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Changes to medical staff privileging in British Columbia

In response to findings in the Cochrane report, discipline-specific dictionaries delineating core and non-core privileges are being developed as part of the provincial Privileging Standards Project.

ABSTRACT: Changes to medical staff appointment and reappointment are now being introduced in British Columbia under the provincial Privileging Standards Project. Although "privileging" is often treated as a synonym for "credentialing," the two terms have different meanings. Privileging is the process used to request, review, and grant a practitioner permission to undertake defined activities in a specific facility. Credentialing is the process that confirms a practitioner's identity, training, licensure, experience, reputation, and skill. Inquiries in the UK and Canada have shown that some physicians do not restrict their activities to their areas of competence, and that some physicians may be pressured by colleagues to practise beyond their level of competence. After British Columbia's regional health authorities raised concerns about the misinterpretation of CT images by a small number of radiologists, the Ministry of Health asked Dr Doug Cochrane, chair of the BC Patient Safety and Quality Council, to conduct an investigation. In an effort to ensure patient safety and prevent the erosion of public confidence in medical staff, the health authorities and the College of Physicians and Surgeons of British Columbia are now moving to a new system of privileging. This system is based on discipline-specific dictionaries developed by expert panels to delineate core clinical privileges (activities or procedures permitted by virtue of possessing a defined set of credentials) and non-core privileges (activities or procedures requiring additional certification or a period of proctoring). Dictionaries for several disciplines, including diagnostic imaging, have been completed and are now in use. More dictionaries will be developed as the provincial Privileging Standards Project continues.

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Privileging is the process used to request, review, and grant a practitioner permission to undertake defined activities in a specific facility. It is a cyclical process that involves a review of credentials, experience, judgment, and skill displayed in the permitted activities. Legally, hospitals have an independent duty to grant privileges and monitor the competence of practitioners.[1] In British Columbia, the responsibility for privileging and monitoring is defined in the Hospital Act Regulation.[2]

A review of the literature about professional self-regulation finds many articles focusing on the credentials required for different disciplines and few on the topic of privileging. While many articles use "privileging" and "credentialing" interchangeably, the terms have different meanings.

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Credentials confirm a practitioner's identity, training, licensure, experience, reputation, and skill. Privileges are facility-specific permits to practise, and must take into account the ability of the facility to support an activity. Credentialing is a prerequisite to privileging.

In British Columbia, an application for appointment to the medical staff of a facility triggers the credentialing process. The associated activities include verifying identity and licensure, confirming liability insurance, reviewing training and experience, and reviewing references, which includes telephone calls to referees. Guided by the information obtained, the medical advisory committee of the facility recommends that the governing body accept or reject the practitioner's application for appointment to the medical staff. The governing body is either the board of directors of a regional health authority or, in the case of private facilities, the College of Physicians and Surgeons. Privileges, whether specific or general, are usually granted at the same time.

Responses to privileging problems in BC

An effective privileging system protects the patient from unqualified practitioners, reduces the risk of litigation, and protects the practitioner from unreasonable restrictions in practice as well as unreasonable expectations. Traditionally, permissive privileges have been granted in BC, or privileges have been determined using a checklist filled in by the physician-applicant. Both methods are weak ways to establish a practitioner's ability to undertake defined activities. Permissive privileges are implicit, not explicit. A physician with privileges in psychiatry, for example, is expected to restrict his or her practice to the "normal and customary" activities of that discipline. This nonspecific restriction is open to wide interpretation. Checklists are also problematic since they do not provide objective criteria to determine if a physician is qualified to engage in a particular activity. Relying on a system with such weaknesses has had consequences.

In 2010, the misinterpretation of CT images in three of British Columbia's five regional health authorities became a concern. While the number of practitioners involved was relatively small (about 1% of the province's radiologists), the effect on public confidence was significant. In response, the BC Ministry of Health commissioned an investigation by Dr Doug Cochrane,[3] chair of the BC Patient Safety and Quality Council.

The Cochrane report

Dr Cochrane's investigation began at a time when inquiries in other jurisdictions had identified inadequate self-regulation by the medical profession as a problem. In the United Kingdom, the Shipman inquiry[4] was especially critical of the processes in place to protect patient safety, and the Bristol Royal infirmary inquiry into the heart surgery scandal found some surgeons lacked insight about their abilities.[5] In Canada, reports from the Goudge inquiry[6] into pediatric forensic pathology, the Newfoundland inquiry into estrogen-receptor breast cancer testing,[7] and the Manitoba pediatric cardiac surgery inquest,[8] among others, questioned the adequacy of professional self-regulation.

The Cochrane report echoed reports cited above in finding that self-regulation cannot ensure patient safety. While most physicians are sufficiently professional to practise within their areas of competence, some physicians do not restrict their activities appropriately, and some physicians may be pressured by colleagues to practise outside their area of competence.

Glossary

Context-specific privileges The activities in the privileging dictionary that a facility can support.

Core privileges Activity-specific permits to practise within a facility granted without contest to all members of a discipline.

Credentialing A process that confirms personal identity and licensure, and reviews educational achievement, work experience, and personal reputation in order to determine eligibility to apply for membership on the medical staff.

Currency The minimum level of current experience that will give a practitioner a reasonable chance of remaining competent.

Dictionary A discipline-specific document outlining credentials required, core privileges, non-core privileges, context-specific privileges, and currency requirements for the activities defined.

Non-core privileges Those activities that require specified extra training, whether it be a period of proctorship with a subsequent demonstration of competence or a more formal set of credentials.

Privileging The process of requesting, reviewing, and granting activity-specific permits to practise within a given facility.

In response to Dr Cochrane's findings, the health authorities and the College of Physicians and Surgeons of British Columbia began moving to a system of criteria-based privileging. Since 2011 the provincial Privileging Standards Project has been developing privileging dictionaries (see Glossary). For each discipline represented on hospital medical staffs, members of an expert panel define essential clinical activities (core privileges), activities that require extra training (non-core privileges), and currency standards—the minimum level of current experience that will give a practitioner a reasonable chance of remaining competent.

Where overlap between disciplines is identified, subcommittees formed from those disciplines seek a consensus on the training and currency required.

The diagnostic imaging pilot project

In 2012 the newly formed Physician Quality Assurance Steering Committee, consisting of senior medical administrators from the health authorities, the College, the BCMA, and senior administrators from the Ministry of Health, chose diagnostic imaging for a pilot project to develop and implement a privileging dictionary. The steering committee defined success for the project as follows:

- The lessons learned from the pilot would be transferable to other disciplines. (required)
- The pilot project would establish a system of privileging for diagnostic imaging that would be in place by April 2013. (required)
- The medical community would endorse the end product. (desired)

Each regional health authority nominated at least two specialists in diagnostic imaging to sit on an expert panel. Members represented the different subdisciplines, including general diagnostic imaging, nuclear medicine, interventional radiology, breast imaging, pediatric radiology, and nuclear medicine.

The panel was then asked to start by reviewing a commercial product delineating core and non-core privileges in diagnostic imaging.[9] The panel members agreed unanimously that the product did not satisfy BC requirements. First of all, the standards and training the system was based on were not Canadian and therefore not applicable. For example, nuclear medicine standards were less strict than those in Canada. The commercial dictionary's currency requirements were also felt to be too permissive and unlikely to protect either the public or the profession.

During dictionary development, core privileges were defined as those activities or procedures permitted by virtue of possessing specific credentials, usually obtained through a formal training program. For practical purposes, core privileges were described as those activities that a radiologist or nuclear medicine specialist certified by the Royal College would be capable of performing. Non-core privileges were described as those activities requiring either additional certification or a specified period of proctoring. For example, certain interventional procedures such as embolization were felt to require additional expertise. Privileges were also defined by modality, with the exception of breast imaging, which combined modalities.

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Throughout the pilot project the panel struggled with the concept of currency—the threshold of experience averaged over 3 years that would need to be met, and if not met would trigger a conversation between the physician and the department head. In the absence of other standards, we used the level of activity an average physician would experience in 8 weeks of full-time practice, which is also the minimum level of activity required for ongoing licensure in a medical discipline in British Columbia. We recognize this amount of experience is not by itself a robust measure of competency, but it is a prerequisite to measuring competency and safety.

We also accepted that 8 weeks of experience would not be appropriate for all activities. For example, fluoroscopy was a modality where 8 weeks of experience was considered too long. The panel addressed this by using a modified Delphi

Table. Abridged version of the privileging dictionary for diagnostic imaging.*

Activity	Standard for currency
Radiography	800 examinations per year
1. Core: all plain radiographs	
2. ISCD bone densitometry	ISCD 5-year recertification process
Fluoroscopy	20 procedures per year
1. Core: all barium examinations, hysterosalpingograms, all other joint injections, selected biopsies, lumbar punctures, lumbar facet injections	
2. Cervical/thoracic spine injections	
3. Lumbar spine injections	
Mammography/breast ultrasound	
1. Core: diagnostic mammography, galactography, fine wire localization, stereotactic biopsies, core biopsies	300 examinations per year
2. Screening mammography	2500 examinations per year
Ultrasound	300 examinations per year
1. Core: general ultrasonography	
2. Nuchal translucency	
3. Echocardiography	Transthoracic studies, 250 per year Transesophageal studies, 50 per year
Computed tomography	300 examinations per year
1. Core: general CT, CT angiography	
2. Cardiac CT	25 examinations per year
3. CT colonography	25 cases per year
Magnetic resonance imaging	200 cases per year
1. Core: general MRI (neurological, body, musculoskeletal, MR angiography, pediatric)	
2. Diagnostic breast MRI	
3. Cardiac MRI	25 examinations per year
4. MR guided breast biopsy	3 guided biopsies per year
Interventional radiology	50 non-biopsy procedures per year
1. Core: percutaneous biopsy, percutaneous drainage, percutaneous access	50 imaging guided biopsies per year
2. Vascular	
3. Biliary	
4. Urologic	
5. Gynecologic	
6. Interventional oncology	
7. Cementoplasty	
Nuclear medicine	500 cases per year
1. Core: SPECT CT, thyroid treatment, cardiac, pediatric, general nuclear medicine	
2. PET CT	300 cases per year

*See http://privileging.typepad.com/privileging_project/2012/12/privileging-dictionary-for-diagnostic-imaging.html for the unabridged dictionary.

decision-making process, starting from zero procedures a year, and increasing until at least one member of the expert panel felt the right number was reached. At that point, a discussion occurred and consensus was reached. In the case of fluoroscopy, the panel agreed that a minimum of 20 procedures a year should be the threshold that would ensure safe operation of the equipment.

The abridged dictionary (**Table**) shown here represents many hours of work. Development required 22 hours of face-to-face meetings, 4 hours of teleconferencing, and additional time for research between meetings. The completed dictionary is now in use and will be evaluated for any unintended consequences and revised accordingly.

Lessons learned

We have learned some valuable lessons from our experience with the diagnostic imaging pilot project. The first is that while a commercial product may provide a basis for discussion, it cannot be used without modification. There are many reasons for this. In our case, the diagnostic imaging product was based on a different system of postgraduate medical education and a different regulatory framework than the one guiding medical practice in British Columbia.

A second lesson learned is that practitioners and administrators are separated by culture and by different understanding of concepts. Physicians in British Columbia are self-employed contractors. Theirs is an independent and relatively nonheirarchical culture based on the development of professional expertise, guided by a code of ethics, and governed by the College of Physicians and Surgeons of British Columbia. Administrative staff work within a collaborative and hierarchical structure; the concept of organiza-

tional governance is a matter of daily experience. To bridge these two cultures, we had to find common interests. Finding those interests was facilitated by the public scrutiny this discipline had been under. It may have been more difficult with other disciplines. Indeed, defining those interests early in the panel process has been key to the success of the project.

While developing the diagnostic imaging privileging dictionary was an accomplishment, maintaining it will require both thoughtfulness and diligence. As other jurisdictions develop more rigorous privileging systems, opportunities for collaboration will arise. Alberta, for example, has recently accepted a report on privileging and credentialing in that province.[10] Manitoba has a clinical privileges advisory panel, which may expand its scope of activity. Within British Columbia, a system of health technology advisory committees may help identify new procedures to incorporate into the dictionaries.

Three challenges remain. The first is the challenge of implementing the new system. Moving from a system based on permissive privileges or checklists to a criteria-based system will present some difficulties. The second is the need to ensure the new dictionaries reliably and validly meet the requirements of both health care delivery organizations and practitioners. The third is the need to identify practices that should be removed from dictionaries due to obsolescence. To meet these challenges we intend to reconvene each expert panel after initial implementation to review and modify both the process and the dictionary as required.

At the end of November 2013, 20 dictionaries had been completed and 10 expert panels were underway.

Conclusions

Recent instances of errors made by poorly qualified practitioners have eroded public confidence and trust in the medical system. Consequently, privileging of practitioners is receiving increasing attention across the country from regulatory bodies, payment agencies, and the media.

Going through the process of developing privileging dictionaries has shown us that Rome was not built in a day: The dictionaries we develop will not be perfect, but they will be an improvement on what we have been using. Over time, they will improve further. We've also learned that many roads lead to Rome: Different disciplines may have different ways of assuring competence. And we've learned that when in Rome, do as the Romans do: Patients have a right to expect equal access to outcomes, regardless of which practitioner is treating them.

As with any change, introducing a new privileging system has implications for the profession, many of which we have discussed here. The issue of currency has been an especially hot topic for privileging panels. We have tried to describe how physicians can regain currency, and how to help residents and other learners. We know they will need to structure their training and choice of electives to match their career plans. We also understand that with a new privileging system there will be unintended consequences. By definition, these cannot be foreseen, but we are watching for any that do arise and plan to address them expeditiously.

While privileging is the responsibility of governing bodies such as regional health authority boards, it is also part of professional self-regulation. Practitioners, especially those in leadership positions, need to use the new dictionaries to guide privileging decisions and to ensure continued relevance by supporting maintenance of skills.

To see the ongoing work of the expert panels, visit www.privileging.typepad.com, where everyone is welcome to contribute comments.

Competing interests

None declared.

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