**Gastroenterology Clinical Privileges**

Name: Effective from / / to / /

* Initial privileges (initial appointment)
* Renewal of privileges (reappointment)
* Modification of privileges

All new applicants must meet the following requirements as approved by the governing body, effective / / .

If any privileges are covered by an exclusive contract or an employment contract, practitioners who are not a party to the contract are not eligible to request the privilege(s), regardless of education, training, and experience. Exclusive or employment contracts are indicated by [EC].

**Applicant:** Review education and basic formal training requirements, current competency, FPPE competence, and maintenance requirements thoroughly. Check the “Requested” box for each privilege requested. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of

current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

**[Chair/chief]:** Check the appropriate box for recommendation on the last page of this form [and include your recommendation for FPPE1]. If recommended with conditions or not recommended, provide the condition or explanation on the last page of this form.

## Other requirements:

* + Applicants will be requested to provide documentation of practice and current clinical competence as defined on the attached competency grid.
	+ Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current clinical competence and other qualifications and for resolving any doubts.
	+ Note that privileges granted may be exercised only at the site(s) and/or setting(s) that have sufficient space, equipment, staffing, and other resources required to support the privilege.
	+ This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

# Qualifications for Gastroenterology

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| **Specialty/ Procedure Delineation of Privilege Form** | **Education/Training Documentation for Initial Granting** | **Initial Application (Proof of Current Clinical Competence)** | **FPPE—****Validation of Competence** | **Maintenance Requirements** |
| Gastroenterology | Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association(AOA)–accredited fellowship in gastroenterology.[AND]Current certification or board eligible (with achievement of certification within [n] years of completion of training) leading to certification in gastroenterology by the American Board of Internal Medicine or completion of a certificate of special qualifications in gastroenterology by the American Osteopathic Board of Internal Medicine. | 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– orAOA–accredited residency or clinical fellowship within the past 12 months.Any complications/ poor outcomes should be delineated and accompanied by an explanation. | First [n] cases including [as applicable]. | [Maintenance of Certification is required]Demonstrated current competence and evidence of the performance of at least [n] therapeutic ERCP procedures ([n] sphincterotomies and[n] stent placements) in the past 24 months based on results of ongoing professional practice evaluation and outcomes. In addition, continuing education relatedto gastrointestinal endoscopy should be required.Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges. |

**Core Privileges: Gastroenterology**

This is not intended to be an all-encompassing procedures list. It defines the types of activities/procedures/ privileges that the majority of practitioners in this specialty perform at this organization and inherent activities/ procedures/privileges requiring similar skill sets and techniques.

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| **Request****(Applicant to select)** | **Gastroenterology** | **Approved****(Yes or No)** | **Proctor****(If yes, # of cases)** | **Denied****(If yes, comments)** | **Pending****(If yes, comments)** |
|  | Admit, evaluate, diagnose, treat, perform history and physical, 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 asthe esophagus and pancreas, including the use of diagnostic and therapeutic procedures using endoscopes to see internal organs. May provide care to patients in the intensive care setting in conformance withunit policies. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. |  |  |  |  |
|  | Argon plasma coagulation |  |  |  |  |
|  | Biliary tube/stent placement |  |  |  |  |
|  | Biopsy of the mucosa of the esophagus, stomach, small bowel, and colon |  |  |  |  |
|  | Breath test performance and interpretation |  |  |  |  |
|  | Capsule endoscopy |  |  |  |  |
|  | Colonoscopy with or without polypectomy |  |  |  |  |
|  | Diagnostic and therapeutic esophagogastroduodenoscopy |  |  |  |  |

# Core Privileges: Gastroenterology (cont.)

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| **Request****(Applicant to select)** | **Gastroenterology** | **Approved****(Yes or No)** | **Proctor****(If yes, # of cases)** | **Denied****(If yes, comments)** | **Pending****(If yes, comments)** |
|  | Endoscopic mucosal resection |  |  |  |  |
|  | Endoscopic retrograde cholangiopancreatographies (ERCP) [determine whether core or non-core] |  |  |  |  |
|  | Enteral and parenteral alimentation |  |  |  |  |
|  | 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 [determine whether core or non-core] |  |  |  |  |
|  | Interpretation of gastric, pancreatic, and biliary secretory tests |  |  |  |  |
|  | Nonvariceal hemostasis (upper and lower) |  |  |  |  |
|  | Percutaneous endoscopic gastrostomy |  |  |  |  |
|  | Percutaneous liver biopsy |  |  |  |  |
|  | Proctoscopy |  |  |  |  |

**Core Privileges: Gastroenterology (cont.)**

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| **Request****(Applicant to select)** | **Gastroenterology** | **Approved****(Yes or No)** | **Proctor****(If yes, # of cases)** | **Denied****(If yes, comments)** | **Pending****(If yes, comments)** |
|  | Sengstaken/Minnesota tube intubation |  |  |  |  |
|  | Snare polypectomy |  |  |  |  |
|  | Ultrasound, including endoscopic ultrasound and fine-needle aspiration |  |  |  |  |
|  | Variceal hemostasis (upper and lower) |  |  |  |  |

Non-core privileges (see specific criteria)

Non-core privileges are requested individually in addition to requesting the core. Each individual requesting non-core privileges must meet the specific threshold criteria as applicable to the applicant or reapplicant.

## Qualifications for use of laser

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| **Specialty/ Procedure Delineation of Privilege Form** | **Education/Training Documentation for Initial Granting** | **Initial Application (Proof of Current Clinical Competence)** | **FPPE—****Validation of Competence** | **Maintenance Requirements** |
| Use of laser | Successful completion of an approved residency in a specialty or subspecialty that included training in laser principles or completion of an approved 8- to 10-hour continuing medical education course that included training in laser principles. In addition, an applicant for privileges should spend time afterthe basic training course in a clinical setting with an experienced operator who has been granted laser privileges acting as a preceptor. Practitioner agrees to limit practice toonly the specific laser types for which he or she has provided documentationof training and experience. The applicant must supply a certificate documenting that he or she attended a wavelength and specialty- specific laser course and also present documentation as to the content ofthat course. | Demonstrated current competence and evidence of theperformance of at least 5 procedures in the past 24 months, or completion of training in the past 12 months. Any complications/ poor outcomes should be delineated and accompanied by an explanation. | First [n] cases including [as applicable]. | Current demonstrated competence and an adequate volume of experience ([n] 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. |

**Non-core privileges: Use of laser**

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| **Request****(Applicant to select)** | **Gastroenterology** | **Approved****(Yes or No)** | **Proctor****(If yes, # of cases)** | **Denied****(If yes, comments)** | **Pending****(If yes, comments)** |
|  | Use of laser |  |  |  |  |

**Qualifications for therapeutic endoscopic retrograde cholangiopancreatographies**

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| --- | --- | --- | --- | --- |
| **Specialty/ Procedure Delineation of Privilege Form** | **Education/Training Documentation for Initial Granting** | **Initial Application (Proof of Current Clinical Competence)** | **FPPE—****Validation of Competence** | **Maintenance Requirements** |
| Therapeutic endoscopic retrograde cholangiopan- creatographies (ERCP) | Completion of an ACGME– or AOA–accredited program in gastroenterology that included training in ERCP of a minimum of 200 procedures (including 40 sphincterotomiesand 10 stent placements). | Demonstrated current competence and evidence of the performance of at least [n] therapeutic ERCP procedures ([n] sphincterotomies and[n] stent placements) in the past 12 months, or completion of training in the past 12 months. Any complications/ poor outcomes should be delineated and accompanied by an explanation. | First [n] cases including [as applicable]. | Demonstrated current competence and evidence of the performance of at least [n] therapeutic ERCP procedures ([n] sphincterotomies and[n] stent placements) in the past 24 months based on results of ongoing professional practice evaluation and outcomes. In addition, continuing education related to gastrointestinal endoscopy should be required.Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges. |

**Non-core privileges: Therapeutic endoscopic retrograde cholangiopancreatographies**

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| **Request****(Applicant to select)** | **Gastroenterology** | **Approved****(Yes or No)** | **Proctor****(If yes, # of cases)** | **Denied****(If yes, comments)** | **Pending****(If yes, comments)** |
|  | Therapeutic endoscopic retrogradecholangiopancreatographies (ERCP) |  |  |  |  |

**Acknowledgment of Practitioner**

I have requested only those privileges that by education, training, current experience, and demonstrated performance I am qualified to perform and that I wish to exercise at [hospital name], and I understand that:

* In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
* Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

**Signed Date**

**[Chair/Chief] Recommendation**

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

* Recommend all requested privileges
* Recommend privileges with the following conditions/modifications:
* Do not recommend the following requested privileges:

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| --- | --- |
| **Privilege** | **Condition/Modification/Explanation** |
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**Notes:**

**[Department chair/chief] signature: Date:**

**For Medical Staff Services Department Use Only**

Credentials committee action Date:

Medical executive committee action Date:

[Governing board] action Date:

# Footnote

1. For Joint Commission– and HFAP-accredited hospitals.