ASSOCIATION MÉDICALE CANADIENNE / CANADIAN MEDICAL ASSOCIATION

CMA POLICY

THE PHYSICIAN APPOINTMENT AND REAPPOINTMENT PROCESS 2016

Executive summary

Beginning in the 1990s most jurisdictions established regional health authorities (RHAs) with consolidated medical staff structures and there has been a trend toward requiring all physicians practising in a region to hold an appointment with the RHA in order to access health resources such as diagnostic imaging and laboratory services, irrespective of whether they hold hospital privileges or not. Subsequent to the consolidation of medical staff governance there have been several developments over the past decade that have implications for where and how physicians can practise, and for their ability to advocate freely on behalf of their patients. These include:

- the establishment of formal physician resource plans that link the appointment process to the ability to participate in the provincial/territorial medical insurance plan;
- a greater focus on clinical governance that includes detailed attention on scope of practice and privileges;
- a growing concern about the ability of physicians to advocate on behalf of their patients and the communities they serve; and
- an increase in the number of physicians entering into employment or contractual arrangements.

The Canadian Medical Association (CMA) puts forward the following recommendations for governments, regulatory authorities, RHAs and medical staff structures within RHAs and hospitals.

Recommendations
Where physician appointments are to be approved in relation to Physician Resource Plans, the CMA recommends that such plans must:

- *take into consideration both population need and projected physician supply;*
- *include transparency in the provision of information about available practice opportunities and on the criteria and processes through which applications for appointments are approved;*
- *be based on a documented methodology with results in the public domain; and*
- *be based on a medium-term projection range, using the most current and reliable data available, and be regularly reviewed and updated.*

The CMA recommends that the application of standardized credential templates must take into consideration the quality of care being provided by the physician and local circumstances such as the complement of medical and hospital resources available locally and the timeliness of proximity to secondary and tertiary care.

The CMA strongly supports the implementation of policy to safeguard physicians from fear of reprisal and retaliation when speaking out as advocates for their patients and communities, and the right and duty of medical officers of health to speak publicly to the citizens they serve.

The CMA supports provincial/territorial amendments to public health legislation to protect the right and duty of medical officers of health to speak publicly to the citizens they serve without political interference or risk of adverse employment consequences.

The CMA believes that medical staff bylaws should expressly extend to physicians under contract entitlement to the procedural protections set out in the hospital or health authority bylaws.

The CMA recommends that the processes of granting appointments, reappointments and privileges and allocating resources respect the following principles:

1. *All processes should be fair, equitable, documented and transparent and should protect confidentiality.*
2. *Criteria for reappointment should be clearly specified in medical staff bylaws and should be no more onerous than necessary to verify the ongoing provision of quality care by the medical staff.*
3. *A regular evaluation of appointed physicians should be conducted by the appropriate clinical chief.*
4. *The quality of a physician's care is the most important criterion to be considered at the time of appointment, reappointment and the granting of privileges.*
5. *The information required for the granting of appointments, reappointments or privileges or for the allocation of medical resources must be accurate, valid and appropriate.*

6. *The processes of granting appointments, reappointments and privileges and allocating resources should recognize and accommodate the changes in practice patterns that may occur over the medical career cycle.*
7. *Physicians with established community practices have a significant investment in their practice and the community; this investment should be considered at the time of reappointment or change in privileges.*
8. *A recommendation, without just cause, to withdraw an appointment, to restrict privileges or to significantly reduce resources available to a physician must include appropriate compensation based on individual circumstances.*
9. *The reporting of legal actions or disciplinary actions as part of the reappointment or reappointment process should be restricted to those matters in which a final determination has been rendered and in which there has been an adverse finding to the physician.*

Objective

This policy outlines the principles that should be considered for the granting of physician appointments, reappointments, privileges and access to resources at the health care facility, district or RHA level.

Key definitions

Appointment: The process by which a physician joins the medical staff of a health region or health facility in order to access resources to care for patients.

Credentialing: An approach to obtaining, verifying and assessing the qualifications of a health professional against consistent criteria for the purposes of licensing and/or granting privileges.[1]

Privileges: Permission from an authorized body to a health care provider to conduct a specific scope and content of patient care. Privileges are granted based upon an evaluation of the provider's training, experience and competence related to the service, and are specific to a defined practice setting.[1]

Clinical peer review: The process by which physician peers assess each other's performance. A peer is a physician with relevant clinical experience in similar health care environments who also has the competence to contribute to the review of other physicians' performance.[2]

Background

Historically the formal appointment process applied to physicians wishing to practise in hospitals. Beginning in the 1990s most jurisdictions established RHAs with consolidated medical staff structures and there has been a trend toward requiring all physicians practising in a region to hold an appointment with the RHA in order to access health resources such as diagnostic imaging and laboratory services, irrespective of whether they hold hospital privileges or not.

Since the CMA first adopted principles for the physician appointment and reappointment process in 1997 there have been several developments that are reviewed below:

- the establishment of formal physician resource plans that link the appointment process to the ability to participate in the provincial/territorial medical insurance plan;
- a greater focus on clinical governance that includes detailed attention on scope of practice and privileges;
- a growing concern about the ability of physicians to advocate on behalf of their patients and the communities they serve; and
- an increase in the number of physicians entering into employment or contractual arrangements.

Physician Resource Plans (PRPs): New Brunswick was the first province to require physicians to have privileges with an RHA in order to obtain a billing number.[3] More recently jurisdictions such as Nova Scotia (N.S.) have introduced medium to longer range PRPs that are to be used when approving new appointments. In 2012 N.S. released a PRP for 2012-2021, which has since been updated to 2013-2022.[4] Under the terms of the Nova Scotia Health Authority Medical Staff Bylaws, the RHA CEO or their designate will assess applications for new appointments in relation to need and availability of resources. The assessment is to be completed within 60 days and there is no right of review or appeal of the CEO's decision.[5] Manitoba's medical staff bylaws make a similar provision.[6] While Ontario has not regionalized to the same extent as other jurisdictions, legislation has been introduced that proposes to make the 14 Local Health Integration Networks (LHINs) responsible for primary care planning and performance management.[7] Moreover the Bill will amend the *Health Insurance Act* to authorize the health minister to delegate non-fee-for-service physician compensation to the LHIN.

Recommendation
Where physician appointments are to be approved in relation to PRPs, the CMA recommends that such plans must:

- *take into consideration both population need and projected physician supply;*
- *include transparency in the provision of information about available practice opportunities and on the criteria and processes through which applications for appointments are approved;*
- *be based on a documented methodology with results in the public domain; and*
- *be based on a medium-term projection range, using the most current and reliable data available, and be regularly reviewed and updated.*

Other physician resource planning considerations are set out in the CMA's comprehensive policy on PRPs.[8]

Clinical governance: Since the late 1990s there has been a great deal of attention paid to the concept of clinical governance, which may be defined as the structures, processes and culture needed to ensure that health care organizations and all individuals within them can assure the quality of the care they provide and are continuously seeking to improve it. During the past decade several provinces have carried out inquiries related to problems with pathology and radiology. In British Columbia (B.C.) the Chair of the BC Patient Safety & Quality Council conducted a review of the medical imaging credentialing and quality assurance that reported in 2011. In his final report, Dr. Douglas Cochrane set out 35 recommendations that called for much more rigorous and uniform oversight of medical practice in B.C.[9] The recommendations included a call for:

- the creation of a single medical staff administration to serve all health authorities and affiliated organizations;
- the development of standardized processes for medical staff appointment, and credentialing and privileging, including common definitions; and
- the development of performance assessment and review process for all physicians.[9]

The Cochrane report has resulted in the British Columbia Medical Quality Initiative (BC MQI). BC MQI is implementing an online Provincial Practitioner Credentialing and Privileging System (CACTUS Software) that will be used by all of B.C.'s RHAs to manage these processes for physicians, midwives, dentists and nurse practitioners.[10] BC MQI has developed 62 privileging dictionaries for medical directors and department heads to use with their colleagues during initial and renewal privileging processes. The dictionaries recommend the required current experience to perform a certain activity in the form of numbers where applicable and also recommend the requirements for renewal of privileges and the requirements for return to practice. These recommendations are meant to take into account the individual's own experience and the context of the local site in which they work. They are meant to begin a conversation as needed with the department head, colleagues and others. The Society of Rural Physicians of Canada (SRPC) has raised concerns about the potential impact of volume-based credentialing on rural medical practice. For example, the dictionary for Family Practice with Enhanced Surgical Skills recommends that for operative delivery, a volume of at least five caesarean section deliveries be performed per year averaged over 24 months.[11]The SRPC has put forward recommendations that emphasize the need for appropriate peer review and consideration of geographic diversity and the range of medical practice, and that credential revalidation should be based on the actual quality of care provided by the physician, the continuing medical education completed by the physician and should also consider the impact of changes in delivery on the health outcomes in the community.[12] It seems likely that other jurisdictions will be watching the CACTUS program with interest.

Recommendation

The CMA recommends that the application of standardized credential templates must take into consideration the quality of care being provided by the physician and local circumstances such as the complement of medical and hospital resources available locally and the timeliness of proximity to secondary and tertiary care.

Advocacy: Advocacy has been identified as one of seven core roles of every physician by the Royal College of Physicians and Surgeons of Canada[13] and the College of Family Physicians of Canada.[14] This role entails physicians using their expertise and influence in the interests of their individual patients and the communities and populations they serve. Over the past decade there have been several instances where physicians have either expressed concern about their ability to advocate or have had disciplinary action taken against them, likely as a result of their advocacy activities. As a result of an inquiry carried out by the Health Quality Council of Alberta, the Alberta Medical Association, Alberta Health Services and the College of Physicians and Surgeons of Alberta have adopted a joint policy statement that sets out guidelines for physician advocacy.[15] Eastern Health in Newfoundland and Labrador has a privacy/confidentiality oath or affirmation for physicians that acknowledges that they may have professional standards for disclosure and advocacy regarding patient safety, but stipulates the expectation that such concerns be first addressed through Eastern Health as an initial step.[16] The CMA's policy on the evolving professional relationship between physicians and the health care system sets out nine factors for physicians to consider before undertaking advocacy.[17]

As predominantly employees of some level of government, and with a responsibility to sound an alert on population health risks, public health physicians are at greater risk of being disciplined for advocacy. There have been two high profile cases of public health physicians who have been dismissed for advocacy-related activities since 2000. Thus far only B.C. has enacted public health legislation to protect medical officers of health from political interference and adverse employment consequences. B.C.'s *Public Health Act* stipulates that the provincial health officer (PHO) has a duty to advise on provincial public health issues, which includes public reporting where the PHO believes it will best serve the public interest. Similarly sub-provincial medical health officers must advise on local public health issues and publicly report on them after consultation with the PHO. B.C.'s legislation also provides health officers with immunity from legal proceedings for actions done in good faith in the performance of their duties and for reports they are required to make. In addition the legislation protects health officers from "adverse actions", defined as an action that would either affect or threaten "the personal, financial or other interests of a person, or a relative, dependent, friend or business or other close association of that person" as a result of performing their duties in good faith.[18]

Recommendations

The CMA strongly supports the implementation of policy to safeguard physicians from fear of reprisal and retaliation when speaking out as advocates for their patients and communities, and the right and duty of medical officers of health to speak publicly to the citizens they serve.

The CMA supports provincial/territorial amendments to public health legislation to protect the right and duty of medical officers of health to speak publicly to the citizens they serve without political interference or risk of adverse employment consequences.

Growing employment/contractual relationships: The move to RHAs, consolidation in the hospital sector and changing delivery models have had significant implications for the relationships between physicians and hospitals. The Canadian Medical Protective Association (CMPA) has identified several areas of concern, including patient advocacy, reporting of physicians, responding to adverse events, collection and use of physician information, practice arrangements and liability provision.[19] One issue that the CMPA has highlighted in particular is the increasing trend in some jurisdictions for physicians to be engaged on a contracted employee basis rather than as independent contractors appointed with privileges.[20] This is seen among facility-based physicians such as hospitalists, clinical and surgical assistants and laboratory physicians. The CMPA has cautioned that physicians engaged on a contractual basis may not have the same procedural rights on termination of contracts as those engaged under the privileging model and it has issued guidance on issues to consider with individual contracts, including CMPA assistance, indemnification clauses, liability provisions, confidentiality, termination of contract, dispute resolution and governing law.[21]

Recommendation
The CMA believes that medical staff bylaws should expressly extend to physicians under contract entitlement to the procedural protections set out in the hospital or health authority bylaws.

Principles

Physicians must take a leadership role and be active participants in the development of appointment, reappointment and related processes; medical communities must therefore be aware of the basic principles that should be reflected in these processes.

Once a physician has obtained a licence to practice, the process of appointment approval is the next step in obtaining permission to practise medicine in a health care facility, district or region. The next step is the granting of privileges. This bestows the right to perform specific medical acts within the health care facility, district or region. The final step is the provision of the necessary resources so that the physician is able to provide appropriate medical services for patient care.

A medical committee with a clear structure and mandate to deal with appointments, reappointments and privileges must be maintained in all health care facilities, districts and regions so that physician input may be given during the appointment, reappointment and related processes. Clinical peer review must be foundational to these processes. Time, training and resources must be sufficient to support consistent peer review processes.

The principles proposed below apply to all of the following processes: the appointment and reappointment processes, the granting of privileges and the allocation of health care facility, district or regional resources.

Principles for the processes of granting appointments, reappointments and privileges and allocating resources

1. All processes should be fair, equitable, documented and transparent and should protect confidentiality. They should be completed in a timely manner and follow the rules of natural justice. At a minimum, the rules of natural justice give the physician the right to notice and the right to be heard before, and provided with reasons by, an impartial adjudicator. Given the nature of the physician's interests in the appointment, reappointment and other related processes, the following principles should also be included:
    - the right to be heard, either in person and (or) by representation;
    - the right to full disclosure of the information being considered by the committee that makes recommendations on appointments, reappointments and privileges;
    - the right to present evidence;
    - the right to a hearing free from bias, either real or perceived;

- the right to a record of the proceedings;
- a decision within a reasonable period;
- the right to receive written reasons for the decision; and
- the right to an appeal process by an independent and impartial body other than the board of the health care facility, district or region.

It is important that all processes, including any review processes, follow the principles of natural justice. These processes should be part of the medical staff bylaws that guide the operation of the health care facility, district or region and should be known to all appointed physicians.

2. Criteria for reappointment should be clearly specified in medical staff bylaws and should be no more onerous than necessary to verify the ongoing provision of quality care by the medical staff.

   Medical staff appointments are typically for a one-year term. Criteria for reappointment vary across Canada, ranging from the provision of evidence of renewed licensure and liability coverage with a discretionary in-depth performance evaluation to the foregoing plus a mandated in-depth performance evaluation and reporting on continuing professional development activity.

3. A regular evaluation of appointed physicians should be conducted by the appropriate clinical chief. It should consist of a fair, documented process with explicit, agreed-upon criteria for the review of the physician's qualifications and credentials and the quality of care provided. If there is demonstrated inappropriate behaviour or a quality-of-care issue, a program for remediation should be established with regular follow-up over a period deemed appropriate by the physician's peers.

   As in other jobs, the objective of regular performance evaluations for a physician is to improve the physician's performance and the focus should be on opportunities for learning and improvement. The appraisal should entail a standardized peer evaluation process, in addition to self-assessment. The self-assessment process should include the recognition of satisfactory existing skills and the identification of new skills to be learned. In some situations remediation may be justified, for example when there is a need to upgrade skills, when interpersonal and communication skills are unacceptable, and when there is alcohol or drug abuse.

   Physician evaluations conducted by RHAs should take into account requirements already asked of the physician by their certifying and/or licensing body or other speciality organization in order to avoid duplication of effort.

   Looking ahead, with the increasing focus on team-based collaborative care, performance of team function and its impact on overall performance to meet health service requirements and quality of care is expected to become increasingly relevant.

Conflict resolution mechanisms, scopes of practice and shared roles and responsibilities will need to be considered in order to assess individual and team performance.

4. The quality of a physician's care is the most important criterion to be considered at the time of appointment, reappointment and the granting of privileges.

   Quality care may be defined as the provision of service that satisfies the needs of the patient and meets the standards set out by recognized bodies of the profession, such as licensing bodies, national clinical societies and others. The essential components of quality include competence, accessibility, acceptability, effectiveness, appropriateness, efficiency, affordability and safety.

   The cost of a physician's care should not be the primary criterion considered during appointment, reappointment and related processes. Practice patterns, resulting in differences in cost of care, will differ for numerous reasons, including severity of illness, patient mix and patient choices.

   If there is a local, regional or district physician resource plan, then the need for a particular physician skill base as identified in the plan is an important criterion for appointment or reappointment to institutions within the plan. Physicians must be involved in the development of such a plan, and the plan must be supported by physicians at the local, district or regional level. If a practice and remuneration plan is introduced for a facility, hospital or academic health sciences centre, then participation in such a plan should not be a criterion for reappointment.

5. The information required for the granting of appointments, reappointments or privileges or for the allocation of medical resources must be accurate, valid and appropriate. The information required for these purposes should generally be limited to that which is reasonably necessary to determine the physician’s ability to provide safe care. Physician’s privacy should only be violated if it is determined that a medical condition or other disability poses an unacceptable risk to patients. The physician's credentials, skills, expertise and quality of care, as judged by peer assessment, should be considered during the appointment or reappointment process.

   Utilization data and associated indicators are being used more frequently as criteria for appointment and reappointment. Therefore, physicians must be involved in the development of such indicators, and there must be agreement by all parties on the type and quality of data or indicators to be used. In addition, before appointment or reappointment, physicians must be made aware of the data or indicators that will be used to evaluate them and the criteria by which these indicators will be applied.

6. The processes of granting appointments, reappointments and privileges and allocating resources should recognize and accommodate the changes in practice patterns that may occur over the medical career cycle. These processes should be

flexible and reasonable concerning other issues such as on-call responsibilities or time needed to fulfil research and teaching commitments.

It is important to recognize that a physician's practice pattern may change during his or her medical career. These changes may reflect the desire to no longer take call, the narrowing of the physician's practice to achieve a higher level of expertise in a specific area or the desire to pursue academic interests or responsibilities. Pregnancy, parental leave and the wish to practice part-time must also be considered. The quality of a physician's personal life and other special needs should be viewed as important and should be considered by those making decisions in these areas.

7. Physicians with established community practices have a significant investment in their practice and the community; this investment should be considered at the time of reappointment or change in privileges.

   An established physician may face financial loss if he or she is not reappointed or if there is a recommendation to substantially change his or her privileges. This possibility should be considered at the time of reappointment or change in privileges.

8. A recommendation, without just cause, to withdraw an appointment, to restrict privileges or to significantly reduce resources available to a physician must include appropriate compensation based on individual circumstances. Appropriate compensation includes financial restitution, retraining, relocation assistance and counselling assistance as required. Sufficient notice and other elements of due process should also be components of this recommendation.

   Generally, physicians are not employees of a health care facility, district or regional authority. Nonetheless, there are often extensive restrictions on physician mobility and limited opportunities to practice both inside and outside a province or territory. Age may also be a factor in the ability to find placement elsewhere, particularly if the physician is nearing retirement age. For these reasons, an interruption or cessation of a physician's career caused by withdrawal of an appointment, restriction of privileges or reduction in the resources available to the physician justifies appropriate compensation and due notice; this is in keeping with good human resource practices.

   Appropriate notice should be provided to physicians so that there is minimal impact on patient care. What constitutes timely and appropriate notice may in some cases be several months and will differ depending on the impact of the decision. Examples of decisions that could have a significant impact on physicians include:
   - temporary or permanent closure of operating rooms or other facilities;
   - strategic redirection of the hospital that may adversely affect a particular medical service or department, such as regionalization of laboratory testing or provincial centralization of a specialized service; and
   - implementation of a retirement policy.

9. The reporting of legal actions or disciplinary actions as part of the reappointment or reappointment process should be restricted to those matters in which a final determination has been rendered and in which there has been an adverse finding to the physician.

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