Credentialing, Privileging, & Patient Safety
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Commentary: An Opportunity to Identify Fundamental Risks

by John L. McCarth

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For a long part of the history of modern medicine, the mention of credentialing and privileging a physician conjured images of paper stacks, rubber stamps, and file cabinets. Every couple of years, someone would make sure the new stack of papers were in order, stamp them, and add them to the file cabinet. The process often was perfunctory—frequently political—but infrequently rigorous. Those in a position to authorize (or reauthorize) a physician’s appointment were reluctant to mount a challenge against a substandard candidate—a potential legal quagmire—and simply followed the path of least resistance. Every so often, the newspapers would chronicle patient tragedies linked to a clinician who should never have been practicing medicine. Hospital leaders would dismiss those as unavoidable circumstances: bad apples who cheated the system.

Competition and the burgeoning patient safety movement now demand a different response from the entities that credential and privilege physicians. Safety and quality improvements cannot be solely assigned to systems. The individual providers operating those systems have to be ascertainably competent to practice as privileged, and need to keep pace with advances in diagnosis and treatment. Institutions that still perceive credentialing and privileging as mechanical, rather than essential, undervalue it. The process of verifying and assessing a physician’s background, experience, and skills provides an unparalleled opportunity to identify fundamental risks in the care continuum.

In reality, however, the culture of many hospitals inhibits an effective, results-oriented, approach to credentialing and privileging. Centralized or uniform credentialing is an unrealized concept, and each department has its own unique privileging process. More stacks of paper, more file cabinets, but less certainty for patients that their care is being provided by a clinician adequately experienced and trained to be providing it.

The Expanding Roof

Aside from doing a more consistent job of weeding out the providers who should not be practicing under their roofs (or who should be closely monitored) health care entities may also need to up the ante for privileges. The one size fits all model that pools, for example, all surgical procedures under one check box is outdated. Specific procedures, settings, or populations may need specific privileging—and that certainly needs to be linked to continuing education and training. Some specialty societies have taken a step in this direction by granting time-limited board certification. Hospitals would do well to follow suit by linking privileging to lifelong training. Those clinicians who acquire and maintain appropriate skills are less of a liability; those who are unwilling or unable to stay adequately qualified will reduce their practice or move on; the patient population will shift to fully qualified providers.

Patients assume and expect that each person they encounter under a health care institution’s roof has been deemed competent by that institution. In the Harvard system, more than 20 percent of hospital-based care (and a significant portion of crico claims and losses) involves residents. Can we guarantee that their skills have been sufficiently developed for much of the independent care they provide? How do we accommodate for the fact that a physician can complete his or her entire residency without ever encountering a sizeable list of common patient presentations, then go into private practice? Some level of standardization and competency requirement seems necessary, and crico/rmf is working with the teaching hospitals to address this concern.

More than a third of crico-insured physicians practice in an office setting—the “roof” now covers a much broader expanse. More than half of crico malpractice claims stem from outpatient care, and many of those involve an inadequate diagnostic process that began in the doctor’s office. Patients being seen by a physician affiliated with Hospital X Medical Associates (and then transferred to Hospital X) are likely to assume that Hospital X has credentialed that physician—and to hold that hospital partially accountable if that physician’s care is negligent. Hospital X may need to pay closer attention to what’s going on “out there.”

Payors and patients are having their say, too. Pay for performance, physician report cards, and quality databases all signal a growing insight into what is important from a quality standpoint. The good news is that some hospitals and specialty groups have begun to retool credentialing and privileging in a way that capitalizes the opportunity those processes present. Mount Auburn Hospital has turned a tragic event—a public relations nightmare—into the turning point for a major overhaul in the appointment process (see Page 6). The American College of Surgeons is working on more rigorous standards and many institutions are approaching physician assessment and training as an ongoing responsibility to be coordinated with credentialing and privileging. crico/rmf is working with a number of specialties (e.g., obstetrics, anesthesia, internal medicine) through programs that offer premium reduction incentives linked to ongoing training programs. Most importantly, hospital boards of directors are seeing credentialing as a form of governance and oversight requiring their active involvement.
M\textit{i}chael Swango graduated from Southern Illinois University Medical School in the early 1980s. Because he lied during the credentialing process, the two residency programs that accepted Dr. Swango did not know he had been convicted of aggravated assault and had had his medical license suspended in two different states. Had the schools verified the events surrounding his conviction, they might have discovered that he had been convicted of poisoning coworkers. Eventually, Swango was dismissed from both schools and moved outside of the United States. When he tried reentering the country, he was arrested for having falsified information. Suspected of having killed up to 60 people, Dr. Swango was ultimately sentenced to three life terms for murdering three patients by lethal injection.\textsuperscript{1}

When we hear horrendous stories of physicians or other health care workers hurting or killing their patients, our first response is one of horror. Our first question is, how could the hospital let this happen—let this person practice within its walls? Credentialing experts estimate that approximately seven percent of physician applications contain some falsification.\textsuperscript{1} Another concern are physicians, such as “Dr. Green” in the case study on Page 19, who exhibit behavior patterns that may indicate a potential risk to patient safety.

Credentialing and privileging serve to ensure that patients receive safe high quality care from providers with appropriate skill, training, and experience. Unfortunately, some clinicians seeking privileges (even the most well-intentioned) fall outside those criteria. The American Medical Association’s online newsletter recently quoted an expert who estimated that “one-third of all physicians will have a condition that impairs their ability to practice medicine safely, putting patients in harm’s way…” at some point in their careers.\textsuperscript{1} In that same article, patient safety expert and adjunct professor of health policy at the Harvard School of Public Health, Dr. Lucian L. Leape, said he sees systems problems related to physicians whose performances are not where they ought to be. “We don’t have good methods for identifying them, and we don’t have good resources for getting them rehabilitated,” said Leape. “The problem isn’t the sensational cases you read about in the newspaper. It’s really good doctors who are slipping for understandable and human reasons.”\textsuperscript{3}

\textbf{A Universal Hassle}

Getting applicants to complete and submit the various forms is a universal hassle. Physicians face the fact that they are being asked to provide the same information to multiple entities, often in multiple formats. For example, a physician with admitting privileges at two hospitals and contracting with four managed care organizations (MCOs) has to go through six credentialing processes. On top of that, she must provide information for periodic credentialing by the state licensing boards and her malpractice insurer. With different renewal periods, it’s quite likely that she will feel like this time-consuming process is never ending.\textsuperscript{1} Some states are working on requiring the use of a common credentialing form, while others are trying to establish a centralized credentialing database; none is there yet.

Another barrier is verifying the data received. As Gwen Gilchrist points out (see Page 5), locating the correct contact information for the primary sources needing to be verified (such as schools, former employers, or malpractice insurers) who may change their names, move, or go out of business can be almost impossible.

And finally, hospitals have long grappled with having thorough and consistent performance data available to assist in evaluating physician performance. Some data are easier to capture than others. For example, volume data such as admissions, surgeries, deaths, and length of stay, are objective and fairly easy to retrieve consistently. Other data, which look more closely at the quality of care, are more subjective and difficult to obtain.

\textbf{Opportunities}

This issue of \textit{Forum} presents Jeanette Clough’s story behind a hospital that experienced a sentinel event which, in retrospect, may have been averted with a more robust credentialing and privileging process (see Page 6). The many changes that institution put into place to mitigate future risk—and to ensure a qualified medical staff to care for its patients and community—are tools that other institutions may want to imitate.

Credentialing, recredentialing, and privileging present challenges to all health care institutions, not just those working to shore up the infrastructure. Our authors explore several of these problems, and their solutions:

\textbf{Dr. Mona Sigal} and \textbf{Sally DiGennaro} describe how their emergency department has been working closely with the North Shore Medical Center’s performance improvement team to tackle the issue of incorporating performance data into department-level credentialing and privileging processes (see Page 18). The key factors for success have been leadership and physician buy-in.

Being sure that physicians are keeping pace with rapidly changing medical knowledge and technology is the topic that surgeon \textbf{Dr. Donald Moorman} takes a look at (see Page 9). Dr. Moorman suggests that keeping up with medical advances requires a multifaceted approach.\textbf{ Dr. Christine Cassel}

\textit{Continued on next page}
Dr. Eric Holmboe, of the American Board of Internal Medicine believe one of those facets is board certification, especially for less experienced physicians (see Page 11). But, because a one-time certification cannot ensure a physician’s ongoing competency, some specialty boards are now also requiring a maintenance of certification program which will reassess the physician’s competency periodically.

The question of age, i.e., how a physician’s knowledge and skills may change over time, is also addressed by attorney Susan Lapenta, who discusses some of the difficulties in credentialing/privileging older physicians (see Page 13). She explores the relationship between performance and years of practice, as well as some practical solutions to this potential credentialing dilemma.

Unfortunately, even an honest, well-trained, and thoroughly experienced physician with no malpractice claims can pose a problem when he or she acts inappropriately (e.g., yelling at staff, throwing things, consciously neglecting to answer pages). The question of how such behavior should be dealt with, on both individual and systemic levels, is explored by Elizabeth Becker and Dr. William Norcross (see Page 15). Their work through the University of California’s PACE program offers options in between tolerate and terminate.

Future Concerns

As CRICO/RMF president and CEO, Jack McCarthy, points out in his Commentary (see Page i), most credentialing and privileging takes place within inpatient institutions, but most health care begins in outpatient settings. As a result, malpractice insurers cannot always be certain that underwriting is aligned with actual practice. Although this has not been a major liability issue to date, Mount Auburn Hospital CEO, Jeanette Clough, expresses a growing concern “…we are entering into an era where many of the primary care/attending physicians care for their patients outside the hospital, leaving much of the inpatient care to the hospitalists and intensivists. The question for hospitals credentialing these physicians is: how do you evaluate the quality of care they render outside the walls of their institutions?”

Notes and References

1 ECRI: HRC Volume 3: Risk Analysis: Medical Staff Credentialing, p. 1
3 The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires hospitals to recredential physicians every two years. The National Committee for Quality Assurance (NCQA) requires MCOs to recredential contracting physicians, at least, every three years.
CRICO/RMF

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Reviewing, Verifying, and Evaluating Credentials

by Deborah LaValley, BSN, RN, CPHQ

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Credentials are “documents showing that a person is entitled to confidence” and a privilege is “something special one is allowed to have, be, or do.” In health care, these definitions become a little more refined. For example, the American Society of Addiction Medicine (ASAM) defines credentialing as the process of:

“reviewing, verifying, and evaluating a practitioner’s credentials (i.e., professional education, clinical training, licensure, board and other certification, clinical experience, letters of reference, other professional qualifications, and disciplinary actions) to establish the presence of the specialized professional background required for membership, affiliation, or a position within a health care organization or system. The result of credentialing is that a practitioner is granted membership in a medical staff or provider panel.”

ASAM defines privileging as the process of:

“determining a health care professional’s current skill and competence to perform specific diagnostic or therapeutic procedures that the professional requests to perform as a participant in, or an affiliate of, a health care facility or system. The result of privileging is that a practitioner is permitted by a health care organization or network to conduct those specific procedures.”

Credentialing and privileging help ensure that patients receive appropriate care, treatment, and services from truly qualified and competent practitioners. Perhaps less compelling to the public, diligent credentialing and privileging protects health care facilities from being sued for patient injuries stemming from care provided by an unqualified clinician practicing under their auspices. In 1965, a landmark decision (Darling vs. Charlestown Community Memorial Hospital) established that health care facilities “can 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.”

Many licensing, regulatory and accreditation agencies have a say in the credentialing of health care providers, including:

- Centers for Medicare and Medicaid Services (CMS)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- National Committee for Quality Assurance (NCQA)
- State agencies
- URAC (a.k.a. American Accreditation HealthCare Commission)
- Accreditation Association for Ambulatory Health Care
- United States Department of Health and Human Services
- United States Government Accountability Office

While they all have similar credentialing requirements; each has some modifications. For instance, JCAHO requires that health care facilities privilege practitioners as well as credential them; NCQA does not require health plans to privilege practitioners. JCAHO requires practitioners to supply peer references. NCQA allows for a triennial credentialing cycle; JCAHO requires two-year renewals.

The Process

Credentialing/privileging functions follow a formal, documented process. Each institution’s rules and regulations and medical staff bylaws must specify (and uniformly apply) the criteria and procedures for granting admission to the medical staff, renewing of appointments, and granting clinical privileges.

In general, the process involves three phases:

1. Pre-application

To determine whether or not the applicant is eligible to receive an application, the institution requests basic, objective information (e.g., name and address, education history, evidence of malpractice coverage, and current medical license) which can be used.

2. Competency evaluation

Eligible candidates must complete a full application, which includes:

- Education history
- Current medical license(s)
- Board certification(s)
- Prior hospital affiliations
- Work experience
- Military experience
- Letter of health status
- Malpractice insurance coverage and claims history
- Disciplinary actions taken by other hospitals
- References from previous department chairpersons or divisional chiefs and others who have recent knowledge of the applicant’s clinical work
- Previously successful or currently pending challenges to any licensure or registration or voluntary relinquishment of licensure or registration
- Voluntary or involuntary terminations of medical staff membership or voluntary or involuntary limitations, reduction, or loss of clinical privileges at another hospital

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Any suspension of participation in the Medicare and Medicaid programs or any other third-party payer program
Delineated list of all privileges requested
Current photo (for initial applicants)
Attestation that the practitioner has received, read, and agrees to abide by the medical staff and hospital bylaws and the department rules and regulations
Attestation that the practitioner has completed all CME credits needed to retain a valid state medical license (for reappointments)
Attestation that the practitioner is board certified or will meet (facility-specified) certification requirements following graduation from residency or fellowship training
Authorization 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.\(^5\)

Obviously, completing credentialing/privileging applications can be long and tedious; information can be easily forgotten or omitted. Nevertheless, the burden of proof should be on the applicant, not the institution, to provide all the information needed to establish that he/she is qualified for staff membership and/or specific clinical privileges. This includes completing and submitting the application in a timely manner. While this may sound straightforward, some health care institutions feel pressured to push through incomplete or inadequate applications in order to provide a particular service to patients or coverage for other physicians. But today’s rushed approval can become tomorrow’s big problem, leaving the accommodating facility vulnerable to allegations that it was party to patient harm caused by an unqualified clinician.

Once a candidate has completed the application, then the institution has to verify that 1) the person applying is indeed the same person identified in the credentialing documents, 2) the applicant has attained the credentials as stated, 3) his/her credentials are current, and 4) there are no challenges to any of the credentials.\(^6\) JCAHO and NCQA require that much of the information undergo primary verification (i.e., verification obtained directly from the original source or from a credentials verification organization). For example, licensure must be verified by the state, board certification via the specialty certifying boards, education via letters from professional schools, and completion of training via letters from residency or postdoctoral programs.

The Healthcare Quality Improvement Act of 1986, requires that health care facilities query the National Practitioner Data Bank (NPDB) when credentialing practitioners. The NPDB houses information from multiple sources regarding medical malpractice payments and adverse actions taken against the practitioner related to professional competency and conduct (i.e., licensing actions, clinical privilege actions, professional society membership actions, Medicare and Medicaid exclusions, and Drug Enforcement Administration actions).\(^7\)

Another database also available to health plans, health care practitioners, and federal/state government agencies is the Healthcare Integrity and Protection Data Bank (HIPDB), which contains data related to health insurance fraud and abuse. However, because the HIPDB cannot be queried by health care facilities, they must request that the applicant query the data bank and provide them a copy of the report.

Once the application has been completed and verified, the responsibility shifts from members of the medical staff office to the chair of the department to which the applicant is applying. Each clinical department develops the criteria used to establish competency for the procedures and therapeutics used or requested by the practitioners assigned to the department. Upon receipt of a verified application, the department chair is responsible for reviewing the data collected, and making recommendations to the facility’s credentialing committee or medical executive committee regarding staff membership and clinical privileges.

### 3. Committee review and final decision

The next step in the process is to send the applicant’s entire credentialing file, including the department chair’s recommendations, to the facility’s credentialing committee for review. The committee then interviews the applicant, addresses any concerns it may have, and submits a written report to the facility’s medical executive committee with its recommendation(s). The medical executive committee then reviews all the information and submits its recommendation to the facility’s governing body, which makes the final decision.\(^8\)

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**Notes and References**

5. ECRI: HRC Volume 3: Risk Analysis: Medical Staff Credentialing, p.2.
7. ECRI: HRC Volume 3: Risk Analysis: Medical Staff Credentialing, p.3.
10. ECRI: HRC Volume 3: Risk Analysis: Medical Staff Credentialing, p.3.
11. ECRI: HRC Volume 3: Risk Analysis: Medical Staff Credentialing, p.4.
Barriers and Obstacles in the Credentialing and Privileging Processes

by Gwen Gilchrist

Ms. Gilchrist is Director, Provider Services, for Brigham and Women’s Hospital in Boston.

Credentialing physicians is an important step toward protecting patients from harm, while privileging the physicians ensures that organizations have the most qualified and competent physicians on their medical staffs. This is achieved by confirming that health care providers are who they say they are and that they are appropriately trained for the services they wish to provide. The credentialing department must establish policies and procedures that meet or exceed a cadre of regulatory requirements established to further ensure patient safety and quality of care. The following are among the many challenges a credentialing service must overcome:

Remain Current and Compliant

When evaluating medical staff applicants, one of the main challenges is that multiple agencies are continuously updating and changing their standards and rules, often with little notice. The credentialing department needs to have a mechanism in place to enable continuous review of the standards and to compare them to the department’s own policies and procedures.

Application Gaps

Appointment applications may seem a bit unwieldy (and duplicative) to an applicant—especially when the same information is available on the applicant’s curriculum vitae (CV). Credentialing specialists are usually advised not to accept an incomplete application, even when the applicant may refer to his or her CV. Close comparison between the application and the CV can uncover discrepancies or unexplained gaps in time that require further research.

When the physician has left off information or the credentialer cannot verify information, the application may be considered “incomplete.” The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standards, and many states’ regulations, require that a facility verify an applicant’s history. This may seem easy, but even just locating the correct contact information can become almost impossible. Credentialing specialists are often left trying to obtain verification from former employers or malpractice carriers who have changed names, moved, or who are no longer in business.

When to “give up the search” for a detail of an applicant’s history depends on the remainder of verifiable information already received by the credentialing office. In some instances, there may be enough information for the facility’s leadership to make an informed decision regarding the application status, but many facilities place the burden on the applicant to provide complete and up-to-date contact information.

Mountains of Paper

Excessive amounts of paper still fill the desks and drawers of credentialing departments. Yes, the Internet has simplified the process for credentialers. Yes, state licensing boards and other agencies have developed secure, password-protected sites for verification purposes. And, yes, some hospitals have developed sites that allow the user to verify a physician’s past training in their programs. But, even with these options, credentialing can still be time-consuming and paper intensive. Although more and more facilities are considering the paperless process, most still print and store paper files.

Tough Calls

One of the tough calls for credentialing specialists is privileging “low or no volume” physicians and aging physicians. How can an organization accurately assess whether a practitioner’s skills are appropriate for requested privileges if the physician is new to the facility or rarely practices there? How can a facility determine if a semi-retired physician’s skills are still adequate if he or she rarely provides patient care or performs a particular procedure?

Each facility must determine the type of information that is acceptable as a true measure of competence, and how to handle the application in the absence of such information. The credentialing specialist may bear the burden of compiling the performance data for review, but when such data are not readily available, a facility may put the burden on the individual applicant to provide acceptable documentation of proof of current clinical competence.

Approve Dr. Smith, Stat

Possibly the most challenging obstacle credentialing specialists face is pressure to rush an application—with that pressure coming from hospital or medical staff leaders, department chiefs, and the applicants themselves. Some situations may be valid, i.e., an immediate, emergent patient care need. Most other requests, however, do not justify emergency privileges. Credentialing departments must continue to meet all regulatory requirements regardless of the pressure. They must continue to verify all of the physician’s background from the appropriate sources, check all the Internet sites, and follow the organization’s policies and procedures in the same manner for all applicants. Calling or faxing verification requests to an applicant’s former clinical practices or malpractice carriers may reduce the turnaround time, but the verification process should not be skipped entirely.

Certainly, the pressure to complete the process can be daunting, but the risk of being less than thorough is one that your organization—and especially its patients—can ill afford.
A More Rigorous Approach to Credentialing and Privileging

by Jeanette G. Clough

Ms. Clough is President and CEO of Mount Auburn Hospital in Cambridge, Massachusetts.

The credentialing and privileging process has received careful dissection and rigorous review throughout the last four years at Mount Auburn Hospital in Cambridge, Massachusetts. A sentinel event that received widespread media attention involving one of our attending physicians prompted this scrutiny. We hope that the changes Mount Auburn has made, and the lessons learned, will guide others engaged in credentialing and privileging.

The overarching purpose of Mount Auburn’s credentialing and privileging process is to protect patients. The changes we made do indeed enhance that protection for our patients, but they also serve to protect the hospital and the other physicians on our staff. The changes have also given physicians being appointed—and those already on staff—clear expectations of initial appointment, on-going staff membership, and reappointment. The updated structure also provides physicians with ways to seek assistance and guidance when issues arise that conflict with staff membership expectations.

A Privilege, Not an Entitlement

Mount Auburn places the onus and accountability for a fully completed and truthful application on the applicant. Our leadership team strongly believes that joining our medical staff is a privilege and not an entitlement. Applications must include full disclosure of disciplinary actions, malpractice experience, gaps in professional practice, and any other incident that may be relevant to clinical or personal background. A query of the National Practitioner Databank is standard practice. All physicians must consent to a criminal offender record information check that exposes any criminal offenses within Massachusetts. In addition to the standard primary source verifications and reviews, applicants must also undergo review through the Fraud and Abuse Control Information System database, which shows any disciplinary action by any board of registration in medicine throughout the United States. All physicians must appear for an interview by the department chair that includes double verification of identity. ID badges, passwords, and staff appointment are held until the application and the applicant have been reviewed by the chief of the division, the department chair, the credentials committee, medical staff executive committee, and the board of trustees (which includes the hospital CEO). The process generally takes go–120 days, a timeline made known to all parties.

Under our enhanced process, each leader involved in credentialing and privileging has a unique role and is accountable to hospital and medical staff leadership to perform that role. Thus, it is Mount Auburn’s responsibility to ensure that all are properly educated around this process. Hospital and medical staff leaders are required to attend several educational programs on this subject. All new chiefs or chairs must also participate in similar educational sessions and be fully oriented to their roles in assuring thorough and complete credentialing and privileging.

Rethinking the recredentialing, or reappointment, process was also necessary. Looking back, we see that this biennial process was often undertaken with less scrutiny—perhaps because it involved physicians already on the staff with whom the physician leaders practiced routinely, i.e., colleagues, friends, and loyal department members. Mount Auburn’s leadership team feels strongly that the same rigor must be applied to reappointment as is applied to the initial application. Being a “good guy” or “good gal” who receives a superficial review is no longer accepted as sufficient. Physicians experience many clinical and interpersonal interactions over a two-year period, both within and outside the hospital. Those interactions and outcomes are critical to the reappointment and recredentialing process and thus are subject to review at the time of reappointment. Clinical incidents, incident reports, patient or staff complaints, malpractice events, or any other data involving patient care,
interaction with staff, or civil or criminal charges are subject to review at the time of reappointment for each physician. These are brought to the credentials committee for review by the risk management staff. The reappointment applications of division chiefs and department chairs receive the same respectful, yet rigorous, review and follow the same credentialing path as all other physicians on staff.

The composition of the credentials committee was also the subject of much discussion following the sentinel event. Mount Auburn determined that the committee should be expanded to include additional “members-at-large” from the attending staff to allow for greater objectivity and input to the process. A quorum requirement has been established so that a minimum number of physicians will be present to review the applications. All physicians are required to commit to the monthly meeting and to the two or three hour committee meeting time. Rushing in and out to answer pages, leaving halfway through the meeting to attend to other business, and other similar distractions, are no longer acceptable. One of the biggest changes is the addition of a voting, non-physician member of the hospital’s board of trustees to the committee in order to have a non-physician voice early on in the review of applications. This participation also serves to bring the essence of the dialogue and discussion about applicants to the full board of trustees by a trustee who sits with the credentials committee. While decisions for staff appointment or reappointment still fall fully under the powers of the hospital’s board of trustees, having a trustee represented early on in the credentialing pathway is extremely helpful.

Standards of Professional Practice for Physicians
A great source of pride for Mount Auburn’s leadership was the crafting of a document outlining the standards of professional practice for physicians (see Page 8). This document was written by a sub-group of the medical staff executive committee, endorsed whole-heartedly by the entire medical staff, and is included in every application packet sent to prospective physician staff members. The standards serve as a guide and reference for all physicians and give the hospital a guidepost by which to evaluate interactions and behavior, allowing aberrant behavior to be recognized and dealt with in a timely manner.

Equally important has been the establishment of a physician support committee that can be voluntarily accessed by any physician who may need assistance with personal or professional issues without prejudice. Resources are available to address issues in a preventive and supportive manner. For example, an older attending physician was noted by nursing staff to have difficulty with physically coordinating some newer operative equipment. It was initially unclear whether this was because the equipment was new, because of insufficient training, or whether the physician’s age had any bearing on these difficulties. The department chair wisely asked this physician to meet with the physician support committee as “preventive medicine,” and the physician agreed. Unfortunately, it was determined that the physician’s health had deteriorated and the lack of energy and stamina were, indeed, becoming a limiting factor in his practice. Fortunately, through the resources, counseling, and support that this physician received via the physician support committee, he was able to conclude that he should limit his practice and take steps to improve his health. The outcome was achieved without disciplinary action and judgmental review, allowing the physician’s “elder statesman” status to be preserved as well as patients’ interests to be further protected.

Even with our commitment to the credentialing pathway that we have set down, it is tempting to stray off to a shortcut. Gaps in moonlighter coverage, opportunities to quickly place a physician where a vacancy exists, or some other urgent situation begs for bending of the rules. While we still maintain a temporary privileging mechanism, we severely restrict its use to compassionate need and other rare instances that are ultimately seen as in the best interests of the patients and not necessarily in the best interests of the physician. Failure to plan ahead for coverage or other vacancies is not considered reason enough to “jump the line” in the credentialing pathway.

Interns, Residents, and Others
Past practice did not include the exact same pathway of credentialing for interns and residents. The thinking behind this was that practitioners just starting out had not built up a clinical track record by which to judge their applications. This thinking has changed. Mount Auburn now requires that all interns and residents, as well as any residents who rotate to the hospital, proceed through the staff physician pathway. In fact, interns and residents do indeed have a track record to which to the hospital, proceeds through the staff physician pathway. In fact, interns and residents do indeed have a track record by which to judge their applications. This thinking has changed. Mount Auburn now requires that all interns and residents, as well as any residents who rotate to the hospital, proceed through the staff physician pathway. In fact, interns and residents do indeed have a track record by which to judge their applications. This thinking has changed. 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Mount Auburn Hospital
Standards of Professional Conduct

Preamble
The primary concern of the physician is patient welfare; our primary responsibility is to the patient. The optimal care of the patient requires a clear set of standards of professional behavior.

Problem behaviors are those that interfere with the provision of care to the patient. There is growing recognition that problem behaviors on the part of physicians occur, and that they must be addressed by physicians. A health care organization must maintain an environment that optimizes professional performance, and that addresses performance problems in a constructive manner. Physicians need to support and help each other with regard to problem behaviors, in the interest of promoting patient welfare and optimal patient care.

The Medical Staff of Mount Auburn Hospital endorses the following principles of professional behavior. Physicians will agree in writing to these standards at time of initial credentialing, and at each subsequent recredentialing.

The physician will, at all times:
- Treat with respect all patients, families, visitors, all professional and hospital staff, and students and trainees. The physician is responsible for contributing to an environment that is respectful and civil.
- Act with honesty and integrity in all professional matters.
- Refrain from behavior that is intimidating or harassing. (Compliance with Human Resources policy on harassment.)
- Respect patient confidentiality, and adhere to established policies for protected health information. (Compliance with Human Resources policy on confidentiality.)
- Work collaboratively with colleagues and staff to provide optimal patient care.
- Be receptive to critical feedback. The physician will respect differences in clinical opinion on the part of all members of the clinical team, realizing that critical input is essential to good patient care and patient safety.
- Respond in a timely manner to patient care requirements.
- Act with integrity in dealing with adverse outcomes and medical errors. The physician will show commitment to disclosure of information to patients and family, and to collaborating fully with efforts to learn from adverse events to improve our quality of care.
- Share in the responsibility to insure competent and safe care of patients by all physicians and staff at Mount Auburn Hospital. The physician will address directly and respectfully transgressions to this code on the part of colleagues. The physician will participate in and respect processes of remediation and discipline duly enacted in response to problem behaviors.
- Manage conflicts of interest with integrity. The physician will show commitment to recognize, disclose, and manage with integrity conflicts of interest involving the pursuit of personal gain or organizational gain that conflicts with the primacy of patient welfare.

Mount Auburn Hospital is proud of the changes and improvements it has made—despite the fact that they were prompted by an unfortunate event. It is a testament to our medical staff leadership that we have been able to move rapidly and effectively to implement change. We continue to learn and adapt as the environment for practice presents new challenges in an effort to provide the safest and most secure environment for the care of patients.

Notes and References
Credentialing Review and Clinical Privileging: A Time for Change?

by Donald W. Moorman, MD

Dr. Moorman is a surgeon at Beth Israel Deaconess Medical Center, in Boston, and an Associate Professor in Surgery at Harvard Medical School.

C redential review and clinical privileging is a local process. Hospital boards rely on medical staff review mechanisms to assure that only qualified practitioners will be delivering care at their medical facility, thereby offering the consumer confidence in practitioner selection. Despite the Joint Commission for Accreditation of Healthcare Organizations guidelines, this hospital-specific process is subject to considerable variation in the extent of assessment and practice review.

The major historical parameters by which physicians have been assessed are:
- verification of reported training,
- licensure by the state medical board,
- specialty board certification,
- historical malpractice patterns,
- ability to acquire and maintain adequate malpractice coverage to comply with medical staff requirements, and
- peer evaluations.

However, recent public trends would indicate this is not enough. Concerns regarding physician self reporting and the variable nature of hospital medical staff review motivated the creation of the National Practitioner Data Base (NPDB) as a component of the Health Care Quality Improvement Act of 1986. That federal law, which requires NPDB queries at least every other year, has reportedly increased the accuracy of physician reporting and may have contributed to alteration of granted privileges up to 30 percent of the time in the institutions surveyed.¹

Specialty board certification is a minimum credentialing criterion in some, but not all, organizations and specialties. While most organizations do require surgeons to be certified, 90 percent of health plans surveyed did not require board certification at initial credentialing (only 41 percent required board certification at any time).¹ Initial certification and maintenance of recertification should be central to the process of credentialing and certifying boards should be publicly accountable.³ Peer review processes are less often driven by reliable outcome and performance data and more frequently guided by the subjective assessment of competency by senior clinicians.

As evidenced by 1) mandated error reporting, 2) procedure volume levels as a quality surrogate, 3) unrefereed provider grading systems such as HealthGrades,⁴ and 4) pay for performance mandates, health care consumers are questioning the validity of this process. To assure patients that their providers are indeed competent, we need a non-arbitrary process. To accomplish that, we need a more robust assessment mechanism that can be tested across both local and national standards.

A Multifaceted Approach

First, retain the traditional credentialing parameters, with the additional requirement that all providers acquire and maintain specialty board certification.¹ Evidence of appropriate safe and effective clinical practice, and metrics to assess professionalism, should be included.

Second, physicians need to participate in an assessment of their practice outcomes, including disease management, evidence-supported care processes, and surgical procedures. Now is the time to develop outcomes assessment in a reliable and reproducible fashion. Volume surrogates are no longer acceptable.

Third, we need data from multiple performance areas—intrinsically better than single data sets, especially when data outcomes are concordant.

The outcomes must be reviewed as a product of the care system. Only when individual providers statistically emerge as outliers should individualized (rather than systems) remediation be the focus. The burden will fall on health care organizations to create and manage stable data systems. As demands for data reporting escalate, organizations such as the National Quality Forum must step forward to standardized assessment criteria in conjunction with consumers and providers. The American College of Surgeons (ACS) National Surgical Quality Improvement Project leaders are willing to collaborate, and stand prepared to incorporate process metrics in their data set. This will, in turn, provide insight into the relative value of the selected process measures in the generation of optimal outcomes.

The ACS has nationalized its surgical quality improvement initiative developed in the Veterans Administration (VA) medical system to assess and report risk-stratified outcomes for both institutions and individual surgeons. The cases are randomly selected and retrospectively abstracted by trained independent reviewers so that the parameters of pre-operative risk and subsequent outcomes are captured. Concurrent abstracting and reporting allows generation of semi-annual performance profiles. After more than a decade of application in the VA, the system has now been validated in the private sector. At this time, observed/expected outcomes are reported only for general and vascular surgery procedures, but new modules are emerging to assess outcomes in additional areas. More than 200 hospitals are participating in the process of initial training and implementation.

Data provided by this system give participating institutions the ability to assess practice outcomes, at the institution and provider level, benchmarked to national outcomes. Exceptional

Continued on next page
outcomes signal potential “best practices.” Statistically deficient outcomes require assessment of practice systems for opportunities to improve the efficacy and consistency of care. Data sets such as this are emerging within many other specialties and should provide a substantially improved source for credentialing use over the next decade.

Assessing Professional Competencies
Professionalism and active participation in the care system as a team is another area requiring assessment. The Accreditation Council for Graduate Medical Education (ACGME) has established the six professional competencies to guide resident education. These provide a template for the ongoing assessment of physician effectiveness as well. The six competencies are:
1. patient care
2. medical knowledge
3. practice-based learning and improvement
4. interpersonal and communication skills
5. professionalism
6. systems-based practice

Assessment of the adequacy of provider performance in the areas of interpersonal and communication skills, professionalism, and systems-based practice is variable in its documentation. It is often relegated to the assessment of the senior physicians of the credentialing body. We need to develop robust systems to capture these attributes and identify where remediation is necessary. As documented in recent studies, for instance, disruptive behavior and tension in care settings impact patient care. Such events are inconsistently documented and many systems have no standardized queries to identify when providers are creating an unacceptable environment of care.

Assessments by members of the health care team of clinical effectiveness would go a long way to provide some structured feedback for providers and those making credentialing decisions. Along with the patient accolades and complaints that are reported (at least to most credentialing bodies), a random sample assessment of the provider’s communication skills, performance as a team member, and professional behaviors could provide early identification of opportunities for remediation. Since flawless individual provider function is not the goal (Dr. Lucian Leape points out that “systems that rely on error-free performance are doomed to fail”), then assessment of professional behaviors that enhance team performance (e.g., communication, respect, cross monitoring) become critical for effective clinical practice assessment.

Keeping Pace with Technology Advances
We do not always find patient safety concerns at the forefront of the evolution and implementation of new procedural technologies. While minimally invasive surgery has been a great revolution, the initial implementation was often conflicted, and market driven. A simple weekend course on laparoscopic cholecystectomy provided the training for many surgeons, often at a facility funded or owned by the equipment manufacturer. No wonder in those early phases, many patients experienced skill-related biliary and vascular injuries. The lesson to be learned is the need for competency assessment tools to measure provider readiness to use emerging technologies. And because technologies are no longer specialty specific, common, non-arbitrary competency assessment mechanisms must be developed.

Simulation offers hope for the consistent and verifiable assessment of clinical effectiveness, at least as a minimum standard. An example of one such format is Fundamentals of Laparoscopic Surgery, developed and validated by the Society of American Gastrointestinal and Endoscopic Surgeons. Assessing both knowledge and technical skills, this has the potential to be a tool for granting privileges in complex laparoscopic surgery. As further evidence of the potential value of simulation, the American Board of Surgery has also recently appointed an additional associate director specifically to appraise the opportunities for competency assessment through simulation.

Notes and References
4. Healthgrades is a registered trademark of Health Grades, Inc.
5. www.acgme.org/outcome/comp/compFull.asp
6. This may require the development of a pathway for foreign trained physicians with “equivalent certification” to gain eligibility for ongoing maintenance of certification through the American Board of Medical Specialties pathways.
A recent systematic review suggests that physician performance, among multiple specialties, declines over time in both knowledge and skills. At the same time, the growth in medical knowledge and technology continues at an explosive pace. These observations have increased the pressure on and importance of the credentialing process. In order for credentialing to be reliable, the process needs to include multiple sources of valid data about a physician's competence. Much of these data will, obviously, come from local sources and activities, but other sources are emerging.

The Certification Boards

The American Board of Medical Specialties (ABMS) comprises 24 non-profit specialty certification boards that agree to comparable standards for initial and ongoing certification. The American Board of Internal Medicine (ABIM) is responsible for certifying general internists and subspecialties, such as cardiology and rheumatology. Certification is a voluntary process that signifies a physician has attained competence in his or her chosen field. To attain certification, a physician must have successfully completed a residency and/or fellowship training program and passed a comprehensive examination of medical knowledge. During their training, residents and fellows must also have demonstrated a minimum level of competence in six general competencies developed by the Accreditation Council for Graduate Medical Education (ACGME) and ABMS.

The six general competencies are: patient care, medical knowledge, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. Certification, therefore, represents a broad-based evaluation of physician competence across domains of knowledge, skills, and attitudes. For some specialties, such as interventional cardiology and surgery, physicians have to also document successful completion of a specified number of procedures before they can apply for the certification exam.

The majority of studies performed to date find a positive correlation between certification status and quality of care. For example, two studies found a positive relationship between delivery of preventive services (such as mammography screening) and certification status. Two other studies found a positive association between hospital care for acute myocardial infarction and physician certification. These studies (and others) suggest that certification is an important basic credential for physicians.

Maintenance of Certification

The specialty boards, in recognition that the achievement of initial certification does not ensure ongoing physician competence, now provide only time-limited certification. ABIM introduced 10-year certificates in 1990. In 2002, ABMS and its member boards developed a standardized maintenance of certification (MOC) program for all 24 specialties, consisting of four parts. Qualifying physicians must:

- have an active, unrestricted medical license and be in good professional standing;
- complete a minimal number of lifelong learning activities for continuous professional development;
- pass a secure examination of knowledge; and
- evaluate their performances in practice and complete a quality improvement plan for their practices.

All specialty boards must implement this new requirement by 2010. Failure to complete all four parts of the MOC program within the specified time frame will mean the physician is no longer certified until he or she completes the required elements. Only then will a new certificate be issued.

MOC is required to evaluate all six of the general competencies listed above, making the assessment process comprehensive in scope. The program also helps physicians keep up to date in medical knowledge—an under-appreciated physician competency critical for making correct diagnoses and effective clinical decisions. With regard to skills, ABIM is also preparing to pilot a cardiac catheterization simulator as one option in MOC for cardiologists. With the requirements for self-directed learning and passing a rigorous exam, MOC provides a robust assessment of physician knowledge.

The ABIM MOC program is the first to require that physicians perform an assessment of their performance in practice. ABIM developed self-directed, web-based modules in quality improvement, called practice improvement modules. Physicians collect clinical data to measure their performance against established guidelines, receive feedback, make system changes to their practice, and re-measure their performance to determine if a change in performance has occurred. These quality improvement modules are based on the plan-do-study-act improvement cycle. ABIM has developed modules that include medical record audits for a particular medical condition or preventive care, a patient survey, and a survey of the physician's practice systems. Once the data collection is completed, the physician submits the information to ABIM for analysis. Each physician submits the information to ABIM for analysis. Each physician...
receives a comprehensive report of his or her performance to use toward developing quality improvement interventions.

Enrollment in MOC for diplomates who earned their initial certification between 1990 and 1994 was 80 percent for general internists and 88 percent for subspecialists. The frequency of this requirement by most boards is once every 6–10 years, depending on when the time-limited certificate expires. The impact of MOC interventions to promote quality improvement is not yet well-defined and will be a main focus of future research work by the specialty boards. The current goal is to engage physicians in quality improvement, however, early work with the practice improvement modules found the majority of physicians do make changes in their care practices after completing them. Finally, enrollment in MOC, which is voluntary, is an important act of professionalism. It demonstrates that the physician is willing to perform a comprehensive self-assessment for the benefit of his or her patients. Indeed, a survey of physicians by ABIM and the American College of Physicians found that the most important reason for enrolling in MOC was professional pride.

Certification and Credentialing
Currently, despite the comprehensive assessment activities involved, the use of certification and MOC as part of credentialing remains modest. Freed and colleagues recently published results regarding the use of certification and MOC for credentialing among pediatricians. They found that approximately half of hospitals require their pediatricians to attain initial certification within a defined time period, while the proportion of health plans requiring certification was even lower. In a similar study by the same research group, only 38 percent of health plans required internal medicine physicians to be certified. Health plans are just beginning to use certification as a component of physician recognition programs in tiering and pay-for-performance programs, which is likely to lead to greater use in the credentialing process.

Certification, and maintenance of certification are broad-based tools. The four parts of the MOC program help provide an assessment of physician competence across six broad general competencies in medicine during their practice career. Credentialing organizations may want to examine the role of certification and MOC in their credentialing process as part of their efforts to promote safe, effective patient care.

Notes and References
2. www.acgme.org/outcome/comp/compFull.asp
Many hospitals and their medical staff leaders struggle as they attempt to reappoint physicians who are in their late 60s and beyond. The commitment to be fair to all involved competes with other concerns.

Hospitals and their medical staffs are legally obligated to credential and recredential only those physicians who can demonstrate current clinical competence, skill, judgment, and technique. This obligation is reflected in Joint Commission on the Accreditation of Healthcare Organizations and American Osteopathic Association accreditation standards, Centers for Medicare & Medicaid Services conditions of participation, hospital licensing statutes and regulations, and medical staff bylaws. Additionally, many states have adopted the legal theory of negligent credentialing, meaning that hospitals have a direct duty to patients to make sure that only qualified, competent physicians are appointed and reappointed to the medical staff.

Recredentialing an older physician is particularly challenging. If the older physician forgets to round on patients, writes orders for medications that have long been off the hospital’s formulary, or seems shaky in the OR, he or she often has allies who cover for those slips and colleagues who are reluctant to do anything that might taint an otherwise stellar reputation. This network of support is there because the older physician is often well known and respected, has dedicated his or her life to the practice of medicine, and has served the hospital, medical staff, and community well.

In these situations, the medical staff often feels stuck between the proverbial rock and hard place. Add to this the potential that the older physician might allege a claim for age discrimination, and a difficult situation just gets worse. A closer look at these competing concerns illuminates how an appropriate balance can be struck.

Studies Confirm Concern about Older Physicians

In February 2005, the *Annals of Internal Medicine* explored the relationship between clinical experience (i.e., age) and quality of care. The authors found in a majority of the more than 60 studies they reviewed an inverse relationship between performance (for all outcomes assessed) and years of practice. Decreased performance with increasing experience in some, but not all, outcomes was reported in another 20 percent of the studies. Only two studies supported any positive relationship between increasing age and outcomes of care.

Those results were a surprise to the industry. Many people had just assumed that a physician’s skill and knowledge would be enhanced by clinical experience, but that assumption was not supported by the literature. Shortly thereafter, another article added fuel to the fire. In the January 2006 edition of *Annals of Internal Medicine*, Drs. Lucian Leape and John Fromson reported that existing systems aimed at monitoring physician performance are inadequate. Older physicians were mentioned only as one example of a potential quality concern, but the message was clear: relying on your routine processes to identify and deal with quality concerns is not a good strategy.

**Discrimination Law and the Older Physician**

Any discussion about the recredentialing of an older physician inevitably invokes a question about whether any kind of preemptive action would violate the Age Discrimination in Employment Act (ADEA). Like many federal civil rights statutes, the ADEA was designed to protect a particular class of individuals: in this case, individuals over age 40. The courts have been rather lenient in allowing challenges to employment practices to go forward (without early dismissal) whenever the practice includes any age-based criterion.

One of the keys to understanding the ADEA is to appreciate that it prohibits age discrimination in “employment” arrangements. Absent an employment arrangement, the ADEA will not apply. In health care, this is an important qualification because most physicians have an “independent contractor” relationship with the hospital where they practice as opposed to an employment relationship. Thus, in many situations, hospitals do not need to be concerned with the ADEA in terms of the recredentialing of older physicians because they do not employ such physicians.

In those situations where hospitals do employ older physicians, use of age in the credentialing process should be consistent with the ADEA’s requirements. While the ADEA makes it unlawful for an employer to “discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s age,” there is an exception in the law that allows the use of age when it is a “bona fide occupational qualification” (BFOQ) of the job.

Determining whether age is a BFOQ is complicated and the courts have not made it easy for employers to claim age as a BFOQ. In order to do so, the employer must prove that the challenged practice effectuates a public safety goal and that there is no acceptable alternative to advance the goal which would have a less discriminatory impact.
Practical Solutions

The literature supports that age is a factor that can have variable effects on a physician's ability to practice medicine. However, the effects of age on a physician's competence are often difficult to assess, and standard peer review processes are rarely sensitive enough to detect subtle effects. Because the consequences of medical mistakes can be catastrophic, many hospitals and medical staffs have decided that they need new triggers or steps in their credentialing processes to help assess whether the older physician is experiencing any adverse effects in terms of clinical competence.

As with all credentialing dilemmas, the best place to start in dealing with the older physician about whom there are concerns is an informal attempt at resolution. Direct personal communication, or collegial intervention, where concerns are identified and a plan of action is proposed, is the approach most likely to have the greatest success. Collegial intervention should be used “early and often.” Documentation of these efforts should be maintained, especially in the event they are not successful, in order to provide a record of concerns and the attempts that were undertaken to resolve those concerns.

Hospitals are required to reappoint physicians and renew their clinical privileges at least every two years. If the two-year cycle is thought to be too long for physicians over a certain age, annual reappointment would effect more frequent focused reviews. Annual reappointment also provides an opportunity for leadership to discuss practice objectives and plans with the older physician.

Another option is a requirement that physicians over a certain age obtain a thorough physical and mental assessment as part of the reappointment process. In order to be meaningful, the assessment should be designed to actually measure deterioration in a physician's skills (if any), i.e., a cursory physical examination by a colleague would not be adequate. Instead, appropriate neuropsychological tests should be part of the assessment process to ensure that “the challenged practice does indeed effectuate” the goal of public safety.

A third step to consider is a more focused reappointment review. This is important for the older physician who is likely to have fewer patients, especially in the hospital setting. Thus, in addition to annual reappointment and/or physical and mental assessments, physicians over a certain age might also be required to have a number of cases reviewed, on a concurrent basis, as part of the reappointment process. Direct observation of the physician interacting with patients and staff and performing invasive procedures would help greatly in determining whether the physician continues to be current and competent.

Credentialing at any level presents challenges, but credentialing the older physician carries with it special legal and practical challenges, and those challenges are likely to be even more amplified as the overall U.S. population over age 65 increases. Thinking about these issues and planning for them will help put the hospital and medical staff leadership in a position where patients can be protected and the older physician can be treated fairly, with dignity and respect.

Notes and References

Dealing With Disruptive Physician Behavior

by Elizabeth Becker, LCSW, and William A. Norcross, MD

Ms. Becker is Director of Behavioral Programs for the University of California at San Diego’s Physician Assessment and Clinical Education (PACE) program. Dr. Norcross is Professor of Clinical Family Medicine at UCSD and Director of the PACE program.

Although most of us conceptualize the problem of the disruptive physician as centering around an individual, the dilemma is actually systemic, cultural, and multifactorial. And the challenge of dealing effectively with disruptive physicians is that they may be very (technically) competent, bring in lots of money to the hospital, and deliver services that may be difficult to replace. Observers have even suggested that the cultures of some residency programs model, teach, and reinforce disruptive behavior. (We feel compelled to acknowledge that nurses can be disruptive, too. Indeed, such behavior can be found in all walks of life.)

The problem would be ameliorated if hospitals and medical groups had specific expectations for physician communication, leadership, and behavior—and held their colleagues accountable for adhering to these standards. The medical staff policies and procedures should clearly describe behavioral expectations and specific plans for investigating departures from the standard, options for remediation, and unambiguous consequences for recurring misbehavior. Such policies would be especially effective if they were reviewed and signed by physicians at the time of applying to or joining the medical staff, and were accompanied by a brief educational program that enhanced communication skills and hospital behavioral expectations.

A Culture that Tolerates Disruptive Behavior

For disruptive behavior to be tolerated, it requires a work environment and hospital culture that allows, sustains, and ultimately reinforces such behavior. The consistent outcome of disruptive behavior is poor workplace morale, high staff turnover, and a climate of fear and distrust. Such an environment splinters the health care team, potentially impacting patient care. Divisive and disruptive behavior also decreases effective communication, contributes to medical errors, and is associated with patient dissatisfaction and complaints. Ultimately, trust in the leadership of the medical staff and hospital is undermined through the tolerance of obviously dysfunctional behavior. Staff and physician colleagues begin to devote more time to avoiding triggering the noxious behavior of the disruptive physician than they do to patient care. While no study to date has examined the effects of disruptive behavior on clinical performance, everyone who deals with this issue firmly believes that it causes poorer medical and surgical outcomes than would be found with a well functioning team in a supportive work environment.

Naturally, the perpetrators disagree. Typical battle cries of the disruptive physician include:

“I’m only interested in quality of care!”

“T’m passionate about excellence, but misunderstood!”

“I wouldn’t get mad if we had competent nursing staff!”

Their colleagues see it differently. A large survey of nurses, physicians, and hospital executives found that 2–3 percent of physicians demonstrated seriously disruptive behavior, often several times per month. The most common responses to a question regarding barriers or resistance to the reporting of disruptive physicians were:

- fear of retribution,
- the belief that ‘nothing ever changes’,
- lack of confidentiality,
- lack of administrative support, and
- physician lack of awareness or unwillingness to change.

A Culture that Reduces Disruptive Behavior

An ounce of prevention is worth a pound of cure. Each hospital that hopes to create a work environment of excellence must have a critical mass of physicians and staff who consistently demonstrate good communication and interpersonal skills, leadership, mutual respect and trust, and teamwork. Such a hospital creates a culture of excellence in which disruptive behavior is unacceptable. The medical staff policy and procedure document of every hospital should clearly proscribe disruptive behavior and should detail the specific unacceptable behaviors. The document authors should keep in mind that, in addition to the “classical” expressions of disruptive behavior (e.g., yelling, belittling, throwing instruments), passive-aggressive behaviors (e.g., ignoring staff questions, failure to respond to paging) may be equally disruptive. The document should clearly describe how allegations of disruptive behavior will be investigated, the disciplinary steps that will result from persistent misbehavior, a remedial plan for dealing with motivated physicians, and the consequences to the physician if he or she does not participate in remedial efforts or fails to achieve a satisfactory level of remediation.

The disciplinary sequence for severe, persistent disruptive physician behavior should (ultimately) result in dismissal from the medical staff. Failure to deal with disruptive physician behavior quickly, firmly, and clearly results in positive reinforcement to the physician: he or she quickly learns that such behavior is accepted with no consequences. For this reason, every hospital should have a policy that ensures that all employees are able to report disruptive or unprofessional behavior in a manner free from intimidation or retaliation. In fact, the hospital should expect and require such reporting.

When disruptive behavior is allowed to continue, a maladaptive culture develops that allows for disruption and creates a niche for the physician. Nurses and other staff begin to spend more...
time trying to avoid the situations that trigger the disruptive behavior. A small group of favored nurses (those who tolerate or adapt to the disruptive behavior) evolves and may actually take sides in a sick dynamic against the majority of the staff who are intolerant of the misbehavior.

In one hospital, the birthday gift for each member of the operating room nursing group was a full week in which they were not scheduled to work with the disruptive surgeon! While this may seem strange, cultures develop insidiously. Over the course of years, aberrant systems and relationships come to be regarded as the norm. The negative fallout from this toxic culture commonly has a more widespread consequence, spreading beyond the hospital’s borders into the larger medical community. Gossip and distrust lead to an erosion of confidence in the clinical program and even the entire hospital, with a consequent decline in referrals and admissions.

When a physician joins the medical group or hospital medical staff, he or she should participate in an orientation program that includes communication training and a careful review of the policy and procedures document. Having the physician sign the document will indicate his/her understanding and agreement to comply. Regular social and team building activities involving the medical and hospital staff help develop personal relationships, communication, and empathy. Although the problem of disruptive behavior can be recalcitrant, we have consistently witnessed improvement when the index physician begins to know his or her staff colleagues on a personal level.

Every hospital would do well to build the leadership capacity within its nursing staff, medical staff, and administration. Among a wide variety of sources for such training, state and local medical societies frequently offer educational programs. In dealing with the physician culture of a hospital or medical group, the chief of staff occupies a critical position. When we ask hospitals who come to us with problems of disruptive physician behavior, “Why did you consult with us now?” the most common answer is, “This year we have a strong chief of staff.” Hospitals may find it to their advantage to send physicians in queue for chief of medical staff to a program that will teach them about the position and enhance leadership skills. An excellent program in California is Essentials for New Medical Staff Leaders offered regularly by the Institute for Medical Quality.5

360 Assessments

In its extreme manifestations, disruptive physician behavior is not difficult to detect, but in its beginning stages, especially when taking place in a hospital culture that tolerates or accommodates such behavior, it can be a challenge to characterize. While confidential reporting of a specific incident might seem desirable, that is very difficult to achieve. Retaliation by the reported physician must be strictly forbidden, and consequences in place, if it occurs.

An interesting tool that has been used in the corporate world for decades, but only recently in medicine, is the 360 degree assessment: a series of survey instruments evaluating the clinical performance and professionalism of the index physician that are typically completed by patients, staff (nurses, OR personnel, receptionists, etc.), physician colleagues, the physician himself/herself, and the physician’s supervisor (e.g., department chair, chief of staff). The 360 is easy to complete, provides much data, and gives feedback from the people who form the sphere of the physician’s professional environment. The survey instruments typically ask the respondents to rank the physician’s performance compared to other physicians they know. A 360 allows for specific feedback for all physicians, not only those identified as manifesting disruptive behavior, and can help detect deficiencies in communication skills or unprofessional behavior that previously may not have been appreciated by medical staff leadership.6

Of course, detection only solves part of the problem, and the next steps can be more difficult. Disruptive physician behavior, like all human behavior, is complex with an underlying spectrum of severity that affects the prognosis. Consider two vignettes that vividly demonstrate the complexity of addressing disruptive physician behavior.7

1 An emergency physician is identified as having spoken to several intoxicated patients in an angry fashion. A staff nurse reported this behavior, and the physician was confronted by the ED chief. She discovered that the physician’s wife had been seriously injured in a motor vehicle accident caused by a drunk driver six months previously—and he was suffering from depression. The physician agreed that his behavior was inappropriate and complied with a referral to a psychiatrist for evaluation. A subcommittee of the medical executive committee determined that no further action was required.

2 A prominent cardiologist is accused by a nurse of sexual harassment and referred by the hospital to the physician health service for assessment. When interviewed, the cardiologist denied the allegations and painted a picture of himself quite different from other sources of evidence. During the investigation, other nurses came forward with similar stories of harassment, and it became apparent that the cardiologist had intentionally misrepresented information regarding his behavior. The hospital medical executive committee held a disciplinary hearing and
ultimately revoked the cardiologist’s hospital privileges, as per existing hospital and medical staff policies. Several nurses filed civil suits against the cardiologist, but the hospital was not named because it had acted promptly and in accordance with its own policies.

Important differences between these cases guide our responses to the different situations. In both incidents, the hospital had a definitive policy in place and effective, competent leadership. In Vignette 1, the staff nurse had the courage to file the report and was supported by the ED head nurse. Although the chair of the medical staff executive committee was aware of the situation, the intervention was conducted by the ED chief. The physician demonstrated insight, acknowledging that his behavior was unacceptable, cited an event that helped to explain—though not excuse—his behavior, and suffered from a highly treatable condition. This case has a good prognosis.

In Vignette 2, it quickly becomes apparent that the cardiologist is a liar who has repeated his misbehaviors. From the thumbnail sketch of events, we can guess that he has a personality disorder, probably narcissistic personality, and may even be a sociopath. He was dealt with quickly, firmly, and competently by the hospital and physician leadership. His prognosis is poor.

Most hospitals are quite competent to handle low-grade disruptive behavior (Vignette 1) without outside consultation; however, even in this case, the hospital had clear policies, educated and empowered nursing staff, and strong physician and nursing leadership. The 2001 Joint Commission on the Accreditation of Healthcare Organizations revisions to medical staff standards direct hospital and physician leadership to have processes in place that optimize professional functioning. One of many useful resources is A Practical Guide to Preventing and Solving Disruptive Physician Behavior by Drs. Richard Sheff and Todd Sagin, step-by-step guidelines for documentation, intervention, and correction of disruptive physician behavior.

The More Difficult Cases
Life would be wonderful if all problems with disruptive physician behavior were as manageable as Vignette 1 or as clear cut as Vignette 2. But what about those cases that fall in between: serious, but not felt to warrant revocation of medical staff membership. And what if the problem is complicated by a maladaptive hospital culture that conforms to or nurtures the disruptive behavior? One approach is offered by a UCSD PACE on-site consultation program.

The Team Effectiveness: Assessment and Management (TEAM) program group “diagnoses” the problem through personal interviews and survey instruments, then designs and implements an intervention for the entire clinical unit (and sometimes the entire hospital) to address the problem. Because each situation is different and each hospital culture is unique, each engagement is tailored for the individual client hospital.

The consultation group comprises a variety of professionals with expertise in the health care industry. The basic philosophy is that these problems are best viewed and treated as systemic cultural dysfunctions of the clinical unit, not focused solely on the individual “disruptive” physician. TEAM consultations are intensive interventions aimed at the index physician’s entire clinical team. Such consultations generally last a minimum of one year, but two to three years (or longer) may be optimal. Specific education and training emphasizing communication and leadership is given to the entire team (physicians, nursing and other staff, and sometimes hospital leadership, too). Individual coaching is provided for the identified disruptive physician and for other team members as necessary.

Disruptive physician behavior begins with selection to medical school and is developed and supported throughout education into practice. Undergraduate colleges; medical schools; residencies; credentialing, professional, and licensing organizations; hospitals (including staff and administration); and medical groups all own a piece of this problem: its causes and its solutions. The solutions are not easy, but help is available for the health care institutions that wish to seek it.

Notes and References
5 www.imq.org
6 The University of California at San Diego PACE Program, and the Division of Family Medicine, UCSD School of Medicine use the tools and processes created by the College of Physicians and Surgeons of the Province of Alberta for their Physician Achievement Review (PAR) Program. Available at www.par-program.org. Accessed August 29, 2006.
Performance Assessment in the Emergency Department

by Mona Sigal, MD, and Sally DiGennaro, RN

Dr. Sigal is Acting Chief of Emergency Services for North Shore Medical Center (NSMC) in Salem, Massachusetts. Ms. DiGennaro is a Quality Specialist in the Department of Performance Improvement and Patient Safety for NSMC.

In 2002, the North Shore Medical Center (NSMC) Emergency Service had no formal processes or metrics in place to help qualify or quantify Emergency Department (ED) physician medical practice—or any other clinical activity in the ED. No one in the ED was assigned for the purpose of quality improvement at any level. There was a framework for peer review case selection at NSMC, but there was no peer review process within the ED. Physicians in this setting had no input into the case review process, nor any benefit from the associated learning opportunities.

Once this deficiency was recognized, the first goal was to earn the ED staff’s trust in order to better engage them in quality improvement. We started by initiating peer-protected case review. The process included a reason for the review, a severity score, and an outcome recommendation. Our key message to the physicians was that the peer review process would not be punitive; it would offer them chances to learn from each other’s experiences and opportunities to improve patient care. And, because almost every review revealed some aspects of nursing care that merited feedback, we simultaneously launched quality improvement peer review for the ED nurses.

In the four years since this process started, we have seen a steady decline in the number and severity of cases referred for ED physician peer review. The expectation is that this will be positively reflected in NSMC ED’s malpractice experience.

Simultaneously, back in 2002, the NSMC Department of Performance Improvement and Patient Safety was helping to develop a system-wide form for physician reappointments. We used their tool to develop an ED-specific physician report profile. With participation by the ED physicians, and several drafts, the profile now incorporates the following:

- volume indicators: e.g., visit volume, relative value units (RVU) production;
- clinical indicators: e.g., X-ray discrepancy, 72 hour returns, timeliness of dictation, Press Ganey patient satisfaction scores; and
- service quality indicators: e.g., peer review.

This “report card” will always remain a dynamic document, adaptable for new metrics. It enables the chief to review all relevant physician data on one form at any time. The plan is to also use this tool for individual physician feedback every six months so that each physician has an opportunity to make himself/herself aware of what may need special attention.

Using Data

Based on national indicators pertinent to emergency medicine and CRICO/RMF recommendations, NSMC began to collect data and report on: unscheduled returns to the ED (≤72 hours) and the admission rate associated with it, codes, and deaths in the ED. With input from all the ED physicians, department-specific benchmarks for internal metrics were developed for:

- compliance with dating/time stamping medication orders,
- timeliness of dictation, and
- X-ray discrepancy rate (along with the need for change in treatment).

Productivity metrics reported on a regular basis include:

- RVU production,
- patient length of stay, and
- admission rates.

The Department of Performance Improvement and Patient Safety collects and analyzes the data. Those analyses are then reported to the chief of emergency services. Our interpretations are developed into recommendations for process changes or improvements, which are shared during monthly ED physician staff meetings. From a performance improvement perspective, it is essential to have one key person to work with the department chief and the physicians. Long-term relationships lead to trust, acceptance, and consistency of results.

Nursing, Too

From the start, we identified nurses and other staff members in the department who had important ideas but nowhere to take them. With an investment of time and effort, we developed a project wish list, and chose the most pressing items (from the nursing perspective). The Department of Performance Improvement and Patient Safety was again instrumental in developing metrics we could collect, report, and follow up on. Eventually, our ED operational quality improvement committee became “famous” within NSMC and is a regular participant at the monthly hospital quality improvement committee.

Again, leadership is key: an enthusiastic nurse leader stepped up to this challenge at the right time to lead this group on the path of project development and data collection. Some of the initiatives and metrics developed to measure them are:

- door-to-triage times,
- door-to-EGK times,
- nursing reassessment after analgesic administration,
- compliance with required screening processes, and
- problem-oriented nursing documentation.

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Red Flags*
A planned adrenalectomy resulted in the unintended excision of pancreatic tissue from a 38-year-old patient who subsequently suffered significant related health problems.

by Jock Hoffman
Jock Hoffman is Editor of Forum

Clinical Sequence
During his residency, Dr. Green was twice named in malpractice suits by patients with post-op complications (one was settled, the other was eventually dropped by the plaintiff). In June 2001, after completing his residency, Dr. Green joined a general surgery practice and was granted attending status at a teaching hospital.

In August 2001, 38-year-old Toni Goodman was referred to Dr. Green for an adrenalectomy. Goodman’s medical history, was significant for congenital blindness, hypertension since age 24 (poorly controlled), chronic otitis media with partial hearing loss, and obesity (5’2”, 223 lbs). She had previously undergone a cholecystectomy.

During the 11 months prior to her referral to Dr. Green, Goodman suffered daily morning dizzy spells, muscle aches, and weakness. Testing revealed elevated blood sugar and low potassium. Goodman was diagnosed with mild diabetes and Conn’s syndrome (excess production of the hormone, aldosterone) and placed on an ADA diet and an oral hypoglycemic medication. An abdominal CT scan revealed a 1cm nodule on the medial limb of her left adrenal gland.

In September 2001, Goodman was scheduled to meet with Dr. Green for her pre-operative workup and informed consent discussion. To avoid a scheduling conflict, Dr. Green asked a resident to meet with Goodman. The resident explained the procedure and its risks including bleeding, infection, need for further surgery, injury to other organs, and death. Goodman signed the consent form and was scheduled for surgery in early November.

On the morning of surgery, Goodman met Dr. Green for the first time. He began the procedure laparoscopically but, when he encountered excessive bleeding, converted to an open procedure. Per his surgical note, he

… carried the incision down into the abdomen and easily identified the adrenal … Schnidts were used to shell the adrenal out of its bed… Given [the patient’s] body habitus, bleeding, and the small size of the left adrenal, adequate visualization of the left upper quadrant retroperitoneum was extremely difficult.

In the recovery room, Dr. Green told Goodman that the procedure was “a little trickier than we expected, but a success.” Later that day, when asked about the case by the senior surgeon in his practice, Dr. Green replied: “Well, her size posed some unexpected problems, but we got it done.”

Two days after surgery, the pathology examination revealed that the specimen consisted of 44 grams of pancreatic tissue (a normal pancreas weighs 60–140 grams). No adrenal tissue was identified.

When informing Goodman of the pathology finding, Dr. Green told her, “due to your body shape, I had difficulty locating the adrenal gland.” When he recommended to her subsequent surgery (to perform the adrenalectomy) Goodman adamantly refused. Two months later, her hypertension and hypokalemia returned and she was placed on Aldactone. Because her blood sugars began to rise, she had to switch from oral hypoglycemics to insulin. She also began taking oral enzymes for pancreatic insufficiency.

Following this incident, the hospital submitted a report regarding the wrong site surgery to the Department of Public Health. Several months later, Goodman wrote a letter to the hospital CEO indicating that she considered him and Dr. Green responsible for her injuries. Her case was also discussed during one of the hospital’s surgery morbidity and mortality (M&M) meetings. In June 2003, Dr. Green (now board eligible) applied for recredentialing to the hospital.

Claim Sequence
Two years after her surgery, Goodman filed a malpractice claim against Dr. Green and the hospital. She alleged that the surgeon wrongfully removed a portion of her pancreas, resulting in her becoming insulin dependent. She further alleged that the hospital was negligent in allowing Dr. Green to practice within its setting. Based on the nature and extent of the injuries, Goodman’s claim was settled in the high range (>500,000). In the report filed with the National Practitioner Data Bank, CRICO/RMF allocated 100 percent of the payment to Dr. Green.

Discussion Points
1. After reviewing Dr. Green’s initial application, references, and other credentialing materials, the hospital granted him membership into its medical staff and awarded him “general surgery” privileges—allowing him to perform the same surgeries as many of his more experienced colleagues.

Rigorous credentialing and privileging of new attending physicians takes into account the experience they have had performing the surgeries for which they are requesting privileges. Some of the more complex procedures, may warrant a time-limited proctorship in which the physician can gain experience while being observed by a more experienced colleague and the hospital can gain confidence in the physician’s skills. Requirements related to board certification can also be implemented.

2. When Dr. Green encountered intraoperative complications he, perhaps inhibited by the prevailing hospital culture, chose not to seek help.

Patients are safer in a health care setting where physicians are encouraged to seek consultation or mentoring when they encounter unusual medical conditions or attempt unfamiliar procedures. A culture that encourages asking for help when you are in over your head avoids risks encountered in those environments that interpret such practice as a sign of weakness or lack of intelligence. Mentoring programs for aligning inexperienced physicians with more experienced colleagues to review and discuss their questions may be enough to keep their practice safe and successful.

*The case study is drawn from actual closed malpractice cases naming CRICO-insured clinicians. Names and some non-essential facts have been altered to protect identities.

Continued on next page
The exciting results are that all of these projects have positively affected staffing patterns and overall clinical practice.

**Follow-up**

When NSMC ED saw a need to better educate physicians about liabilities and improving risk management around ED patient follow-up, we developed a new protocol: patients who leave without being seen by a physician, are phoned the next day.

Coincidentally, NSMC ED also faced a lack of reliable communication and follow up of X-ray discrepancies. To improve that process, Emergency Services and Radiology worked together to develop a scannable form that enables continuous communication between the ED physician and the radiologist. This was matched with an internal ED protocol for patient follow-up aimed at ensuring seamless communication between the ED, the patient, and the primary care provider. The metrics collected on the form provide feedback directly to the ED physicians. Initially, the physicians were skeptical, but quickly recognized the value of this information—and it has improved their performances.

We have made numerous changes and seen measurable improvement. Of course, we still have opportunities for making the NSMC ED even safer. The important principle in all of these endeavors remains the individual ED physician’s opportunity for input and sense of participation. We know that, if we want to hold physicians accountable, we have to have them fully involved from the start of every improvement effort.

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3. Dr. Green, with limited experience as the primary attending surgeon, met Goodman, a patient with a complex history and a potentially problematic physical stature, for the first time the morning of her adrenalectomy. Patients undergoing elective procedures should be able to meet their surgeon and ask questions, and every patient deserves to be treated as unique, not routine. A surgeon—especially one with limited experience—should know exactly what he or she will encounter in the OR. One way to build trust and align expectations is to meet and examine the patient first hand. In this case, had Dr. Green examined this patient he may have concluded that given her height, weight, and medical condition, beginning with an open procedure may have been more advantageous.

4. Dr. Green exhibited a number of behaviors that might indicate communication or attitude problems: delegating the consent discussion, eschewing the need for assistance in the OR, downplaying the complications he encountered, and shifting the blame to the patient.

Multiple points of questionable behavior draw a picture of concern, but only if someone can see the whole picture. Colleagues who only encounter one incident lack the context to see a bigger problem. Credentialing and privileging entities need processes that enable them to fully “know” the individual being assessed. More comprehensive credentialing structures, such as those now in place at Mount Auburn Hospital (see Page 6), or 360-degree assessments such as those promoted by the UCSD PACE program (see Page 15) facilitate a broader view.

5. Dr. Green has invested considerable time and expense to earn the right to practice surgery. His potential to earn income for both himself and the hospital is significant; his opportunity to improve and even save lives is worthy of protecting his reputation and improving his individual and team skills. Only a small percentage of behavioral issues merit punitive measures. For the remainder, the option of tolerating them or addressing them along informal channels may put the sponsoring institution at unnecessary risk if the concerning behavior persists. Formal programs aimed at improving behavior and communication skills better serve patients and providers and may reduce the hospital’s liability.

6. Goodman had not yet filed her malpractice claim prior to Dr. Green’s recredentialing deadline, but her complaint letter had been shared with Dr. Green and the chief of surgery.

A recredentialing process that reaches beyond the components of the standard application affords the assessment team a more complete understanding of a candidate’s day-to-day practice. Among additional information hospitals might opt to include in the analysis are: complaint data; incident reports; M&M reports which contain recommendations; volume-related data (e.g., admissions, readmissions, deaths, complications); and staff interactions. These measures should be collected on an ongoing basis. Any troubling trends should be identified and dealt with early, not necessarily waiting for the recredentialing process to catch them.

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**Notes and References**

1. Salem Hospital is a 248-bed community hospital in the North Shore Medical Center system north of Boston. The ED sees more than 45,000 patients a year. Currently, 13 board-certified Emergency Medicine physicians provide ED coverage. Between 8 a.m. and midnight, North Shore Children’s Hospital operates a separate pediatric ED with an annual volume of about 15,000 patients (from midnight to 8:00 a.m., pediatric patients are seen in the adult ED by ED pediatricians).

2. Pertinent cases (with nursing issues) which have been referred by the ED physician quality improvement peer review are presented during monthly nursing staff meetings, in a non-punitive atmosphere. This process, which is mostly educational in nature, has generated internal changes and sparked a hospital wide nursing peer review committee.

3. Centers for Medicare and Medicaid Services (CMS) and other insurers use relative value units (RVUs) to determine the reimbursement rate for services.
The following additional resources related to clinician credentialing and privileging were selected from the Pubmed (Medline) database of indexed literature published from 2000 through August 2006.

General Interest

Specialty Specific
Gynecology

Pediatrics

Psychology

Radiology

Rehabilitation Medicine

Surgery