American Society For Gastrointestinal Endoscopy

Methods of granting hospital privileges to perform gastrointestinal endoscopy

This is one of a series of statements discussing the utilization of gastrointestinal endoscopy in common clinical situations. The Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy prepared this text. In preparing this guideline, a MEDLINE literature search was performed, and additional references were obtained from the bibliographies of the identified articles and from recommendations of expert consultants. When little or no data exist from well-designed prospective trials, emphasis is given to results from large series and reports from recognized experts.

Guidelines for appropriate utilization of endoscopy are based on a critical review of the available data and expert consensus. Further controlled clinical studies are needed to clarify aspects of this statement, and revision may be necessary as new data appear. Clinical consideration may justify a course of action at variance to these recommendations.

STATEMENT ON CREDENTIALING AND GRANTING PRIVILEGES FOR GI ENDOSCOPY

Scope: This document is intended to provide the principles by which credentialing organizations may create policy and practical guidelines for granting gastrointestinal endoscopic privileges. Additionally, guidelines for defining continued competence, quality improvement, and the granting of privileges for newly developed or evolving endoscopic procedures are provided. The principles set out in this document are intended to apply universally to all those who perform endoscopic procedures.

DEFINITION OF TERMS

Clinical Privileges: Authorization by a local institution to perform a particular procedure or clinical service.

Competence: The minimum level of skill, knowledge, and/or expertise, derived through training and experience, required to safely and proficiently perform a task or procedure.

Credentialing Process: The process of assessing and validating the qualifications of a licensed independent practitioner to provide patient care. The determination is based on an evaluation of the individual's current license, knowledge base, training or experience, current competence, and ability to perform the procedure or patient care requested.

Credentials: Documents provided after successful completion of a period of education or training as an indication of clinical competence.

May or could: Indicates an optional recommendation, alternatives may be appropriate.

Must or shall: Indicates a mandatory or indispensable recommendation.

Should: Indicates a highly desirable recommendation.

GENERAL PRINCIPLES OF CREDENTIALING AND GRANTING PRIVILEGES

This statement outlines principles of credentialing that are intended to promote high-quality patient care and safety in the area of gastrointestinal endoscopy. These guidelines are intended to complement those of other organizations, including the JCAHO, in the area of granting hospital privileges for the performance of endoscopic procedures. As such, they are intended to apply to all endoscopists and all areas where gastrointestinal endoscopy is performed.

The practical implementation of a credentialing guideline and the granting of privileges are the responsibility of the individual organizations.[1-5] The credentialing process should focus on the assurance of high-quality patient care and be free from political or economic pressures.[2]

Principles of initial credentialing

1. Credentials and privileges should be determined independently for each type of endoscopic procedure (sigmoidoscopy [flexible and rigid], colonoscopy, esophagogastroduodenoscopy [EGD], endoscopic retrograde cholangiopancreatography [ERCP], endoscopic ultrasonography [EUS]) and any other endoscopic procedures.[6,7]
2. Credentialing for all procedures, except sigmoidoscopy, should require the ability to perform common associated therapeutic modalities.
3. Competence in each endoscopic procedure requires both cognitive and technical components.[8,9]
4. Appropriate documentation should be required in the determination of competence in each procedure. This may include the completion of a formal training program (residency or fellowship), or documentation of equivalent training in other settings. Documentation of continued competence should be required for the renewal of endoscopic privileges.[8-11]

5. After the successful completion of a gastrointestinal endoscopy training program (as detailed in "Principles of Training in Gastrointestinal Endoscopy" Gastrointest Endosc 1999; 49:845-50) the trainee:
   A. Must be able to integrate gastrointestinal endoscopy into the overall clinical evaluation of the patient.
   B. Should have sound general medical or surgical training.
   C. Must have a thorough understanding of the indications, contraindications, individual risk factors and benefit-risk considerations for the individual patient.
   D. Must be able to clearly describe an endoscopic procedure and obtain informed consent.
   E. Must have a knowledge of endoscopic anatomy, technical features of endoscopic equipment, accessory endoscopic techniques, including biopsy, cytology, photography, thermal, and nonthermal endoscopic therapy.
   F. Must be able to accurately identify and interpret endoscopic findings.
   G. Must have a thorough understanding of the principles, pharmacology and risks of sedation/analgesia.
   H. Must be able to document endoscopic findings and therapy, and communicate with referring physicians.
   I. Must competently perform those procedures that were taught.

The training in endoscopic techniques must be adequate for each major category of endoscopy for which privileges are requested. Performance of an arbitrary number of procedures does not guarantee competency.[7,11-14] Whenever possible, competence should be determined by objective criteria and direct observation. The number of supervised procedures necessary to obtain competency will vary tremendously among trainees.[15] Previously published required numbers of procedures were an estimate of the "…threshold number of procedures that must be performed before competency can be assessed. The number represents a minimum, and it is understood that most trainees will require more (never less) than the stated number."(Training the Gastroenterologist of the Future: The Gastroenterology Core Curriculum. Gastroenterology 1996;110:1266-300.)

Recent prospective studies using objective measures of endoscopic competence in ERCP and colonoscopy have demonstrated that the published threshold numbers (Appendix A) are not adequate for most trainees to achieve competence.[6,7,9,12] This emphasizes the need to use objective criteria of skill, rather than an arbitrary number of procedures performed when granting privileges to physicians for endoscopic procedures. For example, in ERCP, the ability to cannulate the duct of interest in 80% of cases is used as the minimum measure of competency.[15] A prospective evaluation of trainees has demonstrated that at least 180 supervised procedures are required for trainees to reach that threshold, a number much higher than the previously published minimum of 75 procedures.[9] Evaluation of colonoscopic skills has also demonstrated that the number of supervised procedures necessary to achieve competency is greater than the previously suggested minimum.[7,12,13] Specific measures of competency have not yet been developed for all endoscopic procedures. These measures should be rapidly adopted in credentialing processes as they are developed. Even with objective measures of procedural success, the evaluation of endoscopic skills and the ability to interpret endoscopic findings and incorporate these findings into patient care requires repeated direct observation of the candidate by an experienced endoscopist.

Competence in all procedures, exclusive of sigmoidoscopy, requires the ability to perform appropriate therapeutic maneuvers at the same setting. The performance of diagnostic procedures without the ability to treat all lesions reasonably expected to be encountered during endoscopy cannot be supported.

6. A clinician can obtain training in formal settings, such as fellowship or residency program, or through less formal training ("Alternative Pathways To Training in Gastrointestinal Endoscopy" Gastrointest Endosc 1996;43:658-60).
7. New endoscopic procedures, or significant advances in existing procedures, may occur. Endoscopists who have not received conventional formal training may wish to acquire privileges to perform these procedures. The degree of training, direct supervision, and proctoring will vary with the experience of the endoscopist and the nature of the procedure.[16] When possible, objective criteria of competence should be developed and met.

PRINCIPLES OF RECREDENTIALING AND RENEWAL OF PRIVILEGES

The goal of recredentialing is to assure continued clinical competence, promote continuous quality

improvement, and maintain patient safety.[17-19] The principles of maintenance of competence are detailed in ASGE publication "Maintaining Competency in Endoscopic Skills" (Gastrointest Endosc 1995;42:620-1). These guidelines should be applied in conjunction with those of national accrediting organizations, such as the JCAHO.

Assuring continued competence in the performance of endoscopic procedures includes ongoing:

1. Documentation of adequate procedure volume to maintain clinical skills. This can include procedure log books or a review of patient records. Such a review should include documentation of objective measures of the number of procedures, procedure success, therapeutic interventions and complications.
2. Review of above statistics in a continuous quality improvement setting.[20]
3. Documentation of continued cognitive training through participation in educational activities.

The purpose of this review and documentation should be restricted to use in continuous quality improvement and endoscopic credentialing.

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DOCUMENTATION OF GUIDELINES

Appendices B & C include criteria for assessing competence for credentialing and recredentialing. Appendix B may be used by the program director or endoscopic trainer as means of attesting to the satisfactory attainment of each of the skills for each procedure. Appendix C includes criteria for recredentialing by a department chair based on supporting records of each activity and skill. Satisfactory accomplishment should be documented in each cognitive and technical area.

APPENDIX A

MINIMUM NUMBER OF PROCEDURES BEFORE COMPETENCY CAN BE ASSESSED

Standard procedure	Number of cases required
Flexible sigmoidoscopy	30
Diagnostic EGD	130
Total colonoscopy	140
Snare polypectomy	30*
Nonvariceal hemostasis (upper and lower; includes 10 active bleeders)	25*
Variceal hemostasis (includes 5 active bleeders)	20
Esophageal dilation with guidewire	20
PEG	15
Advanced procedures	
ERCP	200†
EUS: submucosal abnormalities‡	40
Pancreaticobiliary‡	75
EUS-guided FNA	
Nonpancreatic§	25
Pancreatic‖	25
Tumor ablation	20
Pneumatic dilation for achalasia	5
Laparoscopy	25
Esophageal stent placement	10
Enteroscopy	¶

*Included in total number.

†Includes at least 40 sphincterotomies and 10 stent placements.

‡For competence in imaging both mucosal and submucosal abnormalities, a minimum of 100 supervised cases is recommended. For comprehensive competence in all aspects of EUS, a minimum of 150 supervised cases, of which 75 should be pancreaticobiliary and 50 EUS-guided FNA is recommended.

§Intramural lesions or lymph nodes. Must be competent to perform mucosal EUS.

‖Must be competent to perform pancreaticobiliary EUS.

¶Data are not yet available on the minimum number of enteroscopies performed.

APPENDIX B

INITIAL CREDENTIALING GUIDELINES

- Preliminary training
- Cognitive skills
  - Indications/contraindications
  - Consent
  - Endoscopic anatomy
  - Technical aspects
  - Sedation/analgesia
  - Reporting/documentation
  - Integration of care
- Endoscopic skills
  - Technical skill
  - Number of procedures
  - Success rate
  - Complication rate
- Interpretation
  - Therapeutic intervention
- Patient care

APPENDIX C

RECREDENTIALING GUIDELINES

- Endoscopic skills
  - Number of procedures
  - Success rate
  - Complication rate
- Educational activity
- Participation in continuous quality improvement