

Oversight of the Hospital-Based Credentialing and Peer Review Process

Arthur S. Shorr, F.A.C.H.E.

The current process of credentialing, privileging, and managing the peer review process, fundamentally unchanged since the mid-20th century, is effectively obsolete.

Healthcare leaders must find alternatives that will restore the effectiveness of this necessary and complex process, preserving the prerogatives of the self-governing medical staff while increasing patient safety and reducing the hospital's exposure to lawsuits from medical malpractice claims.

One of the most important fiduciary duties and responsibilities assumed by a hospital's governing body is the credentialing and granting of delineated privileges to licensed independent practitioners (LIPs), who include physicians, dentists, and all licensed clinical affiliates who are granted practice privileges in ancillary medical staff categories. It is only through this authority that LIPs can practice the complex healing arts that modern technology and science have made available. Because of the governing body's duty to limit clinical practice privileges to only those LIPs who are properly qualified, obvious questions are:

- Are the 5,500 hospital governing boards consistently and uniformly acting appropriately and in the safest manner possible when credentialing, granting clinical privileges, and reviewing peer review allegations?
- Are our 5,500 hospitals vulnerable and exposed to legal actions for ratifying inappropriate physicians, or engaging in maliciously motivated sham peer reviews that harm highly qualified practitioners?
- Are governing boards inadvertently placing patients at higher risk and in harm's way?
- Are there more effective management mechanisms that, if implemented, could materially enhance patient safety, lower the incidence of malpractice, and reduce the hospital's risk of litigation?
- Can national community clinical standards and rapidly evolving information technology offer new, effective strategies for credentialing and sham peer review avoidance, and thereby enhance patient safety?

Systemic Redundancy

Since patient safety is or should be the highest priority of every acute care hospital, it is important to appreciate that one of the distinguishing management characteristics of such a hospital is widespread adoption of the principle of systemic redundancy: the creation of backup systems for those foreseeable circumstances where critical equipment,

environmental, or staff failures create extraordinary hazards for patients, visitors, and staff. Obvious examples of systemic redundancy include standby generators, review of physician medication orders by clinical pharmacists, over-reads by radiologists of clinical interpretations of X-rays by emergency department physicians, and RN patient advocacy.

How do hospitals create systemic redundancy in oversight of the otherwise self-governing medical staff? How is oversight of complex issues of credentialing accomplished? Can more effective oversight from governing bodies prevent sham peer review from harming well-qualified physicians?

As is reflected in the corporate bylaws of all accredited hospitals, oversight of the medical staff is the duty of the chief executive officer (CEO). To enhance oversight, the CEO acts as an ex-officio medical executive committee member.¹ Members of the administrative staff, representing the CEO, attend all clinical department and working committee meetings of the medical staff. The CEO or his designee is further obliged to review all medical staff committee minutes to assure the governing body that no medical staff business takes place outside CEO oversight and that all medical staff committee activities comply with the medical staff bylaws. Executive oversight should not be misinterpreted as a constraint on self-governing prerogatives but rather as an added patient safety mechanism, a systemic redundancy.

Granting of delineated clinical practice privileges is reserved to the governing body, often a group of prominent lay community leaders, serving in a voluntary capacity, absent clinical expertise or insight. The governing body therefore relies heavily on recommendations of the medical staff committees and in particular the medical executive committee.

Why Does Oversight Fail?

There are a number of possible reasons why otherwise well-qualified, competent CEOs have problems discharging medical staff oversight duties. These include:

- The CEO may not understand the duties and responsibilities.
- The CEO himself may be a co-conspirator or enabler.
- The personal and career-threatening risks of intervening in these matters causes CEOs to avoid addressing these problems.²

Although as a whole hospital administration students are well trained and experienced, there are some deficits in graduate education of executives. Surprisingly, a number of CEOs who, when testifying under oath about their oversight

duties and responsibilities, demonstrate a fundamental lack of understanding of the implications of those responsibilities when unqualified LIPs are credentialed or when sham peer review occurs.

CEOs sometimes become co-conspirators or enablers, often as a result of economic performance pressures or medical staff political agendas. In many instances CEO tenure is directly affected by the political climate and rapport, or lack thereof, with the medical staff. The risk/reward ratio of intervening in a polarized medical staff situation may be too risky to the CEO's career and personal interests. It is tempting to side-step the problem situation and concentrate on other pressing issues, such as budget management, cost containment, nursing shortages, and reimbursement problems. If there is infighting among physicians, whether from economic competition or power struggles, the CEO may perceive that he faces a choice between doing the right thing, and putting his career and his family's economic security at risk. For senior executives over age 50, the risk is even greater. Additionally, economic pressure on CEOs in investor-owned hospitals can be intense, leading to rationalization of the recruitment of questionable but high-revenue-producing physicians.

Implications of Failed Oversight

If a flawed applicant is credentialed, or an LIP is knowingly permitted to practice beyond the scope of training, experience, and current competence, ostensibly resulting in patient injury, the hospital faces serious financial liability and damage to reputation. This insight results from first-hand administrative experience and from testifying as an expert witness in some 150 cases alleging negligent credentialing.

On the other side of the mal-credentialing spectrum, hospital administrators can be complicit in sham peer review that damages highly qualified LIPs.

How can the governing body be assured that the oversight mechanism has not been circumvented, corrupted, or even subtly compromised? How does the governing body evaluate the CEO's effectiveness in discharging oversight duties and responsibilities of the medical staff? Given the enormous pressures for economic performance, and the intense political environment in which the CEO must operate, are present-day CEO accountability mechanisms for medical staff oversight adequate?

A Novel Solution for Improving Oversight Effectiveness

Today there are no mechanisms in the interactions, motivations, and reporting relationships between the governing body, medical staff, and CEO designed to identify CEO oversight failures. Often, the governing body does not become aware of medical staff issues until a claim of corporate negligence or negligent credentialing is brought in the context of a medical malpractice suit, or a formal complaint by a member of the medical staff reaches the latter stages of

the disciplinary appeal process. These vulnerabilities suggest the need for additional mechanisms to assist the governing body. To that end, the governing body should commission a formal, comprehensive annual audit of the CEO's oversight as an additional safety mechanism.

Engaging external auditors is not unprecedented. Annually, the governing body retains independent certified public accountants to audit the financial records, accounting systems, and internal controls of the hospital's finances. The governing body could similarly engage an independent external executive auditor to certify and assure the effectiveness of the oversight mechanisms specific to credentialing and peer review.

Hospital chief financial officers (CFOs) recognize that the annual audit process is a powerful management tool that reduces errors and enhances financial accuracy. Likewise, an external audit would strengthen the credibility of the CEO in the eyes of the medical staff, afford greater independent authority to insist on strict compliance with the medical staff bylaws, and diminish the personal risk that might otherwise be focused on the CEO for doing his job.

To minimize the potential for administrative and medical staff resistance, the scope of the audit could be narrowly limited to evaluating and reporting on the effectiveness of the CEO in discharging oversight duties and responsibilities. Specifically, these responsibilities focus upon "process compliance" with medical staff bylaws and regulations. The audit report should be made directly to the governing body in executive session. If results reveal material defects, expanding the scope of the external review is a prerogative that should be reserved to the governing body.

Components of the Proposed Audit Process for Credentialing

The community standards for privileging and credentialing are reflected in the medical staff bylaws, hospital policies, and Joint Commission standards. All are designed to maximize patient safety. Among the critical standards and concepts are those designed to ensure compliance in:

- Completing a thorough due-diligence process of verification of all application elements prior to formal action on the application to assure from the onset that applicants are actually eligible to apply for the requested privileges;
- Defining and correlating the requirements for core privileges in terms of specific training and experience requirements, if the core privilege concept is used;
- Validating that each clinical department defines each non-core delineated privilege, correlated to specific training and clinical experience requirements;
- Ensuring that all initial privileges are properly limited to conditional, provisional, or restricted status without exception, and that these restrictions are enforced;
- Ensuring that direct observation and/or contemporaneous chart review that objectively validates current competence is completed before upgrading a practitioner to unrestricted (unsupervised) status, without exception;

- Establishing and enforcing administrative systemic redundancies in the surgical scheduling office to validate that the LIP has been granted the appropriate delineated privilege required for the procedure and is in good standing at the time a case is scheduled; and
- Empowering and supporting the circulating nurse to discharge the duty to properly validate active, delineated privileges in the operating room, and verify that the surgeon is in good standing prior to allowing a surgical procedure to start.

These are the baseline administrative elements that independent auditors can effectively review in order to render an opinion about the effectiveness or ineffectiveness of the CEO in properly discharging oversight of the medical staff credentialing process.

Role of the CEO in Preventing Sham Peer Review

Just as the CEO has oversight of the credentialing and privileging process, the CEO must also assure the governing body that all peer review processes and all elements of the disciplinary action process are discharged fairly, honestly, and in strict compliance with the intent and safeguards defined in the medical staff bylaws. Use of a court reporter or audio recording of all proceedings involving disciplinary actions should be required.

Under no circumstances can the CEO be an enabler or co-conspirator. The CEO must ensure that all elements of the disciplinary process are objective, and that the rights of the defendant physician are respected. These include:

- Strict compliance with time requirements in the medical staff bylaws;
- Accurate recording of minutes of all meetings and deliberations;
- Demonstration that all notice requirements are discharged in a timely manner;
- Affording proper access to records and documents to the defendant physician in a timely way;
- Allowance of adequate preparation time to the defendant once document requests are received;
- Representation by legal counsel that is in no way restricted or compromised;
- An unbiased hearing committee, free of conflicts of interest;
- Objective external review for all allegations involving clinical performance in order to validate claims made through peer review; and
- Assurance that all principles of fair play are honored in all elements of the process.

Given the profound financial and reputational harm to an individual LIP whose privileges are wrongfully terminated, as well as the financial and legal exposure to the hospital resulting from valid claims of malicious peer review,³ the governing body and CEO are morally obligated to rethink how best to safeguard against sham peer review.

An Objective Hearing Master

All peer review matters and disciplinary actions of consequence, defined as those that could affect an individual's credentials, practice privileges, and income-earning capacity, or could require a report to the National Practitioner Data Bank, should be presided over by an unbiased attorney hearing master, with a court reporter recording all formal disciplinary sessions. The concept of a hearing master is drawn from the procedures established in our legal system. Hearing masters are appointed at the direction of the presiding judge in those circumstances in which supervision of attorneys is necessary to ensure objectivity and compliance with the court's rules and procedures.

The hearing master should have no linkage or relationship to any of the parties involved, including the defendant physician, medical staff leadership, or hospital executives. Choice of the hearing master should be agreed upon by both the hospital and the defendant physician. The hearing master would supervise all aspects of the disciplinary process to assure compliance with the principles of due process afforded under the medical staff bylaws, and arrange for a proper, anonymous peer review by specialists in the same specialty as the defendant physician.

To further maximize objectivity, a pre-determined limit on the maximum number of cases that a particular hearing master could accept should be established. Hearing master compensation must also be considered. Allowing the hospital to compensate the hearing master is shortsighted and not in the best interests of maintaining procedural transparency. To that end, all fees and costs are best split evenly between the hospital, medical staff, and the physician under review. In this fashion, the bias that could result from the anticipation of future engagements from the hospital is minimized.

Conclusions

To assure patient safety while protecting the medical staff against sham peer review, better oversight of the credentialing and peer review process is needed. Periodic external audits of the effectiveness of CEO oversight, the use of unbiased hearing masters, and requiring use of stenographic reporters to ensure accuracy of all proceedings involving disciplinary matters are three relatively simple, implementable, cost-effective administrative mechanisms that can have an immediate positive impact.

Arthur S. Shorr, F.A.C.H.E., is a former hospital administrator and an expert witness on hospital corporate negligence. Contact: avishorr@gmail.com.

REFERENCES

1. JCAHO 2012 Hospital Accreditation Standards, MS. 02.01.01: Elements of Performance.
2. Stewart JB. *Blind Eye: How the Medical Establishment Let a Doctor Get Away with Murder*. New York, N.Y.: Simon & Schuster; 1999.
3. *Poliner v. Texas Health Systems*, WL 22255677, N.D. Tex., 2003.