Providence
Saint Joseph
Medical Center

PROVIDENCE SAINT JOSEPH MEDICAL CENTER
DEPARTMENT OF SURGERY
RULES AND REGULATIONS

I. MEMBERSHIP

The Department of Surgery shall consist of members of the Professional Staff of Providence Saint Joseph Medical Center assigned to the department by the Credentials Committee who are in good standing and have been granted membership, as set forth in the Professional Staff Bylaws and General Rules and Regulations.

All members shall have completed the requirements for Board Certification, be Board Certified or possess other special qualifications accepted to the Department of Surgery. For specific Cardiac Surgery membership requirements, please see Section XV.

II. ORGANIZATION

The Department of Surgery shall be supervised by the Chair of the Surgical Committee and is responsible for supervising all departmental activities. The Chairman and Vice-Chairman shall be selected in accordance with the Professional Staff Bylaws and shall serve as Chairman and Vice-Chairman of the Surgical Committee. The Chairman is a member of Executive Committee reporting Surgical Committee findings and recommendations to the Executive Committee and Executive Committee deliberations and actions to the Surgical Committee and Department.

The Department includes sections of: Anesthesiology, Cardiac Surgery, Dental and Oral Surgery, General Surgery, Neurosurgery, Ophthalmology, Orthopedics (including Podiatry), Otolaryngology, Plastic Surgery, Thoracic Surgery, Urology and Vascular Surgery. Each section includes all members of that specialty. The Chair of each Section, or designee, shall carry out functions of patient care review, criteria and critical path development, and credentialing recommendations as delegated by the Surgical Department Chair; the Section Chairs may call a meeting of the entire Section for input as deemed necessary. The Sections may develop Section Rules and Regulations, which must be in accord with the Surgical Department Rules and Regulations, the General Rules and Regulations and Bylaws, and approved by the Surgical Committee.

SECTION CHAIRS:
Are selected in accordance to the Professional Staff Bylaws. The Section Chairs are responsible for serving as Chairperson of their respective section; serving as a member and reporting regularly to the Surgical Committee; and implementing policies and procedures.

The Chair of the Surgical Review Committee shall be the Vice Chair of the Surgical Committee, unless both the Vice-Chairman and the Chairman of the Surgical Department select another member of the Active Staff. The Surgical Review Committee is responsible for reviewing the quality and appropriateness of surgery performed by Surgical Department members. A portion of these functions may be delegated to surgical sections.

ADDITIONAL COMMITTEE MEMBERS:
Shall be selected by the Chair from Active and Associate members of the Department. Representatives may be appointed by the Chair, to include representatives from Administration, Nursing, or other Medical Center departments.

III. DUTIES

APPOINTMENT:
The applicants to the Professional Staff assigned by the Credentials Committee to the Department of Surgery will be reviewed by the Surgical Committee Chair for membership and qualifications for the privileges for which they are applying. Section Chairs will be responsible for recommendations regarding applicants who, if approved, will be assigned to their Section at the Chair's request.

PRIVILEGES:
The Surgical Chair has the responsibility for studying a candidate's credentials, qualifications and surgical competence. The Chair shall evaluate them as compared to the surgical privileges requested and make recommendations to the Credentials Committee. All new applicants to the Department of Surgery must submit a list of all their surgical cases at their primary hospital for the preceding year; such list to include the patient's name, hospital record number, surgical procedures performed and complications, if any.

All members shall be granted surgical privileges on the basis of training and experience, board certification or equivalent, and current competence.

A Staff member who wishes additional privileges, which had not initially been requested or granted, must apply for them meeting the above standards and evaluation. If approved, the privilege sheet will be updated.

Members of the Surgery Department may apply to other departments for privileges. If granted, Surgery Department members, in the exercise of these privileges are subject to supervision and evaluation by the department granting the privileges.

DELINEATION OF PRIVILEGES FORM:
Documentation of privileges granted will be kept current for each Professional Staff member with surgical privileges. A copy will be kept in the Professional Staff Office. Privileges will be reviewed concurrent with the reappointment review by the Surgical Committee.

PROCTORING:

A. Definition

1. Prospective Proctoring
   Prospective proctoring is a review by the proctor of either the patient's chart or the patient personally before treatment. This type of proctoring may be used if the indications for a particular procedure are difficult to determine or if the procedure is particularly risky;
2. Concurrent Proctoring
   Concurrent proctoring is when the proctor actually observes the physician's work. This is usually used for invasive procedures so that the medical staff has first-hand knowledge necessary to satisfy itself that the physician is competent;
3. Retrospective Proctoring
   Retrospective proctoring involves a retrospective review of patient charts by the proctoring physician. Retrospective review is usually adequate for proctoring of non-invasive procedures.
4. Reciprocal Proctoring
   Unless otherwise specified in these Rules and Regulations, reciprocal proctoring may be accepted for up to 50% of the proctoring requirements under the following conditions:
   - Proctoring was carried out at a local JCAHO accredited hospital and was concurrent,
   - Proctoring was performed within the past 24 months to demonstrate current clinical competence, a copy of the proctor report is supplied to the Professional Staff Administration by the facility,
   - The proctor is a member of the PSJMC Professional Staff who is eligible to proctor and shall hold the "same" privileges being proctored at PSJMC and the outside facility, and
   - 1/3 of proctoring reports may be from those within the same group

   All privileges for new Staff members or current Staff members with new privileges in the Department of Surgery will be supervised. They shall be subject to peer supervision by the Chairperson of the Department or his/her designee. Members in this category shall be required to have a proctor, a qualified Staff surgeon, and of the same qualified specialty where possible, in all major procedures. This proctor shall complete an evaluation form for each case. After a number of surgical procedures acceptable to the Department have been completed usually 10 cases, 5 of which must be major, or at the discretion of the Surgical Committee Chair the Chair and/or Committee will evaluate the member's performance and make recommendations regarding change from supervised to unsupervised privileges. Unsupervised privileges may be recommended in some areas, and continued supervised in others.

   Members with Unsupervised privileges in their specialty who request privileges for a new procedure within their specialty similar to unsupervised privileges they already have, and who present to the Surgical Committee documentation of having successfully completed training in a recognized program, may be granted Unsupervised Privileges for these procedures at the discretion of the Surgical Committee Chair. Members with Supervised Privileges may not cover the Emergency Department until they have been granted Unsupervised Privileges.

REAPPOINTMENT:
Each member of the Department will be reviewed for reappointment as set forth in the Professional Staff Bylaws. The Chair will be responsible for evaluating professional activity, professional performance and judgement, participation in departmental and educational activities, information from other departments and committees regarding evaluation and disciplinary actions, professional and health capacity to continue quality of medical care, and making recommendations to the Credentials Committee regarding continuation or modification of membership and privilege status. Any surgeon in the Active or Associate Category who has not been a primary surgeon on a least ten (10) cases for the previous twelve (12) months prior to reappointment, and all Courtesy Category members, may be required to submit a letter from the Chair of the Department of Surgery of his/her primary hospital declaring his/her competency, and submit a list of all his/her cases for the twelve-month period.

Please see Section XV for specific reappointment requirements for Cardiac Surgery Section Members.

QUALITY ASSURANCE & IMPROVEMENT:
The review of the quality and appropriateness of surgery is the responsibility of the Surgical Department. This includes a review of outcomes, participation in critical path development and multidisciplinary studies, the development of screening criteria to identify trends, patterns, and individual cases needing in-depth review. These review functions are a major responsibility of the Surgical Review Committee, supported by the Surgical Sections. Results and any adverse recommendation for action regarding privileges and/or membership are reported to the Surgical Committee. Please see Section XV for specific requirement for the Cardiac Surgery Section.

EDUCATION:
Recommend and/or establish education programs for the department and/or general CME programs, based in part upon patient care evaluations.

CONFER & COOPERATE:
With other Professional Staff members, departments, or medical center departments.

INTEGRATE:
The patient care provided by the department's members with Nursing, Ancillary, and Administrative Services.

ADVISE:
On matters concerning the development of new surgical programs, the purchase of new surgical equipment, and the construction of facilities for use by the surgical staff.

IV. MEETINGS

The Departmental, Surgical Committee, Surgical Review Committee and Section meetings shall be held as often as necessary to enhance communication with department members, discuss outcomes of patient care review functions, and for educational purposes. When appropriate, these meetings may be combined with other meetings. Three (3) members shall constitute a quorum.

V. CONSULTATIONS

Consultation is recommended in all cases where there is unusual risk, obscure diagnosis, untried or multiple therapeutic choices. The Department Chair may mandate consultation when it appears necessary and in the patient's best interest.

TEMPORARY PRIVILEGES FOR INDIVIDUAL CASES:
Temporary privileges for individual cases may be requested as per the Professional Staff Office by furnishing the patient's name, procedure to be performed, and the names of the surgeon and assistant. After verification by the Professional Staff Office, permission may be recommended by the Chair of the Department and granted by the Administrator. This privilege shall be limited to three (3) cases in one (1) year.

VI. PERMISSION TO OPERATE

There must be no doubt in the patient's mind as to who is to perform the operation. The consent for the operation must clearly establish to whom the patient gives this authority. In every instance, the surgeon(s) who perform the operation will be listed on the operative record as the surgeon(s) and not the assistant. If multiple procedures are being considered, each operation must be listed on the consent.

The witness to the signature is to sign the surgical consent in the presence of the patient or the person giving permission for the operation. The exact time and date the consent is signed is to be recorded. The consent for operation on a mentally incompetent patient or minor must be signed by the patient's attorney-in-fact specified in a Durable Power of Attorney for Health Care, the legal guardian or the closest available relative. In no case may the surgeon sign the consent. In cases where there are no relatives or guardian available in person, a telephone consent may be obtained as specified in the consent manual.

The consent should be completed, signed, and witnessed before the patient is given any sedation or narcotic. If the patient's mental status is altered after having received sedation or a narcotic, a proper time interval must intervene before signature is obtained. If an alert patient signs an Authorization For and Consent to Surgery or Special Diagnostic or Therapeutic Procedures Form after having been given a narcotic and/or other sedation, a note should be made on the consent form or in the Medical Record as to the alert mental status of the patient at the time of signing.

In those cases that are true emergencies and consent of the patient for some reason cannot be obtained, the responsible physician must document this fact in the medical record on the Progress Notes and may then proceed with the operation or procedure. Where time permits, written permission should be obtained as listed above.

Non-competent patients who are scheduled for non-emergency procedures should have written permission from the family, the attorney-in-fact or the conservator/legal guardian. When circumstances warrant an operation and there is no one to sign the consent for the operation, the surgeon may take complete responsibility for the procedure by documentation in the progress notes.

The attending surgeon or physician should document the justification for proceeding with treatment without a valid consent in the progress notes. A reference to the progress note and the date should be entered on the consent form in the signature area.

The surgeon is responsible for a proper informed consent being received from the patient and/or family, whichever is appropriate and/or in compliance with State laws as applicable. Obtaining an informed consent is the attending surgeon or physician's responsibility. This must be documented in the dictated History & Physical or dictated in the Progress Note, and by completion on the Informed Consent form in the patient's record prior to surgery or performing an invasive procedure requiring an informed consent.

On elective cases, no patient will be taken into the Operating Room until a complete typed History and Physical is available in the Medical Record. (A complete History and Physical includes a review of systems). This requirement does not preclude rendering emergency medical or surgical care to a patient.

VII. OPERATIVE REPORTS

The post-operative or procedure form shall be completed and signed immediately after surgery or a note with similar contents entered into the progress notes. Operative and Procedure reports shall be dictated immediately following surgery/procedure by the operating surgeon and made a part of the patient’s medical record. The report shall include a detailed account of the findings at surgery as well as the details of the surgical technique.

Co-surgeons should both dictate an operative report, if they are in different specialties. Physicians must sign their own operative (and procedure) reports. The surgeon must document that he has seen and evaluated the patient prior to surgery.

VIII. TISSUES

All tissues and foreign bodies removed must be sent to the Department of Pathology for identification and/or further diagnostic procedures at the discretion of the pathologist.

IX. ADMINISTRATIVE POLICIES

Scheduling of operative cases is done on a first-come first-serve basis. The Operating Room Nurse Manager/Director has full charge and control of the schedule and responsibility for it. The scheduling for all surgical cases shall be done in the Surgery Department, through the Surgery Scheduling Office. The hours for scheduling future surgeries shall be limited to 8:30 a.m. to 4:30 p.m. weekdays. The Scheduling Office is closed Saturday, Sundays and Holidays.

Emergency cases are scheduled through the surgery control desk. One Saturday room available from 0800-1530 may be booked at 8:30 a.m. on Friday through the scheduling office. Emergency cases after 2300 Monday through Friday: after 1500 Saturday to 0600 Monday morning must be scheduled through the Nursing Supervisor. Weekend and Holiday cases are considered emergent and urgent inpatient cases only and will run consecutively. Holiday cases can be booked with the nursing supervisor that day only.

Cases in the Special Procedure room are to be booked through that department. When Special Procedures is closed, the calls are forwarded to Radiology for booking. Special Procedures coordinates scheduling with the Operating Room.

Doctors who are on the Medical Record Suspension List are not allowed to schedule elective or emergency surgeries, or perform any cases previously scheduled, or assist in surgery, until they have had their names removed from the list.

BLOCK BOOKING:
Block booking arrangements and release times will be made with the approval of the Surgical Committee Chair.

WEEKENDS:
Only emergent and urgent inpatient cases can be done on Saturday, Sunday and Holidays. An emergency shall be so noted and recorded in the charts by the attending physician.

An Emergent Case is defined as a condition threatening the loss of life, a limb, or a major body function.
An Urgent Case is one in which there is a condition where undue delay is hazardous.
An Elective Case is one where surgery can be regularly scheduled in a pre-planned manner.

BUMPING:
Emergency surgery has priority over elective surgery. In case of emergency where priority must be established, the physicians involved will be responsible to resolve the issue. In the event of an impasse, the Chair of Surgery will be called in to resolve the issue.

TIME:
The Surgeon and Anesthesiologist must arrive at least fifteen (15) minutes before scheduled start time. The surgery may be canceled by the Anesthesiologist and Department Chair if the surgeon is late. Surgeons who are late for a 0730 case more than three (3) times in three (3) months will not be allowed to schedule 0730 elective cases for a period of six (6) months. A log of late surgeons is maintained at the Surgery Control Desk. If the surgeon has not checked in with the Surgery Control Desk by 0730, they are considered late.

IDENTITY:
The responsibility of the patient's identification rests with the Operating Room Team, Operating Surgeon and Anesthesiologist.

BLOCK RELEASE:
Block release for elective procedures will be seventy-two (72) hours before block time for all except open heart and vascular surgery. The block released time will be used according to a First Come First Serve (FCFS) basis.

BLOCK UTILIZATION:
0-33% Lose block time
34-66% Reduce Block time if utilization remains below 50% for three (3) months in a row
67-80% Block time remains the same
81-100% May request for additional time if current Block Time is insufficient. Block utilization will be reviewed in two (2) months to justify usage

NEW SURGEON AND BLOCK TIME:
New Surgeons are offered available time for their scheduled cases. Their utilization is computed based on total time used in surgery. Based on their average usage over two (2) months, appropriate time will be assigned to them on a trial basis for two (2) months. A review of their block utilization will be done monthly over two (2) months to finalize block designation, decrease, (i.e., keep the same or increase block time based on utilization).

X. VISITORS IN SURGERY

A request for a visitor in surgery must be made to the Operations Director, Surgery Nurse Manager or designee in advance and must be approved by the Surgeon, the Anesthesiologist and the patient.

Visitors are restricted to medical and nursing personnel, medical and nursing students who have a current contract with the hospital, surgical product representatives required for the procedure, and selected hospital employees after clearance by the Surgeon, the Surgery Nurse Manager, and the Anesthesiologist.

Medical Students shall be limited to observation only (non-scrubbed).

XI. REQUIREMENTS FOR SURGERY PATIENT WITH ANESTHESIA OR ANESTHESIA STANDBY

A. Surgical consent signed and witnessed.
B. Informed Consent Form completed by the surgeon.
C. An elective operation shall be performed only after an appropriate history, examination, and required laboratory and x-ray examinations have been completed and the pre-operative diagnosis recorded. Results shall be recorded on the chart or available by electronic means.
D. Pre-op Lab Tests in Surgery: Admission guidelines for surgery, as approved by the Executive Committee are maintained in Short Stay, Day Surgery, Surgery and Pre-screening offices.
E. Appropriate other pre-operative evaluation.
F. The use of a surgical assistant is at the discretion of the primary surgeon, unless the otherwise indicated in these Rules & Regulations or mandated by regulatory or licensing agencies.
G. History and Physical or consultation note must be performed within 24 hours before an elective surgery. If the History and Physical is older than 24 hours, an interval note must be made by the physician to validate that the findings are unchanged or document any changes.
H. Postoperatively, any patient who has received other than a local anesthesia shall be examined by a physician, or when appropriate an oral surgeon (and the visit documented) before the patient leaves the recovery area. In lieu of such visit, patients may be discharged from the PACU according to criteria developed by the Anesthesia Section and approved by the Surgery Committee.

XII. REQUIREMENTS FOR SURGERY PATIENT WITH LOCAL ANESTHESIA ONLY

Pre and post-operative instructions and treatment plan shall be provided by the surgeon. No labs are required.

XIII. DISCHARGE REQUIREMENTS FOR OUT PATIENT SURGERIES

Surgical outpatients may be discharged by an R.N. who has been certified by the Standardized procedure "Discharge of the Outpatient Operative/Invasive Procedure". Postoperatively the patient may be discharged by the physician, or the Discharge Nurse if the physician has an order, "Discharge when criteria are met."

XIV. PEDIATRIC SURGERY GUIDELINES

No inpatient surgery will be done on infants less than 36 months of age except in emergencies or infants admitted to the NICU. An emergency case is defined as a nontransferable patient. These cases require preoperative consultation by a Pediatrician unless a life-threatening situation or a significant adverse impact will occur if the patient is not promptly taken to surgery. If this exists, this requires either an intraoperative or an immediate postoperative consultation by a Pediatrician.

A. Outpatient Surgery
   1. Any pediatric case with chronic cardiac, GU, CNS, renal, or pulmonary disease must have:
      a. Complete history and physical or consultation by a Providence Saint Joseph Medical Center pediatrician or family practitioner with appropriate pediatric privileges.
      b. A Pediatrician or a covering Pediatrician must be available for post-op management and/or care if needed.
   2. Patients converted postoperatively to an inpatient basis:
      a. Require notification of a Pediatrician within one (1) hour and prompt consultation (within six (6) hours.
      b. ICU admission requires a visit by the Pediatrician within four (4) hours. The transfer of a patient to a PICU will be the responsibility of the Pediatrician and Surgeon with input if necessary from the Chief of Staff or his/her designee.

B. Inpatient Surgery
   1. Neonates and small infants (less than 28 days) requiring surgery are candidates for admission to the ICNN. Individual cases should be discussed with the Neonatologist. The patients will be managed jointly by the Surgeon and Neonatologist.
   2. Emergency patients less than 36 months would require:
      a. Consult by Pediatrician or Family Practitioner with appropriate pediatric privileges within 12 hours postop.
      b. The baby to be seen by the Pediatrician or Family Practitioner preoperatively if practical.
   3. Patients NPO more than 36 hours; anesthesia complications; chronic cardiac, GI, renal, CNS, or pulmonary disease would require the same as B. (3) above.
   4. Post-op ICU Admissions would require:
      a. Consult by Pediatrician within 4 hours. Timely transfer of patients to a PICU will be the responsibility of the Pediatrician and Surgeon with input if necessary from the Chief of Staff or his/her designee.

XV. CARDIAC SURGERY REQUIREMENTS

<u>MEMBERSHIP:</u>
All members of the Professional Staff who have privileges in Cardiac Surgery, in addition to being assigned to the Department of Surgery, will be members of the Cardiac Surgery Section. All new applicants must be board certified or board eligible by the American Board of Thoracic Surgery.

All new applicants, who have completed an approved residency or fellowship training program within one year of the application, must submit a case listing from their residency or fellowship program and their primary hospital if applicable.

All new applicants, who have completed an approved residency or fellowship training program and have been out of training for more than one year, will be required to submit a listing of cases and outcomes which demonstrates he/she has performed at least 50 adult cardiovascular surgical cases with cardiopulmonary bypass or standby as the primary surgeon during the preceding 12 months with a mortality rate not in excess of 6%.

<u>REAPPOINTMENT:</u>
To maintain cardiac surgery privileges, all physicians must be Board Certified/Eligible by the American Board of Thoracic Surgery and:

A. Have performed a minimum of 100 adult cardiovascular surgical cases with cardiopulmonary bypass or standby as primary surgeon per two-year reappointment cycle. At least 25 such cases must be performed at PSJMC.
B. Maintain a surgical mortality rate not in excess of 6% per year at any hospital. Mortality rates shall be monitored on an ongoing basis and any physician whose rates fall outside the surgical mortality rate criteria shall be subject to appropriate review and action in accordance with the Professional Staff Bylaws.

Any deviations from A & B above, must be approved by Executive Committee.

ORGANIZATION AND RESPONSIBILITIES:

The Cardiac Surgery Section shall consist of all Professional Staff members who are cardiac surgeons. Two representatives from the Cardiology Section of the Department of Medicine, one representative from the Anesthesia Section and one clinical perfusionist shall serve as non-voting members in the patient care review and quality improvement activities of the section. These members shall be appointed by the Chair.

The Cardiac Surgery Section shall be responsible for reviewing the quality of the clinical perfusionists.

Clinical perfusionists shall operate under the supervision of the cardiovascular surgeon in the operating room.

Anesthesia for cardiac surgery procedures shall be administered by a physician certified or eligible by the American Board of Anesthesiology.

Except as defined above, all Department Rules & Regulations apply to this section.

ENDOSCOPIC RADIAL ARTERY HARVESTING:

Criteria for performing Radial Artery Harvesting:

- A physician or P.A. that has performed five (5) open radial artery harvests.
- A physician or P.A. that has attended an approved course for Endoscopic Radial Artery Harvest with documentation of training.
- A P.A. must have supervision of at least three (3) cases from a cardiac surgeon or a qualified P.A. to become un-proctored.

MINIMALLY (MINI) INVASIVE VALVE SURGERY:

Indications for Procedure:

- Any isolated valve procedure including tricuspid, mitral, aortic and Pulmonic valve procedures.
- Patients with intra-atrial pathology such as atrial septal defects of myxomas are also ideal candidates for this approach.
- Patients needing concomitant bypass grafting would not be suitable to this approach given the limited access to the heart.

Physician training requirements:

- Surgeons requesting to perform Minimally (Mini) Invasive Valve Surgery shall document similar training at a center which performs this procedure on a regular basis.

Proctoring:

- A minimum of two (2) cases.

Requirements for maintaining current clinical competence:

- Performance of a minimum of five (5) Minimally (Mini) Invasive Valve Surgery procedures annually.

XVI. ORTHOPEDIC SURGERY SECTION REQUIREMENTS

That all future applicants to the Professional Staff, Department of Surgery, Section of Orthopedics, upon completion of proctoring, be required to participate on the Orthopedic On-Call Panel for a minimum of ten (10) years.

XVII. PODIATRIC SURGERY

Based on AB 932 passed/signed and entered into law by the California Governor on 06/30/04, a DPM may assist on any surgical procedure under the direct supervision of a physician (MD). A DPM may perform amputations of the foot no further proximal than the Chopart's joint (mid-tarsal joint of the foot).

"Surgical assist" on any procedure other than a podiatric case be inclusive (documented) of current malpractice coverage with limits of liability in accordance with established amounts (currently 1/3 million).

XVIII. NEUROSURGERY - LUMBAR DISC ARTHOPLASTY (I.E. DISC REPLACEMENT)

Physician Training Requirements:

- Those requesting privileges shall hold privileges to perform anterior approach spine surgery at PSJMC. Completion of the Depuy Spine training course (Certificate course @ Cincinnati). Procedure shall be performed with an access surgeon (i.e., General Surgery or Vascular Surgeon) similar to ALIF.

Proctoring Provisions:

- Concurrent review by the Surgery Q.A. Committee shall be required.

Requirements to Maintain Clinical Competence:
Maintenance of current clinical competence in disc arthroplasty may be demonstrated by:

- CME in contemporary spine surgery
- Performance of interbody lumbar spine surgery

Malpractice Provisions:
Currently inclusive of standard malpractice coverage for spinal surgery and interbody fusion. Documentation to be provided by each applicant.

Licensing Provisions:
Fluoroscopic licensure by the State of California is required **(mandatory)**

XIX PHYSICIAN QUALIFICATIONS FOR STEREOTACTIC BREAST BIOPSY

Stereotactic breast biopsy may be performed by surgeons in collaboration with radiologists (using ABBI device), or independently by radiologists following consultation with primary care physicians and/or surgeons (using Mammotome or other core needle biopsy device). The following criteria has been adopted from the physician qualifications for stereotactic breast biopsy developed jointly by the American College of Surgeons and the American College of Radiology.

1. In a situation where a radiologist and surgeon practice collaboratively as noted above, patient selection and quality assurance including medical audit are the joint responsibility of the radiologist and surgeon. The physician should be present at the appropriate time during their procedure.

    A. Requirements for surgeons:
        1. Initial Training and Qualifications
            - Have at least 3 hours of Category I CME in stereotactic breast biopsy, which should include instruction in imaging triangulation for lesion location.
            - Have performed at least 3 hands-on stereotactic breast biopsy procedures under a physician who is qualified to interpret mammography under MQSA and has performed at least 24 stereotactic breast biopsies or is fully privileged to perform stereotactic breast biopsy.
            - Be experienced in post-biopsy management of the patient.
        2. Maintenance of Proficiency and CME Requirements
            - Perform at least 3 stereotactic breast biopsies per year or requalify as specified in B.1.
            - For surgeons who perform stereotactic breast biopsies in collaboration with radiologists, the requirement of at least 3 hours of category I CME in stereotactic breast biopsy every 3 years is fulfilled by the radiologists.

2. Surgical privileges will first be reviewed by the general surgery section and recommendations forwarded to the Department of Surgery.

3. Participation in the general surgical panel for the Providence Breast Center is contingent upon meeting and maintaining the requirements for privileges as stated above and through direct participation in the educational activities of the Providence Cancer Center.

XX. BARIATRIC SURGERY PRIVILEGING CRITERIA

Patient Selection:
1. Patients should be at least 100lbs over their ideal weight BMI of 40 or above or 35 with co-morbid conditions, and should meet, ASMBS, SAGES or NIH guidelines to become surgical candidate. These patients should be screened pre-operatively to make sure that they have been consulted for appropriate psychological, internal medical-endocrinology and nutritional consultants and receive ongoing treatment from these consultants.

Privileging Criteria Core Bariatric Privileges:
1. Graduate from residency fellowship program
2. MIS Bariatric fellowship graduate
3. Have advanced laparoscopic privileges and general surgical privileges
4. Produce a case log from their fellowship with a minimum of 50 cases in a 12 month period of bariatric procedures.

Bariatric Surgeon In Practice:
1. Documentation of bariatric training or experience
2. Minimum of 50 bariatric cases in the previous 12 month period (all must be bariatric cases involving GI tract trans-section)
3. Procedure standard, "Center of Excellence Compliant", outcome statistics for past 24 months for bariatric cases
    - All privileged bariatric surgeons must perform 50 cases minimum per year per surgeon (125 per group/team) at the institution and produce "Center of Excellence" compliant to include documentation of long term follow-up and in line with the overall service outcome statistics

- Yearly review by bariatric department will apply
- All bariatric surgeons must attend 8 bariatric related CME courses per year and be part and comply with all Center of Excellence guidelines
- Attend all bariatric hospital meetings (50% attendance required)

Additional Gastric Banding or Lapband privileges:
Privileges for the gastric band of lapband will be granted only in addition to the core bariatric privileges if surgeon provides documentation of training course and required proctoring by as per FDA guidelines.

Proctoring:
Proctoring of five (5) cases for each of these procedures by a member of the Bariatric Surgery Section

Mal-Practice Coverage Requirements:
Surgeon must show evidence of malpractice insurance (Rider) which reflects coverage for Bariatric surgery in the amount of $3/5 million.

XXI. BRACHYTHERAPY IN THE O.R.

Radiation Oncology - Performing procedures in the O.R.:
1. Placement of HDR Brachytherapy Catheters for Prostate Brachytherapy.
2. Placement of Gynecologic Applicators for Brachytherapy.
3. Placement of Catheters for Breast Brachytherapy.

Radiation Oncology practitioners shall co-admit patients with a physician members who has general privileges and will assume responsibility for the patient's medical care.

XXII. VASCULAR SURGERY

Effective June 1, 2010, Active Board Candidates shall have 5 (five) years from their initial appointment date to obtain certification by the American Board of Surgery, Vascular Surgery. Physicians who fail to achieve "Board Certification" status with the American Board of Surgery, Vascular Surgery within five (5) years of their initial appointment date shall be considered to have voluntarily resigned from the Professional Staff, hearing rights shall not apply. Applicants and Section members shall meet the qualifications, standards, and requirements of the Vascular Surgery Section for both appointment and subsequent reappointments to the Department of Surgery, Professional Staff of the Medical Center as set forth in the Professional Staff Bylaws and General Rules & Regulations.

<u>Qualifications/Criteria:</u>
Category I
New Applicant: Completion of an ACGME approved fellowship in Vascular Surgery AND Board Certified/Eligible by the Vascular Surgery Board of the American Board of Surgery (Certificate of added qualification in Vascular Surgery).

Reappointment:
Compliance with the Qualifications/Criteria for Category 1; AND Evidence of an active current practice in Vascular Surgery.

Category II
Compliance with Qualifications/Criteria for Category 1; AND Documentation of residency or fellowship training for the specific privileges requested; AND Documentation of successful completion of an approved training program/course for the specific privileges requested.

Category III
Completion of an ACGME approved fellowship in Vascular Surgery AND Certificate of Added Qualification in Peripheral Vascular Surgery by the Vascular Surgery Board of the American Board of Surgery AND Documentation of successful completion of an approved two (2) day training program/course for the specific privileges requested.

Proctoring Requirements:
Category I
Concurrent proctoring of at least six (6) Category I cases AND 2 Aorta; 2 Carotid; and 2 Femoral Distal Bypass

Category II
Concurrent proctoring of at least three (3) Category 2 cases AND 2 Flush; 2 Cerebral; 2 Selective; 2 Lower Extremities; 2 Balloon; and 2 Stent

Category III
Concurrent proctoring of at least three (3) cases for each procedure requested.

Closure Procedure - Varicose Veins:
Indications for Procedure:
- Presence of varicose veins without venous ulcers

Physician Training Requirements:
- Endovascular surgery training

Proctoring:
- A minimum of three (3) cases

Thoracic Aortic Stent Graft:
Indication for Procedure:
- Thoracic aortic aneurysm requiring repair

Physician Training Requirements:
- Completion of ACGME accredited Fellowship in both Vascular & Endovascular Surgery (with experience in at least ten (10) thoracic endograft procedures as the surgeon)
- Completion of FDA approved device specific course(s)
- Current Privileges to perform abdominal, thoracic and thoracoabdominal aortic aneurysm repair
- Completion of proctoring for endovascular Abdominal Aortic Aneurysms
- First ten (10) cases to be reviewed

Proctoring:
- Minimum of Five (5) Thoracic endograft cases

XXIII. MISCELLANEOUS

A. Clinical perfusionist shall operate the extracorporeal equipment under the immediate supervision of the cardiac surgeon. Training and supervision is the responsibility of the Chair of the Cardiac Surgery Section.
B. Any research projects undertaken by a member of the Department of Surgery shall be in conformity with the Research Committee's rules and regulations.
C. Members of the Department of Surgery may use the name of the Medical Center in any published works with the permission of the Chair of the Department and Administration. He/she shall also have the right to identifying him/herself as a member of this Medical Staff.
D. Physician Assistants are approved through the Surgery Department Chair and work under the direct supervision of their supervising physician(s).

XXIV. VIOLATIONS IN REGARD TO SURGICAL PRIVILEGES

The Operations Director for Perioperative Services is responsible for reporting violations to the Chair of the Surgery Department. Violations shall be investigated at the discretion of the Chair of the Department. All recommendations regarding action affecting members and/or privileges shall then be referred to the Executive Committee.

These Rules and Regulations of the Department of Surgery were adopted by the Surgical Committee of Providence Saint Joseph Medical Center, Burbank, California, as presented at the Executive Committee meeting of March 20, 2019.

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Shahan V. Yacoubian, M.D.
Chair, Department of Surgery

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Manzar S. Kuraishi, M.D.
Chief of Staff

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Karl Keeler
Chief Executive

Revised: 07/2013: 05/2018: 03/2019
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