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CONSENSUS STATEMENT

Principles of Privileging and Credentialing for Endoscopy and Colonoscopy

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This consensus document was jointly prepared and endorsed by the Society of American Gastrointestinal Endoscopic Surgeons (S.A.G.E.S.), the American Society for Gastrointestinal Endoscopy (A.S.G.E.), and The American Society of Colon and Rectal Surgeons (A.S.C.R.S.). This document is being published simultaneously in *Surgical Eudoscopy* and *Gastrointestinal Endoscopy*.

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 A.S.G.E., A.S.C.R.S., and S.A.G.E.S.[1–7] More comprehensive discussions of issues surrounding the granting of privileges for gastrointestinal endoscopy are available on the societies' websites, *i.e.*, www.asge.org, www.sages.org, and 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 guidelines for 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 health care facilities 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 goal 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 health care facility. 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 (ACGME) 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 Equivalent Program

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 judgment 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 verified adequately by submitted written material.[5] The procedural details of proctoring should be developed by the credentialing body of the health care facility 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 health care facility 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.

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Editorial

This document is the first substantive cooperative venture among The American Society of Colon and Rectal Surgeons, the American Society for Gastrointestinal Endoscopy, and the Society of American Gastrointestinal Endoscopic Surgeons. The ease with which this was accomplished is a tribute to those who worked so diligently to reach consensus. Particular thanks should go to Michael Kimmey, Past President of the American Society for Gastrointestinal Endoscopy, Steve Wexner, Secretary of the Society of American Gastrointestinal Endoscopic Surgeons, and Neil Hyman, member, and Clifford Simmang, Chairman of the Standards Committee of The American Society of Colon and Rectal Surgeons for facilitating this process. This document should find a place as a consensus statement, allowing credentialing organizations and hospitals a guideline for granting privileges in endoscopy. We hope that it marks the beginning of similar cooperative activities among our professional societies.

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