopy nurse/technician. This should be recorded in the log book and be verifiable (i.e. the cleaning supervisor should be contactable if required). This is a requirement for all procedure types, but only needs to be completed once.

**Supervision and referees**

There must be a designated endoscopy supervisor for each run during which endoscopy training occurs. The endoscopy supervisor should:

- Be recognised by the NZCCRTGE in the particular type of Gastrointestinal Endoscopy, or be known to be of equivalent standard. In the absence of recognition by the NZCCRTGE, an attestation of equivalent standard of the supervisor 's training should be sent and held by the Committee from the training programme director
- Have personally supervised some of the applicants training and be in a position to comment on their skill and attest that the trainee is competent by using the referee report form
- The trainee is responsible for ensuring the accuracy of their logbook, which must be verified by the supervisor(s) on a regular basis. The endoscopy supervisor may be requested to help with validation at the request of the NZCCRTGE.
- Two referee reports are required for each procedure type, to be completed in the final stages of training, by independent referees. Links to the reports can be found on Information and Forms for Endoscopy Training Recognition » New Zealand Society of Gastroenterology (nzsg.org.nz)
- Where part of the training was undertaken in Australia, at least one referee must be from New Zealand and familiar with the trainees' current practice (including sedation safety).
- The NZCCRTGE may contact Supervisors or referees directly to discuss the trainees' practice and confirm the contents of the referees' reports.
- The referees should be able to attest that;
    - the candidate is competent to perform the procedures safely, including the safe provision of sedation
    - able to assess and integrate patient risk factors and indications for endoscopy
    - recognise and integrate endoscopic findings to formulate patient management plans
    - recognise and manage complications should these occur
    - recognise personal and procedural limits.

**APPLICATION**

Applications must be lodged on the online form. Please keep a copy of the files from your application for your records._The Committee will only review fully completed applications.. Please ensure all the documents required for the pathway and procedure are received by the deadline date for submission found on Apply for Recognition » New Zealand Society of Gastroenterology (nzsg.org.nz)

---

## Experienced Practitioner Pathway (EPP) for currently practicing endoscopists via New Zealand Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy (NZCCRTGE)

Quality Endoscopy by Quality Endoscopists.

**BACKGROUND**

NZCCRTGE has provided recognition of training for Endoscopists within Advanced Training Programmes for decades. Responsibility for conducting training remains with the training bodies (RACP and RACS) with the role of NZCCRTGE being to provide a collegial review of whether submitted logbook data meets the criteria laid out for recognition of training. The overall goal is to provide consistency for all Endoscopists regardless of training background. For a range of historical reasons, many competent endoscopists were not able to apply for recognition of training at the completion of their advanced training. NZCCRTGE aims to support this group of capable endoscopists by providing a mechanism for gaining recognition of training where this is needed. While non-mandatory in New

Zealand, holding NZCCRTGE recognition may be helpful in some circumstance (e.g. if wishing to practice in Australia).

NZCCRTGE recognition of training can be used in support of Hospital credentialing decisions, however the responsibility of determining practitioner competence for credentialing remains with the DHBs. As such, while encouraged, NZCCRTGE recognition of training is non-mandatory to gain Endoscopy credentialing in New Zealand. As Australia offers an EPP, the NZCCRTGE has introduced a comparable pathway to allow those who have not have the opportunity to obtain recognition of training to do so, should they wish to.

For calculating KPIs, unadjusted Colonoscopy Completion Rate (CCR) is calculated for all procedures attempted on patients who have had mechanical bowel prep and where the intention is to inspect the entire colonic mucosa. There are no exclusions, so the CCR is the total number of unassisted successes (to caecum, TI or neo-TI) divided by the total number of attempts. ADR is calculated for patients over 50 years old who had a complete colonoscopy.

## EXPERIENCED PRACTITIONER PATHWAY

EPP will be offered for adult gastroscopy, colonoscopy and ERCP, paediatric gastroscopy and colonoscopy, and capsule endoscopy.

Data from an electronic endoscopy reporting system (ERS) such as ProVation or Endobase (including retrospective) will be acceptable, but must include all sequential cases, and be verifiable (e.g. against hospital run sheets) where required. Data points for colonoscopy must include as a minimum Caecal (or TI/neo-TI) intubation, and polyp /adenoma detection for each case. Calculating ADR will require manual checking of histology outcomes unless the electronic reporting system includes this automatically. Where able, withdrawal time should be included also. For gastroscopy, extent of intubation (e.g. D2) must be recorded. Data should be contemporary with the final case in the logbook occurring within three months of submission (unless an explanation is given e.g. maternity leave).

If ProVation or Endobase data in a verifiable format is not available, then an Excel spreadsheet may be submitted as long as the data can be confirmed as accurate if required. Data should have any unique identifiers removed prior to sending, to preserve patient privacy, however it must be possible to rematch the identifiers to allow audit if needed. A proportion of applications may be audited for accuracy, with applicants expected to cooperate with and facilitate this process. Any applications where data manipulation (fraud) is suspected will be automatically referred to the NZMC. The EPP is not available for Nurse Endoscopists at this stage.

### *REQUIREMENTS*

The EPP is based on retrospective and prospective performance data, with a focus on KPIs and formal observation based against a structured assessment tool (ANZ Conjoint DOPS).

Applicant must;

- Have at least five years of endoscopy experience working as a specialist in New Zealand.
- Be able to provide evidence that they have been admitted as a fellow to a recognised New Zealand or Australasian Medical College at least five years prior to their application date, or hold equivalent vocational scope with MCNZ.
- Provide a clear logbook of at least 200 consecutive procedures for adult gastroscopy and colonoscopy or 100 consecutive procedures for paediatric gastroscopy/colonoscopy or adult ERCP, which can be retrospective but must be sequential and verifiable
- Provide at least **two ANZ Conjoint DOPS endoscopy skill assessment forms** for each procedure type, each completed by a directly observing Endoscopist colleague. The two colleagues who observe and complete the ANZ Conjoint DOPS should each be recognised by NZCCRTGE in the relevant procedure (or be of known equivalent standing).
- Gastroscopy requires a **D2 intubation rate of >95%** over 200 procedures. Interventional procedures should be recorded where these have occurred. Patients with post surgical anatomy

(e.g. bypass) and interventional procedures without intent to reach the duodenum may be excluded from the denominator.

- Colonoscopy requires an **unadjusted Colonoscopy Completion Rate (CCR) of 90%** over the 200 logged procedures and **an adenoma detection rate of >25%** which can be calculated over a minimum of the most recent 100 procedures.
- ERCP requires a cannulation rate for the target duct of >90% over 100 procedures. Stent placement should be recorded where this has occurred. The applicant must demonstrate independence in cannulation, cholangiogram interpretation, sphincterotomy; and in therapeutic manoeuvres for stone removal, stent placement and tissue sampling. Demonstration of competence will therefore require sufficient DOPS to document the full range of skills. While two DOPS is the minimum, more may be required to demonstrate this.
- Paediatric Gastroscopy requires a **D2 intubation rate of >95% over 100** procedures in paediatric patients plus at least one out of the two DOPS where an interventional procedure of a type routinely done in the applicants practice is observed by a colleague.
- Paediatric Colonoscopy requires a caecal intubation rate of >90% and terminal ileal intubation rate of >80% over 50 procedures in paediatric patients.
- Provide an **affidavit from the home DHB Endoscopy User Group (EUG)** confirming that there have been no significant complaints or concerns raised regarding your endoscopy practice within the past three years, and that the application is supported by the host institution e.g. DHB

*APPLICATION*

Applications must be lodged on the official form and emailed to the secretary. If you wish to courier your application, please contact the secretary in the first instance. Please keep a copy of your application for your records.

*Reference for Australian EPP*

https://www.conjoint.org.au/pathways.php#pathway4

---

## International Practitioner Pathway (IPP) for Internationally trained specialist endoscopists via New Zealand Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy (NZCCRTGE)

### INTERNATIONAL PRACTITIONERS PATHWAYS

All described options have independent assessment of practice as an underpinning principle.

IPP will be offered for adult gastroscopy, colonoscopy and ERCP, and paediatric gastroscopy and colonoscopy. There will be a fee to process applications.

A de-identified CSV log of ProVation data (including retrospective) must be supplied with a completed summary sheet. The log must include all sequential cases, and be verifiable (e.g. against hospital run sheets) where required. Data points for colonoscopy must include, as a minimum, caecal (or TI/neo-TI) intubation and adenoma detection for each case. This will require post procedure pathology review. Where available, withdrawal time should also be included. For gastroscopy, extent of intubation (e.g. D2) must be recorded.

A proportion of applications may be audited for accuracy, with applicants expected to cooperate with and facilitate this process. Any applications where data manipulation (fraud) is suspected will be automatically referred to the MCNZ Professional Standards Team.

For all pathways, the practitioner should be intending to work in New Zealand for at least a year. Practitioners are advised to contact the Conjoint Committee for advice if needed.

For calculating KPIs, Colonoscopy Completion Rate (CCR) is calculated for all procedures attempted on patients who have had mechanical bowel prep and where the intention at the start of the procedure is to inspect the entire colonic mucosa. Procedures are recorded as complete if they reach the caecum, TI or neo-TI and are reported unadjusted. Adenoma Detection Rate (ADR) is calculated in patients over 50 years old who have had a complete colonoscopy (note – ADR is not required for paediatric colonoscopy).

*Pathway A. Those holding a certificate for recognition of training from a known system*

This pathway allows those who have obtained recognition of training in well-known overseas systems where the competency criteria are clear to submit their certificate without the need for further assessments. It recognises that those systems have already undertaken a process for recognition of training that is satisfactory.

- The two systems currently accepted are GESA (Australian CCRTGE or recertification) and JAG (UK)
- Practitioners simply submit their certificate, pay the administration fee and indicate if they wish to be included on the voluntary online register of endoscopists
    - Accepted procedures include Gastroscopy, Colonoscopy, ERCP, Capsule Endoscopy, Paediatric Gastroscopy and Paediatric Colonoscopy

Where the endoscopist has not had extensive practice with moderate/conscious sedation then evidence of completion of a Safe Sedation Training Course is also recommended for routine practice in adult endoscopy in New Zealand. The American Society of Anaesthesiologists-endorsed SST-Moderate online course is recommended. Where applicable, this evidence should be provided directly to the DHB credentialing committee rather than NZCCRTGE.

*Pathway B. Those from clearly equivalent International training schemes*

This pathway is for practitioners from International training schemes that can be clearly assessed as being equivalent to Australasian training (at least three years of formal advanced fellowship training in endoscopy as a Gastroenterologist or General Surgeon), plus local assessment through a logbook and DOPS. Undertaking this pathway should not preclude practice as long as hospital credentialing requirements have been met.

The applicant must:

- Provide details of the initial overseas training institution including type and length of training, and include supervisors' reports.
- Provide a written reference from a supervisor familiar with the applicant's prior overseas endoscopy training and practice for each procedure type. The referee must be contactable for verification.
- Provide evidence that they have been admitted as a fellow to a recognised New Zealand or Australasian Medical College or hold equivalent vocational scope registration with MCNZ in Internal Medicine (Gastroenterology) or General Surgery.
- Provide a clear **logbook of at least 50 consecutive procedures performed in New Zealand**, which can be retrospective but must be contemporary (last logged case within three months of submission), sequential and verifiable. Logbooks of higher case numbers may be submitted if the practitioner wishes.
- Provide at least **four ANZ Conjoint DOPS forms** for each procedure type completed by a directly supervising Endoscopist colleague recognised by NZCCRTGE in the relevant procedure. DOPS should be completed by at least two different assessors on two different occasions.
- Provide evidence of completion of **safe sedation training** e.g. the American Society of Anaesthesiologists-endorsed SST-Moderate online course or local team-based simulation training. Note this is not required for paediatric endoscopy or capsule endoscopy.
- Provide an **affidavit from the host DHB Endoscopy User Group (EUG)** or equivalent confirming that there have been no significant complaints or concerns raised regarding the applicant's

endoscopy practice since arriving in New Zealand, that the application is supported by the host institution and the applicant intends to practice in New Zealand in the long term (over a year).

***Minimum standards:***

- Gastroscopy requires a **D2 intubation rate of >95%** over the final 50 procedures. Interventional procedures should be recorded where these have occurred. Patients with post surgical anatomy (e.g. bypass) and interventional procedures without intent to reach the duodenum may be excluded from the denominator.
- Colonoscopy requires an unadjusted **CCR of >90%** and an **ADR of >25%** over at least the final 50 procedures.
- ERCP requires a cannulation rate for the target duct of >90% over at least the final 50 procedures. Logging additional procedures may be required to demonstrate this. Stent placement should be recorded where this has occurred. DOPS forms submitted should demonstrate independence in cannulation, cholangiogram interpretation, sphincterotomy; and in therapeutic manoeuvres for stone removal, stent placement and tissue sampling.
- Paediatric Gastroscopy requires a **D2 intubation rate of >95% over the final 50 procedures** in paediatric patients plus at least one out of the two DOPS where an interventional procedure of a type routinely done in the applicants practice is observed by a colleague.
- Paediatric Colonoscopy requires a **caecal intubation rate of >90% and terminal ileal intubation rate of >80% over the final 50 procedures** in paediatric patients This may require more than the minimum number of cases to clearly demonstrate
- The NZCCRTGE reserves the right to ask applicants to submit additional information if required to make an assessment.
    - This could include (but is not limited to)
        - An extended logbook containing a greater number of procedures
        - Additional DOPS forms
        - Additional referee reports
        - Further clarifying information about training background

*APPLICATION*

Applications must be lodged on the online form. Please keep a copy of the files from your application for your records.

Reference for Australian IPP

https://www.conjoint.org.au/pathways.php#pathway2

## CAPSULE ENDOSCOPY

Capsule endoscopy is considered separately as it is less a technical skill and more a cognitive skill. Therefore, the emphasis is on reliable interpretation of images and medical knowledge rather than technical expertise.

Capsule endoscopy may be an under-utilised technique and as demand for it may increase in the future there is a need to establish a method of ensuring that practitioners have received adequate training. It is expected that those applying under the Advanced Training Pathway have direct supervision, with the supervisor clearly identified in the logbook. Those applying under the EPP/IPP are expected to participate in peer or MDT discussions about their cases, with the peer or members of the MDT clearly identified in the logbook.

Safe Sedation Training is not a requirement for capsule endoscopy. DOPS are not currently a requirement however may become so once an appropriate tool is available.

**Advanced Training Pathway**

Trainees must:

- Be trained (or concurrently training) in other endoscopy procedures e.g. gastroscopy and/or colonoscopy
- Submit a logbook using the logbook provided documenting completion of a minimum of 50 supervised dual-read, complete procedures with at least 25 studies showing abnormal findings.
- At least five studies should have the trainee wholly responsible for the unassisted preparation of the equipment, patient set-up and administration of the capsule. These cases should be noted in the logbook and comment made on the supervisor's report.
- Provide an online supervisor's report from the primary supervisor attesting that the trainee has demonstrated an understanding of the indications, contra-indications and complications related to capsule endoscopy
- Evidence of completion of a recognised capsule endoscopy training workshop (e.g. NETI or other equivalent course). Online workshops are acceptable.

**Experienced Practitioner and International Practitioner Pathway**

The same requirements will be used for both EPP and IPP. Undertaking this pathway should not preclude practice as long as hospital credentialing guidelines have been met.

Applicants must:

- Be trained (or concurrently training) in other endoscopy procedures e.g. gastroscopy and/or colonoscopy
- Submit a logbook using the logbook provided documenting completion of a minimum of 50 complete procedures with at least 10 studies showing abnormal findings. A peer or members of MDT who can corroborate the procedures should be identified in the logbook. These cases can be retrospective.
- Provide an online report from a peer or member of the MDT attesting that the applicant has an understanding of the indications, contra-indications and complications related to capsule endoscopy, and is able to administer the capsule safely.
- Evidence of completion of a recognised capsule endoscopy training workshop (e.g. NETI or other equivalent course). Online workshops are acceptable.

NZCCRTGE reserves the right to ask for copies of abnormal capsule reports to review if further corroboration is required.