



CREDENTIALLING OF CANCER CLINICIANS

A guide for Australian health-care organisations



The University of Sydney
AUSTRALIA



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Disclaimer

This document should be used as a guideline only. The document is designed to provide information to assist and promote discussion and to optimise the credentialling processes.

Periodic updates

New information arising in areas considered to be of importance will be posted periodically on the ACN website (www.cancer.org.au/acn).

Copies are available from the Australian Cancer Network website www.cancer.org.au/acn or email acn@cancer.org.au

This report was prepared by the Australian Cancer Network for The Cancer Council Australia

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Foreword

A critical part of the work of the Australian Council for Safety and Quality in Health Care is assisting health care organizations to ensure that care is provided only by qualified professionals whose performance is maintained at an acceptable level.

The Council's "National Standard for Credentialling and Defining the Scope of Clinical Practice" was endorsed by Health Ministers in July 2004. The standard and scope of practice handbook can be found on Council's website www.safetyandquality.org

The two reports produced for the Australian Cancer Network by the Sydney Health Projects Group of the University of Sydney lead by Professor Michael Frommer are the first examples of customisation of the national standard in order to focus on a particular and complex segment of the health system – namely cancer services.

The first of these reports, "The Credentialling of Cancer Clinicians in Australia" (August 2005) describes important aspects of credentialling and defining the scope of practice and interprets the National Standard for Cancer Service Clinicians.

The second report, the appendix, "Credentialling of Cancer Clinicians – A Guide for Australian Health Care Organisations" is essentially a "how to do it" template setting out sixteen practical steps to be followed when developing and implementing a local cancer credentialling system.

I am certain that these documents will be an extremely valuable resource for those who manage cancer services in Australia. On behalf of the Australian Cancer Network, I thank Prof Michael Frommer and his team for their enthusiasm and commitment in producing a great result from a difficult and complex project.

Bruce Barraclough AO
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INTRODUCTION

Purpose of this guide

The purpose of this guide is to assist Australian health-care organisations, such as regional health services and hospitals, in the development and implementation of systems for the credentialling of clinicians involved in the care of cancer patients.

The Australian Council for Safety and Quality in Health Care (ACSQHC) has published a *Standard for Credentialling and Defining the Scope of Clinical Practice*.¹ This guide accords with the definitions, policies and recommendations described in the *Standard* and has been designed to be read in association with the *Standard*. The Table at the end of this guide links the steps covered in the guide to the recommendations given in the *Standard*. Users of the guide should refer to the *Standard* for additional detail where required. This guide is intended to assist with the implementation of the *Standard*, and is not intended to be a substitute for it. For some issues the guide gives more detail, and for other issues the *Standard* is more proscriptive.

The guide focuses on the credentialling of medical practitioners involved in the care of cancer patients, but it can be adapted to other clinicians such as nurses, allied-health practitioners and psychologists. Further explanation can be found in the companion paper entitled *The Credentialling of Cancer Clinicians in Australia*.

What is credentialling?

Credentialling is a formal process for:

- defining the clinical responsibilities of medical practitioners and other clinicians within a particular health-care institution,
- verifying that they are qualified and competent, and
- working with them to review and improve or sustain their performance in fulfilling those responsibilities.

Credentialling refers to individual clinicians. It is distinguished from *accreditation*.

Accreditation is a formal process for assessing the processes and performance of a health-care institution against defined standards.

Credentialling includes *defining the scope of practice* for individual clinicians. This means delineating what an individual clinician may or may not do within a particular health-care institution. An individual's scope of practice takes account of three factors:

- the individual clinician's qualifications, competence and performance,
- the needs of the institution, and

¹ Australian Council for Safety and Quality in Health Care. *Standard for Credentialling and Defining the Scope of Clinical Practice*. Commonwealth of Australia, Canberra, 2004.

- the capability of the institution to support the clinician’s scope of clinical practice. *Clinical privileging* is sometimes used as a synonym for *defining the scope of clinical practice*.

Credentiailling is specific for a particular health–care institution. Thus, a surgeon may be credentiailled to perform a partial hepatectomy (e.g. for a solitary liver metastasis) in one hospital but not in another hospital, because the latter hospital does not have adequate intensive–care facilities to manage complications of the operation, should they occur.

What is the purpose of credentiailling?

The purpose of credentiailling is to ensure that practitioners provide safe, high–quality, up–to–date health services in accordance with known good practice and the achievement of expected patient benefits.

The sole intent of credentiailling is to improve and sustain the safety and quality of health care. Credentiailling should give confidence to the community in the expertise and performance of clinicians.

Credentiailling is not intended to be used for the management of professional and administrative difficulties. Separate approaches are needed to manage these difficulties.

Why do health–care institutions need a credentiailling system for cancer clinicians?

Cancer outcomes have improved markedly in Australia over the last 20 years. This improvement is largely attributable to earlier detection and better clinical management, which have followed from the uptake of new research–based knowledge and technological advances. These advances have occurred and continue to occur very rapidly. However, knowledge and best practice are not uniformly applied, and the appropriateness and quality of clinical management vary for many cancers. A credentiailling system is needed to minimise this variation and ensure that best practice is adopted as widely as possible.

The ACSQHC *Standard*¹ provides an overall generic credentiailling framework that applies to all medical practitioners working in public and private hospitals in all fields of medicine. However, it does not fulfil the specific credentiailling requirements that are essential for developing and sustaining high–quality cancer services. These requirements reflect the characteristics that distinguish cancer from other conditions, distinguish cancer patients from other patients with serious illnesses, and distinguish cancer services from other clinical services.

In particular, there is a need to emphasise the clinicians' responsibility for ensuring that cancer patients receive high-quality, integrated multi-disciplinary care within an organised system of care that is set up to meet patients' needs. Cancer clinicians must have knowledge of the value of multi-disciplinary cancer services; they must demonstrate particular clinical skills but be aware of the boundaries of their expertise within the spectrum of multi-disciplinary care; and in their practice behaviour they must respect patients' roles in clinical decisions, and facilitate and reinforce well-organised systems of care. Only through cancer-specific credentialling is it possible to maintain and enhance the knowledge, clinical skills and practice behaviour that are essential for clinicians' active and consistent engagement with systems of cancer care.

Who should be credentialled?

Any clinician who has independent responsibility for the care of cancer patients should participate in credentialling.

This guide applies to these clinicians. It is not intended to be used for assessing the suitability, competence or performance of trainee medical practitioners or cancer clinicians, such as interns, resident medical officers or registrars, who work under supervision.

However, the clinical supervisors and clinical mentors of trainees should be credentialled. Their credentialling should cover the scope of clinical services in which they provide supervision and mentorship.

IMPLEMENTING A CANCER CREDENTIALLING SYSTEM

A cancer credentialling system has four inter-linked parts:

- Initiating implementation of the credentialling system.
- Standards of practice for cancer clinicians.
- Policies, processes and infrastructure for credentialling.
- Requirements for the assessment of individual cancer clinicians.

Each of these parts requires to a series of decisions and/or actions to be taken by health-care organisations and the cancer clinicians whom they employ.

The implementation of the credentialling system entails 16 sequential steps, as follows.

- 1 Allocate time and resources for the development of the credentialling system.
- 2 Identify and adopt standards of practice.
- 3 Set up a governance structure.
- 4 Develop institutional policies for credentialling.
- 5 Provide infrastructure for credentialling.
- 6 Assess local clinical need for cancer services.
- 7 Assess organisational capability for cancer services.
- 8 Develop data collections and data-collection systems.
- 9 Specify processes for the introduction of new procedures and treatments.
- 10 Verify the qualifications and cancer clinicians.
- 11 Verify cancer clinicians' professional standing, experience, skills and knowledge.
- 12 Define the cancer clinician's scope of practice.
- 13 Verify clinicians' involvement in continuing professional development.
- 14 Determine the frequency and processes of performance audit and review, and obtain clinicians' agreement to a performance review framework.
- 15 Carry out regular performance reviews.
- 16 Analyse performance data and inquire into and manage apparent deviations from standards of care.

These are described below.

BEGINNING THE IMPLEMENTATION PROCESS

Step 1 Allocate time and resources for the development of the credentialling system

Setting up a cancer credentialling system requires a lot of work and a lot of time. It needs management commitment and leadership. It cannot be achieved in the spare time of busy clinicians and health-service managers.

As described in Steps 2–16, the establishment process involves fact-finding, consultations, the development of procedures, documentation and the convening of a credentialling committee.

A regional health service (such as an Area Health Service in NSW) should expect the process to take at least six months.

The regional executive should:

- Nominate an individual to lead the developmental process. This individual should be familiar with the delivery of cancer services and have the respect of cancer clinicians. The regional director of cancer services is likely to be a suitable person for this role.
- Engage a project officer to work with the individual nominated to lead the process. The project officer should have an understanding of cancer services, be capable of managing a developmental project to completion within a fixed time period, be a good listener and an effective communicator, have excellent attention to detail, and have an ability to document procedures.
- Appoint a small steering group to advise the individual nominated to lead the process. The 5–6 members of the steering group should include a nominee of the regional or institutional chief executive as chair, 2–3 clinicians (representing different modalities of cancer care), a senior manager with a knowledge of human resources matters relevant to cancer clinicians, and a legal adviser.
- Allocate funds for the project officer's remuneration, regional travel, and meetings. Up to A\$60,000 may be required over the six-month period (considering costs in 2005).

STANDARDS OF PRACTICE

Step 2 Identify and adopt standards of practice

Any assessment of the qualifications, competence and performance of clinicians must be carried out with reference to agreed standards of practice. Health-care institutions that deliver cancer services must identify and adopt standards that are relevant to local service needs. These standards should be reviewed regularly and updated as new knowledge emerges.

Standards of care for the management of cancer comprise:

- generic standards that apply to all cancers,
- tumour-specific standards that apply to a particular tumour stream, and
- common standards that apply to two or more tumour streams.

At present, Australia does not have a comprehensive set of standards of practice for cancer. Various current national and State initiatives will eventually lead to the production of such standards. Pending these developments, the following standards could be used.

Generic standards

- NSW Department of Health. A Clinical Service Framework for Optimising Cancer Care in NSW.² This gives standards for patient-centred care, multi-disciplinary care, communication between primary, secondary and tertiary services, education, training and continuing professional development.
- American College of Surgeons, Commission on Cancer. Cancer Program Standards.³ URL: <http://www.facs.org/cancer/coc/programstandards.html>. The multi-disciplinary US Commission on Cancer sets out standards that could be used either in the accreditation of health-care institution or the credentialling of clinicians.
- Royal Australasian College of Surgeons Surgical Audit Task Force. Surgical Audit and Peer Review.⁴ Royal Australasian College of Surgeons, Melbourne, 2002.

² NSW Department of Health. A Clinical Service Framework for Optimising Cancer Care in NSW. NSW Department of Health, Sydney, 2003.

³ American College of Surgeons, Commission on Cancer. Cancer Program Standards, 2004. URL: <http://www.facs.org/cancer/coc/programstandards.html>.

⁴ Royal Australasian College of Surgeons Surgical Audit Task Force. Surgical Audit and Peer Review. RACS, Melbourne, 2002.

Tumour-specific standards

- The National Health and Medical Research Council has endorsed and published clinical practice guidelines on a wide range of cancer topics. A list of these topics can be found at: <http://www.nhmrc.gov.au/publications/subjects/cancer.html> (updated 29 June 2005)
- The Australian Cancer Network has also developed clinical guidelines, some of which have been endorsed by the NHMRC. These can be found at: <http://www.cancer.org.au/content.cfm?randid=408243>
- The Victorian Department of Human Services has developed performance indicators that relate to recommended practice for breast cancer.⁵
- A patterns-of-care study for colorectal cancer shows how guideline-based recommendations can be translated into standards of care⁶ (see also Step 15 below).

⁵ Amos A, Brosi J, Chappell G, Collopy B, Kavanagh A, Lockwood S, Nolan G, Phillips S, Sanders P, White M. The Development of Performance Indicators for Hospital Breast Services in Victoria. Victorian Department of Human Services, Melbourne, 2004.

⁶ Spigelman AD, McGrath DR. The National Colorectal Cancer Survey. Australian clinical practice in 2000. National Cancer Control Initiative, Melbourne, 2002.

POLICIES, PROCESSES AND INFRASTRUCTURE

Step 3 Set up a governance structure

The health-care institution should designate an individual or a group that has the authority to:

- develop or modify, and endorse, credentialling policies;
- lead and oversee processes for credentialling and defining the scope of services;
- update standards of care;
- monitor data on the performance of individual clinicians;
- manage variations from expected performance and other problems; and
- prepare reports on aggregated data for the executive of the institution

This authority may be delegated to a credentialling committee. Requirements for such a committee are:

- a formal constitution and explicit terms of reference;
- sufficient independence to review clinicians' performance objectively, and respond appropriately to the findings;
- a membership that has expert capacity to assess clinical cancer services;
- sufficient support to function effectively; and
- linkage to both the organisation's executive and its safety and quality-improvement mechanisms.

In many institutions, cancer services will share a credentialling governance structure with other clinical services. Under those circumstances, it is important to ensure that at least some of those involved in governance have a comprehensive understanding of cancer and cancer services, a capacity to assess organisational capability in relation to cancer services (see Step 7), and skills in the critical interpretation of cancer services data.

Where appropriate, consideration may be given to the establishment of a regional cancer credentialling committee. The involvement of clinicians across a whole region may yield a sufficiently large pool of potential members to give the committee the independence that it needs, allowing for individuals to absent themselves from deliberations in which they have a conflict of interest. Alternatively, two health regions could provide credentialling committee members for each other. The committees would then have members that have no direct local interests, but they could follow the credentialling policies and terms of reference of the region that employs the clinicians undergoing credentialling.

Step 4 Develop institutional policies for cancer credentialling

Those involved in governance of the credentialling system have responsibility for the development of policies that relate to credentialling at the institutional level. They also have a responsibility to ensure that full information on the policies is given to practitioners who are affected by them.

An institution's credentialling policies must be consistent with prevailing Australian Government and State or Territory Government legislation and policies on the safety and quality of health care and the collection, management and use of personal information.

In the following areas, policies for the credentialling of cancer clinicians will be shared with policies for the credentialling of other clinicians:

- requirements for initial credentialling and re-credentialling;
- requirements for verification of individual clinicians' credentials;
- indemnity insurance;
- short-term credentialling (e.g. of temporarily-employed clinicians, or in relation to major emergencies);
- the introduction of new clinical services, procedures or other interventions;
- data collection and analysis for audit purposes;
- communication with clinicians about credentialling and defining the scope of practice;
- circumstances in which a clinician's scope of practice may be altered;
- circumstances in which a clinician's services may be suspended; and
- appeals processes and processes for assisting clinicians to improve their performance.

Some institutional credentialling policies are specific to cancer. These policies should:

- Express commitment to credentialling as a means of promoting the safety and quality of cancer services, recognising the diversity of cancer, the diversity of cancer clinicians, and the extent and complexity of cancer services.
- Emphasise the need for a cancer credentialling system to be dynamic, i.e. to change and keep pace with the rapid production of new knowledge about cancer and cancer management and the evolution of cancer services.
- Highlight the need to assure organisational capability for the services that are within a credentialled clinician's scope of practice.
- Acknowledge the attributes that make a cancer clinician effective – (i) individual attributes (a commitment to continuing education and research, up-to-date knowledge of best practice and high-level clinical skills) and (ii) engagement in well-organised systems that deliver integrated, patient-centred, multi-disciplinary care.
- Ensure that cancer clinicians comply with legal and ethical requirements for the collection, analysis, secure storage and use of data that are applied in the credentialling of cancer clinicians, including data on cancer patients and data on cancer service providers.

Step 5 Provide infrastructure for credentialling

Once established, an effective credentialling system cannot run without adequate infrastructure. The extent of the resources required depends on the size of the cancer service and the number of clinicians that it employs. The resources comprise:

- The time of members of the governance structure, who are likely to have various clinical, teaching, research and managerial responsibilities alongside their role in credentialling. While this may be given *pro bono*, the opportunity cost that it represents for individuals may threaten the sustainability of the credentialling system. It is important that the contribution of clinicians and others is adequately recognised.
- Staff who serve as the secretariat for the governance structure, compile and analyse data and prepare reports on clinicians' performance, and maintain records.
- Information and communication technology.
- Capacity, including legal expertise, for the development and documentation of credentialling agreements between the health-care organisation and cancer clinicians.
- Space for the secure storage of confidential paper records.

Adequate budgetary allowance should be made for these resources. Consideration should be given to remuneration for the chair of the governance structure, given that the chair will devote substantial amounts of time to the credentialling system. If the chair is a staff member, funds could be allocated to 'back-fill' for a proportion of the chair's regular clinical, teaching, research and managerial duties.

Step 6 Assess local clinical need for cancer services

Local need for particular cancer services should be the prime determinant of what clinicians are asked to do and what they are expected to be capable of doing. That is, local need is a prime determinant of clinicians' scope of practice in a particular health-care institution (Step 12). Assessment of need may be based on answers to the following:

- What are the major types of cancer in the community served by the institution?
- What proportion of patients with particular cancers are treated locally (service self-sufficiency), what proportion are referred elsewhere, and what proportion seek treatment elsewhere?
- Are referral patterns appropriate?
- Are the processes of care within the institution appropriate?
- What are the outcomes, and are they as good as they might be?
- What other cancer services exist nearby, and what is their capability?
- What can be inferred about the adequacy of the community's access to high-quality cancer services?

- Given demographic and risk-factor characteristics, what can be predicted about incidence of cancer in this community in five years? 10 years?

The following data should be sought to answer these questions:

- demographic data on the local community, focusing on factors associated with cancer risk (e.g. age, sex, and ethnicity);
- epidemiological data on the occurrence of cancer and cancer outcomes (incidence, mortality and relative survival, by cancer type), and on major known cancer risk factors, especially smoking;
- data on the distribution of particular types of cancer services;
- data on patterns of care, including self-sufficiency and the extent to which local services have the capacity to fulfil recommended standards of care.

Analyses should include appropriate comparisons, e.g. with State or Territory or national data and with known benchmarks.

Step 7 Assess organisational capability for cancer services

A health-care institution's capability to support the delivery of specific clinical services is another important determinant of clinician's scope of practice in that institution (see Step 12). *Organisational capability* refers to the availability of facilities, infrastructure and clinical and non-clinical support services that are essential to carry out specific clinical procedures and treatments safely and effectively. For example, a general physician in a country hospital should only be accredited to administer chemotherapeutic agents that have a risk of causing bone-marrow depression, if (i) facilities and support staff are available in the local hospital to detect complications such as febrile neutropenia reliably and promptly, and (ii) facilities are available to manage such complications or there is a defined pathway for timely transfer of the patient to a higher-level hospital.

Organisational capability may mean in-house capability or capability within a network of linked services.

- In-house capability must exist where services could be needed immediately. For example:
 - In any hospital where major head and neck, thoracic, abdominal or pelvic surgery for cancer is undertaken, there must be in-house capability to provide high-level post-operative care and be able to deal with acute post-operative respiratory, circulatory and other complications. Importantly, this in-house capability must be available 24 hours a day, seven days a week – not just when visiting consultants are present in the hospital.
 - Any hospital in which a radiation oncology unit undertakes Total Body Irradiation for leukaemia must have an in-house capacity to manage leukaemia, and should treat a

sufficient number of cases to ensure that management is safe and accords with best-practice recommendations.

- Capability within a network of linked services is acceptable where appropriate referral pathways exist and transfer times are sufficiently rapid to meet clinical requirements. For example, any health-care facility that manages cancer patients should have the capacity to make a prompt and accurate diagnosis of spinal-cord compression due to metastatic disease. If the facility does not have on-site radiotherapy and neurosurgical services, it should have a defined pathway for the urgent transfer of patients to an institution that can deliver the necessary services without delay.

The assessment of organisational capability requires a comprehensive understanding of the sequelae of all of the conditions and interventions within the proposed scope of practice of the cancer clinicians employed in an institution.

Step 8 Develop data collections and data-collection systems

Efforts should be made to find existing routine sources of data on the indicators that have been specified for performance audit and review purposes (see Steps 14–15). Examples of existing data sources are standard clinical record forms, which may be paper-based or components of electronic patient-record systems – several regional cancer services and individual hospitals have well-developed electronic record systems; hospital-based cancer registries and cancer databases; and inpatient statistics collections. Processes should be set in train to transfer the required data from routine sources to a credentialling database. Where possible, data-transfer processes should occur automatically. If the requisite indicator data cannot be obtained from existing routine sources, it is necessary to collect the data anew, or to modify routine collections so that they can be used to obtain indicator data.

The credentialling database must be secure and confidential, and it must be managed in accordance the Australian Government Privacy Act 1988, relevant State and Territory legislation, and the NHMRC guide, *When Does Quality Assurance in Health Require Independent Ethical Review?*⁷

Cancer-care institutions that compile clinical data for credentialling purposes should apply for registration under the Australian Government Qualified Privilege Scheme⁸ and/or an equivalent State or Territory privilege scheme. The Australian Government Qualified Privilege Scheme is designed to ensure that (i) data collected for specified quality-assurance

⁷ NHMRC. *When Does Quality Assurance in Health Require Independent Ethical Review?* National Health and Medical Research Council, Canberra, 2003.

⁸ Priorities and Quality Branch. *Quality assurance. Commonwealth Qualified Privilege Scheme.* Commonwealth Department of Health and Ageing, Canberra, 2002. URL: <http://www.health.gov.au/pg/qualass.htm> (accessed 6 June 2005).

purposes are confidential, i.e. protected from disclosure and use in medical negligence litigation, and (ii) members of committees that assess or evaluate the quality of health services provided by others are protected from civil proceedings (apart from those relating to the rules of procedural fairness). States and Territories differ in their approaches to the granting of privileges; it is important that health-care institutions clarify the status of data collected for credentialing purposes in their local jurisdictions.

Step 9 Specify processes for the introduction of new procedures and treatments

The introduction of new procedures and treatments in a health-care institution creates a need for additional credentialing of the clinicians who are to carry them out. New procedures and treatments may either be newly-developed, new to the institution, or new to individual clinicians.

New procedures and treatments should only be introduced if the health-care institution has the capability to support them and to manage complications.

New procedures and treatments should be provisionally introduced into the scope of practice of the relevant clinicians. These clinicians should acquire appropriate training, which may require spending a period of time in another Australian institution or even overseas, and submit documentary evidence of satisfactory completion of the training. Each clinician should report on his or her performance of the new procedure or treatment to the credentialing committee when he or she has delivered it an agreed number of times, or after an agreed period of time. The report should contain details of complications and outcomes. If the credentialing committees find that the clinician's performance is satisfactory, the new procedure or treatment may be endorsed in the clinician's scope of practice. Thereafter, the regular credentialing processes apply. If performance is unsatisfactory, the credentialing committee may either require the clinician to undertake further training, or withdraw the procedure or treatment from the clinician's scope of practice.

In relation to surgery, users of this guide are referred to guidelines for the introduction of new procedures, produced under the auspices of the Royal Australasian College of Surgeons.⁹

⁹ Royal Australasian College of Surgeons and the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical. *General Guidelines for Assessing, Approving and Introducing New Procedures into a Hospital or Health Service*. Royal Australasian College of Surgeons, Melbourne, 2002.

ASSESSMENT OF INDIVIDUAL CLINICIANS

Step 10 Verify the qualifications of cancer clinicians

The qualifications of each clinician involved in the care of cancer patients should be verified. Verification should be part of the recruitment checks on newly-appointed clinicians, and should be done as a 'catch-up' process for existing clinicians who have not previously been credentialled. Verification should include an inspection of original or officially-certified documents and some evidence that links the identity of the clinician to the name given on the documentation. If doubt exists, the *bona fides* of the documents should be corroborated, either with the issuing institution or through testimony of a respected referee. Details of the corroboration process should be recorded. For cancer clinicians, three types of documents should be sought:

- Basic academic qualifications (e.g. an undergraduate or graduate degree in medicine).
- Current registration as a medical practitioner with the relevant State or Territory Medical Board.
- Qualifications issued by a recognised institution that provides postgraduate education relevant to cancer practice (e.g. fellowship of a clinical college).
- Details of medical defence insurance, where such insurance is not covered by the employing authority.

In view of recent incidents of forgery in Australia, it is advisable for health-care organisations that employ clinicians to verify their registration status with the relevant State or Territory Medical Board.

Step 11 Verify cancer clinicians' professional standing, experience, skills and knowledge

Verification of the clinicians' expertise should be undertaken iteratively with the definition of the scope of their practice (Step 12), as the two are inter-related.

For newly-appointed clinicians, verification of professional standing, experience, skills and knowledge can be derived from the following:

- Information about training (this overlaps with Step 10).
- Verified information about prior employment.
- Responses to questions on experience, skills and knowledge at the recruitment interview.

- Referees' reports (given orally and documented confidentially).
- Prior involvement in credentialing or other quality-assurance activities.
- Settled or pending litigation.
- Complaints lodged with a statutory health-care complaints system.
- Any current or prior restriction of medical practice registration (e.g. for malpractice, physical or mental disability, or substance abuse).

Access to information on some of these points will require explicit consent by the clinician.¹⁰

Recent events in Australia suggest that rigorous pursuit of the latter three points is important in ensuring that unsuitable practitioners are not endorsed by a credentialing system. A history of litigation, complaints or restriction of practice should not, of itself, exclude an individual from being credentialled. However, it should trigger careful scrutiny of the clinician's credentials and practice performance.

For existing clinicians who have not previously been credentialled, professional standing should be verified at the outset as for new clinicians. Verification of experience, skills and knowledge can be derived from information about caseload and performance. The process for this is essentially the same as that for performance review (Steps 14–15).

Step 12 Define the cancer clinician's scope of practice

The scope of practice of an individual clinician should be determined, taking the following four issues into account:

- Local need (see Step 6).
- Organisational capability (see Step 7).
- The clinician's qualifications and expertise (see Steps 10 and 11).
- The clinician's practice preferences.

The process of defining scope of practice can be conducted as follows.

- The clinician is informed of local need for services and organisational capability.
- He or she is asked to state his or her preferences with regard to clinical practice.
- The suitability of the clinician to pursue the expressed preferences is judged by a credentialing committee in the light of his or her qualifications and expertise.

The assessment of a clinician's expertise may require such measures as:

- Observation, by another credentialled practitioner, of his or her performance of procedures that are essential for the proposed scope of practice. The observation

¹⁰ O'Connor ME, and Committee on Hospital Care. Medical staff appointment and delineation of pediatric privileges in hospitals. *Pediatrics*, 2002; 110: 414–418.

process may begin with relatively simple procedures, and progress to more complex procedures if the simpler ones are performed satisfactorily.¹¹

- Initial provisional endorsement of a proposed scope of practice, with monitoring of practice and outcomes, and full endorsement if performance is satisfactory.

The level of detail in which a clinician's scope of practice is defined may vary with the circumstances of clinical practice. It may be helpful to define two categories:¹²

- Usual and customary practice, covering the scope of practice usually associated with an individual's qualifications.
- Advanced practice, covering procedures or treatments for which special expertise is required.

For example:

- A colorectal surgeon who is a Fellow of the Royal Australasian College of Surgeons (FRACS) in good standing could be credentialled for a broad range of procedures relating to colorectal surgery for cancer under the 'usual and customary practice' heading. Colorectal surgeons would also expect to be specifically credentialled for sphincter-preserving operations to excise malignant lesions situated low in the rectum under the 'advanced practice' heading.
- A general surgeon, also an FRACS in good standing, could be credentialled to perform a laparotomy and carry out urgent procedures to resolve an acute bowel obstruction under the heading 'usual and customary practice'. In this instance, however, 'usual and customary practice' would not cover definitive management of the cancer, which must include review by a multi-disciplinary team, is likely to include other treatment modalities, and may include further surgery in the hands of a colorectal surgeon.
- A radiation oncologist who is a Fellow of the Faculty of Radiation Oncology of the Royal Australian and New Zealand College of Radiologists could be credentialled for the broad range of external beam treatments under the 'usual and customary practice' heading. However, he or she would not necessarily have the requisite experience to deliver brachytherapy for curative treatment of carcinoma of the cervix. If appropriately trained and experienced, he or she could be credentialled to deliver brachytherapy under the 'advanced practice' heading. This would depend not only on the individual's clinical capacity but also the local clinical need and organisational capability for brachytherapy.
- A medical oncologist who is a Fellow of the Royal Australasian College of Physicians in medical oncology could be credentialled for the medical management of the broad range of malignant conditions under the 'usual and customary practice' heading. A medical oncologist who has appropriate training and a sufficient volume of lymphoma patients could have 'advanced practice' credentialling for the treatment of patients with lymphoma, but would not be expected to treat patients with acute leukaemia, whose care requires the recognised expertise of a clinical haematologist. In contrast, a

¹¹ Milad MP, Miller D, Shaw S. Comprehensive gynecologic endoscopic hospital privileging program. Implementation and assessment. *Journal of Reproductive Medicine*, 2000; 45(5): 365–370.

¹² Committee on Hospital Care Clinical Reports. Sample forms for the delineation of privileges. General pediatrics. American Academy of Pediatrics. URL: <http://www.aap.org/visit/cohcclinical.htm> (accessed 27 January 2005).

haematologist–oncologist would be expected to treat patients with acute leukaemia or lymphoma as ‘usual and customary practice’.

In these examples, the credentialling committee should decide on the coverage of ‘usual and customary practice’ for the various specialties.

Specimen statements of scope of practice are included at the end of this guide.

Step 13 Verify cancer clinicians’ involvement in continuing professional development

Newly-appointed clinicians and existing clinicians should be required to provide certified evidence of satisfactory participation in a recognised continuing professional development program relevant to their scope of practice in cancer service delivery.

In some States and Territories (e.g. NSW), this overlaps with criteria imposed by Medical Registration Boards for renewal of registration as a medical practitioner.

Step 14 Determine the frequency and processes of performance audit and review, and obtain clinicians’ agreement to a performance review framework

A full formal review of the clinical performance of each cancer clinician should be conducted on a regular cycle. Performance review is a major part of re-credentialling.

In addition, a limited, focused performance review should be conducted every time a serious critical incident occurs.

The health-care institution and the clinician should agree on the performance review framework at the time of initial credentialling. The agreement should have a format that is uniform across the institution’s credentialling system. It should:

- Describe the frequency and content of the regular performance review cycle.
- Describe how the credentialling committee will appraise the data.
- Define, in general terms, the circumstances that will cause the credentialling committee to seek further information on performance, including explanations from the clinician undergoing credentialling on reasons for apparent deviations from standards of care.
- Describe the nature of a *serious critical incident* that would trigger an immediate limited, focused performance review.
- Be signed by both parties.

Most institutions review the performance of credentialled clinicians on a regular three-year cycle. The three-year cycles should be staggered to avoid over-loading those involved in reviews.

In some instances the interval between reviews should be shortened. These instances could include the following:

- Newly-appointed clinicians who do not have an established track record in the institution.
- Clinicians administering treatments or performing procedures that are new, new to the institution, or unfamiliar to themselves.
- Clinicians who are performing procedures that require excellent eyesight and fine motor skills.
- Clinicians who have suffered significant illnesses that may detrimentally affect their physical or mental capacity to provide services in accordance with their agreed scope of practice.
- Clinicians whose performance has been considered borderline at previous reviews.

The definition of a *serious critical incident* depends on the individual clinician's scope of practice. Examples of events that could be defined as serious critical incidents are:

- Death in hospital of a patient who was not in the terminal stages of disease.
- Unplanned return to the operating room during an admission for elective cancer surgery, for a problem related to that surgery.
- Unplanned readmission to hospital within 28 days of discharge following elective cancer surgery for complications related to that surgery.
- Any major permanent complication of treatment, such as transverse myelitis following radiotherapy.
- Incidents or instances of clinical behaviour that lead to litigation and/or lodgement of a complaint with a statutory health-care complaints system.
- Any new restriction of medical practice registration (e.g. for malpractice, physical or mental disability, or substance abuse).

Clinicians should be obliged to report all serious critical incidents relating to their practice to the credentialling committee, and seek a review. The credentialling committee should also initiate reviews when they learn of serious critical incidents from any source, such as an institutional quality and safety committee.

As a prelude to the regular performance review for re-credentialling, the following should be assessed:

- Currency of certification. The clinician should produce documentation showing that he or she continues to be currently registered as a medical practitioner in the relevant State or Territory, and is in good standing with the professional organisation that issued his or her relevant specialist qualification (e.g. RACP, RACS, RANZCOG).
- Active involvement in continuing professional development. The clinician should produce documentation showing that he or she is actively participating in a recognised continuing professional development program relevant to his or her scope of practice in cancer

service delivery, and has met the requirements of the program in the most recent assessment cycle.

Step 15 Carry out regular performance reviews

Criteria for the assessment of clinicians' performance must be based on the clinical objectives that are given in standards of practice (see Step 2). The indicators (i.e. defined information items) to be used for audit and performance review purposes should reflect these clinical objectives as closely as possible. For practical reasons, the number of indicators should be kept to a minimum.

A patterns-of-care study of Australian colorectal cancer services⁶ illustrates how guidelines can be translated into standards of practice with explicit clinical objectives, and how indicators can be selected to provide information on the achievement of these objectives.

The following are examples of clinical objectives and indicators, taken from the study.

- **Clinical objective:** *All patients undergoing surgery for colorectal cancer should receive prophylaxis for thromboembolic disease. Unfractionated heparin, low molecular weight heparin, and intermittent calf compression are effective in reducing the incidence of thromboembolism.*
Indicator: *Proportion of patients receiving an effective form of prophylaxis for thromboembolism.*
- **Clinical objective:** *People with resected node-positive colon cancer should be offered adjuvant therapy with 5-fluorouracil (5-FU) plus low-dose leucovorin for six months, 5-FU plus low-dose leucovorin plus levamisole for six months, or 5-FU plus levamisole for one year.* **Indicator:** *Proportion of patients with resected node-positive colon cancer who are offered adjuvant therapy with one of these regimens.*
- **Clinical objective:** *All patients with rectal cancer who may require a temporary or permanent stoma should be seen by a stomal therapy nurse before elective surgery where this facility is available.*
Indicator: *Proportion of rectal cancer patients undergoing elective surgery who are seen pre-operatively by a stomal therapy nurse.*

Other examples (not in this study) could be derived from the NHMRC colorectal cancer guidelines.¹³

- **Clinical objective:** For all patients with rectal cancer undergoing pelvic radiotherapy, measures should be taken to reduce bowel exposure within the radiation field. **Indicator:** Proportion of pelvic radiotherapy volumes where a belly board or other method that is known to be effective has been used to reduce bowel exposure within the radiation field.
- **Clinical objective:** Patients with colorectal cancer for whom adjuvant chemotherapy is indicated should have treatment of recommended intensity. **Indicator:** Proportion of colorectal cancer patients eligible for adjuvant chemotherapy who complete the planned course of chemotherapy.

¹³ National Health and Medical Research Council. Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer. NHMRC, Canberra, 1999.

Wherever possible, individuals' performance should be compared with that of peers within the same credentialling system, compared with that of peers in other health-care institutions, and compared with any available benchmarks. External comparisons are important because internal norms may conceal deteriorations in performance, especially where one or a small number of clinicians in an institution carry out most of the caseload.

At the regular performance review, the following aspects of practice should be assessed.

(a) Caseload

The credentialling unit of the institution should produce data on the clinician's caseload *in the institution* since the last credentialling review, or since the launch of the credentialling system – whichever is the more recent). This should comprise:

- a line listing of patients, giving diagnosis, stage, procedures undertaken (this could cover all patients, or a series of, say, 100 consecutive cases);
- summary data on numbers of patients with each diagnosis;
- summary data on numbers of each type of procedure performed or each type of treatment administered.

For example, the summary data for a colorectal surgeon may indicate that he or she treated 102 patients with newly-diagnosed colorectal cancer, and performed 30 sphincter-conserving low rectal excisions. In this instance, data on new cases are a sufficient indicator of caseload, and there is not much to be gained by enumerating other aspects of the surgeon's caseload (e.g. numbers of patients being followed up).

Data on caseload should also show the proportion of the institution's caseload managed by each individual clinician. This proportion is most important for interpreting comparisons between the clinician and his or her peers on other parameters.

If the clinician works in another institution, he or she may wish to supply equivalent summary data on caseload from that institution, so that the credentialling committee is aware of the individual's total caseload. However, this should be presented separately; activity in another institution is outside the ambit of an institution's credentialling committee.

(b) Clinical behaviour

Several aspects of performance should be assessed under the heading of clinical behaviour.

- Assurance of organisational capability. The cancer clinician should report the number of occasions in which an intervention was undertaken without assurance of satisfactory organisational capability, e.g. the number of times that major cancer surgery was performed without access to an appropriate, adequately-staffed, on-site high-level post-operative care service capable of managing recognised complications. The only acceptable count is zero.

- Patient-centred care. A cancer clinician should report on a selection of relevant items from the following list.
 - Accessibility: length of time that new cancer referrals must wait to obtain an appointment for a consultation; access for telephone advice in business hours and out of hours; availability of alternate clinician if the credentialed clinician is unavailable.
 - Provision of information: duration of first-visit consultations for new cancer referrals; types of information routinely provided to newly-diagnosed cancer patients on their disease and its course, how cancer services work, the multi-disciplinary team, treatment choices (what, when, where, by whom); whether or not advice is provided on where to get additional information; whether or not an introduction to a patient support group is offered.
 - Patient choice: examples of approaches used to ensure that all cancer patients can make informed choices on where, how and by whom they are to be treated.
 - Navigation: whether or not the patient is given assistance in making follow-up appointments with other clinicians in the team; types of clinical data routinely provided to other clinicians who are involved in the patient's care.
 - Family and social context: whether or not cancer patients are routinely invited to bring a family member or other support person to consultations where critical management decisions will be discussed or made.
 - Office staff: type of training or briefing given to clinic or consultation-room staff on the elements of patient-centred care for cancer patients; clinic or office policy for giving patients telephone phone access to the cancer clinician on an *ad hoc* basis; existence of opportunities for patients to give feedback on sensitivity and appropriateness of office staff behaviour.
 - Complaints: documentation of any substantive complaints about deficiencies in patient-centredness of care.

An alternative approach to the assessment of patient-centredness of care is for the clinician to survey (as a clinical audit) a random sample of patients regarding their satisfaction with the care that they received.

- Appropriate engagement in multi-disciplinary management. The cancer clinician should report the proportion of newly-diagnosed cancer patients whose management is discussed in at least one multi-disciplinary case conference.
- Appropriate referral. The cancer clinician should demonstrate the following.
 - Connections with an organised cancer-care service to which patients can be referred according to need. Indicators are situation-specific. For example, cancer clinicians in peripheral hospital should list the tertiary-referral centres or affiliated specialist clinicians that patients had been referred to in the preceding year, and the number of patients referred to each.
 - Appropriate referral when a higher level of specialised expertise is needed for effective care. A possible indicator measures this in the breach: cancer clinicians should list

the instances in which they exceeded their defined scope of practice, and provide a brief explanation for each.

- Referral for appropriate care in another field. Indicators are situation-specific. An example is the percentage of patients having definitive surgery for invasive breast cancer, with defined indications for radiotherapy, who are referred to a radiation oncologist⁵.
- Communication with the referring practitioner. Indicators are situation-specific. An example is the proportion of new cancer patients whose practitioner was sent a report within 14 days of (i) the initial consultation, (ii) any definitive intervention (e.g. definitive surgery for breast cancer)⁵.

(c) Safety and quality

Questions of safety and quality of practice arise under many other headings in this guide. Indicators of safety and quality of care should be selected with regard to the cancer clinician's scope of practice and relevant standards of care. Indicator data should be provided by the credentialling unit wherever possible. The indicators should cover adverse processes and outcomes. Indicators of the occurrence of serious critical are examples (see Step 13). Numerous other possible indicators could be chosen. For example:

- A safety and quality indicator for a dermatologist excising pigmented skin lesions is the proportion of lesions excised that were benign on histopathological examination; and the proportion of melanomas for which the width of the excision margin accorded with that stated in agreed standard of care.
- A safety and quality indicator for a histopathologist is the proportion of melanomas for which pathology is reported using a comprehensive structured reporting format.
- A quality indicator in radiation oncology is the proportion of patients with early-stage laryngeal cancer who undergo laryngectomy (given that radiotherapy should be curative).

As an index of safety and quality of practice, cancer clinicians should be required to report on any complaints lodged regarding their practice, either at the institutional level, or through a statutory health-care complaints system, or in the form of litigation. These matters are also covered in Step 11.

(d) Rural practice

Considerations of safety and quality are particularly important for clinicians with relatively small cancer caseloads and/or those working in settings away from major centres. These clinicians could be particularly required to demonstrate that they:

- have the technical skills to carry out those aspects of cancer care that they choose to undertake, and to do so safely and competently;
- adhere to the principles of patient-centred care, especially ensuring that patients understand the advantages and disadvantages of local care versus care in a (possibly distant) specialised centre and can make informed choices without pressure or coercion;
- have the capacity to recognise and carry out at least the initial management of any complications that may arise;

- have connections and established communication pathways with specialists and/or specialised cancer units in major centres, for the purposes of continuing education, clinical advice, and ‘fast-track’ referral;
- follow evidence-based best practice, or at least show that they follow the treatment recommendations of specialised cancer units;
- are integrated with a multi-disciplinary care system, to which they refer patients appropriately; and
- are linked with processes for regular review of their performance.

Some of these points are covered elsewhere in this guide. They are repeated here because they warrant emphasis.

(e) Outcomes

The time period over which cancer outcomes are manifest is often too long for disease outcomes (e.g. survival) to be considered as credentialling criteria. However, the following examples illustrate approaches that can be used as outcome measures in cancer credentialling systems.

- Effective treatment has short-term outcomes that can form the basis of indicators for use in credentialling. For example, an outcome indicator in the field of haematology-oncology is the proportion of patients with specific types of leukaemias in whom a remission is successfully induced.
- Tumour recurrence within a given time period can sometimes be used as an outcome indicator. For example, an outcome indicator in gynaecological oncology is the proportion of patients treated for invasive carcinoma of the cervix who develop a recurrence within 12 months.
- Complication rates can sometimes also be used as outcome indicators. For example, an outcome indicator in radiation oncology is the proportion of patients with prostate cancer treated by radiotherapy who develop persistent rectal bleeding.

(f) Research and the uptake of new knowledge

Cancer clinicians should be encouraged to lead or participate in research, with a particular emphasis on enrolling patients in clinical trials. A possible indicator is the proportion of a clinician’s eligible patients who are enrolled in approved, registered clinical trials. Other possible indicators are numbers of peer-reviewed research grants awarded, and numbers of peer-reviewed publications on cancer.

Step 16 Analyse performance data and inquire into and manage apparent deviations from standards of care

Information collection for credentialling should be kept to a minimum, and the compilation of the information should be relegated to the credentialling unit wherever possible. This both reduces the reporting workload of clinicians and ensures that data are collected in an

objective and systematic manner. The analysis of performance review data should be done primarily by credentialling unit staff, who should consult the clinicians being credentialled and obtain additional data (as outlined in Step 16) from them as needed.

Information collection on critical events should be designed as a sentinel system, with each event triggering a review as soon as practicable. Short-term reviews should be conducted on a case-by-case basis unless a cluster of critical events enables a number of similar events to be reviewed simultaneously.

If performance data suggest that deviation from standards of care and/or deviation from a clinician's defined scope of practice may have occurred, the clinician should be invited to discuss the reasons with the credentialling committee. This invitation should be made in manner that conveys respect for the value of the clinician's advice.

When the credentialling committee has heard the clinician's reasons, the committee should meet *in camera* and in the absence of the clinician to form a collective view on the clinician's explanation, and determine any action to be taken. Action requiring remediation (e.g. specific training in a particular procedure, or a period of supervision) should be negotiated directly with the clinician. Action requiring curtailment of the clinician's scope of practice should be cleared with the institution's executive before the clinician is informed. All communications with the clinician should be made in writing and signed by the chair of the credentialling committee. Any required changes in the clinician's scope of practice should be co-signed by the chief executive of the health-care institution.

The clinician should have a right of appeal with regard to any curtailment of scope of practice arising from performance review.

Table: Relationship between *Credentialling of Cancer Clinicians – a guide for Australian health-care organisations* and the ACSQHC *Standard for Credentialling and Defining the Scope of Clinical Practice*.

Steps in <i>Credentialling of Cancer Clinicians – a guide for Australian health-care organisations</i>	Recommendations given in the ACSQHC <i>Standard for Credentialling and Defining the Scope of Clinical Practice</i>
Step 1 Allocate time and resources for the development of the credentialling system.	<i>Not explicitly stated in Standard</i> 6.5 Supporting processes of credentialling and defining the scope of clinical practice
Step 2 Identify and adopt standards of practice.	<i>Not explicitly stated in Standard</i> 8.2 Establishing essential criteria for a position
Step 3 Set up a governance structure.	5. Governance issues
Step 4 Develop institutional policies for credentialling.	7. Approaches to credentialling and defining the scope of clinical practice 8. The credentialling process
Step 5 Provide infrastructure for credentialling.	<i>Not explicitly stated in Standard</i> 6.5 Supporting processes of credentialling and defining the scope of clinical practice
Step 6 Assess local clinical need for cancer services.	6.2 Establishing organisational need and capability
Step 7 Assess organisational capability for cancer services.	6.2 Establishing organisational need and capability
Step 8 Develop data collections and data-collection systems.	6.6 Maintaining records
Step 9 Specify processes for the introduction of new procedures and treatments.	Part F New clinical services, procedures and other interventions
Step 10 Verify the qualifications of cancer clinicians.	8.6 Information required for initial credentialling 8.8 Verifying credentials
Step 11 Verify cancer clinicians' professional standing, experience, skills and knowledge.	8.6 Information required for initial credentialling 8.7 Information required for re-credentialling 8.8 Verifying credentials
Step 12 Define the cancer clinician's scope of practice.	Part D Defining the scope of clinical practice of medical practitioners
Step 13 Verify clinicians' involvement in continuing professional development.	8.6 Information required for initial credentialling 8.7 Information required for re-credentialling
Step 14 Determine the frequency and processes of performance audit and review, and obtain clinicians' agreement to a performance review framework.	7.5 Frequency of credentialling and defining the scope of clinical practice 8.7 Information required for re-credentialling
Step 15 Carry out regular performance reviews.	15. Performance monitoring and reporting
Step 16 Analyse performance data and inquire into and manage apparent deviations from standards of care.	11.1 Initial review of the recommendations of the committee responsible for credentialling and defining the scope of clinical practice

