



**Competency-based assessment tool for pediatric esophagoscopy: International modified Delphi consensus**

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**TITLE PAGE****Title:**

Competency-Based Assessment Tool for Pediatric Esophagoscopy: International Modified Delphi Consensus

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**Conflict of Interest**

None

**Notes**

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**ABSTRACT**

**Objective:** Create a competency-based assessment tool for pediatric esophagoscopy with foreign body removal.

**Study design:** Blinded modified Delphi consensus process.

**Setting:** Tertiary care center.

**Subjects & Methods:** A list of 25 potential items was sent via the REDCap database to 66 expert surgeons who perform pediatric esophagoscopy. In the first round, items were rated as “keep” or “remove” and comments were incorporated. In the second round, experts rated the importance of each item on a seven-point Likert scale. Consensus was determined with a goal of 7 to 25 final items.

**Results:** The response rate was 38/64 (59.4%) in the first round and returned questionnaires were 100% complete. Experts wanted to “keep” all items and 172 comments were incorporated. 24 task-specific and 7 previously-validated global rating items were distributed in the second round, and the response rate was 53/64 (82.8%) with questionnaires returned 97.5% complete. Of the task-specific items, 9 reached consensus, 7 were near consensus, and 8 did not achieve consensus. For global rating items that were previously validated, 6 reached consensus and 1 was near consensus.

**Conclusions:** It is possible to reach consensus about the important steps involved in rigid esophagoscopy with foreign body removal using a modified Delphi consensus technique. These items can now be considered when evaluating trainees during this procedure. This tool may allow trainees to focus on important steps of the procedure and help training programs standardize how trainees are evaluated.

**Level of Evidence:** 5



## INTRODUCTION

Surgical education has traditionally followed an apprenticeship model, with the staff surgeon evaluating the trainee subjectively at the end of their rotation. This method of evaluation can be prone to recall bias as it can occur several months following completion of a surgical procedure. Delayed evaluation also does not provide time for the trainee to reflect and improve.<sup>1</sup>

The Accreditation Council for Graduate Medical Education (ACGME) and the Royal College of Canadian Physicians and Surgeons have created specific outcome measures to assess surgical competency.<sup>2,3</sup> According to Reznick, valid and reliable assessments are needed to plan instruction and assess the efficacy of curricular interventions designed to enhance technical skills.<sup>4</sup> His group created the Objective Structured Assessment of Technical Skill (OSATS) to provide educators a standardized way to evaluate a learner's abilities.<sup>5</sup>

Objective and reproducible assessment tools can track the acquisition of skills and provide a framework for feedback. A competency-based approach toward medical education has been a goal of education for some time.<sup>6</sup> In Otorhinolaryngology – Head & Neck Surgery (ORL-HNS), OSATS have only been developed for 11 of the 114 core competency procedures for residency training.<sup>6</sup> Although an OSAT for rigid esophagoscopy has been described and obtained excellent construct validity, the tool was developed by a single faculty member, it does not differentiate between pediatric and adult rigid esophagoscopy and it does not evaluate foreign body removal.<sup>7</sup>

We sought to create a tool to evaluate pediatric rigid esophagoscopy with foreign body removal. OSATS have traditionally been created with input from a few experts. We recently created an OSAT for pediatric tracheotomy by seeking input from a large international group of experts using a modified Delphi consensus process to make the tool applicable across many training programs.<sup>8</sup> The Delphi process mathematically narrows down concepts through iterative rounds of anonymous questionnaires until consensus is achieved.<sup>9</sup> We sought to create a task-specific scale to evaluate discrete surgical steps involved in rigid esophagoscopy and foreign body removal, and a global-rating scale to evaluate overall performance, as each scale measures different aspects of training.

## METHODS

Two authors (EJP, EAF) created a list of steps that they commonly perform during rigid esophagoscopy with foreign body removal. Three other authors (NEW, KB, SLI) edited and added to this list. All authors were fellowship-trained pediatric ORL-HNS surgeons who previously developed a competency-based assessment tool for pediatric tracheotomy<sup>9</sup>.

Statements were collated into a questionnaire using Research Electronic Data Capture (REDCap).<sup>10</sup> We selected REDCap because replies are anonymous and respondents can easily complete and submit answers without downloading and uploading files. We tried to simplify questionnaire completion to increase response rates and decrease response times.

We reviewed the American Society of Pediatric Otolaryngology membership list and names of pediatric otolaryngologists at each academic institution in the United States and Canada to generate a list of potential experts. Those with a strong publication history in the field of rigid esophagoscopy and foreign body removal (Pubmed/book chapter editor or author) were included, many of whom had expertise in medical education. Experts with a publication history in this field from Europe and Australia were also included. Sixty-six prospective experts were invited by email to anonymously complete the survey. Experts were promised authorship in the order in which they responded to acknowledge their work. Respondents were ranked in order of response time separately for each round and the average of all rounds created the final authorship order. This worked previously to acknowledge each expert's contributions, increase the response rate and decrease the time to respond<sup>9</sup>. We contacted each expert three times per round (invitation and two reminders), each one week apart.

Experts were asked to rate each item on the Task-Specific list as "keep" or "remove" in the first round, and to provide suggestions for change. Anonymous responses were exported to an Excel (Microsoft, Redmond, WA) file and two investigators (EAF, EJP) reviewed responses and incorporated suggestions. Efforts were made to be inclusive. For a task to be included, 50% of respondents needed to rate it as "keep". In the second round, we used a Global Rating Scale that had previously been validated for many different surgical procedures that was not included in the first round.<sup>11</sup>

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5 During the second round, experts rated the importance of each item on the Task-Specific list  
6 using a 7-point Likert scale (1-Not at all important, 2-Low importance, 3-Slightly important, 4-  
7 Neutral, 5-Moderately important, 6-Very important, 7-Extremely important) and provided  
8 comments. Anonymous results were exported to an Excel file and a mean score was calculated  
9 for each item. Based on previous consensus statements in otolaryngology, consensus for the  
10 task-specific list and the global rating scale were calculated as: 1) Reaching consensus  
11 (individual responses fall within 2 Likert points of mean with only 1 outlier); 2) Near consensus  
12 (individual responses fall within 2 Likert points of mean with only 2 outliers); 3) No consensus  
13 (not meeting criteria 1 or 2).<sup>12,13</sup> Based on previous Task-Specific OSATS tools (mean+/-SD),  
14 we determined that an ideal Task-Specific list should have 7 to 25 items for inclusiveness and  
15 ease of use.<sup>6</sup>  
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26 The study end point was determined a priori, whereby 7 to 25 items reaching consensus in the  
27 second round would obviate the need for another iteration. However, >25 items reaching  
28 consensus would lead to keeping the most highly rated 25 items based on mean score.  
29 Conversely, <7 items reaching consensus would force another iteration whereby experts would  
30 be asked to rate only consensus and near consensus items again. If <7 items reached consensus,  
31 all items reaching consensus plus the most highly rated items reaching near-consensus based on  
32 mean score would be included up to a total of 7 items. This modification was created to decrease  
33 the burden placed on experts and shorten the study.  
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## RESULTS

Sixty-six experts in rigid esophagoscopy and foreign body removal were contacted and two email addresses were erroneous. The first round achieved a response rate of 38/64 (59.4%). Every item evaluated in the first round attained >78% of respondents wanting to “keep” it in the list for the second round. There were no missing responses out of 912 possible items (38 experts, 24 items) for a completion rate of 100%. There were 172 comments incorporated into the second phase (Table 1). The time for completion of round 1 was 30 days.

In the second round, 24 task-specific (Table 2) and 7 previously validated global rating (Table 3) items were distributed and the response rate was 53/64 (82.8%). There were 40 missing responses out of 1,643 possible items (53 experts, 31 items) for a completion rate of 97.6%. For the 24 task-specific items, 9 reached consensus, 7 were near consensus, and 8 did not achieve consensus. The 9 task-specific items that reached consensus were all rated positively, with a mean (SD) Likert rating of 6.29 (0.37) (range 5.67 – 6.83). For the 7 previously-validated global rating items, 6 reached consensus and 1 was near consensus. The 6 global rating items that reached consensus were all rated positively, with a mean (SD) Likert rating of 5.91 (0.27) (range 5.54 – 6.33). Tables 2 and 3 show each item, mean score, and consensus level. The time for completion of round 2 was 20 days.

## DISCUSSION

Decreased resident work hours, increased concerns for patient safety and a constant push from hospitals for greater efficiency have limited time for hands-on surgical training. These restrictions, along with variations in trainee learning curves, reinforce the need for objective and reproducible methods of evaluation. We sought to develop a competency-based assessment tool for pediatric rigid esophagoscopy and foreign body removal because it is a commonly encountered complex procedure with potentially serious risks such as esophageal perforation and injury to the teeth and gums. This tool can be used to evaluate the trainee immediately following completion of the procedure in order to counteract recall bias often seen in end-of-rotation evaluations.

Our response rates were 59.4% and 82.8% for the first and second rounds, respectively. A response rate of 60% is accepted by many biomedical journals for survey research.<sup>14</sup> Also, >97% of items were completed for all submitted questionnaires for each round. This is much higher than the American Association for Public Opinion Research (AAOPR) suggestion that 80% equals a complete response.<sup>15</sup> We believe this response rate reflects clinicians who are experienced and interested in this area of medicine, ease of use of the REDCap system, assurance of anonymity, and offer of authorship. We did not see a drop in response rate in the second round as has been seen in other studies using the Delphi method. The time for completion of this study was 50 days. We believe the short interval between questionnaires maintained a high level of interest.

In the second round, 9 task-specific items reached consensus (Tables 2 and 3). We did not require another round because this fell within the range of 7 to 25 items determined a priori.<sup>6</sup> Final items focused on preparation and prevention of adverse events. A proposed scoring sheet is available in table 4.

Several items approached consensus. One of these was communication with operative team, including intubation and plan if foreign body is visualized at esophageal inlet as well as performing the surgical safety checklist. Communication with the operative team regarding the shared airway reached consensus in our previous OSAT for pediatric open tracheotomy. Though

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3 communication regarding the airway is always important, these may not have reached consensus  
4 because rigid esophagoscopy is most often performed with the patient intubated, making the  
5 shared airway less of a concern, provided that the endotracheal tube does not get kinked by the  
6 esophagoscope or inadvertently dislodged during foreign body retrieval. Other items  
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8 approaching consensus were: “minimizes fog or mucous from obscuring telescope” and specific  
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10 details about how to grasp and withdraw the foreign body. These may have only reached near  
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12 consensus because there was a similar but more important task of identifying the foreign body  
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14 without accidentally pushing it distally. Lastly, the tasks of performing additional  
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16 esophagoscopy to re-evaluate mucosa and rule out an additional foreign body and evaluation of  
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18 teeth, mucosa, temporomandibular joint, and spine for injury reached near consensus. Though  
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20 all are extremely important, a straightforward procedure with good visualization and minimal to  
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22 no bleeding would be unlikely to cause an injury, and additional foreign bodies would be  
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24 unlikely if only one radiopaque foreign body was seen on x-ray.  
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27 Six of the 7 items in the Global Rating Scale reached consensus and 1 was near consensus. The  
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29 6 global rating items reaching consensus were rated positively. Surprisingly, demonstrating  
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31 familiarity with all steps of the operation/procedure only reached near consensus. This item  
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33 received the highest mean Likert score, but only approached consensus because there were two  
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35 outliers. We believe that a mean score of 6.38 out of 7 (91%) for this item justifies using the  
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37 previously validated Global Rating Scale with pediatric rigid esophagoscopy and foreign body  
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39 removal. Additionally, the Global Rating Scale has not been validated for use of a subset of  
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41 items, supporting using it in its entirety. Finally, the Global Rating Scale is complementary to  
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43 the task-specific scale, thus reinforcing its importance. A proposed scoring sheet is available in  
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45 table 5.  
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47 A limitation of this study is that task-specific items for pediatric rigid esophagoscopy with  
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49 foreign body removal were selected based on expert opinion and the scale has not achieved  
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51 construct validity using trainees of various levels. This could be done with live patients or  
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53 potentially using a simulation laboratory. We need to determine if this tool will be helpful for  
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55 trainees and faculty. Experts from developing and resource-limited regions were not included  
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57 during development of this tool. Although our modifications to the Delphi technique have now  
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3 appeared to work well for reaching consensus on the important steps involved in pediatric rigid  
4 esophagoscopy with foreign body removal in this study and open pediatric tracheotomy in a  
5 previous study, we cannot predict if they will work well when creating assessment tools for other  
6 procedures or with a different group of experts. Future studies investigating the construct  
7 validity of this pediatric rigid esophagoscopy with foreign body removal tool are required.  
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9 Broad and structured use of this tool are required to permit independent evaluation.  
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## 14 **CONCLUSION**

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17 Reaching consensus on the important steps of pediatric rigid esophagoscopy with foreign body  
18 removal is possible. The modified Delphi consensus process described herein allowed for this to  
19 happen. These items can be considered to create a competency-based assessment tool for  
20 pediatric rigid esophagoscopy with foreign body removal. This assessment tool may allow  
21 trainees to focus on important steps of this procedure and help training programs standardize  
22 how trainees are evaluated.  
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## TABLES

Table I.  
Pediatric Rigid Esophagoscopy And Foreign Body Removal Objective Structured Assessment of  
Technical Skill Tool Round 1.

Task-Specific Items	No. Completed	No. Rating Keep (%)	No. Comments
Prepares preoperative plan			
1. Reviews history and imaging to identify goal of procedure.	38	38 (100%)	16
2. Appreciates urgency of removal depending on type of foreign body, where applicable.	38	38 (100%)	17
Communicates with nursing		38 (100%)	
3. Selects appropriate esophagoscope (diameter and length).	38	38 (100%)	2
4. Selects appropriate telescope (diameter and length).	38	37 (97.4%)	1
5. Selects appropriate grasper, if required (type, length, optical telescope).	38	38 (100%)	5
Assembles instruments properly			
6. Tests scope(s) for adequate light, broken fibers, and cracks.	38	38 (100%)	8
7. Ensures grasper fits down esophagoscope.	38	38 (100%)	4
8. Ensures bridge and telescope fit into esophagoscope.	38	38 (100%)	8
Communicates with anesthesiologist			
9. Discusses intubation, where required.	38	38 (100%)	12
10. Requests endotracheal tube be secured to left side of mouth and that tape allows mouth to open.	38	38 (100%)	6
Positions patient properly			
11. Brings head of patient to top of bed.	38	38 (100%)	2
12. Uses shoulder roll, if necessary.	38	37 (97.4%)	5
Provides exposure for esophagoscopy			
13. Places tooth guard on teeth or gauze on gums.	38	38 (100%)	5
14. Selects appropriately sized laryngoscope.	38	38 (100%)	7
15. Inserts laryngoscope into esophageal inlet.	38	31 (81.6%)	16
16. Exposes esophageal inlet to provide easy esophagoscope entry.	38	36 (94.7%)	7
Performs rigid esophagoscopy			
17. Prevents esophagoscope from damaging lips and mucosa.	38	38 (100%)	11
18. Prevents fog or mucus from obscuring telescope.	38	38 (100%)	7
19. Identifies foreign body without pushing it distally, where applicable.	38	38 (100%)	7
Retrieves foreign body, where applicable			
20. Withdraws telescope while maintaining esophagoscope in correct position.	38	38 (100%)	4
21. Grasps foreign body without dislodging it distally.	38	37 (97.4%)	5
22. Withdraws foreign body into esophagoscope or to tip if too large to fit inside.	38	38 (100%)	9
Evaluates for injury			
23. Performs additional esophagoscopy to evaluate damage to mucosa or presence of additional foreign body.	38	38 (100%)	2
24. Removes tooth guard to evaluate for dental injury.	38	37 (97.4%)	8

No. = number

Table II.  
Pediatric Rigid Esophagoscopy And Foreign Body Removal Objective Structured Assessment of  
Technical Skills Round 2.

Task-Specific Items	No. Completed	Mean (SD) Likert	Consensus
<b>Surgical goals, preparation and potential challenges</b>			
1. Reviews history, physical examination, imaging (rule out battery) and anatomical and patient factors to identify goal of procedure and whether flexible or rigid esophagoscopy +/- bronchoscopy are indicated.	53	6.83 (0.38)	Yes
2. Appreciates urgency of removal depending on type of foreign body, where applicable.	53	6.77 (0.55)	Yes
3. Consents caregiver(s) for procedure including risks, benefits, and potential complications.	53	6.17 (1.00)	No
<b>Preparation of instruments</b>			
4. Selects appropriately sized laryngoscope(s), when necessary.	53	6.08 (0.97)	No
5. Selects appropriate esophagoscope(s) (diameter and length).	52	6.20 (0.80)	Yes
6. Selects appropriate telescope(s) (diameter and length).	53	6.19 (0.79)	Yes
7. Selects appropriate suction (flexible or rigid).	53	5.67 (0.96)	Yes
8. Selects appropriate grasper(s) (type, length, optical telescope, works on duplicate foreign body) and ensures it passes through and beyond esophagoscope.	52	6.51 (0.73)	Yes
9. Tests scopes, cables and video monitor to ensure functionality (adequate light, broken fibers, cracks, white balance, focus).	53	6.29 (0.87)	No
10. Ensures telescope +/- bridge/rubber guide fit in/on esophagoscope.	53	5.98 (1.13)	Yes
<b>Communication with operative team</b>			
11. Discusses airway plan including intubation +/- rigid bronchoscopy and formulates plan if foreign body is visualized at esophageal inlet.	52	6.39 (0.98)	Near
12. Performs surgical safety checklist and discusses steps of procedure and potential complications.	53	5.98 (1.20)	Near
13. If intubated, requests endotracheal tube be secured to desired side of mouth and that tape allows mouth to open.	53	5.19 (1.37)	No
<b>Patient position and exposure</b>			
14. Brings head of patient to top of bed and uses shoulder roll, when necessary.	52	5.39 (1.22)	No
15. Evaluates and protects teeth and gums in age appropriate manner (tooth guard, gauze).	53	5.80 (1.22)	No
16. Exposes esophageal inlet to provide atraumatic entry of esophagoscope.	53	6.08 (1.06)	No
<b>Rigid Esophagoscopy</b>			
17. Protects lips, teeth, oral mucosa and esophagus from injury.	53	6.23 (0.81)	Yes
18. Minimizes fog or mucus from obscuring telescope (anti-fog, suction, retracts scope proximal to tip of esophagoscope).	53	5.65 (1.05)	Near
19. Identifies foreign body without accidentally pushing it distally.	53	6.23(0.81)	Yes
<b>Foreign body retrieval, where applicable</b>			
20. Withdraws telescope and bridge while maintaining esophagoscope at optimal distance from foreign body for retrieval.	53	6.17 (0.92)	No
21. Passes grasper distal to end of esophagoscope, ensures full opening of grasper and grasps foreign body while accounting for sharp edges, all without complications (mucosal injury, distal dislodgement).	52	6.41 (0.78)	Near
22. Withdraws foreign body into esophagoscope or to tip if too large to fit inside and removes esophagoscope uneventfully if possible or stops to consider alternatives in case of failure.	53	6.50 (0.90)	Near
<b>Final Evaluation</b>			
23. Performs additional esophagoscopy and examination of nasopharynx to reevaluate mucosa and rule out additional foreign body.	52	6.25 (1.06)	Near

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24. Evaluates teeth, mucosa, temporomandibular joint and cervical spine for injury and is able to discuss management when injury is present.	52	5.84 (1.14)	Near
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SD = standard deviation; No. = number

For Peer Review

Table III.  
 Pediatric Rigid Esophagoscopy And Foreign Body Removal Obstructive Structured Assessment of  
 Technical Skills Round 2.

Global Rating Scale	No. Completed	Mean (SD) Likert	Consensus
Respect of tissue			
1. Appropriate handling of tissue, minimizes tissue damage through appropriate use of instruments and appropriate force.	54	6.33 (0.83)	Yes
2. Efficient and economic movement.	54	5.69 (0.92)	Yes
Knowledge of instruments			
3. Familiar with names of instruments required for this procedure, does not ask for wrong instrument or use incorrect names when asking for instruments.	54	5.98 (0.90)	Yes
Instrument handling			
4. Competent use of instruments, fluid movement without stiffness or awkwardness.	54	5.92 (0.79)	Yes
Flow of operation			
5. Demonstrates forward planning; course of operation demonstrated through effortless flow from one movement to the next.	54	5.98 (0.91)	Yes
6. Strategically uses assistants to the best advantage at all times.	54	5.54 (1.06)	Yes
Knowledge of specific procedure			
7. Demonstrates familiarity of all steps of the operation/procedure.	54	6.38 (0.80)	Near

SD = standard deviation; No. = number

Table IV.  
Pediatric Esophagoscopy And Foreign Body Removal Evaluation Sheet.

5	Date: (MM/DD/YY) _____			
6	Trainee Name: (Last) _____ (First) _____			
7	Level of Training: _____			
8	Evaluator Name: (Last) _____ (First) _____			
10	Task-Specific Items	Not Done or Done Incorrectly	Done Correctly	Not Observed
13	Surgical goals, preparation and potential challenges			
14	1. Reviews history, physical examination, imaging (rule out battery) and anatomical and patient factors to identify goal of procedure and whether flexible or rigid esophagoscopy +/- bronchoscopy are indicated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	2. Appreciates urgency of removal depending on type of foreign body, where applicable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Preparation of instruments			
20	3. Selects appropriate esophagoscope(s) (diameter and length).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	4. Selects appropriate telescope(s) (diameter and length).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	5. Selects appropriate suction (flexible or rigid).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	6. Selects appropriate grasper(s) (type, length, optical telescope, works on duplicate foreign body) and ensures it passes through and beyond esophagoscope.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	7. Ensures telescope +/- bridge/rubber guide fit in/on esophagoscope.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	Rigid Esophagoscopy			
28	8. Protects lips, teeth, oral mucosa and esophagus from injury.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29	9. Identifies foreign body without accidentally pushing it distally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Number of items performed correctly: \_\_\_\_\_

Was this a standard case?  Yes  No If not, Why? \_\_\_\_\_

Is this resident competent to perform this procedure?  Yes  No

Table V  
Pediatric Rigid Esophagoscopy Global Rating Scale Evaluation Sheet.

Date: (MM/DD/YY) \_\_\_\_\_  
 Trainee Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_  
 Level of Training: \_\_\_\_\_  
 Evaluator Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Global Rating Scale					
1. Respect for tissue	1 Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments	2	3 Carefully handled tissue but occasionally caused inadvertent damage	4	5 Consistently handled tissues appropriately with minimal damage
2. Time and motion	1 Many unnecessary moves	2	3 Efficient but some unnecessary moves	4	5 Clear economy of movement and maximum efficiency
3. Instrument handling	1 Repeatedly made tentative or awkward moves by inappropriate use	2	3 Competent use of instruments but occasionally appeared stiff or awkward	4	5 Fluid moves and no awkwardness
4. Knowledge of instruments	1 Frequently asked for wrong instrument or used inappropriate instrument	2	3 Knew names of most instruments and used appropriate instruments	4	5 Obviously familiar with instruments and their names
5. Use of assistants	1 Consistently placed assistants poorly or failed to use assistants	2	3 Appropriate use of assistants most of the time	4	5 Strategically used assistants to the best advantage at all times
6. Flow of operation and forward planning	1 Frequently stopped operating or unsure of next move	2	3 Some forward planning with reasonable progression of procedure	4	5 Obviously planned course of operation with effortless flow from one move to the next
7. Knowledge of specific procedure	1 Deficient knowledge. Needed specific instruction at most steps	2	3 Knew all important steps of operation	4	5 Demonstrated familiarity with all aspects of operation

Total score (sum all numbers): \_\_\_\_\_

Was this a standard case?  Yes  No If not, why? \_\_\_\_\_

Is this resident competent to perform this procedure?  Yes  No

**TITLE PAGE****Title:**

Competency-Based Assessment Tool for Pediatric Esophagoscopy: International Modified Delphi Consensus

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**Running Title:**

Assessment tool for pediatric esophagoscopy

**Word Count:** 2087**Keywords**

Esophagoscopy, Delphi, assessment, education, objective structured assessment of technical skills, OSAT

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**Conflict of Interest**

None

**Notes**

This work was presented at the podium at the American Society of Pediatric Otolaryngology Annual Meeting, May 3-5, 2019, Austin, Texas.

**ABSTRACT**

**Objective:** Create a competency-based assessment tool for pediatric esophagoscopy with foreign body removal.

**Study design:** Blinded modified Delphi consensus process.

**Setting:** Tertiary care center.

**Subjects & Methods:** A list of 25 potential items was sent via the REDCap database to 66 expert surgeons who perform pediatric esophagoscopy. In the first round, items were rated as “keep” or “remove” and comments were incorporated. In the second round, experts rated the importance of each item on a seven-point Likert scale. Consensus was determined with a goal of 7 to 25 final items.

**Results:** The response rate was 38/64 (59.4%) in the first round and returned questionnaires were 100% complete. Experts wanted to “keep” all items and 172 comments were incorporated. 24 task-specific and 7 previously-validated global rating items were distributed in the second round, and the response rate was 53/64 (82.8%) with questionnaires returned 97.5% complete. Of the task-specific items, 9 reached consensus, 7 were near consensus, and 8 did not achieve consensus. For global rating items that were previously validated, 6 reached consensus and 1 was near consensus.

**Conclusions:** It is possible to reach consensus about the important steps involved in rigid esophagoscopy with foreign body removal using a modified Delphi consensus technique. These items can now be considered when evaluating trainees during this procedure. This tool may allow trainees to focus on important steps of the procedure and help training programs standardize how trainees are evaluated.

**Level of Evidence:** 5

## INTRODUCTION

Surgical education has traditionally followed an apprenticeship model, with the staff surgeon evaluating the trainee subjectively at the end of their rotation. This method of evaluation can be prone to recall bias as it can occur several months following completion of a surgical procedure. Delayed evaluation also does not provide time for the trainee to reflect and improve.<sup>1</sup>

The Accreditation Council for Graduate Medical Education (ACGME) and the Royal College of Canadian Physicians and Surgeons have created specific outcome measures to assess surgical competency.<sup>2,3</sup> According to Reznick, valid and reliable assessments are needed to plan instruction and assess the efficacy of curricular interventions designed to enhance technical skills.<sup>4</sup> His group created the Objective Structured Assessment of Technical Skill (OSATS) to provide educators a standardized way to evaluate a learner's abilities.<sup>5</sup>

Objective and reproducible assessment tools can track the acquisition of skills and provide a framework for feedback. A competency-based approach toward medical education has been a goal of education for some time.<sup>6</sup> In Otorhinolaryngology – Head & Neck Surgery (ORL-HNS), OSATS have only been developed for 11 of the 114 core competency procedures for residency training.<sup>6</sup> Although an OSAT for rigid esophagoscopy has been described and obtained excellent construct validity, the tool was developed by a single faculty member, it does not differentiate between pediatric and adult rigid esophagoscopy and it does not evaluate foreign body removal.<sup>7</sup>

We sought to create a tool to evaluate pediatric rigid esophagoscopy with foreign body removal. OSATS have traditionally been created with input from a few experts. We recently created an OSAT for pediatric tracheotomy by seeking input from a large international group of experts using a modified Delphi consensus process to make the tool applicable across many training programs.<sup>8</sup> The Delphi process mathematically narrows down concepts through iterative rounds of anonymous questionnaires until consensus is achieved.<sup>9</sup> We sought to create a task-specific scale to evaluate discrete surgical steps involved in rigid esophagoscopy and foreign body removal, and a global-rating scale to evaluate overall performance, as each scale measures different aspects of training.

## METHODS

Two authors (EJP, EAF) created a list of steps that they commonly perform during rigid esophagoscopy with foreign body removal. Three other authors (NEW, KB, SLI) edited and added to this list. All authors were fellowship-trained pediatric ORL-HNS surgeons who previously developed a competency-based assessment tool for pediatric tracheotomy<sup>9</sup>.

Statements were collated into a questionnaire using Research Electronic Data Capture (REDCap).<sup>10</sup> We selected REDCap because replies are anonymous and respondents can easily complete and submit answers without downloading and uploading files. We tried to simplify questionnaire completion to increase response rates and decrease response times.

We reviewed the American Society of Pediatric Otolaryngology membership list and names of pediatric otolaryngologists at each academic institution in the United States and Canada to generate a list of potential experts. Those with a strong publication history in the field of rigid esophagoscopy and foreign body removal (Pubmed/book chapter editor or author) were included, many of whom had expertise in medical education. Experts with a publication history in this field from Europe and Australia were also included. Sixty-six prospective experts were invited by email to anonymously complete the survey. Experts were promised authorship in the order in which they responded to acknowledge their work. Respondents were ranked in order of response time separately for each round and the average of all rounds created the final authorship order. This worked previously to acknowledge each expert's contributions, increase the response rate and decrease the time to respond<sup>9</sup>. We contacted each expert three times per round (invitation and two reminders), each one week apart.

Experts were asked to rate each item on the Task-Specific list as "keep" or "remove" in the first round, and to provide suggestions for change. Anonymous responses were exported to an Excel (Microsoft, Redmond, WA) file and two investigators (EAF, EJP) reviewed responses and incorporated suggestions. Efforts were made to be inclusive. For a task to be included, 50% of respondents needed to rate it as "keep". In the second round, we used a Global Rating Scale that had previously been validated for many different surgical procedures that was not included in the first round.<sup>11</sup>

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5 During the second round, experts rated the importance of each item on the Task-Specific list  
6 using a 7-point Likert scale (1-Not at all important, 2-Low importance, 3-Slightly important, 4-  
7 Neutral, 5-Moderately important, 6-Very important, 7-Extremely important) and provided  
8 comments. Anonymous results were exported to an Excel file and a mean score was calculated  
9 for each item. Based on previous consensus statements in otolaryngology, consensus for the  
10 task-specific list and the global rating scale were calculated as: 1) Reaching consensus  
11 (individual responses fall within 2 Likert points of mean with only 1 outlier); 2) Near consensus  
12 (individual responses fall within 2 Likert points of mean with only 2 outliers); 3) No consensus  
13 (not meeting criteria 1 or 2).<sup>12,13</sup> Based on previous Task-Specific OSATS tools (mean+/-SD),  
14 we determined that an ideal Task-Specific list should have 7 to 25 items for inclusiveness and  
15 ease of use.<sup>6</sup>  
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26 The study end point was determined a priori, whereby 7 to 25 items reaching consensus in the  
27 second round would obviate the need for another iteration. However, >25 items reaching  
28 consensus would lead to keeping the most highly rated 25 items based on mean score.  
29 Conversely, <7 items reaching consensus would force another iteration whereby experts would  
30 be asked to rate only consensus and near consensus items again. If <7 items reached consensus,  
31 all items reaching consensus plus the most highly rated items reaching near-consensus based on  
32 mean score would be included up to a total of 7 items. This modification was created to decrease  
33 the burden placed on experts and shorten the study.  
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## RESULTS

Sixty-six experts in rigid esophagoscopy and foreign body removal were contacted and two email addresses were erroneous. The first round achieved a response rate of 38/64 (59.4%). Every item evaluated in the first round attained >78% of respondents wanting to “keep” it in the list for the second round. There were no missing responses out of 912 possible items (38 experts, 24 items) for a completion rate of 100%. There were 172 comments incorporated into the second phase (Table 1). The time for completion of round 1 was 30 days.

In the second round, 24 task-specific (Table 2) and 7 previously validated global rating (Table 3) items were distributed and the response rate was 53/64 (82.8%). There were 40 missing responses out of 1,643 possible items (53 experts, 31 items) for a completion rate of 97.6%. For the 24 task-specific items, 9 reached consensus, 7 were near consensus, and 8 did not achieve consensus. The 9 task-specific items that reached consensus were all rated positively, with a mean (SD) Likert rating of 6.29 (0.37) (range 5.67 – 6.83). For the 7 previously-validated global rating items, 6 reached consensus and 1 was near consensus. The 6 global rating items that reached consensus were all rated positively, with a mean (SD) Likert rating of 5.91 (0.27) (range 5.54 – 6.33). Tables 2 and 3 show each item, mean score, and consensus level. The time for completion of round 2 was 20 days.

## DISCUSSION

Decreased resident work hours, increased concerns for patient safety and a constant push from hospitals for greater efficiency have limited time for hands-on surgical training. These restrictions, along with variations in trainee learning curves, reinforce the need for objective and reproducible methods of evaluation. We sought to develop a competency-based assessment tool for pediatric rigid esophagoscopy and foreign body removal because it is a commonly encountered complex procedure with potentially serious risks such as esophageal perforation and injury to the teeth and gums. This tool can be used to evaluate the trainee immediately following completion of the procedure in order to counteract recall bias often seen in end-of-rotation evaluations.

Our response rates were 59.4% and 82.8% for the first and second rounds, respectively. A response rate of 60% is accepted by many biomedical journals for survey research.<sup>14</sup> Also, >97% of items were completed for all submitted questionnaires for each round. This is much higher than the American Association for Public Opinion Research (AAOPR) suggestion that 80% equals a complete response.<sup>15</sup> We believe this response rate reflects clinicians who are experienced and interested in this area of medicine, ease of use of the REDCap system, assurance of anonymity, and offer of authorship. We did not see a drop in response rate in the second round as has been seen in other studies using the Delphi method. The time for completion of this study was 50 days. We believe the short interval between questionnaires maintained a high level of interest.

In the second round, 9 task-specific items reached consensus (Tables 2 and 3). We did not require another round because this fell within the range of 7 to 25 items determined a priori.<sup>6</sup> Final items focused on preparation and prevention of adverse events. A proposed scoring sheet is available in table 4.

Several items approached consensus. One of these was communication with operative team, including intubation and plan if foreign body is visualized at esophageal inlet as well as performing the surgical safety checklist. Communication with the operative team regarding the shared airway reached consensus in our previous OSAT for pediatric open tracheotomy. Though



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3 communication regarding the airway is always important, these may not have reached consensus  
4 because rigid esophagoscopy is most often performed with the patient intubated, making the  
5 shared airway less of a concern, provided that the endotracheal tube does not get kinked by the  
6 esophagoscope or inadvertently dislodged during foreign body retrieval. Other items  
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8 approaching consensus were: “minimizes fog or mucous from obscuring telescope” and specific  
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10 details about how to grasp and withdraw the foreign body. These may have only reached near  
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12 consensus because there was a similar but more important task of identifying the foreign body  
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14 without accidentally pushing it distally. Lastly, the tasks of performing additional  
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16 esophagoscopy to re-evaluate mucosa and rule out an additional foreign body and evaluation of  
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18 teeth, mucosa, temporomandibular joint, and spine for injury reached near consensus. Though  
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20 all are extremely important, a straightforward procedure with good visualization and minimal to  
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22 no bleeding would be unlikely to cause an injury, and additional foreign bodies would be  
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24 unlikely if only one radiopaque foreign body was seen on x-ray.  
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27 Six of the 7 items in the Global Rating Scale reached consensus and 1 was near consensus. The  
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29 6 global rating items reaching consensus were rated positively. Surprisingly, demonstrating  
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31 familiarity with all steps of the operation/procedure only reached near consensus. This item  
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33 received the highest mean Likert score, but only approached consensus because there were two  
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35 outliers. We believe that a mean score of 6.38 out of 7 (91%) for this item justifies using the  
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37 previously validated Global Rating Scale with pediatric rigid esophagoscopy and foreign body  
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39 removal. Additionally, the Global Rating Scale has not been validated for use of a subset of  
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41 items, supporting using it in its entirety. Finally, the Global Rating Scale is complementary to  
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43 the task-specific scale, thus reinforcing its importance. A proposed scoring sheet is available in  
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45 table 5.  
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48 A limitation of this study is that task-specific items for pediatric rigid esophagoscopy with  
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50 foreign body removal were selected based on expert opinion and the scale has not achieved  
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52 construct validity using trainees of various levels. This could be done with live patients or  
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54 potentially using a simulation laboratory. We need to determine if this tool will be helpful for  
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56 trainees and faculty. Experts from developing and resource-limited regions were not included  
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58 during development of this tool. Although our modifications to the Delphi technique have now  
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3 appeared to work well for reaching consensus on the important steps involved in pediatric rigid  
4 esophagoscopy with foreign body removal in this study and open pediatric tracheotomy in a  
5 previous study, we cannot predict if they will work well when creating assessment tools for other  
6 procedures or with a different group of experts. Future studies investigating the construct  
7 validity of this pediatric rigid esophagoscopy with foreign body removal tool are required.  
8 Broad and structured use of this tool are required to permit independent evaluation.  
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## 14 **CONCLUSION**

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17 Reaching consensus on the important steps of pediatric rigid esophagoscopy with foreign body  
18 removal is possible. The modified Delphi consensus process described herein allowed for this to  
19 happen. These items can be considered to create a competency-based assessment tool for  
20 pediatric rigid esophagoscopy with foreign body removal. This assessment tool may allow  
21 trainees to focus on important steps of this procedure and help training programs standardize  
22 how trainees are evaluated.  
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3 **TABLES**  
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6 Table I.  
7 Pediatric Rigid Esophagoscopy And Foreign Body Removal Objective Structured Assessment of  
8 Technical Skill Tool Round 1.

Task-Specific Items	No. Completed	No. Rating Keep (%)	No. Comments
Prepares preoperative plan			
1. Reviews history and imaging to identify goal of procedure.	38	38 (100%)	16
2. Appreciates urgency of removal depending on type of foreign body, where applicable.	38	38 (100%)	17
Communicates with nursing		38 (100%)	
3. Selects appropriate esophagoscope (diameter and length).	38	38 (100%)	2
4. Selects appropriate telescope (diameter and length).	38	37 (97.4%)	1
5. Selects appropriate grasper, if required (type, length, optical telescope).	38	38 (100%)	5
Assembles instruments properly			
6. Tests scope(s) for adequate light, broken fibers, and cracks.	38	38 (100%)	8
7. Ensures grasper fits down esophagoscope.	38	38 (100%)	4
8. Ensures bridge and telescope fit into esophagoscope.	38	38 (100%)	8
Communicates with anesthesiologist			
9. Discusses intubation, where required.	38	38 (100%)	12
10. Requests endotracheal tube be secured to left side of mouth and that tape allows mouth to open.	38	38 (100%)	6
Positions patient properly			
11. Brings head of patient to top of bed.	38	38 (100%)	2
12. Uses shoulder roll, if necessary.	38	37 (97.4%)	5
Provides exposure for esophagoscopy			
13. Places tooth guard on teeth or gauze on gums.	38	38 (100%)	5
14. Selects appropriately sized laryngoscope.	38	38 (100%)	7
15. Inserts laryngoscope into esophageal inlet.	38	31 (81.6%)	16
16. Exposes esophageal inlet to provide easy esophagoscope entry.	38	36 (94.7%)	7
Performs rigid esophagoscopy			
17. Prevents esophagoscope from damaging lips and mucosa.	38	38 (100%)	11
18. Prevents fog or mucus from obscuring telescope.	38	38 (100%)	7
19. Identifies foreign body without pushing it distally, where applicable.	38	38 (100%)	7
Retrieves foreign body, where applicable			
20. Withdraws telescope while maintaining esophagoscope in correct position.	38	38 (100%)	4
21. Grasps foreign body without dislodging it distally.	38	37 (97.4%)	5
22. Withdraws foreign body into esophagoscope or to tip if too large to fit inside.	38	38 (100%)	9
Evaluates for injury			
23. Performs additional esophagoscopy to evaluate damage to mucosa or presence of additional foreign body.	38	38 (100%)	2
24. Removes tooth guard to evaluate for dental injury.	38	37 (97.4%)	8

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Table II.  
Pediatric Rigid Esophagoscopy And Foreign Body Removal Objective Structured Assessment of  
Technical Skills Round 2.

Task-Specific Items	No. Completed	Mean (SD) Likert	Consensus
<b>Surgical goals, preparation and potential challenges</b>			
1. Reviews history, physical examination, imaging (rule out battery) and anatomical and patient factors to identify goal of procedure and whether flexible or rigid esophagoscopy +/- bronchoscopy are indicated.	53	6.83 (0.38)	Yes
2. Appreciates urgency of removal depending on type of foreign body, where applicable.	53	6.77 (0.55)	Yes
3. Consents caregiver(s) for procedure including risks, benefits, and potential complications.	53	6.17 (1.00)	No
<b>Preparation of instruments</b>			
4. Selects appropriately sized laryngoscope(s), when necessary.	53	6.08 (0.97)	No
5. Selects appropriate esophagoscope(s) (diameter and length).	52	6.20 (0.80)	Yes
6. Selects appropriate telescope(s) (diameter and length).	53	6.19 (0.79)	Yes
7. Selects appropriate suction (flexible or rigid).	53	5.67 (0.96)	Yes
8. Selects appropriate grasper(s) (type, length, optical telescope, works on duplicate foreign body) and ensures it passes through and beyond esophagoscope.	52	6.51 (0.73)	Yes
9. Tests scopes, cables and video monitor to ensure functionality (adequate light, broken fibers, cracks, white balance, focus).	53	6.29 (0.87)	No
10. Ensures telescope +/- bridge/rubber guide fit in/on esophagoscope.	53	5.98 (1.13)	Yes
<b>Communication with operative team</b>			
11. Discusses airway plan including intubation +/- rigid bronchoscopy and formulates plan if foreign body is visualized at esophageal inlet.	52	6.39 (0.98)	Near
12. Performs surgical safety checklist and discusses steps of procedure and potential complications.	53	5.98 (1.20)	Near
13. If intubated, requests endotracheal tube be secured to desired side of mouth and that tape allows mouth to open.	53	5.19 (1.37)	No
<b>Patient position and exposure</b>			
14. Brings head of patient to top of bed and uses shoulder roll, when necessary.	52	5.39 (1.22)	No
15. Evaluates and protects teeth and gums in age appropriate manner (tooth guard, gauze).	53	5.80 (1.22)	No
16. Exposes esophageal inlet to provide atraumatic entry of esophagoscope.	53	6.08 (1.06)	No
<b>Rigid Esophagoscopy</b>			
17. Protects lips, teeth, oral mucosa and esophagus from injury.	53	6.23 (0.81)	Yes
18. Minimizes fog or mucus from obscuring telescope (anti-fog, suction, retracts scope proximal to tip of esophagoscope).	53	5.65 (1.05)	Near
19. Identifies foreign body without accidentally pushing it distally.	53	6.23(0.81)	Yes
<b>Foreign body retrieval, where applicable</b>			
20. Withdraws telescope and bridge while maintaining esophagoscope at optimal distance from foreign body for retrieval.	53	6.17 (0.92)	No
21. Passes grasper distal to end of esophagoscope, ensures full opening of grasper and grasps foreign body while accounting for sharp edges, all without complications (mucosal injury, distal dislodgement).	52	6.41 (0.78)	Near
22. Withdraws foreign body into esophagoscope or to tip if too large to fit inside and removes esophagoscope uneventfully if possible or stops to consider alternatives in case of failure.	53	6.50 (0.90)	Near
<b>Final Evaluation</b>			
23. Performs additional esophagoscopy and examination of nasopharynx to reevaluate mucosa and rule out additional foreign body.	52	6.25 (1.06)	Near

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24. Evaluates teeth, mucosa, temporomandibular joint and cervical spine for injury and is able to discuss management when injury is present.	52	5.84 (1.14)	Near
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SD = standard deviation; No. = number

For Peer Review

Table III.  
 Pediatric Rigid Esophagoscopy And Foreign Body Removal Obstructive Structured Assessment of  
 Technical Skills Round 2.

Global Rating Scale	No. Completed	Mean (SD) Likert	Consensus
Respect of tissue			
1. Appropriate handling of tissue, minimizes tissue damage through appropriate use of instruments and appropriate force.	54	6.33 (0.83)	Yes
2. Efficient and economic movement.	54	5.69 (0.92)	Yes
Knowledge of instruments			
3. Familiar with names of instruments required for this procedure, does not ask for wrong instrument or use incorrect names when asking for instruments.	54	5.98 (0.90)	Yes
Instrument handling			
4. Competent use of instruments, fluid movement without stiffness or awkwardness.	54	5.92 (0.79)	Yes
Flow of operation			
5. Demonstrates forward planning; course of operation demonstrated through effortless flow from one movement to the next.	54	5.98 (0.91)	Yes
6. Strategically uses assistants to the best advantage at all times.	54	5.54 (1.06)	Yes
Knowledge of specific procedure			
7. Demonstrates familiarity of all steps of the operation/procedure.	54	6.38 (0.80)	Near

SD = standard deviation; No. = number

Table IV.  
Pediatric Esophagoscopy And Foreign Body Removal Evaluation Sheet.

5	Date: (MM/DD/YY) _____			
6	Trainee Name: (Last) _____ (First) _____			
7	Level of Training: _____			
8	Evaluator Name: (Last) _____ (First) _____			
10	Task-Specific Items	Not Done or Done Incorrectly	Done Correctly	Not Observed
13	Surgical goals, preparation and potential challenges			
14	1. Reviews history, physical examination, imaging (rule out battery) and anatomical and patient factors to identify goal of procedure and whether flexible or rigid esophagoscopy +/- bronchoscopy are indicated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15				
16	2. Appreciates urgency of removal depending on type of foreign body, where applicable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17				
18	Preparation of instruments			
19	3. Selects appropriate esophagoscope(s) (diameter and length).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20				
21	4. Selects appropriate telescope(s) (diameter and length).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22				
23	5. Selects appropriate suction (flexible or rigid).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24				
25	6. Selects appropriate grasper(s) (type, length, optical telescope, works on duplicate foreign body) and ensures it passes through and beyond esophagoscope.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26				
27	7. Ensures telescope +/- bridge/rubber guide fit in/on esophagoscope.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	Rigid Esophagoscopy			
29	8. Protects lips, teeth, oral mucosa and esophagus from injury.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30				
31	9. Identifies foreign body without accidentally pushing it distally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Number of items performed correctly: \_\_\_\_\_

Was this a standard case?  Yes  No If not, Why? \_\_\_\_\_

Is this resident competent to perform this procedure?  Yes  No



Table V  
Pediatric Rigid Esophagoscopy Global Rating Scale Evaluation Sheet.

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5 Date: (MM/DD/YY) \_\_\_\_\_  
6 Trainee Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_  
7 Level of Training: \_\_\_\_\_  
8 Evaluator Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_  
9

10 Global Rating Scale					
11 1. Respect for tissue	1 12 Frequently used 13 unnecessary force on 14 tissue or caused 15 damage by 16 inappropriate use of 17 instruments	2	3 18 Carefully handled 19 tissue but 20 occasionally 21 caused inadvertent 22 damage	4	5 23 Consistently handled tissues 24 appropriately with minimal 25 damage
18 2. Time and motion	1 19 Many unnecessary 20 moves	2	3 21 Efficient but some 22 unnecessary 23 moves	4	5 24 Clear economy of movement 25 and maximum efficiency
22 3. Instrument handling	1 23 Repeatedly made 24 tentative or awkward 25 moves by 26 inappropriate use	2	3 27 Competent use of 28 instruments but 29 occasionally 30 appeared stiff or 31 awkward	4	5 32 Fluid moves and no 33 awkwardness
28 4. Knowledge of 29 instruments	1 30 Frequently asked for 31 wrong instrument or 32 used inappropriate 33 instrument	2	3 34 Knew names of 35 most instruments 36 and used 37 appropriate 38 instruments	4	5 39 Obviously familiar with 40 instruments and their names
34 5. Use of assistants	1 35 Consistently placed 36 assistants poorly or 37 failed to use assistants	2	3 38 Appropriate use of 39 assistants most of 40 the time	4	5 41 Strategically used assistants to 42 the best advantage at all times
38 6. Flow of operation 39 and forward 40 planning	1 41 Frequently stopped 42 operating or unsure of 43 next move	2	3 44 Some forward 45 planning with 46 reasonable 47 progression of 48 procedure	4	5 49 Obviously planned course of 50 operation with effortless flow 51 from one move to the next
43 7. Knowledge of 44 specific procedure	1 45 Deficient knowledge. 46 Needed specific 47 instruction at most 48 steps	2	3 49 Knew all important 50 steps of operation	4	5 51 Demonstrated familiarity with all 52 aspects of operation

48  
49 Total score (sum all numbers): \_\_\_\_\_  
50 Was this a standard case?  Yes  No If not, why? \_\_\_\_\_  
51 Is this resident competent to perform this procedure?  Yes  No

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