Hospital Credentialing for the CMO — Why and How

By Mark D. Olszyk, MD, MBA, CPE

This article examines the critical role of hospital credentialing and privileging in maintaining high standards of patient care and ensuring regulatory compliance. Through a historical perspective, it highlights the evolution of these processes, influenced by significant legal cases that underscored the necessity for rigorous vetting and continuous monitoring of medical professionals. The discussion extends to contemporary strategies for effective credentialing, emphasizing the importance of robust policies, streamlined rules, and strong organizational structures.

KEY WORDS: Hospital credentialing; medical privileging; patient safety; legal cases; medical staff; quality assurance.

Vignette: You are the chief medical officer (CMO) of a community hospital. In a Q&A, you are asked why there are so many requirements for applicants who seek privileges and "What does the credentialing committee do anyway?"

As the CMO, you oversee the hospital's credentialing and privileging processes to ensure high standards of patient care and regulatory compliance. This involves verifying the qualifications, training, and professional history of applicants; collaborating with department heads to establish and review clinical privileges; and maintaining consistent standards in line with hospital bylaws and regulatory requirements.

The CMO also monitors ongoing professional performance through peer reviews and quality assurance programs, addressing any issues of conduct or competence as needed. You need not only ensure the integrity of this process, but ensure that the medical staff, the administration, the governing body (board of directors), and the community understand why this is important and why it must be done well.

Understanding the beginnings of credentialing requirements — where they began and why — can help CMOs better answer the questions posed in the vignette above.

THE EVOLUTION OF MEDICAL STAFF CREDENTIALING

Credentialing medical staff members is a fundamental practice in ensuring quality and safety in healthcare. Credentialing maintains high standards of patient care, adheres to hospital bylaws, and complies with mandates from accrediting bodies such as The Joint Commission.

The impetus for credentialing in part stems from historical challenges, problems, harm, or litigation. Medicine has been subject to regulation by central authority since it became a profession. From the courts of the Persian Empire to the medieval guilds, standards of learning and competency have been requirements for licensure.

The Rise of Hospitals and Credentialing

Many physicians become familiar with credentialing and privileging when they apply to become members of a hospital medical staff. States and territories grant licenses, but they do not give authorization or establish competence to perform specific procedures and provide types of care within a specific facility.

Hospitals as we know them arose during the 19th century. The establishment of hospitals in the United States required a sufficient concentration of population, which became feasible only with the urbanization and industrialization following the Civil War.

Early hospital administrators realized they needed patients and physicians to be viable. Until then, physicians worked out of their offices or made house calls. Therefore, to attract physicians, hospitals offered the promise of increased efficiency — consolidating patient care in one location. Hospitals also had trainee physicians (residents, house staff) who would act as assistants.

The new profession of skilled nurses provided substantial support, ensuring the hygiene of patients and carrying out

orders for diet, medications, and therapies. Finally, specialist physicians — pathologists and radiologists — would help diagnose disease.

In return for these services, hospitals required applicants to prove their competence as physicians. The early model of hospital credentialing was relatively simple; admission to the medical staff typically required only a medical license and a letter of introduction. Over time, the requirements became more stringent. Physicians seeking hospital privileges were required to provide documentation such as proof of residency completion, board certification, litigation history, and malpractice insurance.

LANDMARK LEGAL CASES AND HOSPITAL CREDENTIALING

Credentialing and privileging became much more of a concern for hospital administration after a series of landmark legal cases that exposed the need for rigorous processes to ensure patient safety and quality of care. This section reviews key cases that have shaped modern credentialing practices. Familiarity with these cases and the precedent they set would help you as a CMO explain why proper credentialing is crucial.

Darling v. Charleston Community Memorial Hospital (1965)

In 1965, the case of *Darling v. Charleston Community Memorial Hospital* marked a pivotal moment in hospital liability. The case involved Dorrence Darling II, an 18-year-old who broke his leg playing college football. He was treated in the emergency room by Dr. John R. Alexander. The application of a plaster cast was too tight, leading to severe complications, including pain, swelling, discoloration, and ultimately, amputation below the knee.

Darling and his father filed suit against Alexander and the hospital, alleging negligent medical and hospital treatment. Before this case, hospitals were often not held liable for the actions of their medical staff, who were considered independent contractors. The ruling in this case, however, established that hospitals could be directly liable for the negligence of their employees, including nurses and physicians.

This landmark decision led hospitals to implement more rigorous credentialing and monitoring processes for their medical staff, including peer review and medical staff oversight.

Johnson v. Misericordia Community Hospital (1981)

Another significant case, *Johnson v. Misericordia Community Hospital* in 1981, further strengthened the importance of comprehensive credentialing.

Following a hip operation that resulted in a paralyzed leg, the plaintiff discovered that the surgeon had previous restrictions imposed by other hospitals, including a suspension of privileges and outright denial of staff membership because of incompetence.

The ruling in this case emphasized the hospital's duty to conduct thorough background checks and credentialing of physicians before granting them privileges. This includes verifying qualifications, licenses, and histories of malpractice claims or disciplinary actions.

The Florida Supreme Court applied the doctrine of corporate negligence to a hospital for failing to properly credential a physician on its staff — the first such instance.

Insinga v. LaBella (1989)

In 1989, *Insinga v. LaBella* highlighted the importance of apparent agency in hospital liability.

In this case, a patient died under the care of "Dr. Michelle LaBella," who was later discovered to be Morton Canton, a fugitive without medical qualifications. The case reinforced the doctrine of apparent agency, which holds that hospitals can be liable for the actions of independent contractors if the hospital presents them as its agents.

This ruling meant that if a hospital creates the impression that a physician is an employee, it can be held responsible for the physician's negligent acts, even if the physician is technically an independent contractor.

This case prompted hospitals to be more transparent about the employment status of their medical providers.

Garland Community Hospital v. Rose (2005)

The case of *Garland Community Hospital v. Rose* in 2005 addressed the issue of negligent credentialing in a more contemporary context.

A patient successfully sued Garland Community Hospital after suffering permanent scarring and other injuries from a cosmetic surgery performed by a doctor who had received previous complaints. The patient argued that the hospital was both vicariously and directly liable for credentialing and allowing the physician to continue practicing despite known issues.

"Dr. Death"

You may be familiar with the story of Christopher Duntsch from the Wondery Podcast or the 2021 Peacock miniseries *Dr. Death*. Duntsch was a neurosurgeon whose malpractice led to the maiming and deaths of several patients in Texas.

Despite clear signs of incompetence and numerous patient complaints, several hospitals allowed Duntsch to continue practicing. They failed to properly investigate or report his actions, often passing him to other facilities. He currently is serving a life sentence in a Texas penitentiary.

KEY ACTIONS RELATED TO CREDENTIALING

To reduce risk of litigation, loss of reputation, and most importantly avoid harm to patients, it is incumbent upon the medical staff and the governing body to learn the lessons from these cases. Applying these lessons involves a comprehensive approach to policies, credentialing, and staff management.

The CMO plays the pivotal role in coordinating these efforts. Here are some key strategies:

1. Adopt effective policies and procedures. Developing robust and well-thought-out policies and procedures is essential. These policies should be reviewed regularly to eliminate contradictory passages that may have accumulated over time. Clear and transparent procedures help ensure consistent application and understanding across the organization.

Consider adding content to the bylaws stating that an applicant has no appeal rights until after there is a formal action taken on the application. The committee should be allowed complete latitude to ask clarifying questions and seek supporting data until it is satisfied.

2. Minimize and simplify rules and bylaws. Keep rules and bylaws simple and easy to read and understand. Overly detailed and unnecessary policies can create confusion and hinder effective implementation. Streamlined regulations enhance compliance and reduce the risk of oversight or misinterpretation.

3. Institute prudent policies and ensure compliance. Implementing policies that address specific needs, such as those concerning aging physicians, can help manage potential risks. Hospitals must follow these policies diligently to maintain high standards of care and legal compliance.

For example, policies requiring regular competency assessments (physical exam, visual acuity, neuro-cognitive evaluations) for aging physicians ensure physicians remain capable of providing safe care.

4. Establish a strong medical staff structure. Ensuring experienced chairs lead important committees and minimizing turnover in these positions is vital. Stability in leadership contributes to consistent and informed decision-making processes, which is crucial for maintaining quality standards.

For example, experienced committee chairs can provide valuable guidance during clinical quality-improvement projects. Long-term leadership stability helps maintain a strong organizational culture and continuity in patient care practices.

5. Coordinate with human resources. Effective communication and information sharing between medical staff and human resources departments is essential. This coordination includes background checks, contract terms, and pertinent information to support comprehensive credentialing and monitoring of staff.

For instance, coordinated efforts can ensure timely renewal of medical licenses and certifications. Effective HR coordination also facilitates thorough vetting processes that prevent hiring individuals with a history of malpractice.

6. Consider a non-department structure. Adopting a non-department structure can eliminate silos and foster better collaboration and communication across areas of the hospital. This approach can lead to more cohesive and integrated patient care. For example, integrated care teams can better manage complex cases by leveraging diverse expertise.

This structure can also streamline communication, reducing delays and errors in patient care. Including members of administration and the board of directors promotes transparency and adds additional perspectives.

7. Provide proper orientation and guidance for department chairs. Offering thorough orientation and ongoing guidance for department chairs ensures they are well-prepared to lead their teams effectively. Training and preparation for medical staff leaders are critical to maintaining high standards of care and operational efficiency.

For example, well-trained department chairs can effectively mentor junior staff, promoting professional development. Proper guidance helps chairs implement best practices and maintain compliance with regulatory standards.

8. Consider appointments over elections. Appointing leaders rather than electing them can reduce turnover and provide more stability in leadership positions. Consistency in leadership helps maintain continuity and uphold institutional knowledge and practices.

For instance, appointed leaders can develop long-term strategies to improve patient care quality. Stable leadership can also foster a cohesive team environment, enhancing collaboration and morale.

9. Implement core privileges and avoid laundry list privileges. Best practices suggest eliminating extensive lists of specific privileges in favor of core privileges that encompass broader competencies. This approach simplifies credentialing and ensures a focus on essential skills and qualifications.

For example, core privileges ensure that all surgeons meet basic competency standards, enhancing overall surgical safety. Avoiding overly detailed privilege lists can reduce administrative burden and focus on critical areas of expertise.

10. Resist temptation to quickly grant privileges. Hospitals should avoid pressure to rapidly credential new staff without thorough vetting. Quick privileging can lead to negligent credentialing litigation, as highlighted in several landmark cases. A careful and deliberate credentialing process is necessary to ensure the competence and safety of medical staff.

For example, thorough vetting can prevent the hiring of practitioners with undisclosed malpractice history. Deliberate credentialing ensures that all new staff meet the institution's high standards of care.

11. Ensure competency independently. Hospitals should not rely solely on external parties, such as device manufacturers, to train their staff. Comprehensive and hospital-led training programs are essential to ensure all staff meet the required competency standards.

For example, hospital-led simulation training can ensure that staff are well-prepared for emergency scenarios. Independent training programs allow hospitals to tailor education to their specific protocols and standards.

CONCLUSION

Effective credentialing and privileging processes are fundamental to ensuring patient safety and maintaining high standards of medical care. By learning from historical challenges and landmark legal cases, hospitals can implement comprehensive strategies that safeguard against malpractice and enhance overall healthcare quality.

The CMO ensures these processes comply with accrediting standards and regulatory changes through close collaboration with medical staff, administration, and legal counsel, as well as by developing and revising clear, comprehensive policies aligned with the hospital's mission and goals.

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