

Primary Source Verification of Health Care Professionals:

A Risk Reduction Strategy for Patients and Health Care Organizations

A White Paper by Joint Commission International



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Foreword

Why is primary source verification of a health care professional's credentials so important? Not only does this crucial step in your process help protect your organization, but more important, it also protects your *patients*. We are all familiar with reports from around the globe about patients being harmed by care received from a health care provider whose credentials were obtained fraudulently. Is your organization willing to take this risk?

Protecting your patients and avoiding this risk are just some of the reasons your organization should commit to primary source verification. Trusting in your physicians' and other health care providers' skills and experience is also critical. This is

why Joint Commission International (JCI) accreditation—and some governments around the world—requires primary source verification, with numerous JCI standards specifically addressing the need to verify credentials from the primary source.

This white paper provides more information about the importance of primary source verification. It also clarifies JCI's standards addressing primary source verification, and it provides solutions on how your organization can perform this necessary step as part of your management processes.

JCI hopes you find this white paper informative and practical. We share your commitment to protecting your patients, your staff, and your organization.

Paula Wilson
President/CEO, Joint Commission International



In the American film “Catch Me If You Can” (2002), the confidence man Frank Abagnale poses as an emergency physician, among other professions, while he had the qualifications for none of them. The film depicts a true story. Indeed, many individuals around the world have posed as physicians, nurses, and other health care professionals. While fortunately most patients have suffered no long-term harm from their ministrations as far as we know, every now and then, there is a Dr. Jayant Patel (“Doctor Death,” as they called him in Australia) who was repeatedly proven in court to have been responsible for multiple patients’ deaths and suspected of many more.¹ Some of Dr. Patel’s professional education and background were real, but no one verified his U.S. licenses before he arrived in Australia.² In fact, he went to Australia because multiple U.S. states had revoked his license due to demonstrated incompetence.

Health care professionals are in short supply in several countries, and these countries therefore import professionals from elsewhere. But even in countries with adequate home-grown talent, the size and complexity of the educational and training systems make it easy for a determined fraudster to claim having been trained in an institution not familiar to prospective employers and health care organizations. These fraudsters can easily create documentation through modern technology to support their claimed credentials.

There is even a “solution” for the technologically challenged. In May 2015, police in Karachi, Pakistan, arrested Shoaib Ahmed Shaikh, owner and president of Axact, a company that was manufacturing diplomas from several dozen institutions that exist in name only. Since 1997, Axact provided fake diplomas to professionals and non-professionals throughout the world.³ A recent investigative report by *The New York Times* unearthed websites of 145 non-existent universities among other fake institutions from which Axact provided “credentials.”⁴ The problem of diploma mills has long attracted international attention, as evidenced by a special

publication on the subject by the UNESCO Council for Higher Education Accreditation.⁵

Yet another problem is that some medical schools and hospitals falsely claim to have qualified or accredited training programs. Reuters disclosed Indian government records showing that since 2010, at least 69 Indian medical colleges and teaching hospitals have been accused of such transgressions or other significant failings, including rigging entrance exams or accepting bribes to admit students.⁶ This raises a special challenge, because if a university actually acquires national accreditation through fraudulent means, that may be especially difficult to detect.

To prevent fraudulent representation of individuals’ qualifications and experience, health care organizations and those in other fields began verifying credentials from the “primary source,” that is, the university or other institution. The service of credentials verification grew out of background checks performed in a variety of industries for many decades. Many governments have also sought information about individuals’ backgrounds through the security clearance process. The health care professions were actually latecomers to this process, but by the late 1990s, the Joint Commission on Accreditation of Healthcare Organizations (the then-current name of The Joint Commission as well as the parent of Joint Commission International [JCI]) required primary source verification for “licensed independent practitioners,” meaning physicians and dentists who practiced in U.S. acute care hospitals.⁷ Soon thereafter, nurses’ credentials were subjected to the same requirement. JCI followed suit in its hospital accreditation standards.⁸ JCI’s requirement was later extended to ambulatory care⁹ and to other health care professionals in these settings.¹⁰

Absent such verification, the majority of honest applicants for a position cannot be distinguished from the small number of fraudulent ones. Just how big a problem can this be? In the mid-2000s, the Saudi Commission of Health Specialties

embarked on a thorough audit of health care professionals' credentials. It reviewed support documentation of a number of expatriate doctors, nurses, and other professionals, concentrating on documentation from selected sources. While the statistic cannot be extrapolated to all expatriates in the Kingdom of Saudi Arabia, more than 20% of documents submitted from these sources by individuals claiming to be physicians and other health care professionals proved unverifiable or outright false.¹¹ More recently, DataFlow, an international company specializing in primary source verification and background checks, found that since 2013, an average of 2.3% of credentials submitted by health care professional applicants could not be verified, but there has apparently been a surge of "negative" reports since early 2015 (see Figure 1, below).

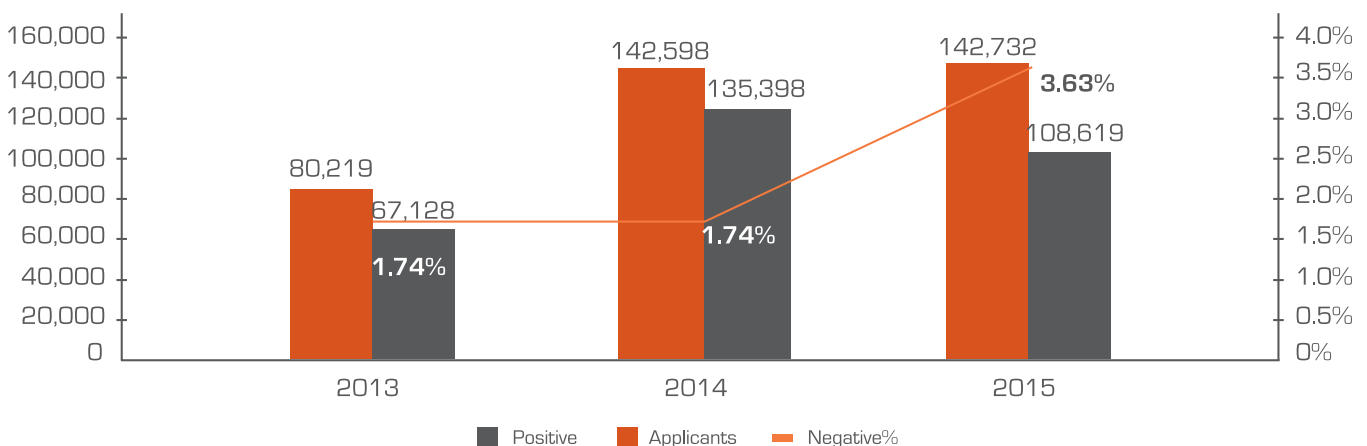
While the Middle East is a focus because of the large number of expatriate professionals, this phenomenon is by no means confined to that region. It was already mentioned that the most prominent hospital accrediting organization in North America, The Joint Commission, found it important to require verification of credentials in the late 20th century; in addition, case reports flow from Europe¹³ and South Asia,¹⁴ to name a few.

Statistics on this subject are difficult to come by. Health care institutions do not like to disclose adverse findings about their staff, fearing litigation or other consequences, while consultants are generally bound by non-disclosure agreements.

What does all this mean for patients and health care organizations? As the cited articles from the press emphasize, every anecdote that led to a publication about an unqualified

physician was triggered by adverse patient outcomes. Patients must rely on a health care organization's due diligence to ensure that staff members are qualified to attend to their health care needs. Patients do not have the knowledge to assess the competence of health care professionals. Thus, the responsibility rests squarely on the shoulders of hospital leaders, as determined by a U.S. court in 1980, when hospital managers attempted to evade their responsibility by claiming that doctors were "independent practitioners."¹⁵ But are hospital managers in any better position than patients to assess professional competence? One can argue that the answer is yes. After all, hospital managers have among them professionals in human resource management, whose training includes background checking. The responsibility cannot be transferred to others, such as government licensing bodies or medical or other professional societies.

However, we now have technology that can produce authoritative-looking facsimiles of official documents. Technology has upped the counterfeiter's game. As a recent analysis of currency counterfeiting noted, "The modern PC can now readily handle gigabyte-size images, more than enough storage for the captured image of an FRN [Federal Reserve Note, the currency of the U.S.A.] scanned at 4,000 pixels per inch."¹⁶ Diplomas and licenses are a great deal less complex than currency. What, then, must health care managers do in order to ensure that the doctors, nurses, pharmacists, and others on their staff are qualified to practice their profession? First, they have to develop criteria that an applicant must meet in order to be considered as a credible candidate for the position.



Annual Applicant Results 2013-2015

Figure 1. Applicants whose credentials were submitted to DataFlow within some of the GCC (Gulf Cooperation Council) countries between January 2013 and October 2015.¹²

It is not enough to examine the candidate's documentation, that is, documents attesting to graduation from professional schools, licenses or registrations issued by appropriate government authorities, and, where applicable, evidence of specialty or other special training (for example, surgery for physicians, intensive care competency for nurses, and so on). It is imperative to ensure that the documents submitted are indeed what the purported source issued—in other words, primary source verification.

CHALLENGES AND GAPS IN PRIMARY SOURCE VERIFICATION

Verifying credentials from the primary source is not a simple matter. Most managers' first reaction is that they must see the original documents (for example, diplomas, registration certificates, and so on). That by itself can be labor intensive, because most applicants are not likely to mail or ship those documents. They must be given time to bring the documents for inspection, after which they will want to reclaim the documents. Furthermore, in a number of countries that rely heavily on expatriate travel, health care managers feel pressured to delegate inspection of those original documents either to an agent, such as a recruiter, or to the diplomatic corps that issues the work visa to the applicant. The common thought is that the diplomatic corps would not have issued a work visa unless it looked at the original document. However, one of the authors of this paper has personal experience that work visas are not carefully vetted. When applying for a short-term work visa, instead of removing his original university diploma from its frame, he sent a not-very-professional-looking copy made on his home copying machine. The visa was issued, no questions asked. Surely, this is not the only situation in which diplomatic staff did not fully vet qualifications for a work visa.

In some instances, a notary's stamp on the document is accepted as evidence of verification. However, in most countries, notaries are not in position to do the actual verification, because that is not their role—they verify that an individual's signature is indeed his or hers, or that the person possessing the document is indeed the person named in the document. Even if a notary stamp is affixed to a diploma, it is possible that the notary stamp itself is fraudulent.

There is a widespread misunderstanding that original documents are equivalent to primary source. This may have to do with the fact that the widespread *use* of the English language in health care around the world is not accompanied by widespread perfect *understanding* of the language. This may be the case at all levels of health care management, even in countries such as the United States, where English is the primary lan-

guage. Nonetheless, health care management is a field that is practiced globally; many managers, just as doctors and nurses, tend to gravitate toward opportunities where rewards exceed those obtainable in their home countries.

Once it is understood that "primary source" or "original source" means the organization or government entity that issued the document which supports the credential claimed, there is still the opportunity to mistake a letter issued in verification of the document and carried by the applicant to be sufficient in this regard. It has to be very clearly stated that any communication from or with the original source that is through a person who is the applicant or his or her agent (such as a spouse or parent) is unacceptable as primary source verification.

Health care management is complex and time consuming. Verification of credentials adds more time spent away from hands-on management. This has caused many health care organizations to look outside themselves to accomplish the task. Credentials verification was originally undertaken in the U.S. by organizations that had been doing background checks for non-health care clients. Eventually, credentials verification organizations (CVOs) developed, many of them concentrating on health care, but others working with non-health care clients, the principal needs of the two types of clients being essentially the same.

During the same period that hospitals embarked on primary source verification, a number of governments concluded that the licensing process itself must protect its integrity and cannot simply rely on documentation submitted by applicants. Since these bodies were even less prepared to investigate the sources of documentation than a well-staffed hospital, some turned to professional and quasi-professional entities, such as the Saudi Commission already mentioned. Others retained the responsibility themselves but turned to one or another CVO for the actual task of researching the primary sources. One way or another, the job gets done. But does this work meet the needs of hospitals? That remains uncertain.

Governments investigating the backgrounds of physicians, nurses, and others seeking professional opportunities may have different goals than hospitals. Many governments simply wish to establish that the physician or nurse satisfactorily completed the professional education required by law for issuance of a license. In the case of expatriates, governments want to know whether they are licensed in their home countries. Others take a more nuanced approach, especially for physicians, and further designate the professionals by status (for example, "consultant," "specialist," "registrar," and so on). On the other hand, hospitals must be certain that the persons

they hire (including *locum tenens* physicians), or the independent physicians they allow to treat patients within their walls, have the requisite skills to perform within their environment. While the hospitals may not be interested in home-country licensing, this is all the same a higher degree of requirement, expressed in a variety of ways: hospital and medical staff by-laws, nursing and other professional policies, job descriptions, and so on. In short, what hospitals require from primary source verification and background checks for health care professionals is more stringent than those of governments.

Hospitals that choose to undergo international accreditation have yet another challenge in this sphere. Joint Commission International (JCI), the organization that accredits the largest number of hospitals worldwide, has explicit and detailed requirements for how documents have to be verified.¹⁷ Other accrediting bodies also address this topic. For example, “[T]he hospital has an effective process for gathering, verifying and evaluating the credentials (registration, education, training and experience) of those healthcare professionals who are permitted to provide patient care without supervision,” and “[t]he registration, education, training and experience of these individuals is verified from the original sources when possible.”¹⁸ Thus, it is frequently inevitable that primary source verification by governments and that required of hospitals do not coincide exactly.

The lack of congruence between government and hospital needs regarding primary source verification is a major cause of gaps in actual performance of primary source verification. Despite bylaws, policies, or accreditation standards to the contrary, health care managers, all of whom have inevitable budgetary constraints, often convince themselves that primary source verification done by or on behalf of government is reliable. And even then, relying on government verification is not so easy. For example, until recently, organizations that operated multiple hospitals in the United Arab Emirates had a further complicating factor; Emirati hospitals are subject to three different government oversight bodies: Health Authority of Abu Dhabi and Dubai Health Authority in those specific emirates, and the Federal Government for selected hospitals in Dubai and Abu Dhabi, as well as all hospitals in the other five, so-called “northern” emirates. This specific issue was resolved when the three authorities agreed in 2013 to set a common baseline for the required qualifications from health professionals (by profession) and engaged the same CVO to conduct primary source verification.

However, gaps exist in the performance of some CVOs. The biggest issue is usually a lack of transparency. Contracts between hospitals and CVOs sometimes create a black box-

like situation; the CVO receives the query and issues a report, but discourages going into details. Sometimes contracts even disclaim CVO responsibility for inaccurate reports. While this situation is by no means universal, where it exists, it creates a major barrier in the hospitals’ ability to satisfy international credentialing requirements, which demand transparency of the process.

Even if a CVO has disclosed its process and demonstrates true transparency at the time of the origin of the contractual relationship, the health care organization has to ensure that the CVO’s *modus operandi* does not change significantly over time. No organization is static in the way it conducts its business, so health care managers should periodically review how the CVO conducts primary source verification. Otherwise, the health care organization may not be able to claim fully reliable primary source verification.

Hospitals that do not contract with CVOs also may experience difficulty in dealing with the primary sources. Institutions in countries that have been affected by war (or civic upheaval) may not have access to records at all, due to destruction of facilities. Certain universities and training programs, particularly from certain countries in the Middle East and South Asia, may not be able to respond to requests for credentials verification because of war or upheaval. However, recently, many CVOs have been able to establish lines of communication with these degree- and certificate-granting entities and have had greater success in receiving answers to queries.

Another problem is dealing with expatriate staff members who present documents from countries with languages that are more “niche” (for example, Albanian, Uzbek, and so on). Once again, CVOs, with broad client base and necessarily broad outreach, are more likely to be able to close the gap by finding competent translators of documents and communications.

Another complicating factor is that hospitals may not know how to access information that may actually be in the public domain. A number of government entities (such as Thailand) and professional associations (for example, the American College of Physicians) maintain websites that may be accessed to glean such information, usually upon paying a modest fee. These websites may be used to establish the validity of the specific credential presented, since the information can be obtained without it passing through the control of the applicant. Care must be exercised, however, because while some professional associations require examinations or verified certifications before they admit candidates to membership, others simply accept self-declared competence and payment of a fee. Therefore, any organization relied upon for this information must be proven to require demonstrated

competence. Again, this knowledge is more likely to reside in an internationally-oriented CVO than in any single hospital.

A very special situation exists in the case of hospitals that form a chain or system and share medical staff with others in the chain. In situations such as this, credentials verified by one hospital, if accredited, may be accepted by the others in the chain. However, notwithstanding the fact of accreditation of the index organization, this sharing of information is acceptable only if the applicable standard(s) has (have) been fully met. This requirement may escape the attention of the medical managers and therefore a gap is created. Situations such as this seldom apply to nursing staff, since nurses are more likely working in a single location only.

Nonetheless, a different special situation arises if the hospital uses a staffing agency to complement its nursing or other professional workforce. The credentials of “contract nurses” and other nurses and professionals who are not permanent employees but serve at longer or shorter temporary intervals (for example, employees of independent physicians who practice at the hospital) must be verified from the original source, just as the credentials of *locum tenens* doctors. If the contracting agency asserts that it has performed this verification, it becomes the equivalent of a CVO and its process has to be able to withstand the hospital’s scrutiny. Without such transparency, the verification becomes the responsibility of the hospital, which it may once again contract to an actual CVO.

A final note of caution, especially applicable to physicians who travel to other organizations in order to acquire new skills: When a medical member presents a certification related to an advanced degree or advanced specialty training, the new credential should be immediately verified from the original source.¹⁹ This requirement for JCI accreditation may escape the attention of health care managers. In fact, even if a CVO has been contracted, this special verification may fall outside the scope of that contract, in which case the responsibility reverts to the hospital. This situation would also be applicable to nurses, pharmacists, therapists, and others.

JOINT COMMISSION INTERNATIONAL (JCI) STANDARDS FOR PRIMARY SOURCE VERIFICATION

JCI recognizes the importance of primary source verification, and has included standards supporting this into its accreditation manual. The requirement of primary source verification is found in the “Staff Qualifications and Education” chapter (SQE) of the 5th edition of the *JCI Accreditation Standards for Hospitals*. Primary source verification is also required for other JCI designations, such as ambulatory care, and will appear in a

different chapter in those standards manuals.

The primary source verification requirements make up the basis of several standards in the Hospital SQE chapter. For medical staff, standards SQE 9.1, 9.2 and SQE 12 reference the primary source verification requirement. For nursing staff, the requirement is included in SQE 13, and for other health care practitioners, the requirements are in SQE 15, and both refer to the parameters found in the intent of SQE.9.

The designation “medical staff” refers to all physicians, dentists, and other professionals who are licensed to practice without supervision. This includes all categories of medical staff, including those who are employed by the hospital and visiting, contract, honorary, or private community staff members. The term “visiting staff” includes those who are *locum tenens*, invited experts, and others who are allowed to provide patient care services temporarily. House officers, or junior doctors, who are no longer in training but are permitted by the hospital to practice independently, will also fall under the classification of medical staff. In countries where traditional medicine practitioners such as acupuncturists, chiropractors, and others are permitted to practice independently, these practitioners are also included in the designation of medical staff.

Independent practitioners who provide patient care services in the facilities of the hospital, but are not employees or members of the clinical staff, must also be credentialed and privileged in the same manner as other medical staff, which includes the primary source verification of credentials (GLD 6.2).

JCI requires certain credentials to be primary-source verified. These credentials include those such as medical school diplomas, specialty training or residency certificates, licenses to practice, registration with a medical or dental council, or any other credential required by law, regulation, or hospital policy, as well as an credentials issued by recognized education or professional entities as the basis for clinical privileges (SQE.9.1 ME 1 & 2).

Other verification, such as professional history, letters of recommendation, criminal background check, identification verification, immigration, and financial documents, are not required by JCI to be verified from the primary source, unless required by hospital policy. These verifications should be highly considered by the hospital, though, because they are best practices and can prevent a potentially harmful situation resulting from appointment of a practitioner who provided fraudulent credentials. Recalling the case of Dr. Jayant Patel, otherwise known as “Doctor Death,” the tragedy of those multiple patient deaths could have been averted if the hospitals had verified his U.S. licenses prior to his employment.

The term “nursing staff” includes all nurses employed by

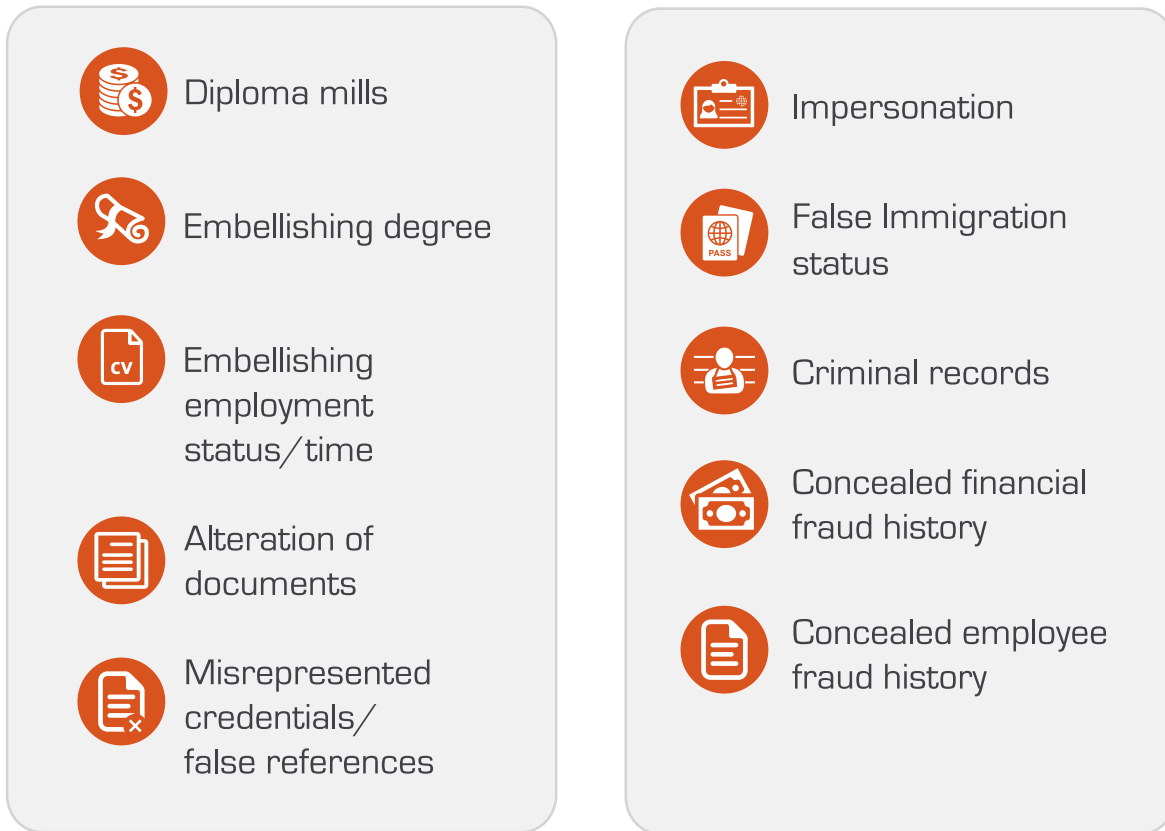


Figure 2. Sources of misrepresentation by some applicants.²⁰

or contracted to a hospital. Other health care practitioners include those such as pharmacists, pharmacy technicians, nurse midwives, surgical assistants, physical therapists, nutritionists, radiographers, laboratory technicians, perfusionists, respiratory therapists, or emergency medical care specialists. In some countries, practitioners such as those who provide services such as herbal medicine or acupuncture also fall under this category. Primary source verification applies only to those professionals who work or practice in the hospital.

During an initial JCI accreditation survey, primary source verification must be performed for all medical staff and nursing staff who joined the hospital within the 12 months prior to the survey. All other medical staff must have their primary source verification completed within 12 months of the initial survey. For other health care practitioners, primary source verification should be carried out for those practitioners who joined the hospital beginning 4 months prior to the initial accreditation survey, and then all practitioners must be verified through the original source in the next three years post-survey.

Primary source verification can be achieved through several

methods, including directly contacting the organization from which the credential was issued. This may be done through methods such as documenting a telephone conversation with the issuing source, or by facsimile, email, or letter. In this case, it would be important to ensure that the organization being contacted is a legitimate, accredited organization, since the rise in diploma mills and associated resume fraud deceptions (see Figure 2, above) poses an additional challenge during primary source verification.

In the case where a secure online database is available to determine the validity of the credentials, this is also acceptable. Some countries or government agencies may have a database that facilitates the retrieval of this information online. For example, Thailand has the government-regulated Medical Council of Thailand and primary-source verifies all physicians trained in Thailand prior to licensing, including their medical training and specialty training. The website allows one to look up the physician in question and contains the most recent licensing information, educational history and dates, and a photograph submitted from the university for further accuracy. Belgium has a similar government website

for primary source verification of physicians. The Japanese Ministry of Health and Social Welfare website has information about physicians and pharmacists, but not nurses.

In some cases, verification of credentials received from institutions outside the country may be challenging, and in some cases not even possible, such as in the event of loss of records in a disaster. There should be evidence of a credible effort to verify the credentials. A credible effort should constitute multiple (at least two within 60 days) attempts by the methods discussed above, with documentation of each attempt, as well as of the results.

Primary source verification may be accomplished by a third party, such as a government agency or a nongovernment agency (such as a CVO). When a third party is used for verification, JCI requires the hospital to verify that the third party implements the verification process as described in policy or regulations and that the process meets the expectations described in the intent of standard SQE.9.1 ME 3. This could include attaining a letter from the third party, detailing the procedure used for verification, or obtaining equivalent information on the third party's website. It is also important to confirm that the third party has verified all the required documents. For example, in the case of medical staff, this includes, at a minimum, verifying medical school education through to the most recent training.

There are three situations in which there is an acceptable substitute for a hospital performing primary source verification of credentials. The first is applicable to those hospitals directly overseen by government bodies. In this case, the government's verification process, supported by the availability of published government regulations about its method of primary source verification, can be acceptable. As before, this is dependent upon the hospital's own verification that the government verification process meets the expectations described in the JCI standards.

The second situation applies to those hospitals seeking primary source verification for a candidate who is currently affiliated with a hospital with current JCI accreditation, with full compliance on its verification process found in standard SQE.9.1, ME 1 and 2. Full compliance indicates that all the measurable elements are fully met, or that any not met or partially met measurable elements that were required to be addressed by a Strategic Improvement Plan (SIP) have been addressed and are now in full compliance.

The last situation is relevant in the case of an independent third-party verifier, such as a designated, official, government, or nongovernment agency. As previously mentioned, in the situation where a hospital uses a third-party verifier,

the hospital should have confidence in the completeness, accuracy, and timeliness of that information. In order to achieve this level of confidence, the hospital should initially evaluate the agency providing the information, as well as periodically thereafter, to ensure that JCI standards continue to be met.

Appointments of medical staff are not to be made until, at a minimum, the licensure or registration has been verified from the primary source. Until all credentials required by laws and regulations have been verified, the medical staff member should provide patient care services only under supervision (standard SQE.9.2 ME 2).

Primary source verification is considered complete following the above processes, unless the medical staff member has obtained subsequent credentials in the period following the initial appointment. In this case, the credentials must be verified from the primary source before use in modifying or adding to clinical privileges (standard SQE.12 ME 3). In addition, all practitioners' subsequent licenses must also be primary-source verified following renewal.

CONCLUSION

JCI recognizes the importance of primary source verification of practitioner credentials. Patients expect that the credentials held by their practitioners represent the experience, knowledge, and skills needed to provide quality patient care. A practitioner who does not possess the credentials required to provide appropriate patient care could cause harm to the patient, which could ultimately lead to serious risk management issues, negative publicity for the health care organization, as well as potential liability actions. Protecting the public is a top priority of health care organizations. While the process of primary source verification is not without its challenges, we hope that this white paper has detailed the necessity for primary source verification and the potential pitfalls, the JCI standards requirements, and solutions that health care organizations may use to successfully accomplish this critical endeavor.

References

1. Taylor, J: "Bundaberg surgeon Jayant Patel barred from ever practising medicine again in Australia." 14 May 2015. www.abc.net.au/news/2015-05-15/jayant-patel-barrd-from-practising-medicine-again-in-australia/6472234. Accessed 15 December 2015.
2. "Australia's 'Dr. Death' linked to 87 fatalities." 26 May 2005. www.nbcnews.com/id/7991906/ns/health-health_care/t/australia-s-dr-death-linked-fatalities/#.VnCbPkrLIU. Accessed 15 December 2015.
3. "FIA raids Axact's offices, computers confiscated." *Daily Pakistan Global* 19 May 2015. en.dailypakistan.com.pk/fia-raids-axacts-offices-seals-records-765. Accessed 2 Jan 2016.
4. Walsh, D: "Fake Diplomas, Real Cash: Pakistani Company Axact Reaps Millions." *The New York Times* 17 May 2015.
5. UNESCO Council for Higher Education Accreditation: "Toward Effective

- tive Practice: Discouraging Degree Mills in Higher Education.” 2009.
6. MacAskill A, Sacklow S, Miglani S (Reuters): “India’s medical schools are plagued with fraud.” 16 Jun 2015. www.businessinsider.com/indias-medical-schools-are-plagued-with-fraud-2015-6 Accessed 15 December 2015.
 7. Deutsch S, and Mobley CS: *The Credentialing Handbook*. Aspen, 1999, p. 27.
 8. *Joint Commission International Standards for Accreditation of Hospitals*, First Edition. Oak Brook, IL: Joint Commission Resources, 1998. Standards SQE.7 and SQE.10.
 9. *Joint Commission International Standards for Ambulatory Care*, First Edition. Oak Brook, IL: Joint Commission Resources, 2005. Standards SQE.7 and SQE.10.
 10. *Joint Commission International Standards for Accreditation of Hospitals*, Third Edition. Oak Brook, IL: Joint Commission Resources, 2007. Standard SQE.15.
 11. Al Hakeem M: “I don’t know how unqualified doctors get their certificates.” *Gulf News* (Dubai) 15 February 2007.
 12. *DataFlow Trend Report 2015*. “Document Quality of Medical Professionals in the GCC Region.”
 13. Papagallo, M: “Clona l’identità di un medico e lavora al proto soccorso.” *Corriere della Sera* 15 September 2010.
 14. Alvi, N: “Court wants action against quacks.” *Hindustan Times* 25 February 2007.
 15. *Johnson v. Misericordia Community Hospital*, 294 N.W. 2d Wis. Ct. App. 1980, quoted by Horty Springer & Mattern, P.C. 1998 in “Hospital-Medical Staff Relations” chapter of Seminar on Ethical Challenges of Physician Executives, American College of Physician Executives, Indian Wells, California, USA, October 2000.
 16. National Academy of Sciences: “Emerging Counterfeiting Technology Threats,” Chapter 3, in *A Path to the Next Generation of U.S. Banknotes: Keeping them Real*. National Academies Press, 2007. Downloaded 15 December 2015 from www.nap.edu/read/11874/chapter/5.
 17. *Joint Commission International Standards for Accreditation of Hospitals*, Fifth Edition. Oak Brook IL: Joint Commission Resources, 2013. Standards SQE. 9, SQE. 13, SQE 15.
 18. COHSASA (The Council for Health Services Accreditation in Southern Africa) Standards for Hospitals, Version 6.7, 2014. Standard 2.5.1 and Criterion 2.5.1.2
 19. *Joint Commission International Standards for Accreditation of Hospitals*, Fifth Edition. Oak Brook, IL: Joint Commission Resources, 2013. Intent of Standards SQE.9 through SQE.9.2.
 20. DataFlow.