

DESERT REGIONAL MEDICAL CENTER
DEPARTMENT OF SURGERY

RULES AND REGULATIONS

SECTION I. PHILOSOPHY

- A. The members of the Department of Surgery at Desert Regional Medical Center, in accordance with the rules of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Title 22 of the California Administrative Code as applicable, hereby adopt these rules and regulations in an effort to more certainly provide the optimal surgical care of our patients.

SECTION II. ORGANIZATION

- A. The Department of Surgery is made up of the Sections of Anesthesiology, Cardiothoracic & Vascular Surgery, General and ENT Surgery, Ophthalmology, Oral/Maxillofacial Surgery & Dentistry, Orthopedic Surgery, Pathology, Urology and Neurosurgery.
- B. The Chair of the Department of Surgery will be elected in accordance with the Desert Regional Medical Center Medical Staff Bylaws. A Vice-Chair of Surgery will be elected every two (2) years from the Active Staff membership, as defined in the Medical Staff Bylaws. The Vice-Chair will serve as Chair of Surgery if the elected Chair of Surgery is ill or unavailable for some reason. The Vice-Chair shall also serve as Chair of the Operating Room Committee.
- C. It will be the Chair of Surgery's responsibility to settle disputes over surgical matters within the hospital that are not otherwise addressed by the rules and regulations here stated. Decisions made by the Chair of Surgery over disputed matters will be subjected to appeal to the Medical Executive Committee. If a member of the surgical staff is concerned that decisions made by the Chair of Surgery are in any way biased or contrary to what might be reasonably considered an effort to improve patient surgical care, he/she may and should write a letter of concern to the Surgery Advisory Committee for discussion and recommendation on this matter. All such letters will be carefully reviewed and a written response to the concerned physician will follow the next scheduled meeting of the Surgery Advisory Committee.
- D. The Department of Surgery will meet four (4) times a year for the purpose of carrying out the business of the Department.
- E. Meeting attendance is not mandatory; however, members are encouraged to attend Department meetings.
- F. The Chair of Surgery shall chair the meetings of the Surgery Advisory Committee, which will meet four (4) times a year, or additionally as needed, for the purpose of assisting the Chair of Surgery in monitoring activities within the Department of Surgery. The Committee shall be composed of the Chair, Vice-Chair, a representative of the Department of OB/GYN appointed by the Department of OB/GYN Chair and all of the Section Chiefs. A trauma surgeon and the Director of Outpatient Surgery shall serve as ex-officio members. Any other person or persons who might be invited to a specific meeting for the purpose of carrying out business according to the desires of the Committee members will be invited by the Chair. Recommendations from the Department of Surgery Chair shall be forwarded to the Medical Executive Committee for action.
- G. New members will be allowed four (4) years to become Board Certified in their specialty. If they fail to do so, or if they fail their board examination three (3) times, additional training will be required at a

teaching institution for at least one (1) year before they can return to the Staff at Desert Regional Medical Center.

SECTION III. PROCESSING THE APPLICATION

- A. Applications will be processed through the Medical Staff Office. Applicants' credentials will be reviewed and he/she will be interviewed by the Surgery Department Chair and the file reviewed by the Section Chief. Recommendations will be made by the Department Chair to the Credentials Chair or Committee.

SECTION IV. APPLICATION FOR PRIVILEGES

- A. Surgical privileges may be granted only to those who are either Board Certified or Board Eligible and meet the qualifications for membership, according to the Medical Staff Bylaws.
- B. Privileges requested that are within the scope of the Department of Surgery shall be considered in accordance with the General Guidelines for Granting Surgical Privileges.
- C. Operating room assistants who meet the criteria set forth by the Department shall be granted assisting privileges by the Department of Surgery. Assistants must have at least one (1) year of general surgery training or at least ten (10) surgical records per procedure, indicating that he/she was first assistant on similar cases.
- D. Registered Nurses who have attended a Registered Nurse First Assistant course and are credentialed shall be granted assistant privileges by the Department of Surgery.
- E. Physician Assistants who have demonstrated successful completion of an approved and recognized course or acceptable supervised training may be granted assistant privileges by the Department of Surgery.

SECTION V. PROCTORING REQUIREMENTS

- A. Privileges for a new Medical Staff member or an existing Medical Staff member requesting additional privileges, in the Department of Surgery shall be granted on a provisional basis during the proctoring period. Members of the Department of Surgery will be responsible for obtaining qualified proctor(s) and notify the Medical Staff Office of it. If they are unable to obtain qualified proctors, they will be assigned by the Department Chair and/or the Section Chief to serve as the proctors and to oversee the proctoring process.
- B. For a new staff member, the proctoring procedure shall be conducted for a minimum of ten (10) surgical cases for which proctoring reports have been completed, representative of the requested core and special procedures. For the dental staff member, the proctoring procedure shall be conducted for a minimum of three (3) surgical cases, and for the oral surgery member the proctoring procedure shall be conducted for a minimum of five (5) surgical cases.
- C. The cases proctored shall include a reasonable sampling of the overall procedures requested and may not necessarily be a consecutive series of cases performed. Proctoring will be allowed for five (5) cases from another facility and Medicare approved facilities. (Proctor must be a member of the Medical Staff at both facilities).
- D. Ophthalmic Cases – 50% of cases can be proctored in any Medicare approved facility. Proctoring should include both emergency and elective cases. The scope of cases for proctoring consists of those in the

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surgery privilege list on the Medical Staff Application form. Retrospective proctoring should be allowed, but limited to a portion of the cases.

The proctors shall determine which cases do not require observation in the operating room, based on recent observation of demonstrated competence at Desert Regional Medical Center. Based on the proctoring reports, the Department Chair, upon the advice of the proctors and/or Section Chief, may recommend discontinuation of proctoring for specific privileges. Proctoring for core and special procedures shall not exceed two (2) years. In the instance of reapplication for privileges, the applicant will be reviewed by the Surgery Department Chair on a case-by-case basis.

- E. For an existing staff member requesting additional privileges a minimum of three (3) cases involving the requested procedure shall be proctored during the provisional period. Proctoring for these additional privileges shall not exceed two (2) years.
- F. Laser Privileges – those practitioners who have been granted laser privileges and have demonstrated competency performing the procedure do not require proctoring for additional laser privileges. The Surgery Advisory Committee, Department Chair and/or Section Chief will determine whether a new/additional privilege request requires proctoring, or is a variation on an existing privilege with modification of instrument, on a procedure-by-procedure basis.
- G. All cases performed by a new Medical Staff member, or new privileges requested by an existing staff member during the provisional period, shall be reviewed by the Department Chair. The review shall include an evaluation as to the adequacy of clinical assessment, judgment, surgical technique, pre and post-operative care, and assessment of complications (Addendum). An overall average score of 70 or higher in each category is necessary for approval of privileges. (It is the responsibility of the physician being proctored to get all proctored information to the Medical Staff Office for each proctored case).
- H. A written report of the overall performance of the surgeon being proctored shall be made by the Section Chief to the Department Chair, indicating that an adequate number of cases have been proctored to assess an overall level of proficiency. The Department Chair, with the advice of the Surgery Advisory Committee and the Section Chief, shall forward a recommendation regarding the requested privileges to the Credentials Committee for consideration. The report shall be made a part of the surgeons credentials file.
- I. The surgeon to be proctored will personally notify the proctors at least 48 hours prior to scheduling elective cases in the operating room. The proctors shall either proctor the case personally or shall delegate this responsibility another staff physician. Whenever possible, the surgeon being proctored shall be observed by multiple proctors. He proctors shall notify the operating room when the presence of a proctor is not warranted for a particular case. All outside proctors must be approved by the Chair of the Department.

Elective cases whereby a physician being proctored is unable to obtain a proctor must go through the Department for approval. The Department Chair should be contacted for all proctoring cases where a proctor is not available. If a physician within a Section refuses to proctor, the Section Chief responsible will intervene and appoint a proctor. If there is no Section Chief, then the Chair of the Department will appoint a proctor.

- J. The operating room supervisors will be notified by the Medical Staff Office of all surgeons being proctored.
- K. The Medical Staff Office will be notified by the operating room of all elective cases scheduled by the surgeon being proctored.

- L. At the time a surgical case is scheduled, a proctor should be identified. If a proctor is not identified by noon on the working day prior to surgery, the Surgery Control Desk shall automatically remove the case from the schedule. At the time of surgery, the designated proctor shall be present and in attendance during the case. On all cases, an attempt must be made to contact the proctors, or if unavailable, permission must be obtained from the Chair of the Department to perform the case.
- M. The proctors so designated may be an assistant on the case. Only a Desert Regional Medical Center Medical Staff surgeon shall be utilized during the proctoring period, except as approved by the Department Chair.
- N. Following the case, the operating room proctor will complete a Proctoring Evaluation form (Addendum) and score the surgeon being proctored in the area of surgical technique in accordance with the guidelines established by the Department of Surgery (Addendum). The form is available at the Surgery Control Desk and will contain the date of the case, name of the surgeon being proctored, patient's hospital number, and type of procedure performed. This form shall be delivered to the Medical Staff Office and filed in the physician's credentials file.
- O. The new surgeon may be placed on the Emergency Department Call Roster upon successful completion of proctoring. At the discretion of the Chair, a surgeon whose proctoring has not been terminated can be placed on the Emergency Department Call Roster when deemed appropriate, i.e., shortage of emergency coverage for specific subspecialty.
- P. Information may be obtained from anesthesiologists and operating room nursing personnel in an effort to further evaluate the applicant surgeon's conduct and surgical skills within the operating room.
- Q. All complications and deaths shall be reported immediately to the Department Chair. The Department Chair shall have the authority to suspend the surgeon's privileges in accordance with the Desert Regional Medical Center Medical Staff Bylaws.

SECTION VI. CONTINUING MEDICAL EDUCATION

- A. All members of the Department of Surgery will be required to show evidence of continuing medical education, as defined in the Desert Regional Medical Center Medical Staff Bylaws.

SECTION VII. GENERAL GUIDELINES

- A. Surgical cases will be scheduled through the Operating Room front office on a first-come first-serve basis. Each surgeon will be required to give an estimated operating time at the time of scheduling and will indicate, if possible, who his/her assistant will be. If for some reason the case cannot be done at the proposed time that it was scheduled, the surgeon must notify the front office of this change as soon as identified to allow the time to be used by other surgeons. The surgeon must also notify his assistant of the changes made. In a reciprocal manner, if the cases are 15 minutes late, the charge nurse or the nursing personnel in the front office will keep surgeons on upcoming cases informed as to new estimate operating times.
- B. Operating Room Schedule conflict – (a) If there is a case on the add-on list and time is available early in the day, but it is the preference of the surgeon not to do the procedure in the available time slot, the procedure will be given a lesser priority and shall give way to other cases on the add-on list which are ready for immediate surgery; (b) If the next surgeon in line on the add-on list is called by the O.R. and does not respond within 30 minutes, the next surgeon in line will be notified to start; (c) If a surgeon believes his/her case to be more emergent than add-on cases ahead of him/her on the list, then he/she may

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elect to bump the schedule, providing he/she notifies the affected surgeon. Should conflict continue, the Department Chair is notified to mediate the conflict. (If the Department Chair is not available then the Vice-Chair will be notified).

- C. Surgeons may not overbook their scheduled block time.
- D. Block time for eligible surgeons will be available upon request through Perioperative Services. All requests will be approved by the Department Chair.
- E. Surgeons who expect to be tardy must communicate by telephone with the Director of Surgical Services or designee.
- F. The Department of Anesthesia will designate the Anesthesiology Director of the Day. Anesthesia Director of the Day shall have the responsibility for efficient utilization of the OR schedule in conjunction with the OR charge nurse and shall be empowered to postpone cases if the operating surgeon is more than thirty (30) minutes late
- G. Physicians that are chronically late (i.e., greater than 10% of their cases are late or delays average 30 minutes or more) and have not followed the guidelines for communication outlined above, will be reviewed by the Chair of the Department of Surgery on a monthly basis. If the Chair determines that there are no extenuating circumstances, then restrictions to scheduling privileges will be imposed to include loss of first-case scheduling privilege and/or reduction of block time and will be reported to the Medical Staff Office for purposes of on-going Physician Performance Review.
- H. The elective surgery schedule can begin promptly at 7:00 AM, with sufficient rooms running to meet the demands of the operating schedule. Two (2) cases are considered sufficient to open one (1) room that day. All intravenous or arterial monitoring lines will be placed by the anesthesiologist responsible for the case early enough so that Anesthesia will begin with the surgeon present 15 minutes prior to start time, so the incision can be made promptly at start time. After 5:00 PM, the anesthesiologist on call will continue unless according to the emergency a second room must be opened. In the event that a second room is required, the case circumstance will be reviewed and a determination will be made as to its true urgency by the Department Chair. If it is determined that the case was not urgent, the Chair will review and forward to the Department of Surgery his recommendations. The operating schedule will be given priority over the surgeon's convenience, unless both can be accomplished under mutual agreement.
- I. The elective surgery schedule can begin at 7:00AM each working day and continue until all cases are completed.
- J. After 5:00 PM, the on call anesthesiologist will assume responsibility for emergency cases in order according to seriousness of the cases. A second anesthesiologist and nursing staff will be on call.
- K. Elective surgery is scheduled on a first-come, first-serve basis. Elective/Urgent cases should be completed by 11:00 pm. After 11:00 pm there is one team on duty to accommodate urgent and emergent cases only.
 - Elective: Any procedure scheduled in advance while the patient is not in the hospital.
 - Urgent: Any procedure on an inpatient with indications for surgery that must be done before the patient can be discharged.
 - Emergent: Any procedure with immediate threat to life, limb, or irreversible harm to organ or body function.

- L. Organ Donor Cases
- Brain Death will be scheduled as an add on
 - Cardiac Death will be scheduled as an emergency when case is ready to go
 - Organ Donation Representative will notify any changes to the Operating Room Charge Nurse ASAP when case is scheduled

SECTION VIII. REQUIREMENTS FOR SURGICAL ASSISTANTS

- A. The First Assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The First Assistant provides aid in exposure; homeostasis and other technical functions, which help the surgeon carry out a safe operation and optimal results for the patient.
- B. The following procedures require a surgeon assistant from the same or related specialty:
1. Cardiac Surgery (per title 22 regulations)
 2. Elective intra-thoracic and intra-abdominal vascular cases:
Thoracic Aneurysms
Porta Systemic Shunt (excluding portocaval and mesocaval shunt)
Thoraco-Abdominal Aneurysm
Complex Aortic Reconstruction
 3. Partial or complete Pancreaticoduodenectomy (Whipple Procedure)

SECTION IX. CHART REQUIREMENTS

- A. History and Physical (Surgical and Moderate or Deep Sedation)

There must be a complete H&P work-up on the chart of every patient prior to surgery before anesthesia begins, except in emergencies. If this has been dictated, but not yet recorded in the patients chart, there must be a hand written updated history and physical in the chart prior to performing surgery on the patient

In emergencies, the practitioner shall make a note regarding the patient's condition prior to surgery.

An H&P performed within thirty (30) days prior to the surgery is acceptable if: Patient for whom moderate or deep sedation contemplated (any procedure deemed high risk) receives a pre-sedation or pre-anesthesia assessment within the twenty-four (24) time frame prior to surgery. The patient must be re-evaluated and examined immediately before moderate or deep sedation use of anesthesia induction for all outpatient surgeries and any inpatient for whom the H&P was completed prior to admission and the patient was moved to surgery without an update or admit note by the physician.

- B. The dictated history and physical examination, or a handwritten history and physical examination, as well as all appropriate lab data, must be in the chart before the patient is taken to the operating room in regularly scheduled cases.
- C. In emergency cases, a written history and physical examination must be present in lieu of a dictated history and physical examination, as well as appropriate lab data available before anesthesia is started. It is understood that certain cases will be of such urgent nature that the surgeon will have to proceed without

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a proper chart for life-saving reasons. The determination to proceed will be the judgment of both the surgeon and anesthesiologist.

- D. Pre-operative screening tests will be as follows:
1. An interval medical history and physical examination performed and recorded within the previous 24 hours.
 2. Screening tests are at the discretion of the surgeon and based on the need of the patient.
- E. Perioperative laboratory work must be performed within 7 days of the date of surgery.
- F. EKG's may be performed within one (1) month of the date of surgery, if patient is 55 or over or has a history of cardio vascular disease.
- G. Chest films may be performed within six (6) months of the date of surgery if patient is 55 or over or pulmonary disease history.

SECTION X. OPERATING ROOM ATTIRE

- A. Proper operating room shirts and pants will be used at all times in the operating theater. Masks and caps will be required at all times within the operating rooms. Physicians with beards and/or long hair will be required to use the full head cap rather than the regular surgical caps. Shoe covers are optional and worn to protect the shoes.
- B. When a person in proper operating room attire leaves the surgical theater and returns, he/she is required to change his/her surgical cap and mask before re-entering the operating theater.
- C. If a surgeon, nurse or technician is involved in an infected case, he/she will change their entire operating room attire before beginning another case.
- D. Headgear: Proper headgear includes bouffant, hood and surgeons caps, all worn pulled down to cover hair from the front of the scalp, over the ear and the nape of the neck. Non-compliance by the Medical Staff shall be reported to the section Chief, Department Chair, or Vice Chair who will be responsible to ensure compliance after appropriate notification and discussion, appropriate action shall be taken by the Department of Surgery Chair.

SECTION XI. PRE AND POST-OPERATIVE HOLDING AREAS

- A. Pre and post-operative care holding areas shall be the responsibility of anesthesia. Prior to beginning a case, the anesthesiologist will have an opportunity and a responsibility to review the patient's chart for critical pre-operative tests, examine the patient and make a final determination that the patient is indeed ready for anesthesia.
- B. Following the surgical effort, the anesthesiologist will remain with the patient in the recovery area until that patient is stable and can readily be cared for by the nursing staff in attendance at that time. The surgeon should also stay with the patient until he feels the patient is stable.
- C. The attending anesthesiologist will be responsible for discharging patients from the Recovery Room. He/she will either see the patient or the patient must meet the departmental approval protocol for

discharge from the Recovery Room regarding the patient's cardiovascular and respiratory stability, as well as mental status.

SECTION XII. OUTPATIENT SURGERY

- A. Desert Regional Medical Center outpatient surgery patients will be handled in a routine fashion and be assigned an operating room according to caseload for the day. More than one room will almost certainly be required in the management of these cases. The Chair of the Department will institute steps of correction.

SECTION XIII. GENERAL

- A. CHANGE OVER TIMES: Change over times between surgical cases greater than 30 minutes shall be reported to the operating room manager by the operating surgeon. Change over time begins when one patient leaves the operating room and ends when the next patient enters that same room. Each case will be reviewed and explained in writing to the Chair of the Department of Surgery. The Operating room manager will be responsible for these reports. The reports may then be discussed at the next scheduled Surgery Advisory Committee meeting and steps will be taken to correct the problems which led to the delays.
- B. PATHOLOGY: Pathological consultation and/or frozen section analysis will be regularly provided in the operating rooms during the working hours 7:30 AM to 5:00 PM or later if arrangements are made with the pathologist on call.
- C. VISITORS IN THE OPERATING ROOMS: Visitors in the operating rooms should be limited to persons directly related to the surgical procedure or observers acting within the bounds of teaching. Any others must have specific permission from the operating surgeon, anesthesiologist, the nursing director of the operating room, and the patient.
- D. PHOTOGRAPHY: Photography in the operating rooms will be permitted during surgical procedures being performed by surgeons who are being monitored for surgical technique. It will also be allowed with the written consent of the patient at the discretion of the operating surgeon.
- E. INFECTION CONTROL: Persons with known upper respiratory or skin infections on the hands or arms will not be allowed to scrub or circulate in surgery. Quarterly reports on infections occurring following surgical procedures will be monitored by the Infection Control Committee and correlation's with specific rooms, surgeons and technicians will be made and reported to the Surgery Department.
- F. RADIOLOGY IN SURGERY: Competent radiological technicians will be constantly available in the operating rooms for appropriate films that may be required during certain surgical procedures. They will have properly maintained and charged equipment and will be specifically trained and licensed to perform these procedures.
- G. CONSENT FORMS: Each patient having an elective surgical procedure will have a hospital prescribed consent form in the chart signed by the patient, guardian or parent, if patient is a minor. In case of emergency where life is threatened, a written note by the surgeon in the progress notes shall suffice. Consent forms cannot be signed after pre-operative medication has been given. The consent will be witnessed by a nurse who will sign the permit as such. The physician may also be witness to the written consent. The consent will indicate which side is to be operated and the exact procedure which will be performed.


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- H. NEW PROCEDURES: Accepted procedures not previously performed in the hospital by a physician in the hospital shall be permitted by the Chair of the Department of Surgery only after proof of training in the performance of such procedure by the physician. This training can be in residency or through designated and accepted hands-on courses offered by experts in the field. Investigational procedures shall be approved by the Institutional Review board.
- I. LEAVE OF ABSENCE: Leave of absence may be granted in accordance with the Desert Regional Medical Center Medical Staff Bylaws.
- J. INCORRECT INSTRUMENT COUNT: When all counts have been completed and the missing item has not been located, the operating surgeon is informed of the discrepancy count. A portable x-ray of the operative site should be taken before the patient leaves the Operating Room.
 - 1. The x-ray may be postponed if, in the medical judgment of the surgeon or anesthesiologist, further delay in completion of the surgery is inadvisable. The Surgeon will document his/her rationale for postponing the x-ray in the medical record.
 - 2. If the missing item has not been located before the patient leaves the Operating Room, the final count must be signed as incorrect by the circulator. A note shall be made on the operative record and a Quality Improvement Screen is written. (Reference Nursing Administrative Policy: Sponge, Needle and Instrument Count)

SECTION XIV. AMENDMENTS

- A. These Rules and Regulations may be amended by a majority vote of the active members of the department by either mailed written ballot or at a regular meeting of the Department at which at least 20% of the active members of the Department are present.

APPROVED:



 Chair, Department of Surgery
 Desert Regional Medical Center

10/3/11

 Date

Approved:	Revised:	Revised:	Revised:	Revised:
Dept: 3/10/97	10/03	Dept: 03/05	Dept: 9/05	Dept: 3/06
MEC: 4/7/97	11/03	MEC: 04/05	MEC: 10/05	MEC: 4/06
		GB: 04/05	GB: 10/05	GB: 4/06
Revised:	Revised:	Revised:	Revised:	Revised:
Dept: 3/08	09/08	Dept: 2/09	Dept: 5/10	05/11
MEC: 4/08	10/08	MEC: 3/09	MEC: 6/10	06/11
GB: 4/08	10/08	GB: 3/09	GB: 6/10	06/11
Revised:				
Dept: 8/11				
MEC: 9/11				
GB: 9/11				

GENERAL GUIDELINES FOR
GRANTING SURGICAL PRIVILEGES

1. A new applicant seeking surgical privileges at DRMC must have satisfactorily completed an accredited surgical residency and/or fellowship specialty training program and at the time of application must be Board Certified or eligible to take the Board Certification examination in his/her specialty. If the applicant is not Board Certified at the time privileges are granted, the applicant must become Board Certified within forty-eight (48) months of appointment to the DRMC staff.
2. Except for those procedures for which the Department of Surgery has determined that special training or experience is necessary in order to ensure a high quality of medical care, the granting of "core" privileges within a specialty (including subspecialties) includes all procedures that are considered by the Surgical Committee to be routinely included in any accredited ACGME (Accreditation Council for Graduate Medical Education) or Canadian residency or fellowship training program. Procedures determined to require special training or documented experience are listed by specialty with the privilege requirements.
3. If the applicant is applying for privileges immediately following completion of residency/fellowship, the applicant is required to submit a supporting letter from his/her training chief, and/or a letter from his/her residency/fellowship training facility documenting the nature of the training and the applicant's professional competency. Based on these letters, "core" privileges within the specialty will be considered.
4. If less than five (5) years has elapsed since completion of residency or fellowship training, the applicant must submit a supporting letter from his/her training chief, plus a similar letter from all hospitals currently associated and four (4) letters of support from current surgical colleagues who, in the opinion of the applicant, are best able to judge his/her professional competence. These letters should substantiate the professional skills of the applicant relative to the privileges being requested. In addition, the applicant must submit a listing, by procedure and date performed, of all surgical procedures performed in the past two (2) years. In-depth documentation of twenty (20) of these cases must be submitted to include the admitting history and physical examination, operative report and discharge summary. The 20 cases should be selected by the applicant to demonstrate a representative cross section of the privileges requested. Based on the above, "core" privileges will be considered.
5. It is the feeling of the Department that if five (5) years or more has elapsed since completion of residency or fellowship training, the applicant should have attained the status of Board Certified in his specialty and this will be a consideration in the granting of privileges. In addition, the applicant must submit documentation as described in #4.
6. All new applicants must have a personal interview with, Department of Surgery Chair and Section Chief prior to a recommendation for surgical privileges.
7. In order to obtain additional privileges, a practitioner must make written application, state the type of clinical privileges desired, and present evidence of pertinent training and experience. A minimum of three (3) consecutive cases will be proctored.
8. All privileges to perform "new" procedures, i.e. surgical advance in a specialty field, must be approved by the, Department of Surgery Chair. In recommending approval, the Chair will consider the currently demonstrated surgical skills, abilities and judgment of the applicant. The applicant must support his request with documentation of adequate recent training or experience to the Chair's satisfaction.
9. All surgical privileges require the approval of the Department Chair, Medical Executive Committee and the Governing Board or its designee.