Communication from the ASGE Standards of Practice Committee

GUIDELINE

AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY ASGE

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

Prepared by: ASGE STANDARDS OF PRACTICE COMMITTEE

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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, RECREDENTIALING, 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. 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

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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.

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