Flexible fiberoptic bronchoscopy

Background

Flexible fiberoptic bronchoscopy involves the insertion of a flexible fiberoptic bronchoscope (FOB) to allow visual examination of the interior of the bronchi. Common reasons for bronchoscopy include recurrent lung collapse, bleeding, lung spots, and infections.

As a diagnostic tool, the FOB can view abnormalities such as tumors or granulomatous lesions and can also obtain appropriate material for microbiologic evaluation via lavage, brushing, and biopsy of lung regions. As a therapeutic tool, the FOB can remove secretions in patients with obstructed airways, remove small foreign bodies, and treat carcinoma of the lung with either laser therapy or brachytherapy.

Flexible fiberoptic bronchoscopy is most commonly performed by pulmonologists and cardiothoracic surgeons. Other physicians, such as otolaryngologists, critical care intensivists, and anesthesiologists, may perform bronchoscopies in certain instances, but it is far less common.

Involved specialties

Pulmonologists, interventional pulmonologists, and cardiothoracic surgeons

Positions of specialty boards

ABTS

The American Board of Thoracic Surgery (ABTS) provides certification in thoracic surgery to candidates who complete one of the following four pathways:

- A residency in general surgery approved by the Accreditation Council for Graduate Medical Education (ACGME), followed by successful completion of an ACGME-approved thoracic surgery residency. Successful completion of a 4/3 general surgery/thoracic surgery joint training program approved by the ACGME, in which candidates complete four years of general surgery followed by three years of thoracic surgery, fulfills this requirement.

- A full residency in general surgery or cardiac surgery approved by the Royal College of Physicians and Surgeons of Canada, followed by the successful completion of an ACGME-approved thoracic surgery residency.

- A six-year integrated thoracic surgery residency that follows the guidelines established by the Thoracic Surgery Directors Association and approved by the ACGME.
Flexible fiberoptic bronchoscopy

➤ An ACGME-approved vascular surgery residency that can lead to primary certification in vascular surgery, followed by the successful completion of an ACGME-approved thoracic surgery residency.

Flexible bronchoscopy is covered in the ABTS Cardiothoracic Surgery Curriculum Outline and is a required procedure for all candidates for certification.

In its *Booklet of Information*, ABTS states that residents must perform 125 major cardiothoracic operations each year. Residents must choose either a general thoracic pathway or a cardiothoracic pathway. Residents who pursue a general thoracic pathway are required to perform 40 bronchoscopies prior to completion of their residency. Residents in the cardiothoracic pathway who began their training between July 1, 2007, and June 30, 2012, are required to perform 20 bronchoscopies prior to the completion of their residency. Residents in the cardiothoracic pathway who began their training on or after July 1, 2012, are required to perform 30 bronchoscopies over the course of their residency.

**ABIM**

The American Board of Internal Medicine (ABIM) offers certification in the subspecialty of pulmonary disease and critical care medicine. Candidates for dual certification in pulmonary disease and critical care medicine must complete three years of training, including 18 months of clinical training, though candidates certified in internal medicine must complete only 24 months of accredited critical care medicine training, including 12 months of clinical training, to qualify for the certification examination. Fiberoptic bronchoscopy and accompanying bronchoscopy procedures are among the procedures that candidates in pulmonary disease and critical care medicine are required to perform during training, but ABIM does not list a specific number of procedures needed to prove competency.

**AOBS**

The American Osteopathic Board of Surgery (AOBS) provides certification in cardiothoracic surgery to candidates who complete four years of training in general surgery followed by two years of cardiothoracic training. The certification examination contains questions pertaining to pulmonary, esophagus, and respiratory topics. The AOBS does not publish a specific number of flexible fiberoptic bronchoscopies required to demonstrate competency.

**AOBIM**

To be eligible for certification in internal medicine from the American Osteopathic Board of Internal Medicine (AOBIM), candidates must complete one of the following American Osteopathic Association (AOA)-approved training programs:

➤ 12 months of a non-medicine track internship followed by 36 months of an internal medicine residency
Flexible fiberoptic bronchoscopy

Procedure 20

- 12 months of a medicine track internship followed by 24 months of an internal medicine residency, or 36 months of an internal medicine residency
- 12 months of an AOA-approved internship followed by 48 months of a combined emergency medicine/internal medicine residency training program, which must contain 24 months each of emergency medicine and internal medicine
- 48 months of a combined internal medicine/pediatrics residency training program, which must contain a minimum of 24 months of internal medicine training and 18 months of pediatric training

AOBIM also offers subspecialty certification in pulmonary diseases. Candidates must satisfactorily complete two years of an AOA-approved fellowship program in pulmonary diseases or a combined program in pulmonary diseases and critical care medicine, and pass a written and clinical examination to achieve certification. AOBIM does not publish requirements specific to flexible fiberoptic bronchoscopy.

**Positions of societies, academies, colleges, and associations**

**STS**

The Society of Thoracic Surgeons (STS) is a professional organization representing cardiothoracic surgeons, researchers, and allied health professionals. The STS does not publish guidelines or specific requirements relating to flexible fiberoptic bronchoscopy.

**ACCP**

The American College of Chest Physicians (ACCP) is a professional organization that provides education and research in chest diseases. The ACCP does not publish specific training requirements relating to flexible fiberoptic bronchoscopy. In its *An Approach to Interventional Pulmonary Fellowship Training*, ACCP notes that interventional pulmonology is an evolving specialty with an emphasis on multidisciplinary care. Although there are fellowship programs for interventional pulmonology, it is not a specialty recognized by the ACGME or AOA. The document calls for structured training in interventional pulmonology, including an additional year of training dedicated to interventional procedures. ACCP recommends the performance of 90 advanced diagnostic and therapeutic bronchoscopy procedures, including rigid bronchoscopy and autofluorescence bronchoscopy, to achieve initial competency.

ACCP also publishes *Prevention of Flexible Bronchoscopy-Associated Infection*, a consensus statement in conjunction with the American Association for Bronchology and Interventional Pulmonology (AABIP). The statement mentions training in relation to infection prevention, but does not offer specific training requirements or recommendations for flexible fiberoptic bronchoscopy.
Flexible fiberoptic bronchoscopy

Procedure 20

**AABIP**

AABIP is a membership organization for physicians and other practitioners with interests in bronchology and interventional pulmonology. AABIP has established the Bronchoscopy Education Project, a program intended to provide bronchoscopy educators and training program directors with tools and materials to train students and assess progress. These training materials cover the full curriculum for basic flexible bronchoscopy, which combines simulation training, lectures, and required readings. However, AABIP does not publish specific requirements for the number of flexible fiberoptic bronchoscopy procedures to establish competency.

**ATS/ERS**

The American Thoracic Society (ATS) and European Respiratory Society (ERS) publish the *ERS/ATS statement on interventional pulmonology*, which outlines the equipment, personnel, technique, and training requirements for multiple types of bronchoscopy procedures. According to the document, physicians should perform at least 20 supervised bronchoscopy procedures before attempting the procedure alone, and should perform 10–15 rigid bronchoscopies annually to maintain competency. The document does not contain specific requirements for the number of flexible fiberoptic bronchoscopy procedures that should be performed to prove competency.

**AOA**

The AOA publishes *Basic Standards for Residency Training in Internal Medicine*. According to this document, residency training in internal medicine must be 36 months, with at least 34 months of training in clinical rotations and at least 30 months of training specific to internal medicine and its subspecialties. The basic standards do not include specific requirements for flexible fiberoptic bronchoscopy.

The AOA also publishes *Specific Basic Standards for Osteopathic Fellowship Training in Pulmonary Diseases*. Fellowship training should be a minimum of 24 months, and the base institution must have a 24-hour fiberoptic bronchoscopy service. Fellows must receive training in flexible fiberoptic bronchoscopy and related procedures, although the document does not list a specific number of procedures required to achieve competency.

In *Basic Standards for Residency Training in Surgery and the Surgical Subspecialties*, the AOA specifies that training in cardiothoracic surgery should be two years, following successful completion of an AOA-approved general surgery residency program that included an OGME-1R year. Candidates may choose either a general thoracic surgery or a cardiothoracic surgery pathway. Residents in the cardiothoracic surgery pathway must perform 20 bronchoscopy procedures during training, while those residents in a general thoracic pathway must perform 40 bronchoscopy procedures.
Flexible fiberoptic bronchoscopy

**ACGME**

The ACGME publishes *Program Requirements for Graduate Medical Education in Pulmonary Disease and Critical Care Medicine (Internal Medicine)*. These requirements state that the educational program in pulmonary disease and critical care medicine must be 36 months in length. Candidates must demonstrate competence in procedural and technical skills, including flexible fiberoptic bronchoscopy. The ACGME requires fellows to perform a minimum of 100 flexible fiberoptic bronchoscopy procedures, including procedures where endobronchial and transbronchial biopsies and transbronchial needle aspiration are performed.

ACGME also publishes *Program Requirements for Graduate Medical Education in Thoracic Surgery*, which states that as part of training residents must demonstrate skill in diagnostic procedures, such as bronchoscopy. Flexible bronchoscopy is also listed as part of the minimum operative experience required of residents during training. The case volume requirements published by the ACGME and ABTS indicate that residents focusing on a general thoracic pathway should perform 40 bronchoscopy procedures, while residents in a cardiothoracic pathway should perform 20 bronchoscopy procedures. This number increases to 30 for cardiothoracic residents who began their training on or after July 1, 2012.

In the publication *Program Requirements for Graduate Medical Education in Otolaryngology*, ACGME notes that residents should diagnose and apply techniques involving endoscopy of the upper aerodigestive tract, including bronchoscopy, but the requirements do not list a specific number of bronchoscopies required during education in otolaryngology.

**Positions of subject matter experts**

**Sadia Benzaquen, MD**

*Cincinnati*

Sadia Benzaquen, MD, assistant professor and director of interventional pulmonology at the University of Cincinnati, says that pulmonologists and cardiothoracic surgeons most commonly perform bronchoscopy, and that both specialties include bronchoscopy as a part of their training.

Benzaquen points to statements released by both ACCP and ATS for guidance on determining criteria, as they both contain training recommendations and information on procedures similar to flexible bronchoscopy. According to those documents, physicians should perform close to 100 various types of bronchoscopy procedures under supervision before attempting to perform bronchoscopy solo, and should perform 10 procedures per year to maintain competency.
“It is important for the committee to evaluate both the number of procedures performed as well as the number of complications,” says Benzaquen. “If someone performs 100 bronchoscopies and 90 of them had complications, I don’t think that person should get privileges.”

Benzaquen notes that flexible bronchoscopy has a low complication rate, between 1% and 5%, and physicians applying for privileges in flexible bronchoscopy should be within the normal range.

Richard Whyte, MD, MBA
Boston

Pulmonologists and cardiothoracic surgeons perform the majority of bronchoscopy procedures (approximately 90%–95%), while anesthesiologists, intensivists, and otolaryngologists may occasionally perform bronchoscopies for specific reasons, according to Richard Whyte, MD, MBA, vice chair for quality, safety, and clinical affairs in the Department of Surgery at Beth Israel Deaconess Medical Center in Boston.

The training required for bronchoscopy varies depending on the field, as does the number of procedures required to prove competency.

“Each specialty defines it on their own, and each specialty defines what it thinks is appropriate,” says Whyte.

Whyte notes that competency varies between individuals, and what some physicians may be able to learn within a few procedures, others may need many more to get a handle on the procedure. According to Whyte, anyone performing bronchoscopies should be skilled with the instruments and equipment, have a thorough understanding of the anatomy, and have skills specific to whatever procedures may be performed in conjunction with the bronchoscopy.

Whyte stresses that the term “bronchoscopy” can encompass a wide range of procedures—from a simple bronchoscopy to clear secretions to a bronchoscopy with debridement and stent placement—and that the training required of physicians will vary based on what a physician is looking to do. As the procedures accompanying the basic bronchoscopy grow more complex, so too should the training requirements become more defined.

“If a physician has done some routine diagnostic bronchoscopies, it doesn’t mean he knows how to do bronchial thermoplasty, although technically it’s a flexible bronchoscopy, just with a twist,” says Whyte.

Whyte recommends referencing the board requirements as well as a physician’s documented experience and training when determining privileges.
Positions of accreditation bodies

**CMS**

CMS has no formal position concerning the delineation of privileges for flexible fiberoptic bronchoscopy. 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 flexible fiberoptic bronchoscopy. 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
Flexible fiberoptic bronchoscopy

Procedure 20

➤ 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 flexible fiberoptic bronchoscopy. 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 flexible fiberoptic bronchoscopy. 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.
Flexible fiberoptic bronchoscopy

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 this procedure.

**Minimum threshold criteria for requesting privileges in flexible fiberoptic bronchoscopy**

**Basic education:** MD or DO

**Minimal formal training:** Successful completion of an ACGME- or AOA-accredited residency in cardiothoracic surgery, pulmonology, or interventional pulmonology.

**Required current experience:** Demonstrated current competence and evidence of the performance of at least 100 bronchoscopy procedures, which should include 15–20 flexible fiberoptic bronchoscopy procedures, in 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.

**Reappointment**

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism.

Applicants must demonstrate current competence and evidence of the performance of 30–40 flexible fiberoptic bronchoscopies in the past 24 months based on results of ongoing professional practice evaluation and outcomes. Indications and complications of these procedures should be noted when determining reappointment.

In addition, continuing education related to flexible fiberoptic bronchoscopy should be required.

**For more information**

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Flexible fiberoptic bronchoscopy

Procedure 20

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