Background

Gastroenterology is the medical subspecialty of internal medicine focused on the diagnosis and treatment of diseases of the gastrointestinal tract, which includes the stomach, bowels, liver, pancreas, and gallbladder. Gastroenterologists, often referred to as “GI doctors,” treat conditions such as abdominal pain, ulcers, diarrhea, cancer, intestinal infections, heartburn, and gastroesophageal reflux disease, and perform complex diagnostic and therapeutic procedures using endoscopes to visualize internal organs.

Board-certified physicians in internal medicine must complete a three-year fellowship in gastroenterology before applying for subspecialty certification through the American Board of Internal Medicine (ABIM) or the American Osteopathic Board of Internal Medicine (AOBIM).

Related white papers:
- Internal medicine

Involved specialties

Gastroenterologists

Positions of specialty boards

**ABIM**

To become certified in the subspecialty of gastroenterology through the ABIM, physicians must:
- Be previously certified in internal medicine by the ABIM
- Satisfactorily complete 36 months of requisite graduate medical education fellowship training accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Royal College of Physicians and Surgeons of Canada, or the Professional Corporation of Physicians of Quebec
- Demonstrate clinical competence, procedural skills, and moral and ethical behavior in the clinical setting
- Hold a valid, unrestricted, and unchallenged license to practice medicine
- Pass the gastroenterology certification examination

The 36-month gastroenterology fellowship must include 18 clinical months, as well as experience in diagnostic and therapeutic upper and lower endoscopy.
ABIM requires documentation that candidates for certification are competent in the following areas:

- Patient care and procedural skills
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

The program director of an accredited fellowship program may propose that an ABIM internal medicine diplomate receive special consideration for admission to a subspecialty examination, provided that the diplomate:

- Has completed the full subspecialty training required by ABIM in another country and has met all current applicable ABIM procedural requirements
- Is a full-time associate professor or higher in the specified subspecialty division of the department of medicine in an Liaison Committee on Medical Education-accredited medical school or an accredited Canadian medical school at the time of proposal
- Has served eight years, after formal training, as a clinician-educator or clinical investigator with a full-time appointment on a medical school faculty
- Possesses a valid, unrestricted license to practice medicine in a state, territory, commonwealth, province, or possession of the United States or Canada

The ABIM also offers certification through a research pathway designed to integrate training in research and clinical internal medicine for those physicians who are seriously pursuing careers in basic science or clinical research. Trainees in the research pathway must complete 24 months of accredited categorical internal medicine training followed by a minimum of 18 months of clinical training in gastroenterology.

**AOBIM**

The American Osteopathic Association (AOA) grants subspecialty certification in gastroenterology through the AOBIM. To become certified in the subspecialty of gastroenterology through the AOBIM, physicians must:

- Be previously certified in internal medicine by AOBIM
- Satisfactorily complete 36 months of an AOA-approved fellowship program in gastroenterology (24 months required if completed prior to September 1, 2002)
- Successfully pass a comprehensive, one-day written/clinical examination

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

**AGA/AASLD/ASGE/ACG**

The American Gastroenterological Association (AGA) publishes *Gastroenterology Core Curriculum* with the American Association for the
Study of Liver Diseases (AASLD), the American Society for Gastrointestinal Endoscopy (ASGE), and the American College of Gastroenterology (ACG). The training requirements referenced in this document reflect the ACGME’s Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine and the Program Requirements for Fellowship Education in Gastroenterology.

_Gastroenterology Core Curriculum_ states that trainees in gastroenterology must first complete a three-year residency in internal medicine or be in the ABIM research pathway at an institution accredited by the ACGME or a foreign equivalent. Training programs in gastroenterology must be at least three years in duration and must include a minimum of 18 months of clinical training, three to six months of research, and an additional 12 months of training that may include further clinical or research training, specialized skills training, or elective experiences.

Level two training, or enhanced clinical training, is specifically for any gastroenterologist who wishes to provide specialized services as a consultant to other physicians and provides detailed training in geriatrics, nutrition, advanced endoscopic procedures, motility studies, biliary tract diseases and pancreatic disorders, and hepatology. Detailed criteria that mirror the requirements set by the ABIM before sitting for the examination for added qualifications in transplant hepatology are included, but would not necessarily be accomplished during a fourth year of training. In most cases, up to 12 additional months of clinical or research training beyond the core clinical curriculum may be required to attain level two expertise in a given area. It is anticipated that under most circumstances, level two training can be accomplished within the context of the three-year training period. However, in some circumstances, such as expertise in advanced therapeutic procedures, an additional year (that is, a fourth year) may be necessary to satisfactorily complete all requirements for level two training.

The patient care experience for trainees is composed of three major elements:
- Every gastroenterology training program must include a core clinical training experience of 18 months to be completed by all trainees, consisting of clinical training in the inpatient and outpatient diagnosis and management of digestive diseases. Approximately five months of this experience is to be devoted to training in liver disorders.
- For those individuals whose career goals consist primarily of patient care, a further 18 months of training will include a total of at least six months of scholarly activity consisting of basic or clinical research, course work, or other structured activity not primarily involving direct patient care. The remaining months will include additional experience in general consultative gastroenterology and experience in specialized areas, depending on the interests and career goals of the trainees and the opportunities available in the programs.
Such areas of study might include enhanced competence in hepatic diseases, motility disorders, inflammatory bowel disease, nutrition, or interventional endoscopy.

- All trainees must spend at least one half-day per week for the entire three-year period in an ambulatory care clinic in which both new and continuing care patients with gastroenterological and hepatic diseases are evaluated and managed. The arrangements must be such that patients recognize the fellow as the physician who is involved in providing their continuous care. To understand the natural history and long-term outcome of digestive diseases, trainees must attend the same clinic for a minimum of six months.

In an older document, *Hospital Credentialing Standards for Physicians Who Perform Endoscopies*, the AGA states that only an accredited gastroenterology fellowship or gastrointestinal surgery residency (or their respective equivalents) is able to provide the education, training, and knowledge needed to ensure that the clinical indications for endoscopies are met, that they are performed safely and effectively, and that the information obtained from the procedure is applied to the full benefit of the patient. Eventually, the patient may require referral to a specialist (e.g., a gastroenterologist or gastrointestinal surgeon) for follow-up treatment and perhaps a second endoscopy.

Granting endoscopy privileges is an endorsement of the physician’s competence and ability to perform endoscopic procedures to diagnose and treat digestive disorders. Therefore, the hospital must ascertain that the physician applying for endoscopy privileges has the required knowledge, training, and experience, as described in the foregoing.

If the applicant has not successfully completed a pediatric or adult gastroenterology fellowship or surgical residency, the hospital should obtain sufficient evidence that he or she has had equivalent formal training. The AGA asserts that “short courses” of endoscopy training provide neither the experience nor cognitive knowledge needed to properly diagnose and treat digestive diseases. Criteria for endoscopy training have been published by the ASGE.

Further, the AGA states that hospitals should grant endoscopy privileges only to physicians who have had training and experience that meets these criteria. To do otherwise jeopardizes the safety and quality of patient care and needlessly inflates the cost of that care.

**ASGE**

The ASGE publishes the following credentialing and privileging position statements, which may be of use when establishing credentialing and privileging requirements in gastroenterology:

- *Multisociety Sedation Curriculum for Gastrointestinal Endoscopy*
• Endoscopy by Non-Physicians
• Renewal of and Proctoring for Endoscopic Privileges
• Guidelines for Credentialing and Granting Privileges for Capsule Endoscopy
• Principles of Privileging and Credentialing for Endoscopy and Colonoscopy
• Methods of Granting Hospital Privileges to Perform Gastrointestinal Endoscopy
• Guidelines for Credentialing and Granting Privileges for Endoscopic Ultrasound
• Methods of Privileging for New Technology in Gastrointestinal Endoscopy

The Multisociety Sedation Curriculum for Gastrointestinal Endoscopy represents a collaborative effort among the national gastroenterology societies to establish best practices in procedure sedation training. According to this document, training for the practice of procedural sedation for gastrointestinal endoscopy should encompass these areas:
• Sedation pharmacology
• Informed consent for endoscopic sedation
• Periprocedure assessment for endoscopic procedures
• Levels of sedation
• Training in the administration of specific agents for moderate sedation
• Training in airway/rescue techniques and management of complications
• Anesthesiologist assistance for endoscopic procedures
• Intraprocedure monitoring
• Postprocedure assessment training
• Endoscopy in pregnant and lactating women
• Assessment of competency in endoscopic sedation

In Methods of Granting Hospital Privileges to Perform Gastrointestinal Endoscopy, the ASGE states that after the successful completion of a gastrointestinal endoscopy training program, the trainee:
• Must be able to integrate gastrointestinal endoscopy into the overall clinical evaluation of the patient.
• Must have a thorough understanding of the indications, contraindications, individual risk factors, and benefit-risk considerations for the individual patient.
• Must be able to clearly describe an endoscopic procedure and obtain informed consent.
• Must have knowledge of endoscopic anatomy, technical features of endoscopic equipment, and accessory endoscopic techniques, including biopsy, cytology, photography, thermal, and nonthermal endoscopic therapy.
• Must be able to accurately identify and interpret endoscopic findings.
• Must have a thorough understanding of the principles, pharmacology, and risks of sedation/analgesia.
• Must be able to document endoscopic findings and therapy and communicate with referring physicians.
• 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. 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.

The ASGE also copublished *Ensuring Competence in Endoscopy* with the ACG. The document details the several guidelines regarding endoscopy published by the ASGE, and it provides examples of endoscopy privileging issues that commonly arise.

**SAGES**

The Society of American Gastrointestinal Endoscopic Surgeons (SAGES) represents surgeons who focus on the gastrointestinal tract and abdomen and perform minimal-access surgeries, endoscopies, and other procedures. SAGES publishes educational materials for physicians, practice and clinical guidelines, and privileging guidelines for specific procedures, including:

- *Guidelines for Institutions Granting Bariatric Privileges Utilizing Laparoscopic Techniques*
- *Granting of Privileges for Gastrointestinal Endoscopy*
- *Guidelines for Granting of Ultrasonography Privileges for Surgeons*
- *Guidelines for Institutions Granting Privileges Utilizing Laparoscopic and/or Thoracoscopic Techniques*

*Granting of Privileges for Gastrointestinal Endoscopy* states that credentialing for the performance of both diagnostic and therapeutic esophagogastroduodenoscopy and colonoscopy should be based on prior demonstration of proficiency in the performance of these techniques. Privileges should be granted for each major category of endoscopy separately (e.g., upper endoscopy, enteroscopy, biliopancreatic endoscopy, sigmoidoscopy, and colonoscopy). Proficiency in endoscopy should include diagnostic and therapeutic procedures.

Individuals applying for privileges for esophagogastroduodenoscopy and colonoscopy should have demonstrated satisfactory completion of an ACGME-accredited training program in 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 necessary, by the credentialing and qualifications committee at the institution at which these privileges are being sought or by other prior teaching faculty from the applicant’s residency program.

In the case of applicants who already have credentialing to perform these proce-
dures and are applying for similar privileges at another facility or for renewal of
privileges at the same facility, attestation as to competency should be provided by
the applicant’s respective chief of service.

Maintenance of continued competency is the responsibility of the respective cre-
dentialing and qualifications committee and should be based on ongoing review
of the applicant’s performance by his or her respective chief of service. These
credentialing guidelines should apply to any site where esophagogastroduodenos-
copy and colonoscopy are practiced.

**ACGME**

In its *Program Requirements for Graduate Medical Education in
Gastroenterology*, the ACGME states that fellowship programs in gastroenter-
ology must be 36 months in duration and must provide advanced education to
allow a fellow to acquire competency in the subspecialty with sufficient expertise
to act as an independent consultant. Additionally, a minimum of 18 months must
be devoted to clinical experience, of which the equivalent of five months should
be composed of hepatology.

Gastroenterology fellows must be able to provide patient care that is
compassionate, appropriate, and effective for the treatment of health problems
and the promotion of health. With regard to patient care, fellows must demon-
strate competence in the practice of health promotion, disease prevention,
diagnosis, care, and treatment of patients of each gender, from adolescence to
old age, during health and all stages of illness. They must also demonstrate com-
petence in prevention, evaluation, and management of the following:
- Acid peptic disorders of the gastrointestinal tract
- Acute and chronic gallbladder and biliary tract diseases
- Acute and chronic liver diseases
- Acute and chronic pancreatic diseases
- Diseases of the esophagus
- Disorders of nutrient assimilation
- Gastrointestinal and hepatic neoplastic disease
- Gastrointestinal bleeding
- Gastrointestinal diseases with an immune basis
- Gastrointestinal emergencies in the acutely ill patient
- Gastrointestinal infections, including retroviral, mycotic, and parasitic
diseases
- Genetic/inherited disorders
- Geriatric gastroenterology
- Inflammatory bowel diseases
- Irritable bowel syndrome
- Motor disorders of the gastrointestinal tract
- Patients under surgical care for gastrointestinal disorders
- Vascular disorders of the gastrointestinal tract
Women’s health issues in digestive diseases

Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Further, they 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
- Esophagogastroduodenoscopy
- 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

With regard to medical knowledge, fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows must demonstrate knowledge of:

- The scientific method of problem solving and evidence-based decision-making
- Indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, including the appropriate indication for and use of screening tests/procedures
- Anatomy, physiology, pharmacology, pathology, and molecular biology related to the gastrointestinal system, including the liver, biliary tract, and pancreas
- Interpretation of abnormal liver chemistries
- Liver transplantation
- Nutrition
- Prudent, cost-effective, and judicious use of special instruments, tests, and therapy in the diagnosis and management of gastroenterologic disorders
- Sedative pharmacology
- Surgical procedures employed in relation to digestive system disorders and their complications

Additionally, fellows must have formal instruction and clinical experience in the interpretation of the following diagnostic and therapeutic techniques and procedures:

- Endoscopic retrograde cholangiopancreatography (ERCP), in all its diag-
nostic and therapeutic applications
• Enteral and parenteral alimentation
• Imaging of the digestive system, including CT and CT entero-/colography, contrast radiography, MRI, nuclear medicine, percutaneous cholangiography, ultrasound (including endoscopic ultrasound), vascular radiography, and wireless capsule endoscopy
• Interpretation of gastrointestinal and hepatic biopsies
• Motility studies, including esophageal motility/pH studies; fellows must have exposure to and clinical experience in the performance of gastrointestinal motility studies and 24-hour pH monitoring

AOA

According to the AOA’s Specific Basic Standards for Osteopathic Fellowship Training in Gastroenterology, fellowship training in gastroenterology must be a minimum of 36 months in duration, including a minimum of 33 months of supervised patient management. A minimum of 12 months of training must be spent in any combination of the following: inflammatory bowel disease, endoscopic ultrasound transplant medicine, motility, nutrition, hepatology, oncology, biliary tract disease, pediatric gastroenterology, and advanced endoscopy, including ERCP. Additionally, a minimum one-month rotation must focus on gastrointestinal motility disorders.

With regard to medical knowledge, the fellow must have learning activities in the following:
• Diagnosis and treatment of:
  - Disorders of the esophagus, including cancer, gastroesophageal reflux, and strictures
  - Non-cardiac chest pain
  - Gastrointestinal 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
  - The hepatobiliary system, including cancer, biliary obstruction, hepatitis, and cirrhosis
  - Infectious diseases of the gastrointestinal system
  - Irritable bowel syndrome
  - Disorders of the small intestine, including obstruction and cancer
  - Inflammatory bowel disease
  - Disorders of the colon, including cancer
  - Intra-abdominal abscesses
  - Acute and chronic malnutrition
  - Mesenteric insufficiency and its complications
- Gastrointestinal disorders in relation to systemic diseases
- Normal gastrointestinal physiology
- Gastrointestinal pharmacology
- Enteral and parenteral alimentation
- Ethics and public policy in relation to gastrointestinal disorders
- The regulations (e.g., from OSHA) regarding the protection of healthcare workers, universal precautions, and other regulatory requirements pertinent to the operation of an endoscopy lab
- The processes involved in the use and maintenance of equipment and in the handling of contaminated and hazardous materials within the endoscopy lab

With regard to patient care, the fellow must have training and experience in the following:
- Diagnoses requiring gastrointestinal procedures
- Patient care exposure to:
  - Histopathology
  - Initial management of gastrointestinal disorders
  - Management of gastrointestinal disorders that have failed to respond to initial treatment
  - Treatment of gastrointestinal disorders
- Interpretation of radiographic imaging of the gastrointestinal system, including barium studies, CT scans, MRI, ERCP, and nuclear medicine scans
- The following procedures, to include at minimum indications, contraindications, complications, limitations, interpretation, and evidence of competent performance:
  - Esophageal dilatation
  - Esophagogastroduodenoscopy
  - Small bowel capsule endoscopy
  - Colonoscopy
  - Polypectomy
  - Paracentesis
  - Percutaneous liver biopsy
  - Percutaneous endoscopic gastrostomy
  - Variceal and nonvariceal hemostasis
  - Biopsy of the stomach, esophagus, small bowel, and colon
  - Enteroscopy
- Diagnostic and therapeutic ERCP and endoscopic ultrasound, to include at minimum indications, contraindications, complications, limitations, and interpretation

An ambulatory clinical experience must also be incorporated within the training program. The duration and time spent in the ambulatory clinical setting will be determined by each institution. Additionally, the fellow must maintain a log of all
outpatient cases.

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for gastroenterology. 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 gastroenterology. 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 gastroenterology. 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 gastroenterology. 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 practice area. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.
Minimum threshold criteria for requesting privileges in gastroenterology

Basic education: MD or DO

Minimal formal training: Successful completion of an ACGME- or AOA-accredited fellowship in gastroenterology and/or current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification in gastroenterology by the ABIM or completion of a certificate of special qualifications in gastroenterology by the AOBIM.

Required current experience: Inpatient or consultative services for at least 100 patients, reflective of the scope of privileges requested, during the past 12 months or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within 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.

Core privileges in gastroenterology

Core privileges for gastroenterology include the ability to admit, evaluate, diagnose, treat, and provide consultation to patients of all ages with diseases, injuries, and disorders of the digestive organs, including the stomach, bowels, liver, gallbladder, and related structures such as the esophagus and pancreas, including the use of diagnostic and therapeutic procedures using endoscopes to see internal organs. Gastroenterologists may provide care to patients in the intensive care setting in conformance with unit policies. Core privileges also include the ability to assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the following procedures and such other procedures that are extensions of the same techniques and skills:

- Performance of history and physical exam
- Argon plasma coagulation
- Biliary tube/stent placement
- Biopsy of the mucosa of the esophagus, stomach, small bowel, and colon
- Breath test performance and interpretation
- Colonoscopy with or without polypectomy
- Diagnostic and therapeutic esophagogastroduodenoscopy
- Endoscopic mucosal resection
- Enteral and parenteral alimentation
- ERCP
- Esophageal dilation
- Esophageal or duodenal stent placement
- Esophagogastroduodenoscopy, including foreign body removal, stent placement, or polypectomy
- Flexible sigmoidoscopy
- Gastrointestinal motility studies and 24-hour pH monitoring
- Interpretation of gastric, pancreatic, and biliary secretory tests
- Nonvariceal hemostasis (upper and lower)
- Percutaneous endoscopic gastrostomy
- Percutaneous liver biopsy
- Proctoscopy
- Sengstaken/Minnesota tube intubation
- Snare polypectomy
- Ultrasound, including endoscopic ultrasound and fine-needle aspiration
- Variceal hemostasis (upper and lower)

**Special noncore privileges in gastroenterology**

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested, including training, required previous experience, and maintenance of clinical competence. Noncore privileges include:

- Use of laser
- Capsule endoscopy performance and interpretation
- Therapeutic ERCP
- Administration of sedation and analgesia

**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 have current demonstrated competence and an adequate volume of experience (200 patients) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges. In addition, continuing education related to gastroenterology should be required.

**For more information**

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Fax: 215-446-3590
Website: www.abim.org

American Gastroenterological Association
4930 Del Ray Avenue
Bethesda, MD 20814
Telephone: 301-654-2055
Fax: 301-654-5920
Website: www.gastro.org

American Osteopathic Association
142 East Ontario Street
Chicago, IL 60611
Telephone: 800-621-1773
Fax: 312-202-8200
Website: www.osteopathic.org

American Osteopathic Board of Internal Medicine/American College of Osteopathic Internists
1111 West 17th Street
Tulsa, OK 74107-1898
Telephone: 918-561-1267
Website: www.acoi.org

American Society for Gastrointestinal Endoscopy
1520 Kensington Road, Suite 202
Oak Brook, IL 60523
Telephone: 630-573-0600; 866-353-2743
Fax: 630-573-0691
Website: www.asge.org

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 877-267-2323
Website: www.cms.hhs.gov

DNV Healthcare, Inc.
400 Techne Center Drive, Suite 350
Milford, OH 45150
Website: www.dnvaccreditation.com
Healthcare Facilities Accreditation Program
142 E. Ontario Street
Chicago, IL 60611
Telephone: 312-202-8258
Website: www.hfap.org

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Telephone: 630-792-5000
Fax: 630-792-5005
Website: www.jointcommission.org

Society of American Gastrointestinal Endoscopic Surgeons
11300 West Olympic Boulevard, Suite 600
Los Angeles, CA 90064
Telephone: 310-437-0544
Fax: 310-437-0585
Website: www.sages.org

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