Medical resident on board: Privileging for visiting practitioners

The scenario: A surgeon on the medical staff at your facility requests permission to allow a resident from a nearby teaching hospital to accompany him or her while performing a procedure.

The issues: Your facility does not have a relationship with the resident’s host teaching hospital, and does not have a residency program of its own to use as a measuring stick to ensure that the guest resident has been properly credentialed.

Further, the request comes straight from the surgeon, rather than from the director of the resident’s program.

“This happens at a lot of organizations,” says Michael Callahan, Esq., an attorney with the Chicago-based law firm Katten Muchin Rosenman, LLP.

“It could be that the surgeon likes to teach or has been asked [to be shadowed by a resident] because he is particularly well-known in his field,” he says.

Before the medical staff grants the surgeon permission to bring the resident into an operating room or other suite in the facility, there are a lot of questions to answer. The first question that must be addressed is, will there be any contact between the resident and patients?

“The fact of the matter is that if this visit by the resident is a part of his or her clinical rotation and he or she is going to be touching patients, not just observing, the facility needs to follow the requirements for graduate medical education,” says Sally J. Pelletier, CPMSM, CPCS, a consultant in the areas of credentialing and privileging with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. “If this visit is external to the resident’s educational program and the resident is moonlighting, he or she would have to be credentialed and privileged through the medical staff standards. In addition, the institution’s bylaws might not allow for someone who hasn’t completed a residency to have privileges.”

Callahan agrees. “Any practitioner who exercises some form of clinical privileges needs to be credentialed,” he says.

If the surgeon intends for the resident to perform any hands-on care to patients, the resident’s role then becomes similar to that of a physician’s assistant, surgical assistant, scrub technician, or any other healthcare practitioner brought into the facility by the physician to help during a procedure, says Callahan.

“The risk may be relatively low, but we all have seen or heard of situations where the resident does the bulk of
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a procedure and the degree of actual supervision is questionable," he says.

The insurance question
Do not forget that it must be expressly determined how the resident in question is insured, if at all. The resident will need some form of insurance, although that insurance may vary, says Callahan.

The supervising physician may believe that his or her malpractice insurance covers the resident, but that is not necessarily the case.

In fact, Callahan advises, be wary of instances in which physicians state that a resident is covered under their policy.

“[The medical staff office must] find out whether the physician’s policy will in fact cover the resident,” he says. Many insurance carriers will not indemnify someone other than the physician unless that practitioner is employed directly by the physician in question—a highly unlikely scenario if the resident is still a part of a residency program.

“Some form of protection is necessary for the hospital,” says Callahan.

Consider the legal ramifications of hosting guest residents

“You’ve got to know where responsibility lies if the resident makes a mistake,” says Callahan. “Whose fault is it? The supervising physician’s? The hospital’s? The resident’s program? Plaintiffs are likely to go for all of the above, although the supervising physician is probably low on the totem pole.”

In terms of corporate negligence, Callahan says, it’s best to stick to a standard credentialing process.

Have the resident fill out an application. Although the application may have parts that are irrelevant or impossible for the resident to fill out due to lack of experience, the application will still have a chance to go before the necessary boards, such as the credentials committee, for approval.

Look at where the resident has been

Callahan strongly recommends that medical staff professionals faced with the prospect of credentialing a guest resident seek information from the resident’s program that is relevant to the decision of whether to grant privileges.

“Some residents can have quite a paper trail that can be overlooked by hospitals that allow circulating residents to render services,” says Callahan. He also points out that there is often a lag in residents’ paperwork as they move...
from one rotation to another, so extra precautions must be taken to make sure the information received is up to date.

Further, he advises, remember that the residency program has a responsibility to be forthcoming with information about the resident.

This is particularly relevant in light of the 2006 Kadlec case (see sidebar at right).

“For the medical school, these [residents] are, in essence, their employees,” says Callahan.

There is some measure of forgiveness for mistakes on a resident’s record—residents are still in the learning phase. However, “at some point, [the hospital must] draw a line and make a judgment on the resident’s qualifications,” says Callahan.

“Any negative statement can ruin a career, even more so for a resident,” he adds, so both the facility attempting to determine whether to credential and privilege a guest resident and the resident’s host facility must tread carefully when assessing competence. At the same time, the program or host facility should put the other side on notice if there has been a problem.

The more things change . . .

Despite the growing pressure for formal performance monitoring, many organizations still lag in reining in the methods used for monitoring not only residents, but also other nonphysician practitioners.

“It’s amazing, to this day, how loosely so much of [competency monitoring] is handled,” says Callahan. “In many facilities, the processes used for nonphysician practitioners and residents tend to be much more informal than they should be, and rely heavily on the supervising physician.”

In the evolving medical staff world, where facilities are generating incredible amounts of data on which to

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Assess competency, it behooves a facility to replace fast-and-loose methods with a more data-based mechanism. All of this may add up to a hesitance on the part of facilities that have no residency program to allow a guest resident to work with a medical staff physician, as it adds to the overall workload of the medical staff office. However, keep the benefits of such a partnership in mind. “You’ve got to allow some flexibility,” says Callahan. Although allowing residents to pass through your facility may add a burden to the credentialing and privileging process, “residents can often improve quality of care. Residents ask a lot of questions and are often extremely diligent, and can bring a lot to the facility.”

Establish a policy for resident rotations

Your organization should have a policy that addresses what is required of residents who are invited by a medical staff member or who are part of a standing agreement with a teaching hospital that regularly allows guest residents to move through your facility. The policy should cover how they are allowed to function, says Sally J. Pelletier, CPMSM, CPCS, a consultant in the areas of credentialing and privileging with The Greeley Company.

Both categories of residents would need to be supervised by licensed practitioners who possess the appropriate privileges at your facility.

With regard to agreements between academic medical centers and community hospitals regarding guest residents rotating through the community facility, ensure that the following information is covered:

- Define the level of supervision required
- Name the residents in the program
- State the residents’ level of training
- Specify patient care responsibilities based on the residents’ level of training
- Provide health status and insurance information of residents in the program

The community facility will need to determine a number of other factors based on its unique requirements, says Pelletier, including whether the residents can write orders and, if so, under what circumstances.

To avoid any confusion, it will also be mandatory to establish communication modes between the residents’ host facility and the medical staff at the community facility about how the residents will be handled, says Pelletier. This information includes not only how the residents will interact with patients, but also how they will interact with the staff in terms of education and supervision.

The Joint Commission’s perspective

The Joint Commission details its requirements for graduate medical education programs in the Comprehensive Accreditation Manual for Hospitals under Medical Staff Standard MS.2.30. The Joint Commission lists nine elements with which community hospitals must comply if they allow residents to rotate through their organization.

These elements include:

- Defining a process for supervision of residents by a licensed independent practitioner
- Creating written descriptions of resident roles, responsibilities, and patient care activities