



**Credentialing
Orientation Handbook:**

*What Practitioners Need to
Know About Credentialing*

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Credentialing Orientation Handbook:

What Practitioners Need to Know About Credentialing

Intended audience:

- Medical staff/physicians
- Medical staff leaders

Intended for the orientation and training of the medical staff in health care organizations and facilities, this booklet will acquaint medical staff members and applicants to your medical staff with the credentialing processes and requirements outlined in the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) medical staff and leadership standards.

The handbook covers the reasons for credentialing practitioners, the steps followed to credential applicants for appointment and reappointment, and provides examples of credentialing policies and procedures. In addition, the authors answer many of the questions practitioners commonly have about the credentialing process—including why the hospital must conduct

primary-source verification, what physicians can do if denied appointment, and when the hospital must file a report with the National Practitioner Data Bank (NPDB).

In addition, the handbook will help your organization meet the JCAHO standard MS.2.1.14 and LD.2.8 that require the orientation and training of all hospital personnel.

What is credentialing?

Credentialing is analogous to the process an individual goes through to gain admission to a college, university, or medical school. It is similar to the process individuals go through to gain employment. Basically, credentialing is designed to permit the gathering of comprehensive information about an applicant's past. This information includes education; training; experience; licensure; malpractice history; criminal actions; peer references; information about the applicant's ability to treat patients safely; and, in some instances, how the applicant will assist the medical staff and hospital in fulfilling their mission.

Credentialing is designed to serve the patient, but many physicians express concern over the complexity and duplication involved in the process. Medical staffs are expected to assist the hospital in identifying the 5% or 10% of applicants with some type of unusual event in their past.

In addition, the privilege delineation process is designed to match, as closely as possible, the physician's clinical compe-

tence with the privileges he or she has been granted by the board of directors.

Credentialing structure

As a medical staff applicant, you might wonder how many days it generally takes the hospital to process an application. The below explanation should help you understand the process better:

1. In nearly all hospitals, applicants to the medical staff submit a completed application to the medical staff office (MSO).
2. The application is reviewed for completeness. The answers on the application are verified by the medical staff services professional (MSSPs), and additional information is collected from external sources.
3. Once the application is complete, and all information gathered and verified, it is sent to a department chair or credentials committee along with all supportive documentation.
4. The chair or committee—often composed of physicians—is responsible for evaluating the application and determining whether to recommend appointment to the medical staff and granting of requested clinical privileges.
5. The application is submitted to the medical executive committee (MEC) for further evaluation after the department

chair or credentials committee concludes their review. The MEC develops a formal recommendation and presents it to the hospital's board of directors.

6. The board acts on positive recommendations and, in most instances, the applicant or reapplicant is invited to accept appointment or reappointment to the staff.

The application process in many hospitals takes longer than most physicians think necessary. Unfortunately, committees do not always meet in a timely manner, and information needed to complete the application is often not forthcoming. Many days are added to the application process because of delays between the department chair's, credentials committee's, and MEC's recommendations and the board's final decision.

Policies, procedures, and bylaws

The credentialing process is governed by the bylaws established and adopted by the medical staff at your hospital. These bylaws require applicants and reapplicants to complete an application. Bylaws stress that it is the applicant's burden to complete all portions of the application.

The bylaws or credentials policies also specify the exact route the application will follow as it moves to the board of directors.

In the past, institutions often relied on references supplied by

Figure 1

Burden on the Practitioner (Applicant or Reapplicant) Policy

Policy

Each individual practitioner who either applies for or maintains medical staff membership/privileges has the burden of providing evidence that demonstrates, in the sole discretion of the hospital, that he or she meets the hospital's established criteria for membership and privileges. This policy applies at the time of initial appointment, reappointment, application for clinical privileges, employment, or at any time during a practitioner's affiliation with the institution.

Procedure

In order to fulfill this responsibility, the practitioner has the burden of producing any information requested by the institution or its authorized representatives that is reasonably necessary, in the sole discretion of the hospital, to evaluate whether the practitioner meets the criteria for medical staff membership and privileges.

In the event that there is undue delay in obtaining such required information or if the institution requires clarification of such information, the medical staff office will request the applicant's assistance. Under these circumstances, the medical staff may modify its usual and customary time periods for processing the application or reapplication. The hospital has the sole discretion for determining what is an adequate response.

Figure 1

**Burden on the Practitioner
(Applicant or Reapplicant) Policy (cont.)**

If, during the process of initial application or reapplication, the applicant fails to adequately respond within 30 days to a request for information or assistance, the medical staff will deem the application or reapplication as being withdrawn voluntarily. The result of the withdrawal is automatic termination of the application or reapplication process. The institution will not consider the termination an adverse action. Therefore, the applicant or reapplicant is not entitled to a fair hearing or appeal consistent with the medical staff's fair hearing plan. The organization will not report the action to any external agency.

the applicant; and they still consider those references. But now it is also recommended (and in certain instances required) that the institution identify which individuals may submit references. The policy on p. 7 (Figure 2) identifies the number and type of references a credentialing committee might require prior to the review of a physician's applications. The policy suggests that the credentials committee obtain information from knowledgeable individuals—not necessarily practitioners in the applicant's specialty.

Figure 2

Policy on Clinical References

It is the policy of this institution to process applications for appointment/clinical privileges only after receipt of acceptable clinical references (either a completed questionnaire or other) by the institution. Such references must be provided by individuals knowledgeable about the applicant's past clinical and professional activities. The application must include references from the applicant's immediate past or current practice settings (such as residency, current hospital, managed care organization, or immediate past hospital or managed care organization). This institution requires references from at least three of the individuals designated below.

Note: In the event this institution does not receive references from the designated individuals, processing of the application will cease and the medical staff services director and credentials chair (VPMA) will review the application to determine further action.

Specialty	References Required
Allergy and immunology	Internist, emergency department physician, and allergist
Anesthesiology	Chief of surgery, operating room supervisor, anesthesiologist
Colon and rectal surgery	Anesthesiologist, operating room supervisor, pathologist, radiologist, colon/rectal surgeon
Dentistry	Pediatrician, family physician, dentist
Dermatology	Internist, family physician, dermatologist

Figure 2

Policy on Clinical References (cont.)

Specialty	References Required
Emergency medicine	Surgeon, internist/cardiologist, emergency department supervisor, emergency medicine physician
Family practice	Emergency department physician, director of nursing, internist, family physician
Internal medicine	Cardiologist, director of nursing, chief of surgery, internist
Neurological surgery	Anesthesiologist, operating room supervisor, emergency department physician, director of nursing, neurosurgeon
Nuclear medicine	Radiologist, pathologist, head technician, nuclear medicine physician
Obstetrics and gynecology	Anesthesiologist, pediatrician, OB/GYN
Ophthalmology	Anesthesiologist, family physician, operating room supervisor, ophthalmologist
Oral and maxillofacial surgery	Anesthesiologist, chief of surgery, oral and maxillofacial surgeon
Orthopedic surgery	Anesthesiologist, operating room supervisor, radiologist, orthopedist
Otolaryngology	Anesthesiologist, operating room supervisor, family physician, otolaryngologist

Figure 2

Policy on Clinical References (cont.)

Specialty	References Required
Pathology	Surgery, internist, director of pathology
Pediatrics	Pediatric unit director, internist, emergency department physician, pediatrician
Plastic surgery	Anesthesiologist, operating room supervisor, emergency department physician, plastic surgeon
Psychology	Internist, family physician, director of nursing, psychologist
Psychiatry and neurology	Internist, emergency department physician, nursing supervisor, neurologist
Radiology	Orthopedic surgeon, emergency department physician, internist, radiologist
Surgery	Orthopedic surgeon, emergency department physician, internist, general surgeon
Thoracic surgery	Orthopedic surgeon, emergency department physician, internist, thoracic surgeon
Urology	Anesthesiologist, internist, director of nursing, urologist

Answers to your commonly asked questions



Why does the credentialing process take so long?



The process often takes longer than necessary because the applicant physician has not provided enough information on the application, forcing the hospital and medical staff to search for the information.

Occasionally credentialing takes longer than necessary because committees do not meet in a timely manner and because too much time is permitted to pass before committees or chairs act on the application. Many medical staffs have taken significant steps to reduce the time necessary for processing an application. However, it is fairly standard for an applicant without “red flags” in his or her application to take between 30 and 120 days to process.



What is primary-source verification and why is it necessary?



Hospitals are required to confirm information about the applicant’s education, training, competence, license, and history. Hospitals must contact the source that issued the medical degree or diploma to confirm this information, contact the colleagues of the applicant who will attest to the applicant’s clinical competence, verify the applicant’s physician’s license with the state that issued the license, and contact the NPDB.

Primary-source verification is required by state law and various accreditation standards, and allows the medical staff and hospital to make decisions based on a complete picture of the applicant.



How can I request a change in my privileges?



Physicians may generally request a change in their privileges by reviewing the procedures in the hospital's medical staff bylaws. In most instances, requesting a change in privileges simply requires the physician to complete a form provided by the institution that gathers information necessary to support the change in privileges.



Will I be reported to the NPDB if I don't reapply?



You will likely not be reported for failure to reapply to the medical staff. The NPDB is interested in information pertaining to physicians found to have professional performance problems. In many instances, physicians choose not to reapply due to relocation or a change in their primary practice location. However, hospitals are required to report to the NPDB any physician who resigns from the medical staff to avoid an investigation that could lead to disciplinary action.

Q

Why does the hospital charge a fee for processing applications?

A

Hospitals that charge an application processing fee often use the fee to cover the cost of primary-source verification, the submission of request for letters of reference, and fees charged by various specialty organizations for information concerning a practitioner. Nearly all colleges, universities, medical schools, and osteopathic schools charge an application fee. It is not surprising that hospitals would charge such a fee to cover the cost of processing numerous applications.

Q

What is my recourse if I am denied appointment, reappointment, or clinical privileges?

A

A physician's options for recourse under these circumstances is detailed in the medical staff bylaws and the institution's policy on fair hearings and appeals. Generally, physicians denied appointment, reappointment, or clinical privileges have a right to a fair hearing before a panel of physicians (and sometimes non-physicians) who are relatively disassociated from the credentialing process and who have no economic interest in the applicant's practice area.

Q

Who can I speak to about my application or reapplication?

A

You can speak to the MSSP, your department chair,

or an officer of the medical staff. In general, the MSSP will be in a position to answer your application or reapplication questions.



What happens if I turn in my reappointment application late?



Physicians who turn their reapplication form in late run the risk of not being reappointed to the staff.

Your appointment will expire on the date designated when you were last appointed or reappointed. If you do not submit your reapplication, your current appointment will expire, requiring that you complete a new application at a later date. In some instances, turning the application in late creates unnecessary work for the MSO, anxiety and hardship for you, and further complicates the application process.



Why am I required to answer all of the questions over and over? Why can't there be one application for the two hospitals in town, the surgicenter, the health maintenance organization, and the insurance company?



The answer to this question is complex. The organizations specified above are generally separate corporations. These corporations think they must require physicians to answer questions on the application or reapplication specifically for their organization. There are instances, however, in which health care facilities establish a common application physicians can use to apply or reapply to all of the organizations.

Q

What is delaying my application?

A

Your application is likely delayed because you failed to submit required information, or because the hospital is having difficulty verifying the information included on the application.

It is possible that your application was illegible, you did not supply addresses or telephone numbers, or you have omitted critical information that the MSO is attempting to track down without your assistance. The best way to ensure that your application is being processed in a timely manner is to contact the MSO to ask whether they need any additional information concerning your past practice, education, training, or experience.

Q

Why isn't the hospital processing my practice partner's application rapidly?

A

Hospitals attempt to treat all physicians equally. It would be unfair for the MSO to process the application of a medical staff member's partner faster than they would the application of a similarly situated physician.

Q

Why is it so hard to obtain temporary privileges?

A

The JCAHO's standards limit the circumstances under which the hospital may grant temporary privileges. To grant temporary privileges simply on the request of a physician

would jeopardize both the hospital's accreditation status and its participation in the Medicare and Medicaid programs.

If there is a significant patient care reason for granting temporary privileges, or if the community's health status might suffer if those privileges are delayed, the hospital can grant temporary privileges if all necessary information concerning the physician's education, training, experience, and competence has been gathered and verified. A hospital may not grant temporary privileges simply because there has been administrative delay in processing the application.

Q *I am bringing a partner in and want her to begin to practice immediately. How can I ensure this?*

A Submit her application as far in advance as possible and assist the MSO, if necessary, to complete the application in a timely manner. In other words, don't wait until the last minute.

Q *I am getting a locums physician to cover for me while on vacation. Are there any problems I should know about?*

A There are a few issues of which you should be aware. Locums physicians often practice at many hospitals. Your hospital is required to contact the majority of those hospitals to verify that the physician was actually there. In

addition, obtaining professional references for locums physicians is often difficult. You and the locums can assist with the processing of the application by cooperating with the MSO, making sure the application has been completed in its entirety. Provide the names, addresses, and telephone number of the facilities in which the locums has practiced. Also provide the names of as many references as possible since the MSO will likely have trouble contacting some of them, stop by the MSO to ask whether everything is going well, and offer to help contact hospitals yourself.

Q *Some of the application questions are personal, particularly those about health status. Does the hospital have a right to ask me these questions?*

A Hospitals have the right and obligation to ask such questions. JCAHO standards require the hospital to ensure that a physician is able to safely and effectively provide the patient care authorized by the physician's clinical privileges. The American Medical Association estimates that there may be as many as 40,000 impaired or potentially impaired physicians in the country today. It is necessary for the hospital and the medical staff to determine that a physician can provide safe and effective care.

Q *What happens if I forget, omit, or falsify information on my application?*

A In most instances, your application will be rendered incomplete and will not be processed. Automatic

termination of the medical staff application process may result if the hospital and the medical staff determine that the falsification or omission was intentional. In addition, the physician may not be permitted to apply again for a defined period of time.

Medical staff leaders and hospitals know that at least 7% of physicians omit or falsify information on the application, which is one of the reasons why the credentialing process has become so complex. Hospitals and medical staff leaders cannot simply “take your word for it” when you present information on the application. To ensure that you avoid this problem, be as candid as possible on the application. If you have a question concerning certain information, do not hesitate to ask the relevant medical staff leader or MSO personnel.

Q *Why do I have to apply every two years? I have been practicing at the hospital a long time; don't they know me yet?*

A Hospitals are required by law to appoint physicians for no more than 24 months. At the conclusion of the two years, a physician may not continue to practice at the hospital unless he or she has been reappointed. To reappoint a physician, a hospital is required to see to it that a reapplication is completed. The physician must answer questions about his or her clinical, professional, and disciplinary history.

If the decision were up to hospitals, most would not require good physicians to reapply every two years since these physicians are subject to evaluation through the quality improve-

ment program. Although the reapplication process does seem to be unnecessary at times, it is a requirement with which the hospital must comply.



What is the NPDB?



The National Practitioner Data Bank is a clearinghouse for information about disciplinary and malpractice actions taken against physicians. The NPDB was created after the Health Care Quality Improvement Act (HCQIA) of 1986, and became operational in 1990. The HCQIA requires that a report be filed by insurance companies and other entities that make a payment on a malpractice claim, state boards of medical examiners that impose a sanction on a physician's license, and health care entities that take a professional review action adversely affecting a physician's privileges for more than 30 days.



Can I resign my privileges?



Yes, a physician may resign his or her privileges. However, such action will trigger a NPDB report if the physician does so to either avoid an investigation that may lead to disciplinary action or to avoid disciplinary action. Some physicians have attempted to resign or relinquish clinical privileges to avoid taking emergency call. This tactic generally fails to accomplish its intended goal because medical staff bylaws often include a provision that all medical staff members have clinical privileges in an emergency.



Why can't I request privileges in an area covered by an exclusive contract?



Practitioners are generally not permitted to request privileges covered by an exclusive contract unless the practitioner intends to become a "party to" the contract. When the hospital enters into an exclusive contract arrangement with a group of physicians—radiologists, pathologists, emergency physicians, or anesthesiologists—the hospital agrees to allow only those practitioners to perform the services covered by the contract. Physicians who are not a party to the contract are generally not eligible to request privileges in that area.



What is an exclusive contract between a hospital and a physician group?



An exclusive contract between a hospital and a group of physicians benefits both the physician group and the hospital. The hospital is able to rely on the physician group for continuous coverage of a particular clinical area, certain directors' obligations, and other performance standards. Such contracts are relatively routine and are often maintained between hospitals and emergency physicians, radiologists, anesthesiologists, pathologists, and other clinical areas of critical importance to the institution.



Who should I contact with questions I have about the credentialing process?



Questions about the credentialing process should

first be brought to the attention of the institution's MSSP. This person is often able to refer you to the credentials policy manual that provides an answer to the question. If questions are not adequately answered at this level, the vice president for medical affairs or the chair of the institution's credentialing committee should provide an answer.



What are clinical privileges?



Clinical privileges are the diagnostic and therapeutic procedures that medical staff members are permitted to perform and they specify the types of patients the provider is permitted to treat. Clinical privileges are often delineated using a list of procedures or diagnoses, or by using a core set of procedures or patient conditions that relate to the practitioner's education, training, and experience. Physicians must request and be granted clinical privileges to provide patient care services in a hospital.



What if an emergency comes up and I don't have the privileges needed to authorize a response?



Nearly all medical staff bylaws include a provision that allows physicians in an emergency to provide any care needed to save the patient's life, or otherwise stabilize and treat the patient's condition.

Do's and don'ts

DO apply/reapply as soon as possible.

DO print legibly or have your application typed. (Some institutions actually allow physicians to apply via the Internet.)

DO provide copies of all supplemental information including copies of licenses, DEA, insurance, and diplomas.

DO complete all sections of the application, especially those requiring the names of hospitals, medical schools, addresses, telephone numbers, and contact persons. (If you supply this information, we will be able to process your application more rapidly.)

DO ask to be notified if there are any items missing on your applications or if there are any problems processing it.

DON'T expect that your application will be processed faster because you frequently contact the MSSP.

DON'T assume that people can read your handwriting. Review the application with the MSO to make sure that it is legible.

DON'T complain to your partners or to medical staff leaders about the time it takes to process an application.

DON'T criticize the hospital for items beyond its control. Most of the credentials process is required by law or JCAHO standards.

DON'T assume that these are hospital rules. Processing the application is described within the medical staff's bylaws and rules and regulations.

DON'T omit important information on the application or reapplication. This will only slow the process down.

A word about requirements

You are likely unconcerned about the credentialing requirements hospitals and medical staffs must meet. However, these requirements dictate many of the credentialing processes followed by hospitals throughout the United States.

There are two major accrediting organizations in the country. The first is the JCAHO. The American Medical Association, the American College of Surgeons, the American College of Physicians, the American Hospital Association, and the American Dental Association direct the JCAHO. For more than 50 years, the JCAHO has established standards in an effort to improve hospital and medical staff performance. The JCAHO's medical staff standards govern medical staff operations and the credentialing process. The second accreditation organization is the Health Care Facility Accreditation program.

Although the standards are often long and complex, the following represents a basic outline of both accreditors' requirements:

- A physician cannot work in a hospital without appointment to the medical staff/clinical privileges.
- Physicians must complete an application for initial appointment to the medical staff. Physicians must also complete an application for reappointment at least every two years. Application questions are largely dictated by accreditation and licensure standards.
- All information on the application must be verified with

a primary source or acceptable secondary source.

- Once the application has been verified and completed, it generally must be presented to a department chair for recommendation. It is then sent to the MEC prior to final board action.
- Only the board of directors has the authority to appoint physicians to the staff or grant clinical privileges.
- Temporary privileges may only be used in extraordinary circumstances.
- A physician who is denied appointment or clinical privileges must generally be offered a fair hearing.
- Every physician is subject to reevaluation by the department chair and MEC prior to reappointment.
- Physician evaluation must include an assessment of judgment, skill, knowledge, adherence to bylaws, health status, and clinical performance as demonstrated by information contained in the credentials or confidential peer review file.
- Clinical privileges must be granted on the basis of information in the credentials files that confirms education, training, licensure, and clinical competence.

Remember, credentialing exists to serve patients by enabling the medical staff and hospital to appoint only highly qualified physicians and other professionals. Credentialing is a required activity governed by regulatory requirements, accreditor standards, and hospital bylaws.

For history buffs: One hundred years of evolution

Credentialing likely began in the early 19th century when physicians established at a hospital attempted to determine whether a new physician should be permitted to practice at the facility. In these early days, credentialing often consisted of nothing more than ensuring that the applicant knew a physician on staff and had a good professional reputation. There was no verification of license, education, or training. These credentialing elements were often taken for granted or not considered terribly important. An applicant's peer references carried the greatest weight.

As the century progressed and the standards established by the American College of Surgeons became recognized throughout the country, physicians were obligated to complete an application seeking appointment to the medical staff and clinical privileges either in medicine, surgery, or general practice. These early credentialing programs required the applicant to explain his or her training and share a bit about his or her background. However, the applicant was not required to thoroughly document his or her education, training, or experience. The opinion of the physicians currently practicing at the hospital remained the primary factor that determined whether the applicant was appointed to the medical staff.

In these early days, many examples of blatant unfairness were reported. For example, physicians were denied staff membership based solely on religious affiliations. Physicians trained in foreign countries were simply turned away.

National origin, race, creed, color, and sex often determined whether a physician would be welcomed to the medical staff.

Between 1950 and 1970, credentialing practices grew slightly more complex. Physicians were required to complete a formal application that detailed their education, internships, residencies, and prior practices. However, there were few personal questions included on these applications. Therefore, there was little ability to differentiate a qualified physician from an unqualified physician. The evaluation of applications was fairly straightforward. In many instances, physicians were permitted to begin practicing on the day they came to town.

Credentialing became much more complex and detailed between 1970 and 2000. The legal system placed hospitals on notice that they had a direct responsibility to ensure that physicians permitted to practice at the facility were highly qualified. Early legal cases also suggested that hospitals must, at the very least, follow their own rules or those established by their accrediting organization.

In addition, credentialing activities became highly organized and professional in the early 1980s as a result of a court case involving a small hospital in Milwaukee. The *Johnson v. Misericordia* case established that hospitals had a duty to protect the public from acts of negligence by physicians on the medical staff. The court asserted that hospitals must ensure applications are complete, and that the hospital and its medical staff collect additional information to ensure a comprehensive evaluation

of a physician's past education, training, experience, background, and clinical/professional record.

During these three decades, hospitals and their medical staffs began to require malpractice insurance, completion of residency, more comprehensive peer references, and detailed information about disciplinary action taken by states or other medical facilities.

The process currently referred to as privilege delineation also became common practice. Clinical privileges were becoming more specific as a result of standards established by the JCAHO, its predecessor, the JCAH, and suggestions by the American College of Surgeons. The "laundry list" soon emerged as the primary mechanism used to request clinical privileges. Physicians were no longer permitted to simply request privileges in "medicine" or "surgery"; they were expected to indicate the clinical areas in which they had been trained and had confidence. The medical staff's responsibility also increased, requiring a detailed evaluation of the application and a formal recommendation for appointment, clinical privileges, staff category, and departmental assignment.

It is interesting to note that it was around this time that Lee Dockerty, MD, stated in *Credentialing and Specialty Medicine*—one of the most significant texts on the subject of privileges and specialty— "Credentialing has no master other than the patient." Accreditation standards would no longer drive the evolution of credentialing, and hospitals would no longer be quite as willing to allow the courts to determine the next credentialing standard.