

Ultrasound in Emergency Medicine

EMERGENCY DEPARTMENT ULTRASOUND CREDENTIALING: A SAMPLE POLICY AND PROCEDURE

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□ **Abstract**—Emergency physician use of bedside ultrasound has increased dramatically over the last two decades. However, many emergency departments find it difficult to gain formal hospital credentialing for bedside sonography. We present the Emergency Department (ED) Ultrasound Credentialing Policy from the University of California, San Francisco. Although the American College of Emergency Physicians has published formal guidelines on this subject, they are not written in such a way that they are readily transcribed into a document suitable for review by credentialing committees and executive medical boards. Our policy details the background of emergency bedside ultrasound, the goals of its use, the scope of emergency physician sonography, credentialing criteria, and an example of a quality assurance program. We have not changed the components of the previously published guidelines. Rather, this document has withstood the rigor of our own credentialing process and is presented as *an example* in the hopes that it may help other EDs who seek credentialing in their institutions. This document is intended as a guideline for credentialing committees and will require alteration to meet the needs of each different hospital; however, the overall framework should allow for a less time-consuming process. © 2009 Elsevier Inc.

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INTRODUCTION

Ever since the early 1980s, the use of bedside ultrasound by emergency physicians has become increasingly popular (1). The major Emergency Medicine societies support focused sonography in the Emergency Department (ED), and the American Medical Association has similarly advocated for its use (1–3). The medical literature abounds with reports that have documented the benefits of bedside sonography performed by emergency physicians. Sample curricula have been developed, and guidelines for credentialing and use have been developed (1,4). Bedside sonography has penetrated the academic emergency environment nearly completely (5,6).

However, there are still great challenges involved with implementing ultrasound programs at most hospitals across the country (7). In 1997, Tandy and Hoffenberg attempted to aid EDs by discussing how to gain hospital approval (8). They covered the goals of an ED ultrasound program, the scope of practice, credentialing requirements, and quality improvement. Lanoix, also in 1997, discussed similar issues, and offered some strategies to help convince the hospital administration of the important role of bedside emergency sonography (9). By 2001, the American College of Emergency Physicians (ACEP) produced guidelines for emergency ultrasound, a tremendous step forward in terms of helping EDs with the credentialing process (1). Despite these efforts, there is still significant debate regarding the use of and the

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credentialing for bedside ultrasound performed by emergency physicians (7). Currently, only 19% of community EDs in the United States have 24-hour-a-day availability of bedside ultrasound (10).

DISCUSSION

At the ED of the University of California San Francisco, we set out in 2002 to establish a process for credentialing physicians in the use of emergency ultrasound. Like other EDs, we encountered significant difficulty, and relied upon the guidelines and recommendations above to form our policy. Although each was quite helpful, none was suitable to use as an example for our internal credentialing process. We attempted to contact several other large university EDs to find a written policy with which to form our own, but were unable to find one. Thus, we present our policy and procedure as a model for other hospital EDs to use as an aid to producing a viable credentialing program in their own institution.

Our document does not intend to address several shortfalls of the ACEP guidelines. For example, current guidelines recommend a certain number of sonographic studies in each area to become proficient, but do not address the need for experience with positive vs. negative studies. Further, there are not reliable studies to justify the number of sonographic studies that are currently recommended to become proficient in each of the different areas. There are also no studies to show that this credentialing process is any better than other credentialing processes. These and other shortfalls should be addressed in future research studies. It is important to realize that we in no way intended to improve upon or validate the existing guidelines. Rather, our only intent was to create a document that would explain the creation and maintenance of an emergency ultrasound program according to the current recommended guidelines that would be understood by a wide range of medical professionals in order to facilitate the credentialing process for emergency physicians.

It is further important to note that for our own particular institution, some requirements that were placed in our protocol may not meet the same goals as those in other institutions. One good example is that we arbitrarily requested a 90% accuracy rate for our credentialing physicians compared to the formal radiology report. Although there is absolutely no medical literature to support this rate, and much literature to support the notion that sometimes radiologists can not even agree with this degree of accuracy, our department nonetheless felt that unless we could achieve this level of proficiency, it wouldn't make sense to implement this process given our level of radiology ultrasound coverage. For those

institutions without regular coverage of ultrasound, it may still be an extremely useful tool with much lower rates of accuracy.

Finally, there are a number of components of our policy and procedure that may seem unusual to those with currently established programs. While going through the process of establishing a program for bedside ultrasonography, we were impressed with the extent to which providers outside the ED had a difficult time understanding the differences between formal radiologic ultrasound and focused emergency sonography, and thus, this concept is discussed in detail in our protocol. In addition, we found that many of our institution's leaders felt that we were somehow trying to use the ultrasound instead of clinical reasoning, and thus, we incorporated a brief discussion of disposition decision-making to help them better understand how the use of ultrasound improves our ability to care for patients.

CONCLUSION

We hope this document aids other EDs in their creation of successful emergency ultrasound programs. We feel that a concise protocol that has successfully passed through a university medical system's credentialing process should be readily available to EDs that are attempting to create their own policies. Our full protocol is presented in the Appendix.

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