

Alberta Health Services  
Guide to  
Medical Staff Credentialing,  
Clinical Privileging  
And  
Appointment

**Provincial Medical Affairs**  
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## Preface

The *AHS Guide to Credentialing, Clinical Privileging and Appointments* has been created to expand on the foundation established by the AHS Medical Staff Bylaws and Rules, by establishing a common understanding of terminology, building an awareness of the purpose and importance of credentialing and privileging, and documenting AHS practices. .

Additional resources related to this work are available (e.g., forms and checklists). These will be referenced in the Guide wherever practical. Links and/or instructions will be provided to assist readers in accessing these additional resources; select items may be appended to the Guide.

The Guide is intended to be a living document, one that will change over time to reflect organizational changes, process improvements and new developments in policy and practice. It will be reviewed on a regular basis (every three years) and the following stakeholders will be consulted during the review process, along with any additional stakeholders that are identified over time:

- Zone Medical Advisory Committees (which will include Zone Application Review Committee Chairs, Zone Clinical Department Heads, Zone Medical Staff Association Presidents);
- AHS Legal Services;
- AHS Patient and Family Advisory Committee;
- Regulatory Colleges (Medicine, Dentistry, Podiatry); and
- Alberta Medical Association.

The Guide will also be updated on an ad hoc basis to reflect relevant changes to:

- The AHS Medical Staff Bylaws and Medical Staff Rules;
- AHS policy and procedure and/or the development of new tools/resources by AHS; and
- Medical, dental and podiatry regulatory college policies or procedures.

## Scope of the Guide

This ***AHS Guide to Medical Staff Credentialing, Clinical Privileging and Appointments*** has been created as a reference tool and supplement to the AHS Medical Staff Bylaws and Rules. The two primary audiences for the Guide are:

- AHS Medical Leaders who receive, review and make recommendations regarding applications for appointment and clinical privileges; and
- AHS Medical Affairs staff who manage the application and implementation processes associated with Practitioner requests for appointment and clinical privileges.

The AHS Medical Staff Bylaws and Rules establish the mechanism by which individuals apply for and are granted appointment to the AHS Medical Staff and receive specific clinical privileges. This Guide will describe in more detail the rationale behind the credentialing, privileging and appointment provisions in the Bylaws and Rules and will provide guidance about how these requirements are implemented within AHS. The Bylaws and Rules define “what” we are supposed to do in regard to credentialing, appointment and privileging; the Guide is intended to provide the “why” and the “how” needed to support consistent interpretation, implementation and application of the credentialing, privileging and appointment processes outlined in the Bylaws and Rules.

The Guide applies to all Practitioners covered by the Medical Staff Bylaws: physicians, dentists, oral-maxillofacial surgeons, podiatrists and scientist leaders. It covers the topics of credentialing, privileging and appointment and is therefore supplemental to Part 3 of the Bylaws (The Process for Medical Staff Appointments and Clinical Privileges) and Section 3.4 of the Rules (Medical Staff Appointment and Clinical Privileges). It is a reference tool and should not be used to replace the Bylaws and Rules.

## Part 1: Background

### 1. Creation of the AHS Medical Staff

On February 28, 2011 the AHS Medical Staff Bylaws were implemented, legally merging the medical staffs of 10 former health regions (who, not many years prior, had been 17 smaller regions and prior to that even more distinct hospital groups) into a single AHS Medical Staff. Each of the 10 former medical staffs had developed processes to manage medical staff appointments and clinical privileges within their organizations and each had its own system of documentation that supported those processes. The merging of these sub-groups, each with its own process and culture, into the single largest and most broadly ranging medical staff in Canada has been a significant undertaking and requires time to fully harness the opportunities it makes available. This document is one tool intended to support the long-term merger, in particular by clarifying the current AHS Medical Staff processes for credentialing, privileging and appointments, and making explicit the principles and rationale behind them.

### 2. Definitions: What do we mean by Credentialing, Clinical Privileging and Appointment?

In order to provide services within AHS facilities or programs, a Practitioner must be a member of the AHS Medical Staff. In order to become a member, they must go through the related but distinct processes of credentialing, appointment and clinical privileging. Although often used casually as interchangeable terms, appointment, credentialing and privileging have distinct meanings.

*Appointment (v.)* is the process of becoming a member of the Medical Staff. An *appointment (n.)* to the AHS Medical Staff establishes the relationship between individual Practitioners and AHS, one which includes mutual responsibility and accountability for providing health services to Albertans and an agreement to be bound by the AHS Medical Staff Bylaws and Rules.<sup>1</sup> AHS Medical Staff Appointments are provincial (in other words, the appointment is to AHS, not to a particular Zone or facility) and they outline the category of Appointment and the Practitioner's rights and responsibilities associated with the Appointment.<sup>2</sup>

#### Definitions: Appointment, Credentialing and Privileges

**Appointment**– the process of becoming a member of the medical staff.

**Credentialing** - the process of screening and evaluating qualifications.

**Privileging** – the process of identifying the specific procedures and patient care services a physician will be able to provide, at specific sites.

<sup>1</sup> AHS Medical Staff Bylaws, 4.0.1 and 1.2.

<sup>2</sup> AHS Medical Staff Bylaws, 3.0.1.

Appointment to the AHS Medical Staff is not a right, but is granted to individuals who initially and continuously meet the requirements of the AHS Medical Staff Bylaws and Rules.<sup>3</sup> An appointment does not entitle a Practitioner to perform procedures or treat patients; the ability to engage in these activities is defined in the clinical privileges granted to a Practitioner.<sup>4</sup>

*Credentialing* is the process whereby a Practitioner's qualifications (education, training, experience and professional attributes) are validated and reviewed against established standards (for example, those of the Royal College of Physicians & Surgeons of Canada) to establish that the Practitioner is qualified to practice within a particular clinical domain or perform particular clinical procedures. In some circumstances, demonstrated experience is used as a proxy or alternative to formal training. The credentialing process informs the decisions to grant an appointment and clinical privileges, by providing information about whether the applicant has the education, training, experience and professional attributes necessary to perform the clinical privileges requested.<sup>5</sup>

*Privileging* is the *process* whereby a Practitioner is authorized to practice within a particular clinical domain and provide particular clinical procedures at a specific site (or sites).

#### Credentialing vs. Privileging

"Credentialing verifies that a physician meets standards as determined by an organization by reviewing such items as the individuals' license, experience, certification, education, training, malpractice and adverse clinical occurrences, clinical judgment, and character by investigation and observation. Privileging defines a physicians' scope of practice and the clinical services he or she may provide." (American College of Medical Quality)

*Clinical privileges* "define the diagnostic or therapeutic Procedures or other Patient care services a Practitioner is deemed competent to perform, the Facility(ies) and Zone(s) within which the Practitioner is eligible to provide care and services to Patients; and the specified AHS Programs and Professional services...that the Practitioner is eligible to access."<sup>6</sup>

The clinical privileges granted to a Practitioner will never be broader than the clinical activities a Practitioner is qualified or licensed to perform. Most commonly, clinical privileges granted would be a subset of the activities an individual is qualified to perform.

Clinical privileges are site specific because they require consideration of site characteristics to ensure the provision of quality care, like site capacity, adequate facilities, equipment, and number and type of qualified support staff and other resources.<sup>7</sup> For example, a cardiac surgeon might be privileged to perform open

<sup>3</sup> AHS Medical Staff Bylaws, 3.1.1.

<sup>4</sup> AHS Medical Staff Bylaws. 3.0.2.

<sup>5</sup> Smith, I. J. (Ed.), (2004), **The Medical Staff Handbook: A Guide to Joint Commission Standards**, Second Edition. Oakbrook Terrace, IL: Joint Commission Resources, p. 19 and 63. Department of Veterans Affairs, (2004). **VHA Handbook 1100.19**. Washington, DC: Veterans Health Administration, p.6.

<sup>6</sup> AHS Medical Staff Bylaws 3.0.2.

<sup>7</sup> Smith, **The Medical Staff Handbook**, p. 64.

cardiac procedures in Hospital #1 with appropriate resources and supports (available ICU beds, cardiac experienced anesthesia and nursing support, appropriate post-operative medical coverage, etc) but not be privileged to perform cardiac procedures in Hospital #2 because it does not possess the necessary resources to support high quality patient outcomes and safety.

In order to make a decision about whether to approve a request for clinical privileges, a Practitioner's credentials are reviewed and aligned with:

- a) Patient need for the clinical activity to be privileged,
- b) Site capacity for safe delivery of the clinical activity to be privileged,
- c) An assessment of the specific education, training, experience and maintenance of competence requirements for the safe delivery of the clinical activity (privilege) being requested, and
- d) Organizational resources available to support/provide the clinical activities.

In the process of becoming a member of the AHS Medical Staff, a Practitioner will always be credentialed, since there always needs to be an evaluation of whether they meet the criteria for Medical Staff appointment and clinical privileges. In most cases, they will be simultaneously granted an appointment and clinical privileges. Occasionally, a Practitioner will be credentialed and appointed but will not be assigned clinical privileges (for example, Scientist Leaders and Community Staff).

#### **a. Emergency Situations**

The process to grant clinical privileges outlined in the AHS Bylaws and Rules does not prevent a Practitioner from responding to emergency situations:

Provincial Rule 3.4.3 e):

No recommendation on Clinical Privileges is meant to prevent any licensed Practitioner from performing any medical procedure on any person in an emergency situation where failure to perform that procedure may result in death or serious injury or harm to the person.

#### **b. Universal Programs and Professional Services**

An AHS Medical Staff appointment or clinical privileges are not required to access universal programs and professional services, when these services fall within the College's defined scope of practice for a Practitioner. These services include, for example, ordering basic laboratory and diagnostic imaging tests (defined in Rule 3.1.3) and referring patients to AHS home care and community rehabilitation programs and services.

### 3. Credentialing, Privileging and Quality

#### a. Credentialing and Privileging as Quality Processes

Although primarily based in science and evidence, many elements of medical care are still very contextual and reliant on human skill, interpretation and judgment. Unlike systems where there are failsafe, logical algorithms to make and carry out decisions with minimal human input, medical care relies on human judgment and is vulnerable to deficiencies in knowledge and skill and to human error. Strategies can however be undertaken to reduce the risk or uncertainty associated with the quality of medical care. One of the key organizational strategies to support patient safety and the delivery of quality care is a robust medical staff credentialing, privileging and appointment process.

Credentialing and privileging, in other words, are about promoting the quality provision of health services to patients by assessing the competence of the Practitioners involved in their care. The credentialing process evaluates whether a Practitioner who wishes to provide services “...is qualified and competent to exercise the clinical privileges that have been granted”, thereby informing decisions to grant an appointment and clinical privileges, and a clear or well-defined privileging process decreases the opportunities for medical error and bad outcomes.<sup>8</sup>

#### b. Public Trust

AHS and the AHS Medical Staff share a commitment to providing health services in a patient centered system.<sup>9</sup> When it comes to the qualifications and competency of their healthcare providers, it is clear that patients expect that they will receive safe, high quality care from all members of the AHS Medical Staff when they arrive in an AHS facility or receive services through an AHS program. However they are not concerned with (or even aware of) distinctions between regulatory College standards of practice, individual Practitioner responsibility and AHS policies because they expect that since they are receiving care in an AHS facility or program, AHS is accountable for the care being provided. Patients also cannot verify whether a Practitioner providing services at an AHS site or program has adequate education, training, and experience. They trust that AHS has fulfilled its responsibility to review the qualifications of Practitioners before granting them an appointment and clinical privileges.<sup>10</sup> The Medical Staff credentialing, privileging and appointment process is one key mechanism by which AHS can reassure the public that its obligation to provide safe, high quality care is taken very seriously.

#### c. The Importance of a Documented, Consistent Process

Credentialing, privileging and appointment processes are not new to the Zones, facilities and medical leaders that are now part of AHS; however, the environment in which we carry out this work has become more

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<sup>8</sup> Gassiot, C.A., Searcy, V.L., and Giles, C.W. (2007). *The Medical Staff Services Handbook: Fundamentals and Beyond*. Mississauga, ON: Jones and Bartlett, p. 139 and 215.

<sup>9</sup> AHS Medical Staff Bylaws, 4.0.1.

<sup>10</sup> Dolt, Thompson, Shepherd, Kinney and Wilt, PSC (2009), *Protecting Patients Through Careful Credentialing and Privileging*.



complex. And as organizations become more complex, the need for clearly defined, explicit and structured processes increases.

In recent years, healthcare quality literature has looked to “High Reliability Organizations” (HRO’s) for wisdom in how to design safe systems of care.<sup>11</sup> Complex organizations that operate in a context of advanced technologies, fast paced tempo of operations and high level of risk, yet manifest very low error rates (or very high rates of reliability) have been called HRO’s (examples include aircraft carriers and nuclear power plants).<sup>12</sup> Efforts have been made to apply lessons from these organizations to the healthcare environment.

The Institute for Healthcare Improvement (IHI) has recommended a three-tier strategy for designing reliable systems and achieving “high reliability” in healthcare. The IHI strategy involves putting in place processes and protocols to:

1. Prevent failure;
2. Identify and mitigate failure; and
3. Redesign process based on identified failures.<sup>13</sup>

Key strategies in the first tier, preventing failure, revolve around the standardization and documentation of a practice or process.<sup>14</sup> Using tools like standardized checklists and protocols “is a basic requirement of a safe system” and helps to reduce errors by aiding (optimizing) information processing.<sup>15</sup> Multiple practices for a single process introduce confusion and may lead to normalized deviation – a situation where small variations from standard process/best practice become normalized and expand over time until significant safety risks are introduced into a process formerly designed to reduce risk.<sup>16</sup>

Development of a standardized, documented process is essential but still only one part of designing a reliable system. The second tier of development requires strategies to identify and mitigate errors. The third tier of development is redesign. With an understanding of failures identified, a system can be successfully redesigned to reduce errors.<sup>17</sup>

In the context of credentialing, privileging and appointment processes, failure might be the approval of a Practitioner for clinical privileges that they are not competent to safely provide or the approval of clinical privileges at a site where they cannot be safely supported. The creation of this Guide and of clinical privilege

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<sup>11</sup> Blouin, A.S., McDonagh, K.J. (2011) A Framework for Patient Safety, Part 2. *Journal of Nursing Administration*, 41(11) 450-452. Nance, J.J. (2008) **Why Hospitals Should Fly; The Ultimate Flight Plan to Patient Safety and Quality Care.** Second River Healthcare Press.

<sup>12</sup> Sanchez, J.A. and Barach, P.R. (2012). High Reliability Organizations and Surgical Microsystems: Re-Engineering Surgical Care. *Surgical Clinics of North America*, (92) 1-14. Luria, J.W., Meuthing, S.E., Schoettker, P.J., Kotagal, U.R. (2006). Reliability Science and Patient Safety. *Pediatric Clinics of North America*, (53) 1121-1133.

<sup>13</sup> Nolan, T., Resar, R., Haraden, C. and Griffin, F.A. (2004), **Improving the Reliability of Healthcare**, (Cambridge, MA: Institute for Healthcare Improvement), p. 6.

<sup>14</sup> Luria, p.1126.

<sup>15</sup> Nolan, T.W. (18 March 2000) System Changes to Improve Patient Safety. *BMJ* (320) 771-773.

<sup>16</sup> Luria, p. 1126 and Nance, p. 104-107.

<sup>17</sup> Luria, p. 1127-8, Nolan, p. 6.

lists for each AHS clinical department are examples of strategies that fall into the first tier— standardizing and documenting practice in order to prevent failure and develop a robust credentialing and privileging system that is patient safety and quality focused.

However, even the best process for reviewing credentials and granting clinical privileges cannot completely eliminate errors. Clinical privileges might still be requested and granted for someone whose clinical competence does not align with those clinical privileges. For example, this could happen where:

- The individual providing a reference, evaluation or recommendation lacks knowledge of the applicant’s actual performance, or is reluctant to assess them honestly or objectively;
- The applicant fails to fully understand the scope of the clinical privileges being requested;
- There is reluctance to limit the clinical privileges requested;
- There are differences in the available equipment or support personnel between the new setting and previous settings where the clinical privilege was exercised.<sup>18</sup>

Strategies are needed to identify and mitigate these potential errors. One strategy for identifying whether newly privileged individuals have been accurately evaluated with respect to credentials and the clinical privileges granted is *proctoring*, a process whereby an individual has someone observe, supervise, monitor, mentor or directly assess their competence.<sup>19</sup> Other examples of second tier quality improvement strategies in the AHS context are Periodic Reviews of Medical Staff, which can help identify and mitigate misalignment between clinical privileges and competency, and the Annual Information Verification and Attestation (AIVA) process, which can identify changes in the status of important indicators/requirements (e.g., criminal charges, licensure status) as well as provide an opportunity for self-reflection on continuing competence and changes in practice.<sup>20</sup> The move to a single, coordinated provincial database for AHS that automates regular verification of practice permits or College approvals and restrictions is an additional strategy to identify and mitigate quality issues.

Finally, processes need to be continually re-examined to reflect what is learned. Applied to credentialing and clinical privileging processes at AHS, this means that the Guide and the clinical privilege lists will need to be viewed as living documents, able to be adjusted as lessons are learned and examined periodically to ensure currency.

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<sup>18</sup> Smith, *The Medical Staff Handbook*, p. 105.

<sup>19</sup> Ibid. p. 103-104.

<sup>20</sup> Periodic Review and AIVA processes are discussed again in this Guide (see section on “Initial vs. Ongoing Assessment of Competence”) and in the Bylaws (Part 5) and Rules (Part 3.4.4 and 3.6).

## 4. The Hospitals Act and AHS Medical Staff Bylaws and Rules

In reflection of their fundamental importance to ensuring quality, credentialing, privileging and appointment processes are mandated in provincial legislation and the Medical Staff Bylaws and Rules. In Alberta, the *Hospitals Act* establishes that AHS, as the operator of approved hospitals in the province, “may grant physicians and other healthcare practitioners access to hospital facilities on any terms and conditions set out in the medical staff bylaws, the general bylaws or any contract for services or employment.”<sup>21</sup> The Act goes on to require that as an operator of approved hospitals, AHS must establish Medical Staff Bylaws and Rules that include among other things, a process to appoint individuals to the Medical Staff and the delineation of hospital privileges to be granted to those individuals.<sup>22</sup>

The AHS Medical Staff Bylaws and Rules have two fundamental underlying goals:

1. To establish a systematic patient safety focused mechanism to grant appointments and clinical privileges to Practitioners, and
2. To transparently outline the respective obligations of AHS to the Medical Staff and the Medical Staff to AHS and the patients of Alberta.

The Bylaws describe the:

- Core AHS medical leadership structure (Part 2),
- Application process for a prospective Practitioner to apply for a medical staff appointment and clinical privileges (Part 3),
- Responsibilities and accountabilities of AHS and the Medical Staff (Part 4),
- Periodic review of Practitioner performance as a quality improvement and assurance initiative (Part 5), and
- Process for investigation and resolution if a concern is raised about a member of the Medical Staff (Part 6).

### Bylaw User Guides

Bylaw User Guides are available on the AHS webpage for Medical Staff:

<http://www.albertahealthservices.ca/7086.asp>

The Medical Staff Bylaws and Rules are to be reviewed at least every three years. To achieve this, a Medical Staff Bylaws and Rules Review Committee has been established and the role that the Bylaws and Rules play in supporting patient safety and quality of care is a core element of the Committees terms of reference.

Collectively, these elements contribute to meeting the expectations of Albertans that when they receive care in AHS facility or program, the Medical Staff involved in providing that care are committed to quality and patient safety.

<sup>21</sup> Alberta Hospitals Act (RSA 2000, cH-12 s13)

<sup>22</sup> Alberta Hospitals Act (RSA 2000, cH-12 s17)

## 5. Complementary Roles of Alberta Regulatory Colleges and AHS

Regulatory Colleges, AHS and Practitioners themselves have shared and overlapping responsibility to ensure that Practitioners are qualified and competent to provide care. The ultimate role of the regulatory colleges is to license individuals who want to practice in the regulated profession. The mandate of AHS includes ensuring reasonable access to appropriate, high quality and safe health services, which includes a role in evaluating the quality and safety of services provided by Practitioners. AHS Medical Staff members are also responsible “for the quality and safety of all professional services provided by Practitioners to Patients and AHS.”<sup>23</sup>

### Alberta Health Profession Regulatory Colleges Relevant to the AHS Medical Staff

- College of Physicians and Surgeons of Alberta
- Alberta Dental Association and College
- College of Podiatric Physicians of Alberta

The overlapping AHS and regulatory college roles has often led to confusion in the use of terms like “credentialing” and “privileging” (for example, the incorrect assertion that College of Physicians Surgeons credentials physicians while AHS privileges and appoints them but does not credential). In fact both AHS and the regulatory colleges engage in credentialing. The regulatory college licensure process includes credentialing as one step in its decision to grant a license and AHS also conducts credentialing to inform decisions about medical staff appointments and clinical privileges.<sup>24</sup>

All three of the Practitioner groups covered by the AHS Medical Staff Bylaws are governed by the *Alberta Health Professions Act (HPA)*. As health professions established under the Act, physicians, dentists and podiatrists are regulated by self-governing Colleges<sup>25</sup> who provide practice permits to appropriate individuals to perform activities (often restricted activities defined in Schedule 7.1 of the *Government Organization Act*). The HPA sets out the expectation that the Colleges establish and oversee processes to protect and serve the public interest, including minimum eligibility requirements for registration, standards of practice, continuing competence requirements, complaint investigation and disciplinary action.

The regulatory Colleges have sole responsibility to determine whether a Practitioner is eligible for a practice permit in Alberta and what, if any, conditions apply. Generally speaking, regulatory Colleges examine the formal educational credentials, formal training experience and, in some cases, demonstrated clinical expertise to determine whether a particular individual is qualified to be granted a practice permit. No individual can practice as a physician, surgeon, dentist or podiatrist in Alberta without having a valid practice permit from the appropriate regulatory College. The practice permit will identify the broad area of

<sup>23</sup> AHS Medical Staff Bylaws 4.0.2 and 1.0(b).

<sup>24</sup> The College of Physicians and Surgeons does have a parallel privileging role in some non-hospital surgical facilities and is responsible for oversight of Practitioners working in the community outside of AHS facilities.

<sup>25</sup> HPA established regulatory Colleges are distinct from post-secondary educational colleges and national self-regulating standard setting organizations such as the *Royal College of Physicians and Surgeons of Canada* or the *Royal College of Dentists of Canada*.

Practitioner activity (for example, General Practice, Pediatrics, and Anesthesia). Colleges may also add conditions (or restrictions) to a practice permit that they feel are necessary to safeguard the public. For example, a physician might be restricted from performing a certain procedure, or prescribing a certain class of medication. They might be restricted to practicing at a certain location or practice setting (e.g., only in a multi-physician office) or be required to have a chaperone present for certain types of patients. These conditions can be placed on a license when it is first granted, or may be put into place at some later date. The College of Physicians and Surgeons of Alberta provides notice of conditions being placed on or removed from a practice permit to all locations where a physician practices.

Colleges may also identify particular activities or procedures that require specific College approval (above and beyond a valid practice permit). For example, the College of Physicians and Surgeons of Alberta (CPSA) requires that physicians apply specifically for additional approval to provide the following services:

- Cardiac Exercise Stress Testing (in private facilities)
- Diagnostic Imaging (in private & public facilities):
  - Echocardiography
  - Ultrasound
  - Nuclear Medicine;
  - MRI,
  - PET,
  - CT
  - Fluoroscopy (non-radiologist only)
- Neurophysiology Testing (EEG, EMG, EP) (in private & public facilities)
  - Sleep Medicine (in private facilities)
  - Vestibular Testing (in private facilities)
- Non-Hospital Surgical Procedures (in private facilities)
- Pulmonary Function Testing (in private & public facilities)
- Performing Medical Hyperbaric Oxygen Therapy (in private facilities).<sup>26</sup>

Since the AHS Medical Staff is primarily comprised of (over 90%) physicians, AHS works very closely with the College of Physicians and Surgeons of Alberta to optimize sharing of CPSA practice permit and approval information. AHS Medical Affairs is working to improve the degree to which this information is automatically

According to the *Health Professions Act* (Part 1, 3(1), the role of a College is to:

- (a) Carry out its activities and govern its regulated members in a manner that protects and serves the public interest,
- (b) Provide direction to, and regulate the practice of the regulated profession by its regulated members,
- (c) establish, maintain and enforce standards for registration and continuing competence and standards of practice of the regulated profession, establish, maintain and enforce a code of ethics and
- (d) Carry on the activities of the college and perform other duties and functions by the exercise of the powers conferred by this act.

<sup>26</sup> Per communication with CPSA March 2013. For the most current list of activities and procedures requiring additional CPSA approvals and for instructions about how to obtain approval, please refer to the CPSA website.

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integrated into AHS' information systems, allowing AHS for example to automatically identify changes in licensure for physicians who are already members of the AHS Medical Staff.

While the Colleges do determine whether an individual is eligible to practice in a certain category of activity, they do not examine the education, training and experience of a Practitioner in relation to the particular clinical privileges that a Practitioner will be exercising within an AHS site or program (with the exception of the additional approvals mentioned above). For example, credentialing and licensing of physicians by the College of Physicians and Surgeons of Alberta generally results in broad decisions about areas of Practitioner activity rather than decisions about focused, specific clinical privileges (e.g., granting a practice permit in anesthesia versus confirming expertise in retrobulbar blocks in hospital X). It is AHS' role and responsibility to screen and evaluate the qualifications of Practitioners in relation to the specific procedures and patient care services they will be providing at specific sites before granting an appointment and clinical privileges.

## 6. Initial vs. Ongoing Assessment of Competence

Credentialing and privileging are often thought of as processes that apply only to the initial request for clinical privileges and Medical Staff appointment, however in reality they are part of an ongoing process of assessing competence.<sup>27</sup> Ongoing assessment of competence is, in turn, a critical component of promoting the ongoing provision of high quality, safe care to patients. In the context of creating a highly reliable, safe system of care, ongoing assessment is necessary to identify and mitigate issues and to redesign processes to prevent future errors.

Ultimately, a Practitioner's current competency is based not only on his or her initial medical education, but also on their ongoing interpersonal and professional skills, mental / emotional health, and continuing professional development through which they maintain and enhance the necessary knowledge, judgment and technical skills required to provide safe patient care. Assessment of qualifications in the initial credentialing and privileging process allows a judgment to be made about whether a Practitioner is qualified at a particular point in time; however qualified yesterday cannot guarantee competent today.

There is a continual challenge of maintaining (for the Practitioner) and ensuring (for the organization) competency years after entering practice/granting Medical Staff Appointment and clinical privileges, especially in the setting of today's rapidly evolving medical and scientific knowledge and progressive advancements in patient care. Therefore AHS has a role in reviewing clinical privileges and competence on an ongoing basis in order to mitigate the risks associated with changes in competence over time and to continuously improve its efforts to evaluate and promote quality and excellence in the performance of its Medical Staff. In AHS this function is met in part by the Annual Information Verification and Attestation (AIVA) and Periodic Review processes. It also involves partnerships with external stakeholders, like the regulatory Colleges, who also have a responsibility to assess competence on an ongoing basis.

### a. AHS Ongoing (Post Appointment) Review

#### Annual Information Verification and Attestation (AIVA) and Periodic Reviews

Once a Practitioner has an AHS Medical Staff appointment and clinical privileges, there are two primary associated processes in place to maintain the appointment and clinical privileges in good standing: Annual Information Verification and Attestation (AIVA) and Periodic Reviews. Although these are administrative processes that can appear bureaucratic and far removed from the realities of patient care, they are important safeguards within the Medical Staff appointment and clinical privileging system. They are part of a process of ongoing learning and quality assurance.

The AIVA process confirms that each Practitioner continues to meet the minimum requirements to be a member of the Medical Staff (relevant regulatory College practice permit, professional liability coverage, legal right to live and work in Canada) and requires Practitioners to identify any professional liability judgments,

<sup>27</sup> Gassiot *The Medical Staff Services Handbook: Fundamentals and Beyond*, p.279.



orders or arbitration decisions the Practitioner has been involved in.<sup>28</sup> The AIVA process also includes an annual reminder of the specific clinical privileges a Practitioner has been granted and in doing so, provides an opportunity for self-reflection on continuing competence plans and reminds them of the need to apply for a change of clinical privileges, if desired.

The Periodic Review process is a key quality improvement and assurance process complimentary to the Medical Staff appointment and clinical privileging process. A Periodic Review is a required, scheduled meeting at least every three years between a Practitioner and the Zone Clinical Department Head (ZCDH) or designate(s) to:

- Review the Practitioner's professional performance,
- Identify professional development goals,
- Exchange information regarding the functioning of the Zone clinical department in the context of the Practitioner's appointment and clinical privileges, and/or
- Discuss actions arising from previous reviews.<sup>29</sup>

Conducting Periodic Reviews can be difficult work, particularly for new Medical Leaders who may have little formal supervisory or management experience, and who may not always be comfortable with a detailed and frank review process. It can also be a challenge for Zone Clinical Department Heads (particularly in larger departments) who do not work directly with many of the Practitioners who ultimately report to them, making it more difficult to reliably and consistently assess their department members' skills.

While challenges exist, AHS is committed to ensuring that Medical Leaders have the knowledge, skills, and support necessary to address concerns, conduct reviews and provide supervision and support to their direct reports. Medical Leaders are encouraged to take advantage of management skills training offered by AHS for Medical Leaders (i.e. conducting reviews, "difficult" and crucial conversations, etc.) and management courses offered through the Canadian Medical Association (CMA) and other external bodies. Information about relevant courses and funding opportunities is available on the AHS Medical Staff website.

## **b. Ongoing Review by the College of Physicians and Surgeons**

The CPSA Physician Achievement Review (PAR) Program gives physicians regular feedback (every 5 years) on their performance, through a series of questionnaires distributed to patients, physician colleagues and non-physician co-workers. The questionnaires ask about topics ranging from medical competency and management abilities to communication skills and patient management. The program identifies good performance and opportunities for improvement as part of the College's ongoing program to promote quality improvement in medical practice.<sup>30</sup>

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<sup>28</sup> AIVA requirements are defined in Provincial Rule 3.4.4.

<sup>29</sup> Periodic Review requirements are outlined in Part 5 of the Medical Staff Bylaws and in Provincial Rule 3.6. A companion guide is also available on the AHS Medical Staff web site: <http://www.albertahealthservices.ca/2376.asp>

<sup>30</sup> For additional information about the PAR Program information, including samples of the questionnaires, see the CPSA website: <http://www.cpsa.ab.ca/Homepage.aspx>



## Part 2: How do we do this work? AHS Standards and Processes

### 1. Standards and Criteria for Appointment

To help ensure the delivery of quality care and the safety of patients, AHS has developed specific standards and criteria for credentialing, clinical privileging and appointment of all Practitioners. In order to obtain an appointment and clinical privileges, a Practitioner must provide evidence of the credentials required for a Medical Staff appointment as well as the credentials required for the specific clinical privileges that they have requested (the minimum education, training and experience required in order to safely provide those services, as outlined in the applicable clinical privilege list). These standards will be used by AHS Medical Leaders in determining appropriate appointment and clinical privileges.

In addition to ensuring Practitioners are licensed by the appropriate regulatory College<sup>31</sup> and carry appropriate professional liability coverage— typically through the Canadian Medical Protective Association or appropriate liability insurance carrier— AHS also looks at:

- Any approvals granted by the regulatory College for the services and/or procedures the Practitioner wishes to provide and/or any conditions placed on their license by the College;
- Additional fellowship or other training required or beneficial in performing the planned services;
- The experience the Practitioner has in providing the planned services; and
- Maintenance of competence requirements, if any, for the planned services.

Credentials Required for Medical Staff Appointment	Credentials Required for Clinical Privileges
<ul style="list-style-type: none"> <li>• Legal ability to work in Alberta within AHS facilities/programs;</li> <li>• Valid practice permit from relevant regulatory College;</li> <li>• AHS satisfaction with Practitioner clinical experience, qualifications, ability and character;</li> <li>• Valid professional liability coverage;</li> <li>• Compliance with core AHS engagement requirements for all clinical workers (security checks, privacy training, etc.);</li> <li>• Practitioner agreement to abide by the AHS Medical Staff Bylaws and Rules.</li> </ul>	<ul style="list-style-type: none"> <li>• Any approvals granted by the relevant College for the services and/or procedures the Practitioner wishes to provide;</li> <li>• Any license conditions;</li> <li>• Additional fellowship or other training required or beneficial in performing the planned services;</li> <li>• The experience the Practitioner has in providing the planned services; and</li> <li>• Maintenance of competence requirements, if any, for the planned services.</li> </ul>

<sup>31</sup> This is most commonly the College of Physicians and Surgeons of Alberta but may alternatively be the Alberta Dental Association and College or the College of Podiatric Physicians of Alberta.

## 2. An Overview: The Credentialing, Appointment, Clinical Privileging Process and the Role of AHS Medical Leaders

Part 3 of the Medical Staff Bylaws outlines the process for a prospective Practitioner to apply for a Medical Staff appointment and clinical privileges or for a current Practitioner to apply to modify their Medical Staff appointment or clinical privileges. Additional details are provided in Part 3.4 of the Medical Staff Rules. The Bylaws and Rules also outline the responsibilities of AHS Medical Leaders in assessing any particular Practitioner application for appointment and/or clinical privileges. This Guide will provide an overview of the process and Medical Leader role and serve as a reference tool, but should not be used as a replacement for the Bylaws and Rules.

### a. Credentialing Before an Application is Submitted

The process of evaluating an individual's credentials and determining appropriate clinical privileges may begin during the recruitment process, before a formal application for an appointment or clinical privileges is ever made. An application for medical staff appointment and associated clinical privileges should, in fact, be the end result of a thorough search, selection and approval process — one which includes interviews with the applicant and reference checks with individuals who are able to comment on their skills, abilities and attributes. The Medical Leaders involved need to ensure that key steps in the process (interviews, reference checks, and follow up on red flags) take place and are documented.

#### Interviews:

At some point during the pre-application (recruitment) stage candidates should be interviewed by an AHS Medical Leader. The extent of the interview process will vary depending on the specifics of the position, but may include one or more interviews by:

- The appropriate ZCDH and/or designate;
- Facility and Community Medical Directors for the facilities/communities of practice;
- Members of the relevant section, department or practice that the individual will be joining; and
- Other non-Medical staff members of the relevant department, site or community.

The interview process and the verbal reference check process described below are a valuable opportunity to assess important interpersonal and professional skills (like communication) that are part of competency.

#### Related Resources

**Medical Leadership:** A Bylaw User Guide is available on the AHS website for Medical Staff:

<http://www.albertahealthservices.ca/7086.asp>

**Recruitment:** Policies related to Medical Staff Recruitment are located on the AHS intranet (Insite):

<http://insite.albertahealthservices.ca/6230.asp>

The AHS Medical Staff Rules provide a summary of the steps involved in the AHS recruitment process (see Part 3.2: Practitioner Workforce Plan and Recruitment). Additional resources/tools/forms are available from Zone Medical Affairs offices.

### Checking References:

In almost all cases, a conversation with references is advisable at some point in the process (versus exclusive reliance on a written recommendation). This may require a delicate balancing of a candidate's desire for confidentiality with the reviewer/recruiters responsibility to confirm details of training and experience, but always bear in mind the primary objective is to ensure safe and high quality care. Reference checks are also advisable even when a candidate is a "known quantity" (e.g., former local resident who has trained elsewhere for a couple of years); confirmation is still needed that the intervening training/experience supports the proposed AHS clinical privileges and that the individual is still (currently) competent. Someone with knowledge of the clinical privileges involved and position requirements should conduct the checks, in order to be sure that the individual's experience/training is an actual match for the clinical privileges that will be requested and to explore any performance issues that might have existed.

Also important to remember when conducting reference checks:

- AHS Reference Check Guidelines and sample questions are available on the AHS intranet (<http://insite.albertahealthservices.ca/frm-18402.pdf>). While the sample reference check questions are generic, they do provide a useful starting point. In the future, Provincial and Zone Medical Affairs hope to develop Medical Staff specific questionnaires that can be used by Medical Leaders conducting verbal reference checks during the recruitment process.
- Reference checks may need to go beyond the names provided by a candidate – make sure candidates understand that this is a possibility. In particular, if a candidate is currently working or has previously worked in a different AHS zone and/or clinical department, an "internal" reference check with a relevant Zone Clinical Department Head or other Medical Leader from that Zone is strongly advised.
- Provide references with a clear understanding of the expectations of the role the candidate will be taking on. Where clinical privilege lists are available, provide a copy of the clinical privilege list and indicate specific clinical privileges that will apply.
- When an applicant is from outside of Canada (for example the USA), the best practice is to still conduct a reference check, and ask all the same questions that would be asked of a referee from Canada. The referees will provide whatever information they feel comfortable with or can legally provide.

### Looking for Red Flags:

The following risk indicators have been identified in the literature as "red flags" that should be investigated prior to making a recommendation regarding appointment or clinical privileges. They are not necessarily grounds to deny an application, but should be investigated:

- Information on the application that does not match information on the CV;
- Gaps in time that are not explained or cannot be verified;
- Frequent moves from jurisdiction to jurisdiction, organization to organization or practice to practice;
- References that contain questionable, negative or vague information;
- References with information contrary to that provided by the applicant;

- Questions not answered on the references received;
- Reference questions not returned;<sup>32</sup>
- A candidate who continually wants to delay and delay reference checks.

For example, receiving a bare bones neutral letter with only the dates the individual was on staff in response to a reference questionnaire may be a sign that deeper digging is needed.<sup>33</sup>

#### Documentation:

Interviews, reference checks and red flag follow-up should be documented. If the candidate proceeds to a formal application for appointment and clinical privileges, this documentation should be forwarded to the Zone Medical Affairs Office (ZMAO) and form part of the package considered in the formal review process.

#### Delegation:

This pre-application work is often done by the Zone Clinical Department Head, but it is also often delegated to or initiated by other medical leaders (including but not limited to Zone Clinical Service Chiefs, Facility Medical Directors, and Community Medical Directors). This is necessary to manage workload and is also a means of ensuring that the individuals who will ultimately work with prospective Medical Staff members are involved in the process of recruiting and evaluating credentials. Medical Leaders taking part in the recruitment/pre-application process can consult their Facility Medical Director, Zone Medical Staff Office, ZCSC ZCDH and/or ZMD for information and advice on establishing Search Committees, confirming Physician Workforce Plan approvals, and other elements of the process.

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<sup>32</sup> Smith, *The Medical Staff Handbook*, p.50.

<sup>33</sup> HCPro (May 2013). Gathering and providing physician references from hospitals. *Credentialing Resource Centre Journal*, (22:5) 9.

## b. The Formal Credentialing, Privileging and Appointment Process

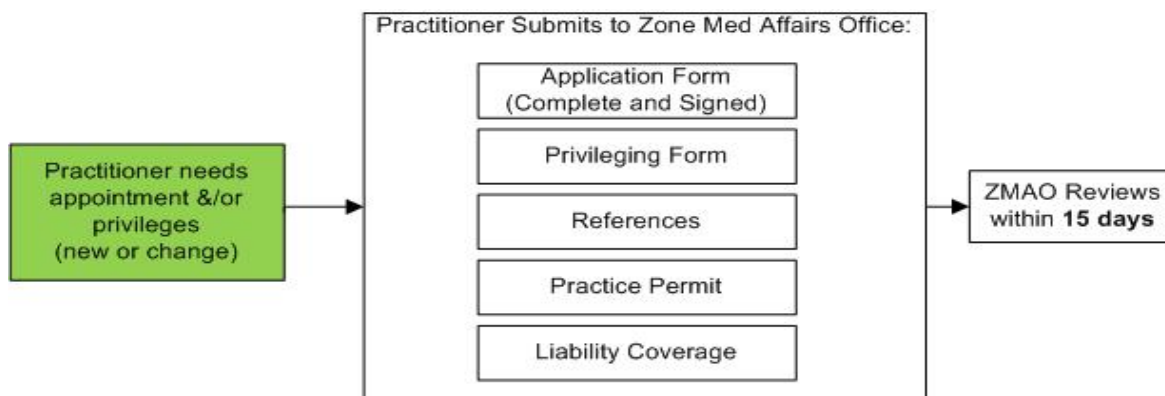
The formal credentialing, clinical privileging and appointment processes are initiated by an application for appointment to the AHS Medical Staff. It is important for everyone involved in the informal and formal processes (candidates, recruiting communities, departments and facilities) to understand that it takes approximately 90 days for an application to go from submission to approval by the CMO. This timeframe can increase, particularly if there are issues with incomplete documentation which delay the progress of an application from one step to the next. Also, after an application is approved, an appointment and clinical privileges do not take effect (i.e., the individual cannot/should not provide services) until they have signed and returned their Letter of Offer. While these timeframes can be frustrating, awareness and planning can ensure that they do not interfere with patient care needs. The process as a whole exists to ensure safe, quality patient care.

### Key Messages for Applicants, Recruiters and Medical Leaders

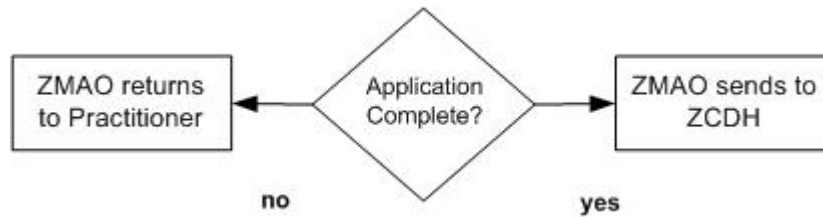
- Onus is on the applicant to provide a completed **and signed application** and all supporting documentation;
- An application takes approximately 90 days to process;
- Applicants must sign and return their Letter of Offer (after application is approved).

Each Zone has a Zone Medical Affairs Office (ZMAO), which is responsible for the intake of requests for Medical Staff appointment and clinical privileges. When contacted by a Practitioner who wishes to apply, the ZMAO must verify that there is a fit with the Practitioner Workforce Plan (or that the request is for Community or Locum Tenens privileges). If the ZMAO confirms that the individual has been recruited to an approved position, the Practitioner is provided with an application to complete. If not, the individual is to be advised that there are no relevant positions available and referred to the relevant Zone Clinical Department Head (ZCDH) if needed (Part 3.4.2 of the Medical Staff Rules(c)).

The onus is then on the Practitioner to complete and sign the application form and provide it, along with the other required documentation, to the ZMAO. As clinical department privilege lists are developed provincially (see Part 4: Clinical Domain Specific Information), applicants will also be required to complete a privileging form indicating the specific clinical privileges being requested.

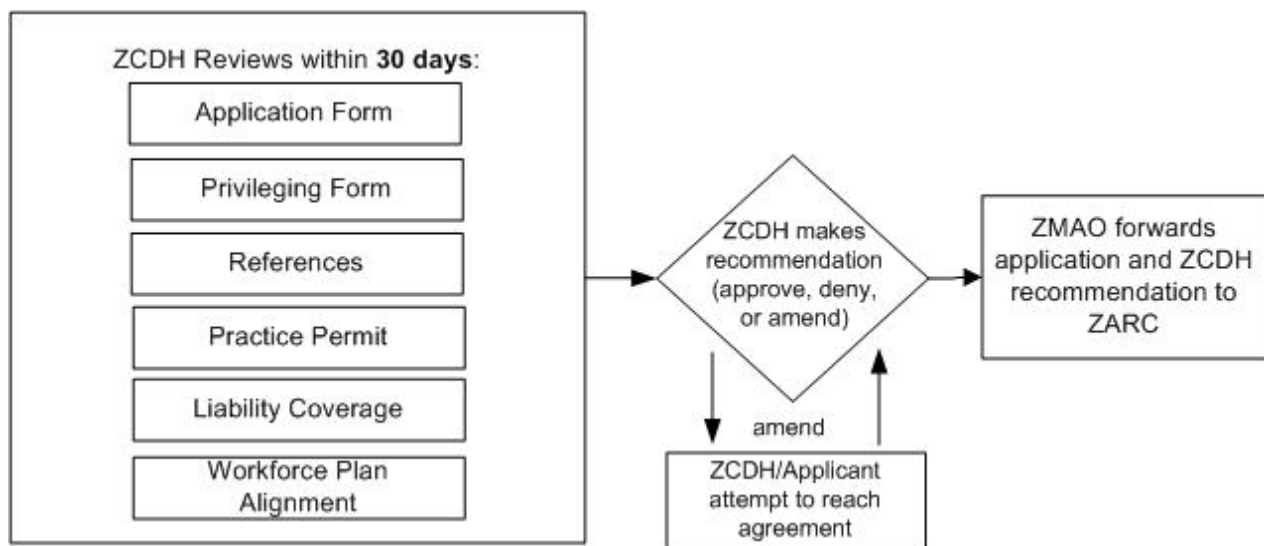


The ZMAO is responsible for reviewing a submitted and signed application and supporting documentation for completeness, and notifying the applicant of any gaps in the application within 15 days of receipt. After receiving a signed application the ZMAO will also send out reference check forms/requests, which may go to the same or different people than were contacted earlier in the process (the pre-application / recruitment phase). If any red flags arise at this stage, they should be followed up by the ZMAO and/or ZCDH/designate. Delay in getting application material back from an applicant could be another flag.



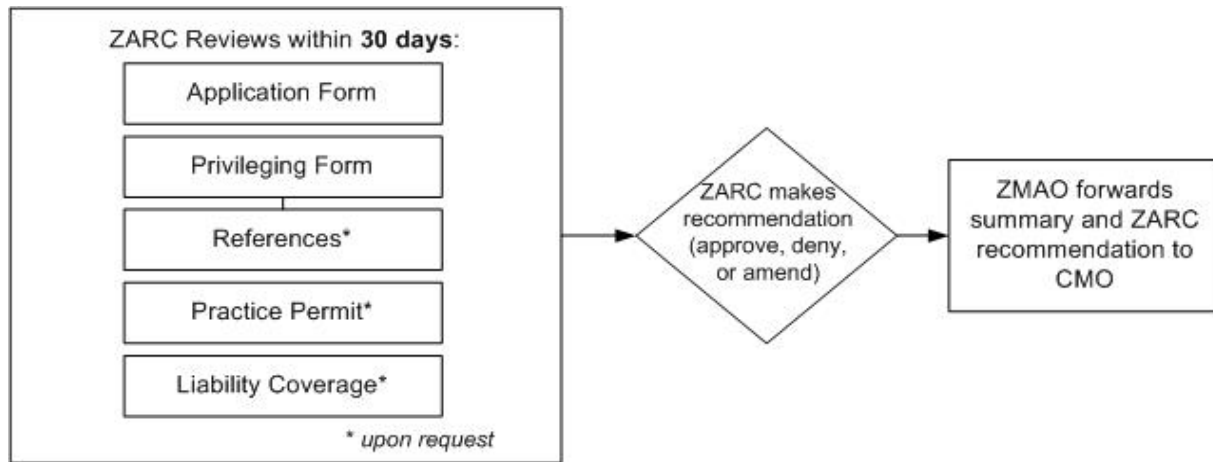
Completed applications along with documentation of interviews and reference checks are sent by the ZMAO to the Zone Clinical Department for review and recommendation. Zone Clinical Department Heads (ZCDH), and in some cases delegates like Zone Clinical Section Chiefs, Facility Medical Directors and Community Medical Directors, play a particularly important role in initially assessing Practitioner applications for Medical Staff appointment and/or clinical privileges on behalf of AHS.

The ZCDH (or designate) reviews the application form and supporting documentation, including references, within 30 days of receipt from the ZMAO. As part of their review, they ensure that all required documentation is present, all red flags have been addressed, and that the applicant is aligned with the Practitioner Workforce Plan. In doing this they consult with other medical and operational leaders as appropriate. As clinical privilege lists are developed provincially, the ZCDHs/designates will also be responsible for reviewing the requested clinical privileges and determining whether the applicant has the required qualifications (as defined in the clinical privilege list) and whether there is alignment between the requested clinical privileges and site/program needs and resources.

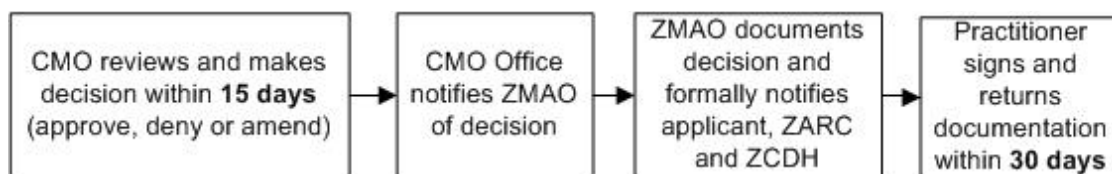




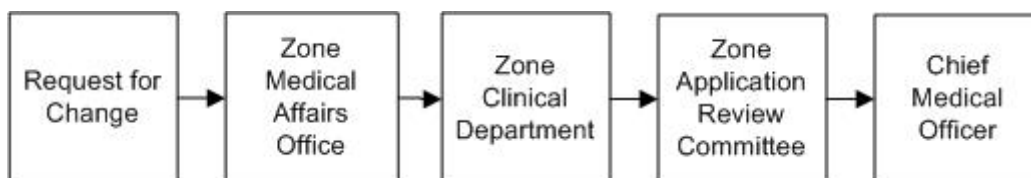
After completing his or her review, the ZCDH /designate makes a recommendation to accept, deny or amend the application and sends the recommendation back to the ZMAO. When parts of the recruitment or application review process have been delegated, the ZCDH/designate needs to ensure that there is clear documentation of who was involved and the factors considered, so that she or he can be comfortable making a recommendation. ZMAO staff forward the application, supporting documentation and Zone Clinical Department recommendation to the Zone Application Review Committee (ZARC), which in turn reviews the request for appointment and clinical privileges and provides a recommendation to the Chief Medical Officer (CMO).



The CMO reviews and makes a decision within 5 days. The CMO's decision is documented by the appropriate ZMAO and the ZMAO notifies the applicant, ZARC and ZCDH. The Practitioner must sign and return their Letter of Offer for an appointment and clinical privileges to take effect; signed Letters of Offer must be returned within 30 days.



Requests for changes to appointment or clinical privileges follow the same basic review process (application → Zone Clinical Department → ZARC → CMO). Request for Change forms are available from the ZMAO and the process is described in Section 3.5 of the Medical Staff Bylaws



An application for appointment/clinical privileges (or request for change to existing clinical privileges) can receive an unfavorable recommendation at any stage in the application process – this could be due to incomplete documentation, or could happen when the Zone Clinical Department, ZARC or CMO recommends an amendment to the requested clinical privileges. The applicant has an opportunity to address deficiencies in their application and/or reach an agreement with the ZCDH about an amendment to their request. If an application or request for change is denied, it can be appealed as described in Section 3.6.7 of the Medical Staff Bylaws.

The diagram on page 25 provides a graphic overview of the AHS application review and approval process. AHS has also created companion guides to the Bylaws and Rules on the topics of Medical Staff Appointments and Clinical Privileges, which include instructions for applicants. These are available on the AHS website: <http://www.albertahealthservices.ca/2376.asp>

#### AHS and Covenant Health:

AHS and Covenant Health are committed to working collaboratively to deliver quality health services and improve safety. Part of this commitment includes a collaborative approach to credentialing and privileging. Covenant Health only appoints Practitioners who meet AHS standards and will not grant an appointment or clinical privileges until a Practitioner has been granted an appointment by AHS. Covenant Health does however have final privileging rights and responsibilities for medical staff at its facilities.

An application for an appointment and clinical privileges at a Covenant Health site should be the end result of a recruitment process which includes interviews and reference checks, as described earlier in this section. In many cases, the recruitment process will be a joint one with AHS, as a large proportion of Practitioners recruited to practice at a Covenant Health site will also practice at an AHS facility. The interviewing and reference checking may also be conducted jointly or may be led by one organization or the other depending on the nature and location(s) of the position being filled. If a Covenant Health applicant is not going to have AHS privileges (will not be practicing at an AHS facility) at least one of their references for AHS appointment should be the CH medical leader who is recruiting them.

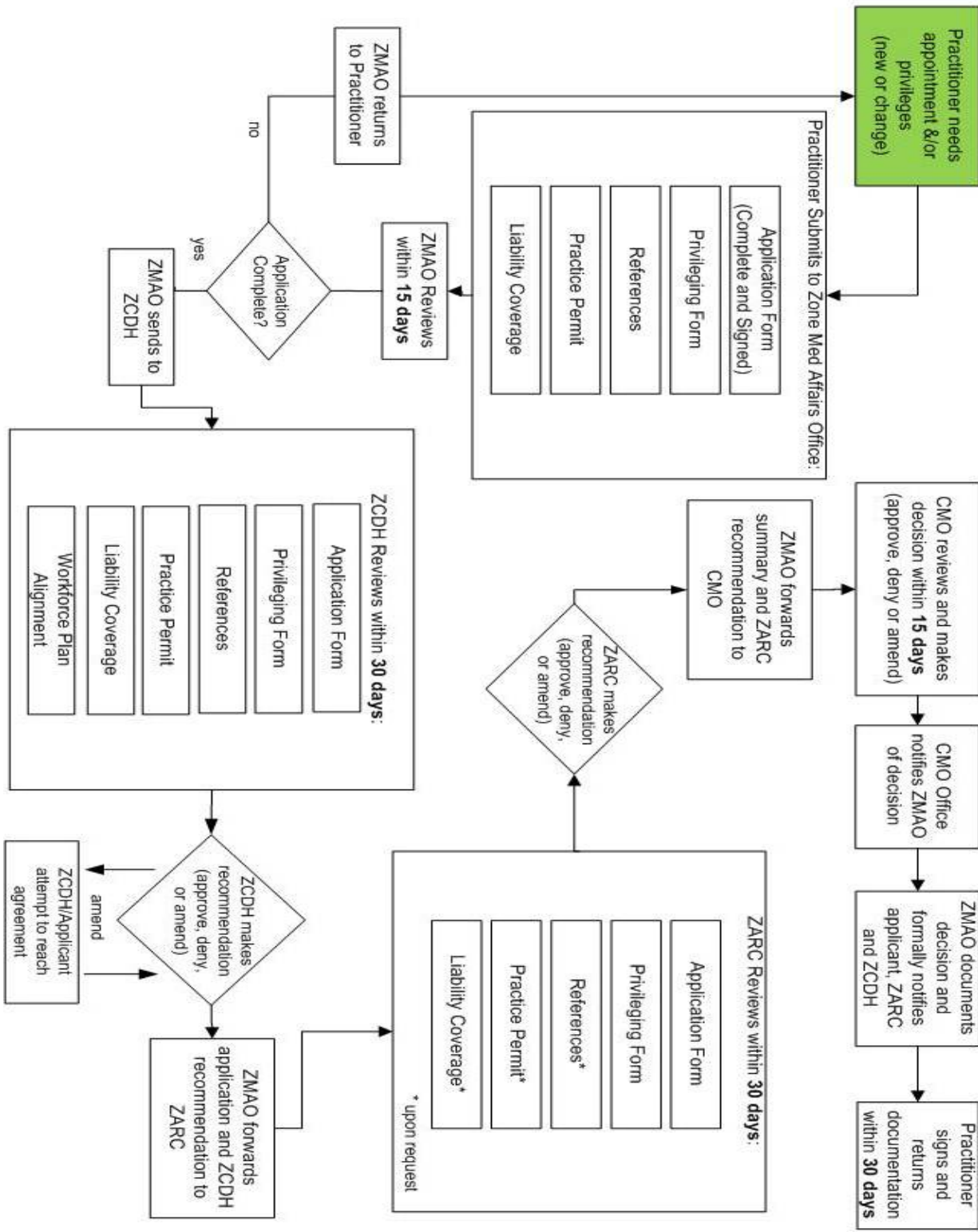
The application process for an individual requesting an appointment and clinical privileges for a Covenant Health site proceeds in the following way:

- The applicant submits an AHS Medical Staff application form and supporting documentation to the relevant AHS Zone Medical Affairs Office.
- A copy of the application and supporting documentation is shared with Covenant Health Medical Affairs, but is not processed by Covenant Health until the AHS appointment process is complete.
- The application proceeds through the same process outlined earlier in this section: review and recommendation by the AHS Zone Clinical Department and ZARC, with final review and decision by the AHS CMO.
- When an application is approved by the AHS CMO and an appointment letter is sent to the applicant, a copy is also sent to Covenant Health.
- Covenant Health then takes the application and AHS appointment documentation to the Covenant Health Medical Advisory Committee and Board for final approval of Covenant Health appointment and clinical privileges.



**Medical Staff Appointment and Clinical Privileges Application Process**

**c. AHS Application Process Flowchart**



### 3. An Alternate Process for “Exceptional Circumstances”

An appointment and privileging process that effectively safeguards quality and patient care takes time. That being said, healthcare often involves managing relative risk and there are times where an urgent or exceptional need to provide care temporarily shifts the usual balance. Section 3.8 of the Bylaws provides an interim, altered process for Exceptional and Urgent Situations. This section allows the Chief Medical Officer (CMO) or Chief Executive Officer (CEO) to approve an appointment and/or clinical privileges on an interim basis for up to a maximum of 90 days without the application proceeding through the usual process. This exception is to be applied only under limited conditions and with important qualifications to ensure patient safety continues to be protected:

- a) Requests through the process must be truly exceptional and urgent and present a situation where having no one available to provide care is a greater risk than allowing the involved Practitioner to provide care on an interim basis without the benefit of the full process;
- b) Key requirements must still be met and key documents provided to the CMO or CEO for review: proof of registration with the relevant College, evidence of current professional liability protection acceptable to AHS and a signed application or change form. The CMO or CEO may also consider other information at his or her request to make the relative risk judgment call and reasonably ensure patient safety, but these minimum standards cannot be waived;
- c) All exceptional and urgent requests, regardless of approval status from the CMO or CEO, will still also proceed through the full Bylaws approval process including review by ZARC resulting in a regular recommendation and decision to whether grant appointment and clinical privileges by the CMO or CEO ; and
- d) Notification must be given to the relevant ZMAC of any exceptional and urgent requests approved by the CMO or CEO along with the nature of the urgency so as to allow ZMAC to follow up with the Zone. Any patterns in urgent situations should be addressed to reduce the likelihood of a repeat of those urgent situations where possible, thereby reducing the need to use an interim process that bypasses the full safeguards inherent in the appointment and clinical privileging process.

While circumstances do arise where urgent or exceptional patient care needs cannot be met following the standard process, exceptional and urgent requests should not be used for administrative ease or as a regular escape valve for slow process. The number and nature of exceptional and urgent requests are to be monitored regularly by the Zones and CMO to ensure that the full appointment and clinical privileging process is still completed appropriately and that an appropriate balance is maintained between patient safety, clinical need and timelines.

## 4. Challenging Areas in the Assessment of Clinical Privileges

There are situations that present particular challenges to organizations and Medical Leaders when assessing requests for clinical privileges. Medical Leaders encountering these challenges (or any others) are encouraged to consult with:

- Zone Clinical Department Heads;
- Zone Medical Directors;
- Zone Application Review Committee Chairs;
- Zone Medical Affairs Directors; and/or
- AHS Legal Services.

### Inter-zone Co-operation to Assess Clinical Privileges:

There will be occasions where due to Practitioner supply, AHS service delivery choices or Practitioner decisions to sub-specialize a particular clinical expertise may not be present in the Zone that is being asked to assess an application for appointment and/or clinical privileges. In circumstances such as this, the significant size of AHS becomes an asset as in most cases the necessary clinical expertise required to make an appropriate judgment on the application can be found in another Zone. In these cases, the leaders from different Zones are expected to collaborate together to review the application and make the best recommendation to the appropriate ZARC.

### New Technologies/Procedures:

Technological advances (newly developed procedures, equipment) are an ongoing challenge to privileging systems – it can be difficult for a reviewer or an organization to determine whether an individual has the necessary credentials to provide safe care when there are no well established or recognized training/certification programs. When dealing with new technologies the organization has a responsibility to first decide if the new procedure or equipment can be accommodated. Then privileging criteria need to be developed, that identify the education, training, certification, experience and monitoring that are required before someone can provide the service.<sup>34</sup> When assessing a request for clinical privileges related to a newly developed procedure or equipment, Medical Leaders should consult with their ZCDH, ZMD and operational leaders to confirm whether AHS can support the activity and to determine a reasonable approach for evaluating credentials.

### Locums:

Locum Practitioners are often recruited on an urgent basis, which has made it difficult to thoroughly assess the Practitioner's ability to competently provide *all* the services that the program, department and/or facility require. In such urgent scenarios, the focus has been mainly on ensuring that patients continue to have access to basic health services. However, it is also important to consider whether there are select, specific services required that may be more specialized than the basic competencies of the discipline in question and to evaluate the competency of the Practitioner to provide or perform the health services that are more specific to the program, department and/or facility. Provincial Medical Affairs is in the process of developing

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<sup>34</sup> Smith, *The Medical Affairs Handbook*, p. 103.

and implementing tools (role descriptions, practice profiles, checklists and approval guidelines) to support thorough assessment of locum appointment and clinical privilege requests.

General Practitioner Requests to Provide “Extended Services”:

Evaluating clinical privilege requests in general practice (especially rural general practice) for “extended services” like advanced obstetrics, anesthesia, surgery, or endoscopy is difficult, as universally accepted standards or credentials do not exist. Determining what is acceptable experience and/or training, balancing Practitioner risk with lack of access to services risk, and coordinating the development of standards for clinical privileges that cross departmental lines make this a particularly challenging area. More guidance will be available as AHS moves forward with the development of clinical privilege lists for General Practice.

Evaluating Credentials of International Medical Graduates:

It can be difficult to assess the education, training and experience of international (foreign) medical graduates as they relate to clinical privileges requested in AHS sites. Not only do reviewers need to evaluate the impact of language and culture on ability to practice, they need to be aware of differences between AHS practice setting and prior training/experience settings (e.g., different drug names and/or clinical protocols), and they should also consider whether there will be any opportunities to provide proctoring or peer support. It is also important for communities, recruiters and foreign applicants to understand that a license from the CPSA does not guarantee AHS approval of an application for appointment and clinical privileges; as mentioned earlier, the CPSA licensure process does not necessarily establish that the individual has the credentials and competence needed for specific AHS clinical privileges and in specific AHS practice settings.

Security Checks:

Satisfactory Security Checks (criminal record checks plus vulnerable sector searches) are required from all prospective Medical Staff members. Sometimes, however, internationally trained recruits may not have lived in Canada long enough for the local police forces to be able to conduct the usual searches and may be coming from jurisdictions that do not provide equivalent documents. In these cases, AHS does rely on the background checking done by federal immigration officials in granting the individual permission to live and work in Canada. In situations where it is not possible to obtain a Canadian Security Check, it is recommended that the Medical Leader(s) involved in recruitment and/or reviewing the application consult with their ZMD and AHS Legal Services.

## 5. Balancing Relative Risks

Despite increasing access to research and technology, healthcare decisions are far from black and white. Even with the best diagnostics, the best facilities and the best health practitioners, there is no guarantee that every patient intervention will result in the anticipated, optimal result. As a core element of patient care, Practitioners with Medical Staff appointments and clinical privileges have a responsibility to operate within the scope of their professional competence and to meet their professional standard of care. Practitioners should discuss with their patients the relative risks of treatment options and together with their patients weigh these risks to determine which course is most appropriate at a particular point in time with the evidence available.

The same relative risk concept is a crucial element in assessing potential future performance of individual Practitioners. Despite the constantly increasing role of technology, healthcare is still first and foremost delivered by individuals and subject to variability in human performance. Uncertainty will always exist in human performance and there is no way to guarantee future performance. Systems such as credentialing, privileging and appointment can however be put in place to balance the relative risk of granting clinical privileges and appointments to independent Practitioners against the risk of those services not being available at all.

A fundamental element in finding the right balance of risk is expert Medical Leader judgment informed by available evidence. The roles of Zone Clinical Department Heads, Zone Clinical Section Heads, Zone Medical Directors, Community Medical Directors, Facility Medical Directors, Zone Application Review Committees and the Chief Medical Officer in reviewing, recommending and approving (or not) applications from individual Practitioners are critically important from a patient safety perspective.

Another fundamental aspect of reducing risk is a documented system that reduces variation. The standards put in place by the Medical Staff Bylaws and Rules are the foundation of the documented system in AHS; this Guide supports and expands on that foundation. Part 4 of this Guide in particular will serve to support a common, systematic approach to making competence decisions about particular clinical privileges, one that is informed by best evidence as well as the knowledge and expertise of AHS Medical Leaders. It will support the ability of Medical Leaders to make the best possible recommendations and decisions, ones that balance the relative risks involved in granting specific clinical privileges to an individual Practitioner at a particular location and a particular point in time.

The experiential knowledge and expertise brought by seasoned AHS Medical Leaders to make recommendations that are in patients' best interests are supported by the systems and minimum requirements put in place by the Medical Staff Bylaws and Rules. The systemic supports and minimum requirements compliment the expert judgment that is needed on the part of Medical Leaders in making recommendations to the relevant Zone Application Review Committee (ZARC). The systemic nature of these supports ensures minimum factors are always considered, regardless of Zone or department. These support systems in turn facilitate the subsequent levels of recommendation through to the ultimate approval or rejection of an application by the CMO.

## Part 3: Clinical Privileges – the AHS Approach

### 1. AHS Framework for Clinical Privilege Lists

In general terms, clinical privileges “define the diagnostic or therapeutic Procedures or other Patient care services a Practitioner is deemed competent to perform; the Facility (ies) and Zone(s) within which the Practitioner is eligible to provide care and services to Patients; and the specified AHS Programs and Services...that the Practitioner is eligible to access.”<sup>35</sup> The granting of clinical privileges should consider:<sup>36</sup>

- The needs of patients served by AHS,
- The Practitioner Workforce Plan;
- The resources available;
- The Practitioner’s documented training, experience, demonstrated ability and skills, and current clinical competence;
- Available AHS resources.

#### Why do clinical privilege lists matter?

Maintaining general clinical privilege lists and assigning individual practitioners specific extended clinical privileges serves primarily as an important patient safety process safeguard but also provides a number of secondary benefits:

- Assisting in quality improvement initiatives by easily identifying which Practitioners are involved in which activities
- Workforce planning and recruitment strategy modeling and planning
- Targeted Practitioner communication based on areas of practice and interest

The Medical Staff Bylaws prescribe the development of specific clinical privilege lists (3.2.6), but do not define or mandate the form that these lists need to take. The Rules do set out a process for establishing, maintaining and changing clinical privilege lists (3.4.3(f)) – lists must be developed by each Zone Clinical Department, and then reviewed by each respective ZMAC and the Provincial Practitioner Executive Committee to ensure consistency with the Bylaws and consistency between Zone Clinical Departments and Zones. However, like the Bylaws, the Rules however only provide very general guidance regarding what clinical privilege lists should look like:

“The list of Procedures for Clinical Privileges shall include the core procedures expected of Zone Clinical Department members with Canadian residency training, and those which require extra training and supervision beyond that normally expected in a Canadian residency program; those procedures which are resource intensive; and those Procedures whose utilization needs to be monitored for quality control and Patient safety reasons.”<sup>37</sup>

<sup>35</sup> Medical Staff Bylaws, Section (3.0.2).

<sup>36</sup> Medical Staff Bylaws, Section (3.0.3).

<sup>37</sup> Provincial Rule 3.4.3(f)(ii).



Clinical privilege lists are essentially classification systems for the diagnostic and treatment procedures provided by a healthcare organization and there are many possible approaches to creating a clinical privilege list. Given the size, scope and complexity of AHS and its clinical departments, the clinical privilege lists contained in Part 4 of this Guide will reflect a variety of approaches. However, while each clinical department may not follow the same format in developing their list, all clinical department privilege lists are expected to follow the same guiding principles:

- All clinical privileging is undertaken from the point of view of patient safety and ensuring that Practitioners have the necessary qualifications to allow them to safely provide the services and procedures for which they will be privileged.
- Specific clinical privileges will only be granted at sites where there are appropriate resources (e.g., infrastructure, equipment and staffing) to safely provide the service to patients.
- Practitioners may request that specific services and procedures be excluded from their core clinical privileges if they do not have the requisite training and/or experience to provide them. This request will be considered by AHS Medical Leaders in light of the potential impact of the request on patient safety, both from the micro perspective of the requesting practitioner and the macro perspective of the department and/or site being able to provide comprehensive, safe and high quality care.
- There may be categories of activity called “extended clinical privileges” in certain AHS clinical departments; these are activities that require particular attention/additional due diligence when defining criteria and reviewing applications. At least one of following characteristics is true of any extended clinical privilege:
  - There are additional College licensure requirements or approvals required in addition to a valid practice permit in order to perform the activity.
  - Additional training is necessary beyond the standard training curriculum delivered by accredited Canadian post secondary institutions.
  - There are explicit, specific re-certification requirements to demonstrate maintenance of clinical competence beyond those required to maintain a valid practice permit.
  - There are maintenance of competence requirements beyond what is expected for other clinical privileges.
  - The activity carries a higher relative risk to patient safety than other clinical privilege activities.
  - The activity requires specialized resources (equipment and/or staff) not uniformly available across all AHS settings in which the clinical discipline is found or that require more deliberate operational allocation by AHS.
- In developing clinical privilege lists, care will be taken to maintain a balance between ensuring sufficient detail in the list to allow AHS to be confident that Practitioners are providing services that they are qualified and appropriately resourced to provide while also ensuring that lists are

not so detailed as to be administratively unmanageable.

- Development of clinical privilege lists will be done through consultation with Zone Medical Directors, Zone Clinical Department Heads, Zone Clinical Section Heads and their designates, and supported by staff from Provincial Medical Affairs.

Even within extended clinical privileges, there is a need to strike the right balance between excessive detail and excessive generality. The right level of detail will be a judgment call made by AHS based on recommendations from each clinical department to satisfy the criteria described above together with administrative efficiency and public expectations. For example if there are no substantive patient safety, Practitioner training or resource requirement differences between performing surgical procedure X via transverse vs. midline incision, it's probably unnecessary to distinguish these as separate extended procedures. If there are differences however, separating does provide a check and balance to manage the differential risks.

It is important to note that particularly in the most urban and tertiary settings, sub-specialization of practice may lead to situations where extended clinical privileges are required as much or more so than general clinical privileges. It would also be incorrect to assume that across the Medical Staff as a whole, extended clinical privileges would rarely be granted; in fact, it is very likely that most Practitioners will be granted a combination of general and extended clinical privileges.

## 2. Types of Privilege Lists

There are a number of possible approaches to developing clinical privilege lists. Some of the most common include:

- “Laundry lists” of procedures or treatments;
- Lists grouped by body parts and anatomical regions or by like procedures/diseases;
- Lists based on patient risk categories and level of training/experience needed;
- Core privileges; and
- Any combination of these methods.<sup>38</sup>

Each approach has advantages and disadvantages. Laundry lists may be most common, but are difficult to maintain and keep current. An overly lengthy, detailed list can actually detract from the patient safety benefit of outlining clinical privileges by making it difficult for staff to readily identify the non-routine, higher patient risk activities within the much larger list of routine items. Lists grouped by body parts, anatomical regions, or like procedures/diseases allow for more general classification, are less cumbersome and reduce the danger that a procedure will be omitted from the listing. However when granting clinical privileges, an organization must still ensure that Practitioners are competent to perform all procedures in the category.<sup>39</sup>

<sup>38</sup> Smith, *The Medical Staff Handbook*, p. 63, 70-94.

<sup>39</sup> Ibid.



Also, a list that is not sufficiently specific increases risk that a Practitioner may choose to perform services or procedures for which they do not have appropriate qualifications and experience and/or which have inappropriate resources at the site to perform safely.

Clinical privilege lists using patient risk categories and level of training/experience are often used in predominantly non-invasive specialties (e.g., internal medicine, pediatrics, family practice).<sup>40</sup> In this system, categories or levels of practice are established, using criteria like complexity of disease, risk to patient, and setting. Usually the list combines a level of training and experience with the complexity of disease/patient risk.

The “core privileges” approach is based on the theory “that a ‘core’ of knowledge and skills is included within a given area of training. Therefore, upon completion of specified training...a practitioner should be competent to treat a core group of diseases and conditions or perform certain categories of procedures. Any disease or procedure beyond the core would then require evidence of additional training or experience and a separate privilege request.”<sup>41</sup> Benefits of this approach can include:

- Reduced need for separate evaluation of competence for clinical privileges that are similar; and
- Simplified processing of applications and monitoring of clinical privilege use.

However this approach may not be easy to apply in every context. Core competencies as defined by training may exceed the menu of services offered at a particular site; as a result the list of core clinical privileges would need to be modified for individuals practicing at that site. Core knowledge and skills based on training may not match the minimum scope of practice expected or minimum competence needed to take call. The use of “core privileges” also does not take away from the fundamental responsibility to assess competence to perform the separate activities contained within the core.<sup>42</sup>

The best approach may vary depending on the clinical department and the organization and approaches can also be combined (they are not mutually exclusive). Combinations can be used to reflect:

- Complexities of various specialties;
- Specialties which combine cognitive and procedural clinical privileges; and
- Complexities of a large health system with sites of widely varying size and acuity.

“There might be no single perfect approach for classifying procedures, diseases, or conditions for purposes of granting specific clinical privileges. What is right for one organization, hospital, or department might not work for another. The organization will sometimes have three or more approaches or combinations evident. Some methods lend themselves to surgical specialties; whereas, others work better with non-invasive diagnostic and therapeutic specialties. Therefore, privileging typically matches not only the organization’s needs but also the needs of individual departments, sections, or specialties. Again, whatever classification systems organizations use, they must ensure

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<sup>40</sup> Ibid.

<sup>41</sup> Ibid. p.81.

<sup>42</sup> CNA HealthPro VP09-3, p. 81

that practitioners are competent to perform all privileges granted to them and that privileges are appropriate to the various settings within the organization.”<sup>43</sup>

Once an approach to creating the list/classifying the clinical privileges is determined, an organization must decide what criteria in terms of level of education, training and experience is necessary to grant clinical privileges. This “establishes a ‘level playing field’ for applicants and provides the basis for recommending clinical privileges based on objective evidence of current competence.”<sup>44</sup>

## 2. Multidisciplinary Overlap of Clinical Privileges

Where clinical privileges cross department lines, there will be a need to coordinate the development of criteria for granting and renewing clinical privileges. Views of the training and experience necessary to exercise the cross department clinical privileges may differ. AHS Medical Leaders and Medical Staff members will need to look for common ground through multidisciplinary discussion of the minimum criteria for granting clinical privileges.<sup>45</sup>

As described in AHS Medical Staff Bylaw 3.2.2, “... (n)o Zone Clinical Department, Zone Clinical Section or specialty ‘owns’ any Clinical Privilege, including Procedures.” Procedures/clinical privileges that may be performed by more than one specialty are called multidisciplinary clinical privileges and it is the responsibility of the Medical Staff to ensure that a minimum standard of care is provided regardless of which specialty is performing the procedure. In most cases, criteria may have to be developed to ensure this single level of care. For example, the departments of Obstetrics & Gynecology and Family Medicine may not agree on minimum qualifications for caesarean sections or high-risk births. In a case like this, the minimum qualifications and volume may not be identical, but they must be equivalent. Any minimum volume should be dependent on the environment and volume of a given procedure within the facility setting, and should also be consistent across the province.

When special training is required to perform a multi-disciplinary procedure — over and above an accredited residency or fellowship — criteria will be developed by representatives of the interested Zone Clinical Departments to ensure that the Practitioner meets the minimum requirements needed to apply for that procedure.

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<sup>43</sup> Smith, *The Medical Staff Handbook*, p. 81 & 94.

<sup>44</sup> *Ibid.*, p. 64.

<sup>45</sup> Smith, *The Medical Staff Handbook*, p. 99.

## Part 4: Clinical Domain Specific Information

### 1. Introduction

As described above, the principles to be followed in granting clinical privileges to any member of the AHS Medical Staff are the same, no matter the geographic location, clinical specialty, or clinical practice setting. There are, however, specific details that vary from one discipline to the next, influenced by training program design, service delivery decisions, relative patient safety risk and regulatory College systems. Part 4 of this guide outlines the clinical discipline-specific elements of AHS decisions to grant clinical privileges.

This section is organized largely by traditional clinical discipline groupings and sub-groupings. The structure of the AHS Medical Staff does not entirely follow this organization; however, each Zone has established clinical departments and sections to best manage its own clinical service and geographic particular needs. As a result, different specific clinical departments and/or sections can be found in some Zones. Regardless of the specific Zone organization, the same standards will be maintained within traditional clinical disciplines outlined here. For example while cardiology might be part of the Department of Medicine in the Calgary Zone, the Department of Internal Medicine in the South Zone and the Department of Hospital Health in the North Zone, the clinical privilege requirements and approach described in the cardiology section here will equally apply to cardiologists in each of those three different departments.

Best available evidence will drive decisions made about privileging; however, the availability, specificity and reliability of that evidence will vary. In some cases, very specific high quality research evidence will be available which may, for example, establish a clear link between a certain number of a particular clinical procedure being performed in order to maintain reliable patient safety outcomes. Far more commonly however, there will not be such explicit measures or criteria. What must be used instead is the experienced judgment of medical leaders to develop a set of criteria and then to use that criteria to make a responsible prediction about the appropriateness of granting those specific clinical privileges to a particular Practitioner in a particular location. As better evidence becomes available, as clinical training programs and standards evolve, as new therapeutics emerge and as others disappear, and as the relative risk of some therapeutics change, the clinical privilege lists will also evolve. Each section in this Part 4 will be reviewed at least every two years to ensure it remains an up to date and valued tool to support the reliable delivery of safe medical care to AHS patients.

### 2. Clinical Privilege Lists by Discipline *\*In Development\**

Province wide clinical privilege lists, aligned with College approvals, will be developed for all disciplines. As the discipline specific lists are developed, they will be appended to the Guide.

## Definitions:

Annual Information Verification and Attestation (AIVA)	Each Practitioner, as a condition of their continuation on the Medical Staff, must submit a completed and signed information verification and attestation form to the Medical Affairs Office within 12 months of being appointed and annually thereafter.
Application	The forms and process used to apply for a Medical Staff Appointment and Clinical Privileges in the manner specified in the Medical Staff Bylaws and the Medical Staff Rules.
Appointment	The process of becoming a member of the Medical Staff. (v.) An <i>appointment</i> (n.) to the AHS Medical Staff establishes the relationship between individual Practitioners and AHS, one which includes mutual responsibility and accountability for providing health services to Albertans and an agreement to be bound by the AHS Medical Staff Bylaws and Rules.
Chief Executive Officer or CEO	The chief executive officer appointed by the board of AHS to have overall administrative responsibility for AHS.
Clinical Privileges	The delineation of the Procedures that may be performed by a Practitioner; the Sites of Clinical Activity in which a Practitioner may perform Procedures or provide care to Patients; and the AHS Programs and Professional Services that are available to a Practitioner in order to provide care to Patients.
College	The relevant regulatory body which governs the Practitioner.
Community Physician, Dentist, Oral & Maxillofacial Surgeon or Podiatrist	A Physician, Dentist, Oral & Maxillofacial Surgeon or Podiatrist with a scope of practice limited to community office or clinic practice.
Covenant Health	Covenant Health is Canada's largest Catholic healthcare organization with over 14,000 physicians, employees and volunteers serving in 12 communities across Alberta. A major provider in Alberta's integrated health system, Covenant Health works with Alberta Health Services and community partners to deliver a broad range of programs and services.

Credentialing	The process of screening and evaluating qualifications
Dentist or Oral & Maxillofacial Surgeon	A person licensed in independent practice and in good standing with the Alberta Dental Association and College pursuant to the Health Professions Act (Alberta).
Executive Vice President & Chief Medical Officer or Chief Medical Officer or CMO	The most senior medical administrative leader of AHS, appointed by the CEO.
Facilities	Approved hospitals, continuing care facilities, community health, urgent care, and public health centres, and any other facilities operated by AHS.
Locum Tenens	A Practitioner temporarily placed into an existing practice and/or Facility in order to facilitate the short term absence of another Practitioner, or to address a temporary shortfall in Practitioner workforce.
Medical Affairs Office	An operational and organizational office of the Executive Vice President & Chief Medical Officer portfolio. Also referred to as “Zone Medical Affairs Office” (ZMAO).
Medical Director	The Practitioner who is the medical administrative leader of a Zone (Zone Medical Director); one or more Facilities (Facility Medical Director), one or more communities (Community Medical Director), an AHS provincial portfolio or program (Senior Medical Director or Medical Director); or a Zone program (Zone Program Medical Director).
Medical Leader	A Practitioner who, at AHS’ request, agrees to provide medical administrative leadership to AHS for an organizational unit or initiative (e.g., Zone, facility, program, etc.).
Medical Staff	Collectively, all Practitioners who possess a Medical Staff Appointment pursuant to the AHS Medical Staff Bylaws.
Medical Staff Letter of Offer	An offer to join the Medical Staff which specifies the category of Appointment, assignment to a Zone(s) Clinical Department(s), delineation of specific Clinical Privileges (if applicable), and the details of major responsibilities and roles.

Periodic Review	A periodic review of the professional performance and all matters relevant to the Appointment and Clinical Privileges of a Practitioner with an Appointment in the Active and Locum Tenens Staff categories.
Physician	A person licensed in independent practice and in good standing with the College of Physicians and Surgeons of Alberta pursuant to the Health Professions Act (Alberta).
Podiatrist	A person licensed in independent practice and in good standing with the Alberta Podiatry Association pursuant to the Podiatry Act/Health Professions Act (Alberta).
Practitioner	A Physician, Dentist, Oral & Maxillofacial Surgeon; Podiatrist, or a Scientist Leader, who has an AHS Medical Staff Appointment.
Practitioner Workforce Plan	An AHS plan which provides projections and direction with respect to the recruitment, retention and organization of an appropriate number, mix and location of Practitioners with the required skill sets.
Primary Zone Clinical Department	The Zone Clinical Department in which a Practitioner undertakes the majority of his/her Medical Staff responsibilities and roles, and through which changes in Appointment, Periodic Reviews, and other administrative actions pursuant to these Bylaws will be managed.
Privileging	The <i>process</i> whereby a Practitioner is authorized to practice within a particular clinical domain and provide particular clinical procedures at a specific site (or sites).
Procedure	A diagnostic or therapeutic intervention for which a grant of Clinical Privileges is required.
Professional Codes of Conduct	The Code of Conduct established by the College of Physicians and Surgeons of Alberta, the Code of Conduct established by the Alberta Podiatry Association, and the Code of Ethics established by the Alberta Dental Association and College.
Request to Change	A request to change the category of Appointment and/or the Clinical Privileges of a Practitioner pursuant to these Bylaws.

Scientist Leader	A person other than a Physician, Dentist, Oral & Maxillofacial Surgeon or Podiatrist who holds a doctorate degree in a recognized health-related scientific or biomedical discipline, and who is an AHS medical administrative leader responsible for, and accountable to, Physician, Dentist, Oral & Maxillofacial Surgeon and/or Podiatrist Practitioners.
Sites of Clinical Activity	The locations and programs, listed in the grant of Clinical Privileges, where a Practitioner may perform Procedures, or provide care or services to Patients. The Sites of Clinical Activity may include Zones, Facilities, specific AHS Programs and Professional Services within Facilities, and/or Telemedicine.
Telemedicine	The provision of services for Patients, including the performance of Procedures, via telecommunication technologies, when the Patient and the Practitioner are geographically separated. This may include Practitioners in Alberta, as well as those outside Alberta who are on the Telemedicine Register of the College of Physicians and Surgeons of Alberta.
Universal Programs and Professional Services	Those diagnostic and therapeutic services and programs available, within their respective scope of practice, to all Alberta Physicians, Dentists, Oral & Maxillofacial Surgeons and Podiatrists without the need for an AHS Medical Staff Appointment or grant of Clinical Privileges.
Zone	A geographically defined organizational and operational sub-unit of AHS, the boundaries of which may be revised from time-to-time by AHS.
Zone Application Review Committee or ZARC	A committee established pursuant to the AHS Bylaws which reviews all initial applications to the AHS Medical Staff and all requests for change to appointments and clinical privileges, and prepares written recommendations.
Zone Clinical Department or ZCD	An organizational unit of Practitioners established by the Zone Medical Director and Zone Medical Administrative Committee to which members of the Zone Medical Staff are assigned.
Zone Clinical Department Head or ZCDH	The Practitioner who is the leader of a Zone Clinical Department.

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Zone Clinical Department Site Chief	The Practitioner who is the leader of Zone Clinical Department members at a particular Facility or Site.
Zone Clinical Section	An organizational sub-unit of a Zone Clinical Department established by the Zone Medical Director and the Zone Medical Administrative Committee.
Zone Clinical Section Chief	The Practitioner who is the leader of a Zone Clinical Section.
Zone Medical Administrative Committee or ZMAC	A committee established pursuant to the Bylaws which advises the Zone Medical Director on matters related to quality and safe patient care at the Zone level (and other duties assigned under the AHS Bylaws and Rules).
Zone Medical Staff	Collectively, all Practitioners who are assigned to Zone Clinical Departments within a particular Zone.
Zone Medical Staff Association	An association of the Zone Medical Staff.