Committee on Hospital Care

Delineation of Pediatric Privileges in Hospitals

In 1973, the Hospital Care Committee of the American Academy of Pediatrics published a statement entitled “Delineation of Pediatric Privileges in Hospitals.” Since that time there have been many new developments in this area, and there is increasing litigation. Many pediatricians are involved not only as individual physicians but also as members of, or advisors to, hospital departmental committees, medical staffs, and hospital governing bodies in decisions as to the general delineation of privileges, specific medical staff appointments, and granting of privileges. Every pediatrician practicing hospital medicine is subject to this process. In view of the continued evolution and increasing importance of this field, the following review and guidelines are offered.

The evolving legal doctrines of hospital corporate liability generally provide that a hospital governing body is responsible for the maintenance of proper standards of professional work in the hospital and for the functioning of the medical staff in conformity with reasonable standards of competency. The hospital credentialing process is one of the methods by which hospital governing bodies meet their legal responsibilities and strive to protect patients from incompetent or unqualified physicians. The hospital governing body has overall responsibility for the quality of patient care, but it delegates to the medical staff the duty to recommend only competent physicians to treat patients in the hospital. A doctor does not have the right to practice in any hospital he chooses; rather, each hospital grants permission or the privilege to practice therein. The Joint Commission on Accreditation of Hospitals (JCAH) considers credentialing to be a major hospital quality assurance measure and an important factor in hospital risk management.

INITIAL APPOINTMENT

When a physician joins a hospital medical staff, two processes are usually involved: initial appointment and the granting of initial clinical privileges. The former is the granting of a request from a physician to become a member of the organized medical staff under one or more of several possible categories. The criteria for appointment involve data that indicate that the candidate should generally be able to perform competently as a staff physician.

CLINICAL PRIVILEGES

A related but distinct process involves the defining and granting of specific pediatric privileges. Becoming a member of a medical staff does not denote the right of an individual to practice the entire spectrum of medicine and surgery in that hospital. To the contrary, the right to perform individual procedures or provide specific types of care must be requested by the prospective member, and it is the responsibility of the hospital medical staff and hospital governing board to assure that the physician meets a reasonable standard of competency in the requested areas of practice. Privileges should be granted on the basis of training, experience, judgment, and demonstrated clinical competence.

Recommendations for pediatric privileges commonly emanate from a pediatric departmental committee. It is necessary to have independent review of the recommendations by multidisciplinary, impartial, and influential groups such as the medical staff executive and credentials committees. The procedure for appointment to the medical staff and granting of pediatric privileges must be defined in the medical staff bylaws, rules, and regulations, and must be followed carefully. Final approval of actions in both areas lies with the governing body.

DOCUMENTATION OF COMPETENCE

In the JCAH guidelines it is stated: “Unless otherwise provided by law, only those physicians and dentists holding an appropriate license and offering evidence . . . adequate to assure the medical staff and governing body that any patient treated by them will receive optimal achievable quality of care (should) be eligible for medical staff member-
ship.” Evidence must reflect demonstrated current clinical competence and must be verified. Minimum documentation must include information relative to medical school and postgraduate training; professional experience; references from persons knowledgeable about the applicant’s competence and ethical character; and current licensure. The JCAH strongly recommends documentation of adverse malpractice action; challenges to licensure or registration; loss of medical organization membership; and loss of medical staff membership or privileges at another hospital. A statement regarding the nature of previous privileges in other hospitals, physical and mental health, and documentation of specialty board certification may be requested as well.

Causes for concern include high mobility, graduation from certain foreign medical schools, malpractice suits, and professional disciplinary actions. In some cases there may be need for extensive written documentation, and verification by telephone or other means. Documents can be falsified and vital information purposefully omitted by applicants. Inquiry into court records for malpractice and vital information purposefully omitted by applicants. In some cases there may be need for extensive written documentation, and verification by telephone or other means. Documents can be falsified and vital information purposefully omitted by applicants. Inquiry into court records for malpractice and clinical privileges have been denied on the basis of inappropriate practices. Courts have decided in favor of physicians who have sued hospitals when their appointments or clinical privileges have been denied on the basis of such inappropriate practices.

Privileges should not depend on any single criterion such as Board certification or membership in a specialty society. Physicians from various specialties may rightfully be allowed to treat the same diseases and perform the same procedures if they meet appropriate criteria. Jurisdictional disputes should be discouraged in favor of rational granting of privileges. Speciality Board qualification and certification may, however, serve as useful benchmarks in granting privileges.

Criteria should relate reasonably to standards of patient care or to the objectives and purposes of the institution. Several items beyond the scope of this paper have been reviewed elsewhere: exclusive arrangements between hospitals and physicians; exclusion of physicians on the basis of unavailable bed space or overabundance of certain specialists; moral, ethical, and behavioral considerations; and the relationship of privileging to antitrust laws.

SPECIFYING CLINICAL PRIVILEGES

There are several ways of specifying clinical privileges. A once popular method was the use of broad categories such as “surgery,” “medicine,” or “pediatrics,” without further defining a physician’s activity in that area. Such broad generalization is now considered too nonspecific to define a physician’s activities commensurate with his or her training and experience.

A horizontal and vertical approach to privileging has been described. For example, a physician may request privileges in a number of categories such as surgery, medicine, and pediatrics (or in certain subspecialties). Within each category, classifications are developed to reflect complexity of patient care.
Thus, the horizontal dimension reflects arenas of patient care activity, and the vertical dimension reflects the degree of skill involved.  

The list approach is the most commonly used method of defining degrees of skill. Physicians are presented a list of medical and surgical procedures and/or disease states and asked to indicate those in which they feel qualified. Although specific, the list approach may be exhaustive and difficult to manage. It is especially difficult for the surgical specialties to produce lists that are all-inclusive. The lists should be long enough to define clearly the scope of a practitioner's activities, but should not be so detailed as to result in hairsplitting.

Another method of defining degrees of skill is termed the level approach. It refines the list approach by outlining groups or levels of procedures or diseases based on progressive difficulty and complexity. For example, hematologic diseases might progress from level 1, exemplified by iron deficiency anemia, to level 4, exemplified by monocytic leukemia. A family physician or pediatrician might qualify for level 1, and a pediatrician who is Board certified in hematology/oncology might qualify for levels 1 through 4. Other disease groups might have similar levels. Practitioners would be free to request privileges at whichever level they feel qualified within each disease grouping, and they would perform certain procedures commensurate with performance at that particular level.

A variation of the level approach is to define levels or categories of physician competency rather than levels of disease. These categories may be based on special training or Board certification in specialties or subspecialties, or on equivalent experience. Appropriate levels of diseases or procedures to be handled by the practitioner are generated on the basis of level of training rather than vice versa.

Lastly, physicians have been granted privileges on the basis of whether the circumstance requires supervision or consultation. Methods that classify illnesses and/or procedures into groups allow flexibility and generalization that fixed lists do not; however, it has been suggested that a combination of the category and list approach may be the best method to delineate privileges. The JCAH allows considerable latitude in the type of method used for defining privileges. There is no requirement of a complicated “laundry list,” but the JCAH permits a listing of procedures or medical diseases as one possible alternative. Surveyor guidelines require evidence of “adequate documentation of previous training and experience, clinical privilege requests forms that at least identify the specialty areas designated by the specialty board, and documentation indicating an effort has been made to match expertise with clinical privileges to the extent that is practical for the individual hospital in view of its location, range of services, and the availability of medical manpower.” The medical staff bylaws may allow each staff member the privilege of performing emergency lifesaving procedures.

Useful and comprehensive reviews of the process for granting privileges have been published.

**REISSUANCE OF CLINICAL PRIVILEGES**

Periodic reappointment to the medical staff and review of privileges is a necessity in view of changing capabilities of practitioners (ordinarily not more than every two years). Reissuing of privileges may be done at any time a significant change in a physician's ability to practice medicine is noted. Renewal of privileges should be recognized by the entire medical staff as a continuing and necessary function applying to all members, and as subject to the same necessity for objectivity and fairness as the initial granting of privileges.

It is stated in the *Accreditation Manual for Hospitals* that

Reappointment policies shall provide for appraisal of each member of the staff at the time of reappointment. The appraisal shall include information relative to the individual's professional performance, judgment, and, when appropriate, technical skill. The appraisal shall also include consideration of the staff member's health status.

Appropriate factors for reappraisal of medical staff include continuing education; timely, accurate, and complete medical records; attendance at required staff and departmental meetings; service on hospital committees as requested; and patterns of care as demonstrated by hospital evaluations. Interchange of information regarding physician performance between hospital departments may be helpful.

Privileges may be expanded in the event of further training or clinical experience. Modification or rescinding of privileges may be indicated if the physician has repeated or significant deficiencies in particular areas identified on medical care evaluation studies, and if counseling or re-education has not been effective. The retrospective medical audit may also provide objective criteria to allow a dispassionate appraisal of the staff member's competence. It is common for practitioners to ask for modification of the requested privileges at the time of periodic review, in recognition of their own changing skills. Supervision by members of the medical staff of a number of clinical cases at the time of reissuance of privileges may be considered. Careful plans for renewal of privileges have been devised for physicians of retirement age.
DUE PROCESS

Should a hospital organization decide to deny staff appointment or reappointment, or deny, curtail, or suspend privileges, it is imperative that due process and equal protection, in accordance with customary legal principles and as defined, where appropriate, in the hospital medical staff bylaws, are provided. Two types of due process exist: substantive and procedural. Substantive due process is concerned with whether the rules and criteria stipulated in the bylaws are reasonable, fair, and not arbitrary, and whether the decisions made by a hospital medical staff or hearing panel are based on the weight of relevant and reliable evidence and only on that evidence which is presented to the medical staff or hearing panel. Procedural due process is concerned with whether such rules are properly administered and applied equally to all staff members. A formal appeals process must be available to each candidate. In view of increasing litigation in this area, consultation with an attorney may help to guarantee due process before the final action is taken.

GENERAL PRACTITIONERS, FAMILY PHYSICIANS, AND NONPEDIATRICIAN SPECIALISTS

Granting pediatric privileges to general practitioners, family physicians, and nonpediatrician specialists may impose dilemmas. Exposure to pediatrics in the various training programs is variable. It may be helpful to request a response from the training program of a nonpediatrician applicant regarding the appropriateness of his set of requested privileges. Some residency programs document residents' exposure to disease entities and procedures; this may be helpful. A statement from the applicant indicating his qualifications to perform each item on his checklist has been suggested as a requirement. In the case of an applicant who has had practice experience, responses by physicians with knowledge of the practitioner's capabilities are useful.

Limited pediatric privileges are commonly granted to nonpediatrician physicians through emergency room, family practice, surgery, and other departmental committees. The Committee on Hospital Care suggests that these privileges should be granted by the physician’s primary committee, but with the advice and consent of the pediatric committee (in departmentalized hospitals). All applicants should be subject to the same criteria and privilege granting process, including monitoring, regardless of the sponsoring committee.

NONPHYSICIAN HEALTH PROFESSIONALS

Pressure to grant hospital clinical privileges to nonphysician health professionals is increasing. Many such professionals are being trained to provide services previously provided only by physicians. The evolving status of hospital privileges for these groups has been reviewed. The responsibility of the hospital organization to allow only competent individuals to engage in hospital health care also extends to this category of practitioner.

It is stated in the Accreditation Manual for Hospitals of the JCAH:

The medical staff shall delineate in its bylaws, rules and regulations the qualifications, status, clinical duties, and responsibilities of specified professional personnel whose services require that they be processed through the usual medical staff channels. This should be performed in consultation with the chief executive officer on a categorical rather than an individual basis. The training, experience, and demonstrated current competence of individuals in such categories shall be sufficient to permit their performing the following: the exercising of judgment within their areas of competence, providing that a physician member of the medical staff shall have the ultimate responsibility for patient care; participating directly in the management of patients under the supervision or direction of a member of the medical staff; and within the limits established by the medical staff and consistent with the State Practice Acts, the writing of orders and the recording of reports and progress notes in patients' medical records.

Such practitioners may include house staff, physician’s assistants, nurse practitioners, nurse anesthetists, midwives, psychologists, doctoral scientists, and others.

The JCAH states that membership on the medical staff, subject to applicable state law, is limited to physicians and dentists. The nonphysician health professional should be accredited through the regular physician staff mechanism with final approval of the governing body. The extent of their final roles and functions should be recommended by the medical staff. The nonphysician health professional must comply with the hospital bylaws, rules, and regulations.

Individual nonphysician health professionals should be assigned to appropriate clinical departments and should be subject to departmental policies. It may be appropriate for the staff bylaws to provide for staff affiliate status. Continuous monitoring of the nonphysician health professional's hospital activity should be implemented as well as a mechanism for renewal of privileges.

SUMMARY

The initial statement and format suggested by the Hospital Care Committee of the American...
Academy of Pediatrics in 1973 has been used successfully in its present form or in modified form throughout the United States. It combines a list approach with a level of competence approach. We believe that its general format is still appropriate but constitutes only one of several alternatives available. The appendix provides an example of a current modification of the 1973 format. Most important is that the principles, as described in this article, are followed in order to protect the patient, hospital, and physician through the process of delineation of hospital privileges.

### ACKNOWLEDGMENT

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### APPENDIX: DELINEATION OF PEDIATRIC PRIVILEGES

Pediatric Privileges Requested by ______

<table>
<thead>
<tr>
<th>Board Qualified</th>
<th>Staff Category</th>
<th>Board Certified</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subspecialty Board Qualified or Certified</td>
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</tbody>
</table>

Please check all categories and privileges desired.

I. Pediatric Privileges (Privileges to perform emergency lifesaving procedures are automatically granted to all staff physicians):

- **Category 0**
  - Privileges usually granted a nonpediatrician specialty consultant who, in the opinion of the attending physician and Chief of Pediatrics, is capable of performing diagnostic consultation and/or specialty services urgently needed in the care of a critically ill patient or one with a diagnostic problem.

- **Category 1**
  - Illness or problem with no apparent serious threat to life. This category is usually granted to family physicians or internists.

- **Category 2**
  - Illness or problem requiring skills usually acquired after one year of pediatric training or its equivalent in experience.

- **Category 3**
  - Complex or severe illness or potentially life-threatening problems usually requiring skills acquired after pediatric training sufficient for Board eligibility/certification or its equivalent in experience.

- **Category 4**
  - Intensive care of children, including ventilatory care and advanced life support.

- **Category 5**
  - Illness or problem requiring expertise acquired only during subspecialty training or similar experience. Subspecialty practice: __________________________ (This category does not necessarily include all others. Please check other categories desired.)

II. Neonatal Care Privileges:

- **Class A**
- **Class B**
- **Class C**
- **Class D**

### IIIA. Surgical Procedures (Venipuncture, laceration repair, and incision and drainage of superficial abscesses are automatically permitted):

- Neonatal circumcision
- Peripheral arterial cut-down
- Myringotomy
- Peripheral venous cut-down
- Simple fracture and dislocations
- Exchange transfusion
- Intubation
- Umbilical catheterization
- Other: __________________________

### IIIIB. Diagnostic Procedures

- Proctoscopy
- Bladder tap
- Subdural tap
- Arthrocentesis
- Abdominal paracentesis
- Skin biopsy
- Thoracentesis
- Laryngoscopy
- Bone marrow aspiration
- Lumbar puncture
- Peripheral arterial puncture
- Other: __________________________

### IIIIC. Subspecialty Procedures

- Renal biopsy
- Tracheostomy
- Peritoneal dialysis
- Gastroscopy
- Hemodialysis
- Sigmoidoscopy
- Pericardiocentesis
- Cisternal puncture
- Cardiac catheterization
- Myelography
- Lung biopsy
- Pneumoencephalography
- Bone marrow biopsy
- Ventriculography
- Bronchoscopy
- Cerebral angiography
- Bronchography
- Intracranial pressure monitor placement
- Hepatic Biopsy
- Angiography
- Ventricular tap
- Lymphangiography
- Ventilatory care of neonates
- Chest tube insertion
- Vasoactive drug drip
- (non emergency)
- Endoscopy
- Other: __________________________

Date of Application __________________________

Signature of Applicant __________________________

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**AMERICAN ACADEMY OF PEDIATRICS 817**
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