Philip R. Raiford, MD
Community faculty of the Department of Family Medicine, Brown Medical School

Trials and tribulations of becoming a family medicine colonoscopist: A personal story

This past year I was granted privileges to perform colonoscopies in our local hospital, culminating more than 2 years of time and effort feeling my way through a vague system to satisfy a moving target of criteria for the procedure. I am a family physician in private group practice in a small community in Connecticut.

Our local community hospital is somewhat unusual for New England in that 2 local primary care physicians have been performing colonoscopies for a number of years. GI specialty services have been provided by several physicians in the past, and currently are provided by members of a large group located elsewhere in the state, with a rotating schedule for our hospital. With increasing numbers of patients requesting colonoscopies for colorectal cancer screening, we would frequently find ourselves with an extensive backlog of patients, and persistent communication problems for reporting results and scheduling.

Several colleagues from our medical staff suggested I consider pursuing additional training to provide screening colonoscopy for our patients conveniently and expeditiously. Initially the thought seemed daunting, but the idea of providing a service for our patients was attractive. I was drawn by the opportunity to indulge my interest in procedures, believed I would enjoy this new facet of patient care, and wasn't discouraged by the prospect of more procedure based reimbursement for our practice.

I discussed the idea with my 2 colleagues already performing the procedure at our facility. They were both encouraging. We hammered together the following prospective game plan: I would arrange to take a course in colonoscopy provided by the National Procedures Institute (NPI), and, upon successful completion of this course, begin performing colonoscopies at our hospital under their preceptorship. When an agreed number of procedures had been successfully performed and documented, I would anticipate being granted privileges. The most recently credentialed of the two had joined the staff 6 years before with extensive colonoscopy experience and had been asked for documentation of 50 procedures. We considered this a reasonable precedent.

The process seemed reasonably straightforward; do the work, earn the privileges. Simple. I put together a proposal and submitted it to the chairman of our credentials committee, a local surgeon. He thought the plan was reasonable and encouraged me to proceed. This process would include approval of my proposal first by his committee, then the hospital executive committee, with final approval from the hospital board of directors. Fueled by a naive optimism, I traveled to Michigan to take the NPI course, prepared to return and begin the local precepting.

CORRESPONDENCE
Dr Raiford is on the community faculty in the Department of Family Medicine, Brown Medical School, who practices in northern Connecticut. E-mail: praiford@pol.net

This, I knew, would involve months of sacrificing both office and personal time to be available for the colonoscopy schedules.

Meanwhile, my proposal comfortably passed the credentials committee, met no resistance in the executive committee, and was waiting on the agenda for the next board meeting. When that meeting convened, my proposal was introduced for consideration. A hospital physician serving on the board voiced an objection, believing that, since our local hospital is not a "teaching institution," I should not be allowed to receive any training locally. The board decided to table the proposal until they could gather some perspective about the hospital's liability exposure having a doctor trained by local physicians performing colonoscopies.

Opinions were garnered from the GI department of our tertiary referral center and the Connecticut Academy of Family Practice (CAFP), among others. Several years ago, it was decided that our board meeting minutes would no longer be available on request, so my information regarding these opinions was based mostly on word of mouth. The letter from the CAFP, however, appeared in their newsletter. Reportedly, and perhaps with no great surprise, the opinion that held the most sway was that delivered by the hospital's attorneys. Their opinion supported the physician board member's objection to my being trained in our hospital. At any rate, the board rejected my original proposal.

Thus began the ordeal

Initially, in a general sense, the decision ignited a small firestorm among our medical staff, many of whom felt insulted that the board would side with an attorney's judgment over that of their own committee system. The surgical staff members, who routinely introduce one another to new materials and techniques in the OR, worried about a precedence that might hinder their future skills. Weeks of fervent corridor conferences and speculations culminated with the Chairman of the hospital board speaking at our quarterly staff meeting to field comments from the staff and explain the board's decision.

For me there remained the question of how to continue my search for colonoscopy privileges. The major problem, I discovered, was a lack of generally accepted criteria for demonstrating competency in performing screening colonoscopies, particularly for primary care physicians. Thus, no "standard of care" was available to defend a hospital should a malpractice claim arise. Understandably, this presented an obstacle for our board to consider when confronted with what has been an increasingly hostile medical-legal environment.

Indeed, the local malpractice climate had worsened since my colleague was credentialed a few years before. At that time an American endoscopic society had published that 50 documented procedures was adequate to demonstrate proficiency. Several years later this was raised to 100 with no explanation given. At last look, the numbers have disappeared, replaced by the phrase "to the satisfaction of the instructor." The AAFP recognized the importance of having established appropriate credentialing criteria for family physicians doing screening colonoscopies, but offered no practical solution to assist in hospital privileges, and no suggestion about how to find one.

Despite my several requests, including a letter from an attorney, I never received direct communication from the board specifying what they would require for credentialing, only that it had to be training by someone with an unspecified form of academic attachment. I found myself with no announced guidelines to follow and the prospect that any solution I may pursue could ultimately meet board rejection with no explanation.

The search ensued for a training opportunity. Month after month, I spent hours each week on the phone, calling every conceivable program, person, and location that could possibly offer assistance in what I came to realize was a unique situation. Residencies were

FAST TRACK

The major problem was a lack of generally accepted criteria for proving competency in screening colonoscopy

sympathetic, but could not help. Even if they offered training, their first responsibility was to their residents. One faculty member even offered to travel to me if arrangements could be worked out. Several VA medical centers took the occasion of my inquiries to ban any endoscopic training in their facilities unless formally part of a GI fellowship program. These decisions were apologetically conveyed to me by their sympathetic gastroenterologists. Other gastroenterologists, however, abruptly hung up on me, occasionally after a few choice words.

At long last, with the help of Dr Jeffrey Borkan at the Brown Family Medicine residency in Pawtucket, Rhode Island, a workable arrangement fell into place. After another 3 months I had 50 procedures documented under acceptable preceptorship and I was granted privileges to perform screening colonoscopies this past March.

My first official "solo" colonoscopy was not one of my patients, but a local surgeon who asked to volunteer. Since March I have been doing at least 3 a week and rare is a week without the discovery of some pathology.

Has it been worth it? Yes!

My rapport with patients is invigorating and I feel a renewed sense of being productive for their benefit. Our endoscopy staff supported me throughout. I enjoy performing each procedure. I also feel very grateful to the many kind souls who offered help or encouragement during what was a very long journey.

The opportunity for primary care physicians to provide colonoscopy services remains a hot turf war in many areas of the country. Just recently, as reported in the *AAFP News Now,* the American College of Gastroenterology has sent mailings to hospital administrators, warning them of "potential litigation exposure" if allowing non-GI personnel to perform endoscopy.

The success of an individual physician in gaining privileges is certainly directly dependent on the opportunity to receive appropriate training; but also, unfortunately, with more universally established standards, it will continue to remain dependent on the local medico-political climate in their medical community. ■

FAST TRACK

The opportunity for primary care physicians to provide colonoscopy remains a hot turf war in many areas of the country