



A Review of Alberta Health Services

**Physician
Credentialing
& Practice
Privileging
for Pathology
& Radiology**

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Introduction

A number of critical incidents in medical diagnostic imaging and anatomical pathology services in Alberta prompted concern on the part of the Minister of Health of Alberta about his capacity to assure Alberta citizens that these services are safe and reliable across the province. The Minister of Health commissioned Dr. Dennis Kendel to conduct an independent review of Alberta Health Services (AHS) credentialing and privilege awarding policies and procedures pertaining to the medical specialties of diagnostic imaging (radiology) and pathology.

This review followed on the heels of a review of the licensing of all radiologists and pathologists in Alberta by the College of Physicians & Surgeons of Alberta (CPSA) which was conducted by Dr. Kendel at the request of the CPSA and with support from Alberta Health (AH).

In the course of the AHS review, Dr. Kendel was directed to review the scope of practice currently undertaken by each radiologist and pathologist to ascertain if any of these physicians are practicing beyond the scope authorized by AHS and/or the CPSA.

These two reviews, in concert, were designed to assess the cumulative rigor and effectiveness of public protection measures administered by the CPSA and AHS to protect Alberta citizens from preventable harm in their reliance upon diagnostic imaging and pathology services.

Definitions

AHS uses the following definitions with respect to the process for regulating physician activity within its facilities and programs.

PRACTITIONER

A physician, dentist, oral & maxillofacial surgeon, podiatrist, or a scientist leader who has an AHS medical staff appointment.

AHS APPOINTMENT

The process whereby a practitioner's credentials and experience are reviewed and aligned with AHS organizational needs and capacity to ensure an appropriate medical staff assignment.

CREDENTIALING

The process whereby a practitioner's formal qualifications are validated and reviewed against established standards (for example, those of the Royal College of Physicians & Surgeons of Canada). Credentialing is used to verify that a practitioner has met the standards set forth by the CPSA and AHS in support of granting a medical practice permit or an AHS medical staff appointment, respectively.

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.

Background

Modern health care systems are extremely complex entities that rely upon the professional expertise of a wide array of health professionals to deliver safe high quality health care consistently day after day. The safety and quality of the services delivered by such systems depends, in part, upon the appropriate deployment of this diverse pool of health professionals and appropriate regulation of their scope of work.

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Health care systems often aspire to achieve the remarkable safety standards which we have come to expect as the norm in commercial aviation globally. The commercial aviation industry has achieved its enviable safety record by being very deliberate in its deployment and regulation of its personnel. Pilots must be licensed and they are obligated to participate in mandatory periodic evaluation of their skills and performance capacity. During flight the roles of the captain and the first officer are well demarcated. Pilots are certified to fly specific aircraft and can only fly commercial aircraft for which they hold current certification.

There are some parallels in the way the commercial aviation industry and the health care industry manage their workforce to optimize safety for the people that both industries serve. However there are also significant differences.

Both industries rely upon licensure systems to ensure that workers possess the foundational knowledge, skills, and performance capacity to be engaged in defined service roles.

In the commercial aviation industry all workers are employees of a specific airline and that airline regulates the roles of its employees in accordance with standards defined by both national and international regulatory agencies.

The overwhelming majority of licensed health care workers are also engaged by health service organizations as employees. They are hired into specific employment positions with well defined scopes of work. The human resources department of the health service organization controls the scope of work undertaken by each employee and evaluates the performance of employees.

In Canada, a relatively small number of physicians are engaged as employees of health service organizations. Others may have explicit professional service contracts with a health service organization.

The overwhelming majority of physicians practice as independent contractors through a medical staff appointment with a health service organization. The organization awards to each appointed physician specific practice privileges which define the scope of practice that may be undertaken by each physician within facilities and programs governed and managed by that organization.

In the section that follows, information is provided about the history of regulating physician scope of practice by health service organizations in Canada and in Alberta.

The History of Post-Licensure Regulation of Physician Scope of Practice

Once physicians are licensed to practice, the mechanism for regulating physician scope of practice across Canada is based upon an assumption that the owners and governors of any health care institution have the legal right and responsibility to regulate the activity of doctors within their institutions in a manner that assures the safety of patients treated in those institutions. However the mechanism still accords doctors a very high degree of engagement in the administration of the mechanism. In fact, it now is one of the last bastions of medical self-regulation with little or no public engagement in the process.

Until relatively recently in Canada every hospital had its own board. Although each of these boards was legally empowered to grant medical staff appointments to doctors and define the practice privileges for each doctor on staff, in reality most boards simply “rubber stamped” the recommendations brought to them by the Medical Advisory Committee (MAC) or Credential

Committee (CC) of the hospital. So the doctors on staff at each hospital were essentially “masters of their own house” in respect to deciding who might be permitted to join them and what privileges would be granted to each new doctor.

Each hospital and its medical staff functioned autonomously from one another. Because the medical staff in each hospital was not bound by any explicit national or provincial policies for regulating physician scope of practice, considerable variance in regulatory practices developed between hospitals. Such variance generally became deeply embedded in the culture of each hospital as the historical practices were passed on from one generation of physicians to another.

With the transition to regionalized governance and management of health services across Canada (excluding Ontario) in the early 1990s there was an expectation that the highly variable approaches to physician privileging at individual health service institutions would give way to a single uniform approach in all the institutions in a region. The extent to which that goal was or was not achieved across Canada, and particularly in Alberta, is a matter of considerable interest.

Since the initial steps were taken to create regional health authorities (RHAs) in all Canadian provinces other than Ontario, most provincial governments have consolidated their initial regions into a smaller number of larger regions. Alberta has been the most aggressive in its pursuit of this trend. The 17 RHAs that Alberta established in 1993 were consolidated into nine regions in 2003, and a single health authority known as Alberta Health Services was established in 2008. Given the fact that Alberta has a unitary health service organization, one might expect that Alberta would have the most unified and standardized approach to physician regulation of all the provinces in Canada. This review has not validated that expectation. Although AHS medical leaders are working valiantly to achieve a unified and

standardized process for regulating physician scope of practice throughout Alberta, at the present time this process is still highly uneven and fragmented.

When AHS was established on May 15, 2008 and became fully operational on April 1, 2009 it inherited the legacy of very non-standardized policies and practices for regulating physician scope of practice in the former nine regions. AHS was effectively hamstrung in its effort to establish common provincewide policies and practices by the lack of a common provincewide set of Medical Staff Bylaws and rules under those bylaws.

A joint AHS-Alberta Medical Association bylaws working group, with representation from AH, the CPSA and Covenant Health, was established to draft provincial Medical Staff Bylaws and rules in Alberta. This proved to be a very protracted process. The new bylaws and rules just came into force on February 28, 2011. AHS is now engaged in a very arduous consultation process with appointed medical leaders in the five zones to make these new bylaws and rules fully functional.

Dr. David Megran, in his capacity as Chief Medical Officer (CMO) for AHS, along with the staff of the CMO office, has established a plan for “Supporting and Ensuring Quality and Excellence in AHS Medical Staff Performance”. The plan addresses initial medical staff appointments and clinical privilege awards plus privilege review based upon individual physician performance evaluation at three year intervals. It takes into account the current state of AHS appointment and privileging procedures, the preferred future state, strategies to be considered in pursuit of the future state, and proposed next actions. The plan identifies some immediate actions that need to be taken by AHS as well as medium to longer term strategies.

One of the actions that is already underway is the development of standardized procedure lists for appointed practitioners by zone clinical departments.

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Dr. Ty Josdal, in his capacity as Associate Chief Medical Officer for AHS, is leading this process, with support from Mr. David Kay. Dr. Josdal describes this change process as occurring in a context that strives to “strike a balance between a provincial approach to standards, policies, procedures and oversight with zone delivery of health services and the organization of the Medical Staff”.

It may be challenging for Dr. Josdal and his colleagues in the Medical Affairs office at AHS to achieve their goal quickly because they are contending with a very long history of variation between the former regions which is very deeply entrenched.

Review Methodology

As noted in the introduction to this report, this review followed on the heels of a review of CPSA physician registration (licensure) policies and practices. That review included a detailed examination of relevant data for every radiologist and pathologist currently holding registration with the CPSA. The CPSA review also examined a special program operated by the CPSA for granting approval to radiologists in Alberta to interpret images derived through the diagnostic imaging modalities of echocardiography, magnetic resonance imaging (MRI) (General), MRI (cardiac), positron emission tomography (PET), nuclear medicine, ultrasound, and cardiac computed tomography (CT).

The CPSA review yielded a finding that all of the radiologists and pathologists authorized to practice in those speciality disciplines in Alberta had been properly and appropriately registered by the CPSA. It also yielded a list of the diagnostic imaging (DI) interpretation modality approvals granted by the CPSA to 345 radiologists.

Medical regulatory authorities (MRAs) and publicly accountable health service delivery organizations, like AHS, have a conjoint and concurrent responsibility to protect patients from harm by ensuring that each physician is competent to practice medicine and that each physician has current competency and performance capacity to safely deliver specific medical services to patients. Once the CPSA has authorized a physician to practice medicine in a specific medical discipline, the responsibility shifts to AHS to effectively regulate the scope of practice of each AHS physician appointee to ensure that patients are not exposed to medical services beyond the current competence and capacity of the physicians delivering those services.

To effectively discharge that public protection responsibility, one might assume that AHS would have:

- 1) Clear and explicit descriptions of the AHS standards and criteria used to assess the initial and ongoing competency and capacity of individual radiologists and pathologists to deliver specific medical services in specific sites throughout Alberta.
- 2) An effective mechanism that is applied consistently across the province to ensure that initial privilege assignment and periodic privilege review are compliant with AHS standards and criteria.
- 3) An effective mechanism to monitor the scope of practice of individual radiologists and pathologists to ensure their scope of practice remains within the boundaries of their assigned privileges.

The information requested from AHS included:

- 1) Historical information about physician credentialing in Alberta prior to the establishment of AHS and since AHS became fully operational.

- 2) The AHS Medical Staff Bylaws and Rules as well as information about implementation of these bylaws and rules.
- 3) Information about AHS standards and criteria for awarding clinical privileges.
- 4) Disclosure of the current privileges held by all radiologists and pathologists who hold an AHS medical staff appointment or provide services in any agency that has an affiliation agreement with AHS or contractual service agreement with AHS.
- 5) Clinical practice activity data for all radiologists and pathologists credentialed by AHS to enable the reviewer to objectively determine if any radiologists or pathologists are practicing outside the boundaries of their AHS privileges.

The review plan included one or more site visits to AHS offices in Calgary to review data and interact with staff at the CMO and Medical Affairs offices.

As the review got underway, it became evident that there are some radiologists and pathologists who practice exclusively in private settings and do not have AHS staff appointments or are not captured in the AHS physician credentialing process through a facility contract or affiliation agreement with AHS.

Because the CPSA has statutory authority and accountability under the *Health Professions Act* to accredit and/or regulate private DI clinic and laboratories, information was requested from the CPSA about the activity of radiologists and pathologists in private clinics. Medical service claim data were also requested from AH to assess whether radiologists in private clinics were practicing beyond the modality approvals granted to them by the CPSA.

Throughout the course of the review regular email and phone communications were maintained with appropriate staff at AHS, AH, and the CPSA to request supplementary information or clarification of information already provided.

Experience with Data Collection in the Course of this Review

The very protracted process for obtaining data essential to the completion of the AHS review offers useful insights into the current status of AHS physician information systems.

The preceding CPSA Review was completed during the course of a three-day site visit to the CPSA. All of the data essential to the completion of that review were accessible through the CPSA's superb electronic physician database. The CPSA also has very explicit and detailed medical licensure policies which enabled the reviewer to readily assess if each physician registration was compliant with those policies.

The nature of the AHS review was very comparable to that conducted by Dr. Doug Cochrane in British Columbia (B.C.) in 2011 except that the Cochrane Review was limited to radiologists and the AHS Review pertained to both radiologists and pathologists. A decision was therefore made to request from AHS data on radiologists and pathologists comparable in scope to that requested of RHAs in B.C. for radiologists only. Dr. Cochrane asked the RHAs to provide the required data to him within eight days and he received it within that time frame.

In contrast with the eight-day data retrieval process in B.C., it took AHS over four months to collect and deliver the requested data for this review. While the

data requested of AHS pertained to two medical disciplines rather than one, the protracted data collection process was attributable substantially to the fact the data are still held in the zones, are not accessible electronically, and are recorded differently between zones.

Findings from the Review

Not all radiologists and pathologists who are registered with the CPSA will seek and/or obtain a medical staff appointment with AHS. Some physicians may maintain registration with the CPSA but not be engaged in clinical practice in Alberta at this time. Some may practice exclusively in private clinics that do not have a contractual service agreement with AHS or may work exclusively in administrative positions.

Radiologists and pathologists who hold medical staff appointments in Covenant Health facilities are credentialed by AHS. Pathologists who are engaged by DynaLIFE_{dx} also are credentialed by AHS.

There are currently 79 radiologists registered with the CPSA who do not hold medical staff appointments with AHS or have been credentialed by AHS. Of these 79, 45 practice in private facilities, 21 are inactive, and 13 are not currently in Alberta.

There are currently 211 pathologists registered with the CPSA and 183 hold medical staff appointments with AHS or have been credentialed by AHS. The remaining 28 practice in private facilities or in agencies like the Medical Examiner's office.

MEDICAL STAFF APPOINTMENTS WITH AHS

Sections 3.1.1 of the AHS Bylaws stipulate: "Appointment to the Medical Staff is not a right. It shall be granted only to professional and competent individuals with a license for independent practice with the relevant College, and who initially and

continuously meet the qualifications, standards, and requirements set forth in these Bylaws and in such Medical Staff Rules as are adopted from time to time."

The criteria for appointment to the medical staff are set out in Section 3.4.1 of the AHS Medical Staff Rules. They may be summarized as follows:

- a) Verification of training, experience, and qualifications
- b) Suitability, ability, and willingness to accept and discharge his/her responsibilities
- c) A determination by AHS that the appointment is warranted within the AHS Practitioner Workforce Plan and supportable after completion of impact analysis
- d) Professional licensure [with the CPSA]
- e) Canadian Medical Protective Association (CMPA) membership or acceptable alternative liability coverage
- f) A willingness to participate in teaching and training
- g) A willingness to perform required administrative and medical staff functions

The review did not find any evidence that current members of the AHS medical staff were inappropriately appointed based upon failure to meet these criteria.

GRANTING OF CLINICAL PRIVILEGES

Section 3.0.2 of the AHS Bylaws makes it clear that a practitioner is not entitled to perform procedures or treat patients by virtue of being a member of the medical staff.

The same section of the Bylaws declares that “clinical privileges that are granted to the practitioner define the diagnostic or therapeutic procedures or other patient care services a practitioner is deemed competent to perform and the facility (ies) and Zone (s) within which the practitioner is eligible to provide care and services to patients”.

This section of the bylaws makes two important points. Being competent to perform a procedure or deliver certain care is the first prerequisite to being awarded a clinical privilege. The second point is that awarded clinical privileges are site specific. Even though a physician may be competent to perform a procedure, a privilege to perform that procedure may not be granted at a site if AHS determines that the service will not be supported at that site.

Section 3.0.3 of the AHS Bylaws stipulates that the granting of clinical privileges shall consider:

- a) The needs of AHS
- b) The Practitioner Workforce Plan
- c) The resources available or facilities required for the requested procedures and access to AHS Services and Programs
- d) The practitioner’s training, experience, demonstrated ability and skills, and current clinical competence.

Sections 3.2.1 of the AHS Medical Staff Bylaws stipulate that clinical privileges granted by AHS to any practitioner shall specify these three things:

- a) AHS programs and professional services that the practitioner is able to access
- b) Procedures that the practitioner is deemed to be competent and eligible to perform
- c) Sites of clinical activity in which the practitioner is eligible to provide patient care and services.

Physicians can only be granted a privilege for which they have applied. Implicit in the process is an assumption that physicians will only apply for privileges to perform procedures or provide other care for which they are currently competent, have appropriate experience, and are not precluded from doing by virtue of conditions attached to their license or any other assessment by their professional regulatory authority (CPSA in this case).

The process set out in the AHS Medical Staff Bylaws for considering an application for medical staff and privileges applications is quite complex and is almost entirely vested in the local zone medical staff organizational structures. The authority for final acceptance or rejection of recommendations from the zones is vested in the AHS CMO.

In such a diffused model for formulating physician-specific privilege recommendations for consideration by the CMO, one would want to see very robust “decision support tools”. AHS does not currently provide any decisions support tools to zone clinical department heads, zone medical directors, or zone application review committees. Consequently recommendations arising from this zone infrastructure are at risk of being highly variable between zones. That is the outcome that is observed in the current process for awarding clinical privileges across the province.

Some regional adaptation of regulatory processes and practices may be essential to accommodate realities imposed by geographic isolation of communities and other factors. However when any inter-zone variance in a regulatory process is permitted or endorsed there must be very compelling evidence that the variance is unavoidable and will not compromise service safety and quality below a defined allowable level.

The allocation of practice privileges in pathology raised some interesting questions, and potential concerns, about inter-zone variation.

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The provisions of medical diagnostic laboratory services and the roles of pathologists have been growing ever more specialized as advances in science and technology expand the range of possible testing. The trend in medical laboratory services globally and across Canada is to concentrate the more technically challenging services in centers of excellence. The impact upon the practice of pathologists has been one of concentrating their practices in specific laboratory medicine disciplines where the number of pathologists makes such arrangements viable.

In smaller communities with fewer pathologists, it is not always feasible for pathologists to restrict their work to a more limited scope of laboratory medicine. However even in communities with as few as two or three pathologists one still sees a trend toward division of responsibilities between the members of group so that each member can establish and sustain greater expertise in some disciplines. It is rare today to see privileges for any pathologist to “cover the whole water front” of laboratory medicine.

In both the Calgary and Edmonton zones, the review found a very clear pattern of pathologist privileges aligned with the trend described above. The same pattern is seen, to a somewhat lesser extent, in the Central zone where 10 pathologists are co-located in Red Deer.

In the North zone there are two pathologists in Bonnyville, two in Grande Prairie, and one in Fort McMurray. One of the two pathologists in Bonnyville currently has the full spectrum of pathology privileges as defined by AHS.

In the South zone there are seven pathologists in Lethbridge and five in Medicine Hat. Two of the pathologists in Lethbridge have the full spectrum of privileges and one in Medicine Hat falls into that category.

There was not sufficient information at hand to be dogmatic about the appropriateness or inappropriateness of such privileging decisions. There may be logical reasons for sustaining such privilege profiles. At a minimum this variation should prompt some reflection about the arrangements that optimally support safe high quality patient care.

The inter-zone variation found in pathology is an example of “micro” variation which focuses on criteria for awarding clinical privileges to individual physicians in a rational evidence-based manner. In respect to privileges in radiology, my observation and concern is more “macro” in nature. It focuses on wide variation between comparable zones in their apparent understanding of the purpose and scope of the privilege awarding activity mandated in the AHS Bylaws.

The primary concern about inter-zone variation in radiology privileges is based upon the observation of profound variance in privilege granting policies in the Calgary zone and Edmonton zone where most major interventional radiology services are provided. In Edmonton, radiologist privilege lists are limited to MRI, PET, cardiac CT, ultrasound, cardiac echo, and nuclear medicine. In Calgary, privilege lists for radiologists include those modalities plus mammography, fluoroscopy, arthrography, vascular angioplasty, vascular stent insertion, vascular occlusion therapies, abscess drainage, myelography, bone mineral density testing, percutaneous organ biopsy, prostate biopsy, biliary drainage procedures, thoracentesis, and many other interventional procedures.

Since many of the procedures on the Calgary lists, and absent from the Edmonton lists, are interventional or invasive procedures with significant attendant risk, one wonders how the Edmonton zone is managing that risk if not through the physician privileging process. It was not possible to get a satisfactory answer to that question.

GRANTING OF AHS PRIVILEGES NOT APPROVED BY THE CPSA

Although medical regulatory authorities (MRAs) like the CPSA are not statutorily obligated to do so they may establish mechanisms for defining the scope of practice which physicians may undertake. Physicians are legally and ethically obligated to comply with such direction from their professional regulatory body.

The CPSA operates a program which assesses the competency of individual radiologists to interpret images from a subset of imaging modalities. Currently the CPSA makes these assessments in respect to the DI modalities of echocardiography, MRI (General), MRI (Limited), MRI (cardiac), PET, nuclear medicine, cardiac CT, and ultrasound.

The CPSA established this program as a safety and quality assurance measure. The expectation of the CPSA is that physicians will not interpret images for modalities for which they do not have approval from the CPSA. Interpretation of images from general radiography and CT, (excluding cardiac CT) and interventional procedures are not impacted by the CPSA program.

During the course of the review of AHS privilege lists for individual radiologists, it became apparent that 14 radiologists were granted AHS privileges to interpret imaging modalities for which they had not obtained approval from the CPSA. Subsequent inquiry by AHS staff disclosed that seven of these radiologists had not used these privileges accorded to them by AHS. However they had legal authorization from the AHS to do so.

In each instance in which radiologists have privileges for and/or are actually interpreting DI modalities without CPSA approval, they will have to either relinquish those privileges or seek and obtain CPSA approval.

PHYSICIANS PRACTICING BEYOND THE SCOPE OF PRIVILEGES AWARDED BY AHS

Of the 183 pathologists subject to AHS credentialing, there was no evidence found of any of these individuals practicing beyond their AHS awarded privileges. AHS defines pathology privileges in terms of pathologist engagement in six different fields of laboratory medicine.

All of the private laboratories in which other pathologists practice are subject to an accreditation program operated by the CPSA. The CPSA does not itself regulate the scope of practice undertaken by each pathologist in a private lab. However, one of the requirements of the CPSA Accreditation Program is that every accredited lab must have a medical director who is accountable to the college for ensuring that individual pathologists in those labs practice within the scope of their current competence. The CPSA requires labs to comply with internationally recognized standards and inspects each laboratory at three year intervals.

With respect to radiologists the review detected a very substantial number of instances in which radiologists are working beyond the range of written privileges recorded with the central Medical Affairs office of AHS. Of the 300 radiologists awarded DI privileges, 39 were identified as providing interventional radiology services with no evidence of having written interventional radiology privileges recorded with the central Medical Affairs office of AHS in Calgary.

The Calgary zone and the Chinook Hospital in the South zone are the only agencies that actually maintain explicit written documentation of interventional radiology procedures. The process for regulating radiologist scope of practice in the other four zones was described by AHS in this manner: "Privileges were not defined any more specifically than a site of activity plus the clinical service of DI under the explicit expectation that a physician would

only practice within a scope of practice they were licensed to perform and within the resources that the facility made available to him or her”.

This more passive and implicit approach to awarding practice privileges, as opposed to the active explicit approach used in the Calgary zone, has several worrisome implications. It essentially permits a physician to do anything he or she perceives him/herself competent to do unless explicitly prohibited from doing so by the CPSA. That effectively “turns on its head” the regulatory concept that a physician cannot undertake professional activity within AHS facilities and programs unless explicitly awarded the privilege to do so.

Beyond the 39 instances relating to interventional radiology, the review detected eight radiologists who were interpreting PET, MRI, CT, and ultrasound studies without documented AHS privileges to do so. Seven of these eight radiologists have approval from the CPSA to interpret these modalities. However, they had failed to request and obtain privileges from AHS.

To date AHS has not had in place a mechanism for monitoring radiologist compliance with CPSA approvals or AHS privileges. This review, which relied upon clinical practice data to explicitly look for evidence of practice beyond the scope of AHS privileges and/or CPSA approval, afforded AHS its first opportunity to do a regulatory compliance check.

When AHS incorporates all physician privilege data into a single electronic database it will be relatively easy to link that database with clinical activity databases and run periodic exception reports to detect potential unauthorized physician scope of practice. Such an automated review process will have some risk of false positive and false negative reporting. It should be calibrated to err on the side of false positive reporting with such reports simply being an alert that requires prompt follow up.

Observations and Impressions: Current Status of AHS Physician Regulatory Policies and Practices

It is apparent that the Chief Medical Officer (CMO) and all of the staff in the Medical Affairs office are deeply committed to building an effective system for regulating the scope of practice undertaken by all physicians who hold a medical staff appointment, contract or employment with AHS and its affiliates. They perceive the AHS Medical Staff Bylaws and Rules which came into effect just slightly more than one year ago as the framework for achieving this goal.

This is an appropriate and commendable future goal. But AHS is still some distance from reaching this goal and the report from this review must accurately reflect the current situation.

The current situation is one of unacceptable variance in the standards for physician privileging between the five zones. Some of that variance is in respect to appropriate management of risk associated with invasive procedures which have historically warranted very careful regulation. And, significantly, that variance is not just evident between the two large metropolitan zones and their more rural neighbours. As noted earlier in this report, it is manifest between the two large metropolitan zones themselves.

Considering the possibility that the Edmonton zone had simply misunderstood the information being sought for the review, AHS staff were asked to make explicit inquiry of the Edmonton zone with respect to privileging of radiologists for interventional procedures. The response was that they simply “don’t do it” through explicit privilege awards and some verbal reference to the issue being managed

differently internally at individual Edmonton hospitals. The zone advised that individual site chiefs were aware of work assignments for individual radiologists but this was never translated into explicit privileges for each radiologist. This local informal mechanism for managing the scope of practice for radiologists was “passed from one leader to the next by way of verbal culture rather than explicit documentation”. In 2012 in a province that claims to have a single health care system this degree of variance between zones is astonishing.

It is astonishing because interventional radiological procedures are invasive procedures that carry some of the same risks as invasive procedures performed by surgeons. One of the expectations of an effective physician privileging process is that it will continually evolve to properly manage risk associated with physician uptake of new technologies. The apparent failure of the Edmonton, North, Central and South zones to manage the risks associated with interventional radiology through active awarding of explicit detailed interventional privileges is troubling.

There was also variance between zones in respect to the impact of CPSA modality approval and the awarding of DI privileges. In fact, the formal documented privileges in the Edmonton zone are currently limited to those modalities subject to CPSA approval. In other zones the list of imaging modalities subject to CPSA approval is a starting point for awarding privileges, but the process extends well beyond that foundation.

The review discovered that the CPSA has not been directly communicating DI modality approvals to AHS. It had rather been relying upon the integrity of radiologists to not apply to AHS for privileges for those modalities the CPSA reviews if they had not obtained CPSA approval.

Quite remarkably, Medical Affairs staff in the AHS central office were not aware of the CPSA approval process although many medical leaders in the zones were. Data about radiology approvals for every licensed radiologist in Alberta is actually publicly accessible through the CPSA website. AHS staff could have easily accessed this information if they had been aware of the CPSA process.

While the new AHS Bylaws and Rules do contain some policy guidance about the procedures to be followed by AHS and the zones in dealing with applications for medical staff appointments and privileges in the future, these policies are not yet fully implemented. When the reviewer asked if AHS or any of the zones have explicit published criteria to guide the awarding of specific privileges to specific applicants, AHS advised that no such published criteria currently exist. This stands in sharp contrast to the situation at the CPSA where a 70-page CPSA Registration Manual serves to ensure that all CPSA medical and non-medical registration staff consistently interpret and apply the registration policies in the *Health Professions Act*, the bylaws under that Act, and those approved by the CPSA Council.

The lack of explicit AHS criteria and administrative manuals to guide privilege granting decisions is disappointing and somewhat alarming. The granting of explicit clinical privileges to each physician is a regulatory process that serves to protect the public from harm. To be optimally effective, regulatory processes must be based upon explicit criteria and those criteria ought to be consistently applied in every AHS site across the province. Regulation is also a public protection process in which decision support tools and check lists can be enormously helpful in elimination of unwanted variation in policy application.

Why does Variance in Physician Privileging Standards Matter?

There is an old adage that “many roads lead to Rome”. Applied to physician privileging this adage might infer that it really doesn’t matter how different agencies conduct physician privileging as long as they all “do something”.

The reality is that while many roads may lead to Rome the risk of getting robbed, beaten or even killed on different roads may be highly variable. Given a choice, most people would elect to take the road most likely to allow them to arrive alive and in good health.

And what if citizens aren’t allowed to make fully informed choices about their chosen road to Rome based upon their willingness to make trade-offs between variables like travel time and risk of harm? What if the government or an agency like AHS actually controls the roads to Rome and offers only one option? Most citizens would then fervently hope that these agencies would select the safest option.

The regulation of physician scope of practice is not a “road to Rome” in which citizens or patients have any choices or control. With respect to the critically important diagnostic services provided by radiologists and pathologists this is particularly true, because these are doctors whom patients rarely even see (far less, get to select). So there is a heavy onus on those regulating these physicians to do so in a manner that optimizes patient safety.

The process of controlling the authorized scope of practice of physicians is a public safety regulatory process no less important than the regulatory process that determines which doctors are licensed by the college.

Effective administration of regulatory procedures that have an impact on the safety of patients today is not something that can or should be deferred to some ill defined future date. These are “must do, can’t fail” responsibilities that need to be a high priority for every health service agency.

So long as variance in physician privileging standards are permitted to exist between AHS zones, no one, including the Minister of Health, can assure Alberta citizens of uniformly safe and high quality of care regardless of where health care is accessed in Alberta.

Variance in standards for the regulation of invasive radiological procedures in Alberta has safety implications for patients today and should be promptly eliminated. Health systems must strive to match the safety record of the commercial aviation industry by becoming intolerant of variance in regulatory standards.

The commercial aviation industry has no tolerance for variance in safety standards between different geographic zones. Even though the weather and other conditions may be highly variable in Vancouver, Calgary, Toronto, and St. John’s, at this moment every pilot guiding a plane to take-off position in each of those locations will be credentialed by precisely the same standards and will be obligated to follow precisely the same safety procedures to optimize the safety of all the passengers under his or her responsibility.

For reasons that defy logic, the health care industry often tolerates variance in safety standards between different sites even though the evidence points to such variance contributing to preventable harm including preventable deaths.

For the sake of patient safety, it’s time to become intolerant of variable standards for regulating the scope of practice of physicians in Alberta.

What is the Potential for the new AHS Bylaws and Rules to Eliminate Variation in Physician Privileging Standards and Practices between Zones?

The new AHS Bylaws and Rules do create a framework with potential to help achieve appropriate uniformity in physician privileging standards and practices. Dr. Josdal and other AHS leaders are certainly working ardently to achieve this goal. However the slow pace at which this transformation has occurred to date is a cause for concern.

The process of creating the new bylaws was protracted primarily by the demands made by physicians for the inclusion of many provisions designed to protect their interests. This is not entirely inappropriate as Medical Staff Bylaws do serve, to some extent, as a surrogate for more explicit individual service contracts between physicians and AHS. However Medical Staff Bylaws also serve as a vitally important tool for protecting patients from risk of harm associated with physician services delivered in AHS facilities and programs.

While these bylaws do vest the ultimate authority to grant medical staff appointments and award practice privileges in the CMO of AHS, the zones are accorded a great deal of discretion to formulating privilege recommendations to the CMO for each physician in their respective zones. This is worrisome in light of the less than stellar track record of the zones in achieving uniform standards between themselves and among the facilities within their geographic boundaries.

Effective standard setting must involve consultation with appropriate stakeholders, and the zones are among those stakeholders. However if AHS is

to avoid the risk of “standard setting paralysis” attributed to an unwieldy consensus building process, AHS corporate office will need to take a much more assertive role in driving the process.

The final concern is that the setting of privileging standards and the application of those standards has no mechanism for any patient engagement in the process, notwithstanding the fact the process exists primarily to protect patients from preventable risk of harm. In an era in which patients are insisting that RHAs honor the dictum “nothing about us without us,” AHS needs to explore mechanisms for patient engagement in the process of regulating physician scope of practice with AHS. The CPSA and other medical regulatory agencies have had significant public participation in their regulatory processes for decades and it is time that RHAs also engage the public in this public protection activity.

One very positive feature of the new bylaws is a provision for mandatory performance evaluation of all physicians with AHS medical staff appointments at three year intervals. The expectation is that information derived from these performance evaluations will have a direct impact on review, revisions and renewal of physician privileges at three-year intervals.

Analysis and Conclusions

To gain some appreciation of the risk of harm to patients that must be managed through the granting of physician privileges, it can be instructive to consider what may go wrong when these processes lack appropriate structure and rigor.

This review was structured in a manner comparable to Dr. Cochrane’s Phase 1 Review in B.C. It was not a forensic review focused on specific critical incidents in health care in Alberta. However, Phase 2 of the Cochrane Review in B.C. did focus on critical incidents linked to suboptimal regulation of the scope

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of practice for several radiologists. It may be helpful to cite several very sobering lessons extracted from Phase 2 of the Cochrane Review in B.C.

CASE 1

The Powell River General Hospital (PRGH), in the Vancouver Coastal Health Regional (VCH), recruited a radiologist from Alberta who had made a voluntary undertaking to the CPSA to not interpret CT scans or obstetrical ultrasound scans while he practiced in Alberta. When he moved to B.C. the College of Physicians and Surgeons of BC (CPSBC) imposed the same restriction upon his license in B.C. At the outset this radiologist was credentialed and granted privileges that were within his licensed scope of practice.

About a year later this radiologist undertook two weeks of training in obstetrical ultrasound at the B.C. Women's Hospital (BCWH). He did not inform the CPSBC of this training. On completion of the two week training program he began interpreting obstetrical ultrasound and the PRGH allowed him to do so.

Seven years later he completed two weeks of CT training at the Royal Jubilee Hospital (RJH) in Victoria. The PRGH then granted him CT interpretation privileges. No one checked with the CPSBC. VCH was not involved in the decision. It was made by the small local hospital in Powell River.

Within five months of this radiologist beginning to interpret CT scans, concerns about his performance were raised by local DI technologists and by clinicians. His privileges to interpret CT and obstetrical ultrasound images were suspended. A review was undertaken of the 894 CT scans he interpreted between April and October 2010.

A decision was made to review his interpretation of other DI modalities. He was obligated to withdraw from practice until that review was completed. He stepped down. On June 15, 2011 he resigned his medical staff membership and privileges at the PRGH.

This case serves to demonstrate risk of harm that may occur when physician privileging decisions are made in individual hospitals without adequate oversight and approval by an RHA and without appropriate communication linkages with the College of Physicians and Surgeons.

CASE 2

A radiologist had been practicing for many years at St. Josephs General Hospital (SJGH) in Comox, which is in the Vancouver Island Health Authority (VIHA).

In June 2001 the old 4-slice CT scanner at SJGH was replaced with a new 64-slice scanner. The radiologist in question planned to take some formal training to ensure that he was fully competent to interpret the images from this new scanner. Personal matters arose that precluded him from taking this training.

He applied for privileges to read images from the 64-slice scanner. He was at a stage in his career at which retirement might be considered. If this radiologist was not granted privileges to interpret images from the new 64-slice CT scanner, he could not be on call. Some of the members of the DI practice group in Comox would not support an arrangement that might increase their on-call commitments. The radiologist in question was granted privileges to interpret images from the new CT scanner and continued to take call.

The following year, when new surgical specialists were brought onto staff at SJGH, they raised concerns that the CT interpretations being done by this radiologist did not meet contemporary standards. A review was undertaken and the radiologist voluntarily suspended his work. The review disclosed an unacceptably high interpretation error rate. The SJGH Board revised this radiologist's privileges to exclude CT scan interpretation.

This case illustrates a number of risks associated with poorly designed and poorly executed physician privileging policies and procedures. It dramatically demonstrates that the granting of safe physician privileges must be a dynamic activity that takes into account the impact of new technologies. It points to risk that may arise from failure to have in place a structured performance evaluation system for physicians that impacts the granting of practice privileges. It reinforces the lesson learned from the Comox case about the inability of small organizations to maintain rigorous quality assessment processes with capacity to detect quality issues in a timely fashion. In this case the working relationship between SJGH and VIHA was also adversely impacted by SJGH's culture of autonomy from VIHA because it is a religiously owned institution. Finally it demonstrates how forces of physician self interest may subvert a process that ought to make patient safety its highest priority.

CASE 3

An internationally educated radiologist, without RCPSC certification, was recruited through Health Match B.C. to join a group of radiologists in the Fraser Valley known as VMI. The CPSBC granted him a provisional license in October 2008 which required sponsorship. The Fraser Health Authority (FHA) sponsored this radiologist, and his supervisor was a VMI radiologist. The FHA granted him a medical staff appointment and privileges. He provided DI interpretation services at five different FHA hospitals. By October 2009 the concerns

about this radiologist's competence coming from multiple communities prompted the sponsoring physician to withdraw his sponsorship. This resulted in termination of his practice license one year after it was issued.

A look back at the process for oversight of the work of this provisionally licensed physician highlights the risks when accountability for supervision and oversight may be shared between a private DI group, an RHA, and the College of Physicians and Surgeons. The primary public protection mechanism in this case was the oversight to be provided by the sponsoring physician but there were unclear expectations with respect to the nature and intensity of the expected supervision.

This case demonstrates the need for much closer collaboration and better bilateral communication between RHAs and Colleges of Physicians and Surgeons in their shared public protection roles associated with physician licensure and credentialing.

Reflection on the lessons learned from the Cochrane Review in B.C. are important because some of the policy and process deficiencies that contributed to risk of patient harm in B.C. are also evident in Alberta.

The most dominant and recurrent theme that emerged from the Cochrane review is that patients are put at risk of harm from **suboptimal communication** between individual health service delivery sites, regional health authorities and the College of Physicians and Surgeons. In Alberta there is abundant evidence of suboptimal communication between the five zones, AHS, and the CPSA. The very protracted data collection process for this review clearly showcased the difficulty that AHS currently has in just gaining accurate information about what is happening in each zone in respect to the process for awarding physician privileges. The fact that AHS was totally unaware of the program operated by the CPSA to approve radiologist

interpretation privileges for certain DI modalities points to very suboptimal bilateral communication between AHS and the CPSA.

Dr. Cochrane noted the need for a fully integrated **electronic information system** to support effective management of the physician performance evaluation process and physician privileging process. He noted that individual sites, RHAs and the CPS need to jointly support such an integrated system and share information between themselves through this system in a way that optimizes patient safety and quality of care. Alberta currently lacks such a system. The fact that Alberta has a single health authority ought to make it easier to build such a system in Alberta. Also the superb system already operated by the CPSA constitutes one of the building blocks for an integrated system for Alberta.

Dr. Cochrane noted that the lack of effective **physician performance evaluation systems** impairs our capacity to quickly detect unsafe physician performance and intervene in a very timely manner before patients are put at risk of harm. He pointed out that small health delivery units have difficulty establishing and sustaining effective physician performance evaluation programs. He called for the prompt implementation of a provincewide system in B.C. and pointed to some of the data sources and tools that might be used to support physician performance evaluation. There is not currently a provincewide system in Alberta for effectively evaluating physician performance. The new AHS Medical Staff Bylaws mandate such evaluation at three year intervals. The clinical department heads and other physician leaders in the zones have been notified that it is their responsibility to meet the requirements of the bylaws. However, AHS has not developed consistent standards and tools for physician performance evaluation. In the absence of provincial standards and tools, the rigor and quality of the evaluation process in the zones is likely to be quite variable.

Finally, the Cochrane Review demonstrated the need for explicit and clear **provincewide standards** for granting physician privileges which are focused on patient safety and not subject to local market pressures. The review surfaced an example of local physicians supporting the granting of privileges to a colleague so their call burden would not be exacerbated rather than focusing on patient safety. While there is no comparable evidence of perverse local incentives influencing the privilege granting process in Alberta, the fact is that the privilege granting policies and procedures between zones are highly variable. More worrisome is the fact that current policies in some zones appear to be verbal only and are handed down verbally from one physician leader to another.

Recommendations

The Quality Assurance Review in Alberta was structured in a manner that required the issuance of separate reports relating to review of CPSA activity and AHS activity. The report related to the CPSA, *Review of Licensure by the College of Physicians & Surgeons of Alberta*, contained two recommendations specific to the CPSA. The recommendations in this report will be specific to AHS.

- 1) AHS should align its current and future DI privileges with the DI modality interpretation approvals issued by the CPSA to individual radiologists. AHS should also engage the CPSA in dialogue about potential expansion of the scope of CPSA DI modality approvals to include interventional procedures.
- 2) AHS should accelerate the work it is currently doing to establish standardized provincewide privilege lists for diagnostic imaging, pathology and all other disciplines. The only permissible inter-zone variation in those lists should be based upon firm evidence that such variation would not compromise safe high quality patient care.

- 3) AHS should promptly develop and implement uniform provincewide standards for the awarding of privileges on these lists to individual physician applicants.
- 4) AHS should develop a pragmatic physician credentialing manual and/or decision support tools for all central and zone staff that play a role in physician credentialing. Such a manual and decision support tools could be provided to all appropriate staff electronically along with an electronic check list to ensure compliance with the provincial standards.
- 5) As a high priority, AHS should develop a single electronic system for managing all information related to physicians. That system should have linkages with the CPSA, Covenant Health, DynaLIFE_{DX} and all other agencies that have any responsibility and/or accountability for regulating the scope of practice of physicians in Alberta. This system should have capacity to promptly detect variance between physician privilege awards and policies of AHS or the CPSA. Where such variance is detected it should be promptly addressed in a manner that ensures patient safety and high quality health care.
- 6) AHS should continue its efforts to implement the physician performance review requirement embedded in the AHS Medical Staff Bylaws and take steps to ensure that the rigor and effectiveness of such performance reviews will be uniform in all of the zones and for all physicians. As data from these performance reviews becomes available, AHS needs to ensure that the data are effectively and consistently applied in the course of periodic physician privilege review.
- 7) AHS should take a leadership role in efforts to strengthen the communication linkages between AHS and its zones, the CPSA, AH, and all agencies that engage physicians in service delivery via contracts or affiliation agreements with AHS.
- 8) In its development of new policies related to physician credentialing and in its review and revision of current policies, including the current Medical Staff Bylaws and Rules, the AHS should ensure that patient safety takes primacy over other interests such as resource management and physician self-interest.
- 9) To ensure that its current and future policies and procedures related to physician credentialing are patient-centred and focused on patient safety, AHS should engage members of the public in its regulation of physician activity in a manner similar to the way the CPSA engages citizens in its regulation of medicine at the macro level.
- 10) To ensure timely implementation of each of these recommendations, AHS should set an explicit implementation target date for each recommendation and adhere to those target dates.



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