

Credentialling (and defining the scope of clinical practice)

A national perspective

CRE in patient safety

15 August 2008

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Background

- Long tradition of 'credentialling' in Australia
- Standard commissioned by ACSQHC in response to consumer and health care organisational concerns – an identified need for and expectation of a clear process
- Based on early work by Queensland Health
- Applies to medical practitioners with independent practising rights
- Approved by Health Ministers July 2004
- Support package available

Queensland Public Hospitals Commission of Inquiry:

Both the Medical Board and Queensland Health failed to check the credentials which he submitted. Had that been done, his discreditable past would probably have been revealed.

At no stage did [X and Y] have Dr Patel's skill and competence assessed by a committee of his peers ... that should have been done before he commenced to see or operate upon patients at the Hospital, and again before he was reemployed a year later.

Queensland Public Hospitals Commission of Inquiry:

In none of the relevant cases ... were the relevant doctors credentialed or privileged. This was astonishing for two reasons. The first was that the obligation to do so, and the manner of doing so, was clear and simple. And the second and more important reason ... was that it was so obviously vital for patient safety to have a doctor's skill and competence adequately assessed before he commenced work. There was no excuse for not doing so.

- 10.6% of orthopaedic registrars who claimed journal publications had misrepresented their citations
- These results are comparable with those reported in other medical fields

Patel MV, Pradhan BB and Meals RA. Misrepresentation of research publications among orthopaedic surgery fellowship applicants: a comparison with documented misrepresentation in other fields. *Spine*, 2003 Apr 1;28(7):632-6

“A thousand successful asylum applicants face a review of their cases after the doctor who gave expert evidence at their hearings admitted yesterday that he was really a former taxi driver with no medical qualifications.

...

Using fictitious qualifications Baluchi set himself up as an expert counsellor, neuropsychiatrist, plastic surgeon and even a professor who had supposedly trained at Harvard and Oxford.

...

Baluchi became so confident in his scam that he even operated on patients.”

The Times On Line January 18 2005

In the UK, Sir Liam Donaldson found that in any 5-year period, approximately 6% of doctors will have serious performance concerns, the management of which calls for assistance from outside the local clinical unit or trust.

Donaldson, L. Doctors with problems in an NHS workforce. *BMJ* 1994;308:1277-82

- Consumers and others expect that ‘someone’ (i.e. from amongst those who are responsible for governing and managing the system) is verifying credentials and agreeing on and monitoring appropriateness of scope of practice
- The objective is to improve safety and quality
- An immediate aim is to verify qualifications and experience (misrepresentation is probably rare but does occur)
- The more significant longer term aim is to establish an ongoing dialogue about, and systems to safeguard, safety and quality in the organisation’s specific circumstances

“The standard’s aim is ... to ensure that relationships between medical practitioners and health care organisations are always based on a mutual commitment to patient safety ... shared responsibility for safe service provision in supportive environments ... importance of the input of medical practitioners ... the responsibilities of health care organisations to provide resources to support the services they wish to offer.”

“There has been a decline in confidence in the medical profession in Bundaberg particularly . . . The big tragedy in this is the loss of trust that’s happened in the medical profession . . . Patel betrayed the trust, and the consequences of that have been bad for the patients and they have been bad for Bundaberg, but in a sense it has sort of rocked the whole of the medical profession in Australia, hasn’t it?”

Physician, quoted in MJA 2007; 186 (2): 80-83

“As for Fraser's former colleagues, most of whom won't speak on the record, they are bitterly resentful. There are many stories of lives disrupted and long periods of depression. One said: "You'd think being investigated would be OK if you're innocent. But it's not. It's traumatic.”

Sydney Morning Herald, 23/12/2005, re: Camden/Campbelltown

Definitions and key principles

'Credentialling' – refers to the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments

Definitions and key principles

'Defining the scope of clinical practice' follows on from credentialling and involves delineating the extent of an individual medical practitioner's clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to support the medical practitioner's scope of clinical practice

Definitions and key principles

- Organisational governance responsibilities, complemented by medical practitioner registration requirements and individual professional responsibilities (principles 1 and 2)
- Patients, communities, health care organisations and medical practitioners will benefit (principle 3)
- Essential components of a broader system of organisational management of relationships with medical practitioners (principle 4)

Definitions and key principles

- The spirit should always be non-punitive (principle 5)
- The professional colleges and societies are partners and are essential if processes are to be effective (principle 6)
- Processes must be fair, transparent and legally robust (comply with principles of natural justice) (principle 7)

Content

- Guides but where possible does not prescribe
- Defines committee structure and processes
- Focuses on need for evidence-based decisions, transparency and natural justice

- Identifies the types of credentials that should be collected and verified, and how to interpret them to reach a conclusion on competence and performance
- Describes referee process
- Discusses how to assess organisational need and capability
- Describes appeal processes
- Proposes a process for the introduction of new technology

Progress in implementation

- ACHS accreditation has assisted uptake enormously
- Many organisations' policies and procedures are not robust – they have inconsistencies and gaps and incorporate processes that do not accord with natural justice requirements
- Capacity is still building, particularly relating to processes that meet the requirements of natural justice

Progress in implementation

- There remains a reluctance to judge individual performance
- Organisations need options other than committee-based processes in some circumstances
- Referee processes need strengthening
- Continuing engagement of colleges and societies is critical

Progress in implementation

- ☑ Strong organisational leadership
- ☑ Clear and comprehensive policies, referred to in by-laws/constitutional documents
- ☑ Linkage of policies to contracts of employment/engagement
- ☑ Clear delegation of authority
- ☑ Clear role and terms of reference for properly constituted committees

Progress in implementation

- ☑ Adequate organisational support
- ☑ Effective process for establishing organisational need and capability, advised by the committee responsible
- ☑ Focus on evidence-based decision making, natural justice, transparency and accountability for all processes
- ☑ Clarity of authority and processes to suspend right to practice that comply with legislation and natural justice

Progress in implementation

- ☑ Review and independent appeal processes that comply with legislation and natural justice
- ☑ Clear processes for introducing new services that assess patient benefit and financial issues prior to credentialling and defining the scope of clinical practice

Conclusion

- The environment was 'ripe' for a national standard
- There has been strong national uptake of the standard, considerably aided by ACHS focus
- The standard has enabled a broader dialogue about safety and quality
- Organisations are developing capacity, but there are more gains to be made
- Flexibility of process is required to deal with difficult performance issues
- May be timely for an evaluation and revision of the standard



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