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Privileged Communication

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Negligent Credentialing

When a physician applies for privileges at a certain hospital, the hospital is required to verify the physician's credentials by investigating their education, training, licensure and certifications. Privilege requests are specific to the physician's practice and training and require evidence of ongoing competence for re-privileging.

Appointments are usually granted for 2 years, but this is stipulated in the medical staff bylaws. A letter is usually sent to the physician stating the privileges have been granted, what specifically they are and the date the appointment will expire. There is usually a check off list included with the application identifying which specific privileges the physician is requesting. The credentialing committee will review the education records and/or continuing education certificates documenting that the physician has completed the appropriate training. The physician also needs to demonstrate current competence in a particular procedure. On the application the physician documents the number of times he has performed each procedure. If the physician has received training but has not performed the procedure in a long time, he may no longer be competent to perform the procedure without additional training or experience.

Rural hospitals often have difficulty attracting specialists and may hire someone with less experience than a city hospital, therefore the standard for credentialing may be less stringent. In addition, due to fewer physicians on staff, the ability of existing staff to monitor newer physician performance is hampered.

A common allegation plaintiffs may make against a hospital is that the hospital failed to adequately and properly scrutinize a physician's application for privileges, staff membership, re-privileging and/or specific procedures for privileging. Another possible allegation against the hospital may be that the hospital failed to supervise the physician.

The plaintiff attorney should always request the physician's "credentialing file" when this allegation is being considered, although it may be protected by peer review privilege. Other documents to request may include the hospital bylaws and a copy of the contract between the hospital and physician. These should also be reviewed by the defense.

Types of documents that may be included in the credentialing file are: department clinical privilege request form, initial application for medical staff appointment, clinical privileges and reappointment, correspondence between hospital department chairs and the physician, board of trustees meeting minutes, temporary staff privileges, state board of medicine certification, verification of licensure from state Board of Medicine, CV of physician, certificate of insurance, controlled substance registration certificate, verification of undergraduate degree, verification of residency and medical school, references from medical school professors, references from hospital CEO to another hospital , documentation that physician acted in accordance with the medical staff bylaws regarding medical records completion and letters from medical specialty Boards regarding certification.

If working for the defense, one must be careful in what you disclose to your credentialing expert, otherwise the privileged protection may be waived.

Source: Journal of Legal Nurse Consulting, July 2003.

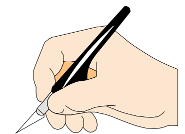
Credentialing Practices Survey

In October 2001 HCPro conducted a survey of organizational credentialing practices. There were 1159 respondents from hospitals, managed care organizations, physician practice groups and long term care facilities. Below are the items this writer found most interesting. The full text can be reviewed at www.credentialinfo.com or call us for a copy.

- 43% of organizations verified all licensure information, as opposed to current licensure only or going back a certain number of years
- 81% verified all post graduate training programs
- 93% obtained the applicant's medical malpractice history
- 67% only went back 5-10 years to verify malpractice history
- 20% did not check specialty board status
- 30% accepted signed references from the applicant, as opposed to department chairman, physician in same specialty or physician who observed the applicant first hand.
- 27% always perform criminal background checks
- 88% always verify prior appointments or
- employment
- 84 % always perform clinical reference checks
- 17% permitted a physician to begin practicing before verifying qualifications in the previous 2 years. ◆

ADDRESS CORRECTION REQUESTED

Universal Protocol for Wrong Site Surgery Established



In spite of widespread acknowledgment that wrong site surgery is preventable and should not occur, the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) receives 5-8 reports every month from organizations that provide surgical services.

In July 2003, the Board of Commissioners of JCAHO approved a "Universal Protocol" for preventing wrong site, wrong procedure and wrong person surgery. Compliance with this protocol by all accredited organizations that provide surgical services will be required beginning July 1, 2004.

Last spring, a national Summit on wrong site surgery was convened by the Joint Commission, the American Medical Association, the American Hospital Association, the American College of Physicians, the American College of Surgeons, the American Dental Association and the American Academy of Orthopedic Surgeons. The Summit concluded that a universal protocol was needed.

The main components of this protocol are: 1) a pre-operative verification process; 2) marking of the operative site; 3) taking a "time out"immediately before starting the procedure; and 4) adaption of the requirements to non-operating room settings, including bedside procedures. For more information about these components visit: http://www.jcaho.org/accredited+organizations/patient+safety/universal_protocol_appendixa.pdf ◆

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