# Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine

**This Policy Resource and Education Paper is an explication of the policy statement**

"Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine"

The American College of Emergency Physicians has developed the following guidelines to assist individuals and institutions in creating application procedures for hospital medical staff appointments in the department of emergency medicine (credentialing), plus delineation of clinical privileges in emergency medicine (privileging).

These guidelines are not a substitute for any hospital medical staff application/reassessment processor for any legislative, judicial, or regulatory body mandates.

## Credentialing

Figure 1 suggests criteria for appointment and reappointment. The medical director must meet the same criteria as other department members. If a medical director's initial appointment or reappointment is in question or disputed, an option is to refer the matter to the hospital's credentials committee, or to the medical executive committee for adjudication.

## Delineation of Clinical Privileges

Figure 2 provides a sample form for request of general privileges in emergency medicine and a checklist for specific procedures. These criteria and forms are presented only as guidelines and are not intended to set a standard for any institution or to be all-inclusive.

The emergency department medical director is responsible for setting competence criteria utilizing input from department members. He is also ultimately responsible for determining the competence of individual department members.

The medical director must also be in compliance with established department proficiency and competence criteria. In the event of question or dispute over the medical director's competency, the matter may be referred to the medical staff's credentials committee or to the medical executive committee.

Establishing criteria for proficiency and the evaluation of proficiency may be problematic. For those medical specialties that perform elective procedures (eg, in the operating room and non-ED outpatient settings), establishing numerical thresholds may be valid (ie, requiring that a minimal number of procedures be performed during the privileging period under review).

However, for those specialties that are primarily "cognitive" in nature, and which employ a wide armamentarium of urgent/emergent procedural skills, establishing numerical thresholds for numerous procedures may be very difficult to track. Further, it is not clear whether such tracking of urgent/emergent procedural skills is a valid component of proficiency assessment.

Many emergency departments will choose to establish clinical privileges assessment methodologies that utilize a combination of procedure tracking (frequency), plus assessment based on sentinel events and information from the department's overall quality improvement activities.

Establishing frequency thresholds in emergency medicine may be problematic. Certain procedures may be performed very rarely (eg, cricothyrotomy). Yet, all emergency physicians must be capable of performing these emergency procedures.

In the event that a member does not meet or exceed numerical thresholds for procedures when such thresholds have been set, an option is to extend a physician's procedure privileges through a process developed in cooperation with the ED medical director and consistent with the current training and board certification of the physician. (eg, educational review, demonstration, maintenance of certification (MOC), and/or testing).

**Considerations for Physicians Practicing in Rural Environments and/or Low Volume Facilities**

ACEP believes that emergency physicians should be capable of providing life-saving procedural care regardless of clinical environment or volume of procedures. Emergency physicians who are emergency medicine board certified or who have completed an emergency medicine residency should be granted initial clinical privileges based on the recommendation of the ED medical director. Privileges should include the duty and responsibility to assess, work-up, and provide management and treatment, consultation, and/or discharge of all patients presenting to the ED with any illness or injury, condition or symptom. For physicians who are not emergency medicine residency trained, other objective measurements of care may be needed, depending on experience and prior training. Emergency physicians appropriately credentialed should be granted privileges to provide any lifesaving procedure necessary on an emergent basis within that physicians training, skill and confidence. Ongoing Professional Practice Evaluation should take into consideration the practice environment of the individual physician.

Originally approved June 2006

The sections “Delineation of Clinical Privileges” and “Considerations for Physicians Practicing in Rural Environments and/or Low Volume Facilities” revised August 2017.

**FIGURE 1**

## CONSIDERATIONS FOR EMERGENCY MEDICINE CREDENTIAL APPOINTMENT/REAPPOINTMENT

Appointment Considerations

1. Graduate/Post-graduate training or practice experience
   - Type I: Board certification by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine; or
   - Type II: Successful completion of an accredited residency in emergency medicine; or
   - Type III: Meets the criteria for membership in the American College of Emergency Physicians and possesses training and/or experience in emergency medicine deemed sufficient to evaluate and manage all patients who seek emergency care.
2. Licensure
   - Current unrestricted medical licensure and registration to practice; and
   - Federal and, where applicable, state registration to dispense controlled substances.
3. Health status (mental and physical)
4. National Practitioner Data Bank
5. Professional liability insurance
6. References and recommendations received directly from credible sources

Reappointment Considerations

1. Continued fulfillment of appointment criteria
2. Emergency medicine professional standards performance review
3. Quality assurance performance review
4. Risk management and professional liability performance review
5. Compliance with hospital and medical staff bylaws
6. Participation in continuing education

* American College of Emergency Physicians. ACEP recognized certifying bodies in emergency medicine [policy statement]. Approved March 1998, Reaffirmed October 2002.

**FIGURE 2**

## SAMPLE REQUEST FOR EMERGENCY MEDICINE PRIVILEGES

Each individual hospital shall determine which skills and experience criteria are required for a physician to be credentialed in emergency medicine in that institution. The following is an example of a request for privileges that may be adapted to the needs of an individual institution.

I. __________________________ requests delineation of privileges in emergency medicine as specified below. The privileges accorded include diagnosis, management and consultation for clinical emergency medicine. In an emergency, any medical staff member who has clinical privileges is permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm - regardless of his or her medical staff status or clinical privileges - provided that the care provided is within the scope of the individual's license.

A. Training or Experience Criteria: Check applicable types of graduate training and/or practice experience, as described in "Considerations for Emergency Medicine Credentials Appointment/Reappointment."

□ Type I □ Type II □ Type III

B. General Privileges: Check the procedures for which privileges are requested.

- The performance of history and physical examinations, the ordering and interpretation of diagnostic studies including laboratory, diagnostic imaging and electrocardiographic examinations normally considered part of the practice of emergency medicine.
- The administration of medications and the performance of other emergency treatments normally considered part of the practice of emergency medicine.
- The requesting of consultations and technical procedures to be performed by other physicians and qualified consultants/technicians.

C. Specific Procedures: Using the following list, check the procedures for which initial or new privileges are requested and indicate your qualifications to perform each of them by:

- Graduate training (GT)
- Postgraduate training (PGT), and/or
- Clinical practice (CP).

Graduate and postgraduate training may include human in-vivo, postmortem or animal laboratory experiences. The medical director may determine other acceptable training methods (ie, computer aids, mannequin simulations, applicable CME or other educational technology.)

This is a list of the most common procedures and is not meant to be all inclusive.

| Procedure Requested | Training/experience (Circle all that apply) | Approved (Initials, director or designee) |
|---|---|---|
| 1. AIRWAY TECHNIQUES | | |
| □ Cricothyrotomy | GT, PGT, CP | |
| □ Nasal endotracheal intubation | GT, PGT, CP | |
| □ Oral endotracheal intubation | GT, PGT, CP | |
| □Mechanical ventilation | GT, PGT, CP | |
| □ Percutaneous transtracheal ventilation | GT, PGT, CP | |

| | Training/experience (Circle all that apply) | Approved (Initials, director or designee) |
|---|---|---|
| 2. ANESTHESIA | | |
| □ Procedural sedation and analgesia | GT, PGT, CP | |
| □ Local anesthesia | GT, PGT, CP | |
| □ Neuro-muscular blockade | GT, PGT, CP | |
| □ Rapid sequence intubation | GT, PGT, CP | |
| □ Regional intravenous (Bier) block | PGT, CP | |
| □ Regional nerve blocks | GT, PGT, CP | |
| 3. CARDIAC PROCEDURES | | |
| □ Closed cardiac massage | GT, PGT, CP | |
| □ Open cardiac massage | GT, PGT, CP | |
| □ Transcutaneous cardiac pacing | GT, PGT, CP | |
| □ Cardioversion/defibrillation | GT, PGT, CP | |
| □ Cardiopulmonary resuscitation | GT, PGT, CP | |
| 4. DIAGNOSTIC PROCEDURES | | |
| □ Arterial blood gases | GT, PGT, CP | |
| □ Arthrocentesis | GT, PGT, CP | |
| □ Culdocentesis | GT, PGT, CP | |
| □ Lumbar puncture | GT, PGT, CP | |
| □ Nasogastric/oral gastric tube | GT, PGT, CP | |
| □ Pericardiocentesis | GT, PGT, CP | |
| □ Peritoneal lavage | GT, PGT, CP | |
| □ Proctoscopy/Anoscopy | GT, PGT, CP | |
| □ Slit lamp exam | GT, PGT, CP | |
| □ Thoracentesis | GT, PGT, CP | |
| □ Tonometry | GT, PGT, CP | |
| 5. GENITOURINARY TECHNIQUES | | |
| □ Foley catheters | GT, PGT, CP | |
| □ Suprapubic catheterization | GT, PGT, CP | |
| 6. HEAD/NECK | | |
| □ Epistaxis control (various methods/devices) | GT, PGT, CP | |
| □ Laryngoscopy | GT, PGT, CP | |
| □ Naso/pharyngeal endoscopy | GT, PGT, CP | |
| 7. HEMODYNAMIC TECHNIQUES - Central Venous Access | | |
| □ Jugular | GT, PGT, CP | |
| □ Subclavian | GT, PGT, CP | |
| □ Femoral | GT, PGT, CP | |
| □ Intraosseus infusion | GT, PGT, CP | |
| □ Peripheral arterial cannulation | GT, PGT, CP | |
| □ Peripheral venous access | GT, PGT, CP | |
| □ Swan-Ganz catheterization | GT, PGT, CP | |
| □ Venous cutdown | GT, PGT, CP | |

| | Training/experience (Circle all that apply) | Approved (Initials, director or designee) |
|---|---|---|
| 8. OBSTETRICAL PROCEDURES | | |
| ☐ Intrauterine fetal monitoring | GT, PGT, CP | |
| ☐ Precipitous delivery of newborn | GT, PGT, CP | |
| 9. ORTHOPEDIC PROCEDURES | | |
| ☐ Closed reduction of fracture/dislocation | GT, PGT, CP | |
| ☐ Immobilization/splinting | GT, PGT, CP | |
| ☐ Injection of bursa/joint | GT, PGT, CP | |
| Spine | | |
| ☐ Cervical immobilization | GT, PGT, CP | |
| ☐ Cervical traction technique | GT, PGT, CP | |
| ☐ Trephination nail | GT, PGT, CP | |
| 10. THORACIC PROCEDURES | | |
| ☐ Emergency thoracotomy | GT, PGT, CP | |
| ☐ Needle thoracostomy | GT, PGT, CP | |
| ☐ Pericardiocentesis | GT, PGT, CP | |
| ☐ Tube thoracostomy | GT, PGT, CP | |
| 11. OTHER TECHNIQUES | | |
| ☐ Foreign body removal | GT, PGT, CP | |
| ☐ Gastric lavage | GT, PGT, CP | |
| ☐ Incision and drainage | GT, PGT, CP | |
| ☐ Wound management/ suture techniques | GT, PGT, CP | |
| ☐ Repair of extensor tendons | GT, PGT, CP | |
| ☐ Repair of flexor tendons | GT, PGT, CP | |
| 12. ULTRASOUND | | |
| ☐ Trauma (FAST) evaluation | GT, PGT, CP | |
| ☐ Gynecologic (transvag & transabdom.) eval. | GT, PGT, CP | |
| ☐ Emergency cardiac evaluation | GT, PGT, CP | |
| ☐ Abdominal aorta evaluation | GT, PGT, CP | |
| ☐ Biliary evaluation | GT, PGT, CP | |
| ☐ Renal evaluation | GT, PGT, CP | |
| ☐ Ultrasound guided procedures | GT, PGT, CP | |

## II. DOCUMENTATION

I hereby attest that the references, reports, records and information are available that verify my qualifications and competency to practice emergency medicine and to perform the requested procedures.

____________________________________

Emergency Physician (Signature)

## III. HEALTH STATUS

☐ Statement on file attesting to health status

IV. VERIFICATION - The following types of verification of qualifications and competencies in emergency medicine have been received/reviewed:

- ☐ Certification by residency training program
- ☐ Certification by graduate/post-graduate training
- ☐ Certification by the site of prior emergency medicine practice
- ☐ Other ____________________________________________________________

V. ENDORSEMENT

____________________________________________
Director/Chief of Emergency Department/Service

Counselman FL, Borenstein MA, Chisholm CD, et al. The 2013 model of the clinical practice of emergency medicine. *Acad Emerg Med.* 2014 May;21(5):574-598. doi:10.1111.acem.12373.