Credentialling—myths, challenges and spirit

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This article was published on 15 Jul 2022 at www.hkmj.org.

Hong Kong Med J 2022;28:280–1
https://doi.org/10.12809/hkmj215132

In early 2022, the Hong Kong Academy of Medicine (the Academy) promulgated a credentialling mechanism for endovascular neurointervantional procedures.[1] The aim of credentialling is to provide formal accreditation of attainment of clinical competencies as a means to protect patients and maintain trust.[2] Taking into account the transdisciplinary nature of neuroendovascular treatment, the exercise is a joint effort by three Academy Colleges—the Hong Kong College of Physicians, the Hong Kong College of Radiologists, and The College of Surgeons of Hong Kong—and represents a key development in our collective effort to uphold professional standards.

The issue of credentialling was raised at the Academy in 2014 by Past President Prof CS Lau, who was Vice President (Education & Examinations) at that time. It was agreed that credentialling should focus on high-risk and complex procedures involving special skills and technologies that fall outside the curricula of specialist training. Neuroendovascular intervention meets these criteria, given the ongoing advancement in endovascular technologies, its potential impact on patient well-being, and the fact that specialist training focuses mainly on theoretical knowledge but not technical proficiency in this area. Post-fellowship credentialling thus serves to assure that an individual doctor is fit for providing such treatment through attaining and maintaining the requisite practical expertise and clinical experience.

Under the established mechanism, Fellows with recognised competencies in neuroendovascular intervention were vetted, and those meeting the required standard were exempted from the initial credentialling process in June 2022. After this so-called 'grandfathering' process, credentialled doctors would then be subject to 3-year cycles of continuous credentialling, alongside those who fulfil the requirement of initial credentialling in future. Failure to maintain continuous credentialling will lead to the removal of the credential, although the doctor concerned may apply for revalidation. The spirit of credentialling therefore moves away from the assumptions that all specialists in Neurology, Neurosurgery, or Radiology are competent at performing neuroendovascular interventions, or that previous attainment of competency automatically implies perpetual fitness-to-practice. It is a necessary and well-established approach to addressing an area of practice characterised by rapid development and a close correlation between practical experience and performance.

Credentialling is indicative rather than restrictive, in that it only indicates who possesses the required level of competency without restricting those who are not credentialled from practising in the designated area. Credentialing by and of itself does not guarantee or imply that the treatment given by the doctor in a particular instance is compliant with professional standards. The label carries no legal or regulatory mandate, and it is up to service providers, regulatory bodies, or the courts to make reference to an individual doctor's credentialling status, or the lack thereof, in granting privileges, licencing, or assessing standards of care. As the list of credentialled doctors is publicly accessible, it will empower patients, ever vulnerable to information asymmetry within the complex world of medical subspecialisation, to make the right decision.[3] Ultimately, the responsibility is on the doctor, and on those contracting or engaging the doctor's services, to ensure that they are indeed fit for providing the treatment.

Credentialling is supposed to add value to patient care and not to be undertaken for its own sake. A major challenge in devising the above mechanism concerns setting the appropriate case volume required for a doctor to obtain and maintain the credential. The disparate arrangement of endovascular services in Hong Kong is such that each centre cares for only a small number of patients, which limits the number of doctors eligible for credentialling. However, each centre will need an adequate number of credentialled specialists for optimal service provision. So, although a higher case volume requirement is better for quality, a balance must be struck against quantity. There might also be the tendency for some doctors, acting in good faith or otherwise, to stretch indications for intervention beyond what would be in patients' best interests so as to attain the required case volume. These two issues are necessarily evolving and will require regular review. Cross-college recognition of training and collaborations in rotational attachment, crucial for sustainability and quality assurrance, are currently under consideration.

Looking forward, there are other areas of practice that will conceivably benefit from credentialling, especially those that fall outside of or across recognised medical or dental specialties where oversight and regulation are weak or non-existent, and where patients are particularly vulnerable due to lack of information. To reach into these areas will entail a rethink of our framework of postgraduate training as well as extensive consultation with and considerable support from various stakeholders. It will not be a light challenge but is certainly one worth taking by the Academy and our Fellows for patients' benefits.

Author contributions

Both authors contributed to the editorial, approved the final version for publication, and take responsibility for its accuracy and integrity.

Conflicts of interest

Both authors have declared no conflict of interest.

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