

Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine



[Ann Emerg Med. 2017;70:446.]

Physician credentialing is the process of gathering information in regard to a physician's qualifications for appointment to the medical staff, whereas delineation of clinical privileges denotes those specific services and procedures that a physician is deemed qualified to provide or perform. The specific processes for physician credentialing and delineation of clinical privileges must be defined by medical staff and department bylaws, policy, rules, or regulations. Each member of the medical staff must be subject to periodic review as part of the performance improvement activities of the organization.

The American College of Emergency Physicians (ACEP) believes that:

- the exercise of clinical privileges in the emergency department (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; and
- 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 the proficiency of each physician will be monitored.

For the purposes of specialty recognition, an emergency physician is defined as one who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM), or an equivalent international certifying body recognized by ABEM or AOBEM in emergency medicine or pediatric emergency medicine, or who is eligible for active membership in ACEP.¹

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 providers of emergency care 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. Board certification by ABEM or AOBEM, or pediatric emergency

*ED medical director refers to the chair, medical director, or his or her designee.

medicine subspecialty certification by the American Board of Pediatrics, is an excellent but not sole benchmark for decisions about an individual's ability to practice emergency medicine. Especially in rural areas, physicians who trained in other specialties may provide emergency care and be granted privileges by an objective measurement of care provided, sufficient experience, previous training, and evidence of continuing medical education.

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Revised and approved by the ACEP Board of Directors April 2017, October 2014, June 2006, and June 2004

Reaffirmed and approved by the ACEP Board of Directors October 1999

Revised and approved by the ACEP Board of Directors with new title "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" September 1995

Revised and approved by the ACEP Board of Directors June 1991

Originally approved by the ACEP Board of Directors with title "Guidelines for Delineation of Clinical Privileges in Emergency Medicine" April 1985

As an adjunct to this policy statement, a Policy Resource Education Paper (PREP) has been developed titled "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine."

REFERENCE

1. American College of Emergency Physicians policy statement titled "Definition of an Emergency Physician" approved by the ACEP Board June 2011.

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Optimizing the Treatment of Acute Pain in the Emergency Department



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The American College of Emergency Physicians seeks to improve acute pain management for patients in the emergency department (ED) and recognizes the need for prompt, safe, and effective pain management. Although a very important topic, treatment of patients with chronic pain, especially those receiving hospice, palliative, or end-of-life care, is beyond the scope of this document.

Optimal acute pain management is patient specific and pain syndrome targeted when feasible, using a multimodal approach that includes pharmacologic and nonpharmacologic interventions. Base the assessment of pain and need for therapy on an overall accounting of

patient status, including functional assessment, rather than solely on patient-reported pain scores.

ACUTE PAIN MANAGEMENT IN THE ED

Pharmacologic Treatments

- Pharmacologic treatment of many acutely painful conditions should optimally begin with a nonopioid agent.
- Choose nonsteroidal anti-inflammatory drugs (NSAIDs) according to their analgesic ceiling dose (which is lower than the anti-inflammatory maximal doses) and prescribe at the lowest effective dose for the shortest expected duration to avoid complications. Use NSAIDs with added caution in individuals with preexisting renal insufficiency, heart failure, or a predisposition to gastrointestinal hemorrhage, and in elderly patients.
- Oral (or rectal) acetaminophen is a good initial analgesic for mild to moderate pain. Intravenous acetaminophen has effects similar to those of oral acetaminophen but is much more expensive, making it best reserved for individuals who cannot receive medications by mouth or per rectum.¹
- Regional anesthesia (nerve blocks), with or without ultrasonographic guidance, may be used for certain acutely painful conditions, either alone or as part of a multimodal approach to pain relief.
- Subdissociative-dose ketamine (SDK) may be used either alone or as part of a multimodal approach to pain relief for traumatic and nontraumatic pain. Emergency care providers should disclose to patients that SDK administration may trigger generally minor, transient adverse effects. Administration of SDK should commence under the same procedures and policies as other analgesic agents administered by the nursing staff in the ED setting.
- Intravenous lidocaine may be beneficial for specific, acutely painful conditions (eg, renal colic, acute radicular back pain, herpetic/postherpetic neuralgia) in patients without known structural heart disease or rhythm disturbances.
- Topical lidocaine patches may be used for certain pain syndromes, such as postherpetic neuropathic pain and myofascial pain.
- Opioid analgesics are commonly used to manage acute severe pain in the ED, as well as pain refractory to nonopioids. Before prescribing, assess risks of harm and counsel patients about serious adverse effects, such as sedation, respiratory depression, risk of tolerance and hyperalgesia, and potential risk of opioid use disorder.

Risks of coprescribing opioids with other central nervous system depressants, such as benzodiazepines, and the patient's individual risk of abuse should also be considered.

- Patients can benefit from knowing opioid alternatives before receiving these agents, allowing shared analgesic planning.
- In severe acute pain, titrate parenteral opioids in incremental doses based on response targeting comfort and function rather than complete pain relief.
- As a general principle, individuals being prescribed opioids should receive only immediate-release opioids in the lowest effective dose for the shortest reasonably practical course.
- Emergency care providers should generally not initiate therapy with extended-release (eg, OxyContin, Opana extended release, fentanyl patch) or long-acting opioids (eg, methadone).
- Patients presenting to the ED for acute exacerbation of chronic pain should generally not receive an opioid analgesic or opioid prescription. When feasible, coordinate treatment with the patient's primary pain management provider. Individualized treatment plans and contracts may be effectively used to guide treatment. If an opioid is deemed necessary, the emergency care provider should prescribe only the minimal amount needed for a reasonable follow-up interval.
- Prescription-monitoring programs allow emergency providers to identify and counsel patients with aberrant use patterns; this helps limit opioid abuse potential and identify those who may benefit from addiction treatment.²
- Patients should also be counseled about safe medication storage and disposal.

Nonpharmacologic Treatments

- Given the adverse effects associated with many analgesics, it is particularly important to understand and use nonpharmacologic treatments, including patient-centered communication techniques, physical interventions, ice or heat, topical coolant sprays, recommendations for activity and exercise, and relaxation techniques. Effective use of these modalities can improve care and lessen risk of harm from pharmacologic therapy.
- Empathic patient-centered communication is a core competency for emergency care providers. Patient-physician interactions characterized by empathy and trust are more likely to lead to optimal outcomes.³

- Mind-body therapies, alone or in combination with other modalities, have documented efficacy in the management of some types of pain; however, there is no evidence in regard to their efficacy for ED patients.⁴⁻⁶
- There is a need for well-designed studies that examine the effect of behavioral therapy in the treatment of pain in ED patients.⁷

Appendix/Definitions

Tolerance: “Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug’s effects over time.”⁸

Physical dependence: Physical dependence is a state of adaptation that often includes tolerance and is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist.⁸

Addiction: Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.⁸

Opioid-induced hyperalgesia: “Opioid-induced hyperalgesia (OIH) is defined as a state of nociceptive sensitization caused by exposure to opioids. The condition is characterized by a paradoxical response whereby a patient receiving opioids for the treatment of pain could actually become more sensitive to certain painful stimuli.”⁹ OIH is difficult to differentiate from tolerance and cannot be reliably diagnosed in the ED.

Pain Classification

Acute: Pain related to acute injury, harm, or repair, and often shorter duration (typically less than 30 days). The cause may be known or unknown. Acute pain usually occurs as part of a single and treatable event. It is often (not always) associated with autonomic nervous system responses (eg, tachycardia, hypertension, diaphoresis). Acute pain typically decreases with time.

Examples of diagnoses that are associated with acute pain include the following: long bone fractures, appendicitis, burns, and procedural pain.

Acute exacerbation of a recurring painful condition: Pain can occur over any duration of time. Pain is due to chronic

organic nonmalignant pathology. Examples of diagnoses that include acute exacerbation of a recurring painful condition are the following: sickle cell pain episodes and migraine headache. There are pain-free episodes between the exacerbations.

Chronic/persistent pain: Chronic (persistent) pain is pain that lasts longer than the expected time of healing. There is continuous pain or the pain recurs at intervals for months or years. In some cases, there are acute exacerbations of chronic pain problems. The cause is often unknown. Examples of chronic or persistent pain include the following: low back pain, diabetic neuropathy, postherpetic neuralgia, multiple sclerosis, and phantom pain.

Cancer pain: Pain caused by “conditions that are potentially life-threatening.” The causes of cancer pain are cancer itself, treatment of cancer, and concurrent disease. Examples of cancer pain include the following: cancer of the pancreas, spinal cord compression caused by tumor infiltration, postsurgical pain associated with cancer treatment, and postmastectomy syndrome.

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Replaces 2009 policy titled “Optimizing the Treatment of Pain in Patients With Acute Presentations” rescinded by the ACEP Board of Directors April 2017

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