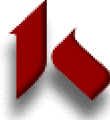
Print Name



Clinical Privileges Profile

Palliative Medicine

Kettering Medical Center System

☐ **Kettering Medical Center** ☐ **Sycamore Medical Center**

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Clinical Service Chief: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements

- Note that privileges granted may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR PALLIATIVE MEDICINE

To be eligible to apply for core privileges in palliative medicine, the applicant must meet the following criteria:

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association (AOA)–accredited residency and a 12-month ACGME or AOA affiliated fellowship in palliative medicine or the equivalent in practice experience.

AND

Current certification or active participation in the examination process with achievement of certification within six years leading to certification by the relevant American Board of Medical Specialties or American Osteopathic Boards and documentation of completion of an approved program in palliative medicine, or certification in hospice and palliative medicine by the American Board of Hospice and Palliative Medicine (ABHPM).

Required previous experience: Applicants for initial appointment must be able to demonstrate the provision of palliative medicine services, reflective of the scope of privileges requested, for at least 50 patients during the past 36 months (with at least 16 in the past 12 months), or demonstrate successful completion of an accredited palliative medicine fellowship program within the past 12 months.

Reappointment requirements: To be eligible to renew core privileges in palliative medicine, the applicant must meet the following maintenance of privilege criteria:

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 ability to perform privileges requested is required of all applicants for renewal of privileges.

CORE PRIVILEGES

PALLIATIVE MEDICINE CORE PRIVILEGES

☐ **Requested** Admit, evaluate, diagnose, treat, and provide consultation to patients of all ages, with life-threatening or severe advanced illness, including assessment of suffering and quality of life, managing terminal symptoms, patient/family education, bereavement, and organ donation. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges include the procedures listed on the attached privilege list and such other procedures that are extensions of the same techniques and skills.

CORE PROCEDURE LIST

This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

To the applicant: If you wish to exclude any procedures, please strike through those procedures that you do not wish to request, initial, and date.

1. Administration and management of palliative sedation
2. Assess pertinent diagnostic studies
3. Direct treatment and forming a treatment plan
4. Manage common comorbidities and complications and neuro-psychiatric co- morbidities
5. Manage palliative care emergencies (e.g. spinal cord compression, suicidal ideation)
6. Manage psychological, social, and spiritual issues of palliative care patients and their families.
7. Manage symptoms including various pharmacologic and nonpharmacologic modalities, and pharmacodynamics of commonly used agents.
8. Perform history and physical exam
9. Perform pain relieving procedures
10. Symptom management including patient and family education, psychosocial and spiritual support, and appropriate referrals for other modalities such as invasive procedures.

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and that I wish to exercise at Hospital, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature: ____ ***Date:*** _____________

CLINICAL SERVICE CHIEF'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with the following conditions/modifications:
- ☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. ______________________	______________________
2. ______________________	______________________
3. ______________________	______________________
4. ______________________	______________________

Notes

____

____

____

Clinical Service Chief Signature: ______________________ ***Date:*** __________

FOR MEDICAL STAFF OFFICE USE ONLY

Credentials Committee action ***Date:*** __________

Medical Executive Committee action ***Date:*** __________

Board of Directors action ***Date:*** __________

Adopted: November 11, 2010