Gastrointestinal endoscopy

Background

Gastrointestinal (GI) endoscopy is a minimally invasive procedure in which the physician uses an endoscope that has a light and camera, allowing for a color view of the digestive tract. Air is pumped through the endoscope to allow for better viewing. There are many different procedures that are classified as GI endoscopies. Esophagogastroduodenoscopy (EGD), often referred to as an upper GI endoscopy, and colonoscopy both fit under this procedural term, depending on which portion of the digestive tract is being examined. A flexible sigmoidoscopy enables the physician to look at the inside of the large intestine from the rectum through the last part of the colon, called the sigmoid or descending colon. More specialty procedures include small bowel endoscopy, endoscopic retrograde cholangiopancreatography, and endoscopic ultrasound.

Endoscopies generally allow for the diagnosis (and sometimes treatment) of GI disease. They are used to identify ulcers and spasms that are difficult to identify through other imaging methods. They can also identify cancers, abnormal growths, bowel obstruction, inflammation, hiatal hernia, polyps, and internal bleeding. Biopsies and the removal of foreign bodies or polyps are also possible during endoscopies, and sometimes blockages are cleared or bleeding is stopped. During an endoscopy, patients lie on their back or side. Upper endoscopies are performed through the mouth and down the esophagus, stomach, and duodenum, while lower endoscopies are passed through the rectum to view the colon. Both varieties are generally done as outpatient procedures, but can be performed on an inpatient basis as well.

Simple GI endoscopic procedures usually take under an hour and can be performed without sedation (with topical anesthesia), with sedation, or under general anesthesia. Side effects include throat soreness (in the case of an upper GI), cramping, or bloating, according to the National Institute of Health.

For more information on flexible sigmoidoscopy, please see Clinical Privilege White Paper, Procedure 21—Flexible sigmoidoscopy.

Involved specialties

Gastroenterologists, general surgeons, internists, and family practitioners
Positions of specialty boards

ABIM

The American Board of Internal Medicine (ABIM) offers certification in the specialty of internal medicine, as well as in the subspecialty of gastroenterology. Candidates for internal medicine must complete 36 months of full-time internal medicine residency training.

Gastroenterology certification requires 36 months of GI training, with 18 clinical months, following certification in internal medicine. Training should include diagnostic and therapeutic upper and lower endoscopy procedures. Training in both internal medicine and gastroenterology must be accredited by the Accreditation Council for Graduate Medical Education (ACGME).

ABIM does not publish specific requirements for GI endoscopy.

AOBIM

The American Osteopathic Board of Internal Medicine (AOBIM) offers certification in the specialty of internal medicine as well as certification in the subspecialty of gastroenterology. To become certified in internal medicine, candidates must complete one of the following American Osteopathic Association (AOA)–approved training programs:

- 12 months of a non-medicine track internship followed by 36 months of an internal medicine residency
- 12 months of a medicine track internship followed by 24 months of an internal medicine residency
- 12 months of an AOA-approved internship followed by 48 months of combined emergency medicine/internal medicine residency training
- 48 months of a combined internal medicine/pediatrics residency training program

Candidates for certification in gastroenterology through AOBIM must be certified in internal medicine and must complete a 36-month AOA-approved program in gastroenterology.

AOBIM does not publish specific requirements for GI endoscopy.

ABFM

The American Board of Family Medicine (ABFM) offers certification in the specialty of family medicine. Candidates must complete three years of training in an ACGME-accredited family medicine residency program, and successfully pass the certification examination. ABFM does not publish specific requirements for GI endoscopy.
**AOBFP**

The American Osteopathic Board of Family Physicians (AOBFP) offers certification in family medicine to those candidates who complete a three-year AOA-approved family medicine and osteopathic manipulative treatment residency training program. Prior to July 1, 2008, the program length was two years after the required one year of AOA-approved internship. AOBFP does not publish specific requirements for GI endoscopy.

**ABS**

The American Board of Surgery (ABS) offers certification in general surgery to candidates who complete a minimum of five years in an ACGME-accredited general surgery program. Candidates must also successfully pass the general surgery qualifying examination and the general surgery certifying examination. ABS does not publish specific requirements for GI endoscopy.

**AOBS**

The American Osteopathic Board of Surgery (AOBS) offers certification in general surgery to candidates who complete a minimum of five years in an AOA-accredited general surgery program; candidates who began residency training prior to 2008 must complete four years of training. Candidates must also successfully pass the written and oral examinations. AOBS does not publish specific requirements for GI endoscopy.

**Positions of societies, academies, colleges, and associations**

**ASGE**

According to a joint statement written in 2002 by the American Society of Gastrointestinal Endoscopy (ASGE), the American Gastrointestinal Association, the Society of American Gastrointestinal Endoscopic Surgeons (SAGES), and the American Society of Colorectal Surgeons titled *Privileging or Credentialing for the Performance of Esophagogastroduodenoscopy and Colonoscopy*, uniform standards should be developed that apply to all hospital staff requesting privileges to perform EGD and colonoscopy, and to all organizations where they are performed. Privileges should be granted for each major category of endoscopy separately.

Individuals applying for privileges for EGD and colonoscopy should have demonstrated satisfactory completion of an ACGME-accredited training program in adult or pediatric gastroenterology, general surgery, colorectal surgery, or pediatric surgery, according to the statement. Formal residency training in gastroenterology or surgery is required.
Informal training outside of formal residencies in such areas should be considered with a detailed description of such training, including how many procedures were performed, how many were performed supervised and unsupervised, and the actual observed competency for each procedure for which the applicant is requesting privileges.

*Alternative Pathways to Training in Gastrointestinal Endoscopy*, published by ASGE, is a set of guidelines for physicians who do not have formal gastroenterology or surgical training but wish to acquire endoscopic privileges. It advises performance under supervision of at least 100 upper endoscopies or colonoscopies to acquire competency in either procedure. Training must also include recognition of lesions and proper translation of findings, understanding of GI disease pathophysiology, and development of appropriate clinical management strategies. Endoscopists performing diagnostic procedures such as colonoscopies must be capable of performing appropriate therapeutics such as polypectomy in the same setting. Short (two- or three-day) courses or self-instruction in endoscopy without additional supervised experience do not provide adequate training in these or other aspects of endoscopy. Physicians should have hands-on training and also be trained in conscious sedation. ASGE also advises hospitals to have the applicant be proctored by an impartial endoscopist before granting privileges to demonstrate competency.

ASGE also advises on the role of short courses in granting privileges for endoscopy in its *Statement on Role of Short Courses in Endoscopic Training: GUIDELINES for Clinical Application*. ASGE does not condone granting privileges based on certifications from short courses alone, with or without supporting letters. The society advises against granting privileges to applicants who have been primarily trained for endoscopic procedures through short courses due to lack of hands-on training and an inequality to ACGME-accredited formal training programs. ASGE notes that “flexible sigmoidoscopy to the non-endoscopist may be facilitated by a short course format, but cannot assure competence in that procedure.”

According to *Methods of Granting Hospital Privileges to Perform Gastrointestinal Endoscopy*, written by ASGE and reviewed and approved in 2008, credentials and privileges should be determined independently for each type of endoscopic procedure, including:

- Sigmoidoscopy (flexible and rigid)
- Colonoscopy
- EGD
- Endoscopic retrograde cholangiopancreatography (ERCP)
- Endoscopic ultrasonography (EUS)
- Any other endoscopic procedure

Furthermore, credentialing for all procedures, except sigmoidoscopy, should require the ability to perform common associated therapeutic modalities.
ASGE urges organizations to assess competency of all endoscopic procedures through direct observation, and notes that previously published numbers of procedures are the minimum number that should be required. ASGE does not support diagnostic-only endoscopies, and therefore does not support deemed competence for such type of procedures.

ASGE suggests the following number of procedures before competency is assessed (but advises that, according to research, these procedural numbers are not adequate for competency in most trainees; the society urges organizations to assess competency by direct observation rather than relying on the number of procedures recorded):

- Flexible sigmoidoscopy—30
- Diagnostic EGD—130
- Total colonoscopy—140
- Snare polypectomy—30 (included in total colonoscopy number)
- Nonvariceal hemostasis (upper and lower; includes 10 active bleeders)—25 (included in total colonoscopy number)
- Variceal hemostasis (includes 5 active bleeders)—20
- Esophageal dilation with guide wire—20
- Percutaneous endoscopic gastrostomy (PEG)—15

Advanced procedures:
- ERCP—200 (this number includes at least 40 sphincterotomies and 10 stent placements)
- EUS: submucosal abnormalities—40
- Pancreatobiliary—75
- EUS-guided FNA (nonpancreatic)—25
- EUS-guided FNA (pancreatic)—25
- Tumor ablation—20
- Pneumatic dilation for achalasia—5
- Laparoscopy—25
- Esophageal stent placement—10
- Enteroscopy—data not available

ASGE recommends the following initial credentialing guidelines:
- Preliminary training
- Cognitive skills
  - Indications/contraindications
  - Consent
  - Endoscopic anatomy
  - Technical aspects
  - Sedation/analgesia
  - Reporting/documentation
  - Integration of care
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➤ Endoscopic skills
  – Technical skill
  – Number of procedures
  – Success rate
  – Complication rate
➤ Interpretation
  – Therapeutic intervention
➤ Patient care

ASGE recommends the following recredentialing guidelines:

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

SAGES

According to Granting of Privileges for Gastrointestinal Endoscopy Privileging for GI endoscopic procedures, published in 2007, SAGES guidelines generally align with that of ASGE. Each GI endoscopic procedure should be evaluated separately. SAGES does not condone privileging for diagnostic-only GI endoscopies. A formal ACGME-accredited residency in surgery or gastroenterology (or the equivalent if based outside the United States or Canada) is strongly suggested, although SAGES does recognize equivalent training and/or experience outside a formal program. However, as stated in ASGE’s Alternative Pathways to Training in Gastrointestinal Endoscopy, the program director must provide a specific written description of the training provided and the observed level of competency, and his or her opinion and recommendation should be taken into consideration. SAGES does not endorse short-course equivalents as an acceptable substitute for competency development.

SAGES does not recommend a specific number of procedures but advises organizations to use quality assurance mechanisms or a multidisciplinary committee, as well as requiring continuing medical education.

ACGME

According to the ACGME Program Requirements for Graduate Medical Education in Gastroenterology, programs should be 36 months in length. Residents should demonstrate competence in the prevention, evaluation, and management of the following:

➤ Acid peptic disorders of the GI tract
➤ Acute and chronic gallbladder and biliary tract diseases
➤ Acute and chronic liver diseases
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➤ Acute and chronic pancreatic diseases
➤ Diseases of the esophagus
➤ Disorders of nutrient assimilation
➤ GI and hepatic neoplastic disease
➤ GI bleeding
➤ GI diseases with an immune basis
➤ GI emergencies in the acutely ill patient
➤ GI infections, including retroviral, mycotic, and parasitic diseases
➤ Genetic/inherited disorders
➤ Geriatric gastroenterology
➤ Inflammatory bowel diseases
➤ Irritable bowel syndrome
➤ Motor disorders of the GI tract
➤ Patients under surgical care for GI disorders
➤ Vascular disorders of the GI tract
➤ Women’s health issues in digestive diseases

Fellows must demonstrate competence in the performance of the following procedures:
➤ Biopsy of the mucosa of esophagus, stomach, small bowel, and colon
➤ Capsule endoscopy
➤ Colonoscopy with polypectomy
➤ Conscious sedation
➤ Esophageal dilation
➤ EGD
➤ Nonvariceal hemostasis, both upper and lower, including actively bleeding patients
➤ Other diagnostic and therapeutic procedures utilizing enteral intubation
➤ Paracentesis
➤ Percutaneous endoscopic gastrostomy
➤ Retrieval of foreign bodies from the esophagus
➤ Variceal hemostasis, including actively bleeding patients

ACGME does not publish a specific number of procedures required to achieve competency.

AOA

The AOA’s *Specific Basic Standards for Osteopathic Fellowship Training in Gastroenterology* requires a full-time training program of 36 months, with 33 months of supervised management of patients. A minimum of 12 months of training must be spent in any combination of the following content areas:
➤ Inflammatory bowel disease
➤ Endoscopic ultrasound transplant medicine
➤ Motility and nutrition
➤ Hepatology
The AOA requires fellows to conduct learning activities in the diagnosis and treatment of:

- Disorders of the esophagus, including cancer, gastroesophageal reflux, and strictures
- Non-cardiac chest pain
- GI bleeding, including upper, lower, and anorectal bleeding
- Disorders of the stomach, including peptic ulcer disease, cancer, and gastroparesis
- Severe malabsorption
- Disorders of the pancreas, including acute and chronic pancreatitis and cancer
- Disorders of the hepatobiliary system, including cancer, biliary obstruction, hepatitis, and cirrhosis
- Infectious diseases of the GI system
- Irritable bowel syndrome
- Disorders of the small intestine, including obstruction and cancer
- Inflammatory bowel disease

Fellows must have training and experience in the indications, contraindications, complications, limitations, and interpretation of the following procedures, as well as demonstrate evidence of competent performance:

- Esophageal dilation
- Small bowel capsule endoscopy
- Colonoscopy
- Polypectomy
- Paracentesis
- Percutaneous liver biopsy
- PEG
- Variceal and nonvariceal hemostasis
- Biopsy of the stomach, esophagus, small bowel, and colon

AOA does not publish a specific number of procedures required to achieve competency.

**Positions of subject matter experts**

**Robert D. Fanelli, MD, FACS, FA**

**Pittsfield, Mass.**

According to Robert D. Fanelli, MD, FACS, FA, of Northern Berkshire General Surgery in Pittsfield, Mass., physicians who perform GI endoscopies
include surgeons, gastroenterologists, and primary care physicians. Fanelli is also a SAGES board member and chairman of the SAGES Guidelines Committee.

“There has been great debate over the quality of these various practitioners, and what it’s really come down to over the years is that anyone who has enough experience can do these procedures quite well and people who don’t have the experience and haven’t been taught by an expert in endoscopy really underperform,” says Fanelli. “So the important part seems to be having been taught by an expert who can show you the maneuvers that are necessary to safely and efficiently perform procedures, being able to learn not just the mechanics of giving these procedures but also recognizing the findings.”

Fanelli confirms that skills for GI endoscopy are taught by the ACGME curriculum in surgical and GI training. As far as competency is concerned, it takes about 100 colonoscopies to reliably reach the secum—the end point of insertion—in about 90% of the cases (a key indicator of competency), he says. It might take 50 EGDs to do a complete examination mechanically, but it probably takes several hundred EGDs or several hundred colonoscopies to be able to achieve true expertise and recognize the pathology that you’re seeing, notes Fanelli.

“Specialty procedures like small bowel endoscopy, ERCP, endoscopic ultrasound, etc., should have even more stringent requirements,” says Fanelli, who stresses that competency should be based less on case numbers and more on objective direct observation of competency.

Maintenance of GI endoscopic competency generally takes fewer procedures than establishing initial competency, says Fanelli. “For ERCP, it’s pretty well accepted that you need to do 200 ERCPs in training to have that procedure down, but most people would say that as long as you’re doing somewhere between 25 and 50 a year, that you can very easily maintain your skills,” he says, adding that competency with simpler GI endoscopic procedures, such as EGD or colonoscopy, adds to competency for more complicated procedures such as ERCP.

Brooks D. Cash, MD, FASGE
Bethesda, Md.

Brooks D. Cash, MD, FASGE, of the Walter Reed National Military Medical Center in Bethesda, Md., agrees with Fanelli regarding what type of physicians perform GI endoscopic procedures, though it varies depending on location, training, and access to specialists such as GIs, as well as how complicated the GI endoscopy is. Cash is also chair of ASGE’s Standards of Practice Committee.

There is a minimum number of procedures that should be performed before competency should even be evaluated, says Cash.
“It depends on the procedure. For flexible sigmoidoscopy, the threshold number is anywhere from 25–30. For upper endoscopy, what we call an EGD, it’s 130. For colonoscopies, it’s 200. There are more advanced procedures with different competency numbers. The evaluation of competency and techniques and awareness of indications and complications are all occurring during the training process,” says Cash. “Some people might require additional training and procedures if not deemed competent by peers and instructors.”

For both acquiring and maintaining competency, Cash stresses that focus should lie less on the number of procedures performed and more on quality metrics “such as adenoma detection rates during colonoscopy, cecal intubation rates, complication rates, time of withdrawal, etc.”

“Typically short course programs are meant for people who have already achieved competency and are looking to develop a new skill,” Cash notes.

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for GI endoscopy. However, the CMS *Conditions of Participation (CoP)* define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

➤ Individual character
➤ Individual competence
➤ Individual training
➤ Individual experience
➤ Individual judgment

The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.
Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

**The Joint Commission**

The Joint Commission has no formal position concerning the delineation of privileges for GI endoscopy. However, in its *Comprehensive Accreditation Manual for Hospitals*, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and implementing a privileging process.” It goes on to state that this process typically includes:

- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information
- Submitting recommendations to the governing body for applicant-specific delineated privileges
- Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
- Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”
The EPs for standard MS.06.01.05 include several requirements as follows:
➤ The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
➤ Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
➤ Consistent application of criteria
➤ A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
➤ Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges requested
➤ A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
➤ Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
➤ A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)
➤ A process to determine whether there is sufficient clinical performance information to make a decision related to privileges
➤ A decision (action) on the completed application for privileges that occurs within the time period specified in the organization’s medical staff bylaws
➤ Information regarding any changes to practitioners’ clinical privileges, updated as they occur

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.
Criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

**HFAP**

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for GI endoscopy. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff’s review of an individual practitioner’s qualifications and its recommendation regarding that individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.
The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

**DNV**

DNV has no formal position concerning the delineation of privileges for GI endoscopy. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

- The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements
- Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status
- Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).

Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.

**CRC draft criteria**

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding this procedure.
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**Minimum threshold criteria for requesting privileges in GI endoscopy**

**Basic education:** MD or DO

**Minimal formal training:** Successful completion of an ACGME- or AOA-approved training program in gastroenterology, internal medicine, family medicine, or general surgery. Training should include an adequate volume of GI endoscopy procedures.

**Required current experience:** Current demonstrated competence and evidence of the performance of at least 50 GI endoscopies in the past 12 months to determine competency based on outcomes, or completion of training in the past 12 months.

**References**

If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

**Reappointment**

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism. To be eligible to renew privileges in gastroenterology, the applicant must demonstrate current competence and provide evidence of the performance of at least 100 GI endoscopies in the past 24 months, based on results of ongoing professional practice evaluation or performance monitoring.

In addition, continuing education that is related to GI endoscopy should be required.

**For more information**

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