Background

According to the Accreditation Council for Graduate Medical Education (ACGME), internal medicine is a specialty that involves the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women, while healthy and through acute and chronic illnesses. The American College of Physicians (ACP) describes doctors of internal medicine as “Doctors for Adults®.” As such, internists mainly practice adult medicine and have received training that prepares them to prevent and treat diseases that commonly affect adults. They can encounter any disease or disorder patients present with and are specifically trained to solve complex and sometimes confounding diagnoses. Internists also manage patients with severe chronic diseases and those with multiple comorbid illnesses. Other areas in which internists are involved include disease prevention, substance abuse, mental health, and common problems of the eyes, ears, skin, nervous system, and reproductive organs.

Given their broad scope of practice, internists often collaborate with physicians across many specialties to manage patients. Their practice also may exist in a variety of places. They may work and care for patients in the office or clinic setting, during hospitalization and intensive care, and in nursing homes.

Although internal medicine physicians also help manage women’s health problems, it is important to distinguish these physicians from family physicians, family practitioners, and general practitioners, whose training does not focus solely on adults conditions. These other physicians also have training that may include surgery, obstetrics, and pediatrics.

The ACGME requires that an accredited residency program in internal medicine must provide 36 months of supervised graduate education. The educational program should include core clinical experiences in general internal medicine, the subspecialties of internal medicine, and other specialties. Likewise, the American Osteopathic Association (AOA) requires candidates for certification to complete a minimum of 36 months of supervised graduate education.

Internists can choose to focus their practice on general internal medicine, or may receive additional training in 13 different subspecialties. Often, one to three years of additional training are required for subspecialty training. The American Board of Medical Specialties recognizes the following subspecialties of internal medicine (related Clinical Privilege White Papers are listed in parentheses):

➤ Adolescent medicine (Practice area 185)
➤ Allergy and immunology
Internal medicine

➤ Cardiology (Practice area 126)
➤ Endocrinology (Practice area 137)
➤ Gastroenterology (Practice area 138)
➤ Geriatric medicine (Practice area 113)
➤ Hematology (Practice area 139)
➤ Infectious disease (Practice area 140)
➤ Nephrology (Practice area 141)
➤ Oncology (Practice area 142)
➤ Pulmonology (Practice area 143)
➤ Rheumatology (Practice area 144)
➤ Sports medicine (Practice area 197)

Involved specialties

Internists

Positions of specialty boards

ABIM

The American Board of Internal Medicine (ABIM) certifies physicians in internal medicine. To become certified as an internist, physicians must:

➤ Complete predoctoral medical education at an institution accredited by the Liaison Committee on Medical Education, the Committee for Accreditation of Canadian Medical Schools, or the AOA

➤ For graduates of international institutions, have either a standard certificate from the Educational Commission for Foreign Medical Graduates without expired examination dates, comparable credentials from the Medical Council of Canada, or documentation of training for those candidates who entered graduate medical education training in the United States via the Fifth Pathway, as proposed by the AMA

➤ Pass graduate medical education training requirements, including 36 months of full-time internal medicine residency training

  − Residency must include at least 30 months of general internal medicine and subspecialty training in internal medicine and emergency medicine; of those 30 months, four may be dedicated to primary care
  − The 36 months also should include at least 24 months of direct patient care (at least six months of which is in the R-1 year) or supervision of junior residents in inpatient or ambulatory settings
  − Residency also may include up to three months of program director–approved electives

➤ Be clinically competent in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice

➤ Be licensed and meet procedural requirements

➤ Pass the Internal Medicine Certification Examination
For certification in internal medicine, the ABIM requires all residents to be competent with regard to the following:

- Demonstration of competence in medical knowledge relevant to procedures through the candidate’s ability to explain indications, contraindications, patient preparation methods, sterile techniques, pain management, proper techniques for handling specimens and fluids obtained, and test results
- Ability to recognize and manage complications
- Ability to clearly explain to a patient all facets of the procedure necessary to obtain informed consent

Certification in internal medicine also depends on evaluation of residents’ competence in performing the following procedures:

- Abdominal paracentesis
- Advanced cardiac life support
- Arterial line placement
- Atherocentesis
- Central venous line placement
- Drawing venous blood
- Drawing arterial blood
- Electrocardiogram
- Incision and drainage of an abscess
- Lumbar puncture
- Nasogastric intubation
- Pap smear and endocervical culture
- Placing a peripheral venous line
- Pulmonary artery catheter placement
- Thoracentesis

Credit may be given to certain candidates who completed training other than that listed above, as outlined on the ABIM’s website and in the publication *Policies and Procedures for Certification*.

The ABIM also recognizes internal medicine training combined with training in the following programs:

- Dermatology
- Emergency medicine
- Emergency medicine/critical care medicine
- Family medicine
- Medical genetics
- Neurology
- Nuclear medicine
- Pediatrics
- Physical medicine and rehabilitation
- Preventive medicine
- Psychiatry
Upon completion of training, candidates who meet licensure, training, and procedural requirements must successfully pass the ABIM certification examination to become board certified.

**AOBIM**

The American Osteopathic Board of Internal Medicine (AOBIM) certifies physicians in internal medicine. According to its document *Regulations, Requirements, and Procedures*, candidates for certification must meet the following requirements:

- Be a graduate of an AOA-accredited college of osteopathic medicine
- Candidates who completed training one or more years prior to application are required to possess a valid, unrestricted, and unchallenged license to practice in the state or territory where their practice is conducted
- Be a member in good standing of the AOA for the past two years
- Provide evidence of conformity to the standards set forth in the AOA Code of Ethics, if requested
- Be clinically competent in the practice of internal medicine
- Have satisfactorily completed one of the following AOA-approved postdoctoral training programs:
  - 12 months of a non-medicine track internship followed by 36 months of an internal medicine residency. Candidates may receive advanced standing credit for training in the internship, which has been granted by the American College of Osteopathic Internists (ACOI), and which may be applied toward the 36 months of internal medicine residency.
  - 12 months of a medicine track internship followed by 24 months of an internal medicine residency, or 36 months of an internal medicine residency.
  - 12 months of an AOA-approved internship followed by 48 months of a combined emergency medicine/internal medicine residency training program. The residency training must contain 24 months of emergency medicine and 24 months of internal medicine and meet the basic requirements for training as approved by the AOA.
  - 48 months of a combined internal medicine/pediatrics residency training program. The residency training must contain a minimum of 24 months of internal medicine training and 18 months of pediatrics training and meet the basic requirements for training as approved by the AOA.

Upon completion of training, candidates who complete the requirements must successfully pass the certifying examination to achieve board certification. Recertification is required within a 10-year period.
Positions of societies, academies, colleges, and associations

**ACP**

The ACP supports the ABIM certification process by offering a board review course and the Medical Knowledge Self-Assessment Program to help residents prepare for the ABIM certification examination.

**SGIM**

The Society of General Internal Medicine (SGIM) is a membership organization that promotes improved patient care, research, and education in general internal medicine. SGIM does not publish training requirements for internal medicine, but does publish research and educational resources relevant to the field.

**ACGME**

In its *Program Requirements for Graduate Medical Education in Internal Medicine* (effective since July 1, 2009), the ACGME states that residency training programs in internal medicine should integrate ACGME competencies into the curriculum. Accredited residency programs in internal medicine must provide 36 months of graduate medical education. At least one-third of the residency training must occur in the ambulatory setting and at least one-third must occur in the inpatient setting.

With regard to patient care, residents must provide compassionate, appropriate, and effective patient care while treating problems and promoting health. They also must demonstrate the ability to manage patients:

- In various roles within the health system with increasing amounts of responsibility that should include being the direct provider, a member of a multidisciplinary healthcare team, a consultant to other physicians, and a teacher to other providers and patients
- In preventing, counseling, detecting, and diagnosing gender-specific diseases
- In various healthcare settings (e.g., emergency setting, ambulatory setting, inpatient ward, and critical care units)
- With a range of disorders commonly treated by internists and subspecialists in inpatient and ambulatory settings
- By exhibiting clinical interview skills and the ability to physically examine patients
- By employing appropriate laboratory and imaging techniques
- While demonstrating competence in ABIM-mandated procedures
- By providing care to adequate numbers of undifferentiated acutely and severely ill patients

Residents also should treat disorders with practices that are safe, scientifically based, efficient, effective, timely, and cost-effective.
Internal medicine

Practice area 135

With respect to medical knowledge, residents should understand and apply their knowledge of established and emerging biomedical, clinical, epidemiological, and social-behavioral sciences to their patient care. They should demonstrate expertise in knowledge of areas appropriate for an internist, including:

➤ The range of clinical disorders that internists may encounter
➤ The core content of general internal medicine, internal medicine subspecialties, non–internal medicine specialties, and relevant nonclinical topics
➤ Appropriate knowledge to do the following:
  – Evaluate undiagnosed conditions with undifferentiated presentations
  – Treat conditions normally managed by internists
  – Provide basic preventive care
  – Interpret basic clinical tests and images
  – Recognize and provide initial management of emergency medical problems
  – Use common pharmacotherapy
  – Use and perform diagnostic and therapeutic procedures

With regard to practice-based learning and improvement, internal medicine residents should be able to investigate and evaluate their care of patients, appraise and assimilate scientific evidence, and continuously improve patient care based on constant self-evaluation and lifelong learning. Residents should develop skills that allow them to achieve the following goals:

➤ Identify strengths and limitations in their knowledge and experience
➤ Set goals for learning and improvement
➤ Identify and perform appropriate learning activities
➤ Systematically analyze practice using quality improvement methods, and implement changes warranted
➤ Incorporate evaluation feedback into practice
➤ Identify, evaluate, and assimilate evidence from studies related to patient’s health problems
➤ Employ information technology in learning
➤ Educate patients, caregivers, students, and other healthcare professionals

Residents must exhibit interpersonal and communication skills that assist in the communication of information and collaboration with healthcare professionals, patients, and their caregivers. In doing so, residents should:

➤ Communicate with patients, caregivers, and the public with a variety of socioeconomic and cultural backgrounds
➤ Communicate effectively with physicians, other health professionals, and health-related agencies
➤ Collaborate as a member or leader of a healthcare team or other professional group
➤ Act in a consultative role to other healthcare professionals
➤ Maintain comprehensive, legible, and timely medical records
Residents should commit to accepting professional responsibilities and adhere to ethical principles. In doing so, residents should demonstrate:
➤ Compassion, integrity, and respect for others
➤ Responsiveness to patient needs that supersedes self-interest
➤ Respect for patient privacy and autonomy
➤ Accountability to patients, society, and the profession
➤ Sensitivity and responsiveness to a diverse patient population, including diversity in gender, age, culture, race, religion, disabilities, and sexual orientation

Internists should be aware of and responsive to the system of healthcare as a whole, as well as the ability to call effectively on other resources in the system to provide optimal care. As such, residents should:
➤ Be able to work in a range of healthcare settings
➤ Coordinate patient care
➤ Consider costs and risk-benefit profiles in patient and/or population-based care
➤ Advocate for quality patient care and optimal patient care systems
➤ Work in interdisciplinary teams to optimize patient safety and care quality
➤ Identify system errors and implement solutions
➤ Work in teams and communicate necessary information to ensure safety and proper patient care, including when patients’ care transitions between settings
➤ Recognize and function effectively in high-quality care systems

**AOA/ACOI**

According to the AOA and ACOI’s *Basic Standards for Residency Training in Internal Medicine* (revised April 2012), core competencies in internal medicine include the following:
➤ Osteopathic philosophy and osteopathic manipulative medicine: Employ osteopathic principles when diagnosing and managing patient clinical presentations
➤ Medical knowledge: Deep understanding of the complex differential diagnoses and treatment options in internal medicine and the ability to integrate the applicable sciences with clinical experiences
➤ Patient care: Efficiently evaluate, initiate, and provide appropriate treatment for inpatients and outpatients with acute and chronic conditions and promote health maintenance and disease prevention
➤ Interpersonal and communication skills: Communicate clearly while being sensitive and respectful of other healthcare professionals, caregivers, and patients, including those with communication barriers, such as sensory impairments, dementia, and language differences
➤ Professionalism: Conduct oneself ethically and with integrity
➤ Practice-based learning and improvement: Commit to lifelong learning and scholarly pursuit in internal medicine for the betterment of patient care
Systems-based practice: Exhibit skills that allow for the effective leadership of healthcare teams in the delivery of quality patient care using all available resources
The ACOI and AOA require residency training in internal medicine to include the following components:

- 36 months of training
- 34 or more months of training should include clinical rotations involving the supervised management of patients
- 30 or more months of training in internal medicine and its AOA-recognized subspecialties
- The final 12 months of training is required to occur in the program that certifies the resident’s training is complete

Residents should have experience in the following:

- Comprehensive histories and physicals, including structural examinations, pelvic exams, rectal exams, breast exams, and male genital exams
- Central venous line placement, arterial puncture for arterial blood gases, osteopathic manipulative treatment and endotracheal intubation (to include, at minimum: indications; contraindications; complications; limitations and evidence of competent performance)
- Arthrocentesis, peripheral blood smears, exercise stress tests, ambulatory electrocardiography monitors, lumbar puncture, spirometry, sputum gram stain, urine microscopy, vaginal wet mounts and thoracentesis (to include, at minimum: indications; contraindications; complications; limitations and interpretation)
- Interpretation of electrocardiograms, chest x-rays, and flat and upright abdominal films

During the first training year, residents must fulfill the following rotational requirements:

- Four months of general internal medicine
- One month of critical care
- One month of cardiology
- One month of care of the surgical patient
- One month of emergency medicine
- One month of women’s health, at least half of which must be ambulatory gynecology
- Three months of electives chosen by the program director

During the second and third training years, the resident must complete no fewer than eight months and no more than 16 months of general internal medicine, and must experience a minimum of one month in each of the following subspecialties:

- Pulmonology
- Endocrinology
- Gastroenterology
Internal medicine Practice area 135

➤ Hematology/oncology
➤ Infectious disease
➤ Nephrology
➤ Rheumatology
➤ Neurology

Positions of accreditation bodies

CMS

CMS has no formal position concerning the delineation of privileges for internists. However, the CMS Conditions of Participation (CoP) define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

➤ Individual character
➤ Individual competence
➤ Individual training
➤ Individual experience
➤ Individual judgment

The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.
CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

**The Joint Commission**

The Joint Commission has no formal position concerning the delineation of privileges for internists. 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 internists. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff’s review of an individual practitioner’s qualifications and its recommendation regarding that individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

**DNV**

DNV has no formal position concerning the delineation of privileges for internists. 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 internal 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. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.
Minimum threshold criteria for requesting privileges as an internist

Basic education: MD or DO

Minimal formal training: Successful completion of an ACGME- or AOA-accredited residency in internal medicine, and/or current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification in internal medicine by the ABIM or AOABIM.

Required current experience: Provision of care to at least [n] inpatients, reflective of the scope of privileges requested, in the past 12 months or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.

References

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

Core privileges for internal medicine

Core privileges for internal medicine include the ability to admit, evaluate, diagnose, treat and provide consultation to adolescent and adult patients with common and complex illnesses, diseases, and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, and genitourinary systems. Internists may provide care to patients in the intensive care setting in conformance with unit policies. They also should be able to assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the procedures list below and such other procedures that are extensions of the same techniques and skills:

➤ Performance of history and physical exam
➤ Abdominal paracentesis
➤ Arthrocentesis and joint injections
➤ Drawing of arterial blood
➤ Management of burns, superficial and partial thickness
➤ Excision of skin and subcutaneous tumors, nodules, and lesions
➤ Incision and drainage of abscesses
➤ Insertion and management of central venous catheters and arterial lines
➤ Local anesthetic techniques

1 Healthcare organizations should define the minimum case/patient volume (the “[n]”) required to maintain clinical competence as recommended by the applicable department chair and the medical executive committee and subject to approval by the governing body.
Nasogastric intubation
Performance of simple skin biopsy
Placement of anterior and posterior nasal hemostatic packing
Placement of a peripheral venous line
Interpretation of EKGs (determine whether core or noncore)
Removal of nonpenetrating foreign body from the eye, nose, or ear
Thoracentesis

**Core privileges for refer and follow**

Core privileges for referring and following patients include the ability to perform outpatient preadmission and history and physical exam, order noninvasive outpatient diagnostic tests and services, visit patients in the hospital, review medical records, consult with the attending physician, and observe diagnostic or surgical procedures with the approval of the attending physician or surgeon.

**Special noncore privileges in internal medicine**

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

- EKG interpretation
- Lumbar puncture
- Exercise testing—treadmill
- Ventilator management (not complex, including continuous positive airway pressure, up to 36 hours)
- Initiation and management of pulmonary artery catheters
- Administration of sedation and analgesia

**Reappointment**

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism. To be eligible to renew privileges in internal medicine, the applicant must have current demonstrated competence and an adequate volume of experience ([n] 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.

In addition, continuing education related to internal medicine should be required.
For more information

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American Osteopathic Association
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American Osteopathic Board of Internal Medicine
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Centers for Medicare & Medicaid Services
7500 Security Boulevard
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Website: www.dnvaccreditation.com

Healthcare Facilities Accreditation Program
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