Emergency medicine

Background

According to the American College of Emergency Physicians (ACEP), emergency medicine is the medical specialty concerned with evaluating, managing, treating, and preventing unexpected illness and injury. Emergency medicine practitioners provide clinical and administrative services to the healthcare delivery system, including care for individuals who lack other access to healthcare, prehospital care planning and medical control, and patient care coordination across venues and among providers.

Emergency medicine physicians possess the training and experience to evaluate and initially manage and treat all patients who seek emergency care. They are the first contact providers who care for a patient population undifferentiated by age or disease. They provide rapid treatment and stabilization of true emergencies, as well as rapid differentiation between emergent and nonemergent conditions over the spectrum of diseases. Their care extends to out-of-hospital assessment, treatment, and transport of patients into emergency facilities by virtue of their management and supervision of emergency medical services systems.

The emergency medicine physician works in an emergency department (ED) that provides access to healthcare for all, particularly in off-hours when primary sites are unavailable. In rural and inner-city communities without adequate primary care access, the ED sees nonemergency patients for large sections of the population (e.g., the uninsured, homeless, substance abusers, immigrants).

The ED, through the Emergency Medical Treatment and Active Labor Act (EMTALA), is the only medical care site obligated by law to see all patients who seek care. EMTALA requires all patients to have a medical assessment regardless of a chief complaint or ability to pay. Then, if the hospital determines that an emergency condition exists, it is obliged to stabilize patients before discharging or transferring them.

Hospitals are divided about the issue of granting admitting privileges to emergency medicine physicians, and state laws generally allow for hospitals to make this determination. Historically, many hospitals did allow emergency physicians to admit patients to the hospital, but various factors (e.g., increased ED volume, increased liability, sicker patients, and the emergence of hospitalists) have influenced this model. Organizations benefit from designing both their physician-specific privileging mechanisms and their overall medical staff policy (i.e., rules and regulations or bylaws) to explicitly address which practitioners are accountable for admissions.
The American Board of Emergency Medicine (ABEM) requires a 36-month residency program for emergency medicine; the American Osteopathic Association (AOA) requires a 46-month residency program.

For privileging criteria in pediatric emergency medicine, see *Clinical Privilege White Paper, Pediatric emergency medicine—Practice area 120.*

**Involved specialties**

Emergency medicine physicians

**Positions of specialty boards**

**ABEM**

The ABEM grants certification in emergency medicine. Applicants must satisfy the following requirements:

➤ Be a graduate of a medical school approved by the Accreditation Council for Graduate Medical Education (ACGME)

➤ Successful completion of a minimum of 36 months of postmedical school training under the control of an emergency medicine residency program accredited by the ACGME or the Royal College of Physicians and Surgeons of Canada

➤ Hold a current, active, valid, unrestricted, and unqualified license to practice medicine in at least one jurisdiction within the United States, its territories, or Canada, and in each jurisdiction in which they practice

ABEM also recognizes specific combined training programs that have been approved in advance by the respective sponsoring boards. These include:

➤ Emergency medicine/internal medicine

➤ Emergency medicine/internal medicine/critical care medicine

➤ Emergency medicine/pediatrics

➤ Emergency medicine/family medicine

Documentation of CME is required if a physician applies to ABEM more than one year following graduation from an emergency medicine residency. Starting one year after the physician’s date of graduation and continuing until the year the physician submits an EM certification application, the board requires that the physician complete and report for review an average of 50 hours of CME per year in emergency medicine.

Beginning with physicians who graduated from their residency programs after June 30, 2006, and who applied for certification in or after 2008, if physicians submit an EM certification application more than three years after the graduation date, of the required CME, at least 50 hours per year must be completed in each of the three years immediately preceding the year in which the application is submitted.
**AOBEM**

To be eligible to receive certification from the AOA through the American Osteopathic Board of Emergency Medicine (AOBEM), the applicant must be a graduate of an AOA-accredited college of osteopathic medicine and must possess a valid and unrestricted license to practice in the state or territory where his or her practice is conducted. Candidates should be able to document evidence of conformity to the standards set forth in the AOA Code of Ethics and should be a member in good standing of the AOA for two years immediately preceding the date of certification.

Candidates completing ACGME residency training must have training approved by the AOA through the reentry process. They should contact the department of postdoctoral training at the AOA. Candidates must have satisfactorily completed an AOA training program in emergency medicine.

Applicants must continue the practice of emergency medicine while completing the certification examination process. Applicants successfully completing an AOA-approved emergency medicine residency program will be eligible to complete the certification examination process after evidence of six months of practice in emergency medicine, or six months of subspecialty training that directly relates to the practice of emergency medicine, upon approval by the board.

Applicants who have successfully completed an AOA-approved dual residency program in emergency medicine and other specialties will be eligible to enter the certification process upon completion of both programs and complete the certification process after evidence of six months of practice in emergency medicine. Applicants must pass written, oral, and clinical examinations to achieve certification.

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

**ACEP**

According to the April 28, 2011, policy statement “Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine,” ACEP states the following:

- The exercise of clinical privileges in the ED is governed by the rules and regulations of the department
- The ED medical director is responsible for periodic assessment of clinical privileges of emergency physicians
- When a physician applies for reappointment to the medical staff and for clinical privileges, including renewal, addition, or rescission of privileges, the reappraisal process must include assessment of current competence by the ED medical director
The ED medical director will, with the input of department members, determine the means by which each emergency physician will maintain competence and skills and the mechanism by which to monitor the proficiency of each physician.

ACEP defines a qualified emergency physician as one who possesses emergency medicine training or sufficient experience in emergency medicine to evaluate and manage all patients who seek emergency care. ACEP believes that the ED medical director should be responsible for assessing and making recommendations to the hospital’s credentialing body related to the qualifications of emergency physicians with respect to the clinical privileges granted to them. At a minimum, those applying for privileges as emergency physicians should be eligible for ACEP membership.

According to ACEP, board certification by the ABEM or the AOBEM is an excellent indication of an individual’s ability to practice emergency medicine, but not the sole benchmark for decisions. Other qualifications may include objective measurement of care provided, sufficient experience, prior training, and evidence of CME.

According to ACEP’s Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine, candidates for credential appointment should show evidence of board certification by the ABEM or the AOBEM, or successful completion of an accredited residency in emergency medicine. Alternatively, candidates may also be considered for appointment if they meet the criteria for ACEP membership and possess training and/or experience in emergency medicine deemed sufficient to evaluate and manage all patients who seek emergency care.

Candidates must also possess a current, unrestricted medical license and registration to practice and must have federal and/or state registration to dispense controlled substances.

According to ACEP, candidates’ mental and physical health status, information from the NPDB, professional liability insurance, references, and recommendations received directly from credible sources should all be considered when credentialing physicians.

Reappointment considerations include:
- Continued fulfillment of appointment criteria
- Emergency medicine professional standards performance review
- Quality assurance performance review
- Risk management and professional liability performance review
- Compliance with hospital and medical staff bylaws
- Participation in continuing education
ACEP also publishes a Sample Request for Emergency Medicine Privileges form, which is available at the ACEP website and may be a useful resource for medical staff professionals and emergency physicians alike.


AEP

The Association of Emergency Physicians (AEP) publishes a certification statement which states that the AEP believes emergency medicine is best practiced by competent, caring, and experienced emergency physicians. AEP supports the efforts of all practicing emergency physicians to demonstrate their qualification and competence through a combination of education, training, experience, certification examination, practice assessment, and the peer review process.

According to the AEP, specialty board examinations serve as a useful, but not exclusive, part of the credentialing process for physicians. AEP considers evaluations by directors of service during residency training and serial measurement of clinical practice outcomes to be the most reliable indicators of the clinical competence and quality of a physician.

AEP states that many emergency physicians who are excluded from participating in EM specialty board examinations practice excellent, high-quality emergency medicine. A lack of board certification alone is not a reasonable criterion for excluding an otherwise competent physician from any position or promotion in private, public, or academic medicine, according to the AEP.

AEP lists courses such as CPR, advanced cardiac life support (ACLS), advanced trauma life support (ATLS), advanced pediatric life support (APLS), pediatric advanced life support (PALS), and basic trauma life support (BTLS) as excellent sources for emergency physicians to review and update. It believes that participation in these courses should not be mandatory for otherwise qualified practicing emergency physicians, and that due to complex historical factors, the public perception of the importance of board certification in determining competence to practice EM has been distorted. AEP states that because this perception is actively fostered by certain organizations, board certification is generally accepted as the most desirable measure of competence.

Due to inappropriate reliance on board certification alone to determine competence, many otherwise qualified emergency physicians have been discriminated against in practice and promotion opportunity, according to the AEP. The association states that it will work toward changing public perception and deception on this issue, but also recognizes that board certification through formal examination is currently regarded by the public as the most reliable measure of competence. AEP states that it will continue working toward access to standard EM board examination for its members and nonmember emergency physicians it represents.
AAEM

The American Academy of Emergency Medicine (AAEM) is a specialty society that supports residency programs, graduate medical education, CME, and board certification in emergency medicine. In its statement paper, *The Value of Board Certification and Residency Training in Emergency Medicine*, AAEM asserts that board certification and residency training lead to improved quality of care in the ED.

AAEM also publishes a *Position Statement on Emergency Physician Credentialing*, which recommends that healthcare organizations verify the following information when credentialing emergency physicians:

- Documentation of ABEM or AOBEM board status, or completion of an ACGME- or AOA-approved postgraduate training program in emergency medicine
- Lifetime medical licensure history
- Healthcare-related employment and appointment history, including terminations, challenges or decisions pending, and voluntary resignations
- Clinical activity from the past 12 months
- Malpractice history from the past 10 years
- Sanctions by licensing or regulatory agencies
- Criminal records
- Signed professional references attesting to adequacy of clinical knowledge, technical skills, judgment, communication skills, overall professional performance, and adherence to rules and bylaws

AAEM’s website contains additional position statements and documents pertaining to emergency physician credentialing and education.

AOA

According to the AOA’s *Basic Standards for Residency Training in Emergency Medicine*, training in emergency medicine should be four years in length. The program should provide the opportunity to develop the teaching skills of residents in emergency medicine and develop an interest in and understanding of research in the specialty. The program should also prepare residents to use critical thinking in making decisions for patient management and demonstrate proficiency in the psychomotor skills required of a competent emergency physician. Residents should be trained in reading, interpreting, and participating in clinical research.

Emergency medicine residents must be American College of Osteopathic Emergency Physician (ACOEP) members and maintain membership throughout training. Residents should keep records and logs that document the fulfillment of the requirements of the program, describing the volume, variety, and scope, and progressive responsibility on the part of the resident for emergency cases and procedures performed under supervision.
Residents must complete a research project during the course of the emergency medicine training program that will be sent to the ACOEP. Additionally, residents will be required to participate in professional staff activities (e.g., department meetings, hospital committees, house/staff associations, OPTI committees) and should participate annually in the ACOEP Resident In-Service Examination. Residents should be certified as a provider in ACLS, ATLS or its equivalent, and APLS or its equivalent.

Each resident must complete the following 48-month program, which may be scheduled as one-month blocks or four-week rotations or any combination thereof:

- Emergency medicine for a minimum of 24 months with a minimum of four rotations per year.
- Critical care for a minimum of two months.
- General medicine that may include training in general internal medicine, medical subspecialties, or hospital-based family practice in any combination for two months.
- Surgery (e.g., general surgery or subspecialty surgeries) including but not limited to anesthesiology, ophthalmology, ENT, hand, or plastic surgery for a minimum of two months.
- Orthopedics for a minimum of one month.
- Pediatrics for a minimum of two months. Strong consideration will be given to a pediatric emergency medicine or pediatric ICU rotation.
- Trauma for a minimum of one month.
- Emergency medical services for a minimum of one month.
- Administration/related activities (e.g., research, medical legal, quality assurance) for a minimum of one month.
- Female reproductive medicine for a minimum of one month; a minimum of 50% of this time should be spent in obstetrics.
- Selective rotations for a minimum of six months, selected by and at the discretion of the program director. These rotations will be used to strengthen academic competence.
- Elective rotations for a minimum of two months at the discretion of the program director.
- Remaining rotations, vacation, and selective time shall be scheduled at the discretion of the program director.

Emergency medicine residents must accomplish the following minimum number of procedures prior to the completion of the emergency medicine residency. Although this list represents a minimum number, it is expected that the resident logs all procedures performed. It is understood that numerous critical procedures in emergency medicine are infrequent/rare. In consideration of this, some procedures may be completed after demonstrating proficiency in an animal lab setting or simulation lab. Such procedure requirements shall be allowed with the approval and at the discretion of the program director.
➤ Cardioversion/defibrillation: 10 procedures
➤ Central venous access: 20 procedures
➤ Chest tube insertion: 10 procedures
➤ Closed fraction reduction: 20 procedures
➤ Dislocation reduction: 10 procedures
➤ Splinting: 20 procedures
➤ Procedural sedation: 15 procedures
➤ Cricothyroidotomy: 3 procedures
➤ Intraosseous line: 3 procedures
➤ Intubation: 35 procedures
➤ Laceration repair: 50 procedures
➤ Lumbar puncture: 15 procedures
➤ Osteopathic manipulative therapy: 30 procedures
➤ Pediatric medical stabilization: 15 procedures
➤ Pediatric trauma stabilization: 10 procedures
➤ Thoracotomy: 1 procedure
➤ Transvenous cardiac pacing: 2 procedures
➤ Pericardiocentesis: 3 procedures
➤ Ultrasound, bedside: 40 procedures
➤ Vaginal deliveries: 10 procedures

Residents should also participate in an average of four hours of didactic educational activities each week, which should be based on the four-year curriculum.

**ACGME**

According to the ACGME’s *Program Requirements for Graduate Medical Education in Emergency Medicine*, the required length of an emergency medicine residency is 36 months in a curriculum under the control of the emergency medicine program director. Programs that extend the residency beyond 36 months must present a clear educational rationale consonant with the program requirements and the objectives of the residency. The program director must obtain the approval of the sponsoring institution and the review committee prior to implementation and at each subsequent accreditation review of the program.

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents must fulfill the following requirements:

➤ Four months full-time equivalent dedicated to the care of infants and children, or 16% of all ED encounters in pediatric experience (defined as the care of patients less than 18 years of age). The program can balance a deficit of patients by offering dedicated rotations in the care of infants and children. The formula for achieving this balance is that a one-month rotation equals 4% of patients. Although this experience should include the critical care of infants and children, at least 50% of the four months should be in an emergency setting.
Treat a significant number of critically ill or critically injured patients at the primary clinical site, constituting at least 3% or 1,200 of the ED patients per year (whichever is greater). These patients should be those admitted to monitored care settings, operative care, or the morgue following treatment in the emergency during off-service rotations.

At least two months of inpatient critical care rotations. During part of this experience, residents should have decision-making experience that allows them to develop the skills and judgment necessary to manage critically ill and injured patients who present to the ED.

No less than 50% of clinical experience should take place under the supervision of emergency medicine faculty. Such experiences can include emergency medical services, toxicology, pediatric emergency medicine, sports medicine, emergency medicine administration, and research in emergency medicine.

Experience in out-of-hospital care, which should include: participation in paramedic base station communications; emergency transportation and care in the field, including ground units and if possible air ambulance units; teaching and oversight of out-of-hospital personnel; and disaster planning and drills. If residents are required to ride in ground or air ambulance units, they must be notified of this requirement during the resident recruitment process.

Sufficient opportunities to perform invasive procedures, monitor unstable patients, and direct major resuscitations of all types on all age groups. A major resuscitation is patient care for which prolonged physician attention is needed and interventions such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (e.g., thrombolytics, vasopressors, neuromuscular blocking agents), or invasive procedures (e.g., cutdowns, central line insertion, tube thoracostomy, endotracheal intubations) that are necessary for stabilization and treatment. The resident must have the opportunity to make admission recommendations and direct resuscitations.

Residents are expected to gather accurate, essential information in a timely manner; generate an appropriate differential diagnosis, and implement an effective patient management plan. They are also expected to competently perform diagnostic and therapeutic procedures and emergency stabilization, prioritize and stabilize multiple patients and perform other responsibilities simultaneously, and provide healthcare services aimed at preventing health problems or maintaining health.

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. Residents must have a curriculum that includes didactic and clinical information to allow them to achieve the goals and competencies of the training program. These include knowledge and skill-based competencies as listed in the Model of the Clinical Practice of Emergency Medicine.
Residents must have a curriculum that includes measurable competency objectives for each year of training and a description of how the objectives will be assessed and remediated when necessary. Measurable objectives should also be developed for each nonemergency medicine rotation with assessment tools described.

Residents are expected to identify life-threatening conditions and the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information. They should be able to properly sequence critical actions for patient care and generate a differential diagnosis for an undifferentiated patient. Residents are also expected to complete disposition of patients using available resources.

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for emergency medicine. 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 emergency 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 emergency 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.

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 emergency 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 emergency 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 in emergency medicine

Basic education: MD or DO
Minimal formal training: Successful completion of an ACGME- or AOA-accredited residency in emergency medicine and/or current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification in emergency medicine by the ABEM or the AOBEM.
Required current experience: Active practice in an ED, reflective of the scope of privileges requested, in the past 12 months with a census equal to or exceeding 10,000 patient visits annually, 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 in emergency medicine

Core privileges for emergency medicine include the ability assess, evaluate, diagnose, and initially treat patients of all ages who present in the ED with any symptom, illness, injury, or condition. They also include the ability to provide immediate recognition, evaluation, care, stabilization, and disposition in response to acute illness and injury. Privileges include the performance of history and physical examinations; the ordering and interpretation of diagnostic studies, including laboratory, diagnostic imaging, and electrocardiographic examinations; and the administration of medications normally considered part of the practice of emergency medicine. Privileges do not include admitting privileges, long-term care of patients on an inpatient basis, or the performance of scheduled elective procedures. The core privileges in this specialty include the procedures on the following procedures list and such other procedures that are extensions of the same techniques and skills.
The following list is not intended to be an all-encompassing procedures list. It defines the types of activities/procedures/privileges that the majority of practitioners in this specialty perform and inherent activities/procedures/privileges requiring similar skill sets and techniques.

➤ Performance of history and physical exam
➤ Biohazard decontamination
➤ Blood, fluid, and component therapy administration
➤ Excision of thrombosed hemorrhoids
➤ Foreign body removal
➤ Gastric lavage
➤ Gastrostomy tube replacement
➤ Incision/drainage
➤ Pain management (see anesthesia)
➤ Violent patient management/restraint
➤ Sexual assault examination
➤ Trephination nails
➤ Wound closure techniques
➤ Wound management
➤ Escharotomy/burn management
➤ Airway techniques
  − Airway adjuncts
  − Cricothyrotomy
  − Foreign body removal
  − Intubation
  − Mechanical ventilation
  − Percutaneous transtracheal ventilation
  − Capnometry
  − Noninvasive ventilatory management
➤ Anesthesia
  − Local
  − Regional nerve block
  − Sedation—analgesia for procedures (in accordance with hospital policy)
➤ Diagnostic procedures
  − Anoscopy
  − Arthrocentesis
  − Cystourethrogram
  − Lumbar puncture
  − Nasogastric tube
  − Paracentesis
  − Pericardiocentesis
  − Peritoneal lavage
  − Slit lamp examination
  − Thoracentesis
  − Tonometry
  − Compartment pressure measurement
Emergency medicine  Practice area 133

➤ Genital/urinary
  – Bladder catheterization (Foley catheter, suprapubic)
  – Testicular detorsion
➤ Head and neck
  – Control of epistaxis
  – Laryngoscopy
  – Drainage of peritonsillar abscess
  – Removal of rust ring
  – Tooth stabilization
  – Lateral canthotomy
➤ Hemodynamic techniques
  – Arterial catheter insertion
  – Central venous access
  – Intraosseous infusion
  – Peripheral venous cutdown
➤ Obstetrics
  – Delivery of newborn
➤ Resuscitation
  – Cardiopulmonary resuscitation
  – Neonatal resuscitation
➤ Skeletal procedures
  – Fracture/dislocation immobilization techniques
  – Fracture/dislocation reduction techniques
  – Spine immobilization techniques
➤ Thoracic
  – Cardiac pacing (cutaneous, transvenous)
  – Defibrillation/cardioversion
  – Thoracostomy
  – Thoracotomy

Special noncore privileges in emergency medicine

If desired, noncore privileges are requested individually in addition to requesting the core. 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 emergency (bedside) ultrasound.

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 emergency medicine, the applicant must have current demonstrated competence and an adequate volume of experience 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 emergency medicine should be required.

For more information

**Accreditation Council for Graduate Medical Education**
515 North State Street, Suite 2000
Chicago, IL 60654
Telephone: 312-755-5000
Fax: 312-755-7498
Website: [www.acgme.org](http://www.acgme.org)

**American Academy of Emergency Medicine**
555 East Wells Street, Suite 1100
Milwaukee, WI 53202-3823
Telephone: 800-884-2236
Fax: 414-276-3349
Website: [www.aaem.org](http://www.aaem.org)

**American Board of Emergency Medicine**
3000 Coolidge Road
East Lansing, MI 48823-6319
Telephone: 517-332-4800
Fax: 517-332-2234
Website: [www.abem.org](http://www.abem.org)

**American College of Emergency Physicians**
1125 Executive Circle
Irving, TX 75038-2522
Telephone: 800-798-1822
Fax: 972-580-2816
Website: [www.acep.org](http://www.acep.org)

**American Osteopathic Association**
142 East Ontario Street
Chicago, IL 60611-2864
Telephone: 312-202-8000
Fax: 312-202-8200
Website: [www.osteopathic.org](http://www.osteopathic.org)
American Osteopathic Board of Emergency Medicine
8765 West Higgins Road, Suite 200
Chicago, IL 60631
Telephone: 773-724-3161
Fax: 773-724-3162
Website: www.aobem.org

Association of Emergency Physicians
911 Whitewater Drive
Mars, PA 16046-4221
Telephone: 866-772-1818
Fax: 866-422-7794
Website: www.aep.org

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 800-633-4227
Website: www.cms.gov

DNV Healthcare, Inc.
1400 Ravello Drive
Katy, TX 77440
Telephone: 281-396-1000
Website: www.dnvaccreditation.com

Healthcare Facilities Accreditation Program
142 East Ontario Street
Chicago, IL 60611
Telephone: 312-202-8258
Website: www.hfap.org

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Telephone: 630-792-5000
Website: www.jointcommission.org
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