Joint Statement by the American Society for Gastrointestinal Endoscopy, the Society of American Gastrointestinal Endoscopic Surgeons, and the American Society of Colorectal Surgeons

Principles of privileging and credentialing for endoscopy and colonoscopy

Granting privileges for GI endoscopy

Ensuring that high-quality endoscopy is provided to the public has been one of the main principles of the ASGE for many years. Appropriate training in GI endoscopy is critical to providing quality endoscopists. ASGE's training guidelines call for acquisition of endoscopic skills in the context of training programs in gastroenterology or surgery and for an assessment of endoscopic skill after a threshold number of procedures has been performed. There has been considerable variability among professional societies in the numbers of procedures required to assess the competence of trainees. As additional studies have been performed, it is clear that more procedures are needed than were previously recommended to ensure competency.

I am very pleased that with the cooperation and understanding of my fellow Society Presidents, William Traverso of the Society of American Gastrointestinal Endoscopic Surgeons and John MacKeigan of the American Society of Colorectal Surgeons, our three societies were able to agree on a joint guideline on granting privileges for gastrointestinal endoscopy. This guideline clearly states that all three of our societies are aligned on the importance of training before granting privileges for upper endoscopy and colonoscopy. The other important principle highlighted in this guideline is that these principles of training for endoscopy apply to endoscopy performed in any setting. As more endoscopy is done in the unregulated office setting, payers will ultimately determine who performs endoscopy. Having uniform guidelines for endoscopic privileges across specialties should help convince payers of the importance of training in ensuring the delivery of high-quality endoscopic services.

Michael B. Kimmey, MD
Immediate Past President, ASGE

PREAMBLE

Privileging or credentialing for the performance of esophagogastroduodenoscopy (EGD) and colonoscopy should be based on prior demonstration of proficiency in the performance of these procedures. Proficiency should be substantiated by documentation provided by the applicant from Residency Program Directors, Chiefs of Service, or other members of the teaching faculty who have directly observed the applicant performing endoscopy. Individuals applying for privileges for EGD and colonoscopy should have demonstrated satisfactory completion of an Accreditation Council for Graduate Medical Education-accredited training program in adult or pediatric gastroenterology, general surgery, colorectal surgery, or pediatric surgery. Attestation to competency in the performance of these techniques should therefore be provided by the Program Director and, if deemed necessary, by the Credentialing or Privileging Committee at the institution at which these privileges are being sought or by other teaching faculty from the applicant's residency program. In the case of applicants who already have privileges to perform these procedures and are applying for similar privileges at another facility or for renewal of privileges at the same facility, attestation of competency should be provided by the applicant's Chief of Service. Maintenance of continued competency is the responsibility of the respective Credentialing or Privileging Committee and should be based on ongoing review of the applicant's performance by their Chief of Service. These credentialing guidelines are intended to apply to any site at which EGD and colonoscopy are practiced. These guidelines should supplement previously published guidelines by ASGE, ASCRS, and SAGES.[1-7] More comprehensive discussions of issues surrounding the granting of privileges for gastrointestinal endoscopy are available on the societies' websites, i.e., the ASGE at www.asge.org, the Society of American Gastrointestinal Endoscopic Surgeons at www.sages.org, and the American Society of Colorectal Surgeons at www.fascrs.org.

PURPOSE

The purpose of this statement is to outline principles and provide practical suggestions to assist hospital privileging or credentialing committees in their task of granting privileges to perform gastrointestinal endoscopy. In conjunction with the standard Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guidelines for

Also published in Diseases of the Colon and Rectum and *Surgical Endoscopy.*

granting hospital privileges, implementation of these methods should help assure that endoscopy is performed only by individuals with appropriate competency, thus assuring high quality patient care and proper procedure utilization.

UNIFORMITY OF STANDARDS

Uniform standards should be developed that apply to all hospital staff requesting privileges to perform endoscopy, and to all areas where endoscopy is performed. Criteria must be established that are medically sound and that are applicable to all those wishing to obtain privileges in each specific endoscopic procedure. The goals must be the delivery of high-quality patient care.

SPECIFICITY OF PRIVILEGING FOR ESOPHAGOGASTRODUODENOSCOPY AND COLONOSCOPY

Privileges should be granted for each major category of endoscopy separately.[1] The ability to perform one endoscopic procedure does not imply adequate competency to perform another. Associated skills generally considered an integral part of an endoscopic category may be required before privileges for that category can be granted.

RESPONSIBILITY FOR PRIVILEGING

The credentialing structure and process is the responsibility of each hospital. It should be the responsibility of the service chief to recommend individuals for privileges in gastrointestinal endoscopy as for other procedures performed by members of his/her department.

TRAINING AND DETERMINATION OF COMPETENCE

Formal residency training in gastroenterology or surgery

The Accreditation Council for Graduate Medical Education has mandated that programs in surgery and gastroenterology must provide experience to each resident in the performance of esophagogastroduodenoscopy and colonoscopy. (Directory of Residency Training Programs—Graduate Medical Education Directory 2000-2001.)

Endoscopic training and experience outside a formal residency program after satisfactory completion of an ACGME accredited general surgery, pediatric surgery, colorectal surgery, gastroenterology, or the equivalent

Equivalent training and/or experience obtained outside a formal program is recognized, but must be at least equal to that described above.[4] Certification of experience by a skilled endoscopic practitioner must include a detailed description of the nature of "informal" training, the number of procedures performed with and without supervision, and the actual observed competency of the applicant for each endoscopic procedure for which privileges are requested. It is no longer acceptable for physicians to acquire equivalent endoscopic experience by performing unsupervised procedures when skilled endoscopists are available in the medical community.

Determination of competence

1. The applicant has completed a residency program that incorporates structured experience in gastrointestinal endoscopy.[2] Competence should be documented by the instructor(s).
2. The applicant can demonstrate proficiency in endoscopic procedure(s) and clinical judgement equivalent to that obtained in a residency program.[4] This generally requires participation in gastrointestinal endoscopic training until competence in the specific procedure(s) is equivalent to that which would have been obtained upon completion of a residency program that incorporates structured experience in gastrointestinal endoscopy.
3. The applicant's endoscopic director should confirm in writing the training, experience (including the number of cases for each procedure for which privileges are requested) and actual observed level of competency. It is recognized that by virtue of completing a residency program, the endoscopist will have acquired sufficient cognitive experience in anatomy, physiology, and disease processes, combined with the progressive development of visual and psychomotor skills and experience necessary for the performance of diagnostic and therapeutic procedures in the gastrointestinal tract. Such experience includes indications, complications and their management, and alternative approaches. The training director's opinion and recommendation should be considered prima facie evidence for the trainee's acceptance as an individual qualified in gastrointestinal endoscopy. Documentation and demonstration of competence is necessary.

NEW PROCEDURES

Self-training in new techniques in gastrointestinal endoscopy must take place on a foundation of basic endoscopic skills. The endoscopist should recognize when additional training is necessary.

PROCTORING

Recognizing the limitations of written reports, proctoring of applicants for privileges in gastrointestinal

endoscopy by a qualified, unbiased staff endoscopist may be desirable, specifically when competency for a given procedure cannot be adequately verified by submitted written material.[5] The procedural details of proctoring should be developed by the credentialing body of the hospital and provided to the applicant. Proctors may be chosen from existing endoscopy staff or solicited from endoscopic societies. The proctor should be responsible to the credentials committee, and not to the patient or to the individual being proctored. Documentation of the proctor's evaluation should be submitted in writing to the credentials committee. Criteria of competency for each procedure should be established in advance. It is essential that proctoring be provided in an unbiased, confidential, and objective manner. A satisfactory mechanism for appeal must be established for individuals for whom privileges are denied or granted in a temporary or provisional manner.

MONITORING OF ENDOSCOPIC PERFORMANCE

To assist the hospital credentialing body in the ongoing renewal of privileges, a mechanism should be in place whereby each endoscopist's procedural performance is monitored.[6] This should be done through existing quality assurance mechanisms or, alternatively, through a multidisciplinary endoscopy committee. This should include monitoring endoscopic utilization, diagnostic and therapeutic benefits to patients, complications, and tissue review in accordance with previously developed criteria.

CONTINUING EDUCATION

Continuing medical education related to endoscopy should be required as part of the periodic renewal of endoscopic privileges. Participation in local, national or international meetings and courses is encouraged.

THE RENEWAL OF PRIVILEGES

For the renewal of privileges an appropriate level of continuing clinical activity should be required, in addition to satisfactory performance as assessed by monitoring of procedural activity through existing quality assurance mechanisms as well as continuing medical education relating to gastrointestinal endoscopy.

REFERENCES

1. ASGE. Guidelines for credentialing and granting privileges for gastrointestinal endoscopy. Gastrointest Endosc 1998;48: 679-82.
2. ASGE. Principles of training in gastrointestinal endoscopy. Gastrointest Endosc 1999;49:845-53.
3. ASGE. Statement on role of short courses in endoscopic training. Gastrointest Endosc 1999;50:913-4.
3. ASGE. Alternative pathways to training in gastrointestinal endoscopy. Gastrointest Endosc 1996;43:658-60.
4. ASGE. Proctoring for hospital endoscopy privileges. Gastrointest Endosc 1999;50:901-5.
5. ASGE. Renewal of endoscopic privileges. Gastrointest Endosc 1999;49:823-5.
6. ASGE. Methods of privileging for new technology in gastrointestinal endoscopy. Gastrointest Endosc 1999;50:899-900.

ADDITIONAL READING

1. Anderson ML, Heigh RI, McCoy GA, Parent K, Muhm JR, McKee GS, et al. Accuracy of assessment of the extent of examination by experienced colonoscopists. Gastrointest Endosc 1992;38:560-3.
2. Barthel J, Hinojosa T, Shah N. Colonoscope length and procedure efficiency. J Clin Gastroenterol 1995;21:30-2.
3. Chak AM, Cooper GS, Blades EW, Canto M, Sivak MV Jr. Prospective assessment of colonoscopic intubation skills in trainees. Gastrointest Endosc 1996;44:54-7.
4. Church JM. Complete colonoscopy: how often? And if not, why not? Am J Gastroenterol 1994;89:556-60.
5. Cosgrove JM, Cohen JR, Wait RB, Margolis IB. Endoscopy training during general surgery residency. Surg Laparosc Endosc 1995;5:393-5.
6. Galandiuk S. A surgical subspecialist enhances general surgical operative experience. Arch Surg 1995;130:1136-8.
7. Gruber M. Performance of flexible sigmoidoscopy by a clinical nurse specialist. Gastroenterol Nurs 1996;19:105-8.
8. Hasseman JH, Lemmel GT, Emad RY, Douglas RK. Failure of colonoscopy to detect colorectal cancer: evaluation of 47 cases in 20 hospitals. Gastrointest Endosc 1997;45:451-5.
9. Jentschura D, Raute M, Winter J, Henkel TH, Kraus M, Manegold BC. Complications in endoscopy of the lower gastrointestinal tract (therapy and prognosis). Surg Endosc 1994;8:672-6.
10. Marshall JB. Technical proficiency of trainees performing colonoscopy: a learning curve. Gastrointest Endosc 1995;42: 287-91.
11. Parry BR, Williams SM. Competency and the colonoscopist: a learning curve. Aust N Z J Surg 1991;61:419-22.
12. Rai S, Moran MR, Rai AM. Are colonoscopies performed by subspecialists more expensive? [abstract]. Dis Colon Rectum 1996;39:A2.
13. Saad, JA, Pirie P, Sprafka JM. Relationships between flexible sigmoidoscopy training during residency and subsequent sigmoidoscopy performance in practice. Fam Med 1994;26:250-3.
14. Wexner SD, Garbus JE, Singh JJ, the SAGES Colonoscopy Outcomes Study Group. A prospective analysis of 13,580 colonoscopies. Reevaluation of credentialing guidelines. Surg Endosc 2001;15:251-61.
15. Wexner SD, Forde KA, Sellers G, Geron N, Lopes A, Weiss EG, et al. How well do surgeons perform colonoscopy? Surg Endosc 1998;12:1410-4.
16. Wigton RS, Blank LL, Monsour H, Nicolas JA. Procedural skills of practicing gastroenterologists: a national survey of 700 members of the American College of Physicians. Ann Int Med 1990;113:540-6.
17. Parry BR, Williams SM. Competency and the colonoscopist: a learning curve. Aust N Z J Surg 1991;61:419-22.
18. Cass OW, Freeman ML, Cohen J, Zuckerman G, Watkins J, Nord J, et al. Acquisition of competency in endoscopic skills (ACES) during training: a multicenter study [abstract]. Gastrointest Endosc 1993;43:308.
19. Cass OW, Freeman ML, Peine CJ, Zera R, Onstad GR. Objective evaluation of endoscopic skills during training. Ann Intern Med 1993;118:40-4.
20. Galandiuk S, Ahmad P. Impact of sedation and resident teaching on complications of colonoscopy. Dis Surg 1998;15:60-3.

Prepared by:

SAGES Credentials Committee

Steven D. Wexner, MD, Chair
Demitrius Litwin, MD
Jeffrey Cohen, MD
David Earle, MD
George Ferzli, MD
James Flaherty, MD
Scott Graham, MD
Santiago Horgan, MD
Brian L. Katz, MD
Michael Kavic, MD
John Kilkenny, MD
John Meador, MD
Raymond Price, MD
Brian Quebbemann, MD
William Reed, MD
Lelan Sillin, MD
Gary Vitale, MD
E. S. Xenos, MD

ASGE Standards of Practice Committee

Glenn M. Eisen, MD, Chair
Jason Dominitz, MD
Douglas Faigel, MD
Jay Goldstein, MD
Anthony Kalloo, MD
Bret Peterson, MD
Hareth Raddawi, MD
Michael Ryan, MD
John Vargo, MD
Harvey Young, MD

ASCRS Standards Committee

Clifford Simmang, MD, Chair
Neil Hyman, MD
Theodore Eisenstat, MD
Thomas Anthony, MD
Peter Cataldo, MD
James Church, MD
Jeff Cohen, MD
Frederick Denstman, MD
Edward Glennon, MD
John Kilkenny, MD
John McConnell, MD
Juan Nogueras, MD
Charles Orsay, MD
Daniel Otchy, MD
Ronald Place, MD
Jan Rakinic, MD
Paul Savoca, MD
Joe Tjandra, MD