

Ensuring Competence in Endoscopy



*Prepared by the ASGE
Taskforce on Ensuring
Competence in Endoscopy*

Douglas O. Faigel, MD, Chair
Todd H. Baron, MD
Blair Lewis, MD
Bret Petersen, MD
John Petrini, MD

and



*American College of
Gastroenterology Executive
and Practice Management
Committees*

Executive Briefing

John W. Popp, Jr., MD, FACG, Pres.
Jack A. DiPalma, MD, FACG
Irving M. Pike, MD, FACG
Ira L. Flax, MD, FACG



Table of Contents

Introduction	3
Ensuring Competence in Endoscopy: A Primer	5
Examples of Endoscopy Credentialing Issues	10

Introduction

Endoscopic procedures have become standard tools for evaluation and treatment of gastrointestinal disorders. Diagnostic and therapeutic procedures are widely available and can be performed safely and competently.

Endoscopists have traditionally been trained in the art and science of endoscopy as part of fellowship in gastroenterology, pediatric gastroenterology, or surgery. These procedures have been considered an integral part of the practice of gastroenterology and surgery. Separate specialty boards have not been developed for endoscopy as a discipline. Since there are no boards specific to endoscopy, individuals who have no formal training as part of a specialty in gastrointestinal diseases often apply for, and in some cases are granted, privileges in endoscopy by hospitals and other payers. In some cases, the motivation is to provide services that would not otherwise be available. In others, it is the ability to generate income from these procedures that constitutes the motivation. Even endoscopists who have completed formal training programs may not have received extensive experience and training in more complex endoscopic procedures, such as therapeutic biliary and pancreatic endoscopy (ERCP, endoscopic retrograde cholangiopancreatography) and endoscopic ultrasonography. Additionally, as new endoscopic techniques are developed, trained endoscopists may require additional training in the new procedure prior to utilization in patient care.

American Society for Gastrointestinal Endoscopy (ASGE) with the support of the American College of Gastroenterology (ACG) has long sought to standardize training in endoscopy, and create guidelines that assist privileging institutions in determining who is competent to perform endoscopic procedures. Without specific boards in endoscopy, efforts to help assist hospitals and endoscopy units in establishing guidelines for determining competence may be seen as self-serving and restrictive. Yet the goal of these guidelines is to provide competent endoscopic services to the widest number of patients possible. Endoscopy by poorly trained personnel is not only more likely to result in a complication, the information provided may not be accurate or complete and may, ultimately, lead to misdiagnosis and poor or inappropriate treatment.

Privileging institutions have a responsibility to their patients to be certain that services provided by their staff are of the highest quality and safety. Legal precedent has been established that can hold hospitals and/or endoscopy centers responsible for granting privileges to unqualified medical staff performing the procedure (see enclosed Hospital Liability Update). Establishing guidelines for granting privileges in endoscopy that apply universally to all members of the medical staff can help safeguard against such causes of action. By providing this informational packet, ASGE and ACG are continuing their tradition of establishing the highest standards for endoscopic services.

How to Use This Guide

This guide was created by the ASGE Taskforce on Competence in Endoscopy with the support of ACG. It was created to help hospitals, credentialing organizations, insurers and healthcare providers who have questions regarding competence in and privileging for gastrointestinal endoscopy.

ASGE has created several guidelines on privileging, credentialing, and training for GI endoscopy. We have included for you a primer—a guide to the guidelines—to help find the information you need. We have also included examples of credentialing issues to illustrate how the ASGE guidelines might be applied to specific circumstances. Next, we have provided you with an update on hospital liability demonstrating how hospitals can be held liable if undertrained individuals are granted privileges to perform endoscopy. This analysis prepared by Williams & Connolly, one of the nation's premier litigation law firms, was originally commissioned by the American College of Gastroenterology in 1992. It was recently updated and rewritten by Williams & Connolly, again under the direction and with the support of the ACG. Finally, the *ASGE Policy and Procedure Manual for Gastrointestinal Endoscopy Guidelines for Training and Practice*, available on CD-ROM, includes the full-text version of each of the ASGE guidelines.

It is our intention that these guidelines be used by hospitals, ambulatory endoscopy centers, payers and other credentialing bodies to guide them in creating policies as to who will be allowed to perform procedures in their facilities. Accrediting organizations will find them useful in ensuring that all institutions have appropriate policies that apply equally to all practitioners. And third-party payers should find them useful in setting reimbursement policy so that only the highest quality of care is provided to their patients.

About ASGE and ACG

ASGE is recognized as the premier specialty society dedicated to the education of its physician members in the appropriate use of endoscopic techniques for the diagnosis and treatment of gastrointestinal diseases. ACG was formed in 1932 to advance the scientific study and medical treatment of disorders of the GI tract. The College promotes the highest standards in medical education and is guided by its commitment to meeting the needs of clinical gastroenterology practitioners. Membership in these societies consists of over 8,000 domestic and international gastroenterologists, surgeons, and other medical specialists who utilize endoscopy as a diagnostic and therapeutic method of treatment for diseases of the digestive tract and the clinical practice of gastroenterology more specifically. Eligibility for membership requires formal training in gastroenterology, gastrointestinal endoscopy administered by physicians and/or surgeons during a residency/fellowship in an adult or pediatric program. Neither ASGE nor ACG are credentialing organizations but are educational and advocacy societies serving the needs of gastroenterologists, endoscopists and their patients.

Ensuring Competence in Endoscopy: A Primer

What is competence?

Competence is the minimal level of skill, knowledge, and/or expertise derived through training and experience that is required to safely and proficiently perform a task or procedure. When applied to endoscopy, this means that the endoscopist has gone through a period of training to develop requisite endoscopic skills and acquire the knowledge-base required to safely perform, interpret, and correctly manage findings of endoscopic procedures.

Competence assures that a safe and technically successful procedure is performed and that the observations and results are accurate. When patients come for an endoscopy, they trust that the endoscopist has the skills to perform this procedure without exposing them to more risk than is absolutely necessary. They also trust that the endoscopist will be able to use the information gained from the procedure to promote the patient's health and well-being.

There are several consequences to an incompetently performed endoscopy. Most obvious are the occurrence of patient injury, such as a perforation, bleeding or a sedation-related complication, and incorrect or missed diagnoses. Technically incomplete procedures expose the patients to two kinds of risks: those of a missed or delayed diagnosis, and those of additional procedures and other testing for the same presenting complaint(s).

Even when properly done, endoscopic procedures may result in a complication. The competent endoscopist will have had adequate training in the recognition and prompt treatment of complications. Delays in diagnosis of procedure-related complications lead only to additional morbidity, and potentially mortality.

How is competence achieved?

There are two aspects to ensuring competence: training and the subsequent assessment of the endoscopist as being competent.

Through training, the endoscopist gains the necessary technical and cognitive skills. The technical skills ensure that safe and technically successful procedures are performed. Cognitive skills take the information gained from the endoscopy, and place it in the appropriate clinical context so that accurate diagnoses are made. An accurate diagnosis is paramount in providing needed therapy, whether that therapy is endoscopic (e.g., polypectomy), medical, or surgical. Additional goals of training include ensuring that only indicated endoscopies are performed, sedation and analgesia are given competently, patient risk factors are identified, and steps are taken to minimize the risks.

ASGE has developed guidelines to ensure that individuals receive adequate training (see *Principals of Training in Gastrointestinal Endoscopy*, and *Guidelines for Training in Patient Monitoring and Sedation and Analgesia*) which are supported by ACG.

Training in gastrointestinal endoscopy should take place within the context of a global clinical training program in the fields of adult or pediatric gastroenterology or general surgery. These training programs must be recognized by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association and should exist within institutions where they are supported by the presence of accredited training programs in internal medicine, pediatrics, general surgery, radiology, and pathology. Through hands-on training with adequate case volume and a supporting curriculum, the training program attains its goal of producing competent endoscopists.

While an adequate procedure volume is clearly necessary to achieve competence, performance of an arbitrary number of procedures in no way guarantees competence. ASGE has established threshold numbers of procedures that must be completed before competency can be assessed (see *Methods of Granting Hospital Privileges to Perform Gastrointestinal Endoscopy*). For example, ASGE recommends that 140 colonoscopies and 130 esophagogastroduodenoscopies (EGDs, i.e. upper GI endoscopies) be performed before competency can be assessed for these procedures. It must be recognized that these are minimum numbers and that most trainees will require more than this number to achieve competence.

ASGE recognizes that some practitioners will seek training outside of formal training programs. ASGE has developed guidelines for training in these settings (see *Alternative Pathways to Training in Gastrointestinal Endoscopy*). We emphasize that the content and quality of this training must conform to the SAME guidelines as for formal fellowship or residency training. Short courses on endoscopy deserve special mention. These should be viewed as adjunctive training opportunities or as tools for continuing medical education. However, in no way are these short courses a substitute for adequate formal training in an accredited, global program of extended duration (see *Statement on Role of Short Courses in Endoscopic Training*).

Once training is complete, competency is assessed. Within a training program, competency is assessed by the training program director who should provide written support documenting the individual's competence to perform individual endoscopic procedures. Direct observation of the applicant performing endoscopic procedures by an impartial credentialed endoscopist is also prudent, and is specifically recommended for applicants who received their training outside of a formal program (see *Proctoring for Hospital Endoscopy Privileges*).

Ensuring competence through privileging.

Privileging is a process by which a local institution authorizes an individual to perform a specific procedure (see *Methods of Granting Hospital Privileges to Perform Gastrointestinal Endoscopy*). Privileges should be determined separately for each type of endoscopic procedure (sigmoidoscopy, colonoscopy, EGD, ERCP, EUS, capsule endoscopy, and any other endoscopic procedures). Competence in one of these procedures in no way ensures competence in another.

This process begins with a review of the credentials provided by the training program. The training director should provide, in writing, the curriculum of the program and confirm the training, experience (including the number of cases for each procedure for which privileges are requested), and an actual observed level of competency (see *Principles of Privileging and Credentialing for Endoscopy and Colonoscopy, and Proctoring for Hospital Endoscopy Privileges*).

Each institution should have specific guidelines regarding privileging, and apply these guidelines uniformly to all applicants across all disciplines. The institution may, and in many cases should, require independent verification of competence through direct observation of the applicant by an independent, unbiased, credentialed endoscopist. The institution's guidelines should specify the level of training, threshold numbers of procedures, and the types of credentials supplied by training programs needed (see *Methods of Granting Hospital Privileges to Perform Gastrointestinal Endoscopy*).

Ensuring continued competence.

Maintaining clinical and endoscopic skills requires an ongoing effort. This includes familiarity with the GI literature, continuing medical education (CME) activities, and familiarity with new developments in endoscopic technologies. The endoscopist must also maintain an adequate case volume to maintain procedural skills (see *Position Statement on Maintaining Competency in Endoscopic Skills*).

In order to ensure competence of their endoscopy staff, institutions should have guidelines on recredentialing and reprivileging. Ideally, an endoscopist that wants to renew privileges should document an adequate case volume with specific documentation of the number of procedures, procedural success, therapeutic interventions, and complications. These statistics should be reviewed as part of a continuous quality improvement program. The applicant should also document continued cognitive training through participation in CME activities (see *Position Statement on Maintaining Competency in Endoscopic Skills, and Quality Improvement of Gastrointestinal Endoscopy*).

Endoscopy by non-physicians.

The decision to utilize non-physician endoscopists should be based on competence in endoscopy, availability of physician resources, and volume of procedural demand as dictated by local conditions. While physician endoscopists undergo extensive formal training in gastrointestinal diseases as well as endoscopic procedures, it is unreasonable to expect non-physicians to be

trained to this extent. Because of this, non-physicians will not attain the cognitive expertise necessary for patient care.

The safety and efficacy of non-physicians performing flexible sigmoidoscopy (i.e., the direct visual examination of a portion comprising the lower 30–40% of the entire colon) as part of colon cancer screening programs has been established. Non-physician sigmoidoscopy for the evaluation of symptoms has not been assessed and cannot currently be recommended. Some non-physicians have also performed upper endoscopy and colonoscopy. For these more complex sedated procedures, non-physicians require supervision by qualified physician endoscopists. However, currently, the medical literature supports the utilization of non-physician endoscopists for screening flexible sigmoidoscopy only (see Endoscopy By Non-physicians), and never for therapeutic procedures (e.g., removal of a polyp).

Competence in advanced endoscopic procedures.

Complex diagnostic and therapeutic procedures are used less frequently than standard procedures and are more likely to have complications and adverse outcomes. Therefore, their performance requires greater skill that is concentrated in fewer individuals. These procedures include, but are not limited to, ERCP, EUS, and endoscopic surgical techniques such as endoscopic mucosal resection (EMR). It is not possible for all training programs to teach all of these procedures to all trainees, nor is it necessary for optimal patient care.

ASGE recommends that trainees wishing to acquire skills in advanced endoscopic techniques first have completed standard endoscopy training during an approved GI fellowship (or demonstrably equivalent training) and have documented competence to perform standard endoscopic techniques (see Guidelines for Advanced Endoscopic Training). Competence and privileges to perform these advanced procedures should be determined separately from other endoscopic procedures. Once threshold numbers of procedures have been reached (as previously established by ASGE), competency can be assessed. Assessment of competence should, whenever possible, include objective measures of competence (such as success rates) and direct observation of the trainee (see Methods of Privileging and Credentialing for Endoscopy and Colonoscopy, and Proctoring for Hospital Endoscopy Privileges).

Competence in new endoscopic technologies.

The field of gastrointestinal endoscopy is dynamic and increasingly more complex. ASGE recognizes that new endoscopic techniques and procedures will be developed and that endoscopists may wish to incorporate them into their practices (see Methods of Privileging for New Technology in Gastrointestinal Endoscopy).

New techniques require new skills. These skills can be roughly divided into major and minor. *Major skill* describes a new technique or procedure that, by its nature, involves a high level of complexity. These techniques require formal training within a training program or through the guidance of a preceptorship before competence can be assessed. *Minor skill* describes a new nonexperimental development that is a minor extension of an accepted and

widely available technique or procedure. For the majority of established endoscopists, obtaining competence in a minor skill would require limited education and practical exposure, such as that obtained from short courses, training videos, CD-ROMs, and interactive computer programs. Granting privileges for new major skills should be viewed as establishing privileges for new surgical techniques and handled in a similar fashion.

Competence in wireless capsule endoscopy.

A capsule endoscope is a self-contained videoendoscopy device that is swallowed and is able to transmit images of the GI tract to an external receiver. While the technical skills to administer the capsule and operate the software to review the images are not major, the cognitive skills are similar to that required for standard endoscopy. For that reason, ASGE recommends that the use of capsule endoscopy be limited to practitioners already competent and privileged to perform standard upper and lower endoscopy and who have extensive experience viewing gastrointestinal mucosa. ASGE recommends additional specific training in capsule endoscopy as well as review of the initial 10 procedures to verify competence (see *Methods of Privileging and Credentialing for Capsule Endoscopy*).

Competence in sedation for gastrointestinal endoscopy.

The majority of endoscopic procedures in the United States are performed under sedation. Competence in sedation is necessary to perform safe, comfortable, and technically successful procedures.

Competence in sedation includes the ability to recognize the various levels of sedation from anxiolysis (minimal sedation) to general anesthesia. The endoscopist must understand the pharmacology of each sedative they intend to use, as well as the appropriate reversal agents. The endoscopist must be able to apply appropriate monitoring techniques (see *Conscious Sedation and Monitoring During Gastrointestinal Endoscopy*).

Of paramount importance is the ability to recognize complications of sedation (chiefly cardiorespiratory depression) and be able to rescue the patient. For moderate (conscious) sedation, the endoscopist must have the skills to rescue the patient from deep sedation. These skills are similar to those taught in Basic Life Support (BLS) but also include the use of reversal agents. For deep sedation (including all uses of propofol), the endoscopist must have the ability to rescue the patient from general anesthesia, including managing a compromised airway (see *Practice Guidelines for Sedation, and Analgesia by Non-Anesthesiologists*).

Out-of-hospital endoscopy.

Endoscopy can be done in a variety of settings, including the physician's office or in freestanding endoscopy centers. ASGE supports seeking accreditation for these facilities. Standards for out-of-hospital endoscopy units (whether they be freestanding or in-office endoscopy units) should be identical to those recognized guidelines followed in the hospital. The endoscopist's training should in all ways be equivalent to those practicing endoscopy in the hospital setting (see *Establishment of Gastrointestinal Endoscopy Areas*). Endoscope reprocessing must adhere to established

guidelines (see Multisociety Guidelines for Reprocessing Flexible Gastrointestinal Endoscopes).

ASGE and ACG's position has always been that the decision of site for an endoscopic procedure should be the sole prerogative of the patient and his/her physician, on the sole criteria of what is best for that patient. Gastroenterologists have steadfastly resisted the site of service policy to create a financial incentive to shift patients from one setting to another. Even more disconcerting than the incentive to change doctor behavior, are the emerging policies of some private payers to fully abrogate to themselves the decision of the site of service, without any consultation whatsoever with either patient or doctor and our societies reject this policy as not in the interest of patients. As noted in the attached legal memorandum, such a policy also carries with it potential liability consequences for the payer.

Examples of Endoscopy Credentialing Issues

The following is a set of examples designed to illustrate how credentialing guidelines may be used to address common issues in granting endoscopic privileges.

Colonoscopy

A physician currently on staff at your hospital applies for privileges in colonoscopy. The physician was trained in flexible sigmoidoscopy by a local gastroenterologist and has been performing sigmoidoscopy for 12 years. Lately, he has been using a colonoscope on selected patients and has been reaching the cecum in many of these patients. He attended a two-day course on colonoscopy that provided him a certificate of attendance upon completion of the course. The department of internal medicine has granted him privileges, and the chief of staff is being asked to sign-off on his request. Should he be granted privileges?

Comment

The applicant does not meet ASGE requirements, and privileges should be denied. He has not completed a formal training program in gastroenterology or surgery. While this individual has completed training and has substantial experience in a related procedure (flexible sigmoidoscopy), the requisite cognitive and procedural skills necessary to perform colonoscopy safely and competently have not been documented. Competence to perform colonoscopy cannot be acquired in a brief or short course. ASGE has recommended that a minimum of 140 supervised colonoscopy procedures be performed in a training program before an assessment can be made of whether an individual is qualified to perform colonoscopy without supervision. Even this minimum number does not assure competence, and training is individualized within an appropriate residency program.

Colonoscopy by a physician assistant

A local family practice group has hired a physician assistant to perform colonoscopy. This individual has spent more than a year being trained in colonoscopy with a GI group in another state. He can provide documentation of having done more than 200 supervised colonoscopies, as well as letters from his supervising GI physicians attesting to his competence. He is requesting unrestricted privileges to perform colonoscopy in your hospital's endoscopy suite. None of the family practitioners in the practice currently have endoscopic privileges.

Comment

The safety and efficacy of non-physicians performing flexible sigmoidoscopy as part of colon cancer screening programs has been established. For more complex and sedated procedures, there is inadequate literature to support this practice. For this reason, ASGE does not currently endorse colonoscopy by non-physician endoscopists. It is recognized that some non-physicians have been trained to perform these procedures. In these rare instances, ASGE recommends that the non-physician be closely supervised by a trained physician endoscopist.

In this scenario, the physician assistant is requesting unrestricted privileges to do unsupervised colonoscopies, and this request should be denied.

Endoscopy by a foreign medical graduate

A graduate of a non-U.S. foreign medical school is seeking privileges to perform endoscopy in a U.S. hospital. She completed training in internal medicine at the same institution where she attended medical school. She completed a university affiliated and accredited three-year gastroenterology fellowship in the United States and can document more than 500 EGDs and colonoscopies, along with a letter from her program director attesting to her competency. She has an unrestricted medical license in the same state as the hospital to which she is applying for privileges and is a permanent resident-alien (she has a green card). Because of her foreign medical training, she is not eligible to take the American Board of Internal Medicine examination in gastroenterology and is, therefore, not board certified.

Comment

This applicant meets all the requirements of training in endoscopy having completed an accredited fellowship, performed more than the recommended minimum number of procedures, and was deemed competent by her program director (see *Methods of Granting Hospital Privileges to Perform Gastrointestinal Endoscopy*). ASGE does not require board certification, and the fact that she is not board certified should not be used to deny privileges.

ERCP

A physician has just finished three years of endoscopic training. The second year of training was dedicated to research and involved no endoscopic experience. During the third year of fellowship training, the fellow was involved with 133 ERCP cases, the vast majority of which were completed by the staff physician. The trainee's competency evaluations during his ERCP rotation specifically commented that the trainee was not competent to

independently perform ERCP. Upon completion of fellowship training, the physician accepted a position at another institution; he is applying for privileges to perform ERCP.

Comment

ERCP is considered by ASGE to be an advanced endoscopic procedure that is complex, technically demanding to perform, and carries a relatively higher risk of complications. Serious life-threatening short-term and long-term complications may arise as a result of ERCP. Providing brief exposure to an advanced procedure is no longer appropriate.

Few studies of the rate at which proficiency is attained have been performed, but available data suggest that at least 180 to 200 ERCPs are required for the usual trainee to achieve competence (see Jowell PS, et al. *Ann Intern Med.* 1996;125:983-9). In the scenario mentioned, the fellow has not performed the minimum 200 procedures recommended by the ASGE before competency can be assessed, and his training program specifically did not feel he was competent.

A trainee's overall numbers are not in and of themselves adequate to ensure competency in ERCP. The following are suggested objective performance criteria for the evaluation of technical skills in ERCP (see Principles of Training in Gastrointestinal Endoscopy): cannulation of desired duct, opacification of desired duct, stent placement, sphincterotomy, and stone extraction. Expert endoscopists are generally expected to perform at a 95% to 100% technical success level, and current research supports establishing a standard of 80% to 90% technical success before trainees are deemed competent in a specific skill. In a given program, small variations in the standard of expected proficiency that is set from one procedure to the next may be appropriate, especially among procedures of varying complexity; however, the expected performance level should be uniform among all trainees. The principles of training and credentialing in endoscopy that have been outlined by ASGE were not met in this case (see Methods of Granting Hospital Privileges to Perform Gastrointestinal Endoscopy). Should an adverse event during ERCP occur after the trainee, in this case, performs ERCP, the hospital granting privileges may be held accountable.

Reclaiming privileges after a leave of absence

A gastroenterologist who was formerly on staff has recently returned to your city and is requesting readmission to the medical staff with privileges in liver biopsy, flexible sigmoidoscopy, upper endoscopy (EGD), colonoscopy, and ERCP. The physician left your staff five years ago to become the medical director of an insurance company out of state. He has not been involved in direct patient care while employed by the insurance company. He has, however, continued to attend national meetings and has kept his license and CME credits current. Should you grant privileges in these procedures?

Comment

The physician has had formal training in gastroenterology and has had experience and training in these procedures. He has not, however, performed these procedures in the last five years, and there is good evidence that proficiency in endoscopic procedures is dependent upon continued practice and performance of adequate numbers of procedures (ASGE. *Gastrointest Endosc.* 1999;49:823-5. See Renewal of Endoscopic Privileges and Position Statement on Maintaining Competency in Endoscopy Skills). It would be necessary for this physician to demonstrate competence through proctoring prior to granting privileges. While this is true for any of the requested procedures, it is particularly true for the more complex and technically demanding procedures, such as ERCP. This request should be treated in a similar manner to a newly trained physician who is seeking initial privileges, with proctoring by someone acceptable to both the privileging body and the applicant (see Proctoring for Hospital Endoscopy Privileges).

Capsule endoscopy

A 52-year-old gastroenterologist requests permission to offer small-bowel capsule endoscopy in the outpatient endoscopy suite at the hospital. He currently has privileges to perform EGD, enteroscopy, and colonoscopy. He has attended a hands-on course in capsule endoscopy and received eight hours of CME credit. He had his first 10 capsule exams reviewed by an experienced capsule endoscopist and is able to produce a letter from this colleague attesting to his good accuracy rate.

Comment

ASGE recommends that the use of capsule endoscopy be limited to practitioners already competent and privileged to perform standard upper and lower endoscopy and who have extensive experience viewing gastrointestinal mucosa. ASGE recommends additional specific training in capsule endoscopy, as well as review of the initial 10 procedures to verify competence. The practitioner in question has met all of these requirements, and privileges should be granted.

New technology

A company develops a new technology for gastroesophageal reflux. It is an implantable device using a proprietary insertion tube and is performed under endoscopic guidance. The technology has been studied in a multicenter trial and is cleared for marketing by the FDA. The technology is then presented at a national meeting at an evening dinner program. Having attended the meeting, a local gastroenterologist returns to his hospital and wishes to start offering this service in the endoscopy suite.

Comment

The new technology requires a major skill since the new procedure involves a high level of complexity. According to ASGE guidelines, this technique requires formal training within a training program or through the guidance of a preceptorship before competence can be assessed. Granting privileges for new major skills is viewed as establishing privileges for new surgical techniques and handled in a similar fashion. The gastroenterologist is told

to contact the manufacturer who is sponsoring hands-on training courses, and privileges should not be granted in the absence of documented training proficiency.

Endoscopic Ultrasound (EUS)

A physician has applied for privileges to perform endoscopic ultrasound. She has privileges to perform standard upper and lower endoscopy as well as ERCP. She has completed a two-week hands-on course that included an animal lab and direct involvement in performing supervised EUS in 20 patients. She supplies a letter and a CME certificate documenting this training. She states that for someone with her level of endoscopic skills, EUS represents a minor skill and privileges should be granted.

Comment

ASGE recognizes EUS as a technically demanding procedure and has specific recommendations as to adequate training. Privileging for EUS should be considered separately from other endoscopic procedures. Competence in other endoscopic procedures (e.g., ERCP) does not automatically indicate competence in EUS. ASGE does recommend at least 24 months of formal GI or surgical training or equivalent and competence in standard GI endoscopy. ASGE recognizes that some physicians may not wish to perform all aspects of EUS. Before competency can be assessed, we recommend that the trainee complete the following minimum number of procedures:

Mucosal tumors:	75
Submucosal lesions only:	40
Mucosal and submucosal lesions:	100
Pancreaticobiliary:	75
EUS-guided FNA	
<i>Non-pancreatic:</i>	25
<i>Pancreatic:</i>	25
Comprehensive competence:	50 (including at least 75 pancreaticobiliary and 50 FNA)

These numbers do not guarantee competence but are thresholds at which competence can be assessed.

The physician in this example does not meet the ASGE guidelines, and privileges should not be granted.

Enclosed you will find a legal memorandum prepared by the prominent litigation firm Williams & Connolly regarding the responsibilities of those granting privileges to perform gastrointestinal endoscopy, commissioned by the American College of Gastroenterology. The research and authorship of the initial legal memorandum were prepared by Williams & Connolly 1992. Recently ACG commissioned a complete review and updating of the same topic, again performed by Williams & Connolly resulting in the following new 2005 legal memorandum. It should be noted that the neither ASGE nor ACG has indicated board certification as part of its requirements to perform gastrointestinal endoscopy.

The ASGE guidelines referenced in this document can be accessed on the *ASGE Policy and Procedures Manual for Gastrointestinal Endoscopy: Guidelines for Training and Practice* on CD-ROM. The CD-ROM is available for purchase at www.asge.org/store.

All guidelines are also available online, free of charge, at www.asge.org.



American Society for Gastrointestinal Endoscopy
1520 Kensington Road, Suite 202
Oak Brook, Illinois 60523
Phone: (630) 573-0600 Fax: (630) 573-0691
E-mail: info@asge.org Web: www.asge.org



American College of Gastroenterology
P.O. Box 342260
Bethesda, Maryland 20827-2260
Phone: (301) 263-9000 Fax: (301) 263-9025
Web: www.acg.gi.org