Analysis of Robotic Surgery Credentialing- Implications for Resident Education

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Objective: As robotic assisted surgery is gaining popularity in gynecologic surgery, resident physicians are becoming more experienced in this modality. Many trainees will utilize this technology after completion of residency either in general practice or subspecialty fellowship. The primary aim of this study was to describe credentialing requirements for robotic gynecologic surgery in Alabama. Our secondary aim was to describe the necessary aspects of residency training to achieve robotic surgery privileges.

Method: Following IRB approval, hospitals in the state of Alabama that currently utilize robotic surgery in the field of gynecology were contacted. The credentialing authority at each of these hospitals was identified. These individuals completed an online questionnaire regarding credentialing policies.

Results: 16 hospitals in Alabama utilize robotic technology for gynecology surgery. 13 hospitals participated in this survey (81 %). The credentialing authority at each hospital was either the Ob/Gyn department chair (77%), chair of general surgery (8%) or director of robotic surgery (15%). The mean number of years each hospital had performed robotic gynecologic surgery was 2.8 years (median 5, range 1-7 years). All hospitals had a credentialing policy for robotic surgery, but only 8/13 hospitals surveyed (62%) had a separate pathway for physicians with recent residency training. This pathway consisted of an attestation letter from a residency program director in all 8 hospitals, a robotic case list in 3/8 (38%) and proctored cases following residency in 2/8 (20%). 6/13 of hospitals surveyed (46%) have hired physicians with robotic training in residency. 4 of 13 credentialing authorities (31%) responded that industry sponsored training is essential for credentialing whereas 9/13 authorities (69%) reported that it is desirable. In 3 of the 6 hospitals (50%) that had hired physicians with robotic training in residency, additional training was required (proctored cases and offsite training). 10/13 authorities (77%) felt there was a minimum number of hysterectomies performed as primary surgeon necessary for credentialing; the minimum number ranged from 2-25 (median 5). 2/13 authorities (15%) responded that regardless of number of cases, new physicians should be proctored.

Conclusions: Robotic surgery credentialing requirements in Alabama are variable. As robotic gynecologic surgery expands, resident training should be critically assessed in order to ensure that graduating residents will have the skills to perform robotic surgery and the necessary requirements for credentialing in these procedures. Aspects of residency training that are useful for future credentialing include keeping a log of robotic cases and participation in industry sponsored training. Residency program directors should anticipate writing attestation letters of competency.