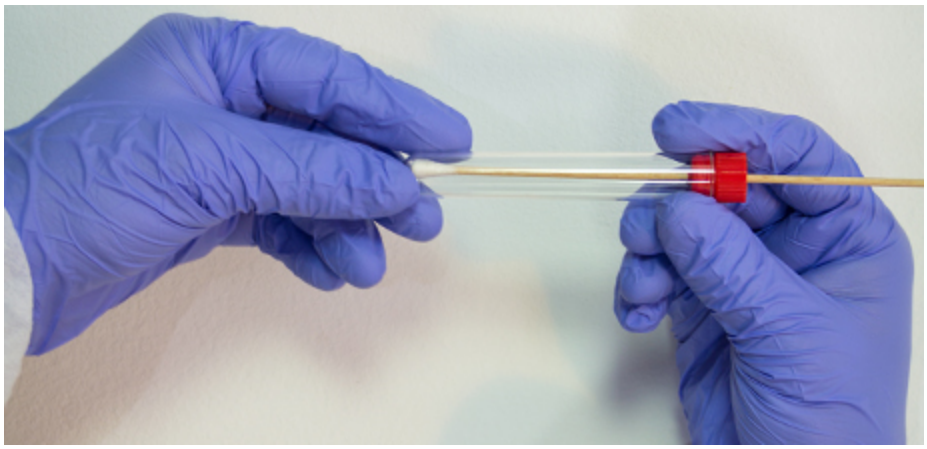

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Strange, and ultimately dangerous, credentialing scenarios highlight the need for MSPs' roles to protect the public

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For those of you who were unable to join us at NAMSS this year, we thought you might enjoy a recap of our session regarding strange credentialing scenarios. It is true that fact can be stranger than fiction, but these situations make it very clear that the role of the MSP is critical in today's fast-paced world.

The Danger of Not Doing Your Homework

We begin with a history lesson — Michael Swango. He was valedictorian of his class and awarded a National Merit scholarship. His favorite movie was "Silence of the Lambs," and he kept a scrapbook of car wrecks. He graduated from medical school in 1983, and during that time, five of the patients he cared for died. He obtained a surgical internship and subsequently, despite a poor evaluation, a neurosurgery residency at The Ohio State University College of Medicine (from which he was ultimately terminated for slovenly work). His nickname was "Double-O Swango." Nursing staff expressed their concerns, but administration thought they were being "paranoid." He was licensed as a physician in the state of Ohio in 1984.

This is where it gets interesting. In 1991, he legally changed his name to Daniel Adams after having been sentenced to five years in prison for aggravated battery —

he poisoned his coworkers while working as an EMT. He then forged his criminal record to reduce the charge and created a "Restoration of Civil Rights" letter allegedly from the Governor of Virginia. He then began working at a Virginia hospital and subsequently obtained a psychiatric residency at Stony Brook School of Medicine. It wasn't until his ex-wife's mother called a nurse at the hospital who, in turn, called Stony Brook, that he was terminated from the residency. And so he started working as a physician and poisoning patients in Zimbabwe. In 1995, OSU conceded it should have done a more thorough investigation and took an in-depth look at Dr. Swango. He is currently serving three consecutive life sentences without the possibility of parole and is estimated to have fatally poisoned as many as 60 patients and colleagues.[1]

You might say, "But this was 30 years ago; times have changed." Enter Dr. Christopher Duntsch. In February 2017, he was given a life sentence on five indictments of aggravated assault with a deadly weapon (his scalpel) and one of harming an elderly patient. In 2011, he obtained an appointment and clinical privileges at Baylor Regional Medical Center. His curriculum vitae said he obtained a doctorate in microbiology from St. Jude's Children's Hospital — but no such program existed at that time. At one of his earliest surgeries, he left his best friend a quadriplegic. He "left" Baylor in April 2012, and the response to third-party queries was, "There have been no summary, administrative restrictions, or suspension of Dr. Duntsch's medical staff membership or clinical privileges during the time he has practiced at Baylor Regional Medical Center at Plano." He applied to Dallas Medical Center and, while exercising temporary privileges, out of three patients, one died and one was paralyzed. Meanwhile, two physicians had submitted complaints to the Texas Medical Board stating that he had "horrendous surgical technique," and that he was "the most careless, clueless, and dangerous spine surgeon" they had ever seen. In December 2012, he obtained appointment and clinical privileges at Legacy Surgery Center and shortly thereafter was granted "emergency privileges" to operate on a patient at University General Hospital. In June 2013, the Texas Medical Board revoked his license. The total tally: More than 30 patients were harmed at four hospitals in a total period of just over 18 months.

And let's look at one more case just to show that Dr. Duntsch is not alone. In 2015, Dr. Aria Sabit pleaded guilty to two cases of performing unnecessary spinal surgery. In 2017, he pleaded guilty to four counts of health care fraud and other charges. He is currently serving 19 years and six months in federal prison, and more than two dozen medical malpractice cases have been brought against him. He began practicing in California in 2009. He moved to Michigan in 2011 and obtained privileges at three different hospitals. All the while he was receiving financial incentives to use Apex implants resulting in the performance of an untold number of unnecessary surgeries.

Handling Difficult Scenarios

Against this backdrop, consider the challenges you face in your day-to-day practice of seeking to ensure that only qualified practitioners will be exercising clinical privileges at your healthcare facility.

It's December 28 and you have just been advised that negotiations with the existing emergency department group have failed, and they will no longer be providing services at your five hospitals as of midnight December 31. You have less than 72 hours to credential more than 50 new providers, and your bylaws require three complete references in order to grant temporary privileges — even for important patient care need. Perhaps it is time to amend your bylaws.

You work in a system that has 12 hospitals (each with its own CMS certification number) all of which are governed by a single board. Dr. Apple has been exercising privileges at Left Hospital for a year. He then applies for privileges at Right Hospital. While processing his application, the system central verification office discovers that it had used an outdated CAQH application for Dr. Apple's application at Left Hospital. The current CAQH application shows that Dr. Apple had relinquished his clinical privileges at a hospital outside of the system in order to avoid an investigation prior to submitting his application at Left Hospital. The medical executive committee at Right Hospital wants to deny Dr. Apple's application. The medical executive committee at Left Hospital wants to terminate Dr. Apple's privileges, even though there have been no quality of care problems during his year there. Dr. Doc applies for clinical privileges at Happy Hospital. No one will return any reference forms. You advise Dr. Doc of this problem, and she says she will take care of it. The next day you receive a laudatory letter from one of the references by email. But if you look closely, you will see that the email did not come from a hospital address. Should you call the reference? And when you look even more closely, you see that Dr. Doc has two email addresses with two different last names, and when you check the internet using the second name (which was not on her application), you obtain a fair amount of concerning information about her.

How Do You Ensure Consistency?

There are no definitive rules that will ensure that you will always have a fully complete application. Every time you think you have thought of everything, a new twist seems to arise. And it is difficult to define a "spidey sense." We also know that the volume of applications and the time constraints for completing them can be challenging. But, at the end of the day, we also know that you need to take the time to do a thorough and complete job. Being told that you need to rush an application and creating shortcuts to meet that demand can ultimately result in patient harm — granting "emergency privileges" to Dr. Duntsch is a case in point.

So, here are just a few reminders:

1. Put the right processes in place. Be sure you have a complete process for each situation — whether it is important patient care need, appointment

only, or appointment and clinical privileges. And then follow that process; update it when you learn something new that will help you even more. If facts are not adding up, or your "spidey sense" is tingling, consider whether you need a criminal background check (if your facility does not already do one) or a more in-depth review.

2. Set checks and balances. When you are receiving information directly from a physician, be sure you have checks and balances in place to verify its accuracy. If a hospital declines to give you a reference, put the burden on the physician to provide the information your committee needs to make an informed decision.
3. Make incident reporting a priority. Encourage a robust incident reporting system (i.e. one where hospital staff feel comfortable filing reports because they know that administration and the medical staff will follow up on them). Encourage effective participation by your medical staff leaders and committees. If you know you have a "bad" practitioner, raise the ethical dilemma of letting this practitioner quietly leave and getting a "clean" reference letter when they apply to another hospital.
4. Require conflict of interest forms. Be sure practitioners are required to complete conflict of interest forms that include disclosure of potentially troubling financial arrangements such as with durable medical equipment suppliers.

Your job is incredibly important. You are the gatekeeper with respect to each practitioner who seeks clinical privileges at your facility. You are often the educator of your medical staff committees, and we thank you for what you do.

[1] Blind Eye by James B. Stewart, Simon & Schuster (2000)

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