Accountability in EUS: Is it possible?

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Although accountability is not easily translatable in every language, it refers to very important issues in health care indeed. Accountability is the quality of being accountable, which implies being able to give an account or capable of being explained for one's activities. In other words, different parties such as individual physicians, multidisciplinary teams, and institutions themselves should be able to justify and take responsibility for their actions and intentions. Accountability comes at different levels of shared decision-making, including physician–patient and physician–physician relationships, economic decisions for expenditures and investments by the administration, and political interactions in the entire community by the governing board.[1]

To what extent does accountability relate to EUS? I believe that EUS should be accountable in many ways, starting from training and competence, progressing through a standardized examination technique and report, and ultimately leading to the quality of the scientific research in the field.

The American Society for Gastrointestinal Endoscopy defines competence in endoscopy as "the minimum level of skill, knowledge, and/or expertise derived through training and experience that is required to safely and proficiently perform a task or procedure."[2]

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However, attaining competence in EUS is not a single event, but a career-long process. In other words, when an endoscopist reaches the standards defined in the training phase, it is not the end of the learning, but merely a platform at which independent practice can commence.[3]

The European Society of Gastrointestinal Endoscopy has indicated that a more experienced colleague mentors endoscopists starting to practice independently for at least 6 months, particularly for challenging cases.[3] Small-volume centers that work together as a network are capable of performing comparably to high-volume centers. For this reason, new EUS programs should remain in a EUS network that has the potential to fulfill the desired service provision outlined by the British Society of Gastroenterology.[4] For healthcare facilities with limited EUS experience, it may also be beneficial for both nurses and physicians to visit other healthcare facilities with more mature EUS programs to learn about strategies for successful long-term results. This on-site experience offers an opportunity to gain valuable insights and expertise in how to handle patient needs, echoendoscopes, and the potential need for additional training.[5]

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Radiologists are far ahead in terms of standardizing imaging techniques, structuring reports, understanding image artifacts and reasons for errors, and assessing reproducibility. A recent systematic review in the field of published radiology literature looked at five key indicators of reproducibility, *i.e.*, availability of data, materials, protocols, analysis scripts, and preregistration, in a random sample of 300 articles. The authors (surprisingly?) found that the indicators were missing, thus potentially affecting the ability to reproduce studies and their relative clinical implications.[6]

Reproducibility issues affect many domains of EUS such as image settings (left *vs.* right screen orientation, gain and contrast, resolution, and penetration depth), techniques of examination (whole exploration *vs.* targeted exploration), standard reports (does it exist at all?), and pictures and videos recording of the procedures (including making them available to the patients).

The endoscopic report has a key role in quality improvement for gastrointestinal endoscopy and may help improve the care of patients undergoing EUS. Unlike other digestive endoscopy procedures, the quality of reporting in EUS has not been thoroughly evaluated and a reference standard is lacking. A recent international survey among 171 endosonographers looked at the case volume, experience, and working environment of respondents (academic, public hospital, private).[7] In brief, everyone agreed on the need for standardization of EUS reporting. The use of minimal standard terminology and a structured tree with mandatory items was considered of primary importance. Image documentation was also deemed fundamental in complementing EUS reports for both patient documentation and research purposes. Strong demand for connection and consultation among endosonographers for clinical and training needs was also seen. In this respect, a formal expert consultation network was advocated to improve the quality of reporting in EUS.

A Canadian group of experts supported the incorporation of quality indicators to standardize the EUS documentation, proposing key reporting elements for endosonographers and endoscopy units.[8] A literature search was performed to identify EUS quality indicators and essential components of high-quality standardized EUS reports. According to the authors, EUS reporting elements can be divided into preprocedural, intraprocedural, and postprocedural items. Preprocedural ones include the type, indication, and urgency of the procedure, patient clinical information, and consent. Intraprocedural components include the adequacy and extent of examination, relevant landmarks, lesion characteristics, sampling method, specimen quality, and intraprocedural adverse events. Postprocedural elements include summary and synthesis of relevant findings as well as recommended management and follow-up.

Finally, the quality of research in EUS was addressed by guidelines, systematic reviews, and meta-analyses.[9] It seems that the majority of the EUS literature still consists of retrospective studies and small-to-medium–sized nonrandomized trials.[10] Nevertheless, the aim to develop prospective high-quality research protocols is common among modern endosonographers, and large-scale multicenter trials are currently underway. In particular, as many EUS-guided treatments are now available (including duct drainage, evacuation of peripancreatic and postsurgical collections, and visceral anastomoses) that may not only bring positive clinical outcomes but also carry a nonnegligible risk of adverse events, conducting prospective trials to validate their role in the clinical arena is of the utmost importance.

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Conflicts of interest
Pietro Fusaroli is a senior editor of the journal. The article was subject to the journal's standard procedures, with peer review handled independently of this editor and his research groups.

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