Family medicine

Background

According to the American Academy of Family Physicians (AAFP), family medicine is the medical specialty that provides continuing, comprehensive healthcare for individuals and families. It integrates biological, clinical, and behavioral sciences. The scope of family medicine is broad and may encompass all ages, all sexes, each organ system, and every disease entity.

The AAFP also states that family physicians, through education and residency training, possess distinct attitudes, skills, and knowledge that qualify them to provide continuing and comprehensive medical care, health maintenance, and preventive services to each member of the family regardless of sex, age, or type of problem, be it biological, behavioral, or social. These specialists, because of their background and interactions with the family, are qualified to serve as each patient’s advocate in health-related matters, including the appropriate use of consultants, health services, and community resources.

Although all family physicians share a core of information, the dimensions of knowledge and skill vary with the individual family physician. Family physicians may include the following clinical areas in their scope of practice:

- Adult medicine
- Pediatrics
- Gynecology
- Obstetrics
- Surgery

Patient needs differ in various geographic areas, and the content of the family physician’s practice varies accordingly. For example, the knowledge and skills useful to a family physician practicing in an inner city may vary from those needed by a family physician with a rural practice. Further, the scope of an individual family physician’s practice changes over time, evolving as competency in current skills is maintained and new knowledge and skills are obtained through continuing medical education (CME). This growth in medical information also confers on the family physician a responsibility for the assessment of new medical technology and for participation in resolving ethical dilemmas brought about by these technological advances.

The types of procedures performed by family physicians are as varied as the scope of practice. The range of procedures includes but is not limited to performing simple skin biopsies or excisions; suturing lacerations; casting; intubation; inserting arterial and
central lines; and performing colonoscopies, endoscopies, Pap smears, pulmonary function testing, ultrasound imaging, and EKGs.

In recent years, many organizations have established hospitalist programs. As a result, many family medicine physicians (and physicians in other specialties such as internal medicine and pediatrics) who once provided the majority of the inpatient care are now primarily office-based. This development allows medical staffs, credentialing committees, and governing bodies to rethink the way they define and grant privileges. Creating and subsequently granting “refer and follow” privileges is often an appropriate option. Because these physicians are not fully exercising hospital inpatient privileges, most are willing to accept referral privileges, maintain medical staff membership, and continue to serve on committees, use the library, and attend medical staff meetings.

Customize the refer-and-follow privileges as appropriate for your organization, but they often state that the physician can:
- Perform the preadmission history and physical
- Refer patients to the hospital
- Order outpatient diagnostic tests
- Follow the patient’s progress, but the attending physician at the hospital provides the necessary inpatient care

According to the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Family Medicine (ABFM), a minimum of three years of graduate medical education is necessary to train a physician in family medicine. For certification in family medicine by the ABFM, physicians must pass a computer-based examination in family medicine given by the ABFM.

The American Osteopathic Association (AOA) and the American Osteopathic Board of Family Physicians (AOBFP) require trainees to complete a two-year AOA family practice residency in addition to the one-year AOA-approved internship. For certification in family practice and osteopathic manipulative treatment (OMT) by the AOBFP, physicians must pass a computer-based examination in family practice as well as have an OMT Performance Evaluation, which requires candidates to attend either the AOA or American College of Osteopathic Family Physicians (ACOFP) convention.

The American Board of Medical Specialties recognizes the following subspecialties of family medicine:
- Adolescent medicine (see Clinical Privilege White Paper—Practice area 185)
- Geriatric medicine (see Clinical Privilege White Paper—Practice area 113)
- Hospice and palliative medicine (see Clinical Privilege White Paper—Practice area 406)
- Sleep medicine (see Clinical Privilege White Paper—Practice area 117)
- Sports medicine (see Clinical Privilege White Paper—Practice area 197)
**Involved specialties**

Family medicine physicians

**Positions of specialty boards**

**ABFM**

The ABFM offers certification in family medicine. To receive certification by the ABFM, physicians must meet the following requirements:

➤ Have satisfactorily completed three years of training in a family medicine residency program accredited by the ACGME after receiving an MD or DO degree from an accredited institution

➤ Have a currently valid, unrestricted license to practice medicine in the United States or Canada

The ABFM also offers certificates of added qualifications (CAQ) in adolescent medicine, geriatric medicine, hospice and palliative medicine, sleep medicine, and sports medicine. These CAQs are offered in conjunction with other medical specialty boards. Family physicians must be currently certified diplomates of the ABFM in order to apply for and maintain certification in a CAQ. Successful CAQ candidates will be awarded the ABFM CAQ. The certificate will be valid for 10 years, at which time recertification is required for renewal of the certificate.

**AOBFP**

The AOBFP offers certification in family practice. It requires trainees to complete a two-year AOA-accredited family practice residency in addition to the one-year AOA-approved internship. The AOBFP offers CAQs in geriatrics, sports medicine, undersea and hyperbaric medicine, hospice and palliative care, sleep medicine, and addiction medicine.

To receive certification by the AOBFP for any subspecialty, physicians must meet the following requirements:

➤ Be a graduate of an approved osteopathic college

➤ Have a current, full, unrestricted license

➤ Be a member in good standing of the AOA for at least two years immediately prior to application, examination, and presentation for certification

➤ Completion within the past six years of a one-year AOA-approved internship and a two-year AOA-approved family practice residency program OR currently in a three-year AOA-approved family practice residency program

The AOBFP specifies the number of CME hours family practitioners need to meet in order to maintain certification. Certified physicians in family practice and OMT are required to maintain a total of 150 CME hours, 30 hours more
than the 120-hour AOA membership requirement. Fifty of the required 150 CME hours for the three-year cycle must be documented in the primary specialty area of family practice and OMT. For more specific information on the AOBFP CME requirements, please visit the organization’s website at www.aobfp.org.

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

**AAFP**

The AAFP considers physicians to be specialists in family medicine when they have satisfied at least one of the following criteria:

- Current board certification by the ABFM
- Successful completion of an ACGME-approved family medicine residency program or a three-year AOA-approved postgraduate family medicine residency program
- Maintenance of eligibility requirements for active membership in the AAFP

In regard to the role of hospitalists, the position of the AAFP states that family physicians’ participation in “hospitalist systems” encourages the following principles:

- The opportunity to participate as a hospitalist in such systems must be open to all interested physicians whose education, training, and current competence qualify them to serve effectively in this role.
- The decision of who should care for a family physician’s hospitalized patients should be made by the patient and his or her family doctor, in the interest of what is best for patient care (i.e., participation in hospitalist models should be voluntary).
- In the interest of preserving continuity, patient advocacy, and healthcare decision-making that is in concert with the patient’s values, the AAFP strongly encourages the use of generalists for inpatient general medical management. Consultation with an intensivist or medical or surgical subspecialist does not preclude the need for the continuing, comprehensive, and personal care provided by a “generalist” physician.
- In the event that family physicians elect to refer their patients for inpatient care management, the AAFP strongly encourages them to maintain open communications with those patients and their families throughout the hospitalization, as recommended in the *AAFP Guidelines for Interaction in “Hospitalist” Models.*
- While family physicians may elect to refer their patients for inpatient care management, the AAFP cautions that they should strongly consider the mid- and long-range implications for their practices before they relinquish hospital privileges. Such implications may include (a) difficulty being credentialed and/or paid by managed care companies for services/procedures in the ambulatory setting if one does not have hospital privileges for those same services/procedures, and/or (b) the very real possibility of being unable to successfully
reapply for hospital privileges at future points of career transition, without the necessity of seeking substantial additional education and retraining.

➤ The AAFP will develop ways to help support members when the opportunity to provide hospital care has been removed by their healthcare system or managed care organization.

ACOG

Together with the AAFP, the American College of Obstetricians and Gynecologists (ACOG) published a Joint Statement on Cooperative Practice and Hospital Privileges. The document acknowledges that midwives, family physicians, and obstetricians are major providers of prenatal care, labor and delivery, and postpartum care. High quality of care is contingent upon a cooperative and collaborative relationship between the three caregivers.

The statement calls for shared common standards of perinatal care that would require a cooperative working environment and shared decision-making. The document states that, “clear guidelines for consultation and referral for complications should be developed jointly. When appropriate, early and ongoing consultation regarding a woman’s care is necessary for the best possible outcome and is an important part of risk management and prevention of professional liability problems. All family physicians and obstetricians on the medical staff of the obstetric unit should agree to such guidelines and be willing to work together for the best care of patients. This includes a willingness on the part of obstetricians to provide consultation and back-up for family physicians who provide maternity care. The family physician should have knowledge, skills and judgment to determine when timely consultation and/or referral may be appropriate.”

The statement addresses quality and competency, stating that obstetricians and family practitioners within an organization should establish a joint practice committee to determine and monitor standards of care and to determine proctoring guidelines.

With regard to practice privileges, the statement says, “The assignment of hospital privileges is a local responsibility and privileges should be granted on the basis of training, experience and demonstrated current competence. All physicians should be held to the same standards for granting of privileges, regardless of specialty, in order to assure the provision of high-quality patient care. Prearranged, collaborative relationships should be established to ensure ongoing consultations, as well as consultations needed for emergencies.

“The standard of training should allow any physician who receives training in a cognitive or surgical skill to meet the criteria for privileges in that area of practice. Provisional privileges in primary care, obstetric care and cesarean delivery should be granted regardless of specialty as long as training criteria and experience are
documented. All physicians should be subject to a proctorship period to allow
demonstration of ability and current competence. These principles should apply to
all health care systems.”

The statement says that the family medicine department maintains responsibil-
ity for those privileges recommended by the department of family medicine.
Similarly, privileges recommended by the department of obstetrics/gynecology
are the responsibility of that department. When privileges are recommended
jointly by the departments of family medicine and obstetrics/gynecology, they
are the joint responsibility of the two departments.

AOA

Basic Standards for Residency and Fellowship Training In Osteopathic Family Practice
and Manipulative Treatment is developed by the AOA. According to the AOA and
ACOFP, the following core competencies should be required of all residents:

➤ With regard to osteopathic philosophy and OMT, residents must:
  − Integrate osteopathic principles into the daily practice of family medicine
  − Appropriately apply osteopathic manipulative medicine to patient
    management

➤ With respect to medical knowledge, residents must:
  − Maintain current knowledge of clinical medicine that reflects the majority
    of patient care issues that present to osteopathic family practice settings
  − Maintain current knowledge of behavioral medicine that reflects the
    majority of patient care issues that present to osteopathic family practice
    settings

➤ With respect to patient care, residents must:
  − Provide osteopathic family practice patient care service in ambulatory
    continuity, hospital, and extended care sites
  − Provide acute, chronic, and preventative care across the full spectrum of
    ages and genders
  − Accurately gather information from all sources including patients,
    caregivers, other professionals, electronic sources, and paper sources

➤ With regard to interpersonal and communication skills, residents must:
  − Develop appropriate doctor-patient relationships in all family practice settings
  − Develop effective listening, written, oral, and electronic communication
    skills in professional interactions with patients, families, and other health
    professionals

➤ With respect to professionalism, residents must:
  − Demonstrate respect for patients and families and advocate for the primacy
    of patients’ welfare and autonomy
  − Adhere to ethical principles in the practice of family medicine
  − Demonstrate awareness and proper attention to issues of culture, religion,
    age, gender, sexual orientation, and mental and physical disabilities
With regard to practice-based learning and improvement, residents must:
- Apply the principles of evidence-based medicine to osteopathic family practice
- Participate in practice-based objective performance improvement projects in osteopathic family practice settings

With respect to systems-based practice, residents must:
- Effectively function within local and national healthcare delivery systems to provide high-quality osteopathic family practice services
- Function in a family practice group to provide care to diverse populations

**ACGME**

In its *Program Requirements for Fellowship Training in Family Medicine*, the ACGME states that residency training programs in family medicine should integrate ACGME competencies into the curriculum.

With regard to patient care, residents must:

- Receive training to perform those clinical procedures required for their future practices in the ambulatory and hospital environments.
- Receive training that focuses on the core principles of continuity of care, a recognized core value of the family medicine specialty.
  - Resident panels must include continuity patients requiring home care and care in long-term facilities.
  - Residents must gain nursing home experience consisting of at least two patients as a continuity experience over a minimum of 24 consecutive months, in addition to that which residents might experience as part of a rotation.
  - They should also perform at least two home visits with at least one being for an older adult continuity patient.
  - Each resident must maintain continuity of responsibility for some of his or her patients in all settings when such patients require urgent or emergent care, home care, long-term care, hospitalization, or consultation with other providers. Continuity of responsibility should include active involvement in management and treatment decisions, and interactive communications about management and treatment decisions. In the second and third years of residency, when other curricular responsibilities temporarily prevent a resident from providing continuity of responsibility in any of these settings, that continuity must be provided by another resident or faculty from the program (e.g., the inpatient team or the physician on-call for the practice). When a substitute physician, such as a member of a family medicine team, is involved in continuity of care, there must be a mechanism to transfer information clearly and expeditiously to the primary continuity physician.
- Provide family-oriented comprehensive care, which is important for the welfare of patients as they function in the family, community, and healthcare system.
Principles of comprehensive care include physician availability, accessibility, efficiency, and continuity.

The family physician assumes responsibility for the total healthcare of the individual and family, taking into account social, behavioral, economic, cultural, and biologic dimensions. Therefore, residents must learn to demonstrate cultural competence in caring for patients from varied ethnic and cultural backgrounds.

Residents must be given the opportunity to achieve high levels of competence in health maintenance and in disease and problem management, and to develop attitudes that reflect expertise in comprehensive patient management and education.

Residents should acquire knowledge and experience in the provision of longitudinal healthcare to families, including assisting them in coping with serious illness and loss, and in promoting family mechanisms to maintain wellness of its members.

Essential elements of residents’ education include health assessment, health maintenance, preventive care, acute and chronic illness and injury, rehabilitation, behavioral counseling, health education, and human sexuality.

Additional essential elements include for the family: family structure and dynamics, genetic counseling, family development, family planning, child rearing and education, aging, end-of-life issues, epidemiology of illness in families, the role of family in illness care, family counseling and education, nutrition, and safety.

Be scheduled to see their own patients during training. Each resident should gain experience with all age groups, in volumes sufficient to achieve competency in all aspects of family medicine.

Document at least 1,650 patient visits, with at least 150 during the first year.

Achieve essential skills/competencies of both productivity and efficiency necessary in an independent clinical practice.

Principles of comprehensive care include physician availability, accessibility, efficiency, and continuity.

Develop the skills required to treat male and female patients of all ages and those having various levels of severity of illness who are hospitalized. Inpatient care must include the continuity of care of adults and children from the residency patient panel. This inpatient experience should occur primarily on a family medicine or an internal medicine service.

Receive clinical experience caring for hospitalized patients in special care units including medical intensive care, coronary care, and newborn nursery. Additional experience will occur on other inpatient services.

Become competent diagnosing and managing common inpatient problems of adults and children as seen by the family physician.

Demonstrate direct management of patients to include initial evaluation, admission of patients, repeat evaluations, development of a plan of care, ongoing management, performance of basic procedures of medicine, appropriate consultation, and discharge planning and continuing care.
➤ Demonstrate the ability to write appropriate admitting orders and to modify them daily according to changes in the patient’s condition.

➤ Maintain involvement in the care of their hospitalized patients whenever possible, even if the program uses the services of hospitalists. The residency must foster a team system that ensures continuity of care from the patient’s perspective when the primary resident is unable to be present in both inpatient and outpatient settings. The continuity resident is expected to communicate daily with the hospital resident and provide long-term continuity care after discharge.

➤ Be competent to provide hospital care by the end of the residency. Residents should have developed competence in knowledge, attitudes, and skills to care independently for hospitalized patients without supervision and to utilize appropriate consultation by other specialists.

With regard to medical knowledge, residents 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.

➤ Receive eight months of adult medicine experience, of which six are inpatient; and residents should:
  – Have the following curricular areas in either longitudinal or block format: cardiovascular, neurologic, endocrinologic, pulmonary, gastrointestinal, rheumatologic, infectious, nephrologic, and hematologic diseases.
  – Gain knowledge in women’s health, including non-obstetrical, non-gynecologic care of women that deals with the study of gender differences and the diversity of women’s health needs throughout the life cycle.
  – Care for at least five inpatients, on average, at any one time. Senior residents who are functioning in a supervisory role may have direct responsibility for a smaller number of patients.
  – Gain the ability to care for critically ill patients (15 required).
  – Understand how to care for older patients, including appropriate preventive modalities, functional assessment, the physiologic and psychological aspects of senescence, as well as the sociocultural parameters of the patients and their greater community.
  – Have supervised clinical experiences dealing with common acute and chronic diseases of aging.
  – Learn about, and practically apply, a multidisciplinary approach to the care of older patients in the hospital, the family medicine clinic (FMC), the long-term care facility, and the home.
  – Be competent in preventive healthcare, promotion of independent living, and maximizing function and quality of life.
— Develop competency in assessing and meeting the healthcare needs of declining elders; episodic, illness-related care; delivery of healthcare in the home, FMC, hospital, and long-term facility; and end-of-life care.

➤ Complete four months of structured experience in the care of infants, children, and adolescents; as part of their experience with infants, children, and adolescents, residents should:

— Gain experience in the following areas: neonates, infant care (both well-baby and ill), hospitalized children, ambulatory pediatrics, emergency care of children, and adolescent medicine. This may include experience gained on the family medicine inpatient service, in the emergency department, in the pediatric hospital and clinic, and in nursery care associated with OB experience, provided that appropriate documentation of such experience is maintained for each resident.

— Receive a minimum of two months of experience in maternity care, including the principles and techniques of prenatal care, management of labor and delivery, and postpartum care.

— Become capable of managing a normal pregnancy and delivery.

— Acquire competency in the common problems of prenatal and postnatal care.

— Be trained in the recognition and initial management of the high-risk prenatal patient, including consultation and referral.

— Be taught to recognize and manage complications and emergencies in pregnancy, labor, and delivery.

— Receive training in genetic counseling.

— Be trained in the management of the high-risk prenatal patient, if appropriate for that resident.

— Perform a minimum of 40 deliveries over the three-year program, of which a minimum of 10 must be continuity deliveries. At least 30 of the total deliveries must be vaginal deliveries.

— For the minimum of 10 continuity patient deliveries, each resident must assume responsibility for provision of antenatal, natal, and postnatal care during their three years of training.

➤ Receive one month of structured curriculum in gynecology, where they must:

— Be trained to competency in normal gynecological examinations; gynecological cancer screening; preventive healthcare in women; common STDs and infections; reproductive and hormonal physiology including fertility; family planning; contraception; options counseling for unintended pregnancy; pelvic floor dysfunction; and disorders of menstruation, perimenopause, and postmenopause, including osteoporosis.

— Gain clinical experience in issues of sexual health, management of breast disorders, and management of cervical disease.

— Become competent in the performance of appropriate gynecological procedures.
Receive instruction with special emphasis on the diagnosis and management of surgical disorders and emergencies and the appropriate and timely referral of surgical cases for specialized care; they also must:

- Appreciate the varieties of surgical treatments and the potential risks associated with them to enable them to give proper advice, explanation, and emotional support to patients and their families.
- Recognize conditions that are preferably managed on an elective basis.
- Receive training in preoperative and postoperative care, basic surgical principles, asepsis, handling of tissue, and technical skills to assist the surgeon in the operating room.
- Develop technical proficiency in those specific surgical procedures that family physicians may be called on to perform.
- Be required to participate in a structured experience in general surgery of at least two months, including ambulatory care (non-inpatient care: e.g., surgical centers, emergency room, and physician offices), operating room experience, and postoperative experience.
- Achieve competency in the diagnosis and management of a wide variety of common surgical problems typically cared for by family physicians.
- Have adequately structured, hands-on educational experiences in the following subspecialty areas: otorhinolaryngology, to include oral health, urology, and ophthalmology. This must be in addition to resident experience with continuity patients during routine care in FMC and must involve disorders that are commonly seen in a family physician’s office.

Have two months’ experience in the care of patients with orthopedic and musculoskeletal problems, including experience in sports medicine.

- Curriculum should include non-articular rheumatic disorders; infectious, supportive, and degenerative arthritic conditions; acquired and congenital abnormalities of bones and joints; musculoskeletal and connective tissue disorders; evaluation and management of common sprains, fractures, and dislocations; preventive care; rehabilitation; and restorative function. Clinical experience should include acute evaluation of musculoskeletal trauma and acute pain syndromes.

- Sports medicine must be a clear and separate curriculum within the two months/200 hours of experience and must include non-orthopedic aspects of sports medicine with emphasis on care of athletes of all ages, both genders, and persons active or anticipating exercise activities.

- The care of the athlete includes performance of pre-participation sports physicals, assessment of common injuries, knowledge of treatment, and rehabilitation.

- Residents should perform procedures common in the evaluation and care of orthopedic and sports medicine patients and participate in the rehabilitation required for these patients, which may include interpreting radiographs, aspiration and injection of joints, splinting, and casting.
➢ Be trained to deliver emergency care that includes didactic teaching, skills training, and clinical experience in caring for patients of all ages with acute illnesses and injuries in an emergency care setting. In addition, residents should:
   – Be trained in all standard current life support skills (e.g., ACLS and PALS) and should learn procedures for both trauma and medical emergencies in patients of all ages
   – Receive 200 hours of emergency medicine training

➢ Acquire knowledge and skills through a program in which behavioral science and psychiatry are integrated with all disciplines throughout the residents’ total educational experience.
   – Develop skills in the diagnosis and management of psychiatric disorders in children and adults, emotional aspects of non-psychiatric disorders, psychopharmacology, alcoholism and other substance abuse, the physician-patient relationship, patient interviewing skills, and counseling skills.

➢ Receive training in community medicine, including:
   – The assessment of risks for abuse, neglect, and family and community violence
   – Reportable communicable disease
   – Population epidemiology and the interpretation of public health statistical information
   – Environmental illness and injury
   – School health
   – Disease prevention through immunization strategies
   – Disaster responsiveness
   – Community-based disease screening, prevention, and health promotion; and factors associated with differential health status among sub-populations, including racial, geographic, or socioeconomic health disparities, and the role of family physicians in reducing such gaps
   – Experience in using community resources appropriately for individual patients who have unmet medical or social support needs
   – Structured interaction with the public health system
   – Occupational medicine including disability determination, employee health, and job-related illness and injury
   – Experience in community health assessment
   – Experience in developing programs to address community health priorities
   – Community-based health education of children and adults

➢ Be exposed to diagnosis and management of common dermatologic conditions, including but not limited to viral, bacterial, allergic, and fungal infections; ulcers, rashes, malignant, and pre-malignant skin lesions; and dermatologic manifestations of systemic disease. This training should include experience in the surgical excision of skin lesions and performance of other dermatologic procedures.

➢ Learn the appropriate application of techniques and specialty consultations in the diagnostic imaging and nuclear medicine therapy of organs and body systems. Instruction should include the limitations and risks attendant to these techniques.
Training must include radiographic film/diagnostic imaging interpretation and nuclear medicine therapy pertinent to family medicine.

Must receive at least 100 hours of management and leadership instruction.

- Residents should be taught how to design and manage a budget, assess practice staffing needs, understand the impact of new technologies on practice, determine value in the marketplace, assess customer satisfaction, and measure clinical quality. Current billing practices, tort liability and risk management, office scheduling systems, computers in practice, alternative practice models, and employment law and procedures should also be covered.
- Residents should learn principles of PR, media training, and personnel management.
- Leadership curriculum should include training to provide leadership for a clinical practice, a hospital medical staff, and professional organizations; and community leadership skills to advocate for the public health.

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for family medicine. However, 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 family medicine. 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 family medicine. 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.

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1Healthcare organizations should customize this statement based on specifics of how family medicine physicians practice at their facility. For example, if all family medicine physicians are treating all ages, then the pediatric core privilege section could be deleted and “patients of all ages” would be kept.
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 family medicine. 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 family medicine. 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. It is reasonable for healthcare organizations to modify the core as applicable for the inpatient setting versus the ambulatory setting. 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 core privileges in family medicine**

**Basic education**: MD or DO

**Minimum formal training**: Successful completion of an ACGME- or AOA-accredited residency in family medicine.

AND/OR

Current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification in family medicine by the ABFM or family practice and OMT by the AOBFP.

**Required current experience**: Provision of care, reflective of the scope of privileges requested, for at least 24 inpatients* as the attending physician during the past 12 months or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.

* if applicable to the setting

**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 family medicine**

Core privileges in family medicine include the ability to admit*, evaluate, diagnose, treat, and provide consultation to patients of all ages1 with a wide variety
of illnesses, diseases, injuries, and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, integumentary, nervous, female reproductive, and genitourinary systems. 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
➤ Abdominal paracentesis
➤ Arthrocentesis and joint injection
➤ Breast cyst aspiration
➤ Management of burns, superficial and partial thickness
➤ Excision of cutaneous and subcutaneous lesions, tumors, and nodules
➤ Incision and drainage of abscesses
➤ Performance of local anesthetic techniques
➤ Management of uncomplicated, minor, closed fractures and uncomplicated dislocations
➤ Performance of needle biopsies
➤ Performance of simple skin biopsies
➤ Peripheral nerve blocks
➤ Placement of anterior and posterior nasal hemostatic packing
➤ Removal of a nonpenetrating foreign body from the eye, nose, or ear
➤ Suturing of uncomplicated lacerations
➤ Suprapubic bladder aspiration
➤ Assistance at surgery
➤ Thoracentesis

Refer-and-follow privileges

Privileges include performing outpatient preadmission history and physical, ordering noninvasive outpatient diagnostic tests and services, visiting patients in the hospital, reviewing medical records, consulting with the attending physician, and observing diagnostic or surgical procedures with the approval of the attending physician or surgeon.

Initial privileges: Education and training, as for family medicine core privileges. Required current experience: Demonstrated current competence. Renewal of privileges: Demonstrated current competence.

Minimum threshold criteria for granting core privileges in pediatrics

Basic education: MD or DO
Minimum formal training: The same as for family medicine core.
Required current experience: Demonstrated current competence and evidence of the provision of care, reflective of the scope of privileges requested, to at least 10 pediatric inpatients in the past 12 months or completion of training in the past 12 months.
References

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

Core privileges in pediatrics

Core privileges in pediatrics for family physicians include the ability to admit, evaluate, diagnose, and treat pediatric patients up to the age of 18 (and young adults with special healthcare needs) who have common illnesses, injuries, or disorders. This includes the care of the normal newborn as well as the uncomplicated premature infant born at or after 36 weeks of gestation.

Physicians should be able to assess, stabilize, and determine 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
- Incision and drainage of abscesses
- Management of uncomplicated minor closed fractures and uncomplicated dislocations
- Performance of simple skin biopsy or excision
- Removal of nonpenetrating corneal foreign body
- Suturing of uncomplicated lacerations

Minimum threshold criteria for granting core privileges in gynecology

Basic education: MD or DO

Minimum formal training: The same as for family medicine core.

Required current experience: Demonstrated current competence and evidence of provision of care, reflective of the scope of privileges requested, to at least 10 gynecologic inpatients in the past 12 months or completion of training in the past 12 months.

References

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

Core privileges in gynecology for family physicians include the ability to admit, evaluate, diagnose, treat, and provide consultation to postpubescent female patients with injuries and disorders of the female reproductive system and the genitourinary system.

Physicians may provide care to patients in the intensive care setting in conformance with unit policies. They should be able to assess, stabilize, and determine 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
- Appropriate screening examination (including breast examination)
- Cervical biopsy and polypectomy
- Colposcopy
- Cryosurgery/cautery for benign disease
- Culdocentesis
- Diagnostic cervical dilation and uterine curettage (including for incomplete abortion)
- Endometrial biopsy
- Excision/biopsy of vulvar lesions
- Incision and drainage of Bartholin duct cysts or marsupialization
- Insertion and removal of intrauterine devices
- Microscopic diagnosis of urine and vaginal smears
- Removal of foreign bodies from the vagina
- Suturing of uncomplicated lacerations

Minimum threshold criteria for granting core privileges in obstetrics

Basic education: MD or DO
Minimum formal training: The same as for family medicine core, plus documentation of two months of obstetrical rotation during family medicine residency, with 40 patients delivered, and current neonatal resuscitation program certification.
Required current experience: Demonstrated current competence and evidence of the performance of at least 10 deliveries in the past 12 months or completion of training in the past 12 months.

References

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

**Core privileges in obstetrics**

Obstetrics core privileges for family medicine physicians include the ability to admit, evaluate, and manage female patients with normal-term pregnancy, with an expectation of noncomplicated vaginal delivery, management of labor and delivery, and procedures related to normal delivery, including medical diseases that are complicating factors in pregnancy (with consultation).

Physicians may provide care to patients in the intensive care setting in conformance with unit policies. They should be able to assess, stabilize, and determine 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
➤ Amniotomy
➤ Augmentation of labor
➤ Dilatation and curettage, including suction and postpartum
➤ Excision of vulvar lesions at delivery
➤ External and internal fetal monitoring
➤ Induction of labor with consultation and pitocin management
➤ Initial management of postpartum hemorrhage
➤ Investigative OB ultrasound for presentation only
➤ Management of prenatal and postpartum care
➤ Management of uncomplicated labor
➤ Manual removal of placenta, postdelivery
➤ Normal spontaneous vaginal delivery of a full-term vertex presentation, including ante- and postpartum care
➤ Oxytocin challenge testing
➤ Postpartum endometritis
➤ Pudendal anesthesia
➤ Repair of episiotomy, including lacerations/extensions
➤ Repair of vaginal and cervical lacerations
➤ Vacuum-assisted delivery

**Special requests in family medicine**

In addition, there are several noncore privileges that may be requested if applicable within the healthcare organization, including:

➤ C-section
➤ Attendance at delivery to assume care of normal newborns
➤ Circumcision
➤ Lumbar puncture
➤ Ventilator management (not complex, including continuous positive airway pressure, up to 36 hours)
➤ Administration of sedation and analgesia

**Reappointment**

To be eligible to renew privileges in family medicine, the applicant must demonstrate competence and an adequate volume of experience (50 inpatients*) 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.

*if applicable to the setting

In addition, continuing education related to family medicine should be required.

**For more information**

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