



Guidelines for privileging, credentialing, and proctoring to perform GI endoscopy

Prepared by: ASGE STANDARDS OF PRACTICE COMMITTEE

Ashley L. Faulx, MD, FASGE, Jenifer R. Lightdale, MD, MPH, FASGE, NASPGHAN representative, Ruben D. Acosta, MD, Deepak Agrawal, MD, MPH, David H. Bruining, MD, Vinay Chandrasekhara, MD, Mohamad A. Eloubeidi, MD, MHS, FASGE, Suryakanth R. Gurudu, MD, FASGE, Lorelee Kelsey, BSN, RN, CGRN, SGNA representative, Mouen A. Khashab, MD, Shivangi Kothari, MD, V. Raman Muthusamy, MD, FASGE, Bashar J. Qumseya, MD, MPH, Aasma Shaukat, MD, MPH, FASGE, Amy Wang, MD, FASGE, Sachin B. Wani, MD, Julie Yang, MD, John M. DeWitt, MD, FASGE, Chair

This document was reviewed and approved by the Governing Board of the American Society for Gastrointestinal Endoscopy.

This is 1 of a series of statements discussing the use of GI endoscopy in common clinical situations. The Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy (ASGE) prepared this text. In preparing this guideline, a search of the medical literature was performed by using PubMed. Additional references were obtained from the bibliographies of the identified articles and from recommendations of expert consultants. When few or no data exist from well-designed prospective trials, emphasis is placed on results from large series and reports from recognized experts. Guidelines for appropriate use of endoscopy are based on a critical review of the available data and expert consensus at the time the guidelines are drafted. Further controlled clinical studies may be needed to clarify aspects of this guideline. This guideline may be revised as necessary to account for changes in technology, new data, or other aspects of clinical practice. The recommendations are based on reviewed studies and are graded on the quality of the supporting evidence (Table 1).¹ The strength of individual recommendations is based on both the aggregate evidence quality and an assessment of the anticipated benefits and harms. Weaker recommendations are indicated by phrases such as “we suggest,” whereas stronger recommendations are typically stated as “we recommend.”

STATEMENT ON CREDENTIALING, RE-CREDENTIALING, AND GRANTING PRIVILEGES FOR GI ENDOSCOPY

A primary mission of the ASGE is to promote high-quality patient care and safety in the field of GI endoscopy.

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0016-5107/\$36.00
<http://dx.doi.org/10.1016/j.gie.2016.10.036>

The purpose of this statement is to provide a suitable framework for determining the competency of practicing endoscopists and for the granting of privileges to perform endoscopic procedures. Guidelines for the granting of privileges for newly developed endoscopic procedures are also provided. As such, this document provides principles and practical guidelines to assist credentialing organizations in creating policy for the granting and renewal of endoscopic privileges.

The principles set out in this document are intended to apply universally to all endoscopists, although some modifications for pediatric procedures are detailed in a separate ASGE guideline.² This guideline replaces a previously published document on principles for competency and privileging by nonphysician endoscopists.³

DEFINITION OF TERMS

A number of terms related to competency and privileging of procedures are summarized in Table 2. Generally speaking, training in endoscopic techniques must be adequate for each major category of endoscopy for which privileges are requested. The need to seek and attain competency in new procedures may periodically arise for endoscopists over the course of their career. New procedures should be taught by preceptors using a validated curriculum. The preceptor should be responsible for setting objectives, demonstrating procedural techniques, overseeing the instruction and practice of skills, evaluating the preceptee, and documenting competency of the preceptee for future credentialing. Whenever possible, competence should be determined based on objective criteria and direct observation. Performance of an arbitrary number of procedures does not guarantee competency, because of differences in individual learning curves. However, minimal threshold numbers may be set below

TABLE 1. GRADE system for rating the quality of evidence for guidelines

Quality of evidence	Definition	Symbol
High quality	Further research is very unlikely to change our confidence in the estimate of effect.	⊕⊕⊕⊕
Moderate quality	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.	⊕⊕⊕○
Low quality	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.	⊕⊕○○
Very low quality	Any estimate of effect is very uncertain.	⊕○○○

Adapted from Guyatt et al.¹**TABLE 2. Common terms and definitions used when discussing criteria for attaining procedural competency, credentials, and privileges**

Term	Definition
Clinical privileges	Authorization by an 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	A process designed to assess and validate the qualifications of a licensed independent practitioner to provide patient care
Credentials	Documents provided after successful completion of a period of education or training as an indication of clinical competence
Preceptor	An endoscopist with clinical experience and appropriate credentials to train a preceptee in new techniques
Preceptee	An endoscopist who possesses sufficient experience to master a new procedure cognitively and technically
Proctor	An independent and unbiased endoscopist in a position to evaluate and monitor the skills and ability of another endoscopist

which competency cannot be assessed. Granting of privileges should be based on evaluation of competence of the endoscopist procedurally as well as his or her knowledge base, training, and experience.

UNIFORMITY OF STANDARDS

The goal of a credentialing organization in granting privileges to perform endoscopic procedures must be to ensure the delivery of high-quality care for all patients undergoing endoscopic procedures. Uniform standards should be developed that apply to all hospital staff requesting privileges to perform endoscopy, regardless of medical specialty, and to all areas where endoscopy is performed. Criteria must be established that are medically sound and applicable to all wishing to obtain privileges for each specific endoscopic procedure.

Privileges should be granted independently for each major category of endoscopy, listed in [Table 3](#). The ability to perform one endoscopic procedure well does not imply adequate competency to perform others. Associated skills generally considered integral to an endoscopic category may be required before privileges for that category can be granted.

GENERAL PRINCIPLES OF CREDENTIALING AND GRANTING HOSPITAL PRIVILEGES FOR GI ENDOSCOPY

[Box 1](#) lists the basic principles of credentialing and privileging for GI endoscopy. The implementation of

credentialing policies and the granting of privileges is the responsibility of individual healthcare organizations.⁴ Credentialing can only begin after successful completion of a GI endoscopy training program in adult or pediatric gastroenterology or general surgery as described in a previous ASGE document.⁵ It should be the responsibility of the service chief or an individual in a comparable role to recommend individuals for privileges in GI endoscopy. The credentialing process should focus on the assurance of high-quality patient care and should be free from political or economic pressures.⁶⁻¹¹ All ASGE guidelines that pertain to granting privileges for the performance of endoscopic procedures are intended to apply to all endoscopists regardless of medical specialty and all sites of service where GI endoscopy is performed.

STANDARDS OF PRACTICE DOCUMENTS FOR CREDENTIALING FOR GI ENDOSCOPY

In the following sections, the ASGE has developed credentialing guidelines, using evidence-based, objective measures whenever possible, for the following procedures/skills: moderate sedation, EGD, colonoscopy, flexible sigmoidoscopy, capsule endoscopy, ERCP, EUS, EMR, endoscopic submucosal dissection, ablative techniques, enteral stent placement, deep enteroscopy (DE), and endoscopic enteral tube placement. [Table 3](#) lists an evidence-based or expert consensus-derived minimum number for each procedure/skill that should be performed before assessment of competency and the granting of initial credentials/privileges.

TABLE 3. Minimum numbers of specific endoscopic procedures/skills that should be performed before assessments of competency and/or seeking of credentials/privileges

Procedure	Minimum number to be performed before assessment of competency	Quality of evidence
Moderate sedation	20	⊕○○○
Upper endoscopy	130	⊕⊕○○
Colonoscopy	275	⊕⊕⊕○
Flexible sigmoidoscopy	30	⊕⊕○○
ERCP	200	⊕⊕⊕○
Capsule endoscopy	20	⊕○○○
DE, lower	20	⊕○○○
DE, upper	10	⊕○○○
EMR (upper GI)	20	⊕⊕○○
Endoscopic submucosal dissection, stomach	30	⊕○○○
Ablation, Barrett's esophagus	30	⊕⊕○○
Enteral stent placement	10	⊕○○○
Enteral feeding tube placement	20	⊕○○○
EUS	225	⊕⊕⊕○

DE, deep enteroscopy; ⊕, grade of evidence.

BOX 1. Principles of initial credentialing

Credentialing should begin after successful completion of a GI endoscopy training program.

1. Determination of endoscopic competence should involve assessments of both cognitive and technical components of each procedure.¹¹
2. Appropriate documentation should be required for determination of competency in each procedure.
3. Credentials and privileges should be determined independently for each type of endoscopic procedure.
4. Credentialing for all procedures should require the ability to perform common associated therapeutic modalities.
5. Documentation of continued competence should be required for the renewal of endoscopic privileges.¹¹

Adapted from Adler et al.⁵

This document endorses the tenet that performance of a specific number of procedures does not guarantee competency.¹² Competency should be assessed using objective criteria (using validated assessment tools when applicable) once the trainee has reached the evidence-based threshold for competency assessment.⁶⁻¹¹ However, evidence-based thresholds that suggest competency should not be assessed below these recommended parameters. Even with objective measures of procedural success, the evaluation of endoscopic skills and the ability to interpret and incorporate these findings into patient care frequently require repeated direct observation of the candidate by an experienced endoscopist. Satisfactory performance of endoscopy should be determined and maintained through existing quality assurance mechanisms developed by individual hospitals and/or credentialing bodies.

Moderate sedation

Moderate sedation is administered during GI endoscopy to reduce patient anxiety and discomfort, improve procedural outcomes, and diminish any unpleasant patient memory of the event. Administration of moderate sedation requires a foundational knowledge in the pharmacodynamic profiles of sedatives, analgesics, and anxiolytics. A multisociety sedation curriculum for GI endoscopy has been developed that provides a comprehensive guide to train providers in all aspects of procedural sedation.¹³ Competency can be assessed through direct observation of technical skills and airway management during procedural sedation and by web-based programs designed to assess cognitive skills and the knowledge base required to provide sedation.¹³ Granting of privileges to endoscopists may also require completion and documentation of practical competencies, including Basic Life Support and Advanced Cardiac Life Support. Credentialing and recredentialing for moderate sedation should be performed in accordance with individual site of service or state requirements on procedural sedation.

EGD

A minimum of 130 EGD procedures, including 25 for the treatment of nonvariceal hemorrhage and 20 for the treatment of variceal hemorrhage, are recommended before competency is assessed.^{14,15} Minimum goals for performance of EGD should include successful intubation of the esophagus and pylorus in over 95% of examinations. Over the last 2 decades the role of EGD has expanded from a diagnostic tool to a therapeutic procedure. In addition to basic proficiency in mucosal inspection and biopsy sampling, the practitioner is expected to be able to

competently control variceal and nonvariceal hemorrhage and perform esophageal dilation, snare polypectomy, and PEG tube placement. Additional therapeutic maneuvers such as pneumatic balloon dilation, stent placement, radio-frequency ablation, complex polypectomy, and cap- or band-assisted EMR, endoscopic submucosal dissection, and peroral endoscopic myotomy should require separate credentialing and monitoring to maintain privileges.⁸

Colonoscopy

A minimum of 275 colonoscopies has been recommended before assessment of competency^{7,16}; however, many endoscopists may not achieve technical competency despite completion of this number of procedures.^{17,18} Some data suggest that 500 colonoscopies may be required to consistently achieve cecal intubation in 90% of procedures for some trainees.¹⁹ For colonoscope insertion, technical competency is achieved when the endoscopist reaches the cecum in over 90% of examinations.

Cecal intubation rate alone may be an inadequate marker of overall technical competence, because it does not reflect the quality of the examination.²⁰ Newer tools have been validated to overcome some of the limitations associated with prior assessment methods.^{15,21-24}

Expected basic technical skills of colonoscopy include the ability to perform full examination of the colon (including a retroflexed view of the rectum) as evidenced by an adenoma detection rate above recommended thresholds.⁶⁻¹¹ The endoscopist must also be able to obtain targeted biopsy specimens, perform snare polypectomy, and achieve hemostasis. Advanced techniques such as stricture dilation, stent placement, and endoscopic submucosal dissection require separate credentialing and monitoring to maintain privileges.

Flexible sigmoidoscopy

Technical competency in flexible sigmoidoscopy includes the ability to perform a full examination of the left side of the colon, retroflexed view of the rectum, and obtain targeted biopsy specimens.²⁵⁻²⁷ Completion of 30 flexible sigmoidoscopy procedures is recommended before competency can be assessed.²⁸ For endoscopists who do not routinely perform colonoscopy, at least 20 of these procedures should be performed under direct supervision and should demonstrate a consistent insertion depth to more than 50 cm.²⁹ Achievement of competency in colonoscopy implies competency to perform flexible sigmoidoscopy. More advanced skills such as hemorrhoidal banding or stent placement require further training and separate credentialing and monitoring to maintain privileges. Providers performing flexible sigmoidoscopy should complete a formal training program or documentation of the nature and procedure volume obtained with any alternative training.^{28,30}

ERCP

ERCP is an advanced endoscopic procedure for treatment of biliary and pancreatic diseases. Competency-based credentialing decisions should be based on achievement of selective cannulation in at least 90% of procedures, accurately interpreting endoscopic and radiologic images, and successful sphincterotomy and stent placement when necessary.^{31,32} There are substantial learning curves associated with ERCP, especially related to selective biliary cannulation of the native papilla. Success has been linked with both experience and volume.^{33,34} Although nearly all trainees pursuing ERCP training are expected to achieve competency in overall cannulation rates, at least 1 study suggests that consistent cannulation of native papilla may not occur before the end of a 3-year fellowship³⁵ or even after completion of a year of advanced endoscopy training.³⁴

At least 200 supervised independent ERCP procedures should be performed before learner competency is assessed.³⁶⁻³⁸ In addition, a trainee should be expected to perform at least 80 independent sphincterotomies and 60 biliary stent placements.^{36,39} A grading scale for ERCP based on procedural difficulty has been adopted by the ASGE as part of their quality assessment document.⁹

Capsule endoscopy

The necessary case volume to achieve competency in capsule endoscopy varies among gastroenterologists, but a consensus minimum number of 20 supervised procedures has been recommended to interpret small intestine capsule examinations independently.⁴⁰⁻⁴² The endoscopist should already possess substantial experience and competency in the recognition and management of endoscopic findings as evidenced by completion of a GI endoscopy or digestive diseases training program. Familiarity with the hardware and software systems necessary to perform and interpret the capsule endoscopy images is also required.

When possible, direct observation or review of saved cases by a qualified preceptor can aid in determining competency. Passing a formalized in-service examination or achieving a 90% or greater correlation rate of significant findings compared with a credentialed provider may be a reasonable expectation.^{41,43}

Deep enteroscopy

DE has become the technique of choice for tissue acquisition or therapy within the GI tract between the ampulla of Vater and the ileocecal valve. DE techniques, which include double-balloon enteroscopy, single-balloon enteroscopy, and spiral enteroscopy, have both diagnostic and therapeutic capabilities.

There are no validated means of determining competency in DE. However, a recommended core curriculum for DE has been published.⁴³ Endoscopists should

complete formal training requirements in upper endoscopy and colonoscopy before learning DE.⁴⁴ DE is most often performed for therapeutic purposes, and thus competency in standard endoscopic therapeutic maneuvers, including argon plasma coagulation, injection sclerotherapy and tattooing, polypectomy, and hydrostatic dilation of strictures, is expected.⁴⁵

An analysis of learning curves among expert endoscopists suggests that measurable improvement after 10 upper DE cases and 20 retrograde double-balloon enteroscopy cases are required to ensure stable overtube intubation of the ileum.⁴⁶ Performance of these minimum numbers has been associated with procedural success, complete examination of the small bowel, and shorter procedure durations.⁴⁷

EMR

EMR involves the removal of superficial neoplasia of the GI tract. Endoscopists performing EMR should understand the role of EMR, management of adverse events, specimen retrieval, defect closure, and, when further staging of neoplasia is required, before attempted resection.⁴⁸ EMR encompasses a variety of techniques that include injection, cap-assisted, and ligation-assisted resection.^{49,50} Recognition of the advantages of 1 technique over another is essential. The endoscopist should understand various options for managing residual neoplasia and be familiar with ablation techniques.

One study found that more than 20 EMR resections in the upper GI tract are required to achieve competency.⁵¹ EMR can be performed in any portion of the GI tract, but this recommendation is limited to Barrett's neoplasia. Similar data for colonic EMR are lacking, although it has been noted that, at the least, competency with colonoscopy and snare polypectomy for smaller lesions is required before training in advanced polypectomy.⁵²

Ablative techniques

Endoscopic ablative techniques, including radiofrequency ablation, cryotherapy, and argon plasma coagulation, are primarily performed to eradicate vascular lesions and abnormal mucosa of the GI tract. The recommendations in this section apply specifically to the use of endoscopic ablation in the esophagus. Individuals performing ablative techniques in the esophagus should be familiar with mucosal inspection of Barrett's esophagus, EMR of Barrett's esophagus, the available accessories and devices, and the management of adverse events.

There are no published minimum procedure threshold criteria for assessment of competency in any of these techniques. An initial study of radiofrequency ablation procedure volume among 7 endoscopists suggested that increased procedure volume was associated with higher complete eradication rates of intestinal metaplasia.⁵³ More recent data from a large multicenter registry found that performance of ablation in up to 30 patients

reduced the number of sessions per patient required to achieve complete eradication of Barrett's esophagus.⁵⁴

Enteral stent placement

Enteral stents provide luminal patency in various benign and malignant conditions of the GI tract.^{28,31-33,55} Indications, risks, and outcomes for esophageal, gastroduodenal, and colonic stent placement may differ, although principles of placement are similar. The endoscopist performing stent placement should have a comprehensive knowledge of available self-expandable metal stents and a basic knowledge in the use and interpretation of fluoroscopy. Institutions may require separate fluoroscopy credentialing and privileging for performing these procedures.

There is currently no standardized minimum number of procedures required before assessing competency in luminal stent placement. Nevertheless, it is expected that higher procedure volumes with congruent skill acquisition during training can produce improved clinical outcomes.¹⁴

Identification of and ability to manage early, immediate, and delayed adverse events such as bleeding, perforation, stent migration, and stent occlusion with tissue/tumor ingrowth/overgrowth is also essential. Expertise in stricture dilation, ablation of tissue with therapies such as argon plasma coagulation, placement of additional stents, and retrieving/repositioning migrated stents is required.

Enteral feeding tube placement

Endoscopically placed enteral feeding tubes, such as PEG, PEG with jejunal extension, or direct percutaneous endoscopic jejunostomy tubes, are used for long-term nutritional support. Endoscopists should be able to perform placement, replacement, and removal of feeding tubes and recognize the adverse events associated with these techniques. Placement of a PEG tube with jejunal extension may require the use of fluoroscopy, and therefore competency and appropriate credentialing in fluoroscopy are recommended.

A recently published document recommends a minimum of 20 supervised PEG tubes before competency can be assessed.⁵⁶ There are no established guidelines for a minimum number of PEG with jejunal extension or direct percutaneous endoscopic jejunostomy procedures that should be performed before assessing competency. Placement of a direct percutaneous endoscopic jejunostomy tube is technically more difficult than placing a PEG tube and is associated with an increased risk of adverse events and overall lower technical success with direct percutaneous endoscopic jejunostomy when compared with PEG.⁵⁷

EUS

EUS can be performed with or without FNA for both diagnostic and therapeutic purposes. Endoscopists who perform EUS should understand proper indications,

applications, contraindications, and adverse events and appropriate alternatives.¹⁰

Current training guidelines recommend that at least 150 supervised EUS procedures should be performed before assessment of competence. It is further recommended that these 150 cases include a minimum of 50 EUS-guided FNAs, 75 pancreaticobiliary cases, 75 mucosal cancer staging cases, and evaluation of 40 subepithelial lesions.⁵⁸ However, a study concluded that 150 cases might be inadequate to achieve competence and recommended at least 225 hands-on cases should be performed before competency can be assessed.⁵⁹

EMERGING TECHNOLOGIES

The practice of GI endoscopy is dynamic and continues to evolve. Standard endoscopic procedures continually undergo refinement, and new major techniques are introduced. New technologies that have left the experimental and developmental stages with demonstrated efficacy may be ready for adoption into clinical practice. Endoscopists who have not received conventional formal training in newly developed techniques may wish to acquire necessary credentials. The degree of training, direct supervision, and proctoring will vary with endoscopist experience and with the nature of the procedure.

When possible, objective criteria of competency for emerging technologies should be developed, and practitioners should be presented a suitable framework for becoming credentialed. In some instances, the acquisition of competency with new technologic developments may require little effort beyond standard acquisition of endoscopic skill and experience. In other cases, however, the acquisition of competency will represent a major addition to the endoscopist's skills and knowledge base. In such instances, a vehicle for formal training will be required with documentation of competency.⁵ Instruction for new technologies may require training at another expert center.

Minor versus major skills

"Minor skill" describes a new nonexperimental development that is a minor extension of an accepted and widely available technique or procedure (eg, radiofrequency ablation of Barrett's esophagus, over-the-scope clips). For most GI endoscopists, obtaining competency in a minor skill should involve education and practical exposure such as that obtained from short courses, training videos, endoscopic simulators, and interactive computer programs.⁶⁰

For a minor skill, the duration of training should not be fixed but rather reflect the time needed for the participant to master it. Properly designed courses can introduce these new techniques to an endoscopist who already has a background and experience in basic skills. Technologic refinements in equipment, including improvements in commonly used equipment such as endoscopes, biopsy

forceps, and snares, do not require formal training, and skill in these techniques can usually be mastered with the aid of instructional videos, package inserts, and demonstration of the technique by other endoscopists.

"Major skill" describes a new technique or procedure that by its nature involves a high level of complexity, interpretative ability, and/or new type of technology. In the initial phases of dissemination, acquisition of competency of emerging technologies involving major skills (eg, per-oral endoscopic myotomy, endoscopic submucosal dissection) should be confined to teaching centers and should require formal training. Furthermore, it is important to recognize that the completion of a short course or workshop that offers limited exposure to cognitive background data or technical skills will not, by itself, result in clinical competency and therefore should not be the sole mechanism for the acquisition of new major skills.⁶⁰ Instead, a preceptorship or other vehicle of formal instruction will generally be considered mandatory for the acquisition of major new skills.¹⁷ The preceptorship should be considered complete when the preceptee has achieved an acceptable level of competency that allows for fully independent performance of the major skill in question. The preceptor should supply written documentation of the successful completion of the preceptorship for credentialing purposes.

It is important to note that the U.S. Food and Drug Administration does not regulate new procedures as it does new drugs and devices. It is recommended that significant new procedural innovations be incorporated into institutional review boards or regulatory oversight at an early stage, so that patients are protected under the federal research regulations. However, the evaluation and implementation of new techniques is typically handled at a local, institutional level.

PRINCIPLES OF PROCTORING FOR ENDOSCOPIC PRIVILEGES

Proctoring may represent an important part of granting endoscopic privileges. Proctoring involves an observational assessment of skills by a credentialed endoscopist that may be used in addition to data from a peer-review process. Candidates for proctoring may include applicants for new staff appointments, incumbent staff members trained in additional or novel procedures, and staff members undergoing routine recredentialing processes or remediation.

The role of proctor is to act as an independent and unbiased monitor with the goal of evaluating, not teaching, the technical and cognitive skills of another endoscopist. It is important that a proctor has no physician or patient relationship with the patient being treated and does not participate directly in patient care. In this way, the proctor remains responsible to the institution and to the process of credentialing those who are seeking endoscopic privileges at an institution. As such, a proctor should not receive a fee

related directly to patient care while proctoring but may receive compensation from the institution for time spent providing proctoring services.

Development of a proctoring policy

Guidelines for proctoring should be specifically included in institutional bylaws as an integral part of the credentialing and privileging process. In departmentalized institutions, it is possible to have bylaws that specify proctoring protocols at the department level.

Proctoring may also be appropriate for privileged incumbent medical staff but have insufficient procedural volume for a given endoscopic procedure. Proctoring may also be 1 of several appropriate actions that can be taken when a potential practice problem with an individual endoscopist is identified by the institution's quality improvement or risk management programs. Provisions for failure to meet the minimum expected competency during proctorship should be outlined, including recommendations for additional training or restrictions of certain privileges and potential avenues for remediation.

Proctoring process

A proctor should be an endoscopist who is credentialed in the procedure being observed and in possession of sufficient expertise to judge the quality and skills of the applicant. He or she should be free of actual or perceived conflicts of interest that may create a bias against or in favor of the applicant. The proctor should directly observe endoscopic procedures by the credentialing candidate for a prespecified period of time or number of cases, as determined by institution-specific bylaws. The proctor should evaluate all aspects of the management of care provided by an applicant during a proctored case, as outlined in Table 4. Applicants must demonstrate competency in both diagnostic and therapeutic maneuvers common to the procedures for which they are seeking credentials.

Once the proctoring process is completed, a confidential written report should be forwarded to the institution for review. The credentialing committee can use the reports to grant privileges to endoscopists with demonstrated clinical competency. Applicants subject to proctoring should retain all rights of appeal under the credentialing process as set forth by the institution.

To minimize liability, the proctor should (1) not interfere with the proctored endoscopist; (2) not offer advice or interact with the patient, other than for the purpose of personal introduction and to state the proctoring role; and (3) only report to the institution or regulatory body that the proctor is representing unless substandard medical care that is harmful to the patient is witnessed. In the event that a proctor notices substandard and detrimental medical care, it is considered appropriate for the proctor to take remedial action. In such a situation, the proctor should first consider contacting an appropriate superior and asking the

TABLE 4. Components to be evaluated during assessment of endoscopic competence

- Reviews patient records/x-ray films
- Identifies potential risk factors
- Understands indications/contraindications
- Believes findings will influence management
- Obtains proper informed consent
- Uses appropriate sedation
- Intubates GI tract with good technique
- Correctly identifies landmarks
- Conducts thorough examination
- Detects and identifies all pathologic conditions
- Completes the examination within a reasonable period
- Obtains tissue sample properly
- Performs therapeutic maneuvers successfully/effectively
- Recognizes and manages procedure-related adverse events
- Prepares an accurate report
- Plans correct management and disposition
- Discusses findings with patient/family and other healthcare providers
- Arranges proper follow-up, review of pathologic findings, and case outcome

proctored endoscopist to stop his or her substandard actions (if possible). Only as a last resort should the proctor actually intervene; when this occurs, appropriate documentation is imperative.⁵³ When an individual being proctored has an associate who also holds privileges in the procedure being proctored, it may be appropriate to ask the associate to be present and to assist (if necessary) to potentially avoid any need for a proctor to intervene.

Any direct patient intervention by the proctor should be disclosed in the patient's chart and in a confidential report prepared by the proctor to the credentials committee. The presence of a proctor may or may not be discussed during the process of informed consent, and the proctor may not be present when an informed consent is obtained. Legal counsel should be consulted to take greatest advantage of peer-review immunity available under state law, which varies from state to state.

RECREREDENTIALING AND RENEWAL OF ENDOSCOPIC PRIVILEGES

It is the responsibility of each institution to develop and maintain guidelines detailing the methods and frequency required to grant and renew privileges in endoscopic procedures. Recredentialing of endoscopic privileges generally follows regional or state regulations but has been mandated by national accrediting organizations to occur every 2 to 3 years. Individual institutions should have a mechanism in place for addressing instances when minimal competency cannot be assured. These mechanisms may include proctoring, participation in continuing medical education offerings, retraining, or limitation of privileges.

The goal of recredentialing is to ensure continued clinical competency, promote continuous quality improvement,

and maintain patient safety.^{6-11,35} The principles of maintenance of competency should be applied in conjunction with those of national accrediting organizations. Ensuring continued competency in the performance of endoscopic procedures includes ongoing assessment of quality benchmarks as set forth in published guidelines.⁶⁻¹¹ Institutions should track outcome data and adverse event rates of individual endoscopists. In addition, there should be evidence of engagement in educational and clinical activities with a focus on continuous quality improvement. Finally, it is important to have documentation provided by an applicant of continued cognitive training in endoscopic procedures through participation in educational activities and/or quality improvement activities. For endoscopists who cannot demonstrate minimal competency, institutions should have mechanisms in place to allow performance improvement and repriviling. These may include proctoring, participation in CME offerings, retraining, or limitation of privileges if minimal competency cannot be fully established.

Decredentialing may be required for individuals who fail to meet accepted national and institutional requirements for competency in endoscopy. A previously employed or decredentialed endoscopist may wish to pursue recredentialing at a future time. Although there are no data on this situation, we suggest that a physician who has not performed endoscopy for at least 12 months or was previously decredentialed for failure to meet appropriate national or institutional requirements should be proctored by at least 1 credentialed endoscopist to document competency in the procedures requested.

RECOMMENDATIONS

1. We recommend that training in endoscopic techniques must be adequate for each major category of endoscopy for which privileges are requested. ⊕⊕⊕⊕
2. We recommend that whenever possible competence should be determined by objective criteria and direct observations and that an arbitrary number of procedures does not guarantee competency. However, minimal threshold numbers for initial credentialing may be set below which competency cannot be assessed. ⊕⊕⊕⊕
3. We suggest that uniform standards be developed that apply to all hospital staff requesting privileges to perform endoscopy, regardless of medical specialty. ⊕⊕⊕⊕
4. We recommend documentation of continuing satisfactory performance using quality benchmark data that should allow an institution to renew the privileges of an endoscopist for that procedure. ⊕⊕⊕⊕
5. We recommend that guidelines for proctoring be included in institutional bylaws to assist in the credentialing and privileging process. ⊕⊕⊕⊕
6. We recommend that individual institutions should have mechanisms in place for addressing instances when

minimal competence cannot be ensured, including proctoring, participation in CME offerings, retraining, or limitation of privileges. ⊕⊕⊕⊕

DISCLOSURE

The following authors disclosed financial relationships relevant to this publication: V. Chandrasekhara: Consultant for Boston Scientific and Olympus; M. A. Khasbab: Consultant for BSCI; V. R. Muthusamy: Consultant for Boston Scientific, research support and honorarium recipient from Covidien GI Solutions; J. Yang: Consultant for Cook; J. M. DeWitt: Consultant for Olympus America. All other authors disclosed no financial relationships relevant to this publication.

Abbreviations: ASGE, American Society for Gastrointestinal Endoscopy; DE, deep enteroscopy.

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