

Medical Staff Credentialing

Risk managers who are familiar with the story of Michael Swango, a doctor suspected of killing at least 60 patients,¹ know that if he had been properly credentialed, his murder spree would have ended much sooner than it did.

Swango graduated from Southern Illinois University Medical School in 1983 with a medical degree. Over the next decade, despite a conviction for aggravated assault in 1985 and suspended medical licenses in Ohio and Illinois, he was accepted to residency programs at both the University of South Dakota School of Medicine and State University of New York's (SUNY) Stony Brook School of Medicine, in which he treated patients for five months in 1992 and three months in 1993, respectively. During the credentialing process in South Dakota, Swango explained that his prior conviction stemmed from false allegations from jealous coworkers.² If the reason for his conviction had been verified with the Illinois Department of Corrections by either program, both schools would have known that Swango was convicted for poisoning facility coworkers.³

Both programs eventually dismissed Swango under clouds of suspicion, and he moved abroad working as a missionary doctor in Zimbabwe. When he attempted to re-enter the United States, Swango was arrested for supplying false information to a federal official when he applied to SUNY's Veterans Administration facility. In 2000, Swango was sentenced to three life sentences in federal prison for murdering three facility patients by lethal injection.⁴

Although most practitioners are not criminals intent on murdering patients, credentialing experts estimate that 7% of physician applications involve some falsification.⁵ One of the most important responsibilities of healthcare facility governing bodies is ensuring that their credentialing and privileging processes are well developed and appropriately used to protect patients from dangerous practitioners.

To help risk managers be proactive in this effort, this Risk Analysis provides an overview of the credentialing and privileging process and criteria for proof of practitioner competency. Because most United States healthcare facilities follow Joint Commission on Accreditation of Healthcare Organization (JCAHO) standards, this Risk Analysis is based on a review of those standards. Risk managers are advised to carefully identify, review, and comply with any state code that regulates credentialing practices, as these statutes vary widely from state to state.

An Overview of Credentialing

Courts have increasingly held healthcare facilities liable for corporate negligence for failing to exercise reasonable care when selecting, supervising, and

HRC TOOLS FOR THIS TOPIC

The following tools and resources on this topic are available in your *HRC System*. Refer to this article and other *HRC* resources for help.

- Resource List
- Case Law
- Checklists
- Sample Letter
- Sample Forms
- Self-Assessment Questionnaire
- Action Recommendations
- Also Available on *HRC* Web Site

reviewing the competency of each staff member's past and present clinical activities. The doctrine of corporate negligence was first set forth in the landmark 1965 decision regarding *Darling v. Charleston Community Memorial Hospital*.⁶ In effect, the theory of corporate liability established in this case and in subsequent cases claiming negligence permits a facility to be held liable for physician malpractice if the facility knows or should have known that the physician was incompetent or was likely to perform negligently. Thus, a process for credentialing practitioners, or determining that they are competent to provide high-quality patient care, is required.

What Is Credentialing?

The term "credentialing" refers to the following separate but related processes:⁷

1. *Appointment*—Evaluation and selection for medical staff membership
2. *Reappointment*—Continuing review and evaluation of each credentialed practitioner to ensure that competence is maintained and is consistent with privileges
3. *Delineation of clinical privilege*—Delineation of the specific surgical or diagnostic procedures that a credentialed practitioner may perform and the types of illnesses that he or she may manage

These processes involve evaluating a practitioner's application for eligibility for staff membership and competency for clinical privileges using established criteria. These criteria are developed by the medical staff and approved by the governing body. Following the evaluation of the application, the medical staff makes a recommendation to either approve or reject the application. This recommendation is communicated to and ruled on by the facility's governing body, which is the ultimate authority for granting membership and clinical privileges.

Who Needs To Be Credentialed?

JCAHO requires that any practitioner defined within the medical staff bylaws as a licensed independent practitioner or a practitioner subject to the credentialing process be credentialed before providing patient care services.⁸ Because each state determines the level of credentialing required for each type of practitioner, state code should be consulted.

For cases in which it is deemed that the standard credentialing process will not provide patient care in a timely manner, abbreviated credentialing options such

as temporary, expedited, or emergency privileges are available. These credentialing options are discussed elsewhere in this Risk Analysis within the Exceptions to the Credentialing Process section.

The JCAHO medical staff (MS) standard places a two-year time limit on medical staff appointment and clinical privileges (MS.4.20). Therefore, practitioners must reapply for appointment and clinical privileges before the end of the two-year limit. Any practitioner who does not complete the application process for reappointment within this time limit loses his or her medical staff appointment and/or clinical privileges.

The process of granting, renewing, or revising clinical privileges is addressed at appointment and every subsequent reappointment. At any time during the appointment (initial or subsequent), practitioners may request and be credentialed for additional privileges.

Establishing Criteria for Staff Membership and Clinical Privileges

The medical staff bylaws and rules and regulations must specify the requirements and procedures for granting admission to the medical staff, renewing appointments, and granting clinical privileges. They must also outline the grievance process available to practitioners for whom staff appointment or clinical privileges have been denied or privileges have been restricted.⁹

All credentialing criteria, whether externally determined by federal and state code (e.g., licensure, educational requirements) or internally determined by the facility (e.g., geographic location of physician's practice, board certification requirements), must be clearly stated in writing in the medical staff bylaws and made known to each applicant. Any changes to these criteria must be made by formally amending the medical staff bylaws; this is a process that requires approval from both the medical staff and the governing body, as neither group may unilaterally amend medical staff bylaws.¹⁰

All credentialing criteria for membership and clinical privileges should be related to the maintenance of high-quality patient care. Concerns such as ensuring smooth facility operations, meeting community and facility needs, and ensuring the financial stability of the institution are all acceptable appointment criteria as long as they affect the provision of high-quality patient care. For references on published credentialing criteria guidelines and policies, see the Resource List in Appendix A.

Because the acceptability of specific criteria depends in part on the individual characteristics of the facility and the composition of the medical staff (as well as case law within the jurisdiction), facilities are advised to consult with legal counsel before adopting credentialing criteria. For a summary of significant case law regarding credentialing, see Appendix B.

Assessing Staffing Needs

A formal medical staff development plan, which takes into consideration the strategic direction of the facility and is supported by managers, medical staff members, and the governing board, should serve as a basis for physician recruitment, appointment/reappointment, and privileging decisions. This plan should contain an objective assessment of community needs and clearly articulate the current needs and goals of the facility, including the desired quantity, quality, and expertise of its medical staff.

This plan should be reassessed as needed to identify areas for which the facility struggles to maintain consistent and adequate availability of physicians, as well as areas in which no additional physicians are needed because volume has been severely reduced or restricted due to the availability of beds, support personnel, or related facilities and equipment or because of other reasons.¹¹

Economic factors. Although economic credentialing is addressed in a separate Risk Analysis, the increased concern expressed by facilities and physicians alike regarding this issue warrants attention when discussing credentialing criteria.

The reasonableness of credentialing criteria is tested by weighing the benefits of the criteria against the potential harm to competition.¹² All medical staff involved in credentialing duties should understand that criteria proposed and adopted by them without the review and approval of the governing body are likely to be challenged on the grounds that they are being adopted for anticompetitive motives and will unreasonably restrain trade. Medical staff members who may obtain some financial benefit from the exclusion of others are more likely than the governing body to be seen as competitors of applicant physicians.¹³

Ideally, the medical staff bylaws should incorporate a description of the process for granting exclusive contracts, recruiting physicians, or considering a physician's economic conflicts of interest. However, the restriction of trade imposed and the prospect of using economic factors in the credentialing process has seen

strong resistance among physicians, and convincing the medical staff to incorporate such items into its bylaws may be difficult. Indeed, it is recommended that the governing body consider and prepare for this resistance in its efforts to incorporate any definition of economic factors into medical staff bylaws.¹⁴ For an in-depth review of the issue of economic credentialing, please refer to the Risk Analysis titled "Economic Credentialing," which is located elsewhere in this section of your *Healthcare Risk Control (HRC) System*.

Staff Membership and Delineated Clinical Privileges

Clinical privileges concern the scope of patient treatment but may or may not be tied to medical staff membership. For example, a facility's bylaws may require that physician assistants request clinical privileges and be credentialed and reappointed in the same manner as physicians to provide oversight for the quality of care provided by physician assistants. However, the bylaws might not offer physician assistants membership to the medical staff, because that could entitle them to specific benefits that the medical staff wishes to reserve solely for physicians (e.g., voting rights on medical staff issues).

Just as a practitioner may be subject to the requirements of credentialing even though he or she is not a staff member, it is possible that medical staff members will go through the credentialing process without asking for clinical privileges. For example, family practitioners often will join a medical staff for insurance company credentialing purposes but will not ask for any clinical privileges, because he or she will only refer patients to the facility, not treat patients there.

While criteria for staff membership are to be applied facilitywide, criteria for granting clinical privileges (discussed later in this Risk Analysis) should be department or specialty specific. The department chairperson is charged with the responsibility of recommending to the medical staff the criteria for clinical privileges within the department and the delineation of specific clinical privileges for each department member.¹⁵

Once established, clinical privileging criteria must be applied uniformly and consistently when initially granting, renewing, or revising clinical privilege requests. As with credentialing criteria for medical staff membership, the criteria to ascertain clinical competency for requested privileges must be approved by the facility's governing body.¹⁶

Credentialing Structure within the Facility

Each facility must create and document in the medical staff bylaws and rules and regulations the organizational structure for its credentialing process.¹⁷ This structure is influenced largely by federal and state law, JCAHO standards, and court decisions; however, aspects of the process may be tailored to suit the needs of individual facilities.¹⁸

Department Chairperson

Although it is not feasible to develop departments and subspecialty sections for some small facilities, most medical staffs are segregated by medical and surgical discipline and by specialty (e.g., cardiology would be a specialty within the department of internal medicine). JCAHO standards require that when such departments exist, the chairperson's responsibilities, many of which are related to credentialing, be outlined in the medical staff bylaws.¹⁹ In facilities in which departments do not exist, the medical executive committee (as discussed elsewhere) is charged with this responsibility.

The department chairperson's responsibilities are to review and make recommendations to the facility's credentialing committee or medical executive committee for staff membership and clinical privileges for each practitioner assigned to the department. The chairperson is also responsible for developing the criteria used to establish competency for each of the clinical procedures and therapeutics used or requested by practitioners assigned to the department.

Credentials Committee

Although JCAHO does not require a facility to have a credentialing committee, such committees are required in some states, such as Pennsylvania.²⁰ The credentials committee is charged with verifying, investigating, and evaluating information submitted on medical staff applications. To save the medical staff time and to avoid involving competing physicians in the information gathering and verification process, these activities are often delegated to the facility's medical staff office. The entire preapplication and application phase of the credentialing process (i.e., information gathering) is administered by impartial and objective medical staff office personnel.

When the medical staff office has received all necessary information and documentation and has verified all information in the application, the department chairperson reviews and makes a recommendation on the application. The entire credentials file is then sent

to the credentialing committee for review. At this point, the committee interviews and confirms the identity of the applicant, addresses all concerns about the application, and submits a written report to the medical executive committee recommending that the application be either approved or rejected. The credentialing report should contain a detailed explanation of the recommended action, and all votes and findings should be included and described in detail.

Medical Executive Committee

In all hospitals, regardless of size and medical staff structure, JCAHO standards require that a medical executive committee be established and that it review and make recommendations to the governing body for all applications for membership and clinical privileges.

In facilities with small medical staffs, the medical executive committee may also serve as the credentialing committee.²¹ In such cases, a panel from its membership is appointed by the medical executive committee chairperson to review and make recommendations for each application. This panel should include the department chairperson most qualified to assess the professional competence of the applicant and to recommend which clinical privileges should be granted.

Governing Body

JCAHO standards require that the medical staff conduct the actual credentialing review process, as the governing body generally lacks the expertise to judge the clinical competency of practitioners. Nevertheless, the authority to make final decisions regarding credentialing stated in the fifth element of performance for standard MS.4.20 resides solely with the governing body.²² This responsibility must be executed in a timely manner and may be delegated to a subcommittee of the governing body, which comprises two or more voting members of the board in accordance with the restrictions outlined in standard MS.4.30.^{23*}

Step by Step—The Credentialing Process

Outlining, following, and documenting a formal credentialing process reduces the risk of liability and antitrust or negligence lawsuits related to credentialing decisions. The procedure or mechanism for appointing and reappointing medical staff and for

* The restrictions that would prohibit an application from being processed by this subcommittee are discussed in the Temporary Privileges section.

granting, renewing, or revising clinical privileges must be fully described in the medical staff bylaws, department rules and regulations, and relevant facility policies. The description should be detailed enough to permit tracking of adherence to the process. Development and use of a credentialing policy and procedure manual explaining the process and guidelines for each activity is also recommended for staff members involved in the credentialing process.²⁴

Preapplication Phase

The preapplication phase begins whenever a practitioner contacts the facility seeking medical staff membership and/or clinical privileges. The medical staff office sends the potential applicant a preapplication form or letter containing requests for objective information.²⁵ This form may request information such as the physician's name, office and home addresses, medical school, residency, evidence of malpractice insurance and current licensure, and any other objective criteria for medical staff membership identified in the medical staff bylaws. (See "Developing Criteria for Applicants" for a list of acceptable and unacceptable information to collect during the credentialing process.) An application processing fee is not requested at this time, and a credentials file need not be created. The completed form does not need to be judged by a peer-review committee, as this phase of the application process does not address the applicant's clinical competency.²⁶ Whether an individual is eligible to receive an application, based on objective threshold criteria, is a management decision, not a medical staff issue.

The medical staff bylaws should specify which nonphysicians will be allowed to apply for medical staff membership.

The potential applicant may be denied further consideration at this point based on such objective criteria as not meeting educational requirements, not holding proper licensure, not having malpractice insurance, or practicing a specialty the facility lacks the resources to support or that does not meet community needs (as defined in the medical staff development plan). Failure to provide an individual with an application because he or she does not meet threshold criteria does not trigger hearing rights or reporting responsibilities under the Health Care Quality Improvement Act (HCQIA). However, this preapplication phase cannot be merely an application process in disguise. The more subjective the preapplication screening appears,

Developing Criteria for Credentialing Applicants

The following criteria are generally considered acceptable for use in making appointment, reappointment, and privileging decisions:

- Completeness of application
- Accuracy of representation on the application
- Reference quality
- Record of conviction
- Level of competence
- Ability to follow hospital rules
- Physical and mental health*
- Geographic location (must be reasonably related to patient care and cannot be set arbitrarily)
- Board certification (cannot be the sole consideration)
- Malpractice insurance
- Ability to work with others
- Hospital and community needs
- Exclusive contracts

The following criteria are generally considered unacceptable for use in making appointment and privileging decisions:

- Race, sex, religion, national origin, and disability (in some instances)
- Nonallopathic or nonphysician licensure (e.g., osteopaths, podiatrists, clinical psychologists, or certified nurse midwives)**
- Medical society membership

Source: Peters BM, Maneval WC. Medical staff membership criteria: a credentialing minefield. *Med Staff Couns* 1991 Summer;5(3):1-10.

* The Americans with Disabilities Act (ADA) places restrictions on the use of disability status as a basis for making employment decisions. ADA clearly applies to applicants for medical staff membership who, if accepted, would become employees of any nonfederal hospital with at least 15 employees. ADA may prohibit inquiry into the health status of an applicant before an offer of medical staff membership is made but may not prohibit such an inquiry after an offer is made. The hospital may still inquire as to the ability of the applicant to perform the specific privileges requested. The Joint Commission on Accreditation of Healthcare Organizations has stated that it will interpret medical staff credentialing standards consistently with ADA.

** Decisions in this area depend to a large degree on particular state statutes.



the more likely it is that a court would find that all the rights and responsibilities that apply to the application process also apply to the preapplication phase.

When determining criteria for those who may receive an application, facilities must consider state

Basic Components of a Medical Staff Application

Initial appointment and reappointment applications should include, at minimum, requests for information about the following:

- All education, including medical school, internships, residencies, fellowships, and other training. This information is not required for reappointment if the information was verified during initial appointment.
- All licenses.
- All specialty board certifications and attempts at certification.
- All prior hospital affiliations. For reappointments, only affiliations of the last appointment period are required.
- All work and military experience. This information is not required for reappointment if the information was verified during initial appointment.
- Letter of health status.
- Complete malpractice insurance coverage and malpractice claims history. For reappointments, only a history of the last appointment period is required.
- All past disciplinary actions taken by other hospitals. For reappointments, only actions during the last appointment period are required.
- References from previous department chairpersons or divisional chiefs and others who have recent knowledge of the applicant's clinical work or, in the case of reappointment/reappraisal of clinical privileges, information concerning professional performance and judgment and clinical and/or technical skills as indicated in part by the results of the facility's quality assessment and improvement activities.
- All previously successful or currently pending challenges to any licensure or registration (e.g., state, Drug Enforcement Agency) or voluntary relinquishment of licensure or registration. For reappointments, only actions during the last appointment period are required.
- All voluntary or involuntary terminations of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital. For reappointments, only actions during the last appointment period are required.
- Any suspension of participation in the Medicare and Medicaid programs or any other third-party payer program. For reappointments, only actions during the last appointment period are required.
- Any professional liability actions, including, at minimum, all pending claims and final judgments or settlements in which the applicant was involved. For reappointments, only actions during the last appointment period are required.
- A delineated list of all privileges requested. Physician agreements of supervision and protocols should be submitted for all practitioners requiring physician supervision. Because these regulations vary by state, it is recommended that state code be consulted to determine the exact requirements of supervision for dependent practitioners such as physician assistants.
- Submission of a current photo of the practitioner, for initial applications only.
- Attestation that the practitioner has received, read, and now agrees to abide by the medical staff and hospital bylaws and department rules and regulations.
- Attestation that the practitioner has completed all continuing medical education credits needed to retain a valid state medical license, for reappointments only.
- Attestation that the practitioner is board certified or will become board certified within (facility specified time period) of graduation from residency or fellowship training.
- An authorization release form releasing from liability the facility and medical staff members engaged in good-faith peer-review efforts, as well as all individuals or organizations that provide information to the facility concerning the applicant's competency, ethics, character, and other qualifications for staff appointment and clinical privileges.



requirements regarding access to facilities for non-physician independent practitioners such as podiatrists and clinical psychologists. Some statutes, for example, prohibit discrimination against certain nonphysician health professionals. The medical staff bylaws should specify which nonphysicians and nondental practitioners (e.g., podiatrists, nurse practitioners, psychologists) will be allowed to apply for medical staff membership and/or privileges.

Application Submission Phase

Once a practitioner is deemed eligible to apply for medical staff membership and/or clinical privileges, an application is sent, and the competency-based phase of the credentialing process begins. (See "Basic Components of a Medical Staff Application" for a list of information to collect from the applicant.) The burden of proof is on the applicant to establish that he or she is

qualified for staff membership and/or specific clinical privileges. This includes completing the application form and providing any information requested to properly evaluate the application.* It is recommended that the medical staff bylaws clearly state that an applicant may be denied appointment and/or privileges based solely on an incomplete or falsified application.

The application should be detailed and comprehensive enough to establish an applicant's background, current competence, and physical and mental ability to perform his or her patient care responsibilities and to assure the medical staff and governing body that patients will receive high-quality care.²⁷ The medical staff bylaws should contain a stipulation that applicants are responsible for establishing their qualifications and supplying additional information when it is requested.

Release from liability. All applications should include a form establishing release from civil liability that is to be signed by the applicant. This form releases from liability the facility and medical staff members engaged in good-faith peer-review efforts, as well as all individuals or organizations that provide information to the facility concerning the applicant's competence, ethics, character, and other qualifications for staff appointment and clinical privileges. The form should be drafted with the intention of protecting the facility, the medical staff, and the applicant's references from libel or other claims. It should include the applicant's authorization to consult with members of the medical staffs of other facilities regarding the applicant's clinical competence, as well as the applicant's consent to the facility's inspection of all records and documents (including current and previous litigation records) that may be material to an evaluation of the applicant's professional competency and qualifications for clinical privileges and staff membership. Signed releases and authorizations should be retained as part of the practitioner's credentials file.²⁸

Verification and Investigation Phase

Between 1995 and 1997, the Massachusetts medical board disciplined 17 physicians for embellishing their credentials.²⁹ If estimates that 7% of practitioners falsify information on their applications are correct, medical staff officers who execute the verification phase

* A distinction is made between requesting that the applicant supply information and obtaining verification of that information. The facility must be able to verify all submitted information (preferably from primary sources), as discussed elsewhere in this Risk Analysis in the section on verification.

properly should expect to find occasional discrepancies during the verification process that require clarification from applicants. These discrepancies may not be substantial enough to warrant reporting to a medical board; however, dishonesty on the part of individuals who have been informed that their credentials will be verified should raise concerns for any credentialing body.

Primary source verification. To determine the veracity of a practitioner's stated qualifications, JCAHO standards require that facilities verify the individual's training, experience, and competence from primary sources whenever possible. Primary source verification is the receipt of information directly from the institution or person being queried. An example of a primary source document is one that is mailed directly to the facility credentialing the applicant from a residency training program. A copy of a letter from a training program submitted by the applicant is not a primary source document because it was not received directly from the originating source and could have been altered or forged.

JCAHO's standards also allow facilities to use primary source equivalents, such as the American Medical Association Physician Masterfile, and the American Osteopathic Association Physician Database.³⁰ These organizations meet JCAHO standards for primary source verification, and JCAHO has granted them the option to supply this information to other organizations. In situations in which the primary source (e.g., hospital, educational institution) no longer exists, designated equivalent sources who verified the information at an earlier date (or other reliable secondary sources) may be used, provided that efforts to contact the primary source are documented.

During the reappointment process, primary source verification of schooling, claims histories, and past hospital affiliations obtained during the initial application need not be repeated. However, hospital affiliations and liability insurance maintained during the previous appointment period must be verified.

Querying the National Practitioner Data Bank. Under HCQIA, healthcare facilities must query the National Practitioner Data Bank (NPDB) during the credentialing process. This database is designed to track the malpractice and disciplinary history of physicians, dentists, and other healthcare practitioners. HCQIA grants limited immunity from antitrust lawsuits for those reviewing the query report and involved in peer review only if a facility and its medical staff engage in good-faith efforts

to determine an applicant's qualifications.³¹ NPDB must be queried at the following times:

- Before initial medical staff appointment or initial granting of clinical privileges
- Before granting additional privileges to a credentialed practitioner
- Before reappointment

Liability insurance payments, licensure actions, clinical privilege actions taken by a healthcare entity, as well as society membership actions against a practitioner must be reported to NPDB by the relevant entity; however, a report issued by the U.S. Government Accountability Office in 2000 found weaknesses in NPDB. The case of Michael Swango highlighted the fact that adverse actions against residents are not reportable to this entity. For this reason, it is strongly recommended that facilities require that the applicant's medical schools and internship, residency, and fellowship directors programs be informed of the clinical privileges being requested and that they submit peer recommendation letters evaluating in detail the applicant's activities. (For an example of a detailed peer recommendation letter, see "Sample Letter: Request for Peer References.") It is also recommended that facilities consider conducting criminal background checks for all healthcare providers. (For more information on using criminal background checks, refer to *HRC's Risk Analysis* titled "Criminal Background Checks.")

Underreporting, late reporting, and the reporting of erroneous information, make the NPDB a questionable source of accurate, complete, or timely information;³² facilities cannot rely solely on NPDB reports when credentialing practitioners.*

Another data bank that serves a limited but useful purpose for facilities is the Healthcare Integrity and Protection Data Bank (HIPDB). HIPDB contains fraud and abuse data about final adverse actions taken against practitioners, including exclusion from participation in state or federal healthcare programs; actions by federal or state agencies responsible for licensing; federal or state criminal convictions relating to the delivery of healthcare services or items; and civil judgments relating to delivery of healthcare services or items (excluding medical negligence). Facilities are not allowed to query this data bank directly, but they may

* The query report received from NPDB must be secured within the practitioner's credentialing file and remain confidential. Under HCQIA, the penalty for violating the confidentiality of these reports is a \$10,000 fine. *HRC* recommends using caution when storing and transporting applications to various committees and meetings during the review process.

ask practitioners to query the data bank themselves and provide a copy of the query report to the medical staff office.

Peer references. Those who have worked with a practitioner know that practitioner's skills best. Facilities should require that references concerning competency are written by those in the same specialty who have had an opportunity to observe the applicant's work.³³ (See "Sample Letter: Request for Peer References.") These references should address the practitioner's competency (including health status) and should not have a financial or familial tie to the applicant; references should *never* be accepted if forwarded by the applicant.³⁴ The facility should also solicit information from the applicant's peers who are not listed in the application but who are known to be knowledgeable about the applicant's training, experience, health, competence, and ethical character.³⁵

Peer references must be received and reviewed for reappointment applications when the clinical data of the practitioner's performance collected by the facility during the two-year period is insufficient to establish the practitioner's clinical competency to perform the clinical privileges requested.³⁶

The medical staff bylaws should state that an applicant may be rejected on the basis that no references were provided (unless the applicant can demonstrate a conspiracy or other wrongful conduct stimulated by others to hurt his or her career).³⁷

As important as they are, personal and professional references are often the most difficult part of the application to investigate because they may be biased, noncommittal, or incomplete. Various types of references have been described as follows:³⁸

A forthright, positive set of statements about the applicant

- A forthright, negative set of statements about the applicant
- Statements that are either equivocal or completely devoid of any information about the practitioner's ability to practice medicine in a competent and ethical fashion
- A positive written reference that is later tempered by verbally expressed concerns or reservations

The first two types of references are straightforward and may require no further verification than perhaps a clarification of details. To avoid receiving incomplete or nonconstructive references, it is

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Sample Letter: Request for Peer References

Editor's Note: This letter can be used to gather information for applicants applying for initial appointment, reappointments, and additional privileges. Facilities are advised to send this type of letter to the applicant's peer references, employers, and medical school, residency, and fellowship directors.

Dear Sir/Madam:

(Practitioner name) has applied for medical staff appointment and/or clinical privileges at our facility. Your name or facility has been noted as a reference capable of rendering an informed opinion of his or her competency as a practitioner. Your thoughts and comments about (practitioner name) would be greatly appreciated, and your response will be kept confidential. Attached please find a photo of the practitioner and a list of the clinical privileges requested.

If you would prefer to speak with me directly about this practitioner, please feel free to call me at (your hospital's phone number).

Sincerely,

Applicant's status within your institution:

Date of initial appointment: _____

Date of resignation or program completion: _____

Do you have a familial or financial relationship with this applicant? If yes, please explain:

Please rate the applicant (see Table).

Has this practitioner ever attempted to perform procedures for which he or she did not have the required training or board approval? If yes, please explain:

Are you aware of any indications that this practitioner is dependent on alcohol or drugs? If yes, please explain:

Are you aware of any other health problems the practitioner may have that would inhibit the delivery of quality care? If yes, please explain:

Please describe below any disciplinary action to which this practitioner was subject at your facility (e.g., reprimand, suspension, termination):

Additional comments:

Please check one:

- Recommend without reservation
- Recommend
- Do not recommend

Signature: _____

Date: _____

Title: _____

Table. Applicant Rating

Clinical Competency	Excellent	Good	Fair	Poor
Clinical knowledge				
Clinical judgment				
Technical proficiency				
Professional manner with patients				
Professional manner with other healthcare workers				
Ethical conduct				
Completes medical records in a timely manner				
Writes orders legibly				
Avoids prohibited abbreviations				
Speaks, writes, and understands English				
Attends required meetings or functions				

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recommended that a form be developed and sent to evaluators requesting that the evaluator rate the applicant on various clinical and interpersonal skills, including a request for information regarding the practitioner's health status. When insufficient responses are received, the facility should consider contacting the evaluator for written clarification.³⁹ For more information on practitioner health issues, see the *HRC Risk Analysis* titled "Physician Substance Abuse."

Most difficult to resolve is the last type of reference. A facility cannot ignore negative information, even if it is received informally. However, it would be difficult to uphold a denial of privileges in court if the denial is based on informal communication. Attorneys have suggested the following ways by which to attack this problem:⁴⁰

- The medical staff coordinator or other facility representative can persuade the evaluator to provide a candid written appraisal of the applicant. It should be made clear to the evaluator that the author of a good-faith reference has limited immunity under HCQIA. If this fails, the facility can request that the evaluator suggest another means by which the facility can document the identified deficiencies (e.g., by identifying specific charts or reports).
- The facility can disregard the reference and request that the applicant provide additional references that may be used to support or contradict the information revealed through informal communication.

Credentials verification organizations. Credentials verification organizations (CVOs) collect and distribute primary source materials to facilities for credentialing purposes. The facility usually contracts with the organization to verify applications. When a practitioner applies for clinical privileges, the facility sends the standard completed application form to the service, which then contacts the primary sources, obtains the necessary documents from them, and forwards the documents to the facility for a fee.

Even when a facility uses a CVO to collect information from primary sources, the facility must compare the information in the applicant's application with the primary source documents collected by the agency. Additional information may be necessary to fully evaluate each applicant. (See "Using a CVO" for more information.)

In addition, the applicant should be asked to sign a release authorizing the CVO to act as the facility's

Using a CVO

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will accept verification documents received by the facility from a JCAHO-accredited credentials verification organization (CVO) as long as the hospital evaluates the CVO using the following criteria:

- The CVO must disclose to the facility what data and information it can provide, and an agreement must be reached regarding the format that the agency will use to transmit individuals' credentials information.
- The CVO must document and provide a description of how it performs data gathering and verification.
- The CVO must provide information about its database functions, including limitations of the database, timeliness of the CVO's responses to requests for information, and a summary of its data security and quality-control processes, including technical specifications.
- The facility must be able to distinguish which information transmitted by the CVO is from a primary source and which information is not. The facility must also be able to distinguish whether the information transmitted from a primary source is all the primary source information in the CVO's possession and, if it is not, where the undisclosed information can be obtained.
- The CVO must indicate when dated information was last updated from the primary source (e.g., dates of licensure or board certification).
- The facility must be able to resort to the CVO's quality-control processes to resolve concerns about data issues.
- The CVO must certify that the information it transmits to the user is an accurate presentation of the information it obtained.

Source: Joint Commission on Accreditation of Healthcare Organizations (JCAHO). *Comprehensive accreditation manual for hospitals*. Oakbrook Terrace (IL): JCAHO; 2004.



agent in the collection of information from primary sources.

Competency Evaluation Phase

After being verified and investigated by the medical staff office, the completed application for initial appointment or reappointment is ready to undergo a peer-review process to determine the applicant's clinical competence for specific privileges. Because this

aspect of the credentialing process poses the greatest antitrust risk, care should be taken to ensure that any recommendation to the board, positive or negative, is supported by documented evidence (e.g., reference to specific conduct or care of specific patients based on records or observation) that could be placed on the record in the event of a hearing or lawsuit.

If it is recommended that the governing body accept the application, the board must feel secure that, in a malpractice action, no basis would exist for a court to find that the facility was negligent in carrying out its assessment of competence. In the event that the medical executive committee recommends denying the application, the board must feel secure that a court would find that the physician was treated fairly and that the denial was based on acceptable criteria.

Competency criteria. In addition to containing standards for practitioner eligibility for staff membership, JCAHO's *Comprehensive Accreditation Manual for Hospitals* also contains standards for determining competency for the clinical privileges that have been requested. Specialty societies and colleges are also a good source to consult for developing procedure- or technology-specific clinical privileges.

JCAHO standards for establishing practitioner clinical privilege competency criteria include the following:

- Professional criteria for clinical privileges must be specified in the medical staff bylaws. At minimum, four core criteria are considered essential to establishing and maintaining a qualified and competent medical staff: verified evidence of current licensure; relevant training or experience; current competence; and physical and mental ability to perform the requested privileges.*
- The granting of clinical privileges must be facility specific for each individual—that is, clinical privileges are based not only on the applicant's qualifications, but also on the care that can be provided within the specific facility. Because an organization may credential its practitioners for several facilities within the organization that offer varying services, a practitioner's clinical privileges must clearly specify the site for which privileges are granted. For instance, an acute care hospital may also have the equipment to support bariatric surgery within the main hospital but not at its off-site ambulatory surgery center.

* It is assumed that non-competency-based criteria, such as proximity of a physician's office to the hospital, was reviewed for compliance before this phase of the review process.

- The decision to grant a particular clinical privilege must be based on the practitioner's specific relevant training and successful results in performing the requested privilege. Evaluation of this information, obtained from primary sources for initial applicants and from facility data for reappointments, should be documented.** For an example of a reappointment clinical evaluation form, see "Sample Form: Evaluation of Clinical Competency for Reappointment." For more information on the methods of delineating privileges, see "Core Versus Laundry List Privileges."
- Recommendations from the applicant's peers, departments, and specialty must be considered when reviewing clinical privilege requests.
- The process for delineating clinical privileges must be described to each applicant.
- There must be a mechanism by which to include limitations on an individual's delineation of clinical privileges. For example, a practitioner may have privileges to perform a laparoscopic cystectomy *only* if he or she is accompanied and proctored by a physician currently fully credentialed to perform that procedure. This limitation must be documented and communicated to all necessary parties.
- The lists (also called delineations) of clinical privileges offered at a facility must be approved by the governing body and in accordance with the governing body and medical staff bylaws, rules and regulations, and policies.
- Each clinical department must develop its own criteria for recommending privileges.
- Medical staff bylaws, rules and regulations, and policies must define the information to be provided by each applicant to determine competency.
- A mechanism must be established to ensure that individuals provide services within the scope of their clinical privileges. This should include a system of communicating in a timely manner all approved or revoked privileges to the practitioner, the department chairperson, all patient care areas, and nursing supervisors.

(continued on page 13)

** As noted previously, if facility data is not available for evaluation when a practitioner applies for reappointment or returns from a leave of absence, information regarding the practitioner's activity and clinical competency must be obtained from other sources, including the department chair of another facility where the practitioner works or a commanding officer if the practitioner has returned from a tour of military duty.

Sample Form: Evaluation of Clinical Competency for Reappointment

Editor's Note: The performance improvement review indices suggested in this chart are based on recommendations made by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO requires that practitioner reappointment data evaluations include facility, department, and/or specialty aggregate data. Risk managers are advised to consult with their facility's performance-improvement and quality-assurance programs when developing a reappointment clinical competency evaluation form to determine and communicate the methods used for tracking, reporting, and comparing data. It is important that the individuals using this data for credentialing purposes understand and approve of the methods used. For instance, pharmacologic review may consider issues such as appropriateness of prescriptions, illegible handwriting, and illegal use of abbreviations. Incident reports may be defined as actions or reports submitted to the state and/or National Practitioner Data Bank, but not as verbal complaints received from a safety hotline.

Practitioner name: _____

Department: _____

Specialty: _____

Date of initial appointment: _____

Last reappointment: _____

I have reviewed this practitioner's quality-assurance data and: (check one)

Recommend approval of this reappointment

Recommend further review of the following issues

Do not recommend approval of this reappointment at this time

Department chairperson

Signature: _____

Date: _____

Discharges	
Consults	
Referrals	

	Required	Attended
Meeting attendance		

	Pending	Dismissed	Settled/\$
Claims history			

	Total	Verbal counsel	Written warning	Restrictions applied
Incident reports				

	Number of practitioner charts re-viewed/total	Practitioner deficiency rate	Department aggregate deficiency rate
Pharmacologic review			
Operative procedure review			
Blood usage review			
Medical record review			
Mortality review			
Infection review			
Utilization review			

(continued from page 11)

- Individuals' credentials files must indicate that criteria are uniformly applied.

Competency criteria for new technology. The rapid introduction of new technologies and procedures into surgery and medicine requires facilities to establish appropriate mechanisms for ensuring that practitioners use these new technologies and procedures appropriately and effectively. Ensuring competence for new procedures is particularly urgent because of the potential for sudden and often serious injury.

For example, consider the issues accompanying the sharp rise in the number of surgeons performing bariatric surgery. The total number of bariatric surgery procedures performed in the United States in 1992 was 16,000. It is estimated that in 2002, 60,000 of these procedures were performed and that in 10 years, bariatric procedures will be the most common surgeries performed in the United States. As a consequence of market demand, more practitioners are requesting bariatric surgery privileges.

Bariatric surgery is usually performed laparoscopically, and the short- and long-term complications can be numerous and serious. While the surgery is risky for the patient, the procedure is also risky for facilities. In addition to physician technical proficiency issues, there are potential liabilities for facilities.

When developing clinical competency criteria for bariatric surgery, facilities must consider the surgeon's technical skill, his or her patient screening and selection process and follow-up care protocols, and the required facility equipment (e.g., operating tables, diagnostic radiology equipment) and skilled staffing (e.g., staff that shows knowledge of obese patient ambulation and difficult ventilator and respirator support). For further information on bariatric surgery, refer to the *HRC Risk Analysis* titled "Bariatric Surgery."

Before considering requests for clinical privileges for new procedures or technology, healthcare facilities should assess and document the facility's capacity to support the procedure or technology, as well as the physician's competence (both technical and cognitive skills) to perform the new procedure.

Additionally, periodic review of competency criteria should be performed by the medical staff. Specialty organizations are a good source to consult for guidelines and statements for clinical privileges.

Some medical specialty and other organizations recommend the establishment of a multidisciplinary committee to advise credentialing bodies on the initial

Core Versus Laundry List Privileges

There is an ongoing debate about the best method to delineate privileges for practitioners. The approaches currently in use are "core privileging," "laundry list privileging," or a combination of the two approaches. The laundry list method requires the practitioner to request each procedure or therapeutic process individually. Core privileging is a method used to define groups of clinical privileges for which practitioners may apply.

An unacceptable example of core privileging would be to delineate "general surgical laparoscopic privileges" as a group. Because each laparoscopic privilege requires a different set of skills and knowledge, each procedure (e.g., laparoscopic appendectomy, laparoscopic cholecystectomy, and laparoscopic bariatric surgery) should be evaluated separately.

The Centers for Medicare & Medicaid Services (CMS) addressed the issue of core privileges in a letter to its surveyors dated November 12, 2004, noting that the specific procedures within each set of core privileges must be clearly and completely listed, that the practitioner's ability to perform each procedure must be assessed and not assumed, and that those procedures for which the applicant is not competent must be removed from the group.

The Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) elements of performance for its Medical Staff standard require that the determination of an applicant's competency include verification of his or her "specific relevant training" (MS.4.10). As of April 1, 2005, JCAHO had not released a clarification of core privileges in response to the CMS letter.



granting of privileges, monitoring of performance, and renewal of privileges. ECRI, for example, recommends that a laser safety committee help to establish criteria for delineation of laser privileges, review applications for laser privileges, and make recommendations to the responsible credentialing committee. For further information on laser privileges, please refer to the *HRC Risk Analysis* titled "Laser Use and Safety."

Cross-specialty privileging. When developing criteria for procedures that will be performed across multiple specialties, it is important that the governing body is confident that the medical staff has reviewed the recommendations for competency criteria with the appropriate certification board from each specialty. Conflicts in developing criteria across specialties are highlighted

Sample Privilege Request Form

Editor's Note: Practitioners occasionally decide to request additional privileges during an appointment period. Below is a form that can be completed by the practitioner and used by the credentialing body to review and document the practitioner's clinical competency for the requested clinical privilege. It is advised that only one procedure or method of treatment be used per form.

Practitioner to complete this section:

Date: _____

Practitioner: _____

Department: _____ Specialty: _____

Medical staff member status: _____

Privilege requested: _____

Documentation of competency submitted:

- Certification from accredited training facility
- Operative reports
- Letter from current preceptor _____
- Letter from residency or fellowship director

I hereby attest that I possess the skills and expertise necessary to perform the above additional privileges.

Practitioner signature: _____

Date: _____

Department chairman to complete this section:

Quality assurance indices reviewed:

- External review of proficiency requirements from appropriate college or society
- Infection rate
- Mortality rate
- Readmission rate

Recommendation for approval of this privilege is granted by:

Specialty Section Chief:
 _____ Date: _____

Department Chair:
 _____ Date: _____

Credentials Chair:
 _____ Date: _____

Medical Executive Chair:
 _____ Date: _____

Approval of this privilege is granted by:

Board of Director Chair:
 _____ Date: _____

by the "turf wars" regarding carotid stenting procedures performed by neurosurgeons and interventional cardiologists. As of November 2004, the American Association of Neurological Surgeons recommends that physicians perform six months of formal cognitive neuroscience training and 100 diagnostic cervicocerebral angiograms to qualify for training for the placement of carotid stents.⁴¹ By contrast, the American College of Cardiology, as of August 2004, recommends that physicians complete a certification course sponsored by a carotid stent manufacturer and perform 30 diagnostic cervicocerebral angiograms.⁴²

When developing competency criteria for clinical privileges, it is important to include a method of documenting clinical competency in the practitioner's file. (For an example of a request form that includes a method of documenting materials used to determine competency, see "Sample Privilege Request Form.")

Evaluation of skills. Facilities should not be concerned that they are being overly stringent in their process for evaluating a practitioner's clinical skills and knowledge, as long as the process is applied consistently and fairly to all applicants. The process of determining the competency of practitioners for new technologies should include the following:

- Establishing competency criteria, considering the recommendations of specialty societies
- Requiring physicians seeking privileges for new technologies to attend and provide evidence of successfully completing training courses and then to be proctored for a specific number of cases before obtaining full and unrestricted privileges (Proctorship is the observation of the applicant by a practitioner currently approved to perform the requested privileges. For more information on proctoring, see the HRC Risk Analysis titled "Proctoring.")
- Developing quality assurance programs to monitor competence as part of the recredentialing process (This can help identify individuals whose skills fall below the accepted level of competence through disuse, inadequate training, or personal impairment.)
- Using the services of an independent credentialing expert when needed, as discussed elsewhere in this Risk Analysis

Communication technology. Telemedicine, or the use of electronic communication or other communication technologies to provide or support clinical care at a distance, has become more commonplace. JCAHO standard MS.4.120 addresses the credentialing and

privileging of licensed independent practitioners who diagnose or treat patients via telemedicine. The standard requires practitioners who prescribe, diagnose, or otherwise provide clinical treatment to a patient via telemedicine to be subject to the credentialing and privileging processes of the organization that receives the telemedicine service. Facilities may use credentialing information from another JCAHO-accredited facility as long as the decision to approve clinical privileges is made at the facility that receives the telemedicine service.

Committee Review and Final Decision

Department chairperson review. The appropriate department chairperson or division chief is responsible for reviewing the application objectively and for assessing and recommending in writing a delineation of clinical privileges for the practitioner based on his or her review of the credentials file and interview with the applicant.

Documents submitted by medical staff members regarding an applicant, or any such comments or any relevant information pertaining to the applicant, should be included in this file. It is important to note that medical staff members providing guidance to the facility regarding applicant clinical competency are protected by the immunity provisions in HCQIA only if they can prove that their actions were performed in good faith. For chairs, division chiefs, and committee members, acting in good faith includes making a fully informed and considered decision based on a review of the entire credentials file.⁴³

Credentials committee review. Once the information contained within the application has been verified by the medical staff office and reviewed by the department chairperson, the credentials committee is required to review the applicant's entire credentials file as well as the department chairperson's recommendation. Copies of any correspondence or other communication between the medical staff office and the applicant, references, or other organizations or entities verifying information should be included in this file. JCAHO requires that this process be completed within a specific time frame outlined within the medical staff bylaws.⁴⁴

The credentials committee conducts a competency-based review for the purpose of determining an applicant's ability to provide patient care services within the entire scope of clinical privileges requested. Criteria used in making this determination might include a specified number of procedures performed and their outcome, review of surgical and other invasive

procedures, drug and blood usage reviews, mortality rates, utilization review and risk management data, and medical records reviews. JCAHO guidelines recommend assessing (at minimum) the number and types of surgical procedures performed by the applicant as the surgeon of record or the number and types of medical conditions managed, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes. The applicant's clinical judgment and technical skills are also assessed.⁴⁵

The credentials committee's report should provide a recommendation that the applicant's request for membership and/or clinical privileges be provisionally approved or rejected or, if further clarification or documentation is needed, that the application be deferred for future consideration.⁴⁶

Medical executive committee review. The medical executive committee is responsible for reviewing the entire credentials file and reports of the credentials committee and department chairperson; the committee may also interview the applicant. The medical executive committee must then formulate and document its independent recommendation to the governing body to either deny or accept the application.

Governing body decision. The governing body has the final responsibility for granting or denying medical staff appointment or specific clinical privileges. While the actual process of review up until this point may have been delegated to the medical staff, it is not the board's function to rubber-stamp the recommendation made by the medical staff. Rather, it must review the credentials file, statements, and recommendations made by the department chairperson and medical staff committees and come to an independent decision taking into account its fiduciary and civic responsibility to provide a full range of quality services to the community. The rationale for each staff appointment or clinical privilege decision should be documented in the facility board minutes.

Due Process

Due-process provisions for credentialing should be contained in the medical staff bylaws and provided to every applicant. These provisions include documenting all phases of the credentialing process, specifying time frames during which various steps in the process must be completed, and establishing procedures for a fair hearing in the event of adverse decisions or recommendations. If a new applicant is denied privileges

or a current staff member is denied reappointment, he or she must be able to discover the basis for the denial and have the opportunity to contest it. If the practitioner has been the subject of a peer or focused review, all processes for reviewing the practitioner's competency must be performed in accordance with the facility's medical staff bylaws and JCAHO standard MS.4.90.

If the activities of the credentials committee or medical executive committee are not documented, or if secret or sealed voting takes place, the facility risks legal challenges on the basis of arbitrary or discriminatory action. Because facilities must report a competency-based denial of medical staff membership or revocation of a clinical privilege to NPDB, physicians' ability to obtain staff membership and/or clinical privileges elsewhere may be affected. Arguably, this might increase the likelihood that physicians will challenge the denial of a medical staff appointment, reappointment, or clinical privileges.⁴⁷

To ensure that the medical staff is aware of and accountable for the administration of the credentialing process, element of performance number 19 of JCAHO standard MS.1.20 requires that all policies and procedures related to credentialing and due process for credentialing grievances be reviewed and approved by the medical staff.⁴⁸ However, this element has been the subject of debate, and implementation of this standard has been delayed until January 2007.

Exceptions to the Credentialing Process

External Peer Review of Applications and Privileges

If it appears that a chairperson or division chief would be unable or unwilling to objectively assess an applicant's qualifications or a currently credentialed practitioner's competency, the facility should consider seeking an independent credentialing expert.⁴⁹ (For more information, see "Retaining an Independent Credentialing Expert.")

The recent verdict against a hospital in *Poliner v. Texas Health Systems* highlights the need for governing bodies to be wary of actions and recommendations from the medical staff that could be determined to be anticompetitive in nature.

In 1998, Texas Health Systems suspended cardiologist Lawrence Poliner's clinical privileges to perform heart procedures when the chairman for the department of internal medicine, the chief of cardiology, and the director of the catheterization laboratory claimed that the quality of Poliner's care posed a risk to the

Retaining an Independent Credentialing Expert

The following guidelines are useful in retaining an independent credentialing expert:

- Delegate the responsibility of retaining an expert to an impartial hospital employee, such as the medical staff coordinator.
- Require that the credentials and objectivity of the expert are beyond reproach.
- Negotiate a contract with the expert that includes an agreement by the hospital to indemnify the expert for any good-faith peer-review actions undertaken.
- Negotiate an agreement that the expert agree to issue a written report and to testify, if necessary, at any intrafacility hearing proceeding and/or any subsequent civil deposition or trial.

Source: Peters BM, Maneval WC. Medical staff membership criteria: a credentialing minefield. *Med Staff Couns* 1991 Summer;5(3):1-10.



hospital's patients. Poliner subsequently sued the hospital, claiming that the removal of his privileges was not based on quality-of-care issues but on "economic politics and personal dislike." On August 27, 2004, a jury found Texas Health Systems liable for \$366 million for defamation and breach of contract.⁵⁰ HRC recommends retaining an independent credentialing expert for peer or focused review consultation for the following situations:

- Staff members cannot objectively investigate and review the activities of a current credentialed practitioner or department chairperson.
- A fair and impartial peer review of a new applicant's professional performance is impossible because other staff members are direct competitors of the applicant or because personal or professional animosity exists between the applicant and his or her peers.
- There are too few physicians on staff with the professional expertise to properly evaluate the applicant (e.g., when a new service is being offered by the facility, when a physician with highly specialized training has applied for clinical privileges).
- A facility needs to evaluate a physician who has no certification in a particular specialty but has background and experience that require evaluation by independent peers.

Temporary Privileges

When appropriate, the facility may authorize temporary or short-term privileges to licensed independent practitioners when there is an emergent patient care need that would not be met in a timely manner if the application proceeded through the normal credentialing process. Requests for temporary privileges as outlined in JCAHO standard MS.4.100 must be approached cautiously. The requisite patient care need should be well documented, the period of validity for the privileges must not exceed a period of 120 days, and medical staff bylaws must include a clear statement of the mechanisms for granting such privileges.

JCAHO considers granting temporary clinical privileges acceptable under either of the following circumstances:

1. To fulfill an important patient care need
2. To consider an applicant who has provided a complete, clean application and is awaiting verification from the medical staff office and review and approval by the medical staff executive committee and governing body

When an important patient care need is the reason for granting temporary privileges, the facility's chief executive officer must obtain the recommendation of either the chairperson of the applicable clinical department or the president of the medical staff before granting privileges. The applicant's current licensure and current competence must also be verified before granting temporary privileges, and NPDB must be queried.

HRC recommends that the department chairperson or the president of the medical staff document his or her assessment of the credentials of applicants for temporary privileges and the basis for the recommendation to grant temporary privileges.

The second circumstance that JCAHO finds acceptable for granting temporary privileges occurs when a new applicant who provided a complete application that has been verified, is clean, and is waiting for review and recommendation by the medical staff executive committee and approval by the governing body. Clean applications are defined as those submitted by physicians with no current or previously successful challenge to license or registration, no involuntary termination of membership from a medical staff, and no involuntary limitations, reduction, denials, or losses of clinical privileges at another institution.

Before a facility grants temporary privileges to physicians meeting these criteria, the facility must ensure verification of the following:

- The application is clean, complete, and verified (with proof of current licensure in good standing) and describes the practitioner's relevant training, experience, and current competence.
- The other requirements of the medical staff bylaws have been fulfilled.

In its revised clarification of standard MS.4.100, JCAHO cautions against routinely granting temporary privileges for administrative purposes to cover the gap between expiration of a practitioner's current privileges and the facility's reappointment decision. JCAHO specifically states that delay in verifying physicians' performance data and information is not an acceptable reason for routinely granting temporary clinical or medical staff privileges. JCAHO also states that it is not acceptable to provide temporary privileges to a practitioner who supplies incomplete information on his or her application for reappointment.

Facilities that grant temporary privileges for administrative reasons without completing the usual evaluation of a practitioner's competency and eligibility for staff membership may face charges of discrimination by other practitioners as well as charges of corporate negligence for improper credentialing.

Expedited Privileges

JCAHO recognizes the need to facilitate credentialing practitioners in an organization in which the governing body does not meet monthly to rule on applications and provides for the option of granting expedited privileges in standard MS.4.30. These privileges may be granted to practitioners once the medical executive committee has reviewed and recommended approval of the application but before the application is presented to the governing body. A committee of no less than two voting members of the governing body must be appointed to review and approve the application. These applications are then presented at the next meeting of the governing body, when the committee's decision is ratified. Although allowed by JCAHO, there is currently no case law to support or dissuade facilities from using this process.

Restrictions that apply to applicants eligible for temporary privileges also apply to expedited privileges.

Disaster Privileges

In the aftermath of September 11, 2001, JCAHO developed standard MS.4.110 outlining a provision for facilities, as part of their overall disaster plan, to credential volunteer physicians who are not members of the organization's medical staff in the event that the facility has insufficient staff to meet patient needs during a disaster. This standard allows facilities to establish a mechanism to identify the individuals who will be responsible for granting disaster privileges on a case-by-case basis during the crisis, delineates the type of identification that may be accepted from practitioners as proof of their identity, and mandates that the medical staff office begin the normal credentialing process for temporary privileges as soon as the situation is under control.

ACTION RECOMMENDATIONS

It is recommended that risk managers, in conjunction with legal counsel, do the following:

- Review medical staff bylaws to ensure that the credentialing criteria and process conform to HCQIA provisions, (including appropriate querying of NPDB,) to obtain the limited protection of peer reviewers from antitrust liability granted under the law.
- Review medical staff bylaws to ensure that the credentialing criteria and process for initial appointment, reappointment, and clinical privileges (including temporary, expedited, and disaster privileges) is stated clearly and complies with JCAHO standards, state and federal regulations, and court decisions.
- Ensure that credentialing criteria address the clinical competency of practitioners, affect the provision of high-quality patient care, and/or address the needs of the facility or community. Criteria that are intended to benefit individual practitioners or practitioner groups should not be approved or applied in credentialing decisions.
- Ensure that credentialing criteria addressing economic factors are developed at the level of the governing body and are considered only in consultation with the facility's legal counsel.
- Ensure that peer-review and credentialing processes are conducted in accordance with medical staff bylaws, that the bylaws are made available to all medical staff members and applicants, and that all applicants for initial appointments, reappointments, and/or clinical privileges (including department chairpersons, division chiefs, and medical executive committee members) are treated equally.
- Review medical staff bylaws, policies, and procedures regarding due-process provisions to ensure that practitioners who are denied medical staff membership or have had privileges restricted are afforded a fair hearing in accordance with federal and state laws and facility standards.
- Review the medical staff bylaws to ensure that all credentialed practitioners are required to report to the facility all claims, disciplinary proceedings, or adverse actions taken by other facilities or entities promptly.
- Ensure that all votes pertaining to credentialing are public and documented.
- Ensure that primary source verification or the accepted equivalent is obtained to verify information provided by a practitioner on his or her application.
- Review contracts with CVOs and independent experts to ensure compliance with medical staff bylaws and JCAHO standards.
- Ensure that peer recommendations are received directly from sources who have worked with the practitioner and have no familial or financial relationship with the practitioner and that the recommendation details the practitioner's competence and ability to work well with others.
- Retain an independent credentialing expert when it is not feasible for staff members to objectively investigate and review the professional activities of an applicant or currently credentialed practitioner.
- Ensure that processes have been established and used consistently to determine practitioner competency (including the health status of the practitioner) for clinical privilege requests, especially for new technology and procedures.
- Ensure that all licensed independent practitioners providing telemedicine services within the facility are subject to the organization's medical staff credentialing and privileging processes.
- Ensure that the medical staff reviews individual and department aggregate risk management data and performance-improvement activities when considering whether to renew or revise clinical privileges.
- Ensure that there is a facilitywide mechanism for communicating to the practitioner, the department chairperson, all patient care areas, and to nursing supervisors in a timely and effective manner all

privileges that have been granted or revoked from practitioners.

- Ensure that applicants receiving temporary or expedited privileges have clean applications. Clean applications are defined as those submitted by practitioners with no current or previously successful challenge to license or registration, no involuntary termination of membership from a medical staff, and no involuntary limitations, reduction, denials, or losses of clinical privileges at another institution.

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46. Peters BM, Maneval WC, *supra* note 13.
47. *Ibid.*
48. Joint Commission on Accreditation of Healthcare Organizations, *supra* note 8.
49. Peters BM, Maneval WC, *supra* note 13.
50. White N. Surgeon awarded \$366 million for revoked hospital privileges. *Lawyers Wkly USA* 2005 Jan 3:11-2. ◆

Appendix A

Resource List

American Academy of Nurse Practitioners

PO Box 12846
Austin, TX 78711
(512) 442-4262
<http://www.aanp.org>

- Position paper on scope of practice is available online at <http://www.aanp.org>
- Position paper on nurse practitioner curriculum is available online at <http://www.aanp.org>

American Association of Nurse Anesthetists

222 S Prospect Avenue
Park Ridge, Illinois 60068-4001
(847) 692-7050
<http://www.aana.com>

- Paper on the qualifications and capabilities of nurse anesthetists
- State-by-state education requirements for nurse anesthetists are available online at <http://www.aana.com/crna/sga/default.asp>
- Paper on legal issues in nurse anesthetist practice

American Board of Medical Specialties

Suite 404
1007 Church Street
Evanston, IL 60201-5913
(847) 491-9091
<http://www.abms.org>

- Listing of all specialties and subspecialty certifications is available online at <http://www.abms.org/approved.asp>
- Presentation paper on credentialing physician specialists is available online at <http://www.abms.org/Downloads/Conferences/Credentialing/Physician/Specialists.pdf>

American College of Nurse Midwives

Suite 1550
8403 Colesville Road
Silver Spring, MD 20910
(240) 485-1800
<http://www.midwife.org>

- Position papers on scope of practice are available online at <http://www.midwife.org/prof/display.cfm?id=348>

- Position papers on core competence are available online at <http://www.midwife.org/prof/display.cfm?id=137>

American Hospital Association

1 N Franklin Street
Chicago, IL 60606
(312) 422-3000
<http://www.aha.org>

American Medical Association

515 N State Road
Chicago, IL 60610
(800) 621-8335
<http://www.ama-assn.org>

- Searchable database for primary source equivalent verification of schooling, licensure, and board certification for medical doctors and physician assistants

American Osteopathic Association

142 E Ontario Street
Chicago, IL 60611
(800) 621-1773
<http://do-online.osteotech.org/index2.cfm>

- Searchable primary source equivalent database of licensed osteopathic physicians

Centers for Medicare & Medicaid Services

Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244
(877) 267-2323
<http://www.cms.hhs.gov>

- Online manual of standards is available at <http://www.cms.hhs.gov/manuals/cmsindex.asp>

Council of Medical Specialty Societies

Suite M
51 Sherwood Terrace
Lake Bluff, IL 60044
(847) 295-3456
<http://www.cmss.org/>

- Links page to all member medical specialty societies and their standards, policies, and statements on credentialing

Joint Commission on Accreditation of Healthcare Organizations

1 Renaissance Boulevard
Oakbrook Terrace, IL 60181
(630) 792-5600
<http://www.jcaho.org/>

- *Comprehensive Accreditation Manual for Hospitals*

National Association of Medical Staff Services

PO Box 140647
Austin, TX 78714
(512) 454-7928
<http://www.namss.org>

- Credentialing resource page providing links to numerous credentialing and accrediting sources, U.S. medical schools, specialty boards and organizations, licensure boards, and government, regulatory, and legal sources.

National Commission on Certification of Physician Assistants

Suite 200
12000 Findley Road
Duluth, GA 30097
(678) 417-8100

<https://www.nccpa.net/pa/credentialpublic.aspx>

- Searchable database for verification of certification for physician assistants

National Practitioner Data Bank

Healthcare Integrity and Protection Data Bank
PO Box 10832
Chantilly, VA 20153-0832
(800) 767-6732
<http://www.npdb-hipdb.com>

- Searchable database for malpractice claims and disciplinary action history against practitioners
- Online standards and guidelines regarding data bank

Office of Inspector General

Office of Public Affairs
Department of Health and Human Services
Room 5541
Cohen Building
330 Independence Avenue SW
Washington, DC 20201
(202) 619-1343

<http://exclusions.oig.hhs.gov/search.html>

- Searchable database of providers excluded from billing for services to Medicare or Medicaid patients

Additional listings can be found in ECRI's Healthcare Standards Directory, a comprehensive source of healthcare standards guidelines, laws, and regulations. The Directory is available from ECRI.

Appendix B

Case Law

The following are brief summaries of the landmark case law cited in discussions of the legal liability of facilities regarding medical staff credentialing. This summary should be given to the individuals in the facility who are responsible for developing and implementing credentialing policies and procedures. Readers are advised to consult with an attorney for specific legal advice. The law varies from one jurisdiction to another.

I. Hospital Corporate Liability and Governing Body Responsibility for Credentialing

*Darling v. Charleston Community Memorial Hospital*¹

Perhaps the most cited case dealing with hospital responsibility for the practice of an independent practitioner member of its medical staff, *Darling* put forth the notion of hospital corporate liability for negligent selection and retention of medical staff members. It also established that the hospital's bylaws, rules, and regulations, as well as the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), are admissible as evidence at trial to define the hospital's duty of care.

*Gonzalez v. Nork & Mercy Hospital*²

In this case, a decision was made establishing that the hospital has a duty to create a mechanism by which it is able to ascertain the quality of practitioners' performance and a duty to prevent harm to patients when poor performance is noted. The hospital board's corporate duty to review practitioner performance is in no way reduced because it was delegated to the medical staff (see *Purcell* below).

*Purcell and Tucson General Hospital v. Zimbalman*³

In this case, the court decided that a hospital could not escape liability simply because it had fulfilled its duty to establish a review mechanism and that the mechanism must be used to take action against practitioners whose lack of skill is apparent.

*Johnson v. Misericordia Community Hospital*⁴

In this case, Wisconsin's highest court ruled that a hospital was liable for injuries caused by an unqualified physician for whom the facility had negligently granted orthopedic privileges. The court ruled that the hospital had contributed to the patient's injury simply

by allowing the physician to have staff privileges and that hospitals have a moral and legal duty to properly review a physician's credentials upon application to the medical staff.

*Elam v. College Park Hospital*⁵

In this case, a California court affirmed a hospital's duty to both select and review staff physicians adequately. A hospital that fails to perform these duties satisfactorily may be held liable for the malpractice of independent physicians, even though these physicians are neither employees nor agents of the hospital.

*Thompson v. Nason Hospital*⁶

In this case, the Pennsylvania Supreme Court adopted the doctrine of corporate negligence, under which a hospital is liable if it fails to uphold the proper standard of care owed to its patients. The court also recognized the following four duties that a hospital owes its patients:

- A duty to use reasonable care in the maintenance of safe and adequate facilities and equipment
- A duty to select and retain only competent physicians
- A duty to oversee all individuals who practice medicine within its walls
- A duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care for patients

However, the court limited application of the doctrine to circumstances in which the hospital had actual or constructive knowledge of the defect and in which the facility's negligence was a substantial factor in harming the patient.

II. Antitrust

*Jefferson Parish Hospital District No. 2 v. Hyde*⁷

This case addressed whether a contract under which a single group of anesthesiologists provided exclusive anesthesia services to a hospital was an illegal "tie-in" under the Sherman Act because all patients undergoing surgery at the hospital were required to use the services of the anesthesiologists.

On appeal, the U.S. Supreme Court held that physicians attempting to gain admission to the hospital's medical staff could be denied membership under the terms of an existing exclusive agreement. The contract

did not violate the Sherman Act because there was no evidence that the market as a whole had been affected by the arrangement, and thus, no restraint on competition could be proven.

Weiss v. York Hospital,⁸ *Patrick v. Burget*,⁹ and *Poliner v. Texas Health Systems*^{10,11}

In these cases, the courts determined that denial or termination of medical staff appointment or privileges based on economic factors that give advantages to current medical staff members by eliminating competitors—not based on concerns regarding quality of care, behavior problems, or legitimate objectives of the hospital—is a violation of antitrust laws.

III. Due Process

Each of these cases dealt with the right to a fair hearing and reasonable notice of charges of professional deficiencies or misconduct before the hearing.

*Klinge v. Lutheran Charities Association of St. Louis*¹²

In this case, the court found that the plaintiff had adequate notice of the charges against him and that the panel hearing the charges could do so objectively, even though it was composed only of medical staff members of the defendant hospital.

*Poe v. Charlotte Memorial Hospital, Inc.*¹³

In this case, the court ordered a physician to be reinstated to the medical staff pending a hearing on the merits of the denial of reappointment to the medical staff and renewal of clinical privileges. The plaintiff was not notified of the action until it had been approved by the governing body of the hospital. The court found that no emergency existed in which the practitioner had to be quickly removed to protect patients who might be harmed as a result of incompetence. The court ruled that the plaintiff was entitled to adequate notice and the right to appear and be heard.

*Bock v. John C. Lincoln Hospital*¹⁴

In this case, the court found that providing only one day's notice of a hearing was fundamentally unfair

because it leaves the physician unprepared to challenge accusations brought against him or her.

*In re Zaman*¹⁵

The Supreme Court of South Carolina ruled that a physician's due-process rights were violated when a hospital terminated his medical staff privileges because one of the hospital committees that reviewed the case included biased physicians who had initiated the termination proceedings.

Notes

1. *Darling v. Charleston Community Memorial Hospital*, 211 N.E.2d 253 (Ill.1965).
2. *Gonzalez v. Nork and Mercy Hospital* No. 228566 (Cal. Super. Ct. Nov. 19, 1973), *rev'd on other grounds*, 131 Cal.Rptr. 717 (Ct. App. 1976), *aff'd and transferred*, 143 Cal. Rptr. 240 (Sup. Ct. 1978).
3. *Purcell and Tucson General Hospital v. Zimbalman*, 500 P.2d 335 (Ariz. App. 1972).
4. *Johnson v. Misericordia Community Hospital*, 301 N.W.2d 156 (Wis. 1981).
5. *Elam v. College Park Hospital*, 183 Cal. Rptr. 156 (Cal. Ct. App. 1982).
6. *Thompson v. Nason Hospital*, 591 A.2d 703 (Pa.1991).
7. *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2 (1984).
8. *Weiss v. York Hospital*, 745 F.2d 786 (3rd Cir. 1984).
9. *Patrick v. Burget*, 108 S.Ct. 1658 (1988).
10. *Poliner v. Texas Health Systems*, N.D. Tex. 3-00-CV-1007-D (2004).
11. White N. Surgeon awarded \$366 million for revoked hospital privileges. *Lawyers Wkly USA* 2005 Jan 3:11-2.
12. *Klinge v. Lutheran Charities Association of St. Louis*, 523 F.2d 56 (8th Cir. 1975).
13. *Poe v. Charlotte Memorial Hospital, Inc.*, 374 F.Supp. 1302 (W.D.N.C. 1974).
14. *Bock v. John C. Lincoln Hosp.*, 702 P.2d 253 (Ariz. Ct. App. 1985).
15. *In re Zaman*, 329 S.E.2d 436 (S.C. 1985).

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