THE GREAT DEBATE 2
CONTRA - Credentialing is unnecessary

Session No.: 3

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First....

Who, the ….. , invented that title of my talk?

I know the game

I will play the role I received

What is credentialing?

The practice of analysing the credentials of an individual or organisation.

Credentials – evidence of:

authority (power)
status
rights
entitlement to privileges

What are arguments against credentialling?

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So it may be regarded as….

Giving priviliges in exchange of:

- fullfilling criteria invented by „experts”

- reaching indicators that can be falsified(PDR, CIR, even ADR)

- passing practical exam (DOPS) that is vulnerable to having luck (in selection of patients)

Is credentialing worth anything?

The fact:

no RCTs proving benefits of credentialing vs no credentialing in terms of clinical outcomes !!!

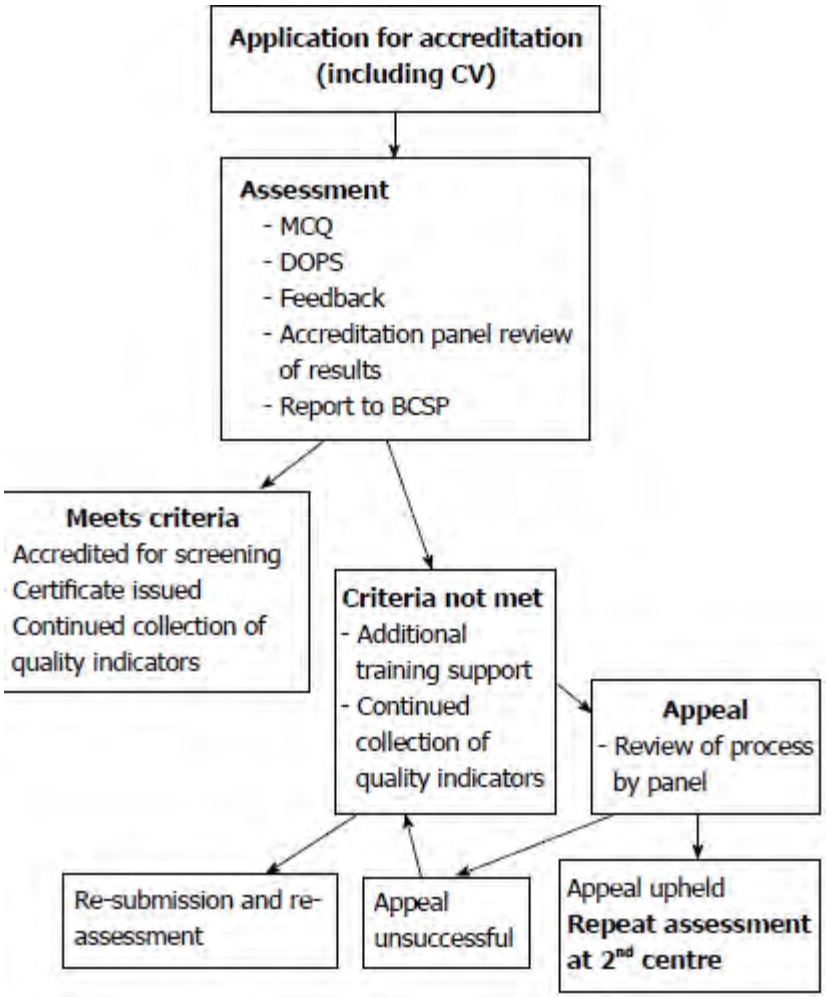
multiple non-RCTs comparing outcomes for institutional credentialing present vs credentialing not present

Are requirements uniform?

Different accross countries and regions
Defined frequently by local hospitals

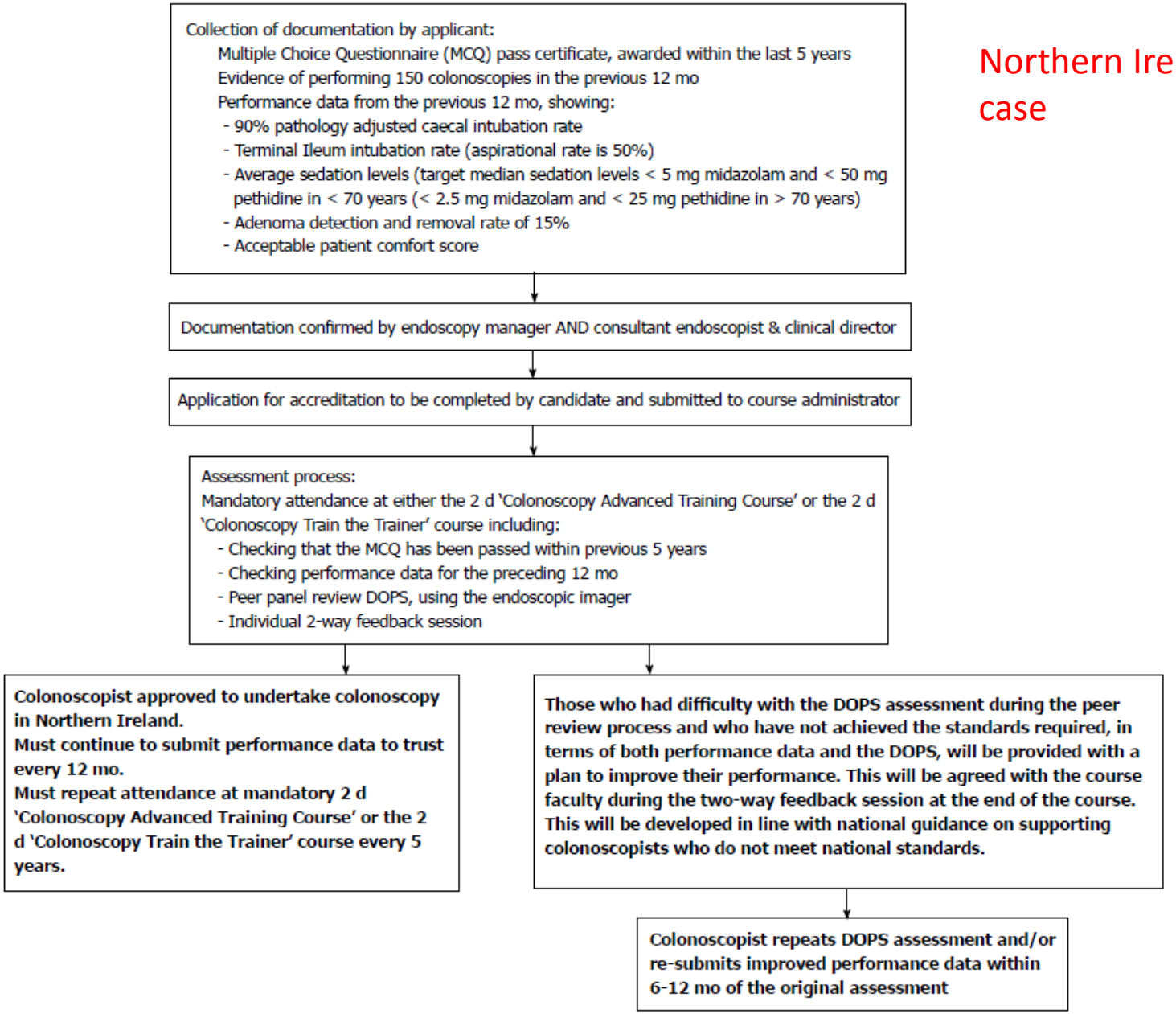
Criteria	JAG accreditation	NHS BCSP accreditation
Lifetime number	> 200	> 1000
Lifetime Perforations	< 0.5%	Not documented
Number last 12 mo	> 100	> 150
Sedation		
Under 70 years	Midaz < 5 mg/ Pethidine < 50 mg	Midaz < 5 mg/Pethidine < 50 mg
70 years +	Midaz < 2.5 mg/ Pethidine < 25 mg	Midaz < 2.5 mg/Pethidine < 25 mg
Caecal intubation	> 90%	> 90%
Polyp detection & Removal	> 10%	> 20%
Data certified	Endoscopic supervisor	Endoscopy sister & consultant colleague/clinical director/ medical director

Tham T, WJGE 2010



Tham T, WJGE 2010

Northern Ireland case



Tham T, WJGE 2010

Problems with credentialing

Multiple indicators/which is most important/ which decides?

No good solutions those who can not be priviliged ?

Risk of depression/(suicide) for those not obtaining credentials

Danger of unjustified accusation of individuals for institutional failures

Low individual quality parameters may depend on:

- institutional organisation
- bowel prep
- fatigue due to tight schedule
- old generation scopes
- lack of institutional training

Imagine you work for 30 years doing good job

Suddenly someone comes and:

- asks you to show your performance
- asks you to prove your quality indicators
- asks you to pass the exam

If you don’t accept:

- you loose your income
- your are regarded as the worst doctor ever

Why someone doesn’t trust you suddenly, after all these years

Maybe improvement can be obtained with just monitoring

	Bowles 1999	UK 2011	England
Procedures	9223	20085	16043
Caecal intubation rate (CIR) (95% CI)	76.9%	92.3% (91.9 to 92.6)	92.6% (92.2 to 93.0)
Adjusted CIR		95.8%	96.1%
Polyp detection rate (95% CI)	22.5%	32.1% (31.4 to 32.7)	32.3% (31.6 to 33.1)
Procedures with polyps ≥1 cm		11.7%	12.1%
Polyp retrieval rate		92.3%	92.1%
No sedation		10.7%	11.2%
General anaesthetic (GA)/propofol		0.4%	0.3%
Conscious sedation	94.6%	88.9%	88.5%
Nitrous oxide		8.4%	9.7%
Comfort score ≥4		9.8%	9.5%
Excellent or adequate prep		88.2%	88.6%

Gavin DR et al. Gut 2013

One can invent many other ways of maining quality

- automatic calculations of quality parameters available at your endoscopic software
- you may control your quality yourself; why not?
- our profession was always based on trust and honesty ;
- What happened? Aren't we just destroying ourseleves the feeling of trust that we enjoyed?

Conclusion

This is too early to introduce uniform credentialing systems

More studies are needed with important outcome measures

Introduction of intuitive credentialing may be harmful

Conclusions (2)

First, experts need to agree what are important, meaningful quality criteria that can easily (practically) can be used for issuing credentials

Then, and only after that – we should support the process of serious credentialling

But currently - NO