Practice area 161

CLINICAL PRIVILEGE WHITE PAPER

General surgery

Background

A general surgeon has principal expertise in the diagnosis and care of patients with diseases and disorders affecting the abdomen, digestive tract, endocrine system, breast, skin, and blood vessels, according to the American Board of Medical Specialties (ABMS). Additionally, general surgeons are trained in the care of pediatric and cancer patients, as well as in the treatment of patients who are injured or critically ill. General surgeons typically treat problems including hernias, breast tumors, pancreatitis, bowel obstructions, gallstones, appendicitis, colon cancer, and colon inflammation.

ABMS recognizes the following subspecialties, which require board certification in general surgery and completion of additional subspecialty training:

- Complex general surgical oncology
- Hospice and palliative medicine
- Pediatric surgery
- Surgery of the hand
- Surgical critical care

Following board certification in general surgery, some surgeons choose to complete additional training and pursue certification in specialty areas such as vascular surgery, pediatric surgery, thoracic surgery, surgical oncology, trauma surgery, and transplant surgery. Residency programs in these areas typically require successful completion of residency training in general surgery.

The Accreditation Council for Graduate Medical Education (ACGME) requires five years of residency training in general surgery to qualify for certifications. Graduates of ACGME-accredited programs may pursue certification granted by the American Board of Surgery (ABS).

The American Osteopathic Association (AOA) also requires five years of residency training in general surgery for candidates seeking certification. The American Osteopathic Board of Surgery (AOBS) offers certification for general surgery.

It is important to note that criteria-based core privileging lends itself to competency clusters. With increased focus on evidence of current competency for all privileges granted comes increased scrutiny on the way that privileges or groupings of procedures are defined. Substantiating proficiency for the entire core can be problematic for certain specialty and subspecialty areas. Therefore, creating smaller clusters or groupings

that more accurately define procedures and allow for a more concentrated approach to applying criteria and monitoring competency is the next evolution for criteria-based privileging.

For more information on the subspecialties related to general surgery, please see the following *Clinical Privilege White Papers*:

- Practice area 110—Pediatric surgery
- Practice area 160—Hand surgery
- Practice area 406—Hospice and palliative medicine
- Practice area 433—Surgical oncology

Involved specialties

General surgeons

Positions of specialty boards

ABS

ABS offers certification in general surgery as well as in its subspecialties, which include pediatric surgery, surgical critical care, surgical oncology, surgery of the hand, and hospice and palliative medicine.

To achieve certification in general surgery, candidates must pass both a qualifying examination and a certifying examination. Applicants for the qualifying examination must fulfill the following requirements:

- Possession of a full and unrestricted license to practice medicine within the United States or Canada within six months of residency
- Five years minimum of progressive residency education in an ACGME-accredited general surgery program
- 60 months of residency training at no more than three residency programs, with the final two years spent in the same program
- No fewer than 48 weeks of full-time experience in each residency year
- At least 54 months of clinical surgical experience with increasing levels of responsibility over the five years, including no fewer than 42 months devoted to the content areas of general surgery
- No more than six months during all junior years assigned to nonclinical or nonsurgical disciplines and no more than 12 months allocated to any one surgical specialty other than general surgery
- Acting in the capacity of chief resident in general surgery for a 12-month period
- Successful completion of the Advanced Cardiovascular Life Support (ACLS), Advanced Trauma Life Support (ATLS), and Fundamentals of Laparoscopic Surgery (FLS) programs

- Performance of a minimum of 750 operative procedures in five years as operating surgeon, including at least 150 operative procedures in the chief resident year
- A minimum of 25 cases in surgical critical care, with at least one case in each of the following categories:
  - Ventilatory management
  - Bleeding (nontrauma)
  - Hemodynamic instability
  - Organ dysfunction/failure
  - Dysrhythmias
  - Invasive line management and monitoring
  - Parenteral/enteral nutrition
- Adherence to the ABS Ethics and Professionalism Policy

Following the successful completion of the General Surgery Qualifying Exam, candidates are admissible to the General Surgery Certifying Examination, an oral examination designed to evaluate a candidate's clinical skills in diagnosing common surgical problems and determining appropriate treatments.

Once certified, surgeons must participate in a three-year Maintenance of Certification (MOC) cycle, and must complete a brief online form about MOC activities at the end of each cycle. Surgeons are required to take a recertification examination every 10 years.

AOBS

AOBS offers certification in general surgery. Candidates for certification must meet the following requirements:

- Graduate from an AOA-accredited college of osteopathic medicine
- Hold an unrestricted license to practice in the state or territory where his or her practice is conducted
- Conform to the standards set in the AOA Code of Ethics
- Be a member in good standing of the AOA for a period of two years prior to certification
- Satisfactorily complete an AOA-approved Osteopathic Graduate Medical Education (OGME)-1 year

As of July 1, 2009, applicants must have completed all the required years of an AOA-approved residency training in general surgery prior to registering for the written qualifying examination. Candidates who entered the certification process prior to July 1, 2009, must have evidence of satisfactory completion of four years in general surgery. Residents who began their residency training with an internship year effective in 2008 must complete five years of training in general

surgery. Candidates must pass both a written qualifying examination and an oral certifying examination to achieve certification.

Certification from the AOBS is valid for 10 years, after which surgeons must complete a recertification examination administered by the AOBS.

Positions of societies, academies, colleges, and associations

ASA

The American Surgical Association (ASA) emphasizes surgical science and scholarship, as well as the advancement of surgical care. The ASA does not publish specific guidelines regarding credentialing and privileging of general surgeons, nor does it publish competency requirements.

ACS

The American College of Surgeons (ACS) is a scientific and education membership association. ACS' Division of Education, in conjunction with the Association of Program Directors in Surgery, publishes *Surgical Skills Curriculum for Residents*, a series of training modules covering the skills required for surgical residents. The training is broken into three phases. Phase 1 of the curriculum covers basic surgical skills and tasks, including:

- Advanced laparoscopy skills
- Advanced tissue handling
- Airway management
- Asepsis and instrument identification
- Basic laparoscopy skills
- Bone fixation and casting
- Central line insertion and arterial lines
- Chest tube and thoracentesis
- Colonoscopy
- Hand-sewn gastrointestinal anastomosis
- Inguinal anatomy
- Knot tying
- Laparotomy opening and closure
- Stapled gastrointestinal anastomosis
- Surgical biopsy
- Suturing
- Tissue handling, dissection, and wound closure
- Upper endoscopy
- Urethral and suprapubic catheterization
- Vascular anastomosis

Phase 2 addresses advanced procedures, including:

- Gastric resection and peptic ulcer disease
- Laparoscopic appendectomy
- Laparoscopic inguinal hernia repair
- Laparoscopic Nissen fundoplication
- Laparoscopic right colon resection
- Laparoscopic sigmoid resection
- Laparoscopic ventral hernia repair
- Laparoscopic ventral/incisional hernia repair
- Laparoscopic/open bile duct exploration
- Laparoscopic/open cholecystectomy
- Laparoscopic/open splenectomy
- Open inguinal/femoral hernia repair
- Open right colon resection
- Parathyroidectomy/thyroidectomy
- Sentinel node biopsy and axillary lymph node dissection

Phase 3 features team-based skills such as:

- Laparoscopic crisis
- Laparoscopic troubleshooting
- Latex allergy anaphylaxis
- Patient handoff
- Postoperative hypotension
- Postoperative MI (cardiogenic shock)
- Postoperative pulmonary embolus
- Preoperative briefing
- Retained sponge on postoperative chest x-ray
- Trauma team training

ACS also publishes *Statements on Principles: Qualifications of the Responsible Surgeon*, which state that qualified surgeons are those who have completed a surgical residency and/or fellowship approved by the ACGME, are certified or qualified for examination by a surgical board recognized by the ABMS, and maintain continuing education and proficiency in their specialty. According to ACS, responsible surgeons should demonstrate competence in the following areas:

- Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of good health
- Medical knowledge about established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care
- Practice-based learning and improvement involving investigation and evaluation of a surgeon's patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

- Interpersonal and communication skills that result in effective information exchange and effective interaction with patients, their families, and other healthcare professionals
- Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
- Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to effectively utilize system resources to provide care that is of optimal value

ACS notes that surgeons should study and evaluate new procedures and become proficient with advances in surgical practice as appropriate. The association stresses lifelong learning and development of skills among surgeons.

In its *Statement on Scope of Practice*, ACS-qualified surgeons are those who have completed an ACGME- or Royal College of Physicians and Surgeons of Canada (RCPSC)–accredited surgical residency or fellowship and who are certified, recertified, or qualified for examination by a surgical board recognized by the ABMS or the RCPSC. Qualified surgeons must also maintain continuing education and proficiency in their specialty.

The *Statement on Scope of Practice* notes that "a surgeon's scope of practice is determined by the appropriate surgical specialty board recognized by the ABMS or the RCPSC. Procedures performed are dictated by the guidelines set by a specialty board." Surgeons must acquire additional education and experience, and, if necessary, certification to perform procedures outside of the defined guidelines, according to ACS. ACS expects surgeons to study, evaluate, and become proficient with new procedures and advances as appropriate. This includes both technical skills and in-depth knowledge and context. ACS requires surgeons to seek additional training by an accredited educational organization when acquiring new skills.

ACS also stresses the importance of public education and states that patients must be informed of a surgeon's qualifications, which must be factual and documented with adequate data.

ASGS

The American Society of General Surgeons (ASGS) is a nonprofit organization that represents the political, ethical, scientific, and professional interests of its member surgeons. According to ASGS' statement *The Specialty of General Surgery and the Definition of a General Surgeon Specialist*, general surgeons are trained and qualified to provide surgical care of the whole patient, and have expertise in

the evaluation and treatment of injuries and illnesses involving a wide range of systems and anatomical regions. ASGS lists the following as areas of major responsibility:

- Alimentary tract
- Abdomen and its contents, including the pelvis
- Breast
- Skin, soft tissue, and musculoskeletal system
- Chest
- Head and neck
- Vascular system
- Endocrine system
- Oncology
- Trauma
- Critically ill patients

ASGS also publishes *Statement on Scope of Practice and Credentialing*, which states that the general surgeon specialist has the experience and training to manage common problems in plastic, thoracic, pediatric, gynecologic, urologic, neurologic, and orthopedic surgery. According to ASGS, credentialing criteria for general surgeons should reflect training, quality of practice, and experience, rather than economic considerations. Practicing surgeons should determine appropriate applications for new technology, equipment, and procedures related to their surgical practice.

ACGME

The ACGME publishes *Program Requirements for Graduate Medical Education in General Surgery*, which state that a surgery residency program should be five clinical years in length. At least 54 months of the 60-month program should be spent on clinical assignments in surgery, and 42 of those 54 months should be spent on clinical assignments in the essential content areas of surgery, which include the following:

- The abdomen and its contents
- The alimentary tract
- Skin, soft tissues, and breast
- Endocrine surgery
- Head and neck surgery
- Pediatric surgery
- Surgical critical care
- Surgical oncology
- Trauma and nonoperative trauma
- The vascular system

Knowledge of burn physiology and initial burn management is required, as is formal transplant experience, which should include patient management and

cover knowledge of the principles of immunology, immunosuppression, and the management of general surgical conditions arising in transplant patients.

No more than six months total may be allocated to research or nonsurgical disciplines such as anesthesiology, internal medicine, pediatrics, or surgical pathology, and no more than 12 months may be devoted to surgical disciplines other than the principal components of surgery. Residents must perform a total of 750 major cases, including a minimum of 150 major cases during the final year of residency.

The final year of residency, known as the chief year, should consist of clinical assignments in the essential content areas of general surgery. Any single essential content area may not occupy more than six months of the chief year. A chief resident may act as a teaching assistant to a more junior resident with appropriate faculty supervision, and up to 50 cases in which the chief resident acts as teaching assistant can be credited toward the 750 total required cases, but these cases may not be credited toward the 150 required cases for the chief year.

With regard to patient care, residents should develop and execute patient care plans appropriate for their level, including management of pain, and should demonstrate manual dexterity appropriate for their level. The documented clinical curriculum of the program should be sequential, comprehensive, and organized from basic to complex, with assignments structured to ensure graded levels of responsibility, continuity in patient care, a balance between education and service, and progressive clinical experiences.

According to ACGME, residents should learn the fundamentals of basic science as applied to clinical surgery, including applied surgical anatomy and surgical pathology, wound healing, homeostasis, shock and circulatory physiology, hematologic disorders, immunobiology and transplantation, oncology, surgical endocrinology, surgical nutrition, and the metabolic response to injury. Residents should be assessed biannually, and assessment should include case volume, breadth, and complexity. Assessment should specifically monitor the resident's knowledge by use of a formal exam.

AOA

The AOA publishes *Basic Standards for Residency Training in Surgery and the Surgical Subspecialties*. According to these guidelines, residency programs in general surgery must be five years in length, including an AOA-approved first year residency (OGME-1R). The final 12 months of the five-year program must be spent performing the functions of chief resident, and no more than four months in the final four years of the program may be allocated to nonsurgical disciplines such as internal medicine, anesthesiology, or surgical pathology.

Each resident must participate in a minimum of 750 major surgical procedures as surgeon or first assistant. During the final year of residency, residents must log 150 major surgical procedures as senior chief. Residents should gain hands-on experience in the preoperative, operative, and postoperative care of surgical patients in the following areas:

- Disease or dysfunction of skin and soft tissue, burns, wound care, and breast: 25 major cases
- Disease or dysfunction of the head and neck: 25 major cases
- Disease or dysfunction of the abdomen:
  - Alimentary tract: 72 major cases
  - Liver: 4 major cases
  - Pancreas: 3 major cases
  - Spleen: 3 major cases
  - Biliary tree
  - Abdominal wall
- Disease or dysfunction of the endocrine systems: 8 major cases
- Disease or dysfunction of the vascular system: 44 major cases
- Disease or dysfunction of the thoracic cavity, including esophagus, lung pleura, and cardiac: 15 major cases
- Operative and nonoperative management of trauma, emergency surgery, interventions of surgical scope, and surgical critical care:
  - Nonoperative trauma: 20 cases
  - Operative trauma: 10 cases
- Disease or dysfunction of gynecologic system
- Endoscopy and laparoscopy:
  - Endoscopy: 85 upper endoscopies and 50 colonoscopies
  - Basic laparoscopy: 60 cases
  - Advanced laparoscopy: 25 cases
- Disease or dysfunction of the urologic system
- Pediatric surgical care: 20 major cases
- Plastic and reconstructive surgery

The OGME-1R year for general surgery must include the following rotations, which may be scheduled as 12 one-month rotations or 13 four-week rotations:

- Rotations for half a day per week, for 46 weeks, in an outpatient clinic or office
- Two months of general internal medicine
- One month of ICU
- One month of emergency medicine
- Four months of general surgery
- Four months of electives in any of the following areas:
  - Urology
  - Orthopedics
  - Anesthesia
  - Ear, nose, throat

- General surgery
- Vascular surgery
- Neurosurgery
- Cardiovascular thoracic surgery
- Plastic and reconstructive surgery
- Radiology
- Female reproductive medicine
- Pediatrics, if available, or other primary care specialty, at the discretion of the training institutions

General surgery residency programs must integrate the basic sciences applicable to general surgery with clinical experiences in a progressive manner. Basic sciences include applied surgical anatomy and surgical pathology, the elements of wound healing, homeostasis, shock and circulatory physiology, hematologic disorders, immunobiology and transplantation, oncology, surgical endocrinology, surgical nutrition, fluid and electrolyte balance, and the metabolic response to injury, including burns.

Residents in general surgery should develop critical thinking skills to assist in making decisions for patient management and integrating research into the practice of general surgery. Residents should develop psychomotor and technical skills, communication skills, practice management skills, and professional attitudes and abilities over the course of residency training. Residents should experience the management of patients with severe and complex illnesses and major injuries in acute care units, and should experience evolving advanced diagnostic, therapeutic, and interventional measures.

Upon the completion of residency training, program directors must submit a resident evaluation report that summarizes the resident's progress and evaluates the resident's general and technical abilities. Residents must complete the annual American College of Osteopathic Surgeons in-service examination.

Positions of accreditation bodies

CMS

The CMS *Conditions of Participation (CoP)* define a requirement for organization and staffing of surgical services in §482.51(a)(4) stating "Surgical privileges must be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical service must maintain a roster of practitioners specifying the surgical privileges of each practitioner."

CMS' *CoP*s also define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, "The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges."

§482.12(a)(6) states, "The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

- Individual character
- Individual competence
- Individual training
- Individual experience
- Individual judgment

The governing body must ensure that the hospital's bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners."

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner's ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner's ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS' *CoP*s include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

The Joint Commission

The Joint Commission has no formal position concerning the delineation of privileges for general surgery. However, in its *Comprehensive Accreditation Manual for Hospitals*, The Joint Commission states, "The hospital collects information regarding each practitioner's current license status, training, experience, competence, and ability to perform the requested privilege" (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and

verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, "The organized medical staff is responsible for planning and implementing a privileging process." It goes on to state that this process typically includes:

- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information
- Submitting recommendations to the governing body for applicant-specific delineated privileges
- Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
- Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, "The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process."

The EPs for standard MS.06.01.05 include several requirements as follows:

- The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
- Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant's current organization, peer and/or faculty recommendation, and a review of the practitioner's performance within the hospital (for renewal of privileges)
- Consistent application of criteria
- A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
- Documentation and confirmation of the applicant's statement that no health problems exist that would affect his or her ability to perform privileges requested
- A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
- Written peer recommendations that address the practitioner's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
- A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)
- A process to determine whether there is sufficient clinical performance information to make a decision related to privileges
- A decision (action) on the completed application for privileges that occurs within the time period specified in the organization's medical staff bylaws

- Information regarding any changes to practitioners' clinical privileges, updated as they occur

The Joint Commission further states, "The organized medical staff reviews and analyzes information regarding each requesting practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privilege" (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, "Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal" (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner's professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

HFAP

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for general surgery. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff's review of an individual practitioner's qualifications and its recommendation regarding that individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, "Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)"

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner's clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

DNV

DNV has no formal position concerning the delineation of privileges for general surgery. MS.12 Standard Requirement (SR) #1 states, "The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges."

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

- The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension,

or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements
- Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner's Medicare/Medicaid status
- Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).
Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner's respective delineation of privilege requests.

CRC draft criteria

The following draft criteria are intended to serve solely as a starting point for the development of an institution's policy regarding this practice area. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.

Minimum threshold criteria for requesting privileges in general surgery

Basic education: MD or DO
Minimal formal training: Successful completion of an ACGME- or AOA-accredited residency in general surgery, and/or current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification in general surgery by the ABS or the AOBS. Certification in ACLS, ATLS, and FLS programs is required.
Required current experience: Applicants must provide evidence of at least 100 general surgery procedures, reflective of the scope of privileges requested, during the past 12 months or demonstrate successful completion of an ACGME-

or AOA-accredited residency or clinical fellowship within the past 12 months.

References

If the applicant is recently trained, a letter of reference should come from the director of the applicant's training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

Core privileges in general surgery

Core privileges for general surgery include the ability to admit, evaluate, diagnose, consult, and provide pre-, intra-, and postoperative care and perform surgical procedures for patients of all ages to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract; skin, soft tissues, and breast; endocrine system; head and neck; surgical oncology, trauma, and nonoperative trauma; and the vascular system. Physicians may provide care to patients in the intensive care setting in conformance with unit policies. They may also assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures in the following procedures list and such other procedures that are extensions of the same techniques and skills:

- Performance of history and physical exam
- Trauma, abdomen, alimentary
- Abdominoperineal resection
- Amputations, above and below the knee, toe, transmetatarsal, digits
- Anoscopy
- Appendectomy
- Circumcision
- Colectomy (abdominal)
- Colon surgery for benign or malignant disease
- Colotomy, colostomy
- Correction of intestinal obstruction
- Drainage of intra-abdominal, deep ischiorectal abscess
- Emergency thoracostomy
- Endoscopy (intraoperative)
- Enteric fistulae, management
- Enterostomy (feeding or decompression)
- Esophageal resection and reconstruction
- Distal esophagogastrectomy
- Excision of fistula in ano/fistulotomy, rectal lesion
- Excision of pilonidal cyst/marsupialization
- Gastric operations for cancer (radical, partial, or total gastrectomy)
- Gastroduodenal surgery

- Gastrostomy (feeding or decompression)
- Genitourinary procedures incidental to malignancy or trauma
- Gynecological procedures incidental to abdominal exploration
- Hepatic resection
- Hemorrhoidectomy, including stapled hemorrhoidectomy
- Incision and drainage of abscesses and cysts
- Incision and drainage of pelvic abscesses
- Incision, excision, resection, and enterostomy of small intestine
- Incision/drainage and debridement, perirectal abscesses
- Insertion and management of pulmonary artery catheters (determine whether core or noncore)
- IV access procedures, central venous catheter, and ports
- Laparoscopy, diagnostic, appendectomy, cholecystectomy, lysis of adhesions, mobilization, and catheter positioning
- Laparotomy for diagnostic or exploratory purposes or for management of intra-abdominal sepsis or trauma
- Liver biopsy (intraoperative), liver resection
- Management of burns
- Management of intra-abdominal trauma, including injury, observation, paracentesis, and lavage
- Management of multiple trauma
- Operations on gallbladder, biliary tract, bile ducts, and hepatic ducts, including biliary tract reconstruction
- Pancreatectomy, total or partial
- Pancreatic sphincteroplasty
- Panniculectomy
- Proctosigmoidoscopy, rigid with biopsy, with polypectomy/tumor excision
- Pyloromyotomy
- Radical regional lymph node dissections
- Removal of ganglion (palm or wrist; flexor sheath)
- Repair of perforated viscus (gastric, small intestine, large intestine)
- Scalene node biopsy
- Selective vagotomy
- Sigmoidoscopy, fiberoptic with or without biopsy, with polypectomy
- Small-bowel surgery for benign or malignant disease
- Splenectomy (trauma, staging, therapeutic)
- Surgery of the abdominal wall, including management of all forms of hernias, including diaphragmatic and inguinal hernias, and orchiectomy in association with hernia repair
- Thoracentesis
- Thoracoabdominal exploration
- Tracheostomy
- Transhiatal esophagectomy
- Tube thoracostomy

- Breast, skin, and soft tissue

- Complete mastectomy with or without axillary lymph node dissection
- Excision of breast lesion
- Breast biopsy
- Incision and drainage of abscess
- Management of soft-tissue tumors, inflammations, and infections
- Modified radical mastectomy
- Operation for gynecomastia
- Partial mastectomy with or without lymph node dissection
- Radical mastectomy
- Skin grafts (partial thickness, simple)
- Subcutaneous mastectomy
- Endocrine system
- Excision of thyroid tumors
- Excision of thyroglossal duct cyst
- Parathyroidectomy
- Thyroidectomy and neck dissection

➤ Vascular surgery
- Hemodialysis access procedures
- Peritoneal venous shunts, shunt procedure for portal hypertension
- Peritoneovenous drainage procedures for relief or ascites
- Sclerotherapy
- Vein ligation and stripping

Special noncore privileges in general surgery

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested, including training, required previous experience, and maintenance of clinical competence. Noncore privileges include:

➤ Use of laser
➤ Esophagogastroduodenoscopy (EGD) with and without biopsy
➤ Colonoscopy with polypectomy
➤ Endovenous laser therapy
➤ Laparoscopic Nissen fundoplication (antireflux surgery)
➤ Advanced laparoscopic procedures (e.g., colectomy, splenectomy, adrenalectomy, common duct, exploration/stone extraction, donor nephrectomy)
➤ Breast cryoablation
➤ Insertion and management of pulmonary artery catheters (determine whether core or noncore)
➤ Open bariatric surgery privileges involving stapling or division of the gastrointestinal tract
➤ Laparoscopic bariatric surgery involving stapling or division of the

gastrointestinal tract
- Laparoscopic bariatric surgery procedures that do not involve stapling of the gastrointestinal tract
- Pancreas transplantation surgery
- Kidney transplant surgery core privileges
- Liver transplant surgery core privileges
- Stereotactic breast biopsy
- Sentinel lymph node biopsy
- Use of a robotic-assisted system for general surgical procedures
- Administration of sedation and analgesia

Reappointment

Reappointment should be based on unbiased, objective results of care according to a hospital's quality assurance mechanism.

To be eligible to renew privileges in general surgery, the applicant must provide current demonstrated competence and an adequate volume of experience (200 general surgery procedures) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for privilege renewal.

In addition, continuing education that is related to general surgery should be required.

For more information

Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, IL 60654
Telephone: 312-755-5000
Fax: 312-755-7498
Website: *www.acgme.org*

American Board of Medical Specialties
222 North LaSalle Street, Suite 1500
Chicago, IL 60601
Telephone: 312-436-2600
Website: *www.abms.org*

American Board of Surgery
1617 John F. Kennedy Boulevard, Suite 860
Philadelphia, PA 19103
Telephone: 215-568-4000
Fax: 215-563-5718
Website: *www.absurgery.org*

American College of Surgeons
633 N. Saint Clair Street
Chicago, IL 60611-3211
Telephone: 312-202-5000
Fax: 312-202-5001
Website: *www.facs.org*

American Osteopathic Association
142 Ontario Street
Chicago, IL 60611-2864
Telephone: 800-621-1773 or 312-202-8000
Fax: 312-202-8200
Website: *www.osteopathic.org*

American Osteopathic Board of Surgery
4764 Fishburg Road, Suite F
Huber Heights, OH 45424
Telephone: 937-235-9786
Fax: 937-235-9788
Website: *www.aobs.org*

American Society of General Surgeons
P.O. Box 4834
Englewood, CO 80155
Telephone: 303-771-5948
Fax: 303-771-2550
Website: *www.theasgs.org*

American Surgical Association
500 Cummings Center, Suite 4550
Beverly, MA 01915
Telephone: 978-927-8330
Fax: 978-524-8890
Website: *www.americansurgical.info*

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 877-267-2323
Website: *www.cms.gov*

DNV Healthcare, Inc.
400 Techne Center Drive, Suite 350
Milford, OH 45150
Telephone: 513-947-8343
Website: *www.dnvaccreditation.org*

Healthcare Facilities Accreditation Program
142 E. Ontario Street
Chicago, IL 60611
Telephone: 312-202-8258
Website: *www.hfap.org*

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Telephone: 630-792-5000
Fax: 630-792-5005
Website: *www.jointcommission.org*