

Supplementary Table 1 Features and recommended management in two case reports of the novel syndrome of bizarre endoscopic behavior by gastrointestinal endoscopists

Features reported in both cases	Rationale/Reason
(1) Rarity of syndrome: reported in 2 (0.0011%) of 181,767 gastrointestinal endoscopies.	Rare syndrome because gastroenterologists generally have to be relatively healthy and physically fit to practice endoscopy. Can occur because gastroenterologists, like other individuals, are subject to human frailties that can cause change in mental status.
(2) Acute change in mental status manifested abruptly during endoscopy as bizarre endoscopic interpretation and technique.	Change in mental status can affect both cognitive and motor skills. Endoscopists may have had subtle changes in behavior not appreciated before endoscopy, but noticed when facing careful scrutiny of endoscopic skills during endoscopy.
(3) Bizarre behavior first detected by endoscopy nurses and not by endoscopy technicians or nurse-anesthetists, who were also present in the endoscopy room.	Nurses should be more adept at recognizing impaired behavior at endoscopy than endoscopy technicians due to more training. Nurses more focused on endoscopic procedure than nurse-anesthetists, who are focused on monitoring patient vital signs and level of anesthesia.
(4) Work-up revealed metabolic encephalopathy in both cases secondary to: Case-1-obstructive nephrolithiasis, urosepsis, dehydration, and ketosis; and Case-2- attributed to dehydration and transient effects of unknown drug received from unidentified stranger.	In both cases bizarre behavior at endoscopy stemmed from acute change in mental status attributed to metabolic encephalopathy from medical disorders.
(5) Endoscopists rapidly and completely	Rapid recovery after appropriate treatment of

recovered from change-in-mental-status after medical disorders that caused toxic encephalopathy. receiving appropriate medical therapy, and resumed seeing patients and performing endoscopy shortly thereafter.

Recommended management (in both cases) Reason

- (1) Realize incident constitutes a medical emergency requiring immediate management. High patient risks when undergoing endoscopy by impaired endoscopist (e.g. gastrointestinal perforation).
- (2) Endoscopy nurse reported incident to endoscopy-unit-nurse-supervisor who reported incident to supervisory gastroenterologist. Follow recommended chain-of-command. Avoids awkwardness of nurse directly confronting a physician about clinical skills.
- (3) Supervisory gastroenterologist paged stat to endoscopy suite and came there emergently to handle incident. Medical emergency must be immediately managed appropriately.
- (4) Supervisory gastroenterologist convinced impaired endoscopist to abort ongoing endoscopy and cancel already scheduled following endoscopies. Intervention intended to disengage impaired endoscopist from patient to prevent patient harm during endoscopy.
- (5) Supervisory gastroenterologist advised impaired endoscopists to go to emergency room for medical evaluation. Standard medical recommendation for any patient with acute change in mental status.

Suggested (optional) management

Proposed reason

- (1) Supervisory GI attending accompanied impaired gastroenterologist to emergency room (with patient permission). Supervisory attending thereby demonstrates collegiality, and facilitates work-up of impaired endoscopist in emergency room.
- (2) Impaired endoscopists underwent comprehensive urine toxic drug screen and Tests recommended to exclude drug abuse by impaired endoscopist because of medico-legal

determination of blood alcohol level (both ramifications of physician drug dependency. negative).
