

## Updated guidelines for live endoscopy demonstrations

Courses that demonstrate endoscopic techniques in real time, termed *live demonstrations*, are valued because they provide invaluable lessons from real-life situations along with the opportunity to demonstrate standards of care. Attendees learn the thought process involved in making decisions while a procedure is being performed. At the same time, live demonstrations must be conducted with the patient as first priority. Endoscopic “experts” are put in a “pressure cooker”-like environment where the emphasis shifts from patient care to demonstration and performance. Further, live demonstrations often involve visiting endoscopists who have not previously had the opportunity to review the patient’s medical history and records and require these visiting “experts” to perform for an audience outside their own familiar environment. Together, these can be a nidus for cloudy judgment, even for the most experienced endoscopists.

An eloquent editorial by Dr. Peter Cotton<sup>1</sup> in *Gastrointestinal Endoscopy* in 2000 raised this dichotomy of live demonstrations, and a subsequent White Paper by Carr-Locke et al<sup>2</sup> proposed American Society for Gastrointestinal Endoscopy (ASGE) guidelines for live endoscopic demonstration courses.

Anecdotes of untoward events at live demonstration endoscopy courses continue to raise questions regarding patient safety and the ethics of continuing these courses. It is the responsibility of the ASGE to ensure that we as physicians, endoscopists, and educators provide ethical, effective, and quality educational programs. The ASGE Continuing Medical Education (CME) Programs Committee reviewed the Cotton editorial<sup>1</sup> and the White Paper<sup>2</sup> on live demonstration courses and discussed the ethics and value of continuing live demonstrations at courses sponsored or endorsed by the ASGE.

The majority opinion of the CME Programs Committee is that live demonstration endoscopy courses have educational value for those who choose to attend these demonstrations. Live demonstration courses provide a unique insight into technologies and techniques that may benefit those in the community as well as in academic practice. Moreover, the nuance and subtlety of endoscopic practices and the dynamic considerations of the effective use

of endoscopy may be best taught within the confines of a live demonstration course.

The dissenting (minority) opinion of the committee was that the benefit of live demonstrations performed at ASGE endoscopy courses is outweighed by the potential harm to patients. The availability of video technology makes the need for live demonstrations nearly obsolete.

Based on the majority opinion that live demonstration courses do have value, the CME Programs Committee decided to modify and adopt the principles set forth in the White Paper.<sup>2</sup>

### HOST RESPONSIBILITIES

1. Invited experts should have adequate skills and knowledge to be effective teachers in live demonstration courses.
2. All cases should be reviewed by a committee that includes the course directors along with the individual who will be performing the procedure before commencement of the course.
3. The course directors are responsible for the actions of all those who participate. The outcomes should be reviewed in a post-course assessment.
4. The necessary regulatory and legal processes have been completed such that all participating members have been vetted and have institutional privileges. Malpractice insurance must be in place. All physicians must be in compliance with institutional, local, state, and federal requirements. Any individual not completing these processes must be excluded from participating in patient care, but may serve as a discussant.
5. All course participants must be compliant with CME regulations including conflict of interest resolution. Any individual not completing these processes is excluded from participation in the course in any manner, including serving as a discussant.
6. A patient ombudsman is determined before the start of each program. This individual is responsible for serving as an advocate for the patient. The ombudsman should be present throughout the live demonstration procedure. An individual should be identified who is not a course director and has no conflict of interest in advocating on behalf of the patient.
7. Should a conflict arise between the course director and the individual performing the procedure:
  - a. The case is delayed until a consensus is reached.
  - b. An alternative program is presented to the audience

- (ie, switching to a different case or presenting instructional videos).
- c. The consensus will be determined by the performing physician, the course director, and patient ombudsman.
8. An individual should be designated before the start of the course to gather data for thorough course evaluation and measurement of patient outcomes.

### **PATIENT PREPARATION**

1. Routine preprocedure standards of care must be adhered to including appropriate documentation, history and physical examination, and informed consent.
2. Patients should be informed that they are participating in a live course, and the consent form should reflect that they agree to participate as is customary with local institutional policy.
3. The patient must be reassured that no change in the standard of care will occur as a result of agreeing to participate in the course.

### **PHYSICAL RESOURCES**

1. To increase the efficiency of live demonstration courses, there should be an opportunity to change the presentation from a situation in which the efficiency of learning is decreased. This can be achieved by having videos available for presentation and discussion and/or by multiple cases being performed simultaneously.
2. The audio/video resources must be sufficient to:
  - a. Provide adequate quality imaging to present live fluoroscopy, endoscopy, and endosonography
  - b. Provide for audience feedback and questions
  - c. Provide enough views of the endoscopist to be instructive in the endoscopic technique
  - d. Switch between rooms and allow interaction between the audience and the treating physicians.
3. A dedicated procedure room with available staff should be considered in case one of the “active” rooms cannot be used because of a difficult case, prolonged procedure, or other unforeseen event.

### **EDUCATIONAL GOALS AND PROCESSES**

1. The educational goals of the course must be clearly defined before the course and communicated to the faculty and audience.
2. The intent of a live demonstration should be to educate and disseminate knowledge, technology, and technique to the audience. The goals of a live demonstration course should *not* be to demonstrate dramatic or spectacular cases.
3. Edited videos on techniques and previously videotaped demonstrations should be available as a substitute for live demonstrations. Live demonstrations should be

used for educational objectives that cannot be achieved through videotaped demonstrations.

4. Each case must have *well-defined teaching points* that will be of value to the audience.
5. Didactic lectures are integral to providing a complete educational experience and should be considered to be a part of a live demonstration course.
6. Attempts should be made to record all live demonstration cases and discussions, to be included in a repository of teaching videos.
7. Post-course assessments of the audience must be obtained from the faculty and participants to assess the effectiveness of the cases selected and the format chosen.

### **PROCEDURE STANDARDS**

1. It is the position of this committee that procedures be preferentially performed by the primary treating physician of the patient whenever possible. Invited guests from outside institutions should avoid performing procedures in an environment and with staff with whom they are not accustomed to working, unless local expertise to perform the procedure is not available. It is the responsibility of invited faculty to decline to perform a procedure if patient safety might be in jeopardy.
2. The physician performing the procedure must have adequate opportunity to review the records including images and laboratory studies, interview the patient, and answer any questions in advance of the procedure.
3. All standard protocols, including sedation, patient monitoring, and staffing requirements, must be adhered to.
4. Patient information must be kept confidential, including all protected health information.
5. At no time should a patient be placed at risk by inappropriate patient selection, physician judgment, physician treatment, or other departure from the highest standards of care.
6. The physician performing the procedure should have adequate expertise to serve as an effective endoscopist and educator.
7. The capabilities of the endoscopy staff, including nurses, technologists, and the physical facilities, must be adequate to perform the planned procedures and help achieve the educational goals.

### **INDUSTRY PARTICIPATION**

1. All efforts should be made to comply with conflict of interest standards and remove industry bias from the course. Attempts should be made to refer to equipment with generic names, particularly when there is more than one device that is suitable for the clinical task. However, when unavoidable or necessary for educational purposes, industry names and recognition may be appropriate.

2. There can be no industry representatives in any clinical areas or on any transmission during a live demonstration course.
3. Company names and logos should be hidden from cameras as much as possible, within reason.

### QUALITY CONTROL/OVERSIGHT

1. Patient satisfaction data should be collected on the day of the procedure before discharge from the endoscopy unit.
2. Deidentified patient outcome data should be collected on the day of the procedure and during follow-up.
3. All patient, procedure, and follow-up outcome data for live demonstration cases should be stored in a secure place with the course director and be available for review.

*Abbreviations: ASGE, American Society for Gastrointestinal Endoscopy; CME, Continuing Medical Education.*

### REFERENCES

1. Cotton PB. Live endoscopy demonstrations are great, but. *Gastrointest Endosc* 2000;51:627-9.
2. Carr-Locke DL, Gostout CJ, Van Dam J. A guideline for live endoscopy courses: an ASGE White Paper. *Gastrointest Endosc* 2001;53:685-8.

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Prepared by:  
ASGE CME PROGRAMS COMMITTEE  
David E. Loren, MD  
Riad Azar, MD  
Roger J. Charles, MD  
John A. Dumot, DO  
Farees Farooq, MD  
Deepak V. Gopal, MD, FASGE  
David L. Jaffe, MD  
Vanessa M. Shami, MD, FASGE  
Virender K. Sharma, MD, FASGE  
Amitabh Chak, MD, FASGE, Committee Chair

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