SAINT JOSEPH HOSPITAL
DEPARTMENT OF SURGERY
RULES AND REGULATIONS
2023

1. ORGANIZATION:

The members of the Department of Surgery of St. Joseph Hospital shall be members in good standing of the Medical Staff who limit their practice to surgery and who are granted privileges on an individual basis commensurate with training, experience and demonstrated current competence. The Department of Surgery is comprised of the following specialties:

1.1 General Surgery
1.2 Neurosurgery
1.3 Oral and Maxillofacial Surgery and Dentistry
1.4 Pediatric Surgery
1.5 Plastic Surgery
1.6 Proctology
1.7 Thoracic and Cardiovascular Surgery
1.8 Urology
1.9 Vascular Surgery

2. MEETING FREQUENCY:

The Surgery Core Committee shall meet as often as necessary, but at least four (4) times a year.

3. QUALIFICATION FOR MEMBERSHIP:

3.1 The minimum requirement for membership is:

3.1.1 Certification by an American Specialty Board approved by The American Board of Medical Specialties or American Osteopathic Board of Surgery or comparably recognized Surgical Boards or,

3.1.2 Submission of evidence of satisfactory completion of an approved training program; and, a letter from the appropriate specialty board admitting the applicant to a qualifying examination.

3.2 Certification must be achieved within the time period designated by the specialty board and/or by the appropriate section of the Surgery Department.

3.3 The Surgery Department Chair (or the Vice Chair in the Chair's absence) will review the credentials of all physicians applying for privileges to the department. Each section Chair will be notified of any applicant applying for privileges in his/her Section prior to the Applicant's interview. The section Chair may request that the entire Section review the Applicant's credentials prior to making recommendation to the Surgery Chair.

3.4 REQUESTS FOR ADDITIONAL PRIVILEGES

Additional privileges requested by the Department members must be via written notice to the Section and Department of Surgery Chairs stating the privileges desired and accompanied by documentation of relevant training, course certification and experience to support the request.

4. PRIVILEGES AND PROCTORING:

4.1. CLASS I:

4.1.1 Class I surgeons are entitled to full or unlimited surgical privileges as requested and approved on his/her privilege sheet.

4.1.2 Class I surgeons are obligated to serve as a Proctor for a surgeon in Class IA category when requested or appointed by the chair of the department or his/her designee. Proctoring will include observation of the surgeon in the operating room and pre-op evaluation.

4.1.3 The Proctor will document findings on the form approved by the Surgery Committee.

5. CLASS IA:

5.1 This category applies to all applicants for a period of at least 6 months.

5.2 Class IA surgeons are required to use at least two (2) proctors for a total of three (3) cases of a satisfactory variety to be proctored in the operating room. If this proctoring is not satisfactory, the Surgery Committee may require additional cases proctored.

5.3 The Surgery Committee reserves the right to request additional proctoring of cases or chart review if the initial review is not satisfactory.

5.4 If a surgeon has been granted Temporary Privileges pending his/her appointment to the staff, the date temporary privileges were granted shall be used to calculate the six months period in surgical category IA.

5.5 A Class IA surgeons may be required to submit to the Surgery Committee, a statement regarding his/her current privilege status or any restriction/reduction of privileges from any hospital, state licensing agency or professional healthcare program.

5.6 If the Class IA surgeon fails to advance within twelve (12) months of initial appointment, he/she may automatically be terminated.

5.7 Specific qualifications for the Specialty Sections may be found in the appropriate Section Rules. In the absence of applicable rules, the general rules of the Department of Surgery will prevail.

6. SPECIAL PROCTORING REQUIREMENTS:

6.1 Class IA surgeons performing esophagoscopies, bronchoscopies and operative laryngoscopies must be observed on two (2) procedures and have approval by letter from their section chairman before being granted unrestricted privileges in those procedures.

7. THE PHYSICIAN SURGICAL ASSISTANT:

7.1 The surgeon is responsible to provide competent and qualified surgical assistance.

7.2 A physician shall not be qualified as an assistant based solely upon a referral or on his/her position as an intern or resident.

7.3 Anyone who assists in Surgery must be a member of the St. Joseph Hospital Medical Staff. When a visiting surgeon of special stature requests privileges to work in the Operating Room, the Chief of Surgery, or in his/her absence, the Section Chairman, may grant such privileges using the procedures set forth in the Medical Staff Bylaws (Temporary Privileges).

7.4 In special circumstances, it may be appropriate for a referring physician to scrub and observe a specific procedure. Such a privilege may be considered on a per case basis by the appropriate Section Chief at the request of the Operating Surgeon.

7.5 Medical Students, interns and residents from any approved university, limited to two for any one case, are permitted to scrub on surgical cases, under the direct supervision and with the specific approval of the operating surgeon. The operating surgeon must have Class I privileges and shall be responsible for such individuals. A medical student may not be utilized or identified as an assistant in such a situation.

7.6 Members of non-surgical departments of the Medical Staff must apply for assisting privileges. They will receive a favorable recommendation based on their previous experience and training in the surgical procedure for which they apply.

7.7 In case of life-threatening emergencies, any healthcare professional can assist in surgery.

8. EMERGENCY DEPARTMENT:

The Surgery Department shall be responsible for providing Emergency Department consultative coverage. The mechanism of coverage is to be established by the individual Section.

The following members are exempt from Mandatory Emergency Department Call Panel:

8.1 Members who have 20 years or more of service on the medical Staff
8.2 Members who served as Chief of Staff. Physicians who resign with 20 years tenure and reapply are not required to serve on the ED Call Panel.
8.3 Emergency Department call shall be mandatory for all neurosurgeons (Including Class IA). Exceptions to the rule are those members who have 20 years of service.

9. FAILURE TO PROVIDE APPROPRIATE COVERAGE:

9.1. Failure to provide appropriate coverage for in-house patients, and/or the Emergency Department, may result in disciplinary action against the practitioner.

10. DOCUMENTATION:

10.1. The Operating Surgeon must place a pre-op history and physical exam, consultation or note on the patient's chart prior to surgery. The case may not commence without the above.

11. REPRESENTATION ON THE SURGERY COMMITTEE:

11.1. The Surgery Department Committee shall include the Chairs of each Surgery Section, and the Operating Room Committee.

11.2. The selection of representatives to serve on the Surgery Committee will be accomplished in accordance with Section 13.

12. ELECTION OF CHAIRMAN AND VICE CHAIRMAN (Refer to the Medical Staff Bylaws Section 8.8 Article 8.5.2)
One of the two nominees for office will be from the section of General Surgery.

13. ADMINISTRATIVE FUNCTIONS:

Sections within the Department are formed to facilitate the administrative functions. In the event that the Section is unable to carry out its expected quality review and peer review functions, the Chairman of the Department may either assume the administrative responsibilities of that Section or delegate this responsibility to an Acting Chairman.

14. ABSENCE OF APPLICABLE RULES:

In the absence of applicable Section Rules, the general rules of the Department of Surgery will prevail.

15. REAPPOINTMENT:

15.1 In order to maintain surgical privileges within the Department of Surgery, the specific section rules will apply. Failure to maintain the criteria specified in the section rules may result in automatic termination of his/her surgical privileges.
(Approved 5/2017)

31. GENERAL SURGERY (reviewed 1/19/2022)

31.1. SCOPE OF GENERAL SURGERY:

Although the field of General Surgery overlaps that of other surgical specialties, the following comprise the major areas of General Surgery:

A. Abdominal Surgery
B. Bariatric Surgery
C. Cancer Surgery of the Skin, Breast, Soft Tissues and Lymphatic Systems.
D. Colon and Rectal Surgery
E. Endoscopic Image Guided Procedures
F. Endocrine Surgery
G. Head and Neck Surgery
H. Pediatric Surgery
I. Peripheral Vascular Surgery
J. Robotics

31.2 BOARD CERTIFICATION:

A. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) – or American Osteopathic Association (AOA)–accredited residency in general surgery. Current certification or active participation in the examination process with achievement of certification within 7 years leading to certification in general surgery by the American Board of Surgery, or the American Osteopathic Board of Surgery. Failure to become board certified by the above-mentioned boards within 7 years of completion of formal training will be deemed a voluntary withdrawal of clinical privileges.

B. Should a physician's Board Certification lapse at recertification time, the physician will have three (3) years to successfully pass the Board recertification process.

31.3. REAPPOINTMENT:

A. In order to maintain surgical privileges within the General Surgery Section, the physician must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience, have a

minimum of 10 surgical procedures performed at SJH or Outpatient Pavilion with acceptable results, reflective of the scope of privileges requested within the two-year reappointment period based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all surgeons for renewal of privileges. Failure to maintain this criteria will result in a voluntary withdrawal of his/her clinical privileges. Exceptions will be made for those physicians on a medical leave of absence.

A pediatric surgeon must have/show a minimum of 10 adult patient contacts for patients 17 years of age or older over the 2-year reappointment period in order to maintain adult privileges. These can be from CHOC and/or SJH**.**

B. **Wound Care Center:** In order to maintain surgical privileges within the General Surgery Section, the physician must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience, have a minimum of 10 patient contacts with acceptable results, reflective of the scope of privileges requested within the two-year reappointment period by providing a case log as evidence from the Wound Care Center and based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all surgeons for renewal of privileges. Failure to maintain this criteria will result in a voluntary withdrawal of his/her clinical privileges.

31.4. EMERGENCY ROOM:

Emergency Department Coverage will be mandatory for all surgeons with operating privileges except as delineated in the Medical Staff Clinical Rules & Regulations Section 9.

Exceptions to the above are as follows:

Pediatric Surgeons
Surgeons who limit their practice to Vascular Surgery only.

31.5 PROCTORING:

A. Class lA surgeons are required to use at least two (2) proctors for a total of three (3) cases of a satisfactory variety to be proctored in the operating room. If this proctoring is not satisfactory, the Surgery Committee may require additional cases proctored.

B. A Class IA surgeon must use a Class I first assistant surgeon in all procedures requiring an assistant.

C. The Surgery Committee reserves the right to request additional proctoring of cases or chart review if the initial review is not satisfactory.

E. A Class IA surgeon may be required to submit to the General Surgery Section and Surgery Committee, a statement regarding his/her current privilege status or any restriction/reduction of privileges from any hospital, state licensing agency or professional healthcare program.

F. If the Class IA surgeon fails to advance within twelve (12) months of initial appointment, he/she will be deemed a voluntary withdrawal of clinical privileges.

31.6 ADVANCEMENT OF LASER PRIVILEGES:

Two (2) satisfactorily proctored cases will be required prior to the advancement of Laser privileges.

31.7 CRITERIA FOR LAPAROSCOPIC PROCEDURES:

Surgeons requesting privileges for this procedure must be Members of the General Surgery Section. Laparoscopic privileges require that physician has either completed a residency program in which laparoscopic procedures were part of the training, or must have completed an acceptable course in a recognized facility, including significant hands-on experience, for the procedures being requested. Surgeons holding Class I privilege in interventional laparoscopic surgery or thoracoscopy may assist in interventional laparoscopy procedures.

Criteria for the granting of Basic and Advanced Laparoscopic Procedures are as follows:

Basic

Basic laparoscopic procedures are defined as Diagnostic Laparoscopy, Laparoscopic Cholecystectomy, and Laparoscopic Appendectomy.

An accepted basic course in Laparoscopic Cholecystectomy or documentation of training will be required prior to granting the basic privileges.

Proctoring for Basic Laparoscopy will be three (3) cases.

Advanced

Advanced laparoscopic procedures are defined as Laparoscopic Bowel Resection, Bariatric, inguinal/ventral herniorrhaphy, vagotomy, splenectomy, adrenalectomy, complex hepatobiliary and Laparoscopic Nissen Fundoplication, bariatric procedures, as well as procedures, which are considered experimental in nature and may lack literature to support its efficacy. To use the laser, the physician must hold privileges for that specific laser modality being utilized.

A physician must present either documentation of training, documentation of attendance at an approved advanced course or a preceptorship/case log acceptable to the General Surgery Section prior to being granted advanced procedures.

Proctoring for advanced procedures will be three (3) cases. These cases will be reviewed by the General Surgery Section before the physician can request advancement.

31.8 Robotics: Refer to separate criteria

31.9 Endoscopy Privileges: Refer to privilege form for criteria

32. ORAL AND MAXILLOFACIAL SURGERY

General Dentistry: To be eligible to apply for privileges in general dentistry, the initial applicant must meet the following criteria: Successful completion of an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation
OR
Successful completion of an approved foreign dental school and successful completion of a hospital based residency.

Required Previous Experience: Applicants for initial appointment must be able to demonstrate the performance of a sufficient volume of dental inpatient, outpatient, emergency service, or consultative procedures, reflective of the scope of privileges requested, in the past 24 months or successful completion of an accredited training program in the past 12 months.

Oral and Maxillofacial Surgery: as defined by the American Dental Association (ADA), the American Association of Oral and Maxillofacial Surgeons (AAOMS), and the American Board of Oral and Maxillofacial Surgery (ABOMS), is the specialty of dentistry that includes the diagnosis; surgical; and adjunctive treatment of diseases, injuries, and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

In order to be eligible to request clinical privileges for oral and maxillofacial surgery, an oral and maxillofacial surgeon must meet the following minimum threshold criteria.

1. Basic Education: DDS or DMD

2. Minimum Formal Training: The oral and maxillofacial surgeon must demonstrate the successful completion of an accredited residency training program in oral and maxillofacial surgery that includes training for procedures of the soft and hard tissues as well as history and physicals. The oral and maxillofacial surgeon must also demonstrate current professional competence and judgment, physical and mental health status, ability to work cooperatively with others and to deliver care at a generally recognized level of professional quality. Those surgeons without such training must demonstrate current competency by proof of training that includes both didactic and hands-on instruction.

3. Board Certification: Current certification or active participation in the examination process leading to certification in oral and maxillofacial surgery by the American Board of Oral and Maxillofacial Surgery. Effective August 1, 1996, any new member(s) to the Oral Surgery and Dental Section are required to obtain Board Certification within 6 years from the date of graduation from their Oral Surgery program. Failure to become board certified by the above-mentioned boards within 6 years of completion of formal training will be deemed a voluntary withdrawal of clinical privileges. If a physician's Board Certification lapses, he/she will have two years from the date of expiration to re-certify.

4. Required previous experience: The oral and maxillofacial surgeon must be able to demonstrate that he/she has performed major oral and maxillofacial surgery on a minimum of 50 patients in the past 2 years, no more than five of whom requires dentoalveolar surgery. For a major surgical case to be counted toward meeting this requirement, the oral and maxillofacial surgeon must have been the operating surgeon or have been supervised by a board certified oral and maxillofacial surgeon.

A. Class IA Oral and Maxillofacial Surgeon shall use as his/her observer a Class I Oral and Maxillofacial Surgeon selected from a list of proctors for the procedure being performed.

B. The first assistant for all Oral and Maxillofacial Surgery cases requiring an assistant must be

a fully trained Oral and Maxillofacial Surgeon, other surgical specialist or surgical resident.

C. Pre-requisite training in a graduated manner shall be required for TMJ Arthroscopies as follows:

1. Documented operative report of 5 or more arthroscopic procedures during residency OR documented operative reports of at least 20 TMJ Surgeries with at least 5 as the surgeon.

2. Recorded attendance at a registered course or symposium in TMJ Arthroscopy including cadaveric practical experience with arthroscopic surgery.

3. Documented observation of 3 clinically performed arthroscopic procedures.

D. Since there is not an active general dental staff presently at St. Joseph Hospital, all dental staff members shall be included in the Oral and Maxillofacial Surgery Section. This Section shall be called the Oral and Maxillofacial Surgery and Dentistry Section. It is understood that when and if the general dentists or other disciplines in dentistry feel it would be in their best interest to have a separate section, they may request to do so.

32.1 DEFINITION:

Dentistry is the diagnosis or treatment by surgery, or other methods, of diseases and lesions and the correction of malposed positions of human teeth, alveolar process, gums, jaws, or associated structures and such diagnosis or treatment may include the use of drugs, anesthetic agents and physical evaluation.

32.2 RESPONSIBILITIES:

The Oral and Maxillofacial Surgery and Dentistry Section are responsible for the quality of dental care and treatment in the hospital. The Section shall have the following duties:

Establishing the rules and regulations of the Section.

Recommendations to the Surgery Committee concerning those who request hospital Oral Surgery and Maxillofacial or dental privileges.

Constant analysis and review of the clinical work done in the hospital.

Support of hospital Bylaws, Rules and Regulations, and policies.

Maintenance of adequate records.

Handling necessary consultations.

Establishing a continuing educational program for staff members and paramedical personnel.

32.3. FUNCTIONAL AREAS:

A. **Administrative:** Conducting the affairs of the Oral and Maxillofacial Surgery and Dentistry Section in accordance with the administrative procedures of the hospital.

B. **Consultative:** Acting in a consultative capacity, through customary channels, on all

problems related to the dental health of the patient.

C. **Clinical:** Rendering professional services to the patients in accordance with the concepts of modern scientific dentistry and periodic evaluation of patient care.

D. **Educational:** Providing guidance for new dental staff members in consultations, problems relative to restorative and surgical procedures in the Operating Room, hospital records, and Operating Room decorum; participating actively in the educational program of the hospital; orienting the Medical Staff in the problems of oral health as they relate to the total health care of the patient; and providing an educational program for dental assistants, hospital technicians, and both student graduate nurses.

32.4 SERVICES RENDERED:

The Oral and Maxillofacial Surgery and Dentistry Section shall include such areas of dental practice as:

Pedodontics
Restorative dentistry
Periodontics
Oral and Maxillofacial Surgery
Prosthodontics
Endodontics
Orthodontics

32.5. SECTION ORGANIZATION:

The Chair of the Oral and Maxillofacial Surgery and Dentistry Section must be a Board Certified Oral and Maxillofacial Surgeon. His/her term of office is to be two years. The Chair shall call and preside at all meetings and shall be a member, ex-officio, of all section committees.

32.6. MEETINGS:

A. The Section Chair may call a meeting as he/she deems necessary.

32.7. PRIVILEGES:

The privileges of the Oral and Maxillofacial Surgery and Dentistry Section shall consist of General Dentistry and Oral and Maxillofacial Surgery.

A. <u>General Dental Privileges:</u>
Shall include operative dentistry, crown and bridge, endodontia (including apicoectomy), periodontia, minor orthodontia, biopsy of oral tissues and extraction of erupted teeth (including alveoplasty).

B. <u>Oral and Maxillofacial Surgery Privileges:</u>
Unlimited Oral and Maxillofacial Surgery Privileges: These privileges shall be granted by the Surgery Committee, as stated in their Rules and Regulations.

Limited Oral and Maxillofacial Surgery Privileges: A dentist in this group

must demonstrate competency, either by training or experience, in the procedures he wishes to perform. He shall be observed and evaluated by members of the staff with UNLIMITED ORAL AND MAXILLOFACIAL SURGERY PRIVILEGES.

An Oral and Maxillofacial Surgeon who has graduated from an ADA certified program in the United States, has received sufficient training to perform history and physicals.

The following procedures may be performed:

1. Removal of impacted teeth
2. Removal of cysts of the jaws
3. Secondary repair of oroantal fistula
4. Caldwell-luc approach for teeth or tooth fragments in the maxillary antrum
5. Incision and drainage of abscesses of dental origin
6. Removal of exostosed (palatal or mandibular tori)
7. Other oral surgical procedures as itemized and approved

Laser Privileges: Laser privileges will be considered on an individual basis for each type of laser requested. The physician must show documentation of training and be proctored on two cases for each type of laser he/she is requesting privileges for.

32.9. <u>PROCTORING / FOCUSED PROFESSIONAL PRACTICE EVALUATION REQUIREMENTS</u> ADVANCEMENT OF PRIVILEGES:

A. Each member of the Dental Staff must be observed on a minimum of three (3) general dental cases. He/She shall also be required to be observed by a member of the staff with Class I general dental or Oral and Maxillofacial Surgery privileges until such time as his/her competency and qualifications are established. The advancement of privileges shall be recommended by the Oral and Maxillofacial Surgery and Dentistry Section to the Surgery Committee for their approval and then forwarded to the Executive Committee.

B. Class IA Oral and Maxillofacial Surgeon are required to use at least two (2) proctors for a total of three (3) cases of a satisfactory variety to be proctored in the operating room. If this proctoring is not satisfactory, the Oral and Maxillofacial Surgery Committee may require additional cases proctored.

C. The Surgery Committee reserves the right to request additional proctoring of cases or chart review if the initial review is not satisfactory.

D. Temporary privileges may be granted only in accordance with the Medical Staff Bylaws.

E. A Class IA surgeon may be required to submit to the Surgery Committee, a statement regarding his/her current privilege status or any

restriction/reduction of privileges from any hospital, state licensing agency or professional healthcare program.

F. If the Class IA surgeon fails to advance within twelve (12) months of initial appointment, he/she may automatically be terminated.

G. The proctor can use his/her discretion in deciding how much of the procedure needs to be observed in order to make a proper judgment as to the proctoree's capabilities or competence.

32.10. ADMISSIONS:

The dentist shall admit, make dental diagnosis, prescribe preoperative medication, post-operative care related to dental treatment and discharge the patient. The physician shall complete the physical examination, history, medical orders, records and be responsible for any medical problems during the course of hospitalization.

- Records shall be kept of all dental work performed. All procedures shall be fully described.
- All tissues excluding extracted teeth shall be submitted to the Pathologist for examination.

32.11. EMERGENCY DEPARTMENT COVERAGE:

A. Emergency Department call is mandatory for all Class I and Class IA Oral and Maxillofacial Surgeons.

(Reviewed/Approved 2/27/08, 2/26/09, 4/2010, 2011, OMS 11/2019, Surgery 1/2020, MEC 11/2020, BOT 11/2020)

33. PLASTIC SURGERY

33.1 Membership – The plastic surgery section chair shall serve as the Plastic Surgery Committee Chair. All members of the Plastic Surgery section shall be members of the Plastic Surgery section.

33.2 BOARD CERTIFICATION:

A. Eligibility for membership in the Plastic Surgery Section will be successful completion of an Accreditation Council for Graduate Medical Education (ACGME or Board Certified by the American Board of Plastic Surgery or American Osteopathic Board of Plastic Surgery, or current active participation in the examination process leading to certification. Failure to become board certified by the above-mentioned boards within 5 years of completion of formal training will be deemed a voluntary withdrawal of clinical privileges. If a physician's Board Certification lapses, he/she will have three (3) years from the date of expiration to re-certify.

33.3. LASER CRITERIA:

A. LASER COURSE:

Laser Physics
Laser Safety
Clinical Use
Hands-on Practical Course

B. PRACTICE:

Proctoring of first two (2) cases in each type of Class IA laser privileges.

If a physician has privileges for C02 and Yag Laser, they are automatically granted privileges for Candela laser once they have provided documentation of appropriate training for use of the Candela Laser.

33.4. SECTION MEETINGS:

A. The Section Chair may call a meeting as he/she deems necessary.

33.4. EMERGENCY DEPARTMENT CALL:

A. Emergency Department call is mandatory for Class I and Class IA Plastic Surgeons.

33.5. PROCTORING/ONGOING/FOCUSED PROFESSIONAL PRACTICE EVALUATION:

A. Class IA Plastic Surgeons are required to use at least two (2) proctors for a total of three (3) cases of a satisfactory variety to be proctored in the operating room. If this proctoring is not satisfactory, the Plastic Surgery Committee may require additional cases proctored.

B. A Class IA Plastic surgeon must use a Class I first assistant surgeon in all procedures requiring an assistant.

C. The Surgery Committee reserves the right to request additional proctoring of cases or chart review if the initial review is not satisfactory.

D. If a surgeon has been granted Temporary Privileges pending his/her appointment to the staff, the date temporary privileges were granted shall be used to calculate the six-month period in surgical category IA.

E. A Class IA surgeon may be required to submit to the Surgery Committee, a statement regarding his/her current privilege status or any restriction/reduction of privileges from any hospital, state licensing agency or professional healthcare program.

F. If the Class IA surgeon fails to advance within twelve (12) months of initial appointment, he/she may automatically be terminated.

G. A proctor may leave during a case at his/her discretion as appropriate for the procedure being performed.

33.7. ENDOSCOPIC SURGERY:

In order to obtain privileges for Endoscopy procedures within the Plastic Surgery Section, the applicant must:

1. Provide documentation of being fully trained in Endoscopic procedures during a residency or fellowship program, or

2. Applicants who have not been fully trained in Endoscopic procedures during their residency or fellowship programs must have:

   a. Approved privileges of comparable open procedures in plastic surgery.
   b. Provide documentation of successful completion of a training course that includes hands-on bioskills, laboratory incorporating cadaver dissection with basic instrumentation and video monitor technique. The course should be approved for at least 12 hours of AMA Category I CME Credit.

   Those physicians requesting Endoscopy privileges who have Class I Plastic Surgery privileges will be granted Class I Endoscopy privileges. Class IA applicants will receive Class IA Endoscopy privileges.

3. Periodic review of plastic surgical procedures performed with Endoscopic technique will be included in the hospital Quality Assurance review process.

33.8. ULTRASOUND ASSISTED LIPOPLASTY PRIVILEGES:

A physician will be granted Class I Ultrasound-Assisted Lipoplasty if they provide documentation of training and have Class I Suction Assisted Lipectomy Surgical privileges.

A. **THORACIC AND CARDIOVASCULAR SURGERY**

Qualifications: Based on the California Reporting Guidelines to qualify for privileges in Thoracic Surgery an applicant must fulfill the following:

1. For applicants with established practices:
   a. Minimum of 24 CABG and 6 other additional cardiac open cases in the past 12 months
   b. Documentation of >than 90% internal mammary artery (IMA) usage when appropriate (last 24 cases)
   c. Outcomes/Expected mortality rate of <1.5 from California Society of Thoracic Surgery data (if out of state applicant, similar data from their state if available, or documentation of outcomes for the last 100 cases from hospitals where the procedures were preformed)
   d. Letter of recommendation from both the Chief of Cardiothoracic Surgery and Chief of Cardiology from each hospital practiced within the past 3 years.

Note: No changes for applicants just completing training.

34.1 PROCTORING REQUIREMENTS:

A. **Thoracic Surgery Privileges:** A total of ten (10) cases of a satisfactory variety to be proctored in the operating room. Class IA physicians must be proctored by a physician who holds Class I in the same procedure being proctored. If this proctoring is not satisfactory, the Thoracic Surgery Committee may require additional cases proctored.

1. Assisting Privileges Only: Physicians who apply only for Assisting Privileges in Thoracic Surgery must be board certified or board eligible in Thoracic Surgery, and must submit documentation of six (6) cases in which they have assisted in the prior two years, including the outcome of the case. In order to maintain privileges, they must assist on at least two (2) cases per year at Saint Joseph Hospital. Physicians who have Assisting Privileges only must submit evidence of attending five hours of continuing medical education related to the specialty every two years.

B. **Cardiovascular Surgery Privileges:** A total of ten (10) cases of a satisfactory variety to be proctored in the operating room. Class IA physicians must be proctored by a physician who holds Class I in the same procedure being proctored. If this proctoring is not satisfactory, the Thoracic Surgery Committee may require additional cases proctored.

1. Assisting Privileges Only: Physicians who apply only for Assisting Privileges in Cardiovascular Surgery must be board certified or board eligible in Cardiovascular Surgery, and must submit documentation of six (6) cases in which they have assisted in the prior two years, including the outcome of the case. In order to maintain privileges, they must assist on at least two (2) cases per year at Saint Joseph Hospital. Physicians who have Assisting Privileges only must submit evidence of attending five hours of continuing medical education related to the specialty every two years. Physicians who are granted Assisting Privileges only will be appointed to the Affiliate Staff.

C. Before being advanced to Class I, the Class IA surgeon must have performed and had reviewed a minimum of twelve (12) surgical cases.

D. The Surgery Committee reserves the right to request additional proctoring of cases or chart review if the initial review is not satisfactory.

E. If a surgeon has been granted Temporary Privileges pending his/her appointment to the staff, the date temporary privileges were granted shall be used to calculate the six-month period in surgical category IA.

F. A Class IA surgeon may be required to submit to the Surgery Committee, a

statement regarding his/her current privilege status or any restriction/reduction of privileges from any hospital, state licensing agency or professional healthcare program.

G. If the Class IA surgeon fails to advance within twenty-four (24) months of initial appointment, he/she may automatically be terminated.

34.2. THORACOSCOPY PRIVILEGES:

A. Requirements for obtaining privileges in Thoracoscopic Surgery are attendance and certification at an approved course. Physicians presenting these credentials will be granted Class I privileges.

34.3. BOARD CERTIFICATION:

A. Members of the Department of Surgery, Thoracic Surgery Section must become Board certified within five (5) years of staff appointment to the St. Joseph Hospital Medical Staff. Failure to become board certified by the above-mentioned boards within 6 years of completion of formal training will be deemed a voluntary withdrawal of clinical privileges.

B. Those members of the Thoracic Surgery Section which hold Affiliate Staff privileges will not be held to the Board Certification requirements as noted in Section 31.2 A of these rules and regulations.

34.4. EMERGENCY DEPARTMENT CALL

A. Emergency Department call is voluntary for Class I Thoracic Surgeons.

34.5. MEETING SCHEDULE

A. The Thoracic Surgery Section will meet on an as needed basis. The Thoracic Surgery Section chair may call a meeting as he/she deems necessary.

35. UROLOGY

A. REQUIREMENTS, CONDITIONS AND CATEGORIES:

QUALIFICATIONS

To qualify for privileges in urology surgery, an applicant should fulfill the following criteria:

Successful completion of an ACGME or AOA accredited Residency/Fellowship approved residency in urology and demonstrated acceptable practice in the privileges being requested for the last two (2) years;

Board certification with the American Board of Urology, Osteopathic Board of Urology or comparably recognized Urological Boards, or current active participation in the examination process leading to certification in, urology. Failure to become board certified by the above-mentioned boards within 6 years of completion of formal training will be deemed a voluntary withdrawal of clinical privileges.

Level 1 Current demonstrated competence and an adequate volume of current experience, with acceptable results. A minimum of six (6) cases will be required in this category of minor or endoscopic cases to maintain all Level 1 privileges.

If the required cases have not been performed at this facility, you may be asked to present a list of cases; including outcomes and operative reports with discharge summaries from their primary hospital (s) over the year period of time to support the specific clinical privileges requested. Such documentation shall be used in the consideration of continued clinical privileges or modification thereof.

Level 2 Meets all requirements for Level 1 clinical privileges: and,

Current demonstrated competence and an adequate volume of current experience, with acceptable results. A minimum of six (6) cases will be required in this category of more advanced clinical procedures in order to maintain these Level 2 privileges.

If the required cases have not been performed at this facility you may be asked to present a list of cases; including outcomes and operative reports with discharge summaries from their primary hospital (s) over the two-year period of time to support the specific clinical privileges requested. Such documentation shall be used in the consideration of continued clinical privileges or modification thereof.

Level 3 Special Procedures – Demonstration of evidence of specific experience during residency training and/or a certificate of training from an approved hands-on post-residency course and observation on the designated number of procedures as determined by the Section of Urology, and,

Current demonstrated competence and an adequate volume of current experience, with acceptable results. A minimum of two (2) cases, with each group (Urologic Laser Procedures, Laparoscopic Urologic Surgery, Extracorporeal Shock Waves Lithotripsy Procedures, and Renovascular Procedures) will be required in order to maintain clinical privileges in Level 3

If the required cases have not been performed at this facility, you may be asked to present a list of cases, including outcomes and operative reports with discharge summaries from their primary hospital (s) over the two-year period of time to support the specific clinical privileges requested. Such documentation shall be used in the consideration of continued clinical privileges or modification thereof.

B. Class IA Urologists must be observed on two (2) cystoscopies by a Class I

Urologists and have approval by letter from their Section Chairman before being granted unrestricted privileges in this diagnostic procedure.

C. Any Urologist requesting endourological privileges must receive those privileges from the Surgery Committee. The following criteria must be met:

a. Must complete a certified hands-on course four or more days or submit documentation of training from the Chief of residency program.

b. If a surgeon is planning to operate radiology equipment solo, he must have a certified operating license.

D. Physicians requesting Laser privileges must complete a certified hands-on course for two (2) or more days or provide documentation of training from their Chief of Residency.

If the physician requesting privileges have Class I privileges, then, upon approval, Class I Laser privileges will be granted.

Applicants, who are Class IA, must have two (2) cases of each type of laser proctored prior to advancement in this privilege.

Once a physician has been granted laser privileges that will include all types of laser once documentation of training is provided for their file.

E. Physicians requesting Transperineal Prostate Brachytherapy: Needle Insertion privileges must complete a certified hands-on course for two (2) or more days, or provide documentation of training from their Chief of Residency.

35.1. PROCTORING:

A. Class IA surgeons are required to use at least two (2) proctors for a total of three (3) cases of a satisfactory variety to be proctored in the operating room. If this proctoring is not satisfactory, the Surgery Committee may require additional cases proctored.

B. A Class IA surgeon must use a Class I first assistant surgeon in all procedures requiring an assistant.

C. Before being advanced to Class I, the Class IA surgeon must have performed and had reviewed a minimum of ten (10) surgical cases. If the Class IA physician is advanced to Class I status prior to end of his/her six months initial appointment period, he/she will remain Associate Class I.

D. The Surgery Committee reserves the right to request additional proctoring of cases or chart review if the initial review is not satisfactory.

E. If the Class IA surgeon fails to advance within twelve (12) months of initial appointment, he/she may automatically be voluntarily resigned.

F. A Class IA surgeon may be required to submit to the Surgery Committee, a statement regarding his/her current privilege status or any restriction/reduction of privileges from any hospital, state licensing agency or professional healthcare program.

35.2 Robotics:

Criteria for Privileges:
- Laparoscopic privileges in specialty
- Must provide documentation of robotic training at a residency or fellowship training program and must provide documentation of scope of training (case log) from residency or fellowship training program, to include the name of procedure and total numbers performed by the applicant during the program. A letter from the residency or fellowship program director attesting to competency for Robotic privileges is also required or Intuitive Robotics course certificate of completion
- 2 complete dry runs in OR when return from training
- 2 case observations in a facility that does these cases

Proctor Requirements:
- The proctor must have privileges to act as a robotics proctor
- If the proctor will assist, must be licensed in the State of California
- Must have robotic clinical experience and privileges at their primary facility

Proctoring Requirements:
- Proctoring must be done on the first two Robotic cases
  If the proctor will assist, must be licensed in the State of California and must have robotic clinical experience and privileges at their primary facility
- Intuitive must be present in the OR for the first two cases for technical direction and support
- Adverse or unexpected outcomes will be reported through SJO's RL Solutions website, and possibly reviewed by the Physician Quality Review Board (PQRB)
- Additional cases may be required based on outcomes
- Must have a laparoscopic trained assistant (i.e., surgeon, PA, RNFA, or NP with RNFA certification)

Reappointment Criteria:
To maintain robotic skills and expertise, robotic trained and privileged physicians are required to complete the following for reappointment in robotic surgery:
1) To maintain robotic privileges, physician must demonstrate twelve (12) robotic cases within the past two-years
2) If the physician holds robotic privileges and performs robotic cases at another facility, documentation from that hospital will be accepted

35.3. TRANSPLANT SURGERY PRIVILEGE REQUIREMENTS:

A. <u>Transplant Initial Applicant Qualifications</u>

The applicant must meet UNOS criteria to be a UNOS approved Transplant Surgeon for

Renal Transplant and have demonstrated satisfactory outcomes. Applicants must be Board Certified or Board Eligible by the American Board of Surgery, the American Board of Urology, the American Board of Osteopathic Surgery, or their foreign equivalent, or current active participation in the examination process leading to certification. Board certification must be obtained within six (6) years of completion of formal training. Failure to become board certified by the above-mentioned boards within six (6) years of completion of formal training will be deemed a voluntary withdrawal of clinical privileges. Should a physician's board certification lapse at recertification time, the physician will have two (2) years to successfully pass the board recertification process.

In addition, Renal Transplant applicants must meet one of the following criteria:

1. Completion of a two-year transplant surgery fellowship fulfilling criteria for transplant surgeon designation as established by OPTN/UNOS. Documentation of training must be verified by the Program or Medical Director of the training program. OR
2. Documentation of performance of a minimum of 20 pancreas transplant procedures at a OPTN/UNOS approved program or its foreign equivalent over a minimum of two years and maximum of five years. Documentation of clinical experience must be verified by the program director, division chief or department chair from the OPTN/UNOS-approved program.

New applicants must act in accordance with St. Joseph Hospital Renal Transplant Center policies and procedures and are required to be proctored for a total of two (2) renal transplants. If proctoring is not satisfactory, the Surgery Committee may require additional cases proctored.

Transplant Surgery Renewal of Privileges/Reappointment

To maintain Renal Transplant Surgery privileges, surgeon must demonstrate two (2) cases in the past two years with satisfactory outcomes.

B. Pancreas Transplant Initial Applicant Qualifications

The applicant must meet UNOS criteria to be a UNOS approved Transplant Surgeon for Pancreas Transplant and have demonstrated satisfactory outcomes. Applicants must be Board Certified or Board Eligible by the American Board of Surgery, the American Board of Urology, the American Board of Osteopathic Surgery, or their foreign equivalent, or current active participation in the examination process leading to certification. Board certification must be obtained within six (6) years of completion of formal training. Failure to become board certified by the above-mentioned boards within six (6) years of completion of formal training will be deemed a voluntary withdrawal of clinical privileges. Should a physician's board certification lapse at recertification time, the physician will have two (2) years to successfully pass the board recertification process.

In addition, Pancreas Transplant applicants must meet one of the following criteria:

1. Completion of a two-year transplant surgery fellowship fulfilling criteria for

transplant surgeon designation as established by OPTN/UNOS. Documentation of training must be verified by the Program or Medical Director of the training program. OR

2. Documentation of performance of a minimum of 20 pancreas transplant procedures at a OPTN/UNOS approved program or its foreign equivalent over a minimum of two years and maximum of five years. Documentation of clinical experience must be verified by the program director, division chief or department chair from the OPTN/UNOS-approved program.

New applicants must act in accordance with St. Joseph Hospital Transplant Center policies and procedures and are required to be proctored for a total of two (2) pancreas transplants. If proctoring is not satisfactory, the Surgery Committee may require additional cases proctored.

C. **Pancreas Transplant Surgery Renewal of Privileges/Reappointment**

To maintain Pancreas Transplant Surgery privileges, surgeon must demonstrate two (2) cases in the past two years with satisfactory outcomes.

D. Definitions

I. "Primary Transplant Surgeon"
UNOS designated Transplant Surgeon who is responsible for performance of transplant surgery at a given program.

II. "Satisfactory Performance/Outcomes"
(Derived from Centers of Medicare and Medicaid Services Conditions of participation for transplant programs)
Deaths and graft failures do not exceed 1.5 times the expected deaths or graft failures. The most recent Scientific Registry of Transplant Recipient (SRTR) data from the applicant's primary program may be used.

OR

If the applicant believes the primary program data is not representative of his/her outcomes then he/she may submit two-years of his/her consecutive patient information with one full year of follow-up including:

- patient name
- UNOS ID number
- outcomes at one-year
- operative reports, and
- discharge summaries

~~If the applicant believes his/her most recent primary program or personal outcomes are not representative or lack statistical significance, he/she may submit data for the prior five (5) years or one-hundred (100) consecutive transplants. Applicants will be required to consent to release SRTR data for application/reappointment renewal is requested.~~

35.4. LITHOTRIPSY PRIVILEGES:

Requirements:

1. Provide evidence of a certified fluoroscopy operating license.
2. Provide evidence of current certification of competence in performing lithotripsy and treatment of the complications thereof.
3. Document performance or observance of four (4) procedures on the Lithostar, at this or any other Lithostar site.
4. If no prior experience on lithotripter can be documented, applicant must observe ten (10) cases done on the Lithostar and participate in didactic instruction by an approved ALS instructor.

35.5 LAPAROSCOPIC UROLOGICAL SURGERY

Urologic surgeons requesting privileges for this procedure must be members of the Urology Section. Laparoscopic urological privileges require that physician has either completed a residency program in which laparoscopic procedures were part of the training, or must have completed an acceptable course in a recognized facility, including significant hands-on experience, for the procedures being requested.

1) Laparoscopic urological privileges includes procedures such as nephrectomy, adrenalectomy and radical prostatectomy.

2) Urologist will be proctored by a laparoscopic surgeon on three (3) cases of laparoscopic urological procedures before being considered for advancement to Class I privileges.

3) Urologist must attain Class I Urological privileges in order to be considered for advancement of Laparoscopic Urological Surgery privileges.

4) Assisting in Laparoscopic Surgery is limited to physicians with Class I or Class IA laparoscopic privileges.

35.6 EMERGENCY ROOM COVERAGE

1. All members of the Urology Section (except for Transplant specialists) are required to take Hospital call except for those excluded by the Medical Staff Bylaws, Rules, and Regulations.
2. Call starts at 7 AM on the date of assignment and ends at 7 AM the following morning.
3. If a Urologist's patient presents to the Emergency Care Center or the Hospital and requires Urologic care, the patient's Urologist of record is responsible for providing that Urologic care. This is independent of the Call Panel. Should the Urologist of record not be available, the Urologist's designated call coverage (who should be notified in advance of that specific date obligation) is responsible for providing such services.
4. The Urologist of record is defined as follows:
   a. If the patient had clinical contact with said Urologist within the last year, that patient shall be assigned to that Urologist. This includes contact in the hospital or in the office (telemedicine visits meet this qualification).

b. It is not the responsibility of the Emergency Care Center physician, the Hospitalist, or other referring physician to make this determination.

c. If the patient indicates they had clinical contact with a Urologist within the one-year time frame, this will be accepted as fact.

d. If a patient presents to the hospital and has not had contact with a Urologist within one-year, the patient will be assigned to the Urologist on the Call Panel. Should it subsequently be determined by the Call Panel Urologist that another Urologist is indeed the Urologist of record given the above criteria, the Call Panel Urologist may arrange for care to be assumed by the Attending Urologist in a time frame appropriate to the clinical context.

5. The physician on call will be responsible for all new consults and Urology admissions. This includes new consultations called on the panelist's assigned date for patients admitted prior to the assigned date. The physician on call is responsible for providing coverage for the assigned date. If the Call Panel physician is not on call for his/her group on the assigned date, he/she must arrange for appropriate coverage.

6. Failure or refusal to respond on assigned call dates without arranging appropriate coverage, failure to answer pages or returning calls to the ECC or hospital requests for inpatient consultations in a timely manner, necessitating another Urologist to be called, or purposely avoiding consultation or admission requests thereby delaying them to the following day will result in the following penalties:

a. The offending physician will assume the next call date on the Call Panel for the physician who covered the call.

b. The physician failing to respond to call appropriately will be subject to fining as outlined in the Medical Staff Rules and Regulations. The first offense will be subject to a fine of $1,000, and each additional offense will be increased by $1,000.

36. VASCULAR SURGERY SECTION

Any applicant desiring vascular surgery privileges must submit a completed application to be reviewed by the Vascular Surgery Section. The Department of Surgery will make the decision whether or not to grant privileges to perform peripheral vascular surgery based on the recommendation of the Vascular Surgery Section.

36.1 MEETINGS:

The Chairman may call for a meeting as he/she deems necessary.

36.2. REQUIREMENTS, CONDITIONS AND CATEGORIES:

APPLICANTS FOR VASCULAR SURGERY PRIVILEGES:

To qualify for privileges in vascular surgery, an applicant is required to fulfill the following criteria:

1. Be a graduate of An ACGME accredited residency in vascular surgery.

2. Satisfy all the requirements for certification in Vascular Surgery by The American Board of Surgery (ABS) or the Royal College of Surgeons (RCS) within 7 years of graduation or have current certification in Vascular Surgery from either the ABS or the RCS. Failure to become board certified by the above-mentioned boards within 7 years of completion of formal training will be deemed a voluntary withdrawal of clinical privileges.

3. Each applicant shall submit an operative case list documenting procedures and outcomes from their last consecutive 50 cases as the primary vascular surgeon. If the applicant has previously practiced vascular surgery, he/she must present a letter from the chief of surgery of each hospital in which he/she currently practices (or most recently practiced), attesting that he/she is in good standing and currently has privileges to perform vascular surgery.

36.3. CATEGORIES OF VASCULAR SURGERY PRIVILEGES & PROCTORING/FOCUSED PROFESSIONAL PRACTICE EVALUATION REQUIREMENTS:

A. **Class IA:**

The Class IA surgeons shall be proctored on a minimum of three (3) reconstructive vascular procedures with a broad mix. The proctor must have the same range and level of privileges as the surgeon he proctors. If this proctoring is not satisfactory, the Vascular Surgery Section may require additional proctored.

Before being advanced to Class I, the Class IA surgeon must have performed and had reviewed a minimum of ten (10) surgical cases. If the Class IA physician is advanced to Class I status prior to end of his/her six months initial appointment period, he/she will remain Associate Class I.

The Surgery Committee reserves the right to request additional proctoring of cases or chart review if the initial review is not satisfactory.

A Class IA surgeon may be required to submit to the Surgery Committee, a statement regarding his/her current privilege status or any restriction/reduction of privileges from any hospital, state licensing agency or professional healthcare program.

If the Class IA surgeon fails to advance to Class I within twelve (12) months

of initial appointment, he/she may automatically be terminated.

B. **Class I:**

See Section 4.1 of the Rules and Regulations governing the Department of Surgery.

36.4 CORRECTIVE ACTION:

If a surgeon fails to meet acceptable institutional standards, their experience shall be reviewed. The surgeon in question will have the opportunity to discuss any extenuating circumstances regarding deaths or complications. Vascular Surgery Section recommendations may include additional proctoring, requirements for additional training or restriction of privileges.

36.5. RENEWAL OF VASCULAR SURGERY PRIVILEGES:

A. All credentialed vascular surgeons must meet acceptable institutional standards as previously listed.

B. Surgeons will be reviewed for renewal of vascular surgery privileges every two years.

C. The application for renewal of vascular surgery privileges must be completed.

D. To maintain vascular surgery privileges, the surgeon should have a minimum of 15 operative vascular and/or endovascular procedures within a two-year period. These procedures must be as primary surgeon. The above patient contacts may be from all hospitals at which the surgeon practices and is the responsibility of the surgeon to provide this experience during the reappointment process.

E. In addition to the required caseload, all applicants for renewal of privileges must satisfy the committee review.

36.6 ELECTION OF THE VASCULAR SURGERY SECTION CHAIRMAN:
Refer to the current Medical Staff Bylaws under section 8.5.2.

36.7 TEMPORARY PRIVILEGES:

Temporary privileges may be granted only in accordance with the Medical Staff Bylaws section 6.4

36.8 NEW PROCEDURES:

The granting of privileges for the performance of procedures new to the field of vascular surgery requires approval of the section of vascular surgery and department chair after demonstration of appropriate familiarity and training with the procedure and its anticipated results and complications.

Additional privileges requested by the section members must be via written application to the Section and Department of Surgery Chairs stating the privileges desired and accompanied by documentation of relevant training and experience to support the request.

37. FAMILY PRACTICE

Any Family Practitioner applying to the staff shall apply for the following surgical privileges, which are also included in the Rules and Regulations of Family Practice:

A. Biopsy and/or removal of benign skin lesions.
B. Biopsy of uncomplicated, readily accessible skin lesions of questionable nature (benign, malignant, etc.)
C. Closure of simple lacerations
D. Incision and drainage of uncomplicated subcutaneous abscesses.

The following procedures shall require proctoring of two (2) cases each by the Urology Section:

1. Meatotomy.
2. Adult circumcision.

Any other privileges will be granted on an individual basis, based on experience, training and demonstrated competence.

37.1. Assisting at Laparoscopic Cholecystectomy: Since members of the Department of Family Practice have requested privileges as surgical assistants at laparoscopic cholecystectomy, the following guidelines with regard to qualifications, training, proctoring, experience and monitoring in attaining and maintaining these privileges are being proposed. However, the ultimate decision regarding the surgical assistant will remain the domain of the primary surgeon.

Qualifications

Every Family Practitioner who desires to be a surgical assistant at laparoscopic cholecystectomy must have adequate liability insurance which is to include coverage to provide surgical assistance.

Training

Attendance at a recent, approved course which includes didactic instruction and "hands-on" experience with live animal models is required.

Proctoring

Before privileges are granted, the physician will require proctoring at Saint Joseph Hospital by a surgeon on at least six (6) cases. No more than three (3) cases can be proctored by the same surgeon. On the first two (2) cases, the physician being proctored will act as the "second assistant".

Experience

To maintain these privileges, the physician must assist at a minimum of six (6) cases per year at Saint Joseph Hospital. This requirement may be modified when the issue is reviewed as described below.

Monitoring

Monitoring will be conducted by the Quality Enhancement Committee of the Department of Surgery. The complication rate as well as the "conversion" rate, i.e. those cases which proceed to open cholecystectomy, will be monitored to determine ongoing eligibility for these privileges. In addition, the duration of the cases at which family practitioners assist will be compared with those cases at which they do not assist. Cases will be reviewed every six (6) months from the time that these privileges are first granted.

38. INTERNAL MEDICINE

38.1. Qualified gastroenterologists from the Department of Medicine shall be granted laparoscopy privileges for diagnostic purposes provided they have a Class I surgeon or gynecologist present in the operating room to observe the procedure. The Class IA internist will become eligible for advancement after he has completed a minimum of six cases under observation.

39. NEUROSURGERY SECTION

39.1. Definition and Scope of Neurosurgery

Neurosurgery is the medical discipline that deals with the evaluation, diagnosis and treatment of patients with disorders of the central, peripheral and vegetative nervous systems, including their supportive skeletal, soft tissues and vascular supply and hypophysis. Neurosurgery includes the operative and non-operative, clinical and critical care management of patients of all ages in the course of their treatment and rehabilitation. Any and all appropriate medical and surgical modalities may be utilized - microsurgery is an integral part of the discipline as is the use of a variety of applicable devices and procedures.

39.2. Organization

The neurosurgical section functions as a section of the Department of Surgery. This section reports to the Surgery Committee. The neurosurgical section chair or his designate is a member of the Surgery Committee. The section chair attends, participates, votes and reports at the meetings of the Surgery Committee. He/she has responsibilities as outlined in the Medical Staff Bylaws and the rules and regulations of this section.

39.3. Membership

Membership in the Neurosurgery Section is limited to those physicians in one of the following categories.

A. Physicians who are certified by the American Board of Neurological Surgery ("Board") or the American Osteopathic Board of Neurosurgery for "board eligibility."

B. Physicians who are declared eligible by the Board to sit for examination for certification. Such physicians must complete and pass the Board Certification Examination within five years of graduation from a certified and accepted neurosurgical program. Failure to become board certified by the above-mentioned boards within ~~5~~ 6 years of completion of formal training will be deemed a voluntary withdrawal of clinical privileges.

C. Physicians who do not meet the requirements of categories A or B above, may be elected to membership by a vote of the two-third majority of all the eligible voting members of the section after due and comprehensive consideration.

39.4. Section Meetings

A. The Chair may call a meeting as he/she deems necessary.

39.5. Clinical Privileges and Responsibilities

A. **Class I:** Each such member may perform any and all of the appropriate medical and surgical procedures for which member is trained and qualified and approved by the section and by virtue of member's California license and approval of section of Neurosurgery, if not specifically prohibited by medical, ethical or legal considerations. Each Class I members shall submit a list of all the types of procedures the member is to do, for approval of the section according to the current list of St. Joseph Hospital neurosurgical procedures - attached here, which upon approval entitles the members to perform them independently, with assistance at his discretion.

B. **Class IA**

1. Privileges are identical to Class I, with the additional requirement of Class I proctor from the section.

2. Upon completion of satisfactorily being proctored on six (6) cases, the Class IA physician may request advancement to Class I privileges.

3. Of the six (6) cases above, at least two (2) must be major cranial surgery, at least two (2) should be major spinal surgery, and others may be peripheral nerve or other less major procedures.

4. The Class IA neurosurgeon must have a Class I

neurosurgeon as an assistant who must remain throughout any procedure during the proctoring session and period. The only exceptions are imminently threatening emergencies.

5. At least three different neurosurgeons must assist and act as proctors.

C. **New Procedures** - The privileges of performing entirely new procedures to the surgeon or to the field of Neurosurgery would require approval of the section of Neurosurgery after satisfactory demonstration of appropriate familiarity and training with the procedure and its anticipated results and consequences.

D. **Proctoring Requirements** - Class I neurosurgeons are required to proctor and report to the section on the work of Class IA neurosurgeons as requested by the Class IA neurosurgeon. At least a majority if not all of the Class I neurosurgeons should be asked by the Class IA neurosurgeon to assist and proctor until the total requirements in numbers is met.

E. **Responsibilities and Duties of Members** - The members of the section shall provide timely and accessible care on an elective, urgent and emergency basis to their own patients.

F. **Emergency Call** - Emergency Department call is voluntary for Class I and Class IA Neurosurgeons.

G. **Continuing Education** - Members are required to keep up to date with the field of Neurosurgery and maintain Category I continuing education credits, equal or more than those required for continuation of licensure and the standards of the concurrent neurosurgical associations as determined by the section.

H. **Assistance in Surgery** - The selection of an assistant for surgery is generally at the discretion of the neurosurgeon. Neurosurgeons, other surgical specialists, non-surgeons with surgical assistance privileges, may be so employed. Neurosurgical assistance during neurosurgical operative procedures affords an additional benefit to the care of the patient in terms of a constant flow of discussion and conversation, rendering augmented education and experience to both. In the current direction of medical care in general to reduce costs, non-physician assistants such as registered nurse first assistants (R.N.F.A.) may be used by neurosurgeons at their discretion. In procedures of less magnitude of risk for the patients, the following list should be regularly considered for use of such assistants; carpal tunnel release for decompression, ulnar nerve decompression at the elbow or wrist, sural nerve graft harvest, tarsal tunnel decompression, tracheostomy, cranial bur holes for chronic subdural hygroma or hematoma, insertion of ventriculostomy systems, harvesting of bone grafts for fusion parts of operations,

incision and drainage of spinal and extracranial postoperative abscesses, and in any emergency neurosurgical procedures where physician assistants are not readily available. Registered nurse first assistants and similar non-physicians may not be utilized as co-surgeons, performing a portion of the operation independently.

Bariatric Surgery Criteria and Requirements:

I. PREREQUSITE CRITERIA AND REQUIREMENTS

A. Surgeons requesting or currently maintaining surgical privileges at St. Joseph Hospital must hold:
   1. **Full Approval** as a Bariatric Surgeon Center of Excellence (BSCOE) from the American Society of Metabolic and Bariatric Surgery (ASMBS)

      OR

   2. **Provisional Approval** as a BSCOE; and within the timeframe established by the Surgical Review Corporation (SRC) for the ASMBS, to become a Full Approval BSCOE.

B. Proficiency for Individual Bariatric Surgeons:
   1. Has successfully completed a Bariatric Surgery Fellowship during the year 2005 or forward, and provide Certificate of Completion

      OR

   2. If surgeon specialized in Bariatric surgery prior to the year 2005, must have completed a course and be able to:
      a. Provide Certificate from Bariatric Training Course
      b. Preformed 125 lifetime bariatric surgery cases
      c. Averaged 50 cases every 2 years with activity throughout both years provided at a Joint Commission approved facility
      d. Mortality and complication rates must not exceed the ASMBS COE standards

      Surgeons who (i) fail to maintain Full Approval from the SRC Program, or (ii) have applied for, but failed to obtain Full Approval from the SRC Program in accordance with the timeframe established by the SRC Program, shall be deemed to have voluntarily relinquished their bariatric surgery privileges.

      All Physicians holding bariatric clinical privileges agree to follow all applicable Hospital bariatric surgery practice guidelines and protocols, including all requirements related to patient follow up.

II. CREDENTIALING

A. **Criteria for Bariatric, Laparoscopic Bariatric, and Laparoscopic Adjustable Gastric Banding Surgery**: In addition to the above listed Prerequisite Criteria and Requirements, St. Joseph Hospital adheres to the following criteria established from the American Society for Metabolic and Bariatric Surgery (ASMBS) *Guidelines for Granting Privileges in Bariatric Surgery*, October 2005 which includes the following requirements.

1. **Global Credentialing Requirements**: To meet the Global Credentialing Requirements in bariatric surgery, the applicant will:
    a. Have credentials to perform gastrointestinal and biliary surgery.
    b. Document that he or she is working within an integrated program for the care of the morbidly obese patient that provides ancillary services such as specialized nursing care, dietary instruction, counseling, support groups, exercise training, and psychological assistance as needed.
    c. Document that there is a program in place to prevent, monitor and manage short-term and long-term complications.
    d. Document that there is a system in place to provide and encourage follow-up for all patients. Follow-up visits should either be directly supervised by the bariatric surgeon of record or other health care professionals who are appropriately trained in perioperative management of bariatric patients and part of an integrated program. While applicants cannot guarantee patient compliance with follow-up recommendations, they should demonstrate evidence of adequate patient education regarding the importance of follow-up as well as adequate access to follow-up.

3. Bariatric Procedures:
    a. Adjustable gastric banding
    b. Revisional metabolic and bariatric surgery
    c. Roux-en-Y gastric bypass
    d. Sleeve gastrectomy

2. **Experience in Bariatric Surgery Required to Train Applicants**: For the purposes of this document, experienced bariatric surgeons serving as trainers for applicants should meet Global Credentialing Requirements and have experience with at least 200 bariatric procedures in the appropriate Category of Procedure in which the applicant is seeking privileges prior to training the applicant.

3. **Definition of Operative Experience**: For the purposes of this privileging guideline, operative experience is defined broadly to include not only procedure performance but also global care of the bariatic patient that encompasses preoperative and postoperative management.

    Specifically, preoperative management experience must include patient evaluation and preparation for surgery.

    Postoperative management experience must include inpatient postoperative management and outpatient management extending beyond the 90-day global period (i.e., 6-month and/or annual follow-up visits).

    Documentation of perioperative management should reflect “hands-on” experience in the outpatient clinic or office as well as hospital unit corresponding to the same patients (or equivalent) that underwent surgery by the applicant.

    Procedure performance experience is defined as “hands on” performance of a significant portion of the operation under the direct supervision of an experienced bariatric surgeon as defined above.

II. BARIATRIC PRIVILIGING

A. Open Bariatric Surgery Privileges Involving Stapling or Division of the Gastrointestinal Tract: To obtain open" bariatric surgery privileges, the surgeon must meet the Global Credentialing Requirements and document an operative experience of 15 open bariatric procedures (or subtotal gastric resection with reconstruction) with satisfactory outcomes during either:

a. General surgery residency, or
b. Post-residency training supervised by an experienced bariatric surgeon*

Surgeons who primarily perform laparoscopic bariatric surgery may obtain open bariatric surgery privileges after:

a. Documentation of 50 laparoscopic cases (see below- number 2), and
b. At least three (3) open cases supervised by an experienced bariatric surgeon.

B. Laparoscopic Bariatric Surgery Privileges for Procedures Involving Stapling or Division of the Gastrointestinal Tract: To obtain laparoscopic bariatric surgery privileges that involve the GI tract the surgeon must meet the Global Credentialing Requirements and:

a. Have privileges to perform "open" bariatric surgery and advanced laparoscopic surgery at the accredited facility; **or**
b. Have privileges to perform advanced laparoscopic surgery and documentation of training for bariatric surgery at the accredited facility; **or**
c. Document 50 cases with satisfactory outcomes during either:
    1. general surgery residency; **or**
    2. post-residency training under the supervision of an experienced bariatric surgeon.*
d. And, have completed three (3) proctored laparoscopic cases

* ***Experience in Bariatric Surgery is required to train applicants-*** For the purposes of this document, experienced bariatric surgeons serving as trainers for applicants should meet Global Credentialing Requirements and have experience with at least 200 bariatric procedures in the appropriate Category of Procedure in which the applicant is seeking privileges prior to training the applicant.

C. Laparoscopic Adjustable Gastric Band Privileges: To obtain Laparoscopic Adjustable Gastric Band (LAGB) privileges, the surgeon must meet the Global Credentialing Requirements and:

a. Have privileges to perform "open" bariatric surgery and advanced laparoscopic surgery
b. Provide documentation of satisfactory completion of the Laparoscopic Adjustable Gastric Band course
c. Have completed two (2) proctored cases

III. QUALITY REVIEW

To confirm patient safety, quality review of the surgeon's outcome data within 6 months of initiation of a new program, after the surgeon's first 50 procedures, as well as at regular intervals thereafter.

All Bariatric Surgeons agree to participate and submit data to Bariatric Outcomes Longitudinal Database (BOLD) in accordance with the ASMBS guidelines.

IV. REAPPOINTMENT

The surgeon should continue to meet Global Credentialing Requirements. Continuing medical education related to bariatric surgery is required as indicated in the current ASMBS guidelines.

Reviewed/Approved: General Surgery 1/20/2021, Surgery Core 3/3/2021, MEC 4/15/2021, BOT 4/29/2021; Surgery 2022, MEC 4/2022 Surgery 11/2/22 MEC 11/17/22