Maternal and fetal medicine

Background

Maternal and fetal medicine (MFM), also known as perinatology, is the subspecialty of OB/GYN that focuses on complicated pregnancies. According to the Society for Maternal-Fetal Medicine (SMFM), an MFM specialist requires advanced knowledge of the obstetrical, medical, genetic, and surgical complications of pregnancy and their effects on the mother and fetus. Specifically, he or she has special competence in diagnosing and treating women with complications of pregnancy, preexisting medical conditions that may be affected by pregnancy, and medical conditions that affect pregnancy.

MFM specialists also provide to patients and other physicians education and research about cutting-edge approaches for diagnosing and treating obstetrical problems. Healthcare providers typically refer women to MFM specialists for care and consultation when a patient is considering pregnancy and knows that she is at risk, or when she is pregnant and existing factors place her at high risk. According to the SMFM, MFM patients most commonly include the following:

➤ Women undergoing diagnostic or therapeutic procedures (e.g., comprehensive ultrasound, chorionic villus sampling, and genetic amniocentesis)
➤ Women with medical and surgical disorders (e.g., heart disease, high blood pressure, and diabetes)
➤ Women with fetuses at markedly increased risk of adverse outcome (e.g., abnormal alpha-fetoprotein blood test, recurrent preterm labor and delivery, and suspected fetal growth restriction)
➤ Antepartum women admitted for reasons other than delivery and women with postpartum complications (e.g., severe hemorrhage, refractory infections, complicated preeclampsia, eclampsia, and difficult post-cesarean complications)

MFM specialists complete four years of residency training in an OB/GYN program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA), followed by three years of fellowship training in MFM. The American Board of Obstetrics and Gynecology (ABOG) offers subspecialty certification in MFM. The American Osteopathic Board of Obstetrics and Gynecology (AOBOG) offers a certificate of special qualifications in MFM.

Involved specialties

MFM physicians
Positions of specialty boards

**ABOG**

In addition to certifying OB/GYNs, the ABOG also offers subspecialty certification in MFM to applicants who satisfy the following minimum requirements:

➤ Hold a certificate in OB/GYN through the ABOG

➤ Are registered with the ABOG and have completed a minimum of 32 of 36 months of training or will have completed training in an ABOG-accredited fellowship program in MFM no later than September 30 of the same year the written test is taken

➤ Have passed a minimum of two postgraduate level courses—one course must include biostatistics and/or epidemiology and emphasize study design and implementation, and the second course must relate to the field of MFM

➤ Have completed a written examination that demonstrates advanced knowledge in MFM

➤ Hold an unrestricted license to practice medicine in the United States

➤ Hold full and unrestricted privileges to practice as a subspecialist in each hospital in which the candidate has privileges (requirement to take the oral examination)

➤ Must not have resigned hospital privileges or membership in any medical organization while under investigation (requirement to take the oral examination)

➤ Must have completed at least 12 months of independent practice as a subspecialist in a center or centers providing or having ready access to the essential diagnostic and therapeutic facilities for the practice of MFM (requirement to take the oral examination)

➤ Must submit a thesis that meets the standards of the Division of Maternal-Fetal Medicine (requirement to take the oral examination)

Candidates must also submit a case list demonstrating sufficient depth and breadth of practice in the subspecialty of MFM. The ABOG outlines the following requirements regarding the number of cases candidates must submit.

Candidates must submit a list of cases relating to medical complications of pregnancy with the following numbers of patients:

➤ Cardiac, cardiovascular (chronic hypertension), and pulmonary (asthma, pneumonia): 5 cases

➤ Endocrine, including pregestational diabetes mellitus and thyroid disorders: 5 cases

➤ Gastrointestinal, including inflammatory bowel disease and gastric bypass surgery: 2 cases

➤ Hematologic and oncologic, including hypercoagulable disorders and thrombophilies, hemoglobinopathies, and thrombophlebitis: 5 cases

➤ Immunological, including autoimmune disorders (collagen vascular disease) and transplants: 3 cases
➤ Infectious disease (HIV, pyelonephritis, hepatitis): 5 cases  
➤ Neurological and psychiatric, including drug or alcohol abuse: 2 cases  
➤ Renal disease: 3 cases  

Candidates must submit a list of cases relating to surgical complications with the following number of patients:

➤ Antepartum and peripartum intensive care, including mechanical ventilation or invasive hemodynamic monitoring, massive hemorrhage, pulmonary edema, acute renal failure, septic shock, anesthesia complications, and ARDS: 3 cases  
➤ Hypertension, preeclampsia, and eclampsia: 5 cases  
➤ Multiple gestations and complications, including twin-twin transfusion syndrome: 5 cases  
➤ Placental abnormalities, including previa, abruption, and accrete: 3 cases  
➤ Preterm labor and preterm cervical dilation or shortening: 5 cases  
➤ Preterm premature rupture of membranes: 5 cases  
➤ Recurrent pregnancy loss, cervical insufficiency, uterine anomalies, and fetal demise: 2 cases  
➤ Surgical (non-obstetric surgery, burns, trauma): 2 cases  

Candidates must submit a list of cases relating to genetics/fetal disorders/fetal anomalies with the following numbers of patients:  

➤ Alloimmunization (Rh, thrombocytopenia), immune and nonimmune hydrops: 3 cases  
➤ Fetal anatomic malformations: 8 cases  
➤ Fetal chromosomal and genetic abnormalities: 8 cases  
➤ Fetal growth restriction: 8 cases  
➤ Fetal infections (CMV, parvovirus, toxoplasmosis): 3 cases  

The ABOG also publishes Guide to Learning in Maternal-Fetal Medicine and General/Special Requirements for Graduate Medical Education in Subspecialty MFM.

AOBOG

The AOBOG grants subspecialty certification in MFM. Certification of applicants in this subspecialty after June 1, 2002, is time-limited and requires recertification every six years. Certification granted prior to June 1, 2002, is for life and does not require recertification. Continued membership in the AOA is required in order for certification to remain active. Candidates for subspecialty certification must satisfy the following requirements in order to receive a certificate:

➤ Must have received primary certification in OB/GYN by the AOA through the AOBOG  
➤ Must have been a member in good standing of the AOA or the Canadian Osteopathic Association for a minimum of the prior two years  
➤ Must have satisfactorily completed fellowship training that has been approved by the AOA
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➤ Must exhibit conformity to the standards as set forth in the Code of Ethics of the AOA
➤ Must have prepared a log of clinical activity subsequent to fellowship training
➤ Must be the primary author of a research paper relative to the subspecialty that meets professional and publishable standards as determined by a review committee of peers, appointed by the AOBOG Subspecialty Committee
➤ Must hold a current unrestricted medical license in the state(s) and or territory(s) where practice is being conducted
➤ Must have been accepted for examination by the AOBOG Subspecialty Credentials Committee

Positions of societies, academies, colleges, and associations

SMFM
The SMFM is a nonprofit organization for OB/GYNs with additional training in MFM.

SMFM does not publish a statement regarding the delineation of clinical privileges, competency, or training for MFM physicians. However, the organization states, “MFM specialists often coordinate the care of high-risk pregnant women with the patient’s obstetrician to develop a plan that’s tailored to her needs as well as the needs of the unborn child. As experts understanding and balancing the risks to the mother and the fetus, MFM specialists also work directly with other medical and surgical subspecialists, anesthesiologists, and critical care team members if the condition warrants. MFM specialists work directly with natologists and/or pediatric subspecialists to ensure an optimal plan for newborn care as well.”

SMFM publishes several clinical guidelines for MFM physicians.

ACOG
The American College of Obstetricians and Gynecologists (ACOG) advocates for women’s healthcare, provides continuing education for its members, and promotes patient education in medical care. ACOG members include generalists and subspecialists in areas such as MFM, gynecologic oncology, reproductive endocrinology, and urogynecology.

The ACOG states that OB/GYNs may choose a scope of practice ranging from primary ambulatory healthcare to concentration in a focused area of specialization. The organization jointly publishes Guidelines for Perinatal Care with the American Academy of Pediatrics. The guidelines define basic, specialty, and subspecialty levels of perinatal care, but do not delineate privileging guidelines specific to MFM.
AOA

The AOA and the American College of Osteopathic Obstetricians and Gynecologists publish the Basic Standards for Fellowship Training in Maternal Fetal Medicine.

The standards state that the fellowship program shall provide the fellows with an in-depth and advanced knowledge of genetic disorders, teratologic disorders, and metabolic disorders, and a detailed study of advanced ultrasonography shall be integrated throughout the entire program for diagnosing fetal health and disease. Fellowship program guidelines are as follows:

➤ Programs must educate fellows in the following:
  − Osteopathic philosophy, principles, and practice as they relate to MFM
  − Basic science training that emphasizes anatomy, pathology, physiology, biochemistry, and bacteriology as they relate to MFM

➤ The program structure and contents shall include outpatient evaluation of MFM patients as follows:
  − The fellow shall receive training and ultimately supervise high-risk pregnancy clinics under the direction of an attending MFM specialist.
  − The fellow shall evaluate patients and perform or order appropriate diagnostic testing and therapeutic regimes as approved by the attending MFM specialist.
  − The service shall provide an adequate number of MFM patients as well as follow-up visits, both on an inpatient and outpatient basis. The clinical problems shall include but not be limited to the following: renal disease; toxemia and hypertension; cardiac disease; vascular disease; diabetes mellitus; thyroid disease; adrenal, pituitary, and parathyroid parasitic infestations; sexually transmitted infections; pulmonary disease; dermatologic disorders; neurologic complications; hematologic disorders; neoplastic diseases; rheumatic diseases; genetic disorders; drug abuse; and musculoskeletal and structural disorders as they relate to the high-risk obstetrical patient.
  − The fellow shall be trained in the pharmacology and therapeutics of all related chemicals and physical modalities utilized in the diagnosis and management of high-risk obstetrical patients.

➤ The training program shall provide effective content with regard to behavioral characteristics involved in the interaction between the fellow, the patient, and the teaching staff. The program should enhance the ability of the fellow to understand the contingencies of health and illness and the development of a mature concern regarding the quality of patient care.

➤ Investigational research shall be a fundamental part of the training program.

➤ The fellowship program director must provide evidence of strong scholarly activity and productivity by faculty and fellows in clinical and/or laboratory research.

➤ The program shall provide for adequate training in all aspects of MFM, including all medical and surgical diseases as they relate to pregnancy, fetal adaptation to the intrauterine environment, and the transition from the in
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utero environment to extrauterine life and neonatal care as it relates to the infant making the transition from the high-risk pregnancy to the intensive care nursery. The fellow must be provided with access to neonatal nursery experience.

Positions of accreditation bodies

CMS

CMS has no formal position concerning the delineation of privileges for MFM. However, the CMS Conditions of Participation (CoP) define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

- Individual character
- Individual competence
- Individual training
- Individual experience
- Individual judgment

The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.
CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

**The Joint Commission**

The Joint Commission has no formal position concerning the delineation of privileges for MFM. However, in its *Comprehensive Accreditation Manual for Hospitals*, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and implementing a privileging process.” It goes on to state that this process typically includes:

- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information
- Submitting recommendations to the governing body for applicant-specific delineated privileges
- Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
- Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”

The EPs for standard MS.06.01.05 include several requirements as follows:

- The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
- Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
➤ Consistent application of criteria
➤ A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
➤ Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges requested
➤ A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
➤ Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
➤ A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)
➤ A process to determine whether there is sufficient clinical performance information to make a decision related to privileges
➤ A decision (action) on the completed application for privileges that occurs within the time period specified in the organization’s medical staff bylaws
➤ Information regarding any changes to practitioners’ clinical privileges, updated as they occur

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).
In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

**HFAP**

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for MFM. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff’s review of an individual practitioner’s qualifications and its recommendation regarding that individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.
DNV

DNV has no formal position concerning the delineation of privileges for MFM. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

➤ The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements
➤ Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status
➤ Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).

Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.

CRC draft criteria

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding MFM. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners
in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.

Minimum threshold criteria for requesting privileges in MFM

Basic education: MD or DO
Minimum formal training: Successful completion of an ACGME- or AOA-accredited residency in OB/GYN, followed by successful completion of an ABOG- or AOA-approved fellowship in MFM.
AND/OR
Current subspecialty certification or active participation in the examination process (with achievement of certification within [n] years) leading to subspecialty certification in MFM by the ABOG or completion of a certificate of special qualifications by the AOBOG.
Required current experience: Provision of care to at least 25 patients, reflective of the scope of privileges requested, in the past 12 months or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.

References

If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

Core privileges in MFM

Core privileges for MFM include the ability to admit, evaluate, diagnose, treat, and provide consultation to adolescent and adult female patients with medical and surgical complications of pregnancy, such as maternal cardiac, pulmonary, and metabolic complications; connective tissue disorders; and fetal malformations, conditions, or disease. MFM physicians may provide care to patients in the intensive care setting in conformance with unit policies. Privileges also include the ability to assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.

The core privileges in this specialty include the procedures on the following procedures list and such other procedures that are extensions of the same techniques and skills:
➤ Amnioreduction
➤ Breech delivery (spontaneous, assisted, application of forceps)
➤ Cephalocentesis
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➤ Cesarean hysterectomy
➤ Chorionic villi sampling
➤ Complicated cesarean delivery
➤ Delivery of multiple gestations
➤ Diagnostic laparoscopy
➤ Episiotomy and vaginal laceration repair
➤ External cephalic version of abnormal lie
➤ Fetal assessment: non-stress test, contraction stress test, biophysical profile, vibroacoustic stimulation test, and Doppler velocimetry (antepartum) and fetal heart rate monitoring and scalp stimulation (intrapartum)
➤ Genetic amniocentesis
➤ In utero fetal transfusion
➤ Induction of labor
➤ Intrauterine fetal therapy (thoracentesis, paracentesis, administration of medications, placement of thoracic shunt, and placement of urinary catheter)
➤ Interoperative support to obstetrician as requested, including operative first assist
➤ Laparoscopic enterolysis
➤ Manual removal of placenta
➤ Medical and surgical control of hemorrhage
➤ Neonatal resuscitation
➤ Operative vaginal deliveries
➤ Percutaneous umbilical blood sampling
➤ Performance of history and physical exam
➤ Sterilization procedures
➤ Transvaginal cervical cerclage
➤ Ultrasound examination, including first-, second-, and third-trimester targeted anatomic fetal evaluation and cardiac evaluation, including color Doppler, Doppler velocimetry (fetal umbilical artery, fetal middle cerebral artery, and maternal uterine artery), cervical and placental evaluation, and 3-D and 4-D ultrasound
➤ Version of second twin

Reappointment

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism. To be eligible to renew privileges in MFM, the applicant must demonstrate current competence and an adequate volume of experience (100 patients) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.
For more information

Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, IL 60610-4322
Telephone: 312/755-5000
Fax: 312/755-7498
Website: www.acgme.org

American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Telephone: 214/871-1619
Fax: 214/871-1943
Website: www.abog.org

American College of Obstetricians and Gynecologists
PO Box 96920
Washington, DC 20090-6920
Telephone: 202/638-5577
Fax: 202/484-5107
Website: www.acog.org

American College of Osteopathic Obstetricians and Gynecologists
8851 Camp Bowie West, Suite 120
Fort Worth, TX 76116
Telephone: 817/377-0421
Fax: 817/377-0439
Website: www.acoog.com

American Osteopathic Association
142 East Ontario Street
Chicago, IL 60611
Telephone: 800/621-1773
Fax: 312/202-8200
Website: www.osteopathic.org

American Osteopathic Board of Obstetrics and Gynecology
1010 Dixie Highway, Suite 313
Chicago Heights, IL 60411
Telephone: 708/755-2490
Fax: 708/755-2495
Website: www.aobog.com
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Telephone: 630/792-5000
Fax: 630/792-5005
Website: www.jointcommission.org

Society for Maternal-Fetal Medicine
409 12th Street, SW
Washington, DC 20024
Telephone: 202/863-2476
Fax: 202/554-1132
Website: www.smfm.org

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